FINAL VERSION 18.11.2015

BOLTON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

SUBJECT: ADULT A

DATE OF DEATH: 4th JUNE 2012

INDEPENDENT AUTHOR: DAVID MELLOR QPM

CONTENTS **PAGE**

SECTION 1 – BACKGROUND TO THE CASE

1. INTRODUCTION

Following the discovery of Adult A's body at her home address on 4th June 2012, a referral was made to BeSafe, Bolton's Community Safety Partnership which concluded that a domestic homicide review (DHR) should be undertaken.

This decision was notified to the Home Office on 27th July 2012 and a panel of senior officers from local agencies was formed to scope the key lines of enquiry and oversee the review. David Mellor was appointed as Independent Chair and Author in line with Home Office guidance. He has no connection with Bolton or any agency which contributed to this Domestic Homicide Review. He served for thirty years in a number of UK police forces including Greater Manchester Police. However he left Greater Manchester Police in 1999 and never served as a police officer in Bolton or Salford.

A DHR overview report was duly completed and submitted to Bolton Community Safety partnership which decided not to publish the report on the grounds that publication might harm the children of Adult A. Bolton Community Safety Partnership has made a commitment to provide copies of the unpublished DHR overview report to the children of Adult A at an appropriate time.

Bolton Community Safety Partnership decided to publish this DHR executive summary subject to references to the children of Adult A being reduced to the absolute minimum.

All of the agencies represented on Bolton Community Safety Partnership wish to express their sincere condolences to the family and friends of Adult A.

2 FAMILY COMPOSITION

The table below shows the composition of the key family members referred to in the case. These have been anonymised for the purposes of the DHR in line with statutory guidance. Only limited information is given here about Adult A's children. The children are generally referred to as Adult A's children throughout the report. For clarity, Adult B was the father of all of Adult A's children.

Family Member Known As	Relationship to Subject
Adult A	Subject (date of death 04.06.2012)
Adult B	Former partner of Adult A
Adult C	Associate of the family referred to as "Uncle"
Adult D	Sister of Adult A, maternal aunt of Adult A's children and Special Guardian for Adult A's children with the exception of Adult A's youngest child.
Adult E	Husband of Adult D, maternal uncle of Adult A's children and Special Guardian in the same circumstances as Adult D.
Adult F	Mother of Adult A and D, Grandmother of Adult A's children. Held a Residence Order in respect of Adult A's children until her death in 2010. Her death preceded the birth of Adult A's youngest child.

3. THE INCIDENT

3.1 On Monday 4th June 2012 the body of Adult A was found at her home address. One of her children was with her. The child was physically unharmed. Adult A had sustained multiple stab wounds to her neck.

3.2 Adult A's former partner Adult B had been released from prison on Friday 1st June 2012 to no fixed address. Later that day he made contact with Adult A and went out with her socially in the evening. During that evening it is understood that Adult B argued with Adult A and accused her of having been unfaithful to him whilst he was in prison. He is alleged to have threatened to "chop her up" if he found she had been with anyone else. He apparently spent that night at Adult A's home address.

3.3 The following day – Saturday 2nd June – Adult B remained in Adult A's company. During the day one of her children was brought to Adult A's home to stay with her for a couple of nights. The child heard Adult A and B arguing after she went to bed for the night.

3.4 When she woke on the morning of Sunday 3rd June, the child found Adult A's body on the settee. Adult B had apparently left the address. The child remained with her mother's body until Adult C arrived to collect her the following day – Monday 4th June. An ambulance was called but Adult A had died.

3.5 It would appear that Adult A died either during the late evening of Saturday 2nd June or during the early hours of Sunday 3rd June 2012. Since this Review has not received definitive information on the date of Adult A's death, it has been decided to state the date of death as 4th June 2012 for the purposes of this Review, as this was the date her body was discovered and life declared extinct by a medical practitioner.

4. CRIMINAL INVESTIGATION AND PROCEEDINGS

4.1 Adult B was arrested and subsequently charged with the murder of Adult A. The first trial of Adult B in February 2013 ended with the jury unable to agree a verdict. He was remanded in custody to await a second trial which resulted in Adult B being found guilty of murder. On 17th September 2013 he was sentenced to life imprisonment with a recommendation that he serve a minimum of 22 years.

4.**2** Following the conclusion of the second criminal trial, the Coroner decided not to hold an Inquest into the death of Adult A.

SECTION 2 – DOMESTIC HOMICIDE REVIEW PROCESS

5. DOMESTIC HOMICIDE REVIEW GUIDANCE

5.1 This Domestic Homicide Review was conducted under guidance contained in Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004).

5.2 The guidance states "Domestic Homicide reviews are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate".

5.3 The purpose of a Domestic Homicide Review (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
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

5.4 Review Panel Members

David Mellor	Independent Chair and Author
Head of Service – Child Protection	Children's Social Care, Bolton Council
Associate Director	Bolton NHS Foundation Trust
Director	Fortalice – a charity to assist women and children affected by domestic violence
Project Manager	Paws For Kids – a charity to support women, children and their pets escape violence and

	abuse
Assistant Chief Executive	Greater Manchester Probation Trust (Bolton)
Assistant Chief Executive	Greater Manchester Probation Trust (Salford)
Detective Inspector	Greater Manchester Police
Branch Crown Prosecutor	Crown Prosecution Service
Deputy Governor	HMP Haverigg
Commissioning Manager, Substance Misuse and Targeted Prevention	Bolton Council
Strategy and Commissioning Manager	Bolton Council
Group Manager	Bolton Community Housing
In Attendance: Neighbourhood Crime and Justice Co-ordinator, Bolton Council Domestic Abuse Coordinator, Bolton Council	 Bolton Council Bolton Council

5.5 Review Panel Meetings

The Review Panel met on six occasions as follows:

25th July 2012

16th October 2012

13th November 2012

19th December 2012

15th January 2013

11th October 2013

6. SCOPE AND TERMS OF REFERENCE

6.1 The first meeting of the DHR Panel took place on 25th July 2012. It was agreed at that meeting that the relevant time frame of the review would be from 1st August 2006 when Adult A was pregnant and a number of incidents of domestic violence were reported against her, until 4th June 2012, the date on which Adult A's body was discovered (in total a period of 5 years and 10 months).

6.2 The Panel agreed that Individual Management Reports, Summary Reports and any other supporting documentation should be confined to this time period.

6.3 The Panel agreed terms of reference, and these are set out below in paragraph 6.5

6.4 The initial target date for completing the review was set as 27th January 2013. However it was noted that the progress of the criminal proceedings would affect the panel's ability to finalise its work by this date. In particular after consultation with the Senior Investigating Officer it became clear that no attempt could be made to seek family involvement until after the criminal proceedings had concluded. Subsequently the Chair of Bolton Community Safety Partnership agreed to extend the completion date for the review to 30th April 2013 and the Home Office was notified. Following the failure of the jury in the criminal trial to reach a verdict and the scheduling of a second trial to commence on 9th September 2013, the Chair of the Community Safety Partnership agreed to further extend the deadline for completion until 30th November 2013. This deadline was further extended to 31st January 2014 to enable meaningful contact with the family and friends of Adult A to be achieved.

6.5 Specific Terms of Reference

a. Whether Multi Agency Public Protection Arrangements (MAPPA) were effectively applied to the perpetrator. Specifically whether information was shared comprehensively, whether the risks posed by the perpetrator were fully assessed and whether a robust action plan was implemented.

b. Whether the risks posed by the perpetrator on his release from prison in June 2012 were effectively assessed and managed.

c. Whether the wide range of agencies which provided services to the perpetrator over many years took appropriate action to challenge his aggressive and violent behaviour and appropriately share information about the risks he posed.

d. Whether Adult A and her children could have been referred to the Multi Agency Risk Assessment Conferences (MARAC) and whether there were any obstacles which prevented such a referral.

e. Whether local professionals and agencies recognised the extent of the risks to Adult A, shared information and worked together effectively to safeguard her and her children.

f. Whether Children's Social Care recognised the extent of, and shared information about, the risks to Adult A, given their involvement in safeguarding her children.

g. Whether the risk of serious harm to one of Adult A's children arising from contact between Adult A and the child at the time of Adult A's death could have been prevented. Specifically whether the need to share information with persons with parental responsibility for the child was fully recognised and acted upon.

h. Whether previous incidents of domestic violence against Adult A were properly responded to and robust attempts made to prosecute the cases.

i. Whether the wide range of agencies which provided support to Adult A over many years fully recognised the vulnerability of Adult A as a victim of domestic violence and took appropriate action to safeguard her and her children.

j. Whether there are any equality and diversity issues that have impacted on the safeguarding of Adult A and her children.

6.6 Bolton Local Safeguarding Children Board considered conducting a Serious Case Review as the result of one of Adult A's children being exposed to serious harm by being present in her mother's home when she was killed and then being alone with her mother's body for 36 hours. However, the Board decided that the criteria for conducting a Serious Case Review had not been met.

6.7 The following documentation was used in the Review:

- Individual Management Reports from the following agencies:
  - Addictions Dependencies Solutions (ADS) Bolton
  - Bolton NHS Foundation Trust
  - Bolton Probation Service
  - Children's Social Care
  - Contour Homes – a registered social landlord
  - Crown Prosecution Service
  - Fortalice
  - Greater Manchester Police
  - Greater Manchester West Mental Health Foundation Trust (GMW MHT)
  - General Practitioner Services
  - National Offender Management Services (HMP Haverigg)
  - Salford Probation
  - Urban Outreach - a charity which works with disadvantaged and vulnerable people in Bolton
  - Victim Support
- Summary Reports from the following agencies:
  - Arch Initiatives – Advice, Rehabilitation, Counselling and Health – an organisation which seeks to enable recovery from substance misuse
  - Bolton at Home – social housing provider which owns homes formerly owned by Bolton Council
  - CAFCASS (Children and Family Court Advisory and Support Service) It is worthy of note that CAFCASS has no statutory obligation to participate in a DHR.
  - East Lancashire's Women's Refuge Association

- Windsor Drop-In – provides a service for homeless and destitute people in Salford

- The Parole Board was afforded the opportunity to comment on, or contribute to, the DHR but declined on the basis that it was operating as a Court when it considered the release of Adult B from prison and it is not appropriate for a Court to explain its decisions other than to give reasons for its decisions at the time of taking those decisions.
- Home Office Guidance on the Conduct of Domestic Homicide Reviews
- Policy documents including the Bolton Be Safe draft Domestic Homicide Review policy, Service Level Agreement between the Police and Crown Prosecution Service on the handling of Domestic Violence cases and a number of Police Risk Assessment documents
- A multi-agency integrated chronology was produced that provided a sequential record of agency involvement.
- Supporting research and information on domestic violence (as cited in the body of the report and recorded below in paragraph 10)

6.8 The Panel wishes to thank the independent agency Advocacy After Fatal Domestic Abuse (AAFDA) for invaluable assistance in engaging with the family of Adult A. Once the criminal trials had been concluded Adult D played a full and constructive part in the DHR. Adult C also contributed. The perpetrator Adult B was asked if he wished to contribute to the review via his offender manager at Manchester Prison. Adult B expressed a wish to contribute and a meeting was arranged with him at Manchester Prison on 13th December 2013 which he cancelled at the last minute stating that he was unwell. Adult B subsequently advised his offender manager that he did not wish to contribute to the DHR.

6.9 Almost all IMRs and Summary reports were completed to at least a satisfactory standard. Some of the IMRs were completed to an excellent standard and generally IMR authors adopted a searching approach and demonstrated a willingness to challenge the performance of their own agencies. Only one agency – the Crown Prosecution Service - did not complete an IMR to a satisfactory standard nor fully engage with this Domestic Homicide Review which the Panel finds extremely disappointing.

SECTION 3 – THE CASE

7. SYNOPSIS OF THE CASE

7.1 The Domestic Homicide Review covers the period from 1st August 2006 until 4th June 2012.

7.2 Adult A and Adult B had been a couple since their teenage years. Both had a long history of chaotic drug and alcohol misuse and neither had meaningfully engaged to address the presenting issues. Adult A also suffered with epilepsy, which was at times unsatisfactorily controlled through a lack of compliance with medication, chronic sleep difficulties and problems with mood and anxiety.

7.3 Adult B has a long history of offending dating back over twenty years with a pattern of acquisitive offending linked to his substance misuse and also convictions for violent offences. He has spent much of his adult life in prison custody.

2006

7.4 Adult A became pregnant. During this pregnancy key concerns remained over the use of illicit substances, lack of engagement with services and domestic violence inflicted by Adult B on Adult A.

7.5 During August and September the police were twice called to reports of domestic violence in which it was believed that Adult B had assaulted Adult A. On both occasions no visible injuries were noted and Adult A denied that anything untoward had occurred, although her denials were in the presence of Adult B. Police officers observed that Adult A was pregnant and "grave concerns" about the welfare of the unborn child were shared with partner agencies.

7.6 Children's Social Care carried out a core assessment in respect of the unborn child and concluded that the child would need to be safeguarded by instigating care proceedings whilst continuing to engage with Adult A and B as parents.

7.7 Adult B was imprisoned on remand from late September until shortly before the birth of Adult A's child later in the year. (Adult B's imprisonment was unconnected to domestic

violence.) Two days after the birth an interim care order was obtained and the child was placed in foster care.

7.8 The police were again called to the address shared by Adult A and B on 14th December. Adult A was at the premises to remove her belongings as the couple appeared to be splitting up. There was no evidence of violence although there had been an argument during which Adult B had accused Adult A of sleeping with another man whilst he had recently been in prison.

2007

7.9 Efforts to continue engagement with Adult A and B following the birth of the child proved unsuccessful and the child was moved to the care of Adult F during the year and a Residence Order and Supervision Order were made.

7.10 On 1st February Adult A called the police to say that she was waiting at a neighbour's home after Adult B repeatedly assaulted her, forced her to remove her clothes and get into a bath of cold water where the assault continued. When reporting the matter to the police, Adult A asked them to say that the matter had been rung through by a passer-by. Adult A had suffered black eyes and other facial injuries. It was noted by the police that the assaults had been preceded by an argument in which Adult B had accused Adult A of working as a prostitute. (Adult D states that this behaviour conformed to a pattern of violence perpetrated by Adult B in which he would send Adult A out to Shifnal Street to prostitute herself to pay for their drugs then beat her up when she came home for having gone through with it.) Adult B was arrested and charged with assault.

7.11 The police attempted to help Adult A obtain a place in a refuge but she was rejected by the refuge on the grounds that she was then on bail for a serious offence (Section 18 assault i.e. wounding with intent to do grievous bodily harm) and that there were concerns about her drug and alcohol use. (This charge was not domestic violence related.) The police then advised her to attend "homeless welfare".

7.12 In August the Crown Prosecution Service (CPS) were advised that Adult A wished to retract her complaint of domestic violence. A statement of retraction was subsequently obtained by the police in which Adult A stated that "no person has threatened or tried to

intimidate me.....I have been offered special measures at court but this will not change my mind".

7.13 On 17th September Adult B appeared at Bolton Crown Court in relation to the assault on Adult A. No evidence was offered and the case was dismissed.

7.14 In April Adult B had been arrested for serious offences unrelated to domestic violence and subsequently sentenced to a period of imprisonment from which he was not released until June 2009.

2008

7.15 Adult B continued serving his prison sentence whilst Adult A came into repeated conflict with her mother, Adult F, who was caring for Adult A's children. The police attended three incidents at the home of Adult F in which intense arguments took place between Adult A and her mother. On two occasions, Adult A's conduct led to her arrest for assaults. (Adult D confirms that there was violence in the relationship between Adult A and Adult F, but that Adult F would frequently perpetrate violence against Adult A. Adult D believes that agencies "gave Adult F the benefit of the doubt" when violent arguments took place between Adult F and Adult A, because Adult F had care of the children.)

2009

7.16 The conflict between Adult A and her mother continued and Adult A was arrested for two further assaults on Adult F in March and arrested again later the same month after twice telephoning Adult F in breach of her bail conditions. Adult A was not prosecuted for either assault as her mother subsequently retracted her complaints as by this time she was terminally ill and apparently wished to reconcile with Adult A.

7.17 Bolton Probation service notified the impending release of Adult B from prison to Children's Social Care who raised safeguarding concerns in respect of Adult A's children who were resident with Adult F and a referral to MARAC was made. Adults F and D were provided with personal alarms and the home of Adult F fitted with a fire retardant letter box.

7.18 Adult B was released to an address in Salford under the supervision of Salford Probation service. He declared himself a born again Christian and vowed to turn over a new leaf. He began attending the Windsor Drop-In in Salford for support and bible studies. The Drop-In was run by "Loaves and Fishes" a Christian organisation which provided support to people who had been released from prison.

7.19 Two months after Adult B's release – on 24th September - the ambulance service reported an assault on Adult A by Adult B. Adult A told the paramedic that, following a verbal argument with Adult B, he had punched her repeatedly in the stomach and ribs, head butted her on the nose, punched her in the face and dragged her along the floor.

7.20 However Adult A refused to confirm this information with the police and would only say "I don't want him to go back to prison. He's been dead good since he got out" (Adult A had also told the paramedic that she did not want to tell the police anything because she was scared).

7.21 Adult A had visible injuries consisting of a swollen and bleeding nose and marks on her neck and back.

7.22 When the matter was referred to the Crown Prosecution Service, they decided that there should be no further action in the case "due to insufficient evidence as the aggrieved person is unwilling to assist".

7.23 Following this incident there was contact between the Accident and Emergency staff at Salford Royal Infirmary – where Adult A had been taken by ambulance – and Bolton Children's Social Care. It is understood a MARAC referral was considered but no record remains of any referral or outcome.

2010

7.24 On 12th March both Adult A and Adult B became involved in a dispute with Adult B's neighbour in Salford which led to all three of them being arrested. The end result was that Adult B was charged with Section 18 assault (wounding with intent to do grievous bodily harm) on the neighbour who alleged that he had been hit over the head with a hammer.

7.25 Salford Probation recalled Adult B to prison on 12th April but he remained unlawfully at large until 6th May when the Police returned him to custody. On 6th December he was sentenced to two years imprisonment for the incident in which he had wounded his neighbour with a hammer. At the time he was sentenced, the Salford Probation Pre-Sentence author assessed the risk of serious harm he posed as medium instead of high, understated his propensity for domestic violence and made no contact with Bolton Children's Services as was required.

7.26 During the year Adult A's mother, Adult F, died. By this time Adult A's children were being cared for by Adult A's sister and her husband (Adult D and E). Adult D was subsequently granted a Special Guardianship Order in respect of the children.

7.27 Prior to Adult B's imprisonment, Adult A had become pregnant once more. The pre-birth core assessment identified concerns with Adult A's lifestyle, specifically her alcohol and substance misuse, which led to the decision to obtain an interim care order following the birth of this child, who was then placed in foster care.

2011

7.28 Significant concerns remained about Adult A's ability to parent the youngest child, in particular her lack of insight into the impact of her relationship with Adult B in terms of the risks his violent behaviour posed to her and the child. As a result there were serious doubts about her ability to protect the child, should she re-engage with Adult B following his release from prison.

7.29 Adult A maintained that she was not in relationship with Adult B, a position compromised by her frequent visits to him whilst in prison and in particular by her visit to him in May after she had been advised by the Circuit Judge dealing with the case of her youngest child that she should not engage in further visits.

7.30 On 2nd June Adult B was released from prison on licence and was seen by his Offender Manager. Adult B was arrested by the Police on 3rd June following an incident in the street in which he threw a brick at the window of a shop and threatened a witness with a street grid cover. He was charged with a public order offence and when he appeared before the Court on 6th June, the Probation Service recalled him to prison.

7.31 Following his recall to prison, Salford Probation raised their assessment of the risk of serious harm Adult B posed to the public from medium to high. This decision should have triggered an immediate re-allocation of his case to a Probation Officer as opposed to a Probation Service Officer, who are generally tasked with managing lower risk offenders and do not usually manage domestic abuse or safeguarding cases, but this did not happen until 9th December 2011. Additionally the raising of the risk assessment should have ensured that the case was placed on the Risk Administration Management Arrangements (RAMA) register and an initial RAMA meeting held. In the event the initial RAMA meeting was not scheduled for a further 8 months (27th February 2012) and then further delayed until 2nd April 2012.

7.32 The assessment carried out by Salford Probation following Adult B's recall to prison expressed concern that Adult B had committed a further offence on the day of his release having consumed alcohol, a known trigger for violent offending in his case. It was concluded that the risk presented by Adult B was not currently manageable in the community unless he addressed his behaviour through a number of specified interventions (See paragraph 8.19) and if suitable accommodation could be secured.

7.33 Following Adult B's recall to prison, Adult A began to engage with services more effectively and a decision was made to rehabilitate her youngest child to her care. But concerns remained that she had not emotionally detached herself from Adult B which were addressed in part by her writing to Adult B on 26th July to say that she would no longer be having any form of contact with him at that time or upon his release from prison. Bolton Children's Services requested the Prison Service to monitor contact between Adult A and Adult B. Adult B had been moved to HMP Haverigg on 19th July to serve out his sentence and this establishment monitored contact between Adult B and Adult A during the period from 30th January 2012 until 17th April 2012 and recorded no visits, written correspondence or telephone calls between them.

7.34 Adult A made and maintained significant lifestyle changes including vastly improved engagement with services. As a result her youngest child was rehabilitated to the care of Adult A in December with intensive multi-agency support.

2012

7.35 Consideration of how best to manage the risks posed by Adult B on his eventual release from prison had been under consideration by Salford Probation for a number of months. Adult B's "sentence expiry date" was 1st June 2012 at which time he would be eligible for release without any statutory supervision. Any decision on release prior to sentence expiry date rested with the Parole Board.

7.36 On 26th January the Ministry of Justice sought information from Salford Probation on behalf of the Parole Board giving a response date of 29th February. Although an Offender Assessment System assessment was initiated in response to this request for information, it was eventually abandoned as incomplete.

7.37 On 10th February Contour Homes – Adult A's housing provider - approved her transfer to a new address. She was afforded the highest priority for transfer on the grounds that she needed larger accommodation for herself and her youngest child and that she would be at risk of domestic violence from Adult B once he was released from prison. At the time of her death, Adult A was still awaiting transfer.

7.38 February also saw the rehabilitation of her youngest child to the care of Adult A beginning to fail through her diminished engagement with services and avoidance of professionals. The child was removed from Adult A's care in March and initially placed with Adult D prior to a foster placement in April.

7.39 On 2nd April the Parole Board considered the case of Adult B. Whilst they decided that there was benefit in him being supervised for a short period on licence before his sentence expiry date of 1st June 2012, no confirmed place in approved premises was available. As the Parole Board would only agree to release on the basis of a confirmed place in approved premises, they were unable to make any recommendation for release. Salford Probation had completed an approved premises referral on 28th February 2012. However, no record exists of the referral being sent to the mailbox of the Central Admissions Unit of Approved Premises, so the referral could not be progressed. Salford Probation finally submitted an approved premises referral on 21st May – 8 working days prior to Adult B's sentence end date.

7.40 2nd April was also the date on which the much delayed RAMA meeting was held by Salford Probation at which it was confirmed that Adult B continued to pose a high risk of serious harm to the public and of reoffending. Those considered most at risk from Adult B were males whom he believed to have threatened or wronged him in some way, although the risk of domestic violence was considered to be present and also safeguarding issues if Adult B was in any relationship. A number of actions were identified which included a check with the Central Admissions Unit of Approved Premises to find out where the approved premises referral was up to, work with Bolton Children's Services regarding his release and his relationship with Adult A and contact with Bolton Police Domestic Violence Unit "in view of Adult A's address." There is no evidence that any of these actions were carried out.

7.41 On 28th May HMP Haverigg made an appointment for Adult B with the Criminal Justice Intervention Team (CJIT) at the GMW MHT Bolton drug service for 2pm on Friday 1st June - the day of his release. This was confirmed by fax sent on 30th May which also stated that Adult B "does not have an address to go to and will rely upon friends to give him a roof over his head". Later in the fax it was stated that "he will require support on release to secure accommodation". The fax added that he hoped to regain contact with his children.

7.42 The police were notified of the release of Adult B by HMP Haverigg at 11.35 hours on Friday 1st June 2012 and an intelligence report was created and circulated to the effect that Adult B had been released that day with no licence and no known release address. Reference was made to his previous convictions. HMP Haverigg released Adult B at 08:43 hours the same day.

7.43 Adult A appeared to have three contacts with her GP during 1st June. On her first visit in the morning she complained of being very low in mood and not sleeping well. She said she wished to start a course of antidepressants. Her GP was concerned about the impact of antidepressants on her epilepsy and arranged to consult the epilepsy team prior to a further consultation with Adult A later in the day. Prior to this Adult A returned to the GP surgery to say that she had had a seizure and mentioned being "extremely stressed". Adult A was later contacted by her GP who prescribed antidepressants suitable for a person with epilepsy. Adult D has disclosed that her sister was "dreading" Adult B coming out of prison as he had allegedly warned Adult A with words to the effect that "you had better not let my child (the

youngest child) be taken into care". Adult C offers a slightly different perspective, stating that Adult B largely blamed Children's Social Care for the youngest child being removed from Adult A.

7.44 Later that day Adult B was seen by a CJIT drug worker from GMW MHT Bolton drug service who described him as "aggressive and abusive". He was sufficiently concerned about Adult B's behaviour to arrange for another worker to be present when Adult B attended his continuation of treatment appointment with a Doctor scheduled for 7th June.

7.45 No agency had further contact with Adult A or Adult B until the police were contacted by Ambulance Control at 12:56 hours on Monday 4th June (Diamond Jubilee bank holiday) to report that the body of Adult A had been discovered at her home address and that she had sustained stab wounds. Also present at the address was one of her children.

SECTION 4 – LEARNING AND ACTIONS

8. ANALYSIS

8.1 Each of the specific terms of reference of the Domestic Homicide Review will now be addressed in turn:

Whether Multi Agency Public Protection Arrangements (MAPPA) were effectively applied to the perpetrator. Specifically whether information was shared comprehensively, whether the risks posed by the perpetrator were fully assessed and whether a robust action plan was implemented. (Terms of Reference (a))

8.2 Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

8.3 There are three categories of MAPPA offenders:

Category 1 – Registered sexual offender;

Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and who has been sentenced to 12 months or more in custody; and

Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Schedule 15 of the Criminal Justice Act 2003.

8.4 There are three levels of MAPPA management which are determined according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at Level 1 (ordinary agency management). This involves the sharing of information but does not require multi-agency meetings. The others are managed

at Level 2 if an active multi-agency approach is required, and at Level 3 for cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the core MAPPA members.

8.5 Adult B was registered as a MAPPA Category 2, Level 1 offender when, on 6th December 2010, he was sentenced to 2 years imprisonment for a specified violent offence. At Level 1 ongoing active liaison between agencies is still required, but the case is not considered to need the additional resources and oversight dedicated to a level 2 or 3 case.

8.6 There is no record of Adult B ever having been subject to Level 2 or Level 3 management. During the period Adult B was registered as a MAPPA offender the lead agency was the Probation service. When Adult B was released from prison on his sentence expiry date of 1st June 2012 he became no longer a MAPPA eligible offender and was therefore not subject of management by any agency.

8.7 Salford Probation service takes the view that Adult B was managed at the appropriate level within MAPPA arrangements and this Review revealed no evidence to contradict this.

8.8 However, moving away from the specifics of the MAPPA process, the Probation service acknowledge that decisions taken about the risks posed by Adult B were sometimes flawed and led to unsatisfactory outcomes. For example the decision to reduce his risk of serious harm to medium in April 2009 meant that the case was removed from the RAMA register in June, around 2 weeks before he was released from custody. The implications of this were that when Adult B was released from custody on 17th June 2009, he was released as a Tier 3 prisoner. This was unfortunate. (Adult D takes the view that this was more than "unfortunate" and should be recognised as a mistake.)The result of this re-assessment was that when he was transferred to the Salford office on 13th July 2009, he was allocated to a Probation Service Officer as a medium risk of serious harm, Tier 3 case. The case was also no longer subject to regular management scrutiny. It is the view of the Salford probation IMR author that the additional risks associated with the relationship between Adult B and Adult A might have been explored more and therefore better understood if Adult B had been released as a Tier 4 case with a Probation Officer Offender Manager as opposed to a Probation Service Officer who as stated earlier do not normally manage cases in which domestic violence is present.

8.9 When Adult B committed an offence of Section 20 wounding, he was appropriately recalled to custody on 6th December 2010 but at this time the writer of the Probation Service Pre-Sentence Report assessed his risk of serious harm as medium. In the view of the Salford Probation IMR author this was incorrect because a two step model for assessment would clearly indicate that Adult B's risk was high. The first step - does the behaviour cross the threshold for serious harm? - is answered clearly in the affirmative as this was a serious assault. The second step - are there protective factors to be taken into account which mean that the risk is mitigated? – is clearly answered in the negative as the offence was committed whilst Adult B was on licence for a previous offence and under the supervision of the Probation Service. This indicated that legal sanctions were ineffective and that Adult B's compliance with supervision, and the work that has been carried out with him, had not impacted upon his capacity to commit offences including violence. This should then have led to an assessment of high risk of serious harm. The initial Offender Assessment System post-sentence would then have been undertaken by a Probation Officer and the expectations of liaison with colleagues in the prison establishment and elsewhere would have been higher. Also, the case would have been subject to regular management oversight via the RAMA process.

8.10 When the Probation Report for review of re-release was completed following Adult B's recall to prison in June 2011, the risk of serious harm was reviewed and correctly elevated to high on the basis that no controls on Adult B's behaviour were seen to be effective. The case was re-tiered to Tier 4 and at this point should have been allocated to a Probation Officer as a matter of routine. As stated in the synopsis this did not happen until 9th December 2011 and the case was not brought into the RAMA arrangements as soon as it should have been. If the case had been re-allocated in a timely way, it would have been brought into the RAMA arrangements much sooner and it is judged possible, even likely, that the issue of the approved premises bed could have been resolved in time for Adult B to be released early.

8.11 It is clear that there were occasions when the risks posed by Adult B were incorrectly assessed which prevented appropriate action being taken. And following his recall to prison in June 2011, despite the risks he posed being elevated, the expected actions were not then

triggered which contributed to the significant failure to secure an approved premises bed for Adult B which would have made early supervised release from prison possible.

Whether the risks posed by the perpetrator on his release from prison in June 2012 were effectively assessed and managed. (Terms of Reference (b))

8.12 Paragraphs 7.35, 7.36 and 7.39 – 7.42 set out how the risks posed by Adult B on his release from prison on 1st June 2012 were assessed and managed. Opportunities to obtain approved premises so that Adult B could be released with a measure of supervision prior to his sentence expiry date were not taken. Further actions necessary to manage the risks posed by Adult B were agreed at the meeting within Salford Probation on 2nd April but not implemented. As a result, Adult B's period of incarceration drifted to his sentence expiry date and he was released without any supervision to no fixed address. This was undoubtedly a significant failure. The National Offender Management Service (NOMS) was consulted on aspects of this DHR. (See Finding 6 and Recommendation 6) NOMS takes the view that a pre-release RAMA should have been held which would have revealed that the actions agreed on 2nd April had not been implemented.

8.13 It is instructive to contrast this failure with what happened when Adult B was released from prison in June 2009. Children's Services received a referral from Probation Services informing them of the impending release, accompanied by a synopsis of Adult B's previous offending behaviour and details of the license to be applied at the time of his release from custody. The referral provided a trigger for action by Children's Services within their duty to safeguard Adult A's children who at that time were resident with Adult F. A strategy meeting was convened which identified the need for target hardening to be provided to Adult F. A joint visit is recorded to the home address of Adult F by Children's Services and the Police. There was also a referral to MARAC.

8.14 As Adult B's sentence expiry date drifted ever closer those who were aware of the date of release did not appear to fully recognise that there was a problem which needed addressing. For example on 22nd May 2012 Adult B was scheduled to attend a video conference with his offender manager and his offender supervisor to discuss a release plan for his sentence expiry date. Adult B failed to attend and the IMR completed in respect of HMP Haverigg states that it was decided not to follow up on Adult B's non-attendance as his

sentence expiry date was so close and he was not being released under statutory licence, therefore no conditions would apply to his release. HMP Haverigg points out that they had no power to compel Adult B to attend the video conference and attempts to persuade him to comply were unlikely to be successful given Adult B's poor record of compliance with efforts to exercise supervision over him. However, given the fact that someone with Adult B's track record was being released to no known address, with no supervision and with minimal support, greater priority should have been given to following up on Adult B's non-attendance at the meeting

8.15 The IMR completed in respect of HMP Haverigg states that efforts were made by the prison offender management unit (OMU) to secure a release address for Adult B but it is not clear what these efforts consisted of. The IMR goes on to state that it was believed that Adult B would reside with a family member. It is unclear what the basis for this belief was. Adult D points out that Adult B went to stay with Adult C immediately after his release from HMP Haverigg. Adult C was known by Children's Social Care to provide substantial support for Adult A. Adult C describes himself as Adult A's carer as does Adult D. Adult D feels that agencies should have been aware that Adult B would be staying with Adult C after his release and would therefore be able to have direct contact with Adult A. In the fax sent to the CJIT at GMW MHT Bolton drug service on 30th May (see paragraph 7.41) it was stated that Adult B "will require support on release to secure accommodation". Although the fax was sent less than two working days prior to Adult B's sentence expiry date, I am advised that this period of time was sufficient to enable accommodation to be secured for Adult B. No information about any efforts to secure accommodation has been obtained.

Whether the wide range of agencies which provided services to the perpetrator over many years took appropriate action to challenge his aggressive and violent behaviour and appropriately share information about the risks he posed. (Terms of Reference (c))

8.16 None of the wide range of agencies involved with Adult B appeared to be in any doubt about his potential for aggressive and violent behaviour. For example when Magistrates granted an interim care order in respect of one of Adult A's children, the justification they gave for the decision included the view of the Probation Service that Adult B was "paranoid and potentially dangerous" and the Magistrates also noted his abusive and intimidating

behaviour towards staff. Many agencies took measures to protect their staff from him. For example following the birth of one of Adult A's children, post natal visits were carried out by 2 Midwives accompanied by 2 Police officers. In an assessment carried out by Children's Social Care in 2011, it was stated that "Adult B is still presenting as an extremely violent, volatile, unpredictable and dangerous man". On occasions when Children's Social Care attempted to engage with Adult B whilst in prison he refused to leave his cell and meet them and when not in custody he would not allow them access to his home.

8.17 However there may have been insufficient "forensic curiosity" about how this man who at times presented as difficult and aggressive, behaved in his closest relationship. Throughout most of the contact Salford Probation had with Adult B, the issue of the potential for serious harm in the form of domestic abuse on Adult A may have been insufficiently understood and was not explored with sufficient rigour. It may be that had the appropriate amount of attention been focussed on this issue, Salford Probation would have been confident to say whether or not there was a risk of serious harm being caused to Adult A.

8.18 It is unclear whether efforts to challenge Adult B's aggressive and violent behaviour were well co-ordinated by agencies. For example a drug worker reported that anger management issues were noted as an unresolved issue but that the availability of courses and support for this issue was (and still is) very limited within the community. The expectation of the worker was that prison would address this issue. Although Adult B engaged with a number of programmes during his long periods in prison, there is little evidence of his aggressive and violent behaviour being addressed other than through the prison disciplinary processes.

8.19 Indeed following Adult B's recall to prison in June 2011 (see paragraphs 7.30 to 7.32) Salford Probation recommended that before his release could be considered further intervention would be required to address his alcohol use, he would need to accept greater responsibility for his actions and develop insight into his own risk factors and his suitability assessed for either the CALM (Controlling Anger and Learning to Manage it) or COVAID (Controlling Violence for Angry, Impulsive Drinkers) programmes.

8.20 Adult B went on to complete PASRO (Prison Address Substance Related Offending) and engaged with the CARAT (Counselling, Assessment, Referral, Advice and Throughcare) but there is no evidence that his suitability for CALM or COVAID was assessed. Indeed it is the position of HMP Haverigg that it was unrealistic to expect Adult B to obtain places on these programmes given that the availability of places is greatly outstripped by demand. Evidence is also absent that Adult B was prepared to accept greater responsibility for his actions, indeed the HMP Haverigg IMR notes that on two occasions Adult B presented as very angry and unwilling to take responsibility for the actions which had resulted in his recall to prison.

8.21 Additionally, drug workers felt that an over reliance on self-reporting did not give a sufficiently accurate picture of Adult B's past suicide attempts, criminal history or risk to Adult A.

Whether Adult A and her children could have been referred to the Multi Agency Risk Assessment Conferences (MARAC) and whether there were any obstacles which prevented such a referral. (Terms of Reference (d))

8.22 Multi-Agency Risk Assessment Conferences (MARAC) were introduced in Greater Manchester in early 2006 and are non-statutory meetings at which information is shared on the highest risk domestic violence cases. After sharing information about a victim, those present discuss options for increasing their safety and generate an action plan. Bolton Domestic Violence Unit receives 8500 referrals annually and around 40 of the highest risk cases are referred to the MARAC each month.

8.23 There is no evidence that Adult A was ever subject of a MARAC referral as a victim. Attempts were made to make a MARAC referral following the assault on her by Adult B on 24th September 2009. Adult A was treated for her injuries at Salford Royal Infirmary and there is a record of the Accident and Emergency sister considering a MARAC referral although it is recorded that Adult A was unwilling to consent to this course of action. At that time MARAC was in its infancy in the acute hospital sector. Salford Royal was the first acute hospital in Greater Manchester to begin making MARAC referrals but at that time referrals were not made without the victim's consent. This is no longer the case and practitioners would now be supported to make referrals based on their professional judgement, whether

or not the victim consented. It is worthy of note that in September 2009 Salford Royal made contact with Bolton Children's Services and other agencies to ensure Adult A's children were safe.

8.24 Adult A's mother Adult F was referred to MARAC as a victim of domestic violence perpetrated by Adult A in March 2009 and Adult F together with Adult A's children were referred to MARAC in June 2009 because of concerns over the impending release from prison of Adult B.

8.25 The author of the Police IMR reviewed the opportunities the police had to refer Adult A to MARAC and concluded that a MARAC referral for Adult A could have been considered following incidents in August, September, October and December 2006 but that following the incident on 1st February 2007 (see paragraphs 7.10 – 7.11) Adult A should have been considered a high risk victim of domestic violence and that incident alone could have triggered a MARAC referral without taking into account the escalation of incidents in previous months which made the case for a MARAC referral even stronger.

8.26 The Police IMR author goes on to add that a MARAC referral would have been a consideration for the Police following the incident in September 2009 (see paragraphs 7.19 – 7.23) given the history of domestic violence although two and a half years had elapsed since the previous recorded domestic violence incident in February 2007. (Paragraph 8.23 suggests a MARAC referral was considered by Salford Royal Infirmary following this incident but there is no record of a referral or of any outcome.)

8.27 The author of the Children's Social Care IMR found records of at least ten discussions between professionals identifying differing levels of concern regarding Adult B's behaviour towards Adult A which might have triggered a MARAC referral.

8.28 There were a number of obstacles which may have prevented MARAC referrals in respect of Adult A. Firstly when reported incidents of domestic violence began to escalate in late 2006 the MARAC process had been implemented relatively recently meaning that staff awareness and confidence may not have been high. Secondly Adult B was incarcerated for 49 of the 64 months which elapsed following his assault on Adult A on 1st February 2007 and her death on 4th June 2012. He could not physically harm her whilst he was locked up.

When Adult B was not in custody domestic violence incidents were reported and injuries to Adult A were noted which could have been the result of assaults by Adult B but his long absences prevented any pattern of reported incidents taking place which would have signalled more clearly that Adult A was at risk. Thirdly Adult A's children were not generally resident with her which may explain why some agencies particularly Children's Social Care - whose focus was on safeguarding her children – did not make MARAC referrals.

8.29 A fourth obstacle was information sharing failures between partner agencies. For example in December 2009 Adult A made a disclosure to her Drug worker that Adult B had been violent to her before apparently moving out of the area to escape domestic violence for the next three months. The response of the Drug worker was limited to making enquiries about Adult A's welfare. Information was not even shared with Adult B's Drug worker despite the fact that Adult A and Adult B were accessing the same service in the same building and their records were recorded on the same data management system. Both victims and perpetrators of domestic violence are disproportionately affected by problematic substance use yet research suggests that many drug workers do not feel confident in addressing the needs of such clients. (1)

8.30 However the most significant information sharing failure was between Salford Probation and Bolton Children's Social Care in the weeks prior to Adult B's release from prison on 1st June 2012. Whilst Bolton Children's Social Care were entitled to expect Salford Probation to notify them of the release date of Adult B, when this did not happen they should have been more proactive in seeking this information out. Had they communicated with each other as they should have done, Children's Social Care would have become aware of Adult B's release date and been able to consider the extent to which he posed any threat to Adult A's children. Salford Probation would have been made aware of the letter Adult A had sent Adult B in July 2011 to end their relationship which may have inflamed the jealous possessiveness which had been a feature of earlier assaults on Adult A. It is possible that this sharing of information could have led to a referral to MARAC even though none of the children were living with Adult A by this point in time.

Whether local professionals and agencies recognised the extent of the risks to Adult A, shared information and worked together effectively to safeguard her and her children. (Terms of Reference (e))

8.31 There were numerous occasions when Adult A presented with injuries which she claimed had been caused by epileptic fits. Many - but not all - of these events corresponded with periods when Adult B was out of prison. However the view of the author of the General Practitioner IMR is that "it is likely that her injuries could have been accounted for by poorly controlled epilepsy". And it is clear that some injuries were the result of assaults perpetrated by persons other than Adult B. However It is worthy of note that Adult B claimed to his Probation Officer that the injuries sustained by Adult A in the September 2009 incident - in which Adult B subjected Adult A to a vicious assault – were the result of Adult A having a fit on leaving his property.

8.32 Whatever the cause of the injuries Adult A claimed to be the result of epileptic fits, agencies often did not explore these incidents fully. For example, during one attendance at Bolton Probation Office, Adult A had a number of injuries, which she stated were the result of an epileptic fit. She went on to state that this had occurred in the presence of her partner, who had the same forename as the Adult B - and is assumed to have been Adult B. Had service policy been adhered to and contact made with her GP or other partner agencies such as the Police Domestic Violence Unit, this may have raised the alarm regarding possible domestic violence issues. As this was not done, the opportunity was missed.

8.33 Bolton Probation also acknowledge an initial flaw in a Pre-Sentence assessment of Adult A in that Children's Social Care were not contacted in order to ascertain the Child Protection status of Adult A's children, although Adult A was identified as being a risk to them at that time. Had such contact been made, it may have been possible to gain information about any domestic violence issues at the time, despite Adult A maintaining that she was not in a relationship. Had such information been obtained, it would then have been possible to develop plans to ensure the safety of Adult A and her children. In addition, such information may have affected the grade of staff to which the case was allocated. As this information was not available, the responsibility for the management of the case was allocated to a Probation Service Officer, which as has been previously stated is a grade of

staff tasked with managing lower risk cases who would be less likely to identify evidence of domestic violence.

8.34 Unfortunately, throughout the course of Adult A's contact with Bolton Probation Office, the information recorded in respect of her was not properly reviewed and, as a result, the error in relation to Child Protection issues referred to in the previous paragraph was replicated throughout the course of the Order to which she was subject. It would appear that reviews of the original assessment were copied almost wholesale from the assessment initially completed at pre-sentence stage with little evidence that attempts were made to review or update information. As such, opportunities to review or check Child Protection arrangements or to examine Adult A's relationship status were lost.

8.35 The period during which Bolton Probation Office supervised Adult A was also punctuated by episodes of further offending, especially in the form of convictions for prostitution. It is possible that further investigation into the reasons for these offences may have provided evidence of domestic violence. Despite these offences, the frequency at which Adult A was required to report to her offender manager was relaxed and early revocation for good progress was both applied for and granted when Adult A gained a place at a drug rehabilitation centre. This indicates that practice in supervising Adult A was unsatisfactory. It would be expected that, should Adult A continue to offend, more frequent contact would be needed in order to address such offending, in conjunction with an updated sentence plan to meet offending needs and this may in turn have provided evidence of domestic violence issues.

Whether Children's Social Care recognised the extent of, and shared information about, the risks to Adult A, given their involvement in safeguarding her children. (Terms of Reference (f))

8.36 Clearly the priority for Children's Social Care was to safeguard the children of Adult A and Adult B. However in order to keep the children safe it was necessary to fully understand the risks to which they could be exposed. This was not always the case. For example the pre –birth core assessment in respect of Adult A's youngest child which was conducted in 2010 largely overlooked risk of domestic violence to Adult A. The author of the Children's Social Care IMR notes that at that time Adult B was "out of the picture once more" (serving a term

of imprisonment from May 2010 until June 2011) which may have been a contributing factor.

8.37 It is apparent that Children's Social Care shared the concerns of the Family Court Judge that rehabilitating her youngest child to the care of Adult A was a "high risk strategy" and that throughout the period preparing for and supporting the return of her youngest child to Adult A's care, safeguarding that child was the paramount concern, as one would expect it to be. Once the placement broke down in March 2012, the youngest child was properly removed and prompt action taken to place the child in foster care.

8.38 In their strong focus on safeguarding Adult A's youngest child, Children's Social Care appear to have largely lost sight of the risk of domestic violence to Adult A once the youngest child had been removed from her care. They were in possession of a key fact that during the care proceedings which resulted in the youngest child being returned to Adult A, she wrote to Adult B in prison to say that she would no longer be having any further contact with him at that time or upon his release from prison. There is conflicting evidence over whether this letter increased the risk to Adult A from Adult B or not. Prison service monitoring of contact between Adult A and Adult B suggests she followed through on her decision to end the relationship although the early contact with Adult B following his release from prison possibly undermines this. And the role of Adult C in facilitating contact between Adult A and Adult B may have undermined the impact of Adult A's letter. However jealousy on the part of Adult B appeared to be a key dynamic in the relationship which appeared to trigger violence on his part. Therefore the letter and the lack of visits from Adult A - who had previously been an assiduous visitor during Adult B's long periods of imprisonment - may have increased the risk that he would be violent to her on his release. There is no evidence that Children's Social Care either appreciated the risk that the sending of this letter might pose to Adult A on Adult B's release from prison or that the fact that the letter had been sent was shared with relevant partner agencies.

8.39 Additionally Children's Social Care's initial submission to the Domestic Homicide Panel and the Local Safeguarding Children Board Serious Case Review Consideration Panel stated that it was thought that Adult B had no knowledge of the address of Adult A as the time of his release from prison in June 2012 approached, and that she had been moved to a "safe

place". Although Contour Homes had approved Adult A's transfer to a new address partly on the grounds that she would be at risk of domestic violence from Adult B when he was released from prison, she was still awaiting transfer at the time of her death. (See Paragraph 7.37) Children's Social Care's assumption that Adult A had been moved to a "safe place" was based upon the fact that Adult A had written to Adult B to end the relationship in July 2011 and that he had never lived with her at the address in which she was residing at the time of his release from prison on 1st June 2012.

Whether the risk of serious harm to one of Adult A's children arising from contact between Adult A and the child at the time of Adult A's death could have been prevented. Specifically whether the need to share information with persons with parental responsibility for the child was fully recognised and acted upon. (Terms of Reference (g))

8.40 Paragraphs 3.3 and 3.4 briefly set out the ordeal experienced by one of Adult A's children who awoke on the morning of Sunday 3rd June 2012 to discover her mother's body and remained alone with the body until the arrival of Adult C the following day.

8.41 This child was cared for by her maternal aunt and uncle (Adult D and E). A Special Guardianship Order had been granted to Adult D in 2011 which gave her responsibility for caring for the child and for taking the decisions connected with her upbringing. She and Adult E made decisions over contact between the child and Adult A and Adult D has disclosed that at the time of Adult B's release she had been allowing the child to spend weekends with Adult A. Adult D has also disclosed that she would never have let the child go to her sister's house if she had known Adult B had been released from prison. However on Saturday 2nd June Adult D discovered by chance that Adult B had been released from prison. When Adult D challenged Adult A on the issue of Adult B's release, her sister reassured Adult D that Adult B would not go round to her house and cause trouble. Adult D reluctantly accepted her sister's assurance and allowed the child's stay with Adult A to continue.

8.42 Children's Social Care appear to have had complete confidence in the ability of Adult D and E to safeguard the child in considering contact arrangements with Adult A. Historically when Adult D and Adult E had expressed concerns for the child within contact with Adult A, then at that point contact had appropriately been stopped which evidenced their ability to

safeguard and to promote appropriate contact arrangements. Additionally Adult D was able to verbalise her dissatisfaction with Adult A over the breakdown of the attempt to rehabilitate Adult A's youngest child to her care and Adult D subsequently verbalised that Adult A would need to prove that she had made the necessary changes before any further contact would be allowed.

8.43 The Children's Social Care IMR states that there is no information detailed within Children's Services case files that notification of the impending release of Adult B from prison on 1st June 2012 was shared. This appears to be confirmed by the IMR submitted by Salford Probation (See Paragraph 7.40) which concludes that the actions resulting from the RAMA meeting to discuss Adult B on 2nd April 2012 were not implemented. These actions included making contact with Bolton Children's Services.

8.44 However the author of the Children's Social Care IMR goes on to state that there is no evidence to suggest that Children's Services contacted the Probation service to seek out such information. Given Adult A's youngest child was subject to, at that time, a full Care Order, the local authority had shared parental responsibility with Adult A and Adult B for this youngest child. As a Looked After Child, Adult A's youngest child would have been subject to the statutory monitoring of their welfare, placement and the local authority care planning within the protocols of Looked After Children's Statutory review.

8.45 At the time of Adult B's release, Adult A shared parental responsibility with Adult D and Adult E for her other children. Given that Children's Social Care had previously identified that Adult A did not recognise or accept the level of risk that Adult B presented, that she had previously sought to mislead Children's Services regarding the level of contact she had had with Adult B whilst in custody and given that the rehabilitation of her youngest child to her care had failed in part due to a recurrence of historical concerns regarding lack of engagement with professionals, Children's Social Care should have been more proactive in seeking out information about the date of Adult B's release from prison.

8.46 From the information provided in the IMRs there appears to have been some confusion over the release date for Adult B. Two agencies – Urban Outreach and Contour Homes -

appear to have been under the impression that the release date was 5th June 2012. It is possible that Adult C, who had maintained contact with Adult B whilst he was imprisoned in HMP Haverigg, may have been the source of this information. HMP Haverigg have re-checked the method by which the sentence expiry date was calculated and are adamant that the correct sentence expiry date was, and always had been, 1st June 2012. In any event there is no evidence that any agency communicated the date of Adult B's release from prison to Adult D or E or considered doing so.

8.47 In any event it appears that the ordeal suffered by the child who discovered the body of her mother could have been prevented. It is clear that both Salford Probation and Bolton Children's Social Care had a duty to communicate with each other as the release date for Adult B drew closer. There is no evidence to suggest that they did communicate with each other. Had they done so it seems extremely likely that the date of Adult B's release from prison would have been shared with Adult D and E. If this had been done it is reasonable to assume that they would not have agreed to the child being allowed to stay over with Adult A over the weekend immediately following Adult B's release from prison. Adult D has disclosed that she would not have allowed the child to stay with her mother on the weekend of Adult B's release from prison had she known the date of his release. Adult D has described the failure to inform her and her husband of the date of Adult B's release on 1st June 2012 as "ridiculous." She added that she had also not been informed of Adult B's short-lived release from prison in June 2011. Adult D's view is that as the person with parental rights over the children of a violent person, she should have been informed of the date of Adult B's release on both occasions. Adult D points out that the foster carer of Adult A's youngest child was informed of Adult B's release in June 2011 and advised to be vigilant.

Whether previous incidents of domestic violence against Adult A were properly responded to and robust attempts made to prosecute the cases. (Terms of Reference (h))

8.48 There were two occasions when the police arrested Adult B on suspicion of inflicting domestic violence on Adult A. The first incident took place on 1st February 2007 (see Paragraphs 7.10 – 7.13) and the second incident took place on 24th September 2009. (see Paragraphs 7.19 -7.23)

8.49 The Crown Prosecution Service made decisions in both of these cases but their files had been destroyed after three years in accordance with their policy. However the author of the CPS IMR has had access to the Police files in respect of these incidents and has been able to make observations which assist in addressing this term of reference.

Domestic violence incident on 1st February 2007

8.50 The author of the Police IMR takes the view that the prospects of a successful prosecution would have been enhanced by a more thorough approach to the gathering of forensic evidence. Adult A had apparently bled as a result of her injuries so forensic examination of the scene and Adult B's clothing could have been of value but unfortunately was not considered by the officer in the case.

8.51 After examining the Police files, the author of the CPS IMR notes that the case was prosecuted at the highest level charge merited by the evidence and taken to the Crown Court. When the CPS subsequently received information about a potential retraction from Adult A they requested enquiries by the Police who obtained a retraction statement from her. The CPS IMR author notes that there is no information about any risk assessment being carried out by the Police which the author says should have automatically accompanied the retraction statement in accordance with domestic violence policy. A Service Level Agreement (SLA) on the handling of domestic violence cases between the CPS and Greater Manchester Police states that the withdrawal statement should be forwarded by the Police to CPS accompanied by a "full assessment of the risks to the victim, any child and any other person's safety, and to include details of what support is available to the victim and whether it has been offered." The SLA shared with this Domestic Homicide Review was circulated to CPS staff in July 2007 which is six months after the incident in February 2007. So it is unclear whether the requirement for the Police to carry out a risk assessment was in force at the time of the incident and as the CPS file has been destroyed it is unclear whether or not any risk assessment was done. Had a risk assessment been conducted at that time it would have revealed that Adult B was once again in prison which might have made it more likely that CPS would have sought the issue of a witness summons to compel Adult A to give evidence in the case.

Domestic violence incident on 24th September 2009

8.52 Following this incident Adult B was arrested and the case was referred to CPS for a charging decision. The prosecutor concluded that the evidence was insufficient to charge Adult B on the grounds that Adult A would not support a prosecution, had not provided a statement, had given two different accounts for her injuries and would not allow her medical records to be accessed or photos taken of her injuries. The prosecutor considered whether a prosecution could be brought on the hearsay evidence of the paramedic to whom Adult A had disclosed that Adult B had "repeatedly punched her in the stomach and ribs, head butted her on the nose, punched her in the face and dragged her along the floor" (see Paragraph 7.19) but decided that given Adult A's comments to the police that account was undermined.

8.53 Clearly Adult A's unwillingness to assist the prosecution in any way was a major obstacle to charging Adult B but it is surprising that the opportunity to use the hearsay evidence of the paramedic is so categorically ruled out by the fact that the victim gave a different account to the police.

8.54 Both incidents were responded to positively but the first case might have had a stronger chance of success had a forensic examination of the scene taken place and a risk assessment been carried out at the time Adult A made a retraction statement. The second case was seriously undermined by Adult A's unwillingness to assist the prosecution case from the outset and the CPS decision to disregard hearsay evidence.

Whether the wide range of agencies which provided support to Adult A over many years fully recognised the vulnerability of Adult A as a victim of domestic violence and took appropriate action to safeguard her and her children. (Terms of Reference (j))

8.55 Following the incident of domestic abuse on 1st February 2007, the police sought a place in a refuge which declined to accept Adult A. The refuge conducts a risk assessment of all women referred to ensure the safety of all residents, staff and volunteers. Adult A was rejected on the grounds of her drug and alcohol misuse and the fact that she was on bail for a serious offence. The decision to reject Adult A was a defensible decision and entirely in accordance with the policy of the refuge. However it raises the question of refuge provision

for the victims of domestic violence whose behaviour poses risks to others which is further addressed in the findings.

8.56 Contour Homes regarded Adult A as a vulnerable resident and provided her with additional support as a result but were unaware of domestic violence as a potential risk until they received an email from Cafcass on 10th February 2012 which expressed concern about the risk posed by Adult B's impending release from prison and his knowledge of Adult A's address. The email went on to state that Adult A needed to be moved before Adult B's release from prison. Whilst this request was met by Contour prioritising her for a transfer (within their own stock), Contour Homes did not follow their own risk assessment policies once they became aware of the risk of domestic violence, omitting the completion of a vulnerability matrix and failing to make a referral to their internal Community Safety Team or work in conjunction with other appropriate agencies.

8.57 The domestic violence suffered by Adult A did not exist in isolation but was complicated by co-existing factors in her vulnerability such as her history of drugs and alcohol misuse, physical and mental ill health and her own aggressive behaviour at times. When considering Adult A's history of drug and alcohol misuse, it is worth noting that research suggests a strong association between experiencing domestic violence and using substances or drinking problematically. (2)

8.58 Some practitioners did not evidence good ability to see and assess risk to Adult A from perspectives other than hers, often taking their cue to an extent from Adult A's own attitude. For example practitioners did not 'read' the concerns from Children's services about Adult B's violent behaviour as evidence of risk to Adult A of domestic violence, rather they saw this as she did - an issue that placed in jeopardy her strongly expressed desire to have to her youngest child in her care.

8.59 She was described by practitioners as always minimising the risk and making excuses for Adult B. For example a Fortalice counsellor records that on one occasion Adult A said that "she was in a volatile relationship where she used to ring the police when her partner hadn't done anything just to wind him up."

8.60 There is no record of any GP or allied professional directly asking Adult A about the risk of domestic abuse. The Royal College of General Practitioners' published guidance in 1998 (Domestic violence: the general practitioner's role by Dr Iona Heath) regarding patients who may be considered at risk of Domestic Abuse. Those with a history of drug dependence and depression are highlighted to be at higher risk and the guidance recommends that GPs consider the possibility that the patient may be a victim of domestic abuse. The guidance then goes on to recommend that the GP specifically asks the question about presence of domestic abuse, documents the conversation and provides a risk assessment for the victim and any children. Support and advice should be given to the victim, including making them aware that they are the victim of a crime. This guidance is not currently widely available to or utilised by General Practitioners and doesn't appear to have been followed in this case.

Whether there are any equality and diversity issues that have impacted on the safeguarding of Adult A and her children. (Terms of Reference (k))

8.61 The ethnicity of both the victim and the perpetrator was White British.

8.62 It is possible that there could have been some unwitting discrimination against Adult A because of her demeanour, previous criminal record and her substance misuse particularly when one considers the decision to refer Adult F to a MARAC in 2009 as a victim of domestic abuse perpetrated by Adult A and how this correlates with Adult A's position as a victim of domestic abuse, who was reluctant to engage with the police, pregnant in 2006 and also prone to substance misuse, all of which could have been factors to trigger a MARAC referral.

8.63 A suitably anonymised case study based on these contrasting decisions could be a valuable feature of future domestic violence training.

9 FINDINGS AND RECOMMENDATIONS

9.1 This Domestic Homicide Review reveals countless examples of good practice by staff who worked hard to engage with and support Adult A. However the purpose of the review is to learn lessons from this tragedy in an effort to reduce the risks to victims of domestic violence so it is inevitable that this section of the report focusses on areas in which there were failings. Indeed most agencies contributing to this review have identified improvements they can make to their practices and developed single agency action plans.

9.2 Because this Domestic Homicide Review covers such a lengthy period it is apparent that some policies, processes and practices described in this review have been developed and improved over the intervening years. Examples include the fact that the MARAC process is much more embedded now than it was in 2006 when domestic violence against Adult A began to escalate and Independent Domestic Violence Advisor (IDVA) support is now in place.

9.3 Finding 1: Despite the strong general commitment to partnership working in Bolton, of which there is much evidence in this DHR, there were too many occasions when a single agency approach was adopted. This was particularly apparent when the agencies concerned did not operate within the same geographical area. Whilst effective single agency working is essential, it is important that staff adopt a holistic approach to solving the problems with which they are confronted. A telling example of this narrowness of approach is the failure of Adult A's Drug worker to share a disclosure that Adult B had been violent to Adult A with Adult B's Drug worker, despite the fact that both Adult A and Adult B were accessing a service from the same organisation in the same premises and their records were recorded on the same data management system.

Recommendation 1

That the narrow single agency focus which impeded efforts to safeguard Adult A is comprehensively challenged. When the Bolton Domestic Violence Strategy is revised it should set out in the clearest possible terms expectations that colleagues are expected to take a holistic approach, work effectively together and share information so that risks are accurately assessed and professionally managed.

9.4 Finding 2: Information sharing failures probably flow from the single agency focus referred to above. Examples include the absence of information sharing between Salford Probation and Children's Social Care in the weeks prior to Adult B's release from prison on 1st June 2012 and the failure to share information about this prison release date with Adult D and Adult E so that they could take steps to safeguard Adult A's children. However, there are no less than twelve recommendations in the single agency action plans referred to above which address this issue.

Recommendation 2

That the range of single agency plans to improve information sharing are monitored by Bolton Community Safety Partnership to ensure that information sharing necessary to safeguard the victims and potential victims of domestic violence is as effective as possible. In order to fulfil this recommendation the Community Safety Partnership should consider focussed audit activity.

9.5 Finding 3: Individual failings were apparent. Examples include the approved premises referral for Adult B which was submitted too late to be of any use and the lack of follow up on the actions agreed at the RAMA meeting held on 2nd April 2012. But good systems should pick up individual failings so that supervisors and managers can take remedial action. It is suggested that the systems which allowed individual failings to go unchecked need attention. And there were a number of apparent system failings such as the "automatic" reallocation of Adult B's case to a Probation Officer which did not happen when his risk assessment was raised following his recall to prison in June 2011 and the absence of the expected policy response when Contour Homes became aware of the threat of domestic violence to Adult A. The Munro Review of Child Protection (3) cautions against an over focus on the failings of individual members of staff and argues for a "whole system" approach.

Recommendation 3

That Bolton Community Safety Partnership assures itself that the individual agency failings identified in this Domestic Homicide Review are remedied by monitoring of single agency action plans. Where system failings are apparent, the Partnership gains assurance that

systems have been put in place or existing systems strengthened to prevent a recurrence of the failings identified by this Review.

9.6 Finding 4: Adult A was almost unknown to the MARAC process. Several opportunities to refer Adult A to MARAC were not taken. Recent contact with the Home Office reveals that victims in the majority of Domestic Homicide Reviews initiated or completed to date were also unknown to the MARAC process. The Home Office suggest that this demonstrates the effectiveness of the MARAC process as the overwhelming majority of high risk cases referred to the process are successfully managed. (4) This is an arguable point but the challenge is to try and identify why so many domestic homicide cases had not been referred to MARAC so that we can refine and enhance our approach to identifying the riskiest cases. An analysis of Domestic Homicide Reviews would probably be a good place to start. It seems likely that there could be common themes. In this case the fact that Adult B was incarcerated so regularly and for such long periods prevented the manifestation of a pattern of escalation of incidents which is often a feature of the cases with highest risks. For example a MARAC referral could have been considered following the assault upon Adult A by Adult B in September 2009 but two and a half years had elapsed since the previous recorded incident. There is a danger that cases which do not fit the anticipated profile of a high risk case are excluded from consideration by the MARAC process. The current system allows for staff to use their professional judgement and refer cases which do not reach the necessary threshold but nonetheless exhibit sufficient concern to merit referral. However, there is a risk that the large volume of cases which already meet the criteria for MARAC referral might act as a disincentive to staff fully utilising the professional judgement referral option.

Recommendation 4

That Bolton Community Safety Partnership write to the Home Office to propose an analysis of the Domestic Homicide Reviews completed so far in an effort to identify the reasons why a number of domestic homicide cases are unknown to the MARAC process. This analysis could then be used to further develop and enhance the MARAC process.

Recommendation 5

That the procedure by which cases are referred to the MARAC process is reviewed to ensure that cases are not overlooked because they do not obviously fit the criteria and that the scope for referring cases on the grounds of professional judgement is reinforced.

9.7 Finding 5: At times there appeared to be a preference for compliance with process rather than solving the problem. Staff appear to have become transfixed by the term "sentence expiry date" and lost sight of the much more important duty to protect the public. As the clock ticked by and 1st June 2012 approached there seemed to be no mechanism available to alert any manager in any agency to the fact that there might be a problem developing which required attention.

9.8 Finding 6: It is unclear how large a problem the unsupervised release at sentence expiry date of offenders who pose risks such as those exhibited by Adult B is. The DHR Panel is aware that the National Offender Management Service (NOMS) commissioned a "Serious Further Offence" (SFO) review in this case on the grounds that a serious further offence was committed within 28 days of release from prison. This SFO review is a restricted document so it has not been possible for it to be shared with the DHR Panel. However the Chair of Bolton Community Safety Partnership agreed that this DHR could be shared with NOMS in order that NOMS could make comments on the DHR which were informed by the SFO Review. NOMS subsequently communicated with the DHR Panel and stated that they were aware of a "small number of cases" in which offenders posing similar risks to Adult B had been released unsupervised at sentence expiry date. NOMS expressed the view that these cases did not suggest that there were wider policy issues to be addressed but added that the Offender Management and Public Protection Group (OMPPG) of NOMS would review the current process of pre-release planning where someone is released at sentence expiry date to check whether anything needed to be put in place to improve the process.

Additionally NOMS stated that a further pre-release RAMA should have been arranged in order to ensure that all essential pre-release actions had been completed. The possibility of a pre-release RAMA was not raised in the Probation IMRs submitted to the DHR. Subsequent to the communications from NOMS, the Greater Manchester Probation Trust has stated that a pre-release RAMA would have been regarded as good practice but not

seen as a “must” under the procedures in operation at the time or indeed currently. Recommendation 6 proposes that a pre-release RAMA in cases such as this should be mandatory.

Recommendation 6

That Greater Manchester Probation Trust review its use of RAMA in cases where high risk offenders will be released at sentence expiry date, and to put a further stage in the process where a RAMA should take place a few weeks prior to release to ensure that a risk management plan is in place, agreed by all agencies.

9.9 Finding 7: There was a lack of “forensic curiosity” by far too many professionals. So self-reporting of Adult B’s criminal history was too heavily relied on, explanations were taken at face value such as Adult B’s false account of his vicious assault on Adult A in September 2009 in which he attributed her injuries to a fit , assessments were not updated and searching questions were not asked.

9.10 Finding 8: Adult A’s status as a victim of domestic violence was obscured by a number of issues such as the culture of violence which surrounded her substance misuse which was too readily accepted by some of the staff who worked with her. Adult D says that agencies saw her sister as a “smack head” and did not recognise her as a victim of domestic violence, partly because she came across as a strong and confident woman. Her status as a victim of domestic violence was also obscured by the crucial importance of safeguarding her children. For example a pre-birth core assessment in respect of one of her children largely overlooked the risk of domestic violence to Adult A. Ironically Adult A’s youngest child was a protective factor for Adult A. Whilst she was attempting to make and sustain the lifestyle changes necessary for her youngest child to be rehabilitated into her care, she received substantial support from a range of agencies. After her youngest child was removed from her care in March 2012, Adult A’s engagement with services, and their engagement with her, greatly diminished in most cases.

Recommendation 7

That multi-agency and single agency domestic violence training is informed by this case. In particular, the issues raised in paragraphs 8.61(contrasting decisions in respect of Adult A and Adult F), 9.8 ("forensic curiosity") and 9.9 (the obscuring of Adult A's status as a victim) should be addressed in such training.

9.11 Finding 9: Substantial work was done to address Adult B's behaviour by a range of agencies but it appears to have been uncoordinated. For example drug workers had expectations that Adult B's aggressive behaviour would be addressed within the prison system but the primary focus of the programmes with which Adult B engaged in prison appears to have been to address his substance misuse. And when Adult B was recalled to prison in 2011, Salford Probation identified a number of interventions which they considered it necessary for Adult B to address whilst in prison which the Prison Service considered unrealistic. Several studies have revealed the lack of an integrated approach by those agencies working with perpetrators. (5) and (6)

Recommendation 8

That Bolton Community Safety Partnership work with partners to improve the planning and co-ordination of work carried out across a range of agencies to challenge the behaviour of violent and aggressive offenders.

9.12 Finding 10: Given the obstacles to securing a criminal conviction for domestic violence, too much importance appears to rest on perpetrators being convicted. There needs to be a stronger emphasis on building a comprehensive analysis of the risks posed by perpetrators which makes use of intelligence in the absence of specific convictions for domestic violence. This issue is addressed in the single agency plans developed by Salford Probation, Police, Children's Social Care and GMW MHT.

9.13 Finding 11: Adult A was rejected by a refuge on the grounds that she may pose risks to herself, staff and residents on the basis of her alleged violent behaviour and substance misuse. Research suggests that there is a lack of refuge provision for women substance misusers. (7) However, those providing support to the victims of domestic violence need greater awareness of the range of refuge provision available.

Recommendation 9

That Bolton Community Safety Partnership ensure that all staff who have roles in safeguarding the victim of domestic violence are able to readily access information about the range of refuge provision available.

Was the death of Adult A predictable?

9.14 It was predictable that the release of Adult B from prison unsupervised and of no fixed address would present a risk of serious harm to the public. On his most recent release from prison in June 2011 – at a time when he was supervised – he had drunk to excess and committed offences involving weapons and the threat of violence within 24 hours of his release.

9.15 This is reinforced by the way in which Adult B presented when he attended his appointment with CJIT at GMW MHT Bolton drug service on the day of his release. He presented as "intimidating and hostile". However, Adult B made no threats or expressed any intent to harm Adult A (or any other person) at that appointment.

9.16 It was predictable that Adult B's release from prison would be a time of heightened risk for Adult A. She had written to him in July 2011 to end the relationship and had (apparently) had no direct contact with him since that time, although it is now known that Adult C acted as a conduit for passing information between Adult A and Adult B. There is a difference of opinion between Adult D and Adult C over whether Adult B blamed Adult A for the removal of her youngest child from her care. But given Adult B's past behaviour towards Adult A, it seems likely that he would have instigated conflict with her on some pretext or another following his release from prison.

9.17 However it could not have been predicted that Adult B would murder Adult A within 48 hours of his release from prison although he had previously subjected her to violent and prolonged assaults.

Was the death of Adult A preventable?

9.18 In the light of the speed of Adult B's reoffending on his previous release, it is unlikely that he would have complied with a stay at approved premises.

9.19 Even if Adult B had been released early into approved premises it is unlikely that any of the measures which would have been taken to manage his risk, would have impacted significantly upon the specific risk to Adult A. He would have been unlikely to comply with restrictions on his contact with Adult A. It is in any case hard to imagine what could have been put in place without Adult A's consent and cooperation which may not have been forthcoming. Adult A continued to demonstrate a lack of insight into the threat Adult B posed to her. Adult A also had a misplaced confidence in her ability to "handle" risk to herself.

9.20 Adult C was an integral part of Adult A and Adult B's life and a support within contact arrangements between Adult A and one of her children. He was seen as very supportive of Adult A, often accompanying her to appointments and taking her to collect her prescriptions. The risk that Adult C could have undermined any measures put in place to safeguard Adult A from Adult B was not fully appreciated or explored. Cafcass influenced the decision to attempt to rehabilitate the youngest child to the care of Adult A and recommended that Children's Social Care assess the suitability of Adult C to be part of Adult A's support network. Although Adult C informed Cafcass that he was willing to undertake any form of assessment necessary, he declined to fully co-operate with Children's Social Care. It is unclear whether this lack of co-operation led to any reappraisal of Adult C's role in Adult A's support network. It has subsequently been established that Adult C was in regular contact with Adult B whilst he was imprisoned in HMP Haverigg. Adult C acknowledges that he facilitated contact between Adult A and Adult B whilst the latter was in HMP Haverigg. He did this by passing on messages between Adult A and B.

9.21 Had Contour Homes been able to progress Adult A's housing transfer application more swiftly, once approved in February 2012, this might have afforded her more protection although Contour point out that properties of the type requested by Adult A and in the area requested by her, are rare.

9.22 A MARAC referral in advance of Adult B's sentence expiry date would have facilitated full information sharing between agencies and led to the generation of some kind of plan.

9.23 The heightened risks faced by Adult A following Adult B's release from prison could also have been reduced by the holding of a pre-release RAMA which NOMS say should have

happened. A pre-release RAMA would have revealed that the actions agreed at the 2nd April 2012 RAMA had not been addressed, enabling remedial action to be taken.

9.24 It is clear that the heightened risks faced by Adult A following the release from prison of Adult B could have been reduced by effective information sharing, which would probably have led to a better appreciation of the risks she faced. Better appreciation of risks could have resulted in actions which might have afforded her some measure of protection. However there were a number of factors which had the potential to undermine any efforts to protect Adult A, which include the history of non-compliance with supervision by Adult B, the extent to which Adult A would fully co-operate with efforts to protect her given her lack of insight into the threat that Adult B posed to her and the partially hidden threat of Adult C's role in facilitating contact between Adult B and Adult A. The references to the co-operation of Adult A in this paragraph and in paragraph 9.18 above do not ignore the probability that her scope for freely making decisions was limited by the coercive control exercised by Adult B. "Coercive control" is defined as "an ongoing pattern of sexual mastery by which abusive partners interweave repeated physical abuse with three equally important tactics: intimidation, isolation and control." (8)

10. References

(1) Harvey, S. and Rowland, J. (2011) *Supporting the development of safe and affective responses within drug and alcohol agencies,* retrieved from www.avaproject.org.uk/media/64002/mara%20engagement%20project%20stage%201%20exec%20summary%20may%202011.pdf

(2) Humphreys, C. et al (2005). *Domestic Violence and Substance Use: Overlapping Issues in Separate Services?* Home Office and Greater London Authority.

(3) Munro, E. (2010). *The Munro Review of Child Protection-Part One: A Systems Analysis,* retrieved from http://www.education.gov.uk/munroreview/downloads/TheMunroReviewofChildProtection-Part%20one.pdf

(4) Wills, A. (2012). *Standing together against domestic violence: Adding value to local domestic abuse partnerships,* available from www.Standingtogether.org.uk

(5) Howarth, E. et al (2009). *Safety in Numbers: A Summary of Findings and Recommendations from a Multi-Site Evaluation of Independent Domestic Violence Advisors,* retrieved from www.henrysmithcharity.org.uk/documents/SafetyinNumbers16ppSummaryNov09.pdf

(6) Steel, N. et al (2011). *Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs)* retrieved from www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/horr55-report?view=Binary

(7) Harvey, S. and Rowland, J. (2011) *Supporting the development of safe and affective responses within drug and alcohol agencies,* retrieved from www.avaproject.org.uk/media/64002/mara%20engagement%20project%20stage%201%20exec%20summary%20may%202011.pdf

(8) Stark, E. (2009) *Coercive Control: The Entrapment of Women in Personal Life.* Oxford University Press Inc., New York.

11. Glossary

CALM: Controlling Anger and Learning to Manage. It is a programme to help participants manage their anger and other emotions that could lead to offending.

CARAT: Counselling, Assessment, Referral, Advice and Through care is a programme offered by the Prison Service to prisoners with substance misuse problems.

CJIT : The Criminal Justice Integrated Team provide access to drug and alcohol treatment for offenders. The team is made up of health workers, probation officers, police officers and staff from the voluntary sector. The primary concern of the team is to reduce offending and make communities safer. To do so they will work with offenders to help them stay in treatment, gain employment or undertake training and assist with accommodation.

Community Safety Partnership: Community safety partnerships (CSPs) are made up of representatives from the 'responsible authorities', which are the:

- Police
- local authorities
- fire and rescue authorities
- probation service
- health

The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

Core Assessment: A Core Assessment is an in depth led by a qualified and experienced social worker. It aims to inform the enquiry process and establish whether action is required to safeguard and promote the welfare of the child or children who are subject of the enquiries

COVAID: Controlling Violence for Angry, Impulsive Drinkers is a group work programme for male offenders who have offended by using violent or aggressive behaviour after drinking alcohol.

DHR: Domestic Homicide Review

Domestic Violence: "Any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

"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 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 definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Bolton Domestic Violence Unit: Department within Bolton Police Division which dealt with victims and perpetrator of Domestic Violence

GMW MHT: Greater Manchester West Mental Health Trust

Independent Domestic Violence Advisor (IDVA): A trained specialist whose role is to promote the safety of domestic abuse victims, focusing on victims at high risk of harm. The IDVA's job is to be a bridge between victims and the MARAC meeting.

Individual Management Report (IMR): Each organisation involved in a DHR produces this report which contains a chronology of their involvement with the key persons. The report reviews and evaluates the practice of the organisation and identifies lessons to be learned. It is written by a person who is independent from the case and is quality assured by the senior officer in the organisation. This senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.

Interim Care Order: Order that is made at the first hearing after Care Proceedings have been issued. This Order can last for up to 8 weeks and can be renewed every 4 weeks after that. The Order can only be granted if the Court feels there is good reason to believe that a child may be at serious risk of harm.

Licence: Persons serving a custodial sentence can be release on temporary licence meaning they are able to leave the prison for a short time usually to help them settle back into the community when they finish their sentence

MAPPA: Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders. The core MAPPA members are the Police, Prison service and Probation service in each area.

MARAC: Multi-Agency Risk Assessment Conferences are multi-agency meetings where statutory and voluntary agency representatives share information about high-risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. The agencies that attend MARACs will vary but are likely to include, for example: the Police,

Probation, Independent Domestic Violence Advisers (IDVAs), Children's Services, health and housing. There are approximately 250 MARACs currently in operation across England and Wales.

Offender Assessment System: System used in by the Prison Service and the National Probation Service to measure the risks and needs of criminal offenders under their supervision.

Panel/Review Panel: Review Panels for DHRs in Bolton can are created on a bespoke basis for the purposes of undertaking a particular DHR. The Panel includes individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004 together with individuals from the Voluntary and Community Sector including specialist domestic violence and abuse services. The Panel is led by an Independent Chair and meets on a regular basis throughout the review to consider information submitted by the participating agencies and to scrutinise the Overview Report

PASRO: Prison Addressing Substance Related Offending is a programme offered by the Prison Service which is designed to address drug dependence and related offending.

Plea and Case Management Hearing: A hearing held in Crown Court to ensure that all necessary steps have been taken in preparation for trial and sufficient information has been provided for a trial date to be arranged.

Offender Manager: A Probation Officer who works in the community with offenders. Their key role is to help offenders to make changes to their life so that they are less likely to offend in the future.

Professional judgement: This allows a professional who has serious concerns about a victim's situation to refer the case to MARAC even if they do not meet specific criteria for MARAC referrals. This can be applied where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly.

RAMA: A RAMA (Risk Administration Management Arrangements) is a meeting in which all high risk of harm offenders are reviewed by the Probation Service Offender Manager and a middle manager. Actions to manage the risks posed by the offenders are identified and reviewed.

Refuge: A safe house for women and children escaping domestic violence. The address is confidential and no men are allowed in the building. A refuge is a place where women can be sure they are safe, and where they can access emotional and practical support from staff who understand what they have been through.

Residence Order: An order which settles the arrangements to be made as to the person with whom a child is to live.

Scoping Meeting: A meeting held to enable the Chair of the Community Safety Partnership to make the decision whether or not to hold a Domestic Homicide Review and to facilitate the required consultation with partners. The meeting provides an accountable decision making process and assists in ensuring that all relevant issues are considered before a decision is made and before any review panel is convened.

Sentence Expiry Date (SED): The date of release of an offender from prison or detention other than temporary release as calculated from the original sentence.

Service Level Agreement (SLA): Contract between a service provider (either internal or external) and the end user that defines the level of service expected from the service provider.

Special Guardianship Order: Special Guardianship provides legal permanence for those children for whom adoption is not appropriate. It offers greater security than long-term fostering but without the absolute legal severance from the birth family that stems from an adoption order. Special Guardianship will;

- Give the carer clear responsibility for all aspects of caring for the child and for taking the decisions to do with their upbringing. The child will no longer be looked after by a local authority

- Provide a firm foundation on which to build a lifelong permanent relationship between the child and their carer
- Be legally secure
- Preserve the basic link between the child and their birth family
- Be accompanied by access to a full range of support services including, where appropriate, financial support.

Supervision Order: This gives the local authority the legal power monitor a child's needs and progress while the child lives at home or somewhere else. Conditions can be attached to a supervision order; for example, the parent may have to tell the supervisor if they change their address and allow the supervisor to visit the child at home.

Unlawfully at Large: When a prisoner escapes from lawful custody or is on bail and fails to surrender to custody or is released temporarily on and fails to return or is released early from the custodial part of their sentence on home detention curfew but are recalled and subsequently abscond.