DOMESTIC HOMICIDE REVIEW

UNDER SECTION 9 OF

THE DOMESTIC VIOLENCE CRIME AND VICTIMS ACT 2004

IN RESPECT OF THE DEATH OF A WOMAN

'Binesh'

REPORT PRODUCED BY PETER MADDOCKS

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Contents

Introduction

1. This report examines the response of organisations and the appropriateness of professional support given to the 35 year old female victim referred to as Binesh for the purpose of this report who was a resident of Stockport prior to her death on the 23rd August 2014. The review has considered the extent and quality of contact and involvement from the 1st June 2013 to the 23rd August 2014 with Binesh and the 36 year old perpetrator who was her estranged husband. He was convicted of manslaughter in late 2015 and was sentenced to life imprisonment to serve a minimum of 15 years.

2. The purpose of a domestic homicide review is to identify learning that contributes to improving the identification and response to domestic abuse and preventing domestic homicides.

3. In order to support lessons being learned as widely and thoroughly as possible professionals need to be able to understand as fully as possible what has happened in each homicide and identifies what needs to change in order to reduce the risk of such tragedies occurring in the future.

4. An appendix provides a list of people and organisations who receive copies of the published report.

5. For the purpose of clarity the use of acronyms is kept to a minimum. Extended family members are referred to by their relationship to Binesh or the perpetrator such as victim's mother, father or sibling. Binesh's two children are referred to as Child 1 and Child 2. Professionals are referred to by their roles such as GP, police officer, teacher or social worker for example.

Summary of the circumstances for the review

6. The regional ambulance service was summoned to Binesh's home in the early hours of the 18th August 2014. She was found unconscious on the floor of her bedroom. She was taken to hospital but died from her injuries five days later on the 23rd August 2014. It is now known that there was a delay before the perpetrator sought medical assistance. The perpetrator was arrested at the scene initially on a charge of assault. He was subsequently charged with murder and was remanded into custody.

7. The circumstances of the death were reported to the chair of the Stockport Community Safety Partnership. It was agreed that the criteria for a domestic homicide review were met. The circumstances under which a domestic homicide review must be carried out are described in legislation and national guidance. The

relevant legal requirement is the Domestic Violence, Crime & Victims Act (2004) Section 9 that came into force on the 13th April 2011. The relevant national guidance is described in *Multi-agency statutory guidance for the conduct of domestic homicide reviews.*

8. A domestic homicide must review the circumstances in which the death of person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or been a member of the same household as themselves.

Methodology and terms of reference

9. The time period under review is from 1st June 2013 until 23rd August 2014.

10. The review began with the initial scoping meeting on the 6th October 2014. That meeting agreed the scope and terms of reference for the review with the intention of completing the review by May 2015. A draft report was completed within this timescale although the criminal proceedings were not completed until later in 2015 when the report could be finalised.

11. The most significant and material issue for the completion of the review by May 2015 was being able to contact the family to invite their contribution to the review. In view of the fact that relatives had provided statements and were potentially witnesses for the criminal trial the Crown Prosecution Service did not want any potential conflict of interest to arise between the criminal trial and the completion of the review.

12. The trial was postponed and therefore the draft report was presented to the Stockport Community Safety Partnership in August 2015 before that had been completed and therefore before it was possible for family members to be invited to provide information for the review. A family member agreed to speak with the author of this report in December 2015. Work began on implementing action plans arising from the individual agency reports.

13. This final report was published with an executive summary in May 2016 when the Home Office completed their evaluation. Their letter is included as an appendix.

14. The methodology of the review complies with national guidance for the conduct of a domestic homicide review. This includes identifying a suitably experienced and qualified independent person to lead the review and to provide an overview report for publication. The scoping meeting agreed that the role of chair and author would be combined and initiated the commissioning of Peter Maddocks as the independent reviewer in November 2014 and is the author of this report.

15. Agencies contributing reports or information to the domestic homicide review used the following key lines of enquiry to provide information and analysis for the domestic homicide review.

    a) What contact did agencies have with family members?

    b) What services did agencies offer to the subject and other family members? Were these services accessible, appropriate and sympathetic to the presenting needs?

    c) Did any agency have knowledge of domestic abuse in this family? If so, how was this knowledge acted upon?

    d) What safety planning was offered to Binesh and/or family members including referral to specialist domestic abuse services?

    e) What (if any) services were offered to the perpetrator of domestic abuse?

    f) What knowledge did Binesh's family and friends have about domestic abuse within the family composition and what did they do with it?

    g) How did agencies, family members and friends deal with any confidentiality issues Binesh might have requested of them?

    h) Were there any specific diversity issues relating to the subject/family?

    i) Were issues with respect to safeguarding (children and adults) adequately assessed and acted upon?

    j) Were there issues in relation to capacity or resources in any agency that impacted the ability to provide services to Binesh and to work effectively with other agencies?

    k) Was information sharing within and between agencies appropriate, timely and effective?

    l) Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?

    m) Do any agency's policies / procedures / training require amending or new ones establishing as a result of this case?

    n) Was it possible for any agency to predict and prevent the harm that came to Binesh?

o) Is there any other information that maybe relevant to this review?

16. The scoping meeting agreed the list of services who would be asked to provide an individual management report if their involvement was significant; for services who had very brief contact a shorter statement of information was requested.

Contributors to the review

17. The scoping meeting identified the services who had contact or knowledge about Binesh and/or the perpetrator. Most of the organisations were required to complete an individual management review (full report) whilst other organisations who had less significant involvement provided a short report.

CAFCASS (full report in regard to the private law proceedings in 2014);

Central Manchester University Hospitals NHS Foundation Trust (short report in relation to historical treatment and provided emergency hospital care following the fatal assault);

Greater Manchester Police (notification of homicide and a full report about historical contact and then response to disclosure of rape in April 2014 and murder investigation[1]);

NHS England in regard to the GP (full report about provision of general medical care to the family);

North West Ambulance Service (NWAS) (short report in regard to emergency response to Binesh's fatal injury);

Pennine Care NHS Foundation Trust (short report about contact with Child 1);

Primary School (full report about Binesh's employment and the education for Child 1 and Child 2).

Stockport Children's Social Care and Safeguarding (children's social care services) (full report in regard to an assessment and provided a report in regard to the private law proceedings in 2014);

Stockport NHS Foundation Trust (short report in regard to school nursing services);

[1] Not all of the police contacts described in the agency police review and chronology are referenced in this report; some such as a burglary are not relevant to the domestic homicide review.

Self Help Services (full report about an assessment of the perpetrator's mental health in August 2014);

Victim Support (full report in relation to burglary in November 2013 and then following Binesh's disclosure of rape in April 2014);

18. A close family relative of Binesh provided information in the form of a discussion with the author after the criminal proceedings had been completed.

19. The perpetrator denied the charge of manslaughter for which he was convicted in November 2015. In view of the limited potential for any likely contribution to learning and improvement in respect of preventing domestic abuse homicides and not wishing to delay publication of the review the decision was taken to not pursue any input from the perpetrator following the trial.

Details of the panel membership and independent reviewer

20. The first meeting of the panel was on the 17th December 2014. The panel, chaired by the independent reviewer and author of this report, met on three occasions to review progress and findings and agreed the key areas of learning for single agencies and for multi-agency learning. The membership of the panel is listed below.

Organisation	**Job title**
Greater Manchester Police	Detective Sergeant (Serious Sexual Offences Unit)
NHS England	Patient Experience Manager
NHS Stockport Clinical Commissioning Group	Named Nurse Safeguarding Children
Stockport Metropolitan Borough Council	Head of Service Children's Social Care
Stockport Metropolitan Borough Council	Deputy Head of Service Community Safety Unit
Stockport Metropolitan Borough Council	Service Manager Children's Social Care
Stockport Metropolitan Borough Council	Manager Children's Safeguarding
Stockport Metropolitan Borough Council	Head of Social Care
Stockport Metropolitan Borough Council	Head of Safeguarding
Stockport Metropolitan Borough Council	Community Learning Mentor Cultural Issues
Stockport NHS Foundation Trust	Child Programme Team Leader
Stockport Self Help Service	Lead Officer
Stockport Women's Centre	Business and Development Manager

Tameside Metropolitan Borough Council Education	LADO[2] and Safeguarding Advisor for Education Services[3] in Tameside
Tameside Metropolitan Borough Council	Named Nurse
Victim Support	Service Delivery Manager

21. The panel was attended by the Officer for Domestic Violence from Stockport Metropolitan Borough Council. The panel co-opted specialist advisors to provide specific advice as required. For example the Stockport Ethnic Diversity Team were consulted in regard to issues of culture, ethnicity and religion and provided advice to the panel and the authors of individual management review reports.

22. Peter Maddocks is the independent chair and overview report author for this domestic homicide. He was commissioned in December 2014. He has over thirty-five years' experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council (HCPC). He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has completed domestic homicide reviews with other community safety partnerships in England. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales. In compliance with national guidance he has used the online toolkit and online learning provided by the Home Office. He has also participated in training in relation to serious case reviews including the use of systems learning as developed by SCIE (social care institute for excellence) in regard to serious case reviews.

Synopsis of the homicide

23. At approximately 01.50hrs on Monday 18th August 2014 the North West Ambulance Service received a call from the perpetrator. He stated during this call that his wife was dead and that he had given her a slap. The ambulance service subsequently contacted Greater Manchester Police which was timed at 01.53; the emergency medical despatcher had noted the flag placed on the address by the police in May 2014 (indicating domestic abuse). The emergency medical despatcher talked the perpetrator through administering cardiopulmonary resuscitation.

[2] LADO is the local authority designated officer and is described in national guidance (*Working Together to Safeguard Children*). The LADO role applies to paid, unpaid, volunteers, casual, agency or anyone self-employed and they capture concerns, allegations or offences emanating from outside of work.

[3] Binesh was employed by Tameside Metropolitan Borough as a teacher and taught at the school attended by both of her children.

24. Uniformed police officers were despatched to the address. The door was answered by the perpetrator. He was struggling with the keys and upon opening the door it was noted that his hands were shaking. As officers went into the address they asked where his wife was and he indicated up the stairs to the front bedroom of the address. A police officer stayed with the perpetrator downstairs in the address. Another officer went upstairs. In the front bedroom of the address by the bay window on the floor was light coloured duvet on the floor. The officer pulled the duvet back and saw that it was an unconscious Asian female (later identified as Binesh); the duvet was covering her entire body and face. This was described like a body would be wrapped up by an undertaker. She was lying on her back and there was blood coming from both of her ears and across her face.

25. The officer checked for a pulse and breathing and found there was none present. He commenced cardiopulmonary resuscitation on Binesh and completed heart compressions. He stated that her eyes were half closed and bulging and there was no response. A paramedic first responder in a rapid response vehicle then arrived on scene and advised the emergency medical despatcher that Binesh was in cardiac arrest. Simultaneously a crewed ambulance arrived at 02.02. Defibrillation machines were used and a faint pulse was found although Binesh was not breathing. Binesh was transported by ambulance to the Manchester Royal Infirmary and admitted into the intensive care unit.

26. At 02.02hrs the perpetrator was arrested on suspicion of a section 18 assault; he was formally cautioned to which he made no reply. He was taken to a police station where the facts were relayed to the custody officer and his detention was authorised. He was subsequently charged with murder.

Details of the post mortem and coronial inquest

27. The post-mortem examination and tests provided evidence that Binesh had suffered a fatal compression to the neck. The post-mortem also highlighted inconsistencies between the account given by the perpetrator and the location and severity of injury caused to Binesh. Both of her nasal bones were fractured from one or more blows, which would have required significant force.

28. The cause of death by ligature strangulation using a bra and electric heater flex was determined by the crown court proceedings in late 2015 and therefore required no further involvement by the coroner. The attack involved a sustained strangulation accompanied by a forceful blow or blows to Binesh's face.

Members of the respective families and the household

29. Binesh's family live in the south of England and this is where Binesh grew up until she moved to Greater Manchester to live with the perpetrator in 2001. Binesh's father died in 1997. Binesh has four siblings; two sisters and two brothers. Binesh also has a step brother. Binesh had a relative who lived in north-east England and with whom she had regular contact.

30. The perpetrator's mother died when he was a child and he was brought up by one of his two sisters. His father lived in Scotland working in a family restaurant business.

31. Binesh was, and the perpetrator is, British Asian Bangladeshi and Muslim and have English as their first language.

32. The perpetrator and victim had lived at the same property until April 2014 although had separate bedrooms from February 2014.

33. Binesh was a qualified teacher and taught at a school in Tameside between July 2013 and her death in August 2014; the two children attended that school. Binesh was well regarded by colleagues and children.

34. It is understood that the perpetrator has no higher education qualifications. He has a history of casual employment including work as a club doorman.

Children

35. Binesh and the perpetrator were the parents of two children aged nine (Child 1) and five (Child 2) at the time of Binesh's death. Child 1 was a planned baby and was an unsettled baby who was a light sleeper and very alert. The first two years of Child 1's life were difficult. Child 1 was breast fed but was a fussy eater. Child 1 met all developmental milestones within acceptable limits.

36. The children lived with Binesh at the family home and were at home when Binesh was subject of the physical assault that resulted in her fatal injuries. The children attended a school in Tameside where Binesh was a teacher.

History of the relationship between victim and perpetrator

37. According to information given by the perpetrator to children's social care services on the 26th March 2014, he and Binesh had separated in March 2014. With hindsight, it is now possible to see that the perpetrator was attempting to control Binesh's contact with a relative who lives in the north east of England when the perpetrator

initiated the application for a prohibited steps order (further information about this is contained in the later narrative chronology).

38. According to children's social care services the perpetrator had stated that the marriage had been arranged in 2001; this was not corroborated by anybody else. Evidence given to the criminal trial in late 2015 was told that the couple met in 1999 and the marriage in January 2002 was not arranged and had been opposed by Binesh's family. The relative who spoke with the author confirmed that the marriage had not been arranged and that Binesh's family had been unhappy about the marriage. Binesh was the first female in the family to have been graduate educated and felt that the perpetrator was not a good match. He had not completed higher education or held a professional role. The family recognised that Binesh was in love with the perpetrator and had tried to make him feel welcome. Binesh and the perpetrator had met at a wedding.

39. According to Binesh's account during the social work assessment in 2014 the marriage had initially been supportive although the perpetrator became increasingly controlling and coercive. This was consistent with the evidence given during the trail summarised in the next section of this report.

40. The family of Binesh were not aware of the abuse although the relative had known about Binesh making the allegation of rape and her decision to retract it. The relative felt that Binesh may have felt unable to disclose what was happening because she had proceeded with the relationship and marriage against the advice and opinions of her family.

41. The police have a record of a contact on the 6th September 2006 from a distressed female believed to be Binesh who called the police and then hung up when the line connected. She was re-called by the call operators and the female who was crying said that ''it didn't matter''. On police arrival at the address it was determined that the baby had been unsettled for a number of nights and had woken up for a feed; both parents were tired and distressed and had a verbal altercation. No offences were disclosed but Binesh did say that they were having escalating rows and she wanted to leave the perpetrator at some point as the relationship was no longer working. This was the one and only contact in relation to the relationship before the disclosures in March 2014[4].

42. In April 2014 Binesh had consulted the GP with a sore throat and stress; during the consultation she disclosed suffering emotional abuse for several years.

[4] The police have provided details of contact they had with Binesh and the perpetrator between January 2001 and August 2014 in regard to issues unrelated to domestic abuse such as burglary and criminal damage.

43. Binesh was employed as a teacher and had discussed with colleagues at school the problems she was having in her relationship with the perpetrator. It appeared to be widely known in the staff group at the school that Binesh and the children were being subjected to emotional and physical abuse. Binesh also described sexual coercion by the perpetrator.

44. The perpetrator had a history of casual employment with no steady income. The trial heard evidence that he ran up debts in Binesh's name. The court was also told that he had several affairs.

Details of criminal proceedings

45. The perpetrator admitted killing Binesh but denied the charge of murder at his trial in late 2015.

46. The court was told that Binesh wrote details of the deteriorating relationship in notebooks, while the perpetrator made audio recordings of their conversations.

47. The prosecution presented evidence that he strangled Binesh at her home after taking her £20,000 gold wedding jewellery from her and becoming 'paranoid' she was seeing someone else.

48. The court was told that the couple began a relationship in 1999, and married in an Islamic ceremony, in spite her family's disapproval of him and 'love matches' in general. The relationship 'burned brightly' at first, the prosecutor said, however over time it was tested by the perpetrator acting in a 'violent' and 'controlling' way and running up debts.

49. In November 2011 the couple were burgled. The perpetrator made a false insurance claim for Binesh's £20,000 gold wedding jewellery and banked the £10,000 pay-out. The jewellery had been given to Binesh by his family on her marriage in accordance with culture and custom.

50. By February 2014 the couple had separated, and the perpetrator arranged to store her jewellery in a safety deposit box in the city centre 'so he could have some control over her'.

51. Using instant messaging records, the prosecution presented the perpetrator as a violent, controlling and sexually obsessive husband who decided if he could not have Binesh, no-one else would after she had resolved to leave him.

52. The perpetrator told the trial that on the night of the killing he had tried to silence Binesh after she threatened to accuse him of rape by putting his arm over her neck.

He said that he could not remember strangling Binesh with ligatures. He had claimed that the sex had been consensual.

53. In a 2013 message presented during the trial, during their drawn-out separation, Binesh said 'why do we have to argue? you frighten me'. In another exchange, between him and a friend, he said 'shall I just ****ing kill her now?'

54. In another message the perpetrator told a friend, 'I feel like destroying her'. An hour later he had contacted Binesh asking for sex. By April 2014, Binesh said in a message: "You really are sick - you forced yourself on me last night...you're going to regret this, you are evil'. The perpetrator denied forcing himself on her.

55. In a message in August 2014, days before Binesh's death, she called him a 'monster'. Two days later she was saying 'I'm a bit scared of going to yours'.

56. Binesh's sister, told the court: "She truly loved (the perpetrator) and she suffered all by herself. She didn't tell us what was going on, all the bullying, hitting – she hid it from us."

57. The perpetrator's defence lawyers told the court that Binesh's family had been hoping the couple would split because it was alleged that they had never felt the perpetrator was 'good enough'.

58. The court found the perpetrator guilty of manslaughter. The judge described Binesh as a strong, articulate and intelligent woman who was frightened of the perpetrator and that there was a history of emotional and some physical abuse from the perpetrator. "On the evidence, I'm satisfied that as the years went by you became increasingly bullying, controlling and paranoid. You became emotionally and physically abusive towards her, by your own admission, you were often vile towards her".

59. The judge said that Binesh was a 'much loved mother, sister, family member and friend, she was by all accounts a brilliant and devoted teacher'. The judge added however, that she did not believe there was pre-meditation, saying that the perpetrator acted out of 'pure and simple anger' following 'a degree of provocation' when Binesh had threatened to go the police to allege rape for a second time.

Narrative chronology

60. There was little historical contact with any of the services over and above the routine education and health arrangements for a family with two young children.

61. The maternity health care for the two pregnancies included routine screening for signs and symptoms of domestic abuse. No abuse was disclosed through that process which relies on a victim disclosing information in the absence of any other observable evidence.

62. In June 2013 the perpetrator contacted the police to report historical concerns about a maternal cousin; this related to the cousin having a relationship with an under-age girl twenty years previously who subsequently became the cousin's wife. The police took no action. The stated motive for the report to the police was concern about his children having contact with the cousin. There was further contact with the police in October and November 2013 regarding non-related issues; on one occasion it was a burglary.

63. In March 2014 the perpetrator contacted children's social care services to inform them that he had recently separated from Binesh but that they were still living in the same household. He stated that he was applying for a prohibited steps order[5] due to his concerns about the safety of his child and about Binesh's ability to protect and safeguard her. He reported that approximately 12-15 months ago (January-March 2013) and when Child 2 would have been aged four he had witnessed Binesh's adult relative put a hand inside Child 2's lower clothing.

64. The perpetrator stated that he had intervened at the time but had not spoken with the relative about the incident until sometime in September 2013. The relative had agreed to stay away from Child 2. The perpetrator stated that he raised his concerns with Binesh describing her response as dismissive and said that she rejected his concerns about what had happened. He said that he had concerns about her attitude towards under age sex. The perpetrator stated that due to his separation from Binesh he was concerned as Binesh recently wanted to take Child 2 with her to North Lincolnshire where she might be in contact with the relative. Children's social care services allocated the referral for a social work assessment.

65. On the 2nd April 2014 Binesh contacted the police to report that she was suffering physical and emotional abuse from the perpetrator and they were going through a separation. She did not want police intervention. The contact was reported to the

[5] Section 8 of the Children Act 1989; a Prohibited Steps Order (PSO) is an order granted by the court in family cases which prevents either parent from carrying out certain events or making specific trips with their children without the express permission of the other parent. This is more common in cases where there is suspicion that one parent may leave the area with their children.

specialist officers in the police public protection investigation unit but not with any other agencies until the 2nd May 2014.

66. On the 4th April 2014 the first social work visit to the home to begin the assessment provided an opportunity for Binesh to disclose being subjected to long standing emotional abuse. She described how the perpetrator had become very controlling during the 12 year marriage and was threatening to destroy her 'in every possible way' and was trying to isolate her from family. People who work with victims of domestic abuse will know that such an early and open disclosure of abuse is significant in that victims generally are reluctant to provide information.

67. There was a second visit to the home the same day to see both children. Child 1 wanted the perpetrator to 'stop shouting' and having arguments. Binesh had decided to take the children to North Lincolnshire to stay with the relatives that the perpetrator had previously reported to the police. The perpetrator had found the notes that Binesh had been making regarding the incidents of abuse and of the abusive phone texts.

68. On the same day the perpetrator contacted children's social care services to report that he thought Binesh had taken the children to North Lincolnshire 'where the danger is'. The perpetrator also reported Binesh and the two children as missing from home to the police. The police attempted to contact Binesh by phone and left a message and Binesh returned the call and informed the police of an address in Greater Manchester where she was staying with the children. The police made a home visit to this property in Greater Manchester to confirm that Binesh and the two children were safe and well. Binesh asked that their location was not disclosed to the perpetrator; they were not staying with the relative in North Lincolnshire.

69. Children's social care services telephoned Binesh ten days later on the 14th April 2014 to 'check on the situation'. Binesh reported that the perpetrator was calling and texting and that he had contacted the police to report her and the children as missing. The perpetrator was refusing to leave the family home. Binesh planned to move from Greater Manchester. She intended applying for a residence order and described incidents of physical assaults by the perpetrator some of which the children had witnessed. Binesh described being in 'mental shutdown'.

70. On the 17th April 2014 Binesh consulted the GP about a sore throat during which she described feeling very stressed and was having 'difficulties in her marriage'. She disclosed a number of years of emotional abuse and 'small incidents' of physical violence.

71. On the 29th April 2014 Binesh met with children's social care services at a local café and shared the paperwork relating to the application for a prohibited steps order

being sought by the perpetrator to prevent Binesh taking the children to the relative's home in North Lincolnshire. The perpetrator was continuing to make unwanted 'sexual overtures' and was also seeking a reconciliation. Binesh was advised to seek legal advice and to report the unwanted sexual advances to the police which she did later the same day.

72. Earlier the same day the social worker visited the children at school. Child 1 described hearing Binesh and the perpetrator arguing and feeling sad. Child 1 described the perpetrator as being the chastiser and that the perpetrator had thrown Child 1 to the floor who was then made to repeat that Child 1 was 'a stupid idiot'. Child 1 described seeing the perpetrator head butt Binesh and that things had become worse since September 2013. Child 2 was less able to discuss particular incidents although described their home as 'noisy'.

73. The social worker spoke with the head teacher who confirmed being aware of the family's circumstances as Binesh had confided in them and other colleagues. The children were described as well presented, regular attendees and were not showing any apparent ill effects. The head teacher had no concerns about Binesh's ability to protect the children and confirmed that Binesh was required to attend safeguarding training every two years as a teacher.

74. Also on the 29th April 2014 Binesh reported being raped by the perpetrator to the police. She was unwilling to be video interviewed or to make a formal statement. Binesh declined to attend the sexual abuse referral centre (SARC)[6]. The perpetrator was arrested and interviewed under police caution; he claimed that the sexual intercourse was consensual. A DASH (domestic abuse, stalking and honour based violence) and an enhanced risk assessment was completed that recorded a medium level of risk[7]. Referrals were made to the police public protection and investigation unit that has specialist officers dealing with domestic violence and sexual offences. The perpetrator was made subject to police bail conditions until the 25th June 2014 which prohibited him approaching or making contact with Binesh or going to the property.

75. On the 30th April 2014 a specialist police officer in the public protection investigation unit recorded an instruction for the details of this and the earlier incident on the 2nd April 2014 to be reported to children's social care services. This was followed up by a telephone call to Binesh on the 1st May 2014 by the public protection investigation unit. During that phone call Binesh said that she had contacted the Stockport

[6] SARCs are specialist medical and forensic services for anyone who has been raped or sexually assaulted to be provided with immediate help and support. They aim to be one-stop service, providing the following under one roof: medical care and forensic examination following assault/rape and, in some locations, sexual health services.

[7] ACPO (Association of Chief Police Officers) Council accredited the DASH (2009) Model which was implemented across police services in the UK from March 2009

Without Abuse (SWA)[8] and witness care services and was having the locks on the property changed and was exploring the installation of an alarm. SWA have no record of any such contact with Binesh. The officer advised Binesh that the police were closing the case as no further action. Binesh was informed by the officer that a MARAC[9] referral would be made; this was incorrect given the risk assessment had been medium rather than high. The case was subsequently closed by the public protection investigation unit on the 5th August 2014 after a peer review by another inspector.

76. On the 9th May 2014 children's social care services completed their assessment. The social worker had attempted to speak with the perpetrator on several occasions during the assessment without success. According to the children's social care services assessment it was agreed that the school would coordinate a team around the child common assessment framework (CAF) plan. A CAF was never opened.

77. A county court hearing on the 21st May 2014 was attended by Binesh and the perpetrator. The judge found no evidence to support making a prohibited steps order. Information was provided to the court about concerns regarding the perpetrator's parenting skills and his methods of chastising the children. There was a reference to one of the children having been locked in the garage. The judge was unwilling to grant unsupervised contact between the children and the perpetrator. The local authority was directed to complete a parenting assessment and a further court hearing was scheduled for the 16th July 2014.

78. A section seven report[10] provided to the court on the 18th June 2014 concluded that the children were well cared for by Binesh who was acting appropriately to protect the children and herself. The report recommended that the children should continue living with Binesh and that the perpetrator should have contact.

[8] Stockport Without Abuse are a local charity who offer a range of services to help and support women, men and children who are affected by domestic abuse.

[9] Multi-agency risk assessment conference (MARAC) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA, a risk focused, co-ordinated safety plan can be drawn up to support the victim. There are currently over 270 MARACs are operating across England, Wales, Scotland and Northern Ireland managing more than 64,000 cases a year.

[10] Section 7 of the Children Act 1989; a court may ask the local authority for a welfare report when they are considering any private law application under the Children Act 1989. A section 7 report is completed by a social worker who provides an independent evaluation and assessment of a child's situation and reports the findings to the court. A Section 7 Report needs to contain background information and the key facts and evidence that the child's needs have been considered in accordance with the *Welfare Checklist*. The report collates all the available evidence and information about the child's situation and sets it out in the form of a comprehensive report advising the court of the child's wishes and feelings and what the social worker considers to be in the best interest of the child.

79. On the 14th July 2014 the perpetrator consulted the GP about his depression and problems with sleeping; he told the GP that allegations had been made about him although the detail of these is not clear in the record. The GP undertook a mental health assessment and the perpetrator was referred to mental health services. The referral include the perpetrator's assertion of a 'malicious rape allegation'. The referral was triaged and allocated for a one-to-one session with a psychological well-being practitioner. The first appointment was cancelled by the perpetrator. A further appointment was arranged.

80. The perpetrator arrived 40 minutes late for the postponed assessment session on the 8th August 2014. During that session the perpetrator asserted that he had been falsely accused of rape two months previously and had now been cleared. The perpetrator completed several clinical measures designed to indicate the severity of anxiety and depression. The scores suggested that the perpetrator was experiencing mild to moderate symptoms. There was no time to discuss a treatment plan on that first visit. The perpetrator attended a follow up continuation session on the 11th August 2014. A further follow up session was planned for the 22nd August 2014 but did not take place because of the perpetrator's arrest and remand into custody.

81. On the 18th August 2014 Binesh was admitted via an ambulance to the hospital emergency department with the serious injuries described in earlier paragraphs.

Analysis of professional decision making and practice

Contact and knowledge about domestic abuse

82. According to national data one woman in four (and one man in six) in the UK are victims of domestic violence during their lifetime. Two women a week are killed by a current or former male partner. Domestic abuse accounts for a quarter of all violent crime[11]. It remains an under-reported crime that occurs in the privacy of intimate relationships. On average a victim will have suffered over thirty incidents of domestic abuse before seeking help. The impact on victims and their children has implications for their physical, emotional and psychological health and well-being.

83. Victims face many barriers in disclosing domestic abuse and also find it difficult to engage with agencies such as the police and children's social care services in strategies to deal with the abuse and the perpetrator. Disclosure of abuse and seeking separation represent threat to the perpetrator's ability to control the victim and they will therefore seek to apply further control and escalate the level of risk for the victim (and the children).

84. It is therefore unsurprising that with the benefit of hindsight and the detailed collation of information for this domestic homicide review it is possible to see that domestic abuse had been a concern for Binesh for far longer than is evident from the record of contact with professional services. Binesh was increasingly disclosing information to some professionals about domestic abuse from July 2013 and from April 2014 was disclosing information to an increasing number of organisations and was asking for help.

85. The people who had most frequent contact with Binesh and the children outside of the family were the school where Binesh was employed from July 2013 and the children were being educated. Binesh talked with colleagues about the 'emotionally abusive environment' at home and which was being observed by both of the children. The emotional abuse was reported as being a 'daily experience both while the perpetrator was in the home and when he moved out'.

86. Binesh's conversations with colleagues at school were informal chats which discussed the problems Binesh was experiencing or were prompted by Binesh wanting to seek advice and support from colleagues. There were some more formal discussions with senior staff to request time off to attend court hearings in relation to the perpetrator's application for a prohibited steps order or for longer periods to sort out personal and family difficulties.

[11] Homicides, Firearm Offences and Intimate Violence 2010/11: Supplementary Volume 2 to Crime in England and Wales 2010/11

87. The school's pastoral manager was asked by Binesh to work with Child 1 due to the physical and emotional abuse. During these sessions Child 1 disclosed violence at home and witnessing the perpetrator 'hurt' Binesh.

88. The only contact made by the school with another service in regard to the disclosures of domestic abuse was in a conversation on the 29th April 2014 when the social worker conducting the assessment spoke to the head teacher. The social worker was already aware of domestic abuse which Binesh had disclosed in the first contact with the social worker on the 4th April 2014.

89. The information that Binesh had disclosed to the school was explicit in describing domestic abuse. Physical assaults and being dragged by her hair; feeling coerced into sexual relations with the perpetrator as a strategy to avoid violence; staying in her bedroom to avoid contact with the perpetrator.

90. The reason for the school not making contact with children's social care services in particular was a belief that Binesh was already taking action to protect herself and her children. The apparent resilience of the children in regard to the emotional and psychological impact of the domestic abuse also contributed to a belief that the situation was being sufficiently dealt with.

91. Some of this optimism and confidence was fed into the enquiries and the assessment by children's social care services. The senior teacher who spoke to the social worker described Binesh as being 'open about the difficulties at home' and had no concerns about Binesh's ability to protect herself and the children. He also confirmed that she had attended safeguarding training that would give her additional knowledge. In fact, Binesh had not attended training about domestic abuse and neither had other school staff.

92. In any event, it is unwise to confuse or conflate professional training and development with being a victim of domestic abuse. Having a professional status with an associated expectation that you should know what domestic abuse constitutes is a potential inhibitor to seeking effective help and can be potentially compounded by associated feelings of inadequacy and shame.

93. It is apparent that for several months, the school was the only place where Binesh had disclosed information which was not shared with any other professional or service. It was not until late March 2014 that information began to be disclosed to several different organisations.

94. The first contact with children's social care services in March 2014 was initiated by the perpetrator and on the advice of his solicitor as part of his effort to prohibit

contact by Binesh and the children with the relative in north eastern England. In his first contact with children's social care services the perpetrator made an allegation of historical abuse and confirmed that he had begun private law proceedings for a prohibited steps order. Children's social care services opened an assessment the following day and allocated the case to a student social worker who was supervised by a senior qualified and experienced practitioner.

95. The report from children's social care services comments that given the referral from the perpetrator was an allegation of abuse there should have been at the minimum a consideration of a strategy discussion with the police to share initial information and make joint decisions about how the allegation would be investigated. There was never a strategy discussion or meeting at this or at the later point when disclosures and information highlighted concerns about the perpetrator's abuse.

96. The assessment initially focussed on Child 2 given the allegation concerned that child; arguably, the assessment should have encompassed both children from the outset; Child 1 was formally assessed from the 16th April 2014 after Binesh had disclosed information about abuse from the perpetrator to herself and to the children. The fact that the second assessment started later did not represent any material detriment to either child on this occasion.

97. The first (and prearranged) direct contact by children's social care services with Binesh was attempted on the 2nd April 2014; she was not at home. Binesh was instead at the local police station reporting physical and emotional abuse by the perpetrator. Binesh was unwilling to agree to police intervention. The information was passed to the public protection investigation unit but was not shared with children's social care services until the 2nd May 2014; a delay of a month. Given the allegation of abuse and involvement of children the response did not reflect either local or national safeguarding standards.

98. There should have been a referral and a strategy discussion to determine what inquiries were required and taking account of Binesh's reluctance to countenance action by the police. It would have provided both services with a much more informed picture regarding Binesh's contact and interaction with the two services, prompted formal consideration regarding what enquiries were appropriate and consider what further action should be taken between the different services rather than operating in separate silos.

99. It was on the 4th April 2014 that children's social care services had their first direct contact with Binesh at home. During that visit Binesh disclosed being the victim of emotional abuse from the perpetrator over several years. She described the marriage as having initially been very supportive but that the perpetrator had become increasingly controlling.

100. Binesh expressed her view that the referral to children's social care services was malicious and that the perpetrator had returned to live in the family home against her wishes and consent; she stated that the property was in her name only. Binesh also described specific threats that included the perpetrator saying that he was 'going to destroy (her) in every way possible' and his efforts to isolate her from her family. Binesh described abusive behaviour towards Child 1. She said that she had been in contact with SWA but had not continued contact with them. Binesh said that she had a log of incidents to report to the police and that she planned to do this after the home visit. Binesh did not appear to mention speaking with the police on the 2nd April 2014.

101. The social worker visited the children's school and spoke with them. They were described as having 'lots of personality' inferring a good degree of emotional resilience. Child 1 stated that if he could change anything at home it would be to stop the shouting by the perpetrator and the arguments in the house. Binesh stated that since the earlier home visit that day she had decided to pack and leave for North Lincolnshire with the children.

102. This infers that Binesh had become concerned about the perpetrator's response having disclosed the information about abuse. The perpetrator had found the notes that she was planning to take to the police and the evidence about his abusive text messages.

103. The social worker also received a text from the perpetrator who had found the letter arranging the home visit to Binesh on the 2nd April 2014 and saying that he believed Binesh was planning to take the children to north eastern England and the home of the relative that he was applying to have a prohibited steps order made. He made a separate call to the police some four hours later reporting Binesh and the children as missing from home.

104. This contact was not reported to the public protection investigation unit or to children's social care services. The police left a telephone message for Binesh who responded and let the police know where she was staying and a visit was made by officers.

105. Within a 48 hour timeframe children's social care services and the police had been given separate disclosures by Binesh about domestic abuse although neither service made contact with the other to have a strategy discussion in regard to the implications for the children or Binesh. There was no further contact with Binesh until children's social care services telephoned her on the 14th April 2014.

106. The phone call on the 14th April 2014 provided further evidence of the perpetrator continuing to harass Binesh by telephone text messages and his refusal to leave the family home. Binesh described further evidence of physical violence that the children had witnessed. Binesh described feeling as if she was in 'mental shutdown'. Binesh expressed plans to consult a solicitor. It was this contact that led to Child 1 being formally included in the statutory assessment by children's social care services. There was no consultation with the police about the allegations of assault or a strategy discussion about risk to the children.

107. It was on the 17th April 2014 Binesh consulted the GP about a sore throat; it was during this consultation that she described feeling very stressed because of 'difficulties in her marriage'. Her description of many years of emotional abuse and 'small incidents of physical violence' resulted in the GP allocating a double consultation session and providing details about counselling services. No other action was taken.

108. The GP saw Binesh again on the 27th May 2014. Binesh was concerned that she might have an infection saying that the perpetrator was having an affair. There is no record of any further clarification being sought during the consultation about the circumstances.

109. During the second face-to-face contact with Binesh on the 29th April 2014 by children's social care services (at a local café rather than at home and being the Easter school holiday) Binesh shared information about the private law application. She had moved back into the family home although the perpetrator was still refusing to leave. Binesh said that she was too frightened to start any further action to prevent him living there. Binesh described the perpetrator as believing the marriage could be 'fixed' and was trying to have sexual relations with her. Binesh was advised to consult a solicitor.

110. The meeting with Binesh was attended by the student social worker and the senior practitioner who was supervising the student. They went on to the school and saw both of the children as well as speaking with school staff. The children provided further information that corroborated the previous disclosures of abuse. This included Child 1 describing the witnessing of the perpetrator 'head butting' Binesh.

111. The head teacher confirmed being very aware of the home circumstances and abuse. The head teacher expressed being confident that Binesh was addressing the issues of concern and that both children were well cared for and loved.

112. It was the same day, Thursday 29th April 2014 that Binesh contacted the police to report being raped by the perpetrator. Binesh's unwillingness to allow a referral to be made to the specialist SARC (sexual assault referral centre) and the perpetrator's

assertion that sex had been consensual led to no further action being taken through court.

113. The perpetrator was interviewed and the conditions of police bail required him to move out of the family home. As on previous occasions there was no direct contact between children's social care services and the police in regard to strategy discussions. An electronic referral on Sunday the 2nd May 2014 notified children's social care services of the allegation.

114. Victim Support tried to make contact with Binesh on the 1st May 2014 with the purpose of completing a risk assessment. The referral to Victim Support misleadingly stated that the case was to be referred to the MARAC (multi-agency risk assessment conference) and during a telephone discussion on the 30th April 2014 A victim care officer at Victim Support was told by Binesh that she had been told the police were referring her case to the MARAC.

115. In fact there was never a referral to MARAC because the DASH risk assessment was graded at medium; the MARAC is focussed on high risk cases. Victim Support attempted to clarify the issue of a referral and left messages for the detective constable but this call was never returned. The risk assessment was completed as a single agency by the police who were not in possession of the information held by children's social care services or the school. Victim Support tried to contact Binesh on the 2nd May 2014 and left a message asking her to contact them. This was not returned and Victim Support closed the case on the 14th May 2014. The home security had been upgraded.

116. The private law proceedings required CAFCASS to screen the application for the purpose of identifying any safeguarding concerns. CAFCASS screened the application on the 30th April 2014 and a local family court advisor was allocated to make further inquiries which included contact with children's social care services. This took place on the 14th May 2014. Children's social care services confirmed an assessment had been completed. The family court advisor was told that an allegation of rape had been made and there was a history of domestic abuse. CAFCASS did not receive information from the police until the day prior to the court hearing (20th May 2014) which confirmed the perpetrator was the subject of bail conditions. Children's social care services were subsequently directed to provide a section seven report at the next court hearing.

Assessment of safeguarding concerns

117. Formal assessments were completed by children's social care services and the police. Not all of the assessments by the police appeared to involve direct input from Binesh. For example the completion of the DASH and enhanced risk police

assessment on the 29th April 2014 appeared to be a desk based activity as opposed to being completed face-to-face with Binesh (or the children).

118. The assessment by children's social care services involved direct discussion with Binesh, both children and the head teacher at school. The children's social care services report acknowledges that the assessment did not sufficiently triangulate different sources of information. This should encompass the direct observation and first person accounts given to the social worker, information from relevant third parties and also checking for any relevant history held by services. There was no contact between the police and children's social care services over and above the routine notifications some of which were the subject of a delay of several days.

119. The assessment of risk by both services relied on Binesh taking appropriate steps to protect herself and her children. The frustration felt by the police when Binesh was unwilling to consent to forensic investigation and a referral to the SARC does not appear to have been factored into the implications for safety planning. Binesh's assertion of having sought an injunction and having left the house contributed to an optimistic view about her circumstances as well as the fundamental misunderstanding that there would be a discussion at a MARAC.

120. The enhanced risk assessment concluded that due to the lack of known domestic violence or criminal history involving Binesh and the perpetrator and the fact that the couple were now residing at separate addresses, the enhanced assessment confirmed the level of risk to be 'medium' therefore the incident was not referred to the MARAC in line with Greater Manchester Police policy. The assessment did not take account of the disclosure of domestic abuse, the fact that such abuse is frequently under-reported and that the couple had separated previously.

121. An assessment by the SARC may well have transformed the risk assessment and strategy. Binesh would have been in contact with specialist professionals who would have had more extensive knowledge and understanding about the barriers for victims and an understanding about the potential for an escalation in risk and threat from perpetrators at the point of disclosure and separation.

122. It is not clear that this was sufficiently understood by other professionals with less specialist knowledge. Efforts were made by Victim Support to contact the police serious sexual offences unit about the lack of consent and following up the referral but messages were not returned. The case was closed by Victim Support the same day that they were told by Binesh that a MARAC was planned giving both parties a false sense of reassurance. The service had attempted to talk with Binesh on three occasions with the purpose of completing a risk assessment but without success.

Services offered to the perpetrator

123. Services provided to the perpetrator focussed on his physical and mental health and never in regard to domestic abuse. He consulted the GP on the 14th July 2014 feeling depressed, tearful and experiencing insomnia. He mentioned that allegations had been made about him although the record of the session is not specific about how much detail was disclosed to the GP. The perpetrator said that the police were no longer involved in investigating the allegations. The GP who saw the perpetrator was not the same GP who saw Binesh and had no direct knowledge of Binesh and her contacts with the surgery in April and May 2014.

124. The GP administered a patient health questionnaire assessment. This resulted in a score of 26 (the maximum being 27); this was a high indicator (but not a diagnosis) of depression and a referral was made to the self-help mental health service.

125. Nobody else was aware of the GP consultation and therefore was never part of any further risk assessment by the police or children's social care services. National evaluations of domestic homicide reviews have identified that domestic abuse has not always been identified because agencies focus on addressing single issues such as mental health and that in those cases there was more tendency to silo working.

126. The report does not explicitly describe the quality of recording of patient contact in respect of Binesh or the perpetrator or whether the GP ever checked previous patient contacts or household or related information. It was different GPs who saw Binesh and the perpetrator respectively.

127. The history was not included in written information passed to the mental health practitioner although during the first session the perpetrator disclosed being accused of rape, stating that he had been 'cleared' of the allegations. This was not true and was not checked.

128. The patient health questionnaire assessment at the mental health service recorded a lower level of depression. Specialist practitioners will not be surprised by a variation in such outcomes which rely on the self-reporting about mood which will inevitably vary due to a number of variables. The perpetrator was not assessed as being a risk to himself or to others. The practitioner was not aware of the significant history of domestic abuse or the evidence of control and coercion.

Management of confidentiality issues and acting on safeguarding concerns

129. The misapplication of confidential data or information sharing protocols is a frequent aspect of reviews. In this case there were opportunities to share information that were not taken.

130. The difficulty that victims of abuse have in giving consent and assisting investigatory processes by statutory services such as the police and children's social care services are a frequent frustration for professionals who may not understand the complex barriers for victims making disclosures about abuse. Victims want their abuse to stop but may fear the consequence of allowing the police and social care professionals to take action. They can also have conflicting emotions and feelings about the perpetrator as well as the potential consequences from a criminal process.

131. It is now understood that Binesh was sharing information with colleagues at school. The fact that the school did not take any initiative in sharing information but offered Binesh emotional support. The GP was also in receipt of confidential information from both Binesh and the perpetrator which did not result in further consideration regarding contact with other professionals.

132. The application by the perpetrator to acquire a prohibited steps order marked an escalation in his attempt to isolate Binesh. This was not immediately apparent to children's social care services or to CAFCASS. Binesh was willing to disclose information to the police and to children's social care services. Her interaction with the police was significant for influencing decision making.

133. The phone call on the 2nd April 2014 to the call handler in the police operational communications room from Binesh provided a clear disclosure about the domestic abuse. Binesh described emotional and physical abuse, threats to destroy Binesh and the perpetrator's increasingly controlling behaviour wanting to know where Binesh was and who she was with. Binesh stated that she would not answer her phone if contacted by the police when the perpetrator was with her. Binesh stated that she had contacted the police as a 'last resort'; the relationship was over, she wanted the perpetrator to leave the house she owns but he was refusing to go.

134. Binesh was subsequently contacted by a police officer and Binesh declined a home visit (because the perpetrator might be at the property) but an appointment was made two days later on the 4th April 2014. The reason for Binesh postponing the meeting was not clarified by the police officer; at least there is not a record of this being done. There is no record from any of these contacts about either of the children.

135. The use of a diary appointment for non-urgent crime or incident reporting is common practice in police services and under those circumstances reflects good resource allocation and management. However investigating a domestic incident is not generally and should never be a diary function since policy requires police services to attend all reported domestic abuse incidents when they are logged. This is in recognition that any evidence such as physical, emotional or mental condition

can be assessed at the moment of disclosure and a victim is generally more likely to support the initial disclosure with a formal statement and provides a better opportunity of securing any relevant forensic or other evidence. There is also the risk of a victim being subjected to intimidation by a perpetrator or otherwise influenced to not pursue a formal complaint.

136. The police report does not comment specifically about the decision to allocate a diary appointment on the 4th April 2014. Binesh was not reporting a specific and current or ongoing incident of physical or verbal domestic abuse but had made clear that domestic abuse was longstanding and was a continuing threat and that she was concerned about the perpetrator's reaction if he was aware that she was speaking with the police and was feeling sufficiently coerced to postpone contact with a police officer.

137. By the time of the scheduled meeting on the 4th April 2014, Binesh was unwilling to 'report any crime' and she did not want the perpetrator to be arrested. The officer recorded that Binesh and the perpetrator had not been married (which was not correct) and that the house was in her name. The officer also recorded that Binesh was informed of her rights to have the locks on the house changed and to refuse entry to the perpetrator; the officer states that Binesh had been unaware of being able to take these measures. It was after this meeting that Binesh left the property with the children. Significantly children's social care services had their first direct contact with Binesh and the children earlier on the same day. As recorded elsewhere in this report Binesh was very forthcoming during the discussion with the social worker about the history of abuse and the perpetrator's increasingly controlling behaviour.

138. According to the senior practitioner during that initial discussion Binesh did not fully understand that the perpetrator's behaviour constituted domestic abuse.

139. This is important because if a victim (as well as any professional) does not understand the nature and significance of domestic abuse they will only have a partial understanding about the potential risk. An additional factor that caused difficulty for Binesh accepting and understanding that she was a victim of domestic abuse was a feeling that it could not happen to a confident and professional woman of her standing and position. Specialist practitioners working with victims of domestic abuse will recognise this and the other aspects of Binesh's behaviour as being very normal for a victim in the circumstances.

140. The reluctance of Binesh for the perpetrator to be the subject of criminal investigation appeared to be an influential and recurring factor in her interaction with the police. The issue of marriage is irrelevant in regard to domestic abuse; the focus should be on the evidence about an intimate partner who is attempting to

control and isolate a victim who has disclosed emotional and physical abuse. It also displays cultural insensitivity about Sharia law that is central to Muslims.

141. Information about the contact by Binesh with the police on the 2nd or 4th April 2014 was not shared with children's social care services. This represented a significant gap in sharing intelligence and information that is acknowledged by the agency report from the police. The application of a more appropriate and accurate closing code on the record that flagged concerns about domestic abuse would have supported better compliance with the police policy. It also meant that the subsequent allegation of rape did not have an accurate history to consider in regard to behaviour and risk relating to Binesh and the perpetrator.

142. On the 8th April a routine audit was conducted by a sergeant who queried the absence of a crime report.

143. The officer responded with the following update;

> *'It has now been 5 days since spending two hours with the informant discussing the options available to her and I cannot recall what direct speech was used but she was asked if she wanted to report any criminal offences previously reported and she told me not and was happy with all advice given and would act on this. Please close, no offences confirmed.*
>
> *She was told that if she is claiming emotional or physical abuse then I would have to submit a crime and offender be arrested and spoken to. At this stage she has stated that she hasn't been a victim of any crime and just wanted advice as to how to remove him from her home. Hence spending two hours discussing special measures but again she was adamant she was not a victim of any crime as previously stated and was seeking advice which she was now happy with and, as such, no crime submitted.'*

144. The incident was referred to the public protection investigation unit who conducted an enhanced risk assessment and confirmed the risk at 'standard level'. No further action was taken and no information was shared with any other service. Nobody appeared to link the report of contact with the perpetrator and Binesh on the evening of the 4th April 2014 when Binesh had left the family home with the children. A significant factor was that the reports relating to Binesh being reported as missing on the 4th April 2014 was initially opened as a general report and closed as a call 'made with good intent'.

145. The significance highlighted in the police management review report was that a referral was not made to the public protection investigation unit for an assessment of risk or consider referral and information sharing with another service. If the public protection investigation unit specialist officers had been in possession of all the information relating to contact with Binesh it might have led to different assessment and action being taken.

146. Binesh's contact with the police on the 29th April 2014 to report being raped by the perpetrator was critically influenced by Binesh's reluctance to make a formal statement, allow a forensic examination of her bedroom or to consent to a referral being made to SARC. According to the notes of the police officer *'Her hope was that ... [the perpetrator] would learn a lesson and change his ways once he had been arrested and did not want this to go to court.'*

147. The previous day during the disclosure to children's social care services Binesh also talked about finding 'really stressful' dealing with the perpetrator and his abuse and reflecting competing emotions of ambivalence and resolve to take action. The contrast in the level of disclosure between the two conversations is very stark.

148. The perpetrator was arrested and interviewed under police caution and in the presence of a solicitor. He gave an account that sexual intercourse had been consensual. He was released on police bail that prohibited contact with Binesh, going to the home address, or contacting the children other than through solicitors or children's social care services.

149. A DASH and enhanced risk assessment were completed at medium level of risk (and therefore not requiring a referral to MARAC). The DASH assessment included a final comment that the *'Victim is in need of support, she has cultural issues which play a factor in her not wishing to pursue a complaint at this stage.'*

150. It is unclear how the officer concluded that Binesh's reticence was 'cultural' rather than symptomatic of other factors. For example, anxiety about the reaction and response of the perpetrator. The public protection investigation unit log had noted that the two previous incidents (2006 and April 2014) had not involved physical violence; this misrepresented the information for example about physical assaults and the history of emotional abuse. A specialist domestic violence advisor agreed with the officer's assessment of medium risk and suggested further contact with Binesh for 'safeguarding advice'.

151. On the 30th April 2014 the specialist officer in the public protection investigation unit recorded an instruction to make a referral to children's social care services and health services and place a domestic violence marker on the address.

152. The public protection investigation unit contacted Binesh on the 1st May 2014 during which Binesh stated that she was fine, had spoken with SWA and witness care and plans were being made to fit new locks and an alarm. Binesh also stated that she had an injunction.

153. The record of the conversation does not clarify details about the supposed injunction. It may have been Binesh being confused about police bail which prohibited contact. If it was not police bail there was no other legal restriction in place. At no stage did Binesh apply for a non-molestation or an occupation order. If she had, the police would have required evidence of an order being made to enable them to enforce it through arrest if the perpetrator had breached it. There is no recorded evidence of a request being made to see the order or to check the police computer system about any record of such an order.

154. The misplaced optimism of Binesh appeared to be a dominant influence and does not appear to have been counterbalanced (at least in recorded evidence) by appropriately informed concerns about factors that discourage victim cooperation and escalation of perpetrator threat at the point of disclosures and separation.

155. The decision to discontinue the criminal investigation recorded the absence of an admissible account by Binesh and her wish not to pursue the matter. The officer concluded that Binesh was 'currently safeguarded' although does not provide a record of the factors that supported that assessment. The officer in charge also assumed that further safeguarding steps would be taken including a referral to MARAC. This shows a misunderstanding about the level of risk that a MARAC would deal with. The inquiry was closed by the public protection investigation unit on the 5th August 2014 noting no further action and 'proportionate safeguarding completed'.

156. In considering the issue of consent or withholding of it and the impact it had on action by the police, additional considerations should have been given to the implications for the children. Arguably, Binesh's reluctance or inability to engage with more effective intervention in response to domestic abuse and a serious sexual offence had implications for her children. It is not clear that this was given sufficient attention in the single agency risk assessment and did not lead to any joint strategy discussion between the police and children's social care services.

Diversity issues relating to the family

157. The two agencies that comment specifically on diversity issues and their impact on responding is the police and to a lesser extent children's social care services. The police comment relates to the DASH assessment in June 2014 that records in its conclusion that Binesh has 'cultural issues which play a factor in her not wishing to

pursue a complaint..', although does not clarify any further what the nature of those cultural issues might be.

158. Abuse that occurs in private and intimate relationships is often difficult for those who are victims to disclose irrespective of their cultural, ethnic or religious background and presents complex ethical and legal issues for the professional services trying to provide help.

159. No evidence is provided that the DASH assessment involved the direct input from Binesh. The reasons for Binesh not wanting to cooperate with the police investigation is not made more explicit other than Binesh hoping that the perpetrator would 'learn a lesson and change his ways'.

160. This process of reasoning by a victim of domestic abuse is not unusual. It is reasoning that should cause an increased awareness of potential risk to a victim and especially against a history of escalating threat and control. These factors do not appear to have been sufficiently recognised and therefore were not included in information to the specialist officers in the police.

161. There is well founded research evidence that cultural diversity will be contributory factors to processing information by victims, perpetrators and professionals. There is a danger in making assumptions though about what a particular cultural tradition will mean.

162. Cultural traditions can influence something as difficult and sensitive as domestic abuse. A previous government through the Government Office for London (now abolished) published a toolkit that focussed on the needs of Asian women in recognition of the vulnerability faced by women from these communities arising from abuse by a husband and the risk of community victimisation. The toolkit described the pressure on women to hide any evidence of abuse and acknowledges that abuse can be psychological and emotional as evidenced in this case.

163. Domestic abuse presents an additional level of stigma and social isolation that can inhibit the ability of victims and families to disclose what is happening and can also influence the response by some professionals who either share a common cultural tradition or are unaware of the significance of different cultural systems. Binesh disclosed to children's social care services that she was reluctant to pursue the rape more formally with the police because she that it brought shame upon her children.

164. South Asian cultural tradition relies on the family structure to provide support and to resolve personal problems and difficulties. It is a tradition that believes strongly in the privacy and primacy of the family and encourages family members to be loyal to the family and to not look to external people and agencies to intervene. It is a

tradition that encourages the family and its various members to take care and responsibility. It is a tradition that is not unique to South Asia.

165. It is equally important that culture does not become the only rationale for the difficulties that face victims when disclosing and talking about domestic abuse and in particular sexual crime.

166. The report from children's social care services acknowledges that there 'were some cultural issues raised by Binesh in relation to both her and the perpetrator's family and tensions within their relationship, exploration could have been made of relevant culturally sensitive services regarding domestic abuse'. This is an acknowledgment that there was a gap in cultural understanding and awareness.

167. Outreach workers are available within Stockport to work with vulnerable families from minority ethnic and cultural backgrounds. There are good links with Mosques. It is not easy for people from diverse backgrounds to open up and speak to non-Muslim people for fear of bringing shame to the family. It is very important to have a link person to support these individuals. In this case if the word had got out that Binesh had reported these incidents she might possibly have been labelled.

Capacity and resources

168. Few of the agency reports provide any comment regarding capacity and resources of their services in regard to the contact with Binesh or the perpetrator. There is generally little comment made about the policy and training framework of the different organisations or the extent to which individual professionals had participated in training and development in regard to identification, recognition and response to domestic abuse.

169. The school identifies gaps in policy and training that are being addressed as a result of the domestic homicide review and may have highlighted wider systemic issues in how schools and education providers are supported in regard to domestic abuse. The report identifies the introduction of charging for training and development having contributed to a reduced take up of opportunities; the charging policy has been withdrawn but there may still be a residual impact.

170. The Stockport NHS Foundation Trust (responsible for school nursing services in this domestic homicide review) highlighted that although they had a policy in place from January 2014 it had not included Tameside services; the review panel has been advised that this has been rectified. The same report comments on the complex organisational issues in implementing meaningful policy and guidance in a large and dispersed organisation comprising individual business units and corporate

arrangements. The complexity as well as organisational change of many services is an issue that extends further than the Stockport NHS Foundation Trust.

171. The police provided information about the implementation of the action plan in response to the HMIC inspection in 2014[12]. This includes a training, awareness and compliance plan that has required the completion of a training needs analysis, delivery of presentations to divisional staff supported with bespoke training in specific domestic abuse measures such as domestic violence prevention notices (DVPN) and domestic violence orders (DVPO).

172. The report from the police highlights persistent issues in regard to information and intelligence; this encompasses limitations in IT as well as human interaction with those systems; in other words how people record and access and use information.

173. The implementation of the improvement plan is ongoing and was at an early stage in 2014 just after publication of the HMIC inspection report.

174. Children's social care services confirmed that the assessment and case management of contact was allocated to a student social worker and provide evidence to support their analysis that the student was appropriately supervised by a senior practitioner. Although the report does not comment in detail about the training or experience of either professional, the report highlights areas for development generally in regard to how information is shared in regard to domestic abuse and in regard to culture and diversity.

[12] Her Majesties Inspectorate of Constabulary (HMIC)*; Greater Manchester Police's approach to tackling domestic abuse*

Conclusions and recommendations

175. Any meaningful analysis of the complex human interactions and processes for decision making that characterise multiagency work with adults vulnerable to domestic abuse has to understand why things happen and the extent to which local systems help or hinder effective work.

176. There is a risk when undertaking a review that has examined the involvement of several different services for it to then result in a range of recommendations that overwhelm rather than promote the further positive development of services and practice. The individual management reviews have generated 14 recommendations single agency learning and improvement which are included as an appendix.

177. The process of undertaking the review has already generated learning across several services and therefore it is of doubtful quality to take an unduly forensic approach of dealing with every detailed aspect; such an approach leads to over complicated and ultimately less effective action plans and strategies. The fact that the final overview report will be a public document also means that the full content is available for relevant training and development to promote continued learning across all services.

178. The key points of learning relate to:
    a) Recognition and understanding about domestic abuse
    b) Risk assessment
    c) Role of universal services
    d) Domestic abuse as a safeguarding issue for children
    e) Policy and training

Recognition and understanding about domestic abuse

179. The domestic abuse strategy in Stockport identifies gaps and inconsistencies within early intervention and prevention services and recognises the importance for workforce development.

180. Professionals need to distinguish between the controlling and coercive behaviour that constitutes domestic abuse and other behaviour that reflects marital or relationship difficulties and tensions. Although separation and divorce are difficult and distressing experiences especially for children that can be ameliorated by strategies such as mediation and support, it is domestic abuse that represents a distinct and different attitude, behaviour and threat that requires clarity in its recognition, definition and response by professionals. It requires having the knowledge, skill and sensitivity to actively look for signs and symptoms of domestic abuse given the barriers that face victims in disclosing it.

181. The Greater Manchester Domestic Abuse Procedures emphasis that workers in all agencies need to be in a position to identify and receive disclosures about domestic abuse and be prepared to ask direct questions. GPs are one group of professionals who will be recipients of information and was the case for Binesh and the perpetrator. Schools or employers more generally can also be other recipients of information.

182. Domestic abuse is when someone in a close relationship behaves in a way that causes the other person physical, mental, or emotional damage. It doesn't have to be physical violence. It includes any incident of threatening behaviour. Domestic abuse can be psychological, physical, social, financial or emotional and this is reflected in the amendments to national definitions of domestic abuse issued in September 2012 to reflect the legal protections set out in the Equality Act 2010.

183. The extent to which Binesh was suffering emotional, physical and sexual coercion (and how this affected her behaviour) was not clearly enough recognised by any of the services. If it had been there would have been better opportunity to have understood the behaviour of both perpetrator and victim particularly from April 2014 onwards. It would have given greater confidence in key interactions with Binesh at school, with the police and with children's social care services.

184. The quality of professional's response influences the likelihood of victims engaging with strategies and action. Victims will not want to leave their home and the disruption of familiar routines and places for adult victims and for children often requires contemplation and involve decisions to subsequently return. Victims will also be concerned and fearful of an escalation in abuse and violence; this was clearly the position for Binesh.

185. Individuals who return to violent or abusive situations require more help not less. Returning home and a familiar situation should be seen as a normal response to separation and part of the process of longer term change. Victims and their children will be under a great deal of emotional and psychological stress. An up-to-date risk assessment should be completed in these circumstances.

186. Binesh had been discussing the domestic abuse with work colleagues at school from the summer of 2013. Victims of domestic abuse who are in employment or training may either disclose information as Binesh did or work colleagues may observe other indicators such as evidence of physical injury or Binesh being controlled in terms of contact in or outside of the workplace. It is for this reason that organisations should have policies about domestic abuse and how employees can be supported.

187. The fact that Binesh was a teacher should have given an enhanced level of professional workplace knowledge within the school about domestic abuse

compared for example to a commercial or manufacturing enterprise. Domestic abuse is an issue that affects individuals across all social and economic groups be they a victim or a perpetrator. This case shows that employers and work colleagues might well be the people who victims talk to about domestic abuse. Clear policies in regard to responding to an employee who is either a victim or a perpetrator of domestic abuse will assist in responding appropriately.

188. Domestic abuse is a safeguarding issue for children and it will be a teacher or primary health worker who is more likely than any other professional to observe or receive information indicating that a child is living in a household with domestic violence. In order to do this, school staff and the school designated safeguarding lead in particular have to participate in training and development that enable them to have the skills and ability to identify signs of abuse and what needs to be done.

189. The domestic homicide review has highlighted that in this school there had not been the level of training required to enable them to effectively respond to the disclosures by Binesh or identify the safeguarding issues in regard to the children. All of the discussions were undertaken on the basis of empathetic support much as a friend might provide rather than bringing the level of professional perspective and action required.

190. The school (and other services) relied too much on Binesh being able to resolve the situation in spite of the evidence that the perpetrator had no intention of agreeing to a separation or allowing Binesh to leave the relationship. Better participation in appropriate training and the development of awareness would are more likely to promote a better understanding about crucial interactions; for example that when the perpetrator was making allegations about the relative it was part of a strategy to isolate Binesh.

191. At no stage did the school, and in particular the designated safeguarding lead consider initiating a CAF as a precursor to more intensive involvement or making a referral to children's social care services ideally with the cooperation of Binesh. The involvement of other statutory services would have provided opportunity for an earlier assessment of the children's circumstances and conceivably would have introduced other sources of advice and help that could have included the use of civil law measures such as a non-molestation order.

192. The response by the police relied unduly on Binesh cooperating with criminal investigations. It is not evident that there was sufficient understanding about the reasons that victims very often will report abuse and violence but are reluctant to formalise statements or undergo forensic procedures. The response to the allegation of the rape took little account of seeking other evidence that included the previous history.

193. The fact that much of the information held by different professionals remained within their organisational silos hampered anybody having a good enough overview. The police and children's social care services had separate disclosures about domestic abuse within a 48 hour timeframe at the beginning of April 2014 although neither service was aware of this at the time. The police sent a routine notification through to children's social care services a month later.

194. All of the services relied on Binesh being able to take sufficient protective action for herself and for the children. The extent to which Binesh felt ashamed of being a victim of domestic abuse partly as a result of being a professional educated and articulate woman was not appreciated.

Risk assessment

195. The overall approach to risk assessment did not appear to appreciate the degree to which a disclosure of domestic abuse and/or an attempt to leave an abusive relationship would represent an increased rather than decreased level of risk to a victim. Binesh left the house when she became aware that the perpetrator had found notes and evidence that she had been talking to the police.

196. This did not feature to any significant level in any risk assessment. There was high reliance on the perpetrator complying with his bail conditions and when this ended after the decision was taken that no further action could be taken there was no explicit risk assessment or sharing of information with children's social care services. There was insufficient attention to the circumstances, needs and voice of the children and the impact on them of being witnesses to domestic abuse.

197. The importance of assessment actively seeking out and considering the views, wishes and feelings of children appropriate to their age and understanding and analysing the implications for their immediate and longer term safety and well-being is a recurring theme in reviews.

198. Victims can also minimise the degree of risk. Some of this reflects a desire to manage the response by professionals and fearing consequences. Some of it is a lack of knowledge and understanding about the nature of coercion and control.

199. None of the professionals appeared to advise Binesh to seek a non-molestation and occupation order. This may have reflected a reliance on the bail conditions imposing controls on the perpetrator although ended when Binesh felt unable to support follow up action after the initial allegation of rape.

200. The confusion about whether the case was to go to a MARAC appeared to have given Binesh some reassurance. In fact the case was closed to both the police and to Victim Support.

201. The inability of Binesh to accept contact with the SARC removed the opportunity for specialist professionals to talk with Binesh. If she had been able to take that step it would have opened up opportunities to encourage and support Binesh in a plan that involved the criminal justice services and the development of a safety plan. There is no recorded reason for why Binesh did not want to have involvement with SARC.

202. The absence of any significant mental health or any evidence of substance misuse probably contributed to an overall optimism that Binesh was not at high risk from the perpetrator.

Role of universal services

203. The value and importance of professionals working in universally accessible services has been reinforced by this review. The first and most persistent disclosures were at school and the GP practice was also receiving information from both Binesh and the perpetrator.

204. The extent to which these services do not have clear enough policy and protocol and the absence of focussed curiosity and ability to ask direct questions is an important learning point.

205. The Royal College of General Practitioners published guidance to help staff working in general practices to respond effectively to patients experiencing domestic abuse[13]. The guidance describes key principles to help develop domestic abuse policy which includes the role of a senior and designated person for domestic abuse, establishing a domestic abuse care pathway and the training requirements for the whole team including clinical and non-clinical staff. The same guidance also highlights the importance for a strategic lead from within the clinical commissioning group. The Royal College of General Practitioners also endorse the IRIS (identification and referral to improve safety) commissioning guidance published by The University of Bristol.

206. The Royal College of General Practitioners also provide through the internet website access to the Violence Against Women and Children e-learning course which enables GPs and other primary care professionals to improve their recognition of and response to patients suffering from violence.

[13] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

207. The Tameside agency report describes training provided to school in that borough and acknowledges that schools need to access this facility. The education service in Stockport has not been a party to the review given the children were not attending a Stockport school. However the learning identified in regard to ensuring there are clear arrangements in place for a designated safeguarding lead who has sufficient knowledge of domestic abuse and there are clear arrangements in place to ensure teaching and non-teaching staff are able to recognise potential signs and symptoms of domestic abuse and are able to respond appropriately is relevant to Stockport and indeed other areas.

Domestic abuse as a safeguarding issue for children

208. The local domestic abuse procedures highlight that research makes clear links between domestic violence and abuse and the abuse and neglect of children and also found more than half of serious case reviews. 30 per cent of children screened through the local multi agency safeguarding hub (MASH) in Stockport show domestic abuse as the predominant issue.

209. The physical, psychological and emotional effects of domestic abuse and violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may act out the aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under stress. Several of the children displayed symptoms of stress that with hindsight were not identified or understood at the time. The symptoms of stress that can been seen in children living in households where there is domestic abuse and violence include:

a) Withdrawal
b) Aggression or bullying
c) Tantrums
d) Vandalism
e) Problems in school, truancy, speech problems, difficulties with learning
f) Attention seeking
g) Nightmares or insomnia
h) Bed-wetting
i) Anxiety, depression, fear of abandonment
j) Feelings of inferiority
k) Drug or alcohol abuse
l) Eating disorders
m) Constant colds, headaches, mouth ulcers, asthma, eczema

210. There are no reports of any of the above symptoms being present for Binesh's children although their distress about arguments and witnessing assaults on Binesh are clearly recorded. The school the children attended is rated as good by Ofsted. A good school is one source of resilience for children dealing with traumatic events in their lives although it is important that this is not allowed to mask the significance of domestic abuse on children's emotional as well as physical well-being.

211. Neither the police nor children's social care services initiated a strategy meeting because the children were not regarded as being at risk of significant harm. This judgment was largely influenced by the way Binesh interacted with both services and appeared to be taking steps to protect her children. The inability to engage with the police and the SARC, returning to the home where the perpetrator insisted on remaining, the ending of bail for the perpetrator and no other legal sanction being in place were indicators that the children could and would be exposed to further abuse.

Policy and training arrangements

212. None of the services have referred to any specific policies in regard to domestic abuse either in regard to looking after employees who are victims of domestic abuse as well as policies for helping patients, pupils and service users. The Crown Prosecution Service (who were not participants in this review) have as an example of good practice developed guidance for employees in that service suffering domestic violence.

213. The NHS accountability and assurance framework described in *Safeguarding Vulnerable People in the Reformed NHS* published in March 2013 by the NHS Commissioning Board makes clear an expectation that GP practices have a safeguarding lead. 35 of the 48 GP practices in Stockport actively participate in the quarterly safeguarding briefings. These have included information about domestic abuse as well as having input from the specialist sergeant from the police domestic abuse team.

214. The Greater Manchester Child Protection Procedures do not make a clear and specific reference to the importance of recognising and understanding the impact of domestic abuse as a source of harm for children. Although the procedures include reference to domestic abuse as an indicator of abuse and it is included in the section that deals with children in specific circumstances it gives little specific advice and guidance on what should be done either in identifying potential signs and symptoms (for example through children's behaviour) or following more specific disclosures for example.

215. Multi agency training in regard to the impact of domestic abuse is included in the Stockport Safeguarding Children Board annual programme. There is e-learning on

domestic abuse awareness provided through delivered the Virtual College which is accessed through licence. This has a cost implication for any professional or services outside of the local authority. The decision was made last year to stop delivering the classroom based sessions because of dropping attendance and to move to the online learning package. No information was available about who was participating in this level of training.

216. The reliance on e-learning to deliver training on complex areas of work such as domestic abuse are being highlighted in other reviews. E-learning provides limited opportunity to develop the level of cognitive awareness necessary to recognise evidence of coercion and to understand the barriers that face victims in making disclosures or engaging with strategies.

Recommendations

1. NHS England should clarify that NHS Stockport Clinical Commissioning Group have a professional lead for domestic abuse which is clearly identified in that post holder's job description. The lead should represent the clinical commissioning group at the strategic forum in Stockport that oversees the domestic abuse strategy.

2. NHS England and Stockport Clinical Commissioning Group should ensure that all GP practices in Stockport have been made aware of the guidance issued by the Royal College of General Practitioners and encourage them to ensure that there is a written policy for the practice and the role of the safeguarding lead in respect of domestic abuse that complies with *Safeguarding Vulnerable People in the Reformed NHS 2013*.

3. NHS England and Stockport Clinical Commissioning Group should encourage clinical and non-clinical staff in GP practices to complete relevant training which for members of the Royal College of General Practitioners (RCGP) includes the Violence Against Women and Children e-learning course.

4. The Stockport Community Safety Partnership should develop a model policy statement that can be used by employers setting out guidance on responding to employees experiencing domestic abuse and that it is promoted through local employer organisations that include the chamber of commerce and professional associations.

5. The safeguarding advisor for schools in Tameside and Stockport should ensure that all schools have a written policy in regard to domestic abuse and

that domestic abuse is written into the role of their safeguarding or designated senior professional.

6. The Stockport Safeguarding Children Board should ensure that the local audit of arrangements under section 11 of the Children Act 2004 and any data collated under section 175 of the Education Act 2002 (governing and responsible bodies for schools complying with safeguarding responsibilities) incorporate data and information on domestic abuse from schools and early years settings.

7. The Stockport Safeguarding Children Board should ensure that specific guidance on the recognition of and response to children affected by domestic abuse and violence is included in local safeguarding policies, procedures and training.

8. Stockport Children's Social Care Services and the Greater Manchester Police should ensure that when their professional staff are responding to information or referrals about domestic abuse that a clear record is made of advice and action to promote the safety of the victim and any children and any contingency arrangement or plans.

9. The Stockport Community Safety Partnership should seek clarification from the Greater Manchester Police public protection and investigation unit about the role and use of diary appointments in regard to contact from domestic abuse victims.

10. The Stockport Community Safety Partnership should review with the Stockport Children Safeguarding Children Board the level and effectiveness of training for professionals in regard to domestic abuse and seek further information about single agency training and development.

11. The Stockport Community Safety Partnership should review with the Stockport Safeguarding Children Board the availability and effectiveness of training and development in regard to cultural awareness and understanding and implications for working with victims vulnerable to domestic abuse.

Appendix 1: people and organisations who will be sent a copy of the final report in addition to family members after the completion of all related processes

1: Panel Members

CMFT	Safeguarding Adults
GMP	IMR Author
Independent Consultant	Chair and Author of Report
NHS England	Patient Experience Manager
NHS Stockport (CCG)	Designated Nurse for Safeguarding Children
Greater Manchester Police	Detective Sergeant – Serious Case Review
Stockport MBC – Community Safety Unit	Deputy Head of Service
Stockport MBC – Children Social Care	Head of Service
Stockport MBC – Children Social Care	Service Manager
Stockport MBC – Children's Safeguarding	Manager
Stockport MBC – Cultural Issues	Community Learning Mentor
Stockport Women's Centre	Centre Manager
Stockport NHS Foundation Trust	Named Nurse Safeguarding (CCG)
Stockport NHS Foundation Trust	Child Programme Team Leader
Self Help Services	Lead Officer
Tameside MBC	LADO and Safeguarding Advisor for Education
Tameside MBC	Named Nurse
Victim Support	Service Delivery Manager

In attendance at the Panel:

Stockport MBC – Community Safety Unit	Officer for Domestic Violence

2: Report Authors

Primary School/Tameside Council

CAFCASS

CAMHS

Children's Social Care and Safeguarding, Stockport Council

Central Manchester University Hospitals NHS Foundation Trust (CMFT)

Greater Manchester Police

NHS Foundation Trust - Nursing

NHS England - GP

North West Ambulance Service (NWAS)

Self Help Services

Victim Support

3: Safer Stockport Partnership Board

Greater Manchester Fire Service

Greater Manchester Police Crime Commissioners Office

Greater Manchester Police Service

Guinness Housing Partnership Association

Home Office

Independent Consultant

Member of Parliament

National Probation Service

Solutions SK

Stockport Council

Stockport Councillors

Stockport Homes

Stockport NHS

Stockport NHS Foundation Trust

Transport for Greater Manchester

Victim Support

Youth Offending Service

4: Home Office

Appendix 2: procedures and guidance relevant to the domestic homicide review

Date	Policy or legislation	Prime agency
1990	**Home Office Circular 60/1990 Domestic Violence:** issued to all police forces in England and Wales advising police to ensure that all police officers involved in the investigation of cases of domestic violence regard as their overriding priority the protection of the victim and the apprehension of the offender. The circular emphasised the importance of multi-agency working, establishment of domestic violence units, reviewing of recording policy and ensuring that officers were aware of the power of arrest and providing support to the victim.	Police
October 1991	**Children Act 1989 implemented;** major legislation in regard to investigation and protection for children at risk of harm. Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need. Section 25 describes the circumstances under which a local authority can seek to restrict the liberty of a child by placing them in secure accommodation. Section 46 provides the police with powers of removal and accommodation of children in cases of emergency to take children into police protection where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm. Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a child has contravened a ban imposed by a Curfew Notice within the meaning of chapter I of Part I of the Crime and Disorder Act 1998. Section 31 (9) defines harm which was extended via section 120 Adoption and Children Act 2002 implemented in January 2005 that now includes 'impairment suffered from seeing or hearing the ill-treatment of another' recognising that children	Social care and police have specific duties and powers described in the Act but implications and duty to cooperate for other services.

	who witness or hear abuse suffer, or are likely to suffer, significant harm as a result.	
1995	**Home Office and Welsh Office (1995)** inter agency circular/inter agency coordination to tackle domestic violence: issued to all agencies involved in tackling domestic violence including the police.	All services
1996	**Family Law Act 1996**: changed the legal framework relating to civil injunctions in the context of family law. Part IV of the Family Law Act 1996 provides single and unified domestic violence remedies in the county courts and magistrates' courts. Two types of order can be granted: • A non-molestation order, which can either prohibit particular behaviour or general molestation; • An occupation order, which can define or regulate rights of occupation of the home.	
1997	**Protection from Harassment Act 1997**: (PHA) introduced the offence of harassment and power of the court to issue restraining orders on conviction. PHA makes it a criminal offence to pursue a course of conduct which amounts to harassment of a person. A court may issue a restraining order against someone found guilty of such an offence. Amendments to the PHA introduced by the Domestic Violence, Crimes and Victims Act 2004 will gives courts the power to issue a restraining order in certain circumstances against a defendant acquitted of a charge of harassment. In addition to the criminal offence, the PHA also creates a civil statutory tort of harassment, which enables a person to obtain a civil court injunction to stop harassment occurring and to claim damages where appropriate. This legislation can provide protection in neighbourhood disputes, cases of racial harassment and can also potentially apply in cases of domestic abuse.	Police and courts
1998	**Crime and Disorder Act 1998**: established the framework of multiagency Crime and Disorder Reduction Partnerships tasked with conducting audits of local crime and disorder and agreeing a local strategy. Section 17 of the Act requires the police (in partnership with local authorities) to exercise all their functions —*with regard to the effect on the need to prevent crime and disorder in their areas*. Domestic violence falls clearly within these duties.	
1998	**Human Rights Act 1998**: introduced positive obligations to protect life and protect victims against inhuman and degrading treatment.	All services and courts

1999	**Youth Justice & Criminal Evidence Act 1999**: introduced special measures within a court setting, for vulnerable and intimidated witnesses.	Police and courts
2000	**Home Office (2000) Domestic Violence Break the Chain multiagency guidance for addressing domestic violence**: the guidance includes advice for the police that *"there must be no suggestion that dealing with domestic violence is in any sense second class police work*" and that specialist officers should maintain close links with other units dealing with issues such as child protection.	Police as well as other agencies
2000	**Home Office Circular 19/2000; Domestic Violence revised circular to the police**: this circular provided more specific and detailed information to the police and reflected changes in legislation since 1990 and the findings of recent research.	Police
2004	**HMCPSI/HMIC (2004)** ***Violence at home, a joint thematic inspection of the investigation and prosecution of cases involving domestic violence***: includes a number of recommendations relating to policing and prosecuting domestic violence cases.	Police and courts
2004	**Domestic Violence Crime and Victims Act 2004;** Civil injunctions (under Part IV of the Family Law Act 1996) offer temporary protection through non-molestation orders or occupation orders. However, breach of injunction by the perpetrator was often not effectively enforced. New provision under section 1 of the DVCVA 2004 is intended to address this issue. Until now a breach has only been punishable as a civil contempt of court. When a non-molestation order either made after July 1st 2007, or an earlier order which has been varied is breached it will be treated like any other criminal offence, meaning that the perpetrator can be arrested, charged and brought before the magistrates' court. The victim, who was the applicant in the original civil process, becomes the key witness in a criminal case. As in other criminal cases, the decision whether or not to prosecute will be made by the Crown Prosecution Service (CPS) in conjunction with the police, where there is sufficient evidence and it is in the public interest to do so. The maximum custodial sentence for breaches dealt with as a criminal offence is five years. The procedure under Family Law Act 1996 Part 6 rule 12A (2)states:- Where an order is made ex parte a copy of the order.... shall be served by the applicant on the respondent personally. Enforcement of orders	

	S20 (1A) states:- ... shall be delivered to the officer for the time being in charge of any police station for the applicant's address or of such other police station as the court may specify (1B) states:- The documents referred to above ... shall be delivered by (a) the applicant, if the applicant is responsible for serving the order on the respondent	
2004	**ACPO (2004) guidance on investigating domestic violence**: guidance includes a clear focus on the investigation of criminal offences relating to domestic violence.	
2004	**Home Office Violent Crime Unit (2004) Developing Domestic Violence Strategies – A Guide for Partnerships.**	
2005	**ACPO (2005) guidance on identifying, assessing and managing risk in the context of policing domestic violence**: includes a list of risk 313 factors and general information about the basic principles of identifying, assessing and managing risk in domestic violence cases.	Police
January 2005	**Adoption and Children Act 2002**, section 120 implemented: amends section 31 of the Children Act 1989 to include the following in the definition of harm: impairment suffered from seeing or hearing the ill treatment of another e.g. witnessing domestic violence.	Police, social care and courts
February 2005	**ACPO (2005) policy on police officers who commit domestic violence related criminal offences**: clearly establishes the principle that evidence that a police officer has committed criminal offences relating to domestic violence is not compatible with a police service that has public confidence.	Police
March 2005	**ACPO (2005) guidance on investigating child abuse and safeguarding children**: guidance includes a clear focus on the investigation of allegations of criminal offences relating to child abuse and the need to identify concerns for children which are managed in the multi-agency structure for safeguarding children.	Police
June 2005	**ACPO (2005) Practice Advice on Investigating Harassment**: this provides information on harassment including that related to domestic abuse.	Police
September 2005	**ACPO (2005) Guidance on Investigating Serious Sexual Offences:** includes specific investigative guidance on investigating domestic or intimate partner sexual offences.	Police
2005	**Home Office (2005) Domestic Violence**: **A National Report**: this developed a national delivery plan for services relating to domestic violence.	All services and courts

December 2005	**Responding to domestic abuse:** a handbook for health professionals and superseded an earlier handbook issued in 2000.	Health
2006	**H M Government (2006) Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children** that includes guidance on children exposed to domestic violence (superseded in 2010)	All services
2007	**ACPO (2007) Police Officers and Police Staff that are Victims of Domestic Abuse**	
2007	**Home Office (2007) National Domestic Violence Delivery Plan: Annual Progress Report 2006-2007.**	
April 2008	**ACPO (2008) Guidance on Investigating Domestic Abuse**: this revised and updated the ACPO (2004) Guidance on Investigating Domestic Violence.	
April 2009	**National MAPPA guidance v3**	
September 2009	**Improving safety, reducing harm. Children and Young People and domestic violence**; A practical toolkit for front-line practitioners	Health
March 2010	Working Together revised and reissued	All services
8th April 2010	The Crime and Security Act (CSA 2010) gained royal assent of which Sections 24-33 of the Act relate to Domestic Violence Protection Notices/Orders. (DVPN/O) These are legislated for under Sections 24 - 33 of the Crime and Security Act 2010 which (when fully implemented after being piloted in Greater Manchester, West Mercia and Wiltshire) will grant powers to the police in England and Wales to issues notices which immediately prevent allegedly violent partners from returning to a family home pending a formal order being issued by a magistrate. Section 33 came into effect when the Act came into force; sections 24-30 were commenced from 30th June 2011 for one year. Sections 31 and 32 have not been commenced.	Police
November 2010	**Call to End Violence against Women and Girls;** national action plan, vision and guiding principles for reducing violence against women and children	
April 2011	Domestic Homicide Reviews were established on a statutory basis under **section 9 of the Domestic Violence, Crime and Victims Act (2004)**	
April 2012	***Striking the Balance*; Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences**); Guidance intended to assist those involved in information sharing between agencies about Domestic Violence to make decisions. It identifies the underlying ethical considerations so that tensions between confidentiality and information	Health

	sharing may be resolved.	
May 2012	**Responding to domestic abuse: Guidance for general practices;** a general guide to GP practices issued by the Royal College of General Practitioners and CAADA to help them provide effective help to patients experiencing domestic violence.	
2012	**CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence** (this is not government guidance or legislation but is included as an important contribution to local and national arrangements	
June 2012	Government issues consultation on revised guidance for working together	
July 2012	Pilot of the Domestic Violence Disclosure Scheme begins for 12 months in Greater Manchester, Nottinghamshire and Wiltshire in England and in Gwent in Wales. The scheme is commonly referred to as Clare's law; this is a reference to Clare Wood who was murdered by her ex-boyfriend in Salford in 2009. The boyfriend had a history of domestic violence that was not known to Clare Wood. The pilot scheme allows a check with police on whether a partner has a history of domestic violence. The scheme was implemented across England and Wales in March 2014.	
September 2012	Definition of domestic violence and abuse widened to include those aged 16-17 and wording changed to reflect coercive and controlling behaviour and includes so called 'honour based violence, female genital mutilation and forced marriage.	
March 2014	Implementation of domestic violence protection notices and orders as well as Domestic Violence Disclosure Scheme across England and Wales.	

Single agency action as a result of the domestic homicide review

Children's Social Care

1. Formal recording on supervision files with personal development plans to specifically identify learning needs.
2. Review the type of cases allocated to student social workers with student placement officer.
3. Briefing on findings to be presented at Children's Social Care Service Seminar meeting
4. Joint training to be provided with the police to improve partnership working and information sharing
5. Training on cultural and diversity issues and domestic abuse to be delivered ideally in a multi-agency forum
6. Refresher training on MARAC process, and MARAC assessment

Greater Manchester Police

1. Greater Manchester Police to fully implement all aspects of the Domestic Violence Action Plan which was drawn up in response to the HMIC inspection
2. Stockport PPIU should re-circulate amongst staff and re-affirm the content of the document 'Guide *to Dealing with Domestic Abuse PPIs*' to ensure that all relevant staff have an awareness and understanding of policy and procedure contained within the document.

GP service

1. Review of single agency safeguarding training to GPs ensure that domestic abuse and its impact on the family is incorporated

School

1. Head teacher to communicate with governors and staff to outline staff welfare and safeguarding responses.
2. Head teacher to write a staff welfare and safeguarding policy with human resources and governing body support
3. All staff to receive child protection awareness training from the local authority
4. To arrange school governor safeguarding training
5. Child protection leads to attend child protection training more regularly and would benefit review and update school child protection policy to reflect local and national guidance from attending a domestic abuse training course
6. Review and update child protection record keeping within school

Self Help Service

1. Services to implement measures prior to assessments to assess risks of clients who may pose a risk either to the practitioner or members of the public.

2. Review record keeping guidance and training to increase the clarity of records
3. To ensure that the final version of referral forms (i.e. with triage decisions indicated) are the versions on the client record.
4. To review the data collection of family members

Stockport NHS Foundation Trust

1. Clarify and update the current Trust wide domestic abuse policy to include staff in Community Healthcare business unit and which includes Tameside staff

Victim Support

1. Management team discussion to consider a change of practice in respect of case-sharing activity between the Victim Care Unit, community service and projects, in order to maximize successful victim contact.
2. Refresher training with Victim Care Unit staff to ensure that risk and safeguarding indicator measures are introduced at initial contact with the victim, in relative cases and that where such measures are declined, that this is clearly recorded.