MANCHESTER COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim FA 1

Nov 2015

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

FA 1	25 years	Victim	Syrian
MA 1	33 years	Perpetrator Husband of FA 1	Syrian
MA 2	38 years	Brother of MA 1	Syrian (naturalised as British Citizen in 2006)
MA 3	35 years	Brother of MA 1	Syrian
Child A	<10 years	Son of FA 1/MA 1	Palestinian (b. Palestine)
Child B	<8 years	Son of FA 1/MA1	Palestinian (b. United Kingdom)
Child C	<3 years	Daughter FA 1/MA 1	Palestinian (b.United Kingdom)

1.2 On 08.06.2013 a friend of FA 1 told Cleveland Police that she was concerned for the welfare of FA 1 and her children. Cleveland Police asked Greater Manchester Police [GMP] to check on the welfare of the family. Those checks were not carried out and the enquiry was closed without either police force recording her as a missing person.

1.3 On Tuesday 02.07.2013 FA 1's uncle reported her missing from home and GMP started a missing person enquiry. A few days later MA 1 and MA 2 were arrested on suspicion of murder. Both were charged with the murder of FA 1 which was alleged to have happened between 07.06.2013 and 08.06.2013. MA 3 was arrested later and was charged with perverting the course of justice in relation to the case. FA 1's body has not been found and that remains the case as of 19.04.2015.

1.4 On 04.06.2014 MA 1 was found guilty of murdering FA 1 and was sentenced to life imprisonment with a minimum tariff of 20 years. MA 2 was found not guilty of murder and pleaded guilty to perverting the course of justice and received three years imprisonment. MA 3 was found guilty of perverting the course of justice and was sentenced to four years imprisonment.

1.5 The following was reported in the media: "The prosecution said FA 1 had been killed for becoming "too westernised" and 'establishing an independent life'". The sentencing Judge said: FA 1 had suffered "years of abuse", adding, "The contempt you showed for FA 1 in death matched the contempt of how you treated her in life."

1.6 Greater Manchester Police's Senior Investigating Officer said, "FA 1's death had been an honour killing" and added that "the irony is that this horrific act of self-pity brought nothing but shame on him and his family".

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 On 08.08.2013 the Chair of Manchester Community Safety Partnership [MCSP] decided the case met the criteria for a DHR.

2.2 Section 5 of the Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and states it should be completed within a further six months. The completion date was set as 08.02.2014; six months from the screening panel meeting. The Chair of MCSP agreed to hold the DHR in abeyance until after the trial and sentence. Additionally, the Independent Police Complaints Commission [IPCC] was investigating some aspects of GMP's response to FA 1 and there was a need for the DHR to establish information sharing protocols. The Home Office was informed of a revised submission date of 30.11.2014.

DHR Panel

2.3 David Hunter was appointed as the Independent Chair and Author on 08.08.2013. He is a self-employed independent practitioner with professional knowledge of investigating and reviewing domestic violence and honour based violence. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. The first of four panel meetings was held on 08.08.2013. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

The Panel comprised of:

- Named Nurse Adults and Children Central Manchester Foundation Trust [CMFT]
- Head of Safeguarding Manchester City Council [MCC]
- Head of Service, Children and Family Court Advisory Support Services [Cafcass]
- Service Manager Independent Domestic Violence Advocate [IDVA] MCC
- Principal Team Leader Homelessness Team MCC
- Project Leader Pakistani Resource Centre
- Head of Internal Affairs Adactus Housing Group
- Named Nurse for Adult Safeguarding Manchester CCG
- Police Sergeant Public Protection Division GMP

- District Head Centre Early Years
- Social Work Consultant MCC Children's Services
- Principal Team Leader Homelessness Team MC
- St Mary's Sexual Assault Referral Service[1]

[1] These members attended once to provide specific advice

Several Panel members were qualified to provide cultural advice and their input was very helpful in understanding the issues.

Agencies Submitting Individual Management Reviews [IMRs]

2.4 The following agencies submitted IMRs.

- Greater Manchester Police
- Cafcass
- Adactus Housing Group
- Sure Start/Early Years
- NHS Central Manchester Clinical Commissioning Group
- Homelessness Division MCC
- Central Manchester University Hospitals NHS Foundation Trust
- Cleveland Police

Note:

The DHR Panel was unable to access MA 1 or MA 2's GP records. The GP was willing to share them but was advised by the Medical Defence Union [MDU] not to do so. The independent chair spoke and twice wrote to: the solicitor representing MA 1 and the Practice Manager at the law firm representing MA 2, asking that they seek their clients' permission to access their GP's record. Despite encouraging noises the authority was not received. Legal Advice was given by MCC who concluded it was a matter for the GP holding the record to decide on its release. Advice was also sought from NHS England but a definitive position was not established.

A letter from the General Medical Council to the Chair of a DHR [Adult A] in Sheffield dated 06.10.2011 said, "We … feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors [paragraph 62] says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHRs as well"

The independent chair of this DHR [FA 1] suggested that the Named Nurse for Safeguarding Adults in Manchester could view the GP records to determine if they

contained any relevant material and if so additional tactics could be considered on how to access them. On the advice of the MDU the GP again declined access.

Access to perpetrators' GP records in DHRs can be problematic. Manchester Community Safety Partnership is working closely with NHS England and the local Clinical Commissioning Groups to resolve these issues.

Where GP information is mentioned in this DHR it has been sourced from other agencies' records.

2.5 Non IMR written information was received from:

- Safer Stockton Partnership
- Education Manchester
- Children's Services Manchester City Council

Notification/Involvement of Families

2.6 The DHR Chair wrote to FA 1's uncle informing him of the DHR and inviting him to contribute after the criminal trial. He is her only relative living in the UK. The letter and Home Office Domestic Violence Review leaflet were handed to him by the GMP Family Liaison officer [FLO]. The independent DHR chair approached the police Senior Investigating Officer [SIO] seeking his views on the probity of seeing the Uncle before the trial. The SIO requested a list of questions the chair wanted to ask the Uncle. These were provided, and permission was given. The independent chair accompanied by the GMP Family Liaison Officer saw the Uncle and his family, in the presence of an interpreter on 13.01.2013. The uncle's views appear in the report as appropriate. FA 1's family was notified of the review findings prior to it being submitted to the Home Office.

2.7 The DHR Panel, advised by the police, felt it was not appropriate to contact the family of MA 1, MA 2 and MA 3 before the conclusion of the trial. After the trial the independent DHR Chair wrote to the perpetrators family but did not receive a response. The DHR Panel was canvassed for its views on whether MA 1 should be approached post sentence. The Panel unanimously concluded that because of MA 1's attitude towards FA 1's death as reported on during the trial, and commented on by the judge during sentencing, that it was not appropriate to see him.

Terms of Reference

Purpose of a DHR

2.8 The purpose of a Domestic Homicide Review is to:

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

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Source: Section 2.7 of the Guidance.

Timeframe under Review

2.9 The DHR covers the period February 2005 when FA 1, MA 1 and Child A entered the country as asylum seekers to 02.07.2013 when FA 1 was reported missing by her uncle.

Case Specific Terms

1. Were the risk indicators for domestic violence present in this case recognised, properly assessed and responded to in providing services to FA 1, MA 1 and Children A, B and C. If not, what was the reason for this?

2. Were the services provided for FA 1 and MA 1 and their children timely, proportionate and 'fit for purpose' in relation to the levels of risk and need that were identified?

3. How did agencies ascertain the wishes and feelings of FA 1 about her victimisation and were her views taken into account when providing services or support?

4. How effective was inter-agency information sharing and cooperation in response to FA 1's victimisation? What consideration was given to sharing information between Cleveland and Manchester agencies in support of FA 1 and her children and was it effective?

5. How does your organisation support victims from black and minority ethnic [BME] backgrounds who disclose domestic violence?

6. What consideration was given to whether FA 1 was at risk from honour based violence and what response was provided? Was it recognised that the risk of domestic abuse and honour based violence would increase post separation and what response was made to manage such risk?

7. How were any: racial, cultural, linguistic, faith or other diversity issues, including immigration status, taken into account during the assessment and provision of services to FA 1, MA 1 and their children?

8. Were the reasons for MA 1's abusive behaviour properly understood and addressed? Was there sufficient focus on reducing the impact of MA 1's

abusive behaviours towards FA 1 and their three children by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

9. Were single and multi-agency policies and procedures, including the MARAC protocols, followed and are they embedded in practice and were any gaps identified?

10. How did MARAC safeguard, FA 1 and the children and address MA 1's alleged offending behaviour. What are the arrangements to ensure an effective interface between MARAC protocols and Children's Safeguarding procedures?

11. How effective was the supervision and management of practitioners involved with the response to FA 1's needs and did managers have effective oversight and control of the case?

12. Were there any issues in relation to capacity or resources within your agency that affected your ability to provide services to FA 1, MA 1 or their children, or to work with other agencies?

3. DEFINITIONS

DOMESTIC VIOLENCE

3.1 The Government definition of domestic violence against both men and women [agreed in 2004] is:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

3.2 The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force in March 2013 is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

3.3 The experiences of FA 1 fall within the various descriptions of domestic violence/abuse.

Honour Based Violence

3.4 The Crown Prosecution Service [CPS] and the Association of Chief Police Officers [ACPO] have a common definition of Honour Based Violence [HBV]:
"Honour Based Violence" is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'.

3.5 Appendix A provides additional information on HBV.

Multi-Agency Risk Assessment Conference

3.6 Multi Agency Risk Assessment Conferences [MARAC] are voluntary meetings where information is shared on the highest risk domestic abuse cases between local public and voluntary agencies, such as health agencies, the police and Independent

Domestic Violence Advisor [IDVA] services. After sharing relevant information about a victim the Chair of the MARAC summarises the risk and then agencies volunteer relevant actions and timescales to reduce the risk[s] to the Victim.

Note: The DHR Panel heard that many agencies attending MARAC undertake standard post MARAC actions which support the victim but do not appear in the minutes. This is explored later in the report.

3.7 In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator [section 2.1.5 of MARAC Operating Protocol December 2012]. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

3.8 MARAC objectives as set out in sections 2.2 of MARAC Operating Protocol 2012 and are as follows:

- To share information to increase the safety, health and well being of adult victims and their children;
- To determine whether the perpetrator poses a significant risk to the victim, other individuals or to the general community;
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- To reduce repeat victimisation;
- To improve support for staff involved in high-risk domestic abuse cases;
- To ensure issues are dealt with by the most appropriate agencies / groups with relevant knowledge and practical applications;
- To assist in the statutory obligations to implement interventions for, and clarify their commitment to, the prevention or detection of domestic abuse and sexual offences; and
- To improve agency accountability.

3.9 MARACs have become an effective means of supporting the highest risk cases of domestic abuse and were introduced in GMP in early 2006. A MARAC implementation guide and protocol was first produced in GMP in June 2006.

The MARAC Operating Protocol 2012 defines high risk as a "risk that is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible."

3.10 The current threshold test for a MARAC referral in domestic abuse cases, as set out in section 5.5.2 of the MARAC Operating Protocol 2013, is as follows:

- Visible high risk – 14 or more 'yes' responses on the Domestic Abuse Stalking and Harassment [DASH] risk indicator checklist [questions 1-28];

- Potential escalation – The number of police callouts to the victim as a result of domestic abuse. This can be used to identify cases where there is not a positive indicator of a majority of risk factors on the list, but where the abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at the MARAC;

- Professional judgement – If a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear; cultural barriers to disclosure, immigration issues or language barriers, particularly in the case of honour-based violence. This professional judgement would be based on the professional's experience.

- Repeat victimisation as defined in clause 5.3.3 of this document.

4. FAMILY BACKGROUND

4.1 Introduction

4.1.1 The sources of information in the following paragraphs are from: FA 1's uncle, IMRs, FA 1's solicitor and FA 1's statement prepared to support her application to the court. FA 1 and the children were lawfully in England and their application to stay was being processed at the time of her death. MA 1 was granted asylum in April 2008, with leave to remain until April 2013. MA 2 and MA 3 were lawfully in the UK.

4.2 FA 1 MA 1

4.2.1 FA 1 was born in Syria and was the third eldest of six children. She went to a United Nations school and is described by her uncle as a Muslim [although not practicing] who wore a hijab and took part in some religious festivals such as Ramadan. FA 1's uncle described her as a loving person, intelligent and motivated to provide a better life for her and the children.

4.2.2 FA 1 met MA 1 when she was about 15 years of age when her older sister married MA 1's older brother in 2001. It appears FA 1 and MA 1 were very much in love and married in Syria on 29.10.2002.

4.2.3 It is believed that FA 1 and MA 1 left Syria in 2003 with the intention of seeking asylum in the United Kingdom [UK]. Child A's United Kingdom of Great Britain and Northern Ireland Travel Document issued on 20.11.2009 shows he was born in "Genin" Palestinian T'ty, [Territory] Occupied.

Note: Genin is thought to be Jenin a city in the Northern West Bank governed by the Palestinian National Authority. FA 1's uncle understands Child A was born during his parents' long journey to England.

4.2.4 FA 1, MA 1 and Child A entered the UK on 15.02.2005 as asylum seekers and initially settled in Teesside. At the time of her death FA 1 was waiting for permanent leave to remain in the UK.

4.2.5 Between February 2005 and August 2008 the family had five changes of address before being permanently re-housed in Teesside. FA 1 and MA 1 attended English classes and accessed amenities. Child A was in a playgroup. Child B was born in Teesside. Health used an interpreter when interacting with FA 1 and MA 1. FA 1 reported feeling isolated and was assessed as highly likely to have post natal depression. She disclosed relationship problems to her GP but not the nature of them. She felt a move to Manchester to be nearer her husband's parents and family would be beneficial. MA 1 was noted to have a low mood because his asylum status prevented him from officially working.

4.2.6 In August 2009 FA 1 told a health professional in Teesside that she had separated from MA 1 about six months ago. She did not say why. In July 2009 FA 1 advised her local council that MA 1 had left the family home and was not contributing financially.

4.2.7 In mid February 2010 FA 1 reported to her landlord that youths congregated outside her house, subjected her to verbal racial abuse and threw stones at her window. An appropriate response was organised by local agencies. FA 1 requested that a female officer attend at any subsequent visits. On 01.03.2010 FA 1 reported that the incidents had stopped because her husband had returned home.

4.2.8 FA 1 did not disclose domestic violence to any agency in Teesside. One of FA 1's friends [Friend 1] described the relationship between FA 1 and MA 1 as fine until 2008. FA 1 disclosed to her friend that MA 1 had beaten her causing bruising to her neck and back. FA 1 photographed the injuries and sent them to her friend. FA 1 described MA 1 as lazy; he regularly took drugs and prevented her from seeing her friends or going to college.

Note: The DHR Panel felt [1] there was a need to provide advice to families and friends who received disclosures of domestic violence. There was a recommendation from a Moss Side DHR [Homicide July 2011 Victim FA 1] to have a publicity campaign aimed at family and friends and the recommendation is repeated here.

[1] Imkaan Vital Statistics 2 Key Findings Report on Black Minority, Ethnic and Refugee Women's and Children's Experience of Gender Based Violence. Dr Ravi K Thiara [University of Warwick] and Sumanta Roy [Imkaan] Sept 2012 reported:

Women were most likely to initially talk to friends [54% n=99] and family members [45% n=83] about what was happening at home.

Overall, women found responses from friends [88%] and other agencies [89%] most helpful whilst reporting family responses as unhelpful [54%]

4.2.9 The family left Teesside on 29.03.2010 and moved to Address 1 in Manchester. At the time FA 1 was pregnant with Child C. The move to Manchester was in part motivated by the desire of MA 1 to be nearer his family. It also appears that MA 1, who is described as a jealous man, had an altercation with a Pakistani shop keeper in Teesside because MA 1 thought he had flirted with FA 1. This further isolated FA 1 and her family from the Teesside community.

4.2.10 Once the family settled in Manchester it is believed that MA 1 continued to travel to Teesside to work in fast food outlets. It is reported that he gambled his wages and did not adequately provide for his family. FA 1 visited her in-laws and appeared to have an affinity with MA 2 who was described as more level headed than his younger brother [MA 1] and seems to have wanted to calm things down between FA 1 and MA 1.

4.2.11 In Manchester, the Children [A, B and C] were receiving universal services, schooling, health and Sure Start/Early Years. FA 1 was accessing adult education.

4.2.12 In late 2012 FA 1's uncle was requested by MA 1's parents to come to Manchester for a family conference following a serious argument between FA 1 and MA 1 after she disclosed he had raped her. FA 1's uncle told the independent DHR chair that he

recalled the meeting and accepted the reassurances of MA 1 that he would change his behaviour. The uncle now deeply regrets accepting what was a false promise. FA 1 wanted a divorce and in early 2013 completed a housing application for another local authority so she could be near her uncle.

4.2.13 FA 1 told Friend 2 that she suspected MA 1 was sleeping with other women, smoking a lot of cannabis and that her marriage was over. FA 1 began to speak to other men which resulted in a dispute in January 2013 when MA 1 took her mobile telephone. FA 1 also informed MA 1 that she had met another man. FA 1 told Friend 2 that she had been told by MA 2 to end the relationship with the man she had met. This is probably evidence of the family collectively acting against FA 1.

4.2.14 FA 1 disclosed to her solicitor on 24.01.2013 that she was the victim of domestic violence, including rape, at the hands of MA 1. This began when she married him in Syria and continued throughout the time they were together. FA 1 also disclosed that the children had witnessed the domestic violence and that MA 1 threatened to take the children from her if she did not comply with his wishes to be obedient. She also reported that MA 1 had been violent to Child A and smoked cannabis in front of all the children.

4.2.15 It is apparent from FA 1's friends that she was a caring mother who wanted the best for her children which did not include living in a violent relationship. FA 1 was not prepared to tolerate MA 1's abusive dominance of her and the impact it had on the children.

5. IMPORTANT EVENTS ANALYSIS

5.1 Introduction

5.1.1 Set out below in date order is a list of important events. The ones in *italics* are designated "Key Events" because of the opportunities they presented for agencies to respond to domestic violence. The others are included to show the history. The Key Events are dealt with in two parts. The first is a factual narrative immediately followed by a critical analysis drawn from: the IMRs, other reports, the deliberations of Panel members.

5.2 Important Events

Date	Event
15.02.2010	FA 1 tells Teesside landlord of racial abuse; appropriate action taken
01.03.2010	FA 1 reports that MA 1 had returned to the family home; he had been absent for about a year; his whereabouts are not known.
March 2010	FA 1, MA 1 and the children [A & B] move to Manchester Address 1
31.03.2010	FA 1 registers with Manchester GP, no disclosures of DV
02.10.2010	MA 1 arrested Teesside for robbery, attacked staff member no charges; this may be linked to the flirtation report; see 4.2.9
Feb 2012	FA 1 tells MA 1 to leave family home Address 1 because violence escalating; he complied and returned to Teesside
Sept 2012	FA 1 allows MA 1 to return to Address 1
Nov 2012	FA 1 subject to serious/sustained violence from MA 1 whom she said also raped her; Police not notified as culturally unacceptable and threat from MA 1 to remove children; family discussed the matter
18.01.2013	*FA 1 made an abandoned 999 call to GMP, officers attended FA 1 reports verbal argument with MA 1*
19.01.2013	*FA 1 requests GMP to attend Address 1 so she could collect her belongings following previous day's domestic incident, advice given on the telephone*
20.01.2013	*FA 1 again calls GMP asking for officer to attend Address 1 while she collects property; officers attends*
21.01.2013	*FA 1 presents at Homelessness Assessment and Advice Service [HAAS] reported fleeing DV needed accommodation; referred to Independent Domestic Violence Advocate [IDVA]*

22.01.2013 *IDVA telephoned FA 1; completed CAADA DASH RIC [Co-ordinated Action Against Domestic Abuse; Domestic Abuse Stalking and Harassment; Risk Identification Checklist] [DASH]*

22.01.2013 *IDVA consults manager and refers FA 1 to MARAC [Multi Agency Risk Assessment Conference] using professional judgement*

23.01.2013 *IDVA refers FA 1 to solicitor who saw her next day [24th] FA 1 discloses MA 1 raped her in Nov 2012*

28.01.2013 *Civil orders granted to FA 1 [non-molestation; prohibitive steps; specific issues order]*

28.01.2013 Civil orders plus FA 1 statement to court served on MA 1

30.01.2013 *Cafcass receive application from court, FA 1 wants Residence Order, specific steps order and prohibited steps order*

14.02.2013 *MARAC*

20.02.2013 *MA 1 presents as Homeless*

22.02.2013 MA 1 told Homelessness he thought FA 1 was seeing someone else

29.04.2013 *Court grants Contact and Residence Order Sec 8 Children Act 1989*

27.05.2013 *FA 1 and Children move to Address 2*

07.06.2013 Adactus heating engineer visits Address 2 sees FA 1

08.06.2013 *Friend tells Cleveland Police she is worried about FA 1 fears DV*

09.06.2013 *Cleveland Police ask GMP to locate FA 1 and the children to ensure they are safe and well; told of DV; and current address provided*

10.06.2013 *Friend 2 calls GMP, very worried about FA 1, GMP unable to establish FA 1's current address; family not seen or located*

02.07.2013 *FA 1's uncle reports to GMP that she is missing*

03.07.2013 GMP "uncover" current address from original Cleveland E mail

08.07.2013 MA 1 charged with FA 1's murder

09.07.2013 MA 2 charged with FA 1's murder

5.3 Key Event: *FA 1 made an abandoned 999 call to GMP, officers attended FA 1 reports verbal argument with MA 1*

5.3.1 At 12.52 pm on Friday 18.01.2013 GMP received an abandoned 999 call. A person was heard sobbing in the background. The number was traced and GMP recalled it. FA 1 said she had an argument with her husband and she had left the home address [Address 1] and went to a neighbours from where she had called.

5.3.2 GMP checked its databases and did not have any record of domestic violence at Address 1. FA 1 agreed to see an officer at Address 1 in ten minutes. After the visit the officer caused the following entry to be made on the incident log. "No offences, Children present, no alcohol". This was coded as a domestic incident where a juvenile was present.

5.3.3 The attending officer completed a DASH risk assessment in which FA 1 answered "no" to 26 of the 28 questions. The two answered questions were about whether the victim was very frightened and why. FA 1's replies are recorded as:

"Scared of her husband now the police are involved": and "that her husband may assault her if she returns home".

The risk assessment deemed FA 1 to be a standard risk which means that the current evidence did not indicate a likelihood of FA 1 suffering serious harm.

Note:
DASH questions 4; 15; 20 and 21 are aimed at assessing whether there is an HBV element to the incident. The responses were, "no" and therefore HBV was not considered an issue at this stage.

5.3.4 A GMP Public Protection Log Investigation [PPI] log was generated and summarised the circumstances of the incident as:

"The a/p [aggrieved party] and her husband have today had an argument over a mobile phone which has resulted in the a/p leaving the home address very upset. She has gone to ... stay at family friends...".

The primary victim was recorded as FA 1 with the alleged perpetrator as MA 1. Details of the three children were recorded on the log.

5.3.5 A specialist officer from the Public Protection Investigation Unit [PPIU] approved the above PPI log notes, adding:

"There are no previous reports of DV between these parties with each other or anyone else. Minor verbal argument, children not subject to CPC [Child Protection Conference] score 2 on DASH. File NFA".

5.3.6 An enhanced risk assessment [ERA] was not completed, nor was a letter sent to FA 1. There is confusion in GMP about when ERA's and letters are required. Additionally, the PPIU log was not closed by a sergeant as required by policy.

Analysis:

5.3.7 GMP's response to the abandoned 999 call was prompt and supportive of FA 1 and her children. No offences were identified. The attending male officer followed GMP's policy and the incident was correctly identified and coded as domestic violence. The log noted that the victim had three children and their details were recorded. The DASH risk assessment judged the victim faced a standard risk, which on the information disclosed to the police was accurate and appropriate. Had FA 1 made a more expansive disclosure the risk assessment would have been different. Has a full

disclosure been made the risk assessment would have shown that FA 1 was at least at high risk of suffering serious harm by MA 1.

5.3.8 Victims have many reasons why they do not make full disclosures when first reporting domestic violence. Manchester Safeguarding Children Board [MSCB] and MSAB have a joint policy titled: "Working Together to Safeguard Adults from Domestic Violence". The following is taken from it:

> **Black and Minority Ethnic Survivors**
> Domestic abuse can affect people from all ethnic backgrounds and there is no evidence to suggest that people from a black or minority ethnic background are more at risk of domestic abuse than others.
>
> However, the forms of abuse that BME survivors are exposed to can vary and they may experience additional barriers to disclosing domestic abuse or in receiving appropriate support. For example, the abuse might be perpetrated by a member of the person's extended family or they may fear the rejection of their community if they disclose abuse or seek help.
>
> The experiences of people from a BME background may also be exacerbated by racism, language barriers or insecure immigration status. You can contribute to improving the outcomes of BME survivors by being aware of some of the specific risks or needs that the person might have and some of the key specialist service provision that is available both locally and nationally.

5.3.9 The Panel discussed that many victims of domestic abuse, particularly from the BME community, use an incremental approach to disclosure and that front line practitioners may not always appreciate this nuance. Coaxing information from victims requires time, patience and a good understanding of the cultural barriers victims have to overcome to reach the point of even minimal disclosure. The experience of the domestic violence specialists on the DHR Panel was that victims are reluctant to disclose until they absolutely trust the person to keep their secret. Some fear their disclosure may leak into the family and community; this adds additional pressure on the victim not to disclose. The DHR Panel recommends that MSAB re-emphasise in its training that the BME victims of domestic violence face additional barriers when considering disclosing domestic abuse, and that it takes patience to build a rapport with victims and gain their trust.

5.3.10 The DHR Panel felt the questions in the DASH risk assessment [see 5.3.3] aimed at identifying whether there was an HBV element to the domestic abuse were not direct enough. For example a direct question on whether the victim had considered HBV may generate a discussion between the officer and victim on what is meant by HBV. In this way a picture may emerge of what is happening in the victim's life. This enables accurate risk assessment followed by a more comprehensive risk management plan. The DHR Panel recommends that MSAB consider whether the questions, as framed, provide the best opportunity to identify HBV.

5.3.11 The incident log was appropriately routed to PPIU for an enhanced risk assessment. This requires a specialist officer to consider an additional eleven questions and search systems for any domestic violence history before finalising the level of risk.

5.3.12 The requirement to conduct an ERA is contained in GMP's Domestic Abuse Policy 2010 and The Public Protection Division's PPIU Divisional Handbook March 2012. On 08.10.2012 the Public Protection Division sent an e-mail to Divisional PPIUs reminding them of GMP's 2010 policy.

5.3.13 The GMP Force policy says:

"...For each incident you must carry out an enhanced risk assessment process which allows you to gather all information and intelligence available in respect of the victim and/or perpetrator which is relevant to risk identification, assessment and management".

The Public Protection Division PPIU Divisional Handbook says:

"An ERA should be completed for all Domestic Abuse Incidents that are classed as Standard but PNC [Police National Computer] and PND [Police National Database] checks should not be carried out".

5.3.14 A senior GMP officer within the Headquarters Public Protection Division gave a verbal instruction on an unknown date that ERAs need not be carried out for standard risk cases. The message had variable penetration within GMP; some PPIU staff knew this, others did not. Therefore, some practitioners received conflicting advice on when to undertake ERAs and in this case the specialist PPIU officer thought it was not necessary to complete an ERA on standard risk cases. If Headquarters Public Protection Division thought it necessary to alter Force policy it should have done so through the established procedures or as a minimum issued a clear "temporary amendment" in writing until a permanent amendment could be made.

5.3.15 The DHR Panel judged that the completion of an ERA would not have altered the level of assessed risk to FA 1; it would have remained as standard on the information disclosed.

5.3.16 FA 1 did not receive a victim's letter. GMP's Domestic Violence Policy 2010 says that a letter should be sent to victims of domestic violence who have been risk assessed as standard. The Public Protection Division PPIU Divisional Handbook 2012 says that standard risk cases will "generally" [author's emphasis] receive a letter, subject to local assessment. This might appear inconsistent with the 2010 Force policy. However, GMP Force policy has the following summarised caveat. "The only time an officer should deviate from the policy is if they feel sending a letter would potentially put the victim at risk or the fact that they have chosen to make a call to the victim. Nevertheless the reasons and justification should be documented with PPI OPUS". [Public Protection Investigations - Operational Policing Unit System]. The officer making that assessment reasoned that as it was the first reported incident, and of a minor nature, a letter was unnecessary, but that a second report would have generated a letter. The DHR Panel felt that the officer's decision not to send a letter was defensible. However, the reason for not sending the letter should have been based on the impact it had on risk to FA 1 and not the "minor" nature of the report.

5.3.17 GMP's Domestic Abuse Policy 2010 says a Divisional Domestic Abuse Sergeant will:

"Finalise all incidents of domestic abuse within PPIU OPUS"

5.3.18 The PPIU Divisional Handbook 2012 states:

> All PPIs relating to SVC [serious violent crime] or SSO [serious sexual offences] should be finalised by an Inspector, all other PPIs by Sergeants. [Some divisions have authorised constables in the triage team to finalise some reports e.g. PPIs that are not classed as investigations and the decision for this level of authority rests with divisional Inspectors and DCI]".

5.3.19 That means in the circumstances of this incident, the PPI log should have been closed by a sergeant. The constable closing it said she had authority from her supervisors to close standard risk logs.

5.3.20 The confusion around when ERA's should be done featured in a Bury DHR [Homicide June 2012 - Victim MA 1]. A recommendation was made for the policy to be reviewed and GMP repeats it in this DHR.

5.3.21 Despite the issues around ERA's, victim letters and the authority to close domestic violence incident logs, the DHR Panel thought the assessment of risk was accurate and the response timely and largely appropriate on the information known. A safety plan would have enhanced the response.

5.4 Key Event: ***FA 1 requests GMP to attend Address 1 so she could collect her belongings following previous day's domestic incident, advice given***

5.4.1 At 4.05 pm on Saturday 19.01.2013 GMP received a 999 call from FA 1. She wanted someone to accompany her to Address 1 when she collected her belongings and told the operator about Friday's domestic incident. FA 1 was advised to recall GMP when she was at the house. FA 1 recalled GMP at 5.00 pm saying that she would try and obtain clothing for the children via her friend. FA 1 said she would not attend Address 1 by herself and re-contact GMP if she needed to. FA 1 did not make any disclosures.

5.4.2 The log was closed with a domestic violence code and a PPI log was created. This was viewed by a specialist officer who finalised the log writing:

> "Non PPI: Reason: Police not attended – resolved via her friend"

Analysis:

5.4.3 The operator considered the risks to FA 1 and knew she was not going to return to the house alone. The response by GMP was generally appropriate and proportionate. The fact that FA 1 wanted the police to accompany her suggests she was frightened of MA 1 and that he presented a risk to her. Additionally, the reason for going to the house was to collect belongings, including clothing for the children. An enhanced response by GMP would have been to actively enquire of FA 1 whether the children were safe and well, and whether FA 1 was capable of protecting them and herself.

5.5 Key Event: FA 1 again calls GMP asking for officer to attend Address 1 while she collects property; officers attends

5.5.1 At 10.56 am on Sunday 20.01.2013 FA 1 contacted GMP saying she wanted to attend Address 1 to collect property. The log was crossed referenced to the previous days and a male officer attended. The log was closed and endorsed: "No offences Property collected". It had a closing code of Civil Dispute.

Analysis:

5.5.2 Again the response was appropriate and supported a victim of domestic violence. On the face of it the incident was almost identical to the previous days, yet the closing codes were different. One was coded domestic violence, the other civil dispute.

5.5.3 Incidents can have more than one closing code to reflect the complex nature of some calls. Both incidents should have included a domestic violence closing code thereby allowing their retrieval and routing to PPIU. The civil dispute code was not wrong but did not tell the full picture. The request for police attendance again suggests FA 1 was not prepared to be alone with MA 1.

5.6 Key Event: FA 1 presents at Homelessness Assessment and Advice Service [HAAS] reported fleeing DV needed accommodation; referred to Independent Domestic Violence Advocate [IDVA]

5.6.1 On Monday 21.01.2013 FA 1 presented at Homelessness Assessment and Advice Service [HAAS] which is part of MCC Homelessness Division. FA 1 was seen by a male Assessment Officer [AO 1] and declined the offer of an interpreter. FA 1 disclosed she was the victim of domestic violence [physical assaults and controlling behaviour] on more than one occasion and had left Address 1 the previous week. AO 1 gathered limited information about her domestic violence history and did not ask where the domestic abuse took place or whether the children had witnessed or had been present during the assaults.

5.6.2 FA 1 elected to be re-housed in North Manchester, but AO 1 did not consider whether MA 1's extended family lived there. She accepted the offer of temporary bed and breakfast accommodation at Address 3. AO 1 referred FA 1 to IDVA. A pre-Common Assessment Framework [CAF] was completed from which the HASS IMR author concludes that the children were present at the initial meeting with AO 1, a fact since confirmed by HAAS. FA 1 was allocated a Family Support Worker [FSW 1]. The Pre CAF remained on HAAS's file and was shared with the IDVA.

Analysis:

5.6.3 FA 1 knew of HAAS through a friend. HASS's response was practical and AO 1 correctly judged that FA 1 was a priority case and thereafter found accommodation for her and the children the same day. He did not probe into her background and therefore did not extract the depth and extend of her victimisation. For example it is known that by this time FA 1 had told her friend and some family members that MA 1 had threatened the children and subjected her to sexual violence.

5.6.4 The HAAS IMR author believes that AO 1 should have been more aware of the cultural and faith issues and that generally practitioners should not be embarrassed to ask probing questions. It is known that when FA 1 was experiencing trouble in Teesside she expressed a preference to be seen by a female worker. That is something it would be unreasonable for anyone in Manchester to have known, but it

does reinforce the point that victims should be asked whether they have a preference on the gender of the service provider. The DHR Panel recognised that BME victims may not want to be seen by someone from their cultural background because they may be judged for taking issues outside of the family.

5.6.5 The Homelessness representatives on the DHR Panel said it was practice, but not policy, to offer clients a choice of whether they wanted to be seen by a male or female AO. Sometimes it was not possible to meet clients' preferences to be seen by a female. The DHR Panel understood the difficulties. FA 1 had found the courage to attend Homelessness and make a limited disclosure of domestic violence. The DHR Panel conclude that it was important that in such circumstances obtaining the disclosure at the first opportunity was more preferable than postponing it until a female AO became available.

5.6.6 The presence of FA 1's children during her initial presentation is likely to have been a bar to fuller disclosures. Homelessness recognises this but do not have creche or other arrangements to cater for these circumstances.

5.6.7 The immediate availability of female AOs and no creche provision are real and practically issues which may hinder female victims of domestic violence from making a disclosure or confining their disclosure.

5.6.8 The DHR Panel makes a recommendation that the Homelessness Division considers:

1. having a written policy on offering clients a gender choice of AO
2. how it would support such a policy
3. how to deal with victims of domestic violence who have children present during disclosure meetings

5.6.9 Completing a pre-CAF was a positive step and evidences that AO 1 knew the link between domestic violence and safeguarding. This contrasts to the oversight in not enquiring whether the children had been exposed to violence perpetrated by on their mother by their father. HAAS determined at the time that the pre-CAF did not meet the threshold for referring to Children's Services on the information obtained. The DHR Panel examined the threshold levels in place at the time [Manchester Domestic Abuse Assessment Tool for Children Working Together To Safeguard Adults and Children From Domestic Abuse Multi-agency Procedures MSAB and MSCB] and judged that the children were at threshold Level two meaning they had additional needs. Therefore on balance the DHR Panel felt the children should have been referred to Children's Services.

5.7 Key Event: IDVA telephoned FA 1; completed CAADA DASH RIC [Co-ordinated Action Against Domestic Abuse; Domestic Abuse Stalking and Harassment; Risk Identification Checklist]

5.7.1 At 4.02 pm on Monday 21.01.2013 the IDVA service received a referral from HASS asking IDVA 1 to make contact with FA 1. IDVA 1 made telephone contact early the following day and FA 1 asked her to call back.

5.7.2 IDVA 1 telephoned at 4.15 pm on Tuesday 22.01.2013; spoke with FA 1, completed a CAADA DASH RIC and obtained permission to refer FA 1 to a solicitor for consideration of civil protection. FA 1 did not disclose the November 2012 rape or the violence to Child A. The DASH scored twelve which is two below automatic MARAC referral threshold. However, IDVA 1 referred the case to MARAC using the discretionary "professional judgement" criteria. This was good practice.

5.7.3 FA 1 told IDVA 1 during the "DASH" telephone call, that MA 1 called yesterday [21.01.2013] crying and asking to see the children. FA 1 declined to give MA 1 her address but was comfortable with him seeing the children under proper arrangements. She feared he might take them away because Child A and Child B's travel documents were missing. Child C did not have a travel document. IDVA 1 established with Children's Services that the children were unknown to them apart from a contact from a health visitor to inform them; "that the mother and 3 children had moved into HF [homelessness family] accommodation, a multi-agency planning meeting was to be held on 31 Jan 2013 but no SW [social worker] attendance was required. If need be a referral would be made later". No agency could find any evidence of the 31.01.2013 meeting and it was not mention at MARAC on 14.02.2013. Health visiting cannot explain the reference to the meeting and therefore the DHR Panel concluded it had not taken place.

5.7.4 IDVA 1 informed GMP of the MARAC. The MARAC Coordinator created a PPI log. FA 1 should have been seen by a GMP officer within 72 hours for the purposes of determining whether a criminal investigation was necessary and to gather other information which might be useful to MARAC. The officer allocated the PPI log spoke with IDVA 1 and Homelessness Division and left a message on FA 1's mobile for her to make contact. FA 1 did not respond and the officer did not follow it up. This meant that neither IDVA 1 nor GMP saw FA 1 prior to MARAC.

5.7.5 IDVA 1 spoke with the children's school [which was in the area she fled from] who agreed that they should not attend pending notification that the civil orders were in place. The school has no record of any contact from IDVA or that FA 1 was a victim of domestic violence. The school did know that FA 1 had left home and initially believed she lived in a refuge. The school did not share that information with anyone or think there might be a child protection issue.

Analysis:

5.7.6 IDVA's response was swift, professional and supportive. The discretionary referral to MARAC was well judged as was her liaison with other agencies. The link between the location of the school and its proximity to the former matrimonial home and the danger that MA 1 would have ready to the children was well thought out and executed. The missing travel documents added to the risk of abduction.

5.7.7 The contact between FA 1 and IDVA 1 was by telephone which may have deterred FA 1 from a more comprehensive disclosure. The experiences of the domestic violence specialists on the DHR Panel believe that face to face meetings are more effective in achieving full or fuller disclosures and are also safer in that the IDVA can be sure there is no one else present who might be influencing the victim. That cannot be guaranteed in a telephone assessment.

5.7.8 A summary of the IDVA Service Manager's reply in responding to a query from the independent author on whether a face to face meeting would have been better is shown below.

1. Up until about 18 months ago IDVA used to interview victims presenting as homeless due to Domestic Abuse at the point of presentation. IDVA lost 3 full time posts in the spending review 2 years ago which reduced our capacity to continue to deliver this part of the service and so a consequence of this was that the IDVA assessments for homelessness applicants had to be carried out over the phone.

2. This part of the role was specific to the Manchester IDVA service and most IDVA services in the country only take referrals from MARAC, which is now the case in Manchester due to reduced IDVA capacity and inadequate staffing numbers based on the level of MARAC referrals and CAADA recommendations.

3. The high volume of MARAC referrals [1090 in 2012/13] into the IDVA service has meant the service has had to prioritise these over homelessness presentations and because of increased staff sickness due to stress we have had to withdraw totally from contacting homelessness applicants at all. Homelessness staff give basic advice and the contact number for Victim Support for victims to self-refer. The risks relating to this are referred to in the Homelessness IMR, however, the IDVA function is primarily to support victims referred in to the MARAC process. We have a waiting list of MARAC referrals to be contacted.

4. In my professional opinion the CAADA DASH RIC should now be completed by the Homelessness staff when a disclosure of DA is made.

5.7.9 The GMP MARAC coordinator told the DHR review that if Homelessness were involved in referring to MARAC they will need to be trained and administrative procedures established. The DHR Panel recommend that the Homelessness Division considers the benefits to victims of its staff completing CAADA DASH RIC and if practical put processes in place to undertake them.

5.7.10 The police officer allocated the MARAC referral enquiry did not see FA 1 at any time. Therefore FA 1's attitude towards supporting a criminal investigation into her allegations was not established. In short MA 1 was never seen or interviewed by GMP for the allegations contained within FA 1's disclosures. The matter is subject of the IPCC investigation but on the face of what is known the DHR Panel felt that GMP should have seen FA 1.

5.7.11 The DHR Panel felt that FA 1 appeared to have disclosed what was necessary to achieve her immediate aim. FA 1 told HAAS enough to be re-housed as a victim fleeing domestic violence and made a full disclosure to her solicitor [Sol 1] to support the application for protective civil orders.

5.8 Key Event: Solicitor sees FA 1 on 24.01.2014

5.8.1 On 24.01.2013 Sol 1 saw FA 1. From the meeting Sol 1 drew up a statement which FA 1 signed in support of her without notice application for the below orders:

- Non-Molestation order
- Prohibited Steps Order
- Specific Issues Order

5.8.2 In her statement FA 1 disclosed the following:

- A long history of frequent physical violence towards her: e.g. hair pulling, pushing her onto the floor, hitting her in the face and head
- MA 1 assaulted her when she was pregnant with Child C
- Physical violence towards Child A
- The children witnessed violence
- Smoking cannabis in front of the children
- Sustained physical assault consisting of slapping, punching, breaking furniture, ripping clothing and ending in rape
- Controlling behaviour: not allowing her makeup, interrogating her mobile telephone, removing the boys' travel documents and taking her bank card

5.8.3 The statement included the following:

1. "I did not call the police. MA 1 always told me that if I ever called the police, or the authorities, then he would take the children and I will never see them again. I believe his threats. Also in my culture it is not acceptable for a woman to report violence".
2. "The police attended at this stage and the Respondent told the police that he had sold my phone. I disclosed to the police at this time [18.01.2013] that I had been the repeat victim of violence at the hands of the Respondent. [MA 1]. The police removed me and the children from my home, and we were placed in refuge accommodation".

5.8.4 On 28.01.2013, the court granted the three orders. These and FA 1's statement were served on MA 1 on the evening of 28.01.2013.

Analysis:

5.8.5 IDVA 1 referred FA 1 to Sol 1 within a day of completing the CAADA DASH RIC. Sol 1 worked quickly and within 7 days of first disclosing to HASS that she was fleeing domestic violence, FA 1 had applied for and obtained three protective civil orders. These orders are likely to have provided FA 1 with confidence and the strength to resist MA 1's reconciliation attempts. FA 1 also came under pressure from MA 1's extended family to have the orders set aside and the matter resolved within the family. Sol 1 reports that in cases of urgency the application can be before the court on the day she sees the victim.

5.8.6 FA 1's disclosure to Sol 1 was the first time an outside body knew the extent of the domestic violence, including the rape. When MA 1 was served with her statement he will have seen the disclosures, including the sexual violence. That potentially

heightened the risk to FA 1 because this was the first disclosure outside of their families. MA 1 complied with the Specific Steps order and returned the boys' travel documents, thereby indicating a willingness to comply with court orders. A lesson for all agencies is to be aware that when such statements are served on perpetrators the risk to the victims should be re-assessed and appropriate steps taken to lessen any increase.

5.8.7 Sol 1 did not inform any agency of the disclosures. She told the independent author that it was not her role to pass on such information and that client confidentiality prohibited it. Sol 1 advised FA 1 to fully cooperative with all agencies including the police, IDVA and social services and that she have nothing to fear from such agencies.

5.8.8 Additionally, Sol 1 deals with about 500 women annually most of whom have been assessed as high risk of domestic violence by a professional agency; of that number Sol 1 estimates that over 50% disclose sexual violence and adds that within the South Asian and Middle Eastern communities that figure is significantly higher. Sol 1's experience is that equality between men and women in such communities is poor and often the issue of women giving consent to sex is not relevant to men.

5.8.9 Sol 1 concluded that while FA 1's case was serious, it was not at the threshold which caused concern where Sol 1 thought there was a risk of homicide.

5.8.10 There is no evidence in GMP's records that FA 1 disclosed she had been assaulted by MA 1 or was a repeat victim. There is nothing on the log to say GMP removed FA 1 and the children from the house and took them to a refuge. Children's Services has no such information. Had GMP exercised their powers to remove the children then it is almost inconceivable that they would not have informed children's services, and at the very least either GMP or children's services would have had a record of such a major event. GMP has no record of FA 1 telling them that she was the repeat victim of domestic abuse. FA 1 disclosed domestic violence to HAAS on 21.01.2013 and they provided immediate temporary accommodation for her and the children. A likely explanation for FA 1 saying these things in a statement to Sol 1 is FA 1's recall of who did what during a traumatic period.

5.9 Key Event: MARAC 14.02.2013

Introduction

5.9.1 Set out below is an extract from GMP's IMR which describes how MARAC works in Manchester.

5.9.2 The MARAC referral procedure via an external agency is as follows:

a. Victim contacts external agency, for example, Independent Domestic Violence Advisor. The member of staff from the external agency then completes a DASH risk assessment. If the risk assessment scores fourteen or more and there has been a recent incident in the past three months the case would normally meet the MARAC referral criteria. If it scores less than fourteen it can still be referred on Professional Judgement.

b. External Agency uploads MARAC referral on to SharePoint. SharePoint is a portal that allows authorised users to access a shared repository for documents and forms and disseminate their contents, for example IDVA domestic abuse referral forms.

c. The MARAC team automatically receives an e-mail alert that the original referral is on SharePoint. The member of staff who is on mailbox duty that day will then save a copy to the MARAC Folder on a Shared Drive; put a 'domestic violence' marker on GMP Integrated Computer System [GMPICS] and add details to a MARAC Master Sheet pending research.

d. Where the research identifies that there is no existing Public Protection Investigation [PPI] log, one will be created by putting an intelligence entry on OPUS and putting high risk domestic abuse victim / perpetrator flags / markers on the respective OPUS nominal records.

e. A brief outline of events is endorsed on the summary page 'circumstances of incident' section of the PPI log. The 'Investigation Type' on the summary page is shown as 'Domestic Abuse – MARAC', thus identifying it at first glance on a MARAC case.

f. The intelligence will automatically create a PPI log and put a note of the number and time of creation on the PPI Journal page for the attention of the relevant divisional PPI specialist officer.

g. An 'action' [enquiry] is then sent to the PPI specialist supervisor on the relevant division to inform the supervisor that the case has been referred to MARAC by an external agency and that markers and flags have been updated.

h. PPI specialist supervisor should acknowledge the 'action' identifying that the case is to be heard at MARAC [if a 'receipt' has been requested].

i. PPI specialist supervisor can then allocate the investigation to a specialist officer within the PPIU.

5.9.3 FA 1's case was one of thirty two presented at North Manchester MARAC on 14.02.2013. The conference judged that FA 1 was at high risk of being seriously harmed by MA 1. The action plan recorded the general comment that MA 1 was the perpetrator; possibility of HBV; IDVA reporting non-molestation order and prohibitive steps order in place although not showing on GMP [sic].

5.9.4 The four actions from the meeting were:

1. IDVA to clarify the situation in relation to the service of the non-molestation order

2. GMP to investigate HBV procedure –DNA, fingerprints and photographs

3. Homelessness to report back to GMP identifying the school the children are attending following meeting with victim

4. IDVA to feedback on MARAC to victim

   Note: Actions 1 and 4 were completed by 19.02.2013. Action 2 is examined below and Action 3 is noted to be on going on 04/03

5.9.5 The HBV action was allocated to Detective Constable 1 [DC 1] to be completed by 21.02.2013. GMP's Policy and Procedure, Forced Marriage and "honour" Based Violence April 2013 states:

> "When dealing with a victim/potential victim of 'honour' based violence/ forced marriage the taking of photographs, fingerprints and DNA samples is a key protective measure. This is a two-fold measure, aimed at addressing identification issues in potential investigations and to protect victims from serious acts of violence, abduction and homicide".

5.9.6 DC 1 obtained two extensions to the completion date; the last being 18.03.2013. On 19.03.2012 DC 1 made the following entry on the log:

> "...FA 1 has been re-housed to Address 4; FSW 1 visited her yesterday and the education authority have offered her children two places at ... [the local] academy to start on 19/04/13. FA 1 is safe and well and happy with the move; IDVA spoken to, they had contact with FA 1 at the end of February and advice has been given. There is no suggestion of HBV ['honour' based violence]. I have tried FA 1's new mobile number today, no reply and I have left a message with my contact details".

5.9.7 On 21.03.2013 a PPIU supervisor closed the log noting:

> "Finalised as DVI [domestic violence incident]; all safeguarding in place. Agencies are supporting her. No further police involvement required".

5.9.8 The judgement that HBV was not a feature in this case was made without DC 1 or a police supervisor speaking with FA 1.

5.9.9 Nationally Cafcass has elected not to be routinely involved with MARAC. Cafcass and CAADA have developed joint Guidance for MARACs regarding disclosure from Family Court proceedings. Therefor the information Cafcass had about domestic violence was not known to MARAC.

Analysis:

5.9.10 In the calendar year 2012, GMP dealt with 3,992 MARAC cases of which 444 were heard at the North Manchester MARAC. The meetings are recorded and only the actions transcribed. The DHR Panel understood the efficiency of this approach and thought it would be useful if the written actions could be accompanied by a short narrative rationale.

5.9.11 For example, the DHR Panel felt the action for GMP to investigate [sic] HBV procedures was wholly appropriate, but did not understand what prompted it. The DHR Chair listened to the MARAC tape to determine the background to the action. There was no discussion about HBV and the action was raised at the end of the discussion by the MARAC Chair. Therefore the rationale for it is unknown. The DHR

Panel recommends that MARAC considers whether it is feasible to include a brief written rationale to complement the action.

5.9.12 The DHR Panel members were aware that in addition to the actions arising from MARAC, that many agencies had their own lists of standard actions which were not recorded; for example, sharing the information with a health visitor or school health adviser. Therefore, the MARAC actions as written reveal only part of the risk management plan.

5.9.13 Section 3.3.1 of the MARAC Operating Protocol [MOP] says:

> "The information sharing that takes place during the MARAC frequently results in an altered perception of the risks posed by an alleged perpetrator. This enables individual agencies to tailor an appropriate response for the victim".

5.9.14 The DHR Panel recommends that the MARAC Coordinator considers whether the MOP should be amended to include a menu of standard actions agencies already undertake post each MARAC case.

5.9.15 The information presented to FA 1's MARAC on 14.02.2013 did not include the full nature of her victimisation i.e. the rape and violence to Child A. The risk assessment was correct on the information presented and the actions agreed added to the protective measures already in place.

5.9.16 The IDVA Service Manager reviewed the information in the Cafcass IMR and redid the risk identification checklist [RIC] based on this additional information and commented as follows.

- Disclosure of the alleged rape would have increased the RIC score and would have opened up discussion about when did this happen, how often, what happened, did you talk to anyone or report this to the police or seek medical attention, have they done this to anyone else for e.g. children or a previous partner, is the client concerned about any sexually transmitted diseases or pregnancy as a result of the attacks? This would also prompt a discussion around referrals to SARC [Sexual Assault Referral Centre/A&E/Police for further medical or criminal investigation.

- FA 1 disclosed to IDVA that she was afraid her husband would kill her but did not disclose that a threat had been made to kill her. This was detailed in Q14. This disclosure would have prompted further discussion and encouraged police involvement to investigate threats to kill.

- Disclosure of aggression towards the older child would have been added as information to Q18 which was already answered positively and would have prompted an automatic referral to Children's Services with a request for an initial assessment.

- Please note, however, this may still not have reached Children's Services threshold for intervention.

- My RIC would have scored 13 based on the new information; however, these additional disclosures and questioning could have influenced other answers that were initially negative.

5.9.17 The DHR Panel reflected that the MARAC acted appropriately on the information it knew at the time. The supplementary information about sexual violence and child protection would have prompted more questions but the risk posed by MA 1 to FA 1 would have remained high. Additional support could have been offered to FA 1, but MARAC agencies cannot be expected to respond to issue it does not know about. The reason for Cafcass knowing about the supplementary information and it not reaching MARAC are explored in Section 5.11.

5.9.18 The DHR Panel thought GMPs decision not to complete its HBV procedures action from MARAC was not appropriate and a more cautious approach should have been taken, particularly as FA 1 was not seen by a police officer. The arguments supporting a view that the domestic violence stemmed in part from honour are generally persuasive and explored later.

5.10 Key Event: MA 1 presents as Homeless

5.10.1 On 21.02.2013 MA 1 presented himself at HAAS declaring he was homeless. He told the AO that his wife and children had left him and he had been of no fixed abode since 18.01.2013 and gave up the tenancy of Address 1 in February 2013. MA 1 reported he had been in Hospital 1 for the last four days because his GP was concerned about his mental health.

5.10.2 The AO checked with the Hospital 1 who reported that MA 1 visited Accident and Emergency a few days ago following the breakdown of his marriage. Hospital 1 said there was no evidence of acute mental health problems; no history of mental health problems, no medication prescribed and he was advised to seek assistance from his GP. The AO noted MA 1 appeared "groggy" but it was not clear why. He was very tearful and it was not possible to obtain a coherent account. MA 1 was told to return to his friends and come back the next day after he had composed himself.

5.10.3 MA 1 returned on 22.02.2013 and the same AO completed a housing assessment. MA 1 claimed he did not know the reason why FA 1 had left him and referred to the row they had about a telephone. This was the incident reported to GMP on 18.01.2013. He produced his non-molestation order which was scanned onto MA 1's case notes. The AO advised MA 1 that he was not in priority need and gave him details of a private landlord.

Analysis:

5.10.4 The DHR Panel discussed whether asking MA 1 to return the next day was appropriate. On balance the DHR Panel thought MA 1 was dealt with appropriately by the AO who gathered information from the Hospital 1 and judged that MA 1 was not in priority need. The decision to ask MA 1 to return the following day when he had settled down was also appropriate and supportive of MA 1, in that it would allow him to state his case for homelessness from a position of calmness. MA 1 was given assistance by being referred to a private landlord.

5.10.5 MA 1 was being disingenuous when he claimed not to know the reasons for the non-molestation order. He had been served with FA 1's supporting statement on

29.01.2013 in which she set out the domestic violence history. MA 1's ability to read English is not known, but the process server reports explaining the orders in full to MA 1. Notwithstanding that, MA 1 knew what he had done. The rape was the subject of a family meeting in late 2012.

5.10.6 The Homelessness IMR author notes that it would have been good practice for the non-molestation order to also have been attached to FA 1's file so that the FSW knew of its existence. Additionally, the IMR author feels that MARAC should have been told of MA 1's homelessness application as it might impact of the risks she faced. This is an excellent point in principle, but in this case the MARAC held on 14.02.2013 predated MA 1's presentation as homeless on 21.02.2013. Nevertheless, it would have been useful information to pass to the IDVA or GMP to see it if impacted on the risk assessment.

5.11 Key Event: Cafcass Contact and Residence Order Sec 8 Children Act 1989

5.11.1 On 30.01.2013 Cafcass central intake team received notification from a Manchester court that FA 1 had applied for a Residence Order, Prohibited Steps Order and a Non-Molestation Order. The notification included FA 1's statement made in support of the orders already granted on the 28.01.2013. A Family Court Advisor [FCA 1] screened the application and noted; the violence and rape elements, the cultural setting and the child protection issues. [MA 1 was alleged to have assaulted Child A]. It was not identified that FA 1 had previously lived in Teesside. There were no contact telephone numbers or e-mail addresses for FA 1 or MA 1.

5.11.2 On 04.02.2013 the case was passed to Manchester's Cafcass team for processing. Checks were made with GMP and Children's Services. The latter were not engaged with the family and only knew them through a query from a health visitor about homelessness. Cafcass did not refer the child protection issues to children's services.

5.11.3 Cafcass was unaware that FA 1 was a MARAC case and therefore could not consider whether within its MARAC information sharing protocol it was appropriate to share it.

5.11.4 The Cafcass IMR author identified that its submission to the court [Schedule 2 letter] was written without having spoken to FA 1 or MA 1. [They were first seen at court on the day the orders were made]. The letter did not have any reference to the allegations of harm that the children were reported to have endured. There was no consideration about whether FA 1 was a vulnerable adult requiring referral to the local authority.

5.11.5 The Cafcass IMR reveals that FA 1 appears to have been under pressure from MA 1 to stop the proceedings. This view is consistent with Sol 1's experience of the case.

5.11.6 On 29.04.2013 the court granted a Residence Order in favour of FA 1, a contact Order setting out when MA 1 could see their children. The Prohibited Steps order was discharged and the non-molestation order amended to allow MA 1 to send text messages to FA 1.

Analysis:

5.11.7 Cafcass general handling of the case was appropriate and accorded with its policies and procedures. A significant oversight was the lack of a referral to Children's

Services on such an obvious and identified child protection issue. The IMR author reports that the family court advisor and a service manager involved in the case "...are at a loss to understand their failure to contact the local authority Children's Services Dept with relevant inter-agency referral information about alleged harm to children". Therefore the DHR Panel felt this was poor individual practice rather than an organisational weakness.

5.11.8 Had Cafcass referred the child protection issues to Children's Services they would have taken them to MARAC. Therefore the oversight in not referring, denied MARAC the opportunity to consider a response and develop an appropriate plan for the family. Such a plan would have included the child protection issues.

5.11.9 While FA 1 was a vulnerable person in the ordinary sense of the term, she did not meet the "vulnerable" person definition set down in No Secrets: Dept of Health 2000. FA 2's vulnerability was being catered for through the MARAC process.

5.12 Key Event: 27.05.2013 FA 1 and Children move to Address 2

5.12.1 The Homelessness Division continued to work with FA 1 to find more suitable accommodation and to support her in changing the children's school. On 21.03.2013 the Homeless Family Unit [HFU] made an on line application on behalf of FA 1 for the tenancy of Address 2, a property owned and managed by Adactus Housing. The application contained details of family including the names, ages and gender of the children. HFU did not share with Adactus that FA 1 was the victim of domestic abuse, the court orders or that MARAC had assessed she was at risk of serious harm from MA 1.

5.12.2 On 13.05.2013 FA 1 met with an Adactus Letting Officer [ALO] and viewed Address 2 which she said was suitable. The ALO completed a Pre-offer interview form and New Lets check list. This seeks core information about the prospective tenant including:

- any physical support needs [mobility, sight, hearing]
- mental health
- drugs/alcohol
- language and literacy
- other complex needs

5.12.3 FA 1 gave her previous addresses but did not say she had lived in Teesside. She said details of her next-of-kin/emergency contact would follow. The Adactus IMR notes:

> On the Pre-Offer Interview form applicants are asked to state the reason for rehousing from a list of options one of which includes "experiencing domestic violence or fear of violence". In this instance the box ticked was the "living in temporary or supported accommodation". There is clearly an expectation on the form to tick just one box.

5.12.4 FA 1 took up the tenancy of Address 2 on 27.05.2013. On Friday 07.06.2013 an Adactus heating engineer accessed the property at 3.50 pm and saw FA 1 and two children.

5.12.5 On 01.07.2013 Adactus learnt that Address 2 appeared to have been abandoned and commenced their standard procedures for such circumstances.

Analysis:

5.12.6 Adactus was unaware that FA 1 had fled domestic violence; had been subject to MARAC or had a non-molestation order against MA 1. At the time there were simply no procedures for the HFU to pass on such details to registered social landlords. The Homelessness representatives on the DHR Panel recognise that they do not have a policy for sharing domestic violence information with social landlords. This is a position they want to change. Therefore the DHR Panel recommends that the Homelessness Division develop a policy and practice which allows responsible social landlords to be furnished with information that their tenants are victims of domestic violence.

5.12.7 Had Adactus known that FA 1 was a victim of domestic violence they would have discussed with her whether she needed additional security. This would be at their expense. They would also have referred her to their Tenancy Enforcement and Support Team who would have monitored the situation for three months.

5.12.8 FA 1 was provided with an opportunity to disclose her history to Adactus but did not. The Adactus IMR suggests a way to make it more likely that such information is collected; it says:

> "It would be beneficial for staff completing the form if they were encouraged to tick all that apply; this would mean that staff could be more proactive in discussing issues such as the need for additional support".

5.12.9 Adactus would like to know when one of their tenants is the subject of a MARAC meeting and have made a suitable recommendation.

5.12.10 There may of course be other reasons why FA 1 did not disclose. It had been several months since her original disclosures and she may simply have wanted to focus on the future. The domestic violence specialists on the DHR Panel acknowledge that some women, who are moving on with their lives, do not want the label, "domestic violence victim", because it can carry shame.

5.13 Key Event: Friend tells Cleveland Police worried about FA 1 and fears DV

5.13.1 At 11.30 pm on Saturday 08.06.2013 Friend 1 told Cleveland Police that she was concerned about the welfare of FA 1 and her children. MA 1 had returned to the family home following a three month separation brought about by his abusive behaviour towards his wife and children. Friend 1 said that Friend 2 [a mutual friend] who lived in Manchester shared these concerns. They were worried that MA 1 would resume his violent ways.

5.13.2 Cleveland Police e-mailed GMP at 2.30 am on Sunday 09.06.2013. The e-mail contained the following information:

- That FA 1 had failed to keep an appointment with Friend 2 in Manchester at 7.30 pm on Saturday 8th June 2014
- That subsequent messages from FA 1's mobile did not appear to have been composed by her; the style was different

- FA 1's current address in Manchester [Address 2 Cheetham Hill]
- Details of FA 1, MA 1 and the three children
- Names of MA 1's two brothers
- FA 1 and MA 1 should be known to GMP and Children's Services
- That FA 1 had suffered mental and physical abuse
- That MA 1 had threatened to cause serious harm or kill FA 1 should she leave him or go to the police

5.13.3 Cleveland Police requested:

> "Can a unit please contact Friend 2 initially via phone [as she is wary of police contact] and establish further info' on the potential whereabouts of FA 1 and then carry out follow up enquiries. This may well be a simple welfare check but might turn into a Missing Person Enquiry
>
> Can Friend 1 please be updated on the telephone number shown above regards any updates/outcome
>
> Finally, can you please confirm receipt of this e-mail and attach the relevant GMP event number

5.13.4 GMP created an incident log [FWIN Force Wide Incident Number] tasking an officer to attend at Friend 2's address. The log contained a summary of the concerns adding that full details are on the e-mail held at the Information Management Unit [IMU] for the attending officer. Importantly, FA 1's current address had been transferred from the e-mail to the log meaning that the attending officer did not have to view the e-mail in IMU to know FA 1's address.

5.13.5 At 5.39 a.m. a copy of the originating e-mail was forwarded to Police Sergeant 1 [P.Sgt 1] following an unsuccessful attempt to contact Friend 2. The contents of the e-mail were reviewed by P.Sgt 1 and an entry placed on the incident log at 6.11 a.m. that stated:

> "FA 1 is shown on OPUS as being a high risk victim of domestic violence currently under MARAC system. It would appear that the A div [division] PPD [Public Protection Department] are involved. The e-mail from Cleveland Police would indicate that FA 1's friends have concerns that she is back with her ex-partner. The enquiry with Friend 2 can be conducted by telephone but if an address is obtained then a physical check may be required. Please delay until a more suitable hour and perhaps liaison with the A div PPD may negate the need to speak to Friend 2 as they may have information as to where she or her ex-partner MA 1 reside. Once these details are obtained then a concern for welfare FWIN may have to be created".

5.13.6 The above entry changed the focus of the enquiry from seeing FA 1 to searching for her current address via contact with Friend 2. FA 1's address was already on two current GMP documents; the e-mail from Cleveland Police and the incident log created from the e-mail. The incident log was then delayed until 8.00 a.m. on 09.06.2013.

5.13.7 At 9.11 a.m. Police Constable 1 [PC 1] updated the log after contacting Friend 1 by telephone. He wrote:

> "...FA 1's brother in law [MA 2] has been trying to convince FA 1 to get back with her husband [MA 1]. The PPD on the A div are aware of this FWIN, FA 1 has been re-housed and is now residing at Address 4. Friend 2 says she has been to this address to see FA 1 but has had no reply there. FA 1's ex-partner MA 1... Has had a non mol [non-molestation order] issued against him on 29/04/13 details of which are on PNC. Due to the concerns raised can this FWIN be switched to the A div [division] for a visit to Address 4 to check FA 1 is safe and well and that the non mol order [non-molestation order] has not been breached".

5.13.8 The incident log was endorsed with a G15 Other General Report opening code and a L24 Passed to Other Agency closing code.

5.13.9 Later that morning PC 2 visited Address 4 and endorsed the incident log with:

> "...Number ... is empty. On speaking with neighbours an 'Iranian' female lived there but moved out approx 2 wks ago to ...., they have no forwarding address".

5.13.10 At 1.59 p.m. GMP sent an e-mail to Cleveland Police that contained an extract from the incident logs stating that Friend 2 had been spoken to and the address supplied by her for FA 1 [Address 4] had been checked with a negative result.

5.13.11 At 9.59 p.m. the same day [Sunday 09.06.2013] Cleveland Police responded to the e-mail stating:

> "...is it possible to interrogate your intel' systems with a view to finding out a home address for MA 1 and making suitable enquiries with him and his family as to the potential whereabouts of FA 1 and the children... Also contacting Social services in your area to see what info' they have..."

5.13.12 At 11.06 on Monday 10.06.2012 GMP received an abandoned 999 call and on returning it spoke with Friend 2. She reiterated her concerns for FA 1 and said where she thought FA 1 lived. It appears that while Friend 2 had been to FA 1's current address she did not know the street name or number.

5.13.13 Over the course of the next few hours several exchanges took place between Friend 2 and GMP. However Friend 2 was not seen and did not have the opportunity to take officers to FA 1's current address. At 3.22 p.m. FWIN 1038 10.06.2013 was closed. The incident log was endorsed with a G15 Other General Report opening code and an L08 Call Made With Good Intent closing code.

5.13.14 At 8.40 a.m. on Tuesday 11.06.2013 an intelligence officer responded to the request for information as follows.

> "From a quick intel [intelligence] check I have found an address for the male [MA 1] of Address 1.
>
> A FWIN needs to be created asap and an officer needs to attend and check on the female's/children's welfare. A referral also needs to be made to social services by the A Div PPIU to inform them of the risk to both the mother and

children". This should not have been delayed as there are potentially vulnerable people at risk of harm".

5.13.15 An incident log was created and at 10.27 a.m. an officer attended Address 1 and the incident log was endorsed with the comment:

> "No reply at the address. Nothing from what I can see through the window to suggest children or female living at the address. I will check with neighbours... no response from neighbours".

5.13.16 At 9.01 p.m. the incident log that had been 'delayed' throughout the day was reviewed by a supervisor who referred it to the patrol inspector who requested that it be allocated as a priority. The originating e-mail from Cleveland Police was then forwarded to an officer. At 10.03 p.m. the officer attended Address 1 and spoke to the current lone male occupant who stated that he had moved into the address the previous week and had no forwarding address or contact number for the previous male occupant.

5.13.17 At 10.16 p.m. the incident log [FWIN 362 of 11/06/13] was endorsed with the comment:

> "Spoken to Cleveland Police – they have e-mailed the details to [name of original enquiry officer]".

5.13.18 The incident log was closed. However, the originating officer was on rest days and off work until 14.06.2013. The incident log [FWIN 362 of 11/06/13] was endorsed with a P01 Suspect Detained opening code [in error] and a L20 Contact Record / Message / Information closing code.

5.13.19 This meant that a request from Cleveland Police to GMP to check on the welfare of a vulnerable woman [FA 1] and her three children did not happen despite Cleveland Police providing the correct address to GMP.

Analysis:

5.13.20 The following extract from GMP's IMR is a useful introduction to the analysis.

> The GMP Missing and Absent Persons Policy issued in November 2012 [page 3, paragraph 3] defines a missing person as:
>
> "Anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be the subject of crime or at risk of harm to themselves or another "
>
> The GMP Missing and Absent Persons Policy [page 3, paragraph 3] also states that in relation to incidents of 'concern for welfare':
>
> "...There have been cases where the police service have been criticised for misuses of this category when the correct one was missing person. It is poor practice to use such a category to avoid the rigours of a full missing person investigation".

5.13.21 Cleveland Police reacted promptly to Friend 1's worries. The e-mail it sent to GMP contained information which accurately identified issues of domestic violence and child protection and provided a rationale for why FA 1's two friends were worried

about the family's welfare. Crucially it provided, in plain sight, the current address of FA 1 and her children.

5.13.22 GMP also acted quickly and within a few hours endorsed the incident log with the fact that FA 1 was known to be at high risk of suffering serious harm from MA 1 as determined at a MARAC.

5.13.23 The request from Cleveland Police suggested a sequence of events for the enquiry; it said:

- contact Friend 2
- establish further information on the whereabouts of FA 1
- carry out follow up enquiries

5.13.24 The DHR Panel felt that in following this sequence GMP lost sight of the original objective which was to check on the welfare of FA 1 and the children. The assignment had subtly changed from the primary task of seeing FA 1, to finding Friend 2 who would know where FA 1 lived. It did not require seeing Friend 2 to determine the current address for FA 1, that was an unnecessary step as the information was in the originating e-mail and also on the log.

5.13.25 As the hours and days passed, the job was passed between divisions, the entries on the logs grew and no one spotted that the ultimate information they were seeking [FA 1's whereabouts] was recorded at the beginning of the entries. GMP never saw Friend 2 face to face. Had they she could have taken them to FA 1's address.

5.13.26 Therefore, the original oversight in not recognising that FA 1's address had been supplied was perpetuated by subsequent staff including supervisors. It was a misfortune that the Cleveland officer who began the enquiry and sent it back for more information was away from work when it was returned to Cleveland the second time. This meant that the enquiry was concluded without the original request from Cleveland Police being completed. Cleveland Police accepted this position did not pursue the matter with GMP.

5.13.27 GMP knew that FA 1 had a non-molestation order and was a high risk victim of domestic violence, yet their databases did not contained her current address. The DHR Panel judged that the process for notifying key agencies that a high risk victim had changed her addresses failed on this occasion. The Family Support Worker from the Homelessness Division knew that FA 1 was a high risk victim and also knew when and where she was moving to. The DHR Panel recommends that GMP satisfies itself that the arrangements for flagging domestic violence victims' addresses are robust.

5.13.28 At 10.38 pm on 02.07.2013 FA 1's uncle reported her missing to GMP. An enquiry was established and the following day a review of the GMP paper work generated by Cleveland Police's request revealed the correct address for FA 1.

5.13.29 The IPCC investigation will make a more detailed judgement on GMP's handling of the request from Cleveland Police and that Force's acceptance of the result. The DHR Panel's thoughts on how GMP missed FA 1's address are contained above.

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Introduction

6.1.1 Each term of reference is commented on from material in the IMRs, the debates of the DHR Panel and the views of family members. Some commentary could fit into more than one term and the decision on where it appears was made on a best fit basis.

6.1.2 The terms appear in ***bold italics*** followed by an analysis.

6.2. Term 1

Were the risk indicators for domestic violence present in this case recognised, properly assessed and responded to in providing services to FA 1, MA 1 and Children A, B and C. If not, what was the reason for this?

6.2.1 There were no reports to any agency in Teesside that FA 1 was the victim of domestic violence or that Child A or Child B had witnessed it. FA 1 told a health professional that MA 1 left the matrimonial home in Teesside for a period in 2009, but the reason was not given. The one contact FA 1 had with the Teesside related to anti-social behaviour and racial abuse. This was dealt with appropriately by the local authority and ended when MA 1 returned home.

6.2.2 The family moved to Manchester in 2010 and FA 1 registered with a GP and accessed maternity and health visiting services. She did not disclose her victimisation. Midwifery asked FA 1 as part of the pregnancy booking procedures [Child C] whether she was or had been a victim of domestic violence. FA 1 said no.

6.2.3 The first public disclosure came on 18.01.2013. FA 1 reported to GMP that she had a verbal dispute with MA 2 because he took her mobile telephone. The police attended and completed a DASH risk assessment. This was later checked by a domestic violence officer who confirmed FA 1 faced a standard risk. This means that the current evidence does not indicate the likelihood that MA 1 will cause serious harm to FA 1. The details, including those of the children, were entered onto a specialist database. The matter was dealt with in accordance with GMP's policy.

6.2.4 FA 1 made disclosures of domestic violence to HAAS on 21.01.2013. They recognised the risk to FA 1 and made an immediate referral to the IDVA service, but did not gather enough information from FA 1 to make a judgment on whether the children faced any risk from their mother's victimisation. IDVA 1 completed a telephone consultation with FA 1 and using the professional judgment criteria referred the case to MARAC. This is excellent evidence that the risks were identified. IDVA 1 checked with Children's Services and discovered the family was not known to them. IDVA 1 checked with her manager whether the case should be referred to Children's Services and it was decided not to do so because they judged FA 1 was doing all she reasonably could to protect her children. Had FA 1 made a fuller disclosure the decision may have been different.

6.2.5 Following the MARAC on 14.02.2013 FA 1 was assessed as being at high risk of suffering serious harm from MA 1. GMP agreed to initiate their HBV procedures which require the victim to provide identity metrics; e.g. Fingerprints and DNA. Eventually it was agreed between two GMP officers that there was no evidence that this was a

HBV case and the requirement to treat it as such was formally reversed by a GMP supervisor. Term 6 examines the case for and against FA 1's case being HBV.

6.2.6 IDVA 1 informed GMP of the MARAC and FA 1 should have been seen by an officer within 72 hours for the purposes establishing a criminal enquiry and gathering information for MARAC. The officer spoke with IDVA 1 and Homelessness Division and left a message on FA 1's mobile for her to contact them. FA 1 did not respond and the officer did not follow it up. This meant that neither the IDVA nor GMP saw FA 1 prior to MARAC. The DHR Panel felt that face to face contact was very likely to have produced more information with which to inform MARAC and support FA 1.

6.2.7 Following the MARAC on 14.02.2013 FA 1 was assessed as being at high risk of suffering serious harm from MA 1. GMP agreed to initiate their HBV procedures which require the victim to provide identity metrics; e.g. Fingerprints and DNA. Eventually it was agreed between the officer and a supervisor that there was no evidence of this being an HBV case and the requirement to treat it as such was formally reversed by a GMP supervisor. This is in contrast to the first GMP Senior Investigating Officer who assessed there was an HBV element to the case.

6.2.8 Sol 1 recognised the risk of serious harm but had no authority to share her assessment outside of the court proceedings. Sol 1 never thought FA 1 was in mortal danger.

6.2.9 Cafcass saw FA 1's statement on 30.01.2013 which set out a full disclosure including; sexual violence; probable significant harm suffered by Child A and the likelihood that Child B and Child C were in need of support and maybe protection. On 04.02.2013 the statement reached Cafcass' Manchester office but the information was not shared with any agency. Cafcass did not know that FA 1 was subject to MARAC. Therefore, collectively the agencies missed an opportunity to work together and undertake a risk assessment using all the known information.

6.2.10 Cleveland Police recognised the risks to FA 1 and the children. They asked GMP [June 2013] to check if the family was safe and well. GMP never completed that task despite realising the importance of tracing FA 1 and the children. GMP's realisation was documented when an operator wrote on a log: "...potentially vulnerable people at risk of harm".

6.2.11 An intelligence sergeant in GMP also recognised the risk when s/he was asked to find an address for the family. S/he endorsed the log, spelling out the dangers to FA 1 and the children.

6.2.12 The information from Cleveland to GMP also included the following:

> "That MA 1 had threatened to cause serious harm or kill FA 1 should she leave him or go to the police".

6.2.13 The significance of that information does not appear to have been recognised by GMP. It was a missed opportunity to inform a new risk assessment.

6.3 Term 2

Were the services provided for FA 1 and MA 1 and their children timely, proportionate and 'fit for purpose' in relation to the levels of risk and need that were identified?

6.3.1 GMP's responses in January and February 2013 were fit for purpose. After the MARAC meeting it flagged FA 1's new address on PNC but not on its local database. GMP took a measured approach to whether the case fitted the HBV criteria and decided it did not.

6.3.2 GMP's response to Cleveland Police's request to see FA 1 and the children was not fit for purpose; it did not support a high risk victim or her children. FA 1's new address had not been notified to GMP and was therefore not flagged.

6.3.3 HAAS initial reaction was good and immediate accommodation was secured for the family. The Family Support Worker missed gathering some background information but worked adequately, albeit a little slowly, with FA 1 to secure a change of school for the Child A and Child B. Additionally, the FSW helped FA 1 with a housing application that saw her move to Address 2 in late May 2013. However, that address was not passed to GMP for flagging.

6.3.4 Sol 1 secured three protective civil orders for FA 1 and her services were fit for purpose.

6.3.5 Cafcass core service to FA 1 was fit for purpose. The weaknesses come under the heading of information sharing.

6.3.6 MA 1 was not judged to be at risk. He received appropriate treatment from health and suitable advice from the Homelessness Division. No MARAC agency suggested that the reasons behind MA 1's offending should be explored and remedial action attempted.

6.4 Term 3

How did agencies ascertain the wishes and feelings of FA 1 about her victimisation and were her views taken into account when providing services or support?

6.4.1 FA 1 knew the level of her victimisation and made variable disclosures. The DHR Panel debated whether the gender of the person who saw her had any influence on what she was prepared to disclose. Equally, was her willingness to disclose swayed by whether she saw the person face to face or spoke on the telephone. It is known that the issues were spoken about within the family, including the rape in November 2012; therefore in the right environment FA 1 was willing to raise them.

6.4.2 The following is a table of her interactions:

Date	Agency	Tel or Face	Gender	Disclosure

18.01.2013	GMP	Face	M	Verbal Argument
20.01.2013	GMP	Face	M	No, picked up property
20.01.2013	HAAS	Face	M	Physical violence
22.01.2013	IDVA	Tel	F	Physical violence
24.01.2013	Sol 1	Face	F	Physical/Sexual violence

6.4.3 The DHR Panel considered the above table but was unable to say whether the gender and/or presence of a person at the point of disclosure were relevant to what was disclosed. It did however note that FA 1 had to make a disclosure to the HAAS male AO in order to secure accommodation. Additionally, the pattern of increasing disclosure may simply reveal FA 1's growing confidence. There was also a view within the DHR Panel that BME victims may not always disclose to the police because they feared they would pursue the matter against the wishes of the victim.

6.4.4 There is evidence that all agencies sought FA 1's views about her victimisation albeit it sometimes on the telephone. Agencies could have listened more closely but overall were sensitive to her needs when providing support. For example, the school knew that on two occasions FA 1 had no money for bus fares and offered financial support. Sol 1 supported FA 1 when she came under pressure from the family to drop the civil proceedings so they could deal with the issues.

6.4.5 The Homelessness Division worked with FA 1 to find accommodation and later supported her with benefit claims. However, the Homelessness IMR identifies that the FSW did not establish what FA 1's wanted or needed. Cafcass did not see or speak with FA 1 before it wrote its Schedule 2 letter and therefore did not independently establish what her wishes and feelings were. Cafcass says this is normal practice and reports a face to face meeting with FA 1 on the day of the court hearing.

6.5 Term 4

How effective was inter-agency information sharing and cooperation in response to FA 1's victimisation? What consideration was given to sharing information between Cleveland and Manchester agencies in support of FA 1 and her children and was it effective?

6.5.1 The sharing of information between Cleveland Police and GMP happened in June 2013 when Friend 1 told Cleveland Police of her concerns for FA 1 and the children. That was promptly passed to GMP, but the response was not effective.

6.5.2 Generally information sharing was mixed, but predominately poor. For example Adactus, School and the GP did not know that FA 1 was a MARAC case. IDVA 1 documented telling the school about the domestic violence but the school has no record of it. The health visitor checked with Children's Services if the family was known to them and spoke of having a multi-agency planning meeting. There is no record of that taking place or what its purpose was.

6.5.3 The child protection concerns seem to have been largely overlooked. Child A was alleged to have been assaulted by MA 1, a point known to Cafcass from FA 1's

statement to the court. Other agencies held pieces of information which if collated would have enabled an accurate picture of family life to emerge, thereby identifying any additional needs. The spoken, but never achieved, of multi-agency planning would have delivered that picture.

6.5.4 The DHR Panel wondered whether professionals knew that solicitors who have knowledge of child protection issues through disclosures from clients do not make referrals to children's services. The DHR Panel recommends the point should be covered in safeguarding training.

6.5.5 GMP were not told by the Homelessness Division that FA 1 had moved to Address 2 and therefore the domestic violence flag was not transferred from her previous address to the new one. The MARAC coordinator says that MARAC has looked at involving schools but it was felt that education had insufficient resources to support the MARAC process.

6.5.6 The DHR Panel recognised that agencies have their own post MARAC procedures and earlier recommended that consideration be given to including them in the MOP.

6.6 Term 5

How does your organisation support victims from black and minority ethnic [BME] backgrounds who disclose domestic violence?

6.6.1 Agencies report that their policies are generic and some such as GMP have additional guidance that reflects the needs of BME victims; these include signposting victims to voluntary groups who specialise in BME support. There is no evidence in this case that such signposting took place, although there is not a bespoke specialist service in Manchester for Syrian/Palestinian victims of domestic violence. MSCB/MSAB Domestic Violence procedures have an advice section on BME victim issues.

6.6.2 GMP report that the domestic abuse policy covers all aspects of diversity and protected characteristics. [See Equality Act 2010 Part 2 Chapter 1 for definition] Other than interpreters and language line there is no specialist facility to cater for BME communities. Raising awareness of officers and staff on BME issues also supports victims. In relation to BME communities the policy says:

Minority Ethnic Communities

"Nationally, under-reporting of domestic abuse within certain communities exists. This may be for a number of reasons such as the lack of awareness of reporting incidents or the lack of confidence in reporting incidents to the police. In some communities it may be taboo to report matters of this nature to the police as it is felt that community members should deal with them.

You should be mindful of these issues when dealing with victims especially those who appear reluctant to make a report"

Incidents involving insecure immigration status and domestic abuse

"Officers should note that in any investigation insecure immigration status might act as a further barrier to reporting"

6.6.3 The MSAB planned campaign to raise awareness of what family and friends can do following disclosures of domestic abuse should provide another source of support for BME victims.

6.7 Term 6

What consideration was given to whether FA 1 was at risk from honour based violence and what response was provided? Was it recognised that the risk of domestic abuse and honour based violence would increase post separation and what response was made to manage such risk?

6.7.1 GMP's policy on HBV says:

"'So-called 'Honour' based violence is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community members' [ACPO Working Definition 2008]

HBV is a collection of practices, which are used to control behaviour within families to protect perceived cultural and religious beliefs and/or 'honour'. Such violence may occur when it is felt that an individual has broken the 'honour' code and brought shame on their family or community by way of their actions.

'Honour' is an unwritten code of conduct that if breached can cause a loss of face to family or community members. There is no 'honour' in the commission of murder, rape, kidnap and the many other acts, behaviour and conduct that make up violence in the name of 'honour'.

You can distinguish HBV from other forms of violence, as there is often a degree of approval and collusion from other family members and the community. 'So-called 'honour' based violence cuts across all cultures, nationalities, faith groups and communities and such violence transcends national and international boundaries.

At first the element of HBV may not be apparent to an officer but with the right questions and risk assessment process it may become apparent.

Often the onus will be on the officer to gain trust and confidence of the victim to enable them to disclose this information.

Appendix A contains additional information on HBV.

6.7.2 The DHR Panel took account of the following issues in deciding whether agencies recognised the case may be one of HBV:

1. MA 1 perceived FA 1 was flirting or allowed herself to be flirted with by Pakistani shop keeper in Teesside. MA 1 allegedly assaulted this shopkeeper
2. MA 1 was reported as wanting FA 1 to stop attending college and seeing her friends
3. MA 1 told FA 1 to remove make up before going to college
4. MA 1 was suspicious that FA 1 was involved with other men
5. FA 1 wanted to leave; saw the marriage as over and wanted a divorce

6. FA 1 disclosed rape to the family; families conference to try and resolve
7. FA 1 disclosed rape outside the family, not culturally acceptable
8. FA 1 wanted to move to Sheffield to be near her Uncle after she disclosed rape to the family
9. FA 1 disclosed DA outside of family, not culturally acceptable
10. FA 1 obtained court orders against MA 1, FA 1 left with the children
11. MA 1 tried to persuade FA 1 not to proceed with the orders
12. Friend 2 said FA 1 had met another man
13. MA 2 warned/told FA 1 to end relationship with another man
14. FA 1 refused to go back to MA1 despite the family pressure
15. FA 1 was resolute in her desire to end the relationship with MA 1
16. MA 1 threatened to cause serious harm or kill FA 1 should she leave him go to the police.

Note: Many of these points equally apply to non HBV domestic violence.

6.7.3 The CAADA DASH RIC completed by GMP on 18.01.2013 screened negatively for HBV. FA 1 did not mention HBV in her statement of 28.01.2013, however, it is not known if she was aware of, and understood the term, HBV. She was aware it was not acceptable in her culture for a woman to report violence, therefore the issue of honour was almost certainly known to her. However, while FA 1 may have understood the concept of HBV, she may not have known it by that name.

6.7.4 IDVAs have to address HBV in their risk assessments. IDVA 1 did not find it present in FA 1's case despite screening for it. GMP recorded on it PPI log the following which it attributed to IDVA 1 following her telephone consultation with FA 1.

> "I am frightened of further injury. I think he is capable of killing me, particularly now that I have removed the children I also think he might try to take the children if he got the opportunity".

6.7.5 It is not possible to say whether FA 1's assessment of MA 1's capabilities was arrived at having considered the question of honour. She was clearly frightened of being injured and maybe worse. As stated previously it may be better to ask victims explicit questions on whether they think there is an honour based element to their victimisation after explaining what it means.

6.7.6 It was known that the family wanted the issues dealt with between them. This is evidenced when FA 1's uncle travelled from Yorkshire to Manchester in November 2012 following the report of rape. The family also wanted to resolve the issues outside of the court process. Seeking family resolutions is not HBV in itself. There was no evidence that the family approved of the violence and like many other perpetrators, MA 1 made unfulfilled promises to change his behaviour.

6.7.7 The MARAC of 14.02.2013 did consider HBV. The minute shows:

"Mr A is the perpetrator. Possibility of honour based violence**.** IDVA reporting non-molestation order and prohibited steps order in place although not showing on GMP".

6.7.8 GMP agreed to "an action for GMP to engage again the HBV procedure to be considered" It is not known why MARAC felt this was necessary. GMP considered the action and decided there was no evidence to support the commencement of HBV procedures. In cases of identified HBV, GMP has a tactical menu of the practical steps that can be taken. GMP did not recognise this case as one involving HBV.

6.7.9 All agencies reported knowing that the risk of further violence increases at the time of separation and the risk assessment took that into account when it judged FA 1 to be at high risk of serious harm from MA 1. There was no overt evidence to say that MA 2 [her brother-in-law] presented a risk to her.

6.7.10 DHR Panel members concluded that FA 1 and MA 1 came from families with an honour based culture. The Panel members' professional knowledge of domestic violence and honour based cultures enabled them to speak authoritatively about the positive and negative potency and influence honour values play in family live. The DHR Panel thought a negative element of honour was MA 1's dominance of FA 1 and his desire that she yielded to his wishes.

6.7.11 The striking feature of this case which was not known to agencies at the time of their involvement with FA 1, is the fact that three brothers have been found or pleaded guilty to murder or charges in connection with FA 1's death; this is very suggestive of HBV.

6.7.12 In conclusion the DHR Panel felt there were identifiable elements of HBV which were not fully explored or recognised. The reasons revolve around specialist domestic violence professionals [IDVA and GMP] not seeing FA 1 face to face and building up a rapport and during the telephone contacts not being more explicit in talking with her about HBV.

6.7.13 It is unreasonable to expect that the GMP front line response officers who took the initial complaint of domestic violence to have extract such information during the DASH risk assessment. As FA 1's confidence grew so did the opportunities for exploring with her whether she thought there was an honour element to her situation. That did not happen because after the MARAC most agencies were not engaged with her. Homelessness was supporting but did not have any suspicions about HBV and the school reported not knowing that FA 1 was a victim of domestic violence.

6.7.14 The DHR Panel makes several recommendations for MSAB to review elements of its HBV training.

6.8 Term 7

How were any racial, cultural, linguistic, faith or other diversity issues, including immigration status, taken into account during the assessment and provision of services to FA 1, MA 1 and their children?

6.8.1 FA 1 and the children were in the country lawfully, a fact Homelessness discovered when they checked her immigration status during her first appointment. A letter

dated 12.06.2013 from the United Kingdom Border Agency to FA 1 acknowledged her recent application for settlement, and saying it would provide an answer within six months. At the time of FA 1's death MA 1, MA 2 and MA 3 were lawfully in the country.

6.8.2 When MA 1 presented as homelessness suggesting he had mental health needs, the Homelessness Division checked with health as part of its assessment. Homelessness suggested he return the next day when he was calmer. No agency reported using an interpreter after the family moved to Manchester.

6.8.3 If diversity was interpreted widely it could include providing facilities to care for children who accompany a parent at a disclosure interview. The school was considerate by allowing the children to remain at home during FA 1's separation from MA 1. That has to be balanced against the school's lack of enquiry as to why she left.

6.8.4 All the reporting agencies have policies covering the items under this term and the DHR Panel saw no evidence that any bias, favourable or unfavourable, was present during their dealings with the family. They were all treated with respect and fairness. It is likely that the additional barriers to disclosing domestic abuse faced by FA 1 because of her cultural background were not fully understood by everyone who had contact with her. Sol 1 had excellent insight and used that knowledge to support FA 1 and the children.

6.8.5 GMP produced figures on Recorded Domestic Homicides by Ethnicity. These appear at Appendix 2. The numbers are small and they may not be statistically significant. However, they should prompt Community Safety Partnerships in Greater Manchester to consider whether women from BME backgrounds are disproportionately more likely to be victims of domestic homicides that white northern Europeans.

6.9 Term 8

Were the reasons for MA 1's abusive behaviour properly understood and addressed? Was there sufficient focus on reducing the impact of MA 1's abusive behaviours towards FA 1 and their three children by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

6.9.1 The DHR Panel members did not see any material that identified why MA 1 was abusive. The DHR Panel members experienced in cultural issues believed that MA 1's culture made him the dominant person in the relationship. However, it does not automatically mean that domestic violence follows. The view of FA 1 as expressed to Sol 1 is that equality between men and women from her community was poor.

6.9.2 The reasons for MA 1's abusive behaviour were not explored and therefore not understood. FA 1 informed IDVA 1 that MA 1 abused Khat. FA 1 stated that MA 1 used Khat all the time; that she thought it had affected his mental health. FA 1 said his abuse of her increased and decreased in line with his use of Khat.

Note:

Khat is a flowering evergreen shrub native to East Africa and the Arabian Peninsula. It is typically chewed like tobacco. Amongst other symptoms, chronic Khat abuse can result in symptoms such as physical exhaustion, violence, and suicidal depression.

6.9.3 The MARAC of 14.02.2013 did not discuss the causative factors or produce any actions to modify MA 1's behaviour; the actions were focussed on reducing the opportunities he had for attacking FA 1.

6.9.4 Nothing emerged from MA 1's psychiatric assessment that shed light on his offending. MA 1 never entered the criminal justice system or received domestic violence services; had he done so, some reasons for his behaviour might have been identified.

6.9.5 MA 1 had left and returned to the family home on several previous occasions. Having established this pattern of behaviour he might have felt empowered to continue and was not prepared for FA 1's determination to end the abusive relationship.

6.10 Term 9

Were single and multi-agency policies and procedures, including the MARAC protocols, followed and are they embedded in practice and were any gaps identified?

6.10.1 Several agencies reported that their policies and procedures had not been followed; for example Homelessness Division identified that their record keeping should have been more comprehensive; Cafcass acknowledged they should have made a referral to Children's Services when they read of the violence towards Child A. The school did not record the contact from IDVA and no one has a record of the planned multi-agency meeting.

6.10.2 GMP has contradictory policies on when an enhanced risk assessment should take place and they have made a recommendation to resolve it. Once GMP knew that a MARAC was taking place, an officer should have seen FA 1 within 72 hours. FA 1 was not seen by GMP at any time between the referral and the MARAC some three weeks later.

6.11 Term 10

How did MARAC safeguard FA 1 and the children, and address MA 1's alleged offending behaviour. What are the arrangements to ensure an effective interface between MARAC protocols and Children's Safeguarding procedures?

6.11.1 In this case MARAC was partly effective in that IDVA 1 using professional judgment referred FA 1 to MARAC. Not all of the available information was known to the MARAC meeting and partly as a consequence the child protection issues were not picked up by Children's Services. Cafcass should have made a referral to Children's Services outside of the MARAC process. Had they done so Children's Services would have assessed whether there were any safeguarding issues.

6.11.2 The MARAC Operating Protocol [MOP] [December 2012] list several objectives one of which is:

> To share information to increase the safety, health and well-being of adult victims and their children

6.11.3 Therefore, an interface is in place between MARAC and Children's Services.

6.11.4 Paragraph 2.1.5 of the MOP says:

> "In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator".

6.11.5 That paragraph recognises that MARAC should consider what services might be appropriate for perpetrators. In this case nothing was actioned at MARAC to address MA 1's offending behaviour.

6.11.6 MSCB/MSAB Procedures for Domestic Abuse, pages 17 to 19 deal with their relationship to MARAC. The procedures clearly recognise the link between domestic violence and safeguarding children and inform agencies how to proceed when MARAC and safeguarding coincide. The DHR Panel heard from the IDVA manager that in about 70% of MARAC cases the victims have children.

6.12 Term 11

How effective was the supervision and management of practitioners involved with the response to FA 1's needs and did managers have effective oversight and control of the case?

6.12.1 GMP exercised effective oversight when a supervisor decided that it was not necessary to undertake its "HBV" protocol following the MARAC. That was a documented and defensible position. GMP's management of Cleveland Police's enquiry was poor and ineffective. The deficiency in not seeing FA 1 after notification of a MARAC was not picked up by supervision.

6.12.2 Cafcass management did not identify that a referral had not been made to Children's Services or Adult Safeguarding.

6.12.3 The Homelessness Division's IMR notes that "...it is evident that the Family Support Team [FST] case notes were 'tidied' up when the police initially made contact with the FST.

6.12.4 The Homelessness representatives on the DHR Panel explained that the last contemporaneous entry on the file was 22.05.2013. There are four subsequent entries; three are dated the other is not. In effect the entries have been "backdated".

6.12.5 The person making the four entries did so after the police had spoken to them during the murder investigation. The person misguidedly thought it was a helpful act and did not appreciate it was wrong. The person's manager has dealt with the issue and there is no need for a recommendation from the DHR Panel.

6.13 Term 12

Were there any issues in relation to capacity or resources within your agency that affected your ability to provide services to FA 1, MA 1 or their children, or to work with other agencies?

6.13.1 The IDVA service lost several posts after a spending review. One of the consequences was that victims presenting as homeless had their CAADA DASH RIC completed by IDVAs on the telephone rather than face to face.

6.13.2 No other agency reported capacity issues.

7. LESSONS LEARNED

7.1 Agencies

7.1.1 The agencies lessons learned have been turned into recommendations and appear in the action plan.

7.2 DHR Panel

7.2.1 The following lessons were identified by the DHR Panel.

Explanatory Note:

There were some indicators of HBV in this case but they were not recognised or followed up thoroughly. Therefore agencies who suspect HBV might feature in a domestic violence case must make thorough enquiries to determine whether or not it is a feature and if in doubt, proceed as though it were.

Lesson: 1

Not recognising when domestic violence has an honour base prevents agencies from applying the additional measures necessary to support victims.

Explanatory Note:

The DASH risk assessment asks tangential questions aimed at identifying HBV. The DHR Panel thought such questions should be explicit. In that way professionals can judge the victims understanding of HBV and not just rely on them recognising the point of a non-direct question. Asking the direct question also allows the victim to query what is meant by HBV.

Lesson: 2

Replying on tangential methods of identifying HBV may not always be successful and there is a need to be explicit with victims when exploring whether HBV is present in a case.

Explanatory Note:

The DHR Panel felt that the opportunity for FA 1 to provide fuller disclosures would have been increased had IDVA and GMP seen FA 1 when they were preparing for MARAC. The fullest disclosure was made in a face to face meeting with SOL 1 who has significant experience of dealing with women suffering domestic abuse from BME communities.

Lesson: 3

Face to face meetings with victims are more likely to result in fuller disclosures thereby making the assessment of risk and the provision of services more appropriate.

Explanatory Note:

FA 1 made incremental disclosures but outside of her solicitor did not disclose her sexual victimisation or that Child A had been assaulted. Therefore, professionals need good skills and time to coax information from victims in order to complete accurate risk assessments and develop support plans.

Lesson: 4

Domestic violence victims do not always make full disclosures at an initial contact.

Explanatory Note:

FA 1 told Sol 1, "in my culture it is not acceptable for a woman to report violence". Professionals should know the cultural context and recognise that victims from BME backgrounds who make disclosures have taken a very significant decision which requires careful appraisal and patience in drawing out the whole story. Disclosures can also bring additional risk to BME victims.

Lesson: 5

BME victims face additional barriers [cultural] when disclosing domestic violence**.**

Explanatory Note:

Child A was assaulted by MA 1 and all the children were exposed to domestic abuse. They also witnessed to MA 1's drug taking. None of these matters were identified which is surprising given the well-established links between domestic abuse and child protection. The focus was on the adult victim. Cafcass acknowledges it should have made a referral to Children's Services. The family may also have benefitted from a referral to The Children's Society in Manchester who offer support services for children in abusive homes.

Lesson: 6

The clear and well established links between domestic abuse and child protection were not recognised in this case, thereby leaving the children potentially unprotected.

Explanatory Note:

Responsible social landlords have much to offer victims of domestic violence; there is practical help in the form of additional physical security and vigilance from staff who engage with victims, including those who visit victims in their homes. There is no system for sharing domestic violence information between Manchester City Council Homelessness Division and social landlords.

Lesson: 7

In order for social landlords to support tenants who are victims of domestic abuse they need to be informed by partner agencies that they are housing victims

Explanatory Note:

In civil court proceedings, perpetrators are served with their victim's statement and will know exactly what has been disclosed, potentially placing the victim at increased risk.

Lesson: 8

Professionals should establish whether the perpetrator has been served with a copy of the victim's statement [or whether there is a plan to serve statements] and take it into account when completing the risk assessment and support plan.

Explanatory Note:

MA 1's family tried to entice FA 1 back into its fold. They asked her to forgive her husband, rescind the non-molestation order and allow the children to see their father when he pleased. The solicitor was lobbied on the telephone in a similar manner by an unknown male, believed to be a family member.

Lesson: 9

Professionals should be aware that breaking free from domestic abuse is not easy and that family pressure should be taken into account when drawing up support and safety plans; this is particularly so when "honour" is involved.

8 Predictability- Preventability

8.1 MA 1 posed a high risk of causing serious harm to FA 1 which is another way of saying that it was predictable that FA 1 would be seriously harmed.

8.2 MA 1's threat to kill FA 1 was predicated on her either leaving him or going to the police. Both of those things happened and research says that the risk to victims increases at the point of separation and a few weeks afterwards. Some five months had passed since FA 1 left MA 1 and his action in killing FA 1 came without warning.

8.3 However, the DHR Panel judged, given the passage of time between the risk assessment and the homicide, that it was not possible to prevent FA 1's death.

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9. CONCLUSIONS

9.1 FA 1 and MA 1 came to England from Syria as asylum seekers and began forging a new life. FA 1 took positives steps to integrate into the community. She was subject to long term and significant domestic abuse including sexual violence. FA 1 began showing elements of independence and wanting to remove herself and her three children from her abusive husband.

9.2 She confided in a friend [probably late 2012 or early 2013] that she had met another man. MA 2 found out and told her to end the relationship, thereby demonstrating an element of family pressure. That pressure was consistent with the reaction to the rape disclosure; it was dealt with internally.

9.3 In January 2013 FA 1 found the courage to leave the family home taking the three children. She disclosed domestic violence to GMP, IDVA, Cafcass and her solicitor. FA 1's case went to MARAC but the full extent of her victimisation was not known. She also disclosed child protection issues to Cafcass and her solicitor but an oversight by Cafcass meant that they were not passed to Children's Services.

9.4 The indicators of HBV while originally considered were later dismissed. HBV should have remained in the thoughts of professionals and have been used to inform the risk assessment. HBV would have necessitated an additional response from agencies part of which would have been much closer liaison between agencies and FA 1. In this way any emerging information would have been used to assess and manage risk.

9.5 GMP's response to Cleveland Police's June 2013 request to carry out a welfare check on FA 1 and the children is included in the IPCC's investigation.

9.6 FA 1 was unyielding in her determination to finish her relationship with MA 1 and despite pressure from the family to return home, stood fast. It is known that the risk to fleeing victims heightens in such circumstances.

9.7 The DHR Panel always believed that FA 1's death was one of HBV and the following media extracts from the case support this view.

9.8 The prosecution at the criminal trial said FA 1 had been killed for becoming "too westernised" and 'establishing an independent life'". The sentencing Judge said: FA 1 had suffered "years of abuse", adding, "The contempt you showed for FA 1 in death matched the contempt of how you treated her in life." Greater Manchester Police's Senior Investigating Officer said, "FA 1's death had been an honour killing" and added that "the irony is that this horrific act of self-pity brought nothing but shame on him and his family".

10. RECOMMENDATIONS

10.1 Single Agency

10.1.1 GMP

The Head of Public Protection Division to clarify the policy and procedure in relation to:

1. The completion of enhanced risk assessments in relation to domestic abuse, stalking and harassment incidents where the initial level of assessed risk is 'standard';

2. The required authorisation levels to file PPI logs;

3. The requirement to send letters to 'standard' victims.

Note: The issues arising from GMP handling of Cleveland Police's request for a welfare check on FA 1 and her children are subject of separate recommendations by the IPCC.

10.1.2 Cafcass

Cafcass IMR records the following:

Cafcass implemented the following processes [listed below] in February 2013 as a result of internal audits and staff development work with practitioners involved in the early stages of Private Law in Family Proceedings within the Service Area:

1. Direct work with practitioners following comprehensive audit by Cafcass National Improvement Team.

2. Implementation of a 'trigger' point process for review of each stage of Cafcass early work which includes: a management review at day 3 to ensure screening and recording of information; contacts with parties timetabled; necessary actions highlighted by Cafcass Central Intake Team are completed.

3. Management overview to ensure contact with parties has been undertaken in a timely manner and Schedule 2 letters [first reports to court from Cafcass] are scrutinised.

4. The review of work also ensures that all safeguarding issues have been addressed, including confirmation that Schedule 2 letter has been read by Cafcass court duty practitioner and, where appropriate, contact with partner agencies has taken place.

5. Weekly sessions with practitioner group to highlight any issues from quality assurance process.

6. Mentoring and group sessions for practitioners involved in First Hearing Dispute Resolution Appointments.

All these actions have been completed – Cafcass therefore has no multi- or single-agency recommendations for action. Learning from all multi-agency reviews is

considered by Richard Green [National Child Care Policy Manager] for its inclusion in the Cafcass research programme.

10.1.3 Adactus Housing Association

1. Highlight the Domestic abuse policy within Safeguarding briefings and training

2. Improve information sharing with Manchester Homeless Families Unit

3. Include addresses on MARAC agenda and if known identity of Social Landlord

4. To be more proactive in determining if new customers have support needs as a result of domestic abuse.

10.1.4 NHS Manchester Clinical Commissioning Group

1. The IRIS project should be offered to targeted Manchester GP practices to enable earlier identification of signs of domestic abuse. This project would also support practice nurses.

2. Practice nurse's role in enquiring about domestic abuse to be explored.

10.1.5 IDVA

1. IDVA to produce an advice sheet for agencies

2. That IDVAs have access to MiCare [Manchester City Council Social Care IT System]

10.1.6 HAAS

1. That an enhanced domestic abuse course is developed which includes: culture, faith and honour based violence.

10.1.7 Central Manchester University Hospital NHS Foundation Trust

1. Single agency domestic abuse training for key professionals to become mandatory across the organisation.

10.2 DHR Panel

1. That MSAB establishes whether the recommendation, from the Moss Side DHR published in spring 2013, to have a publicity campaign aimed at informing family and friends what they can do if someone discloses domestic violence has been completed; and if not, to commence action to do so.

2. That MSAB and MSCB review what HBV training it and/or its constituent agencies provide for front line staff to ensure it reflects how to identify whether domestic violence has an HBV element to it.

3. That MSAB and MSCB ensure its domestic violence training includes the point that solicitors who have knowledge of child protection issues through domestic violence disclosures from clients are not under a legal duty to make a referral to children's services or other authorities but have discretion

whether to do so.

4. That MSAB and MSCB ensure its domestic violence training includes the additional barriers faced by BME victims of domestic violence when considering disclosure to agencies.

5. That MSAB and MSCB consider whether the questions, as framed in the DASH risk assessment provide the best opportunity to identify HBV.

6. That MSAB reinforces in its domestic violence training the links between domestic violence and child protection.

7. That the Homelessness Division of Manchester City Council considers:

    a. having a written policy on offering clients a gender choice of Authorising Officer

    b. how it would support such a policy

    c. how to cater for victims of domestic violence who have children present during disclosure meetings

8. That the Homelessness Division of Manchester City Council develops a policy and practice which allows responsible social landlords to be furnished with information that new and existing tenants are victims of domestic violence..

9. That GMP satisfies itself that the arrangements for flagging addresses of domestic violence victims are robust.

10. That MSAB considers whether women from BME backgrounds are disproportionately more likely to be victims of domestic homicides that white northern Europeans in the Greater Manchester Area.

11. The DHR Panel recommends that the MARAC Coordinator considers whether the MOP should be amended to include a menu of standard actions agencies already undertake post each MARAC case.

12. That School 1 reviews it procedures for recording safeguarding information and reports its findings to MSAB Domestic Abuse Reduction Coordinator and MSCB Business and Performance Manager.

13. That MSAB considers whether it can ensure that all victims who are identified as MARAC cases, have a face to face meeting with a domestic abuse specialist before the MARAC meeting takes place; thereby providing a greater opportunity for a fuller disclosure and an accurate assessment of risk.

14. That Central Manchester Clinical Commissioning Group provides MSAB with written guidance on how to access GP records in DHRs where the patient's permission has not been obtained.

15. That Manchester Community Safety Partnership uses all it influence to secure the proliferation of the IRIS project to those Manchester GP's who have yet to take part in the IRIS project.

16. That Manchester Community Safety Partnership ensures that the findings of this DHR are disseminated to its constituent agencies who should embed the findings in their practice.

END OF REPORT

Post Home Office Quality Assurance Nov 2015

Appendix A

Additional Information on HBV

The CPS/ACPO definition is supported by further explanatory text:

"Honour Based Violence" is a fundamental abuse of Human Rights.

There is no honour in the commission of murder, rape, kidnap and the many other acts, behaviour and conduct which make up "violence in the name of so-called honour".

The simplicity of the above definition is not intended in any way to minimise the levels of violence, harm and hurt caused by the perpetration of such acts.

It is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

Women are predominantly [but not exclusively] the victims of 'so called honour based violence', which is used to assert male power in order to control female autonomy and sexuality.

"Honour Based Violence" can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members.

Examples may include murder, un-explained death [suicide], fear of or actual forced marriage, controlling sexual activity, domestic abuse [including psychological, physical, sexual, financial or emotional abuse], child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment, forced abortion. This list is not exhaustive.

Such crimes cut across all cultures, nationalities, faith groups and communities. They transcend national and international boundaries.

Notions of honour have always existed in our societies. In this context, these notions framed within culture, religion or the need to preserve identity, are used as a vehicle for justifying mainly male violence against women, children and sometimes other men. Ultimately, this is rooted in a patriarchal position which establishes clearly defined gender roles and where women are seen as objects and/or property. They are therefore expected to conform to a prescribed set of appropriate behaviours. This patriarchal position may be supported by varying degrees of social collusion and approval.

Honour based violence may also be referred to by other agencies as "honour crime". There are also a range of culturally specific words or phrases which may be used to refer to honour and are therefore linked to honour based violence. The actions associated with the preservation of this "honour" include a variety of violent crimes carried out predominantly, but not exclusively, against women [men usually become victims when they are accused or suspected of bringing a womans reputation into disrepute]. They can include assault, imprisonment and murder. The victim is being punished for allegedly undermining what the family or community believes is the correct code of behaviour. In purportedly transgressing this code of behaviour, the victim illustrates that they will not be controlled or conform to their family or communities wishes and this is to the "shame" or "dishonour" of the family or community.

This quote from Honour: Crimes, Paradigms and Violence against Women eidited by Welchman, Lynn and Hossain, Zed Books [London] succinctly confirms:

The term crimes of honour encompasses a variety of manifestations of violence against women; including murder termed honour killings, assault, confinement or imprisonment and interference with choice in marriage where the publicly articulated justification is attributed to a social order claimed to require the preservation of a concept of honour vested in male family and or conjugal control over women and specifically women's sexual conduct-actual or suspected or potential.

We are seeking to flag any criminal offence of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional- as in the domestic violence definition] committed as honour based crime. Cases will be prosecuted under the specific offence committed e.g. common assault, inflicting Grievous Bodily Harm, harassment, kidnap, rape, threats to kill, murder. These crimes should be identified as honour crimes on CMS as well as by their named offence[s].

Additionally, honour based crimes could include:

- Attempted murder;
- Manslaughter;
- Procuring an abortion;
- Encouraging or assisting suicide;
- Conspiracy to murder;
- Conspiracy to commit a variety of assaults.

Appendix B

Domestic Homicide Figures GMP

Recorded Domestic Homicide by Ethnicity	Asian	Black	Chinese, Japanese or South East Asian	Middle Eastern	Unknown	White - Northern European	Grand Total
Dec 2008 - Nov 2009	0	0	0	0	2	5	7
Dec 2009 - Nov 2010	0	0	0	0	1	9	10
Dec 2010 - Nov 2011	0	1	1	0	0	3	5
Dec 2011 - Nov 2012	2	0	0	0	1	5	8
Dec 2012 - Nov 2013	1	0	0	0	4	1	6
% of Total							
Dec 2008 - Nov 2009	0.0%	0.0%	0.0%	0.0%	28.6%	71.4%	
Dec 2009 - Nov 2010	0.0%	0.0%	0.0%	0.0%	10.0%	90.0%	
Dec 2010 - Nov 2011	0.0%	20.0%	20.0%	0.0%	0.0%	60.0%	
Dec 2011 - Nov 2012	25.0%	0.0%	0.0%	0.0%	12.5%	62.5%	
Dec 2012 - Nov 2013	16.7%	0.0%	0.0%	0.0%	66.7%	16.7%	
5 year period	**3**	**1**	**1**	**0**	**8**	**23**	**36**
% of Total	**8.3%**	**2.8%**	**2.8%**	**0.0%**	**22.2%**	**63.9%**	

Recorded Domestic Homicide by Ethnicity [Amended]	Asian	Black	Chinese, Japanese or South East Asian	Middle Eastern	Unknown	White - Northern European [Census date 2011 whites = 83.7 % in Manchester]	Grand Total
Dec 2008 - Nov 2009	0	2	0	0	0	5	7
Dec 2009 - Nov 2010	0	0	0	0	0	10	10
Dec 2010 - Nov 2011	0	1	1	0	0	3	5
Dec 2011 - Nov 2012	3	0	0	0	0	5	8

Dec 2012 - Nov 2013	2	0	0	0	0	4	6
% of Total							
Dec 2008 - Nov 2009	0.0%	28.6%	0.0%	0.0%	0.0%	71.4%	
Dec 2009 - Nov 2010	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	
Dec 2010 - Nov 2011	0.0%	20.0%	20.0%	0.0%	0.0%	60.0%	
Dec 2011 - Nov 2012	37.5%	0.0%	0.0%	0.0%	0.0%	62.5%	
Dec 2012 - Nov 2013	33.3%	0.0%	0.0%	0.0%	0.0%	66.7%	
5 year period	**5**	**3**	**1**	**0**	**0**	**27**	**36**
% of Total	**13.9%**	**8.3%**	**2.8%**	**0.0%**	**0.0%**	**75.0%**	