WIGAN

BUILDING STRONGER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

INTO THE DEATH OF

"STAR"

EXECUTIVE SUMMARY

Chair and Author: David Hunter

January 2016

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1. INTRODUCTION

1.1 The main people referred to in this report are:

STAR	Victim	20 years	White British
BOB	Offender	23 years	White British
Child 1	Child of STAR and BOB	Less than 2 years	White British

1.2 This case is about the homicide of STAR who was murdered in early 2015 by her partner BOB who was also the father of their very young child. STAR and BOB had been in a relationship since early 2011. After the death of STAR it emerged that the level and frequency of domestic abuse experienced by STAR was far greater than that known to local agencies. However, despite her family and friends encouragement for STAR to report the abuse to the police she felt unable to do so because she feared significant retaliation by BOB, and believed his threats that their child would be removed by the authorities.

1.3 A post mortem revealed STAR died of a single "stab" wound[1] to her neck which was inflicted in the home she shared with BOB. She also had 36 separate injuries dating back months which, according to the Home Office pathologist, may have been associated with domestic abuse.

1.4 BOB was arrested and charged with her murder and manslaughter. Later that year he was found guilty of murder and sentenced to life imprisonment with a minimum tariff of 16 years. Child 1 is safe and well in the care of STAR's family.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Wigan Building Stronger Communities Partnership decided on 24.02.2015 that the death of STAR met the criteria for a DHR. The completion date was set at24.08.2015. This was extended twice by the Partnership Chair to cater for seeing the families. STAR and BOB moved from Lancashire to Wigan in the summer of 2013. Therefore material relevant to the DHR needed to be obtained from non-Wigan agencies. Several agencies had resource difficulties in providing information which contributed to the delay. The last agency report was received on 13.10.2015.

[1] Caused by scissors

2.1.2 An additional delay happened when STAR's mother felt it was too soon to talk to the independent chair about her daughter. The DHR Panel felt it was right to wait until she had the strength to contribute. That meeting took place in late October 2015. In late November 2015 the report was ready to be shared with STAR's Mother. However and understandably she advised the DHR chair through the family social worker that she preferred to wait until after Christmas 2015 before learning of its contents. Mother's priority was to provide a happy environment for Child 1 at a time when STAR would traditionally celebrate with her family. STAR's Mother felt knowledge of the report in the pre-Christmas period would jeopardise that priority. The Chair of the partnership agreed and the completion date was reset at 15.02.2016. STAR's family were seen by the DHR Chair on 07.01.2016 who shared the findings of the report with them.

2.1.3 This timetable did not stop the agencies or Wigan Building Stronger Communities Partnership from beginning work on implementing the actions.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on24.02.2015.

2.2.2 The Panel Membership:

Jeanette Bailey[2]	Chief Officer	Drop in and Share [DIAS] Domestic abuse support service Wigan
Helen Case	Interim Named Nurse Safeguarding Children	Bridgewater Community Community Healthcare NHS Foundation Trust
Paul Cheeseman	Support for Chair	Independent
Clare Devlin	Detective Chief Inspector	Greater Manchester Police [GMP]
Amanda Crane	WBSCP Project & Implementation Officer	Wigan Council
Jill Cunliffe	Wigan Safeguarding Board Business Support Officer	Wigan Council
Garry Fishwick	Review Officer	Lancashire Constabulary

[2] Jeanette provided additional independence and domestic abuse expertise to the Panel

Reuben Furlong	Assistant Director Safeguarding Adults	Wigan Borough Clinical Commissioning Group [CCG]
Louise Green	Service Manger	The Brick Project
Sharon Heap	Named Midwife & Safeguarding Vulnerable families	Wrightington, Wigan & Leigh NHS Foundation Trust
Andrew Hill	Manager	West Lancashire Community Safety Partnership
Sue Hogan	Well-Being Prevention Early Help	Lancashire County and Council
Elaine Lamprell	Adult Safeguarding Manager	Wigan Council
Barbara Mooney	Manager	Birchwood Centre Supported accommodation
Deborah Morris	Safeguarding Manager	Wigan & Leigh Homes
Kathy Owen	Team Manager Council Children's	Lancashire County Council
Sarah Owen	Strategy Business Manager Well & ISAPP	Wigan Council
Cliff Owens	Community Safety Officer	West Lancashire Borough C
Jenny Scott	Senior Social Worker	Wigan Council
Duncan Shaw	Homelessness Advice and Prevention Officer	West Lancashire Borough Council
Kerry Walton	Assistant Head	Burscough Priory Science College
Paul Whitemoss	BCSP Business Manager	Wigan Council

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

Wigan

- Greater Manchester Police (GMP)
- Bridgewater Community Health Care NHS Foundation Trust
- Wigan Clinical Commissioning Group [CCG]
- The Brick Homeless Project
- Wigan and Leigh Homes
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Children's Services Wigan Council
- Welfare Desk Wigan Council

West Lancashire

- West Lancashire College
- Lancashire Constabulary
- Homelessness Advice and Prevention Team
  West Lancashire Borough Council
- West Lancashire CCG
- Southport and Ormskirk NHS Hospital Trust
- Children and Young Peoples Service
- Health Visiting, School Nursing, Mental Health

2.4 Agencies submitting non-IMR Information

- National Society for the Prevention of Cruelty to Children [NSPCC]
- Merseyside Police
- Birchwood Centre [Assisted Housing]
- Citizen's Advice Bureau Wigan

2.5 Notifications and Involvement of Families

2.5.1 The independent chair wrote to the parents of STAR in May 2015 informing them of the DHR and expressing condolences for their loss. He also wrote to the parents of BOB in May 2015. Both families were invited to contribute to the DHR after the criminal trial.

2.5.2 STAR's mother and another family member were seen in late October 2015 and their views appear in the report as appropriate. The family is devastated by the death of STAR and have not been able to come to terms with what happened.

2.5.3 BOB's mother and step-father were seen in September 2015 and where appropriate their views are in the report.

2.5.4 Both families were seen by the Independent Chair in early January 2016 and told of the review's findings.

2.5.5 Paul Cheeseman saw BOB in prison in early October 2015. He provided unverified information some of which appears in this report. However, what he says must be treated with caution and has not been corroborated. It is known from other facts that his account during this interview minimised his role and responsibility. [3]

2.5.6 The member of the public who reported concerns to the NSPCC was seen by the chair and the information obtained from that meeting has proved useful to the report.

2.6 Terms of Reference

2.6.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.6.2 Timeframe under Review

The DHR covers the period 01.01.1999, when there is a significant entry in BOB's GP record to 15.02.2015 which encompasses a post homicide period so that the care arrangements for Child 1 and support for the families can be examined.

[3] Also see 3.3.6

2.6.3 Case Specific Terms

1. Were there any significant factors in the childhoods of STAR and BOB that could have impacted on domestic abuse once they reached 18 years of age?

2. Were any child protection issues in respect of STAR and BOB as children, recognised and dealt with in accordance with the contemporary procedures?

3. Once STAR and BOB reached adulthood, what if any indicators of domestic abuse did you agency have in respect of STAR and BOB and what was the response in terms of risk assessment, risk management and services provided?

4. How did your agency ascertain the wishes and feelings of STAR and BOB in respect of domestic abuse and were their views taken into account when providing services or support?

5. What knowledge did the family, friends and employers have of any domestic abuse between STAR and BOB that could help the DHR Panel understand what was happening in their lives and if they received disclosures did they know what to do?

6. How effective was inter-agency information sharing and cooperation in response to the subjects' needs [pre and post homicide] and was information shared with those agencies who needed it?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to STAR and BOB.

8. How were the child safeguarding issues dealt with post the homicide? Did the action comply with local single agency and multi-agencies policies and procedures?

9. What consideration was given by agencies to support the families of STAR and BOB in the four weeks after STAR's death?

10. Agencies preparing IMRs should explore the actual day of the incident and if possible say what made that day different and why events led to the homicide

3. BACKGROUND

The information in this section is drawn from the IMRs, statements provided by GMP and contributions from the families.

3.1 STAR [Victim]

3.1.1 STAR was born and spent the majority of her life living in West Lancashire within a loving family. She was a good student at school and is described as a very happy go lucky child. She had lots of friends and this continued when she moved to high school. STAR's mother told their GP that STAR was being bullied at school [STAR was about twelve]. She started going out with boys and one of those relationships lasted throughout secondary school.

3.1.2 During her final year at high school, STAR's outlook changed somewhat and she became what her mother describes as "a bit stroppy". This resulted in a number of disagreements between them. The family, with STAR's agreement, thought they would all benefit if STAR spent a period living with her maternal grandparents. That happened and what the family described as 'generational differences' [between STAR and her grandparents] led STAR to seek alternative accommodation at the Birchwood Centre, an assisted housing project which provides support to young people who are in danger of becoming homeless.

3.1.3 STAR's mother said STAR loved being at Birchwood and benefitted from her stay. In September 2011 STAR began a level 2 Children's Care Learning & Development course at West Lancashire College. The following September she enrolled onto, "level 3 Children's Care Learning & Development" at the same college and withdrew in February 2013 for family/personal reasons. STAR won the student of the year award which made her and the family very proud. STAR did not have any criminal convictions.

3.1.4 Her parents wish her to be remembered as a good person. STAR's mother said "STAR was a perfect mum and gave her baby everything she could and kept him safe from harm, she had dreams and hopes for her and her baby's future. STAR was very well liked, always smiling and kind hearted. She will be missed so much by all her family including her child".

3.2 BOB [Offender]

3.2.1 BOB was the middle of seven children who grew up in Liverpool and West Lancashire. His mother re-married when he was at primary school. During this period of schooling his mother sought help from Child and Adolescent Mental Health Services [CAMHS] for his abusive and compulsive behaviour. His mother said he was bullied at school. At one time BOB wanted to be a vet. He had a particular affinity with animals, sometimes bringing home injured specimens.

3.2.2 In 2009 he enrolled in engineering and youth work courses at a local college but did not complete them. He spent about six months living in supported accommodation. His real passion was music and dance which he supported by working in a national fast food outlet. He lost his job and lived with his

biological father for a while. On return to his mother and step-father's home he was noted to have started taking drugs and was still self-harming. His mother and step-father recognised the harm drugs had on him and strongly advised him to give them up when Child 1 was born.

3.2.3 BOB told Paul Cheeseman that he was diagnosed with depression at nineteen and was given medication. He went to a few counselling sessions. The depression just happened. He noticed he was becoming different because when he was younger he would get angry and stand up and fight back when he was bullied. Later he started to just take things on the chin and let people walk all over him. When he met STAR he changed and had a reason to live.

3.2.4 BOB had convictions for dishonesty, possessing an offence weapon, possession of cannabis, breaching bail conditions[4] and obstructing a police officer.

3.2.5 It is clear from emerged during the review that BOB did not respect STAR and from the above convictions neither did he respect authority.

3.3 Relationship between STAR and BOB

3.3.1 BOB met STAR when he visited the Birchwood Centre [5] in 2011. They met again at college and soon formed a relationship which STAR told her GP about in February 2011. STAR left her supported accommodation and moved in with BOB in February 2011. It emerged during the homicide investigation that their relationship was volatile and on several occasions STAR disclosed to her mother and other people that BOB had assaulted her. On one occasion STAR sent pictures of her facial injuries to her mother. STAR's mother also recalls receiving telephone calls from STAR saying that she had been locked in the house; that she had been arguing with BOB and he had pushed her. The telephone calls continued and her mother suggest telephoning the police but STAR stated she was alright and it was just arguments. Her mother encouraged her daughter to return home but STAR always said she was alright. STAR did return home on a few occasions with the support of her family, but BOB always persuaded her to return, claiming he would change.

3.3.2 In April 2013 BOB was arrested by Lancashire Constabulary for assaulting STAR. He was charged with Common Assault [Section 39 Offences Against the Person Act 1861] and initially remanded in police custody. He was given conditional bail in the Magistrates' Court which he breached. STAR later withdrew her allegations against him and therefore BOB was not convicted of assaulting her. BOB later apologised to STAR saying he loved her and would not assault her again. This "apologetic and promising" behaviour is very common in domestic abuse and is in itself a form of coercive and controlling behaviour. Their relationship continued and appeared settled for a short time.

[4] See paragraph 3.3.2

[5] An organisation that works with Young People [13-25 years old] to prevent homelessness and improve well-being. It also provides supported accommodation, delivers mediation, training, plus development and move on support.

STAR's mother describes an occasion when STAR telephoned her saying that she and BOB had had been arguing and BOB had hit her and smashed her head into the floor. Her mother states she had always taught her children to hit back and asked STAR if she had retaliated, STAR said she had hit back at BOB. As a result of this incident STAR was seen with a black eye and bruising around her ear, she was pregnant at this time. Her mother encouraged STAR to telephone the police. STAR replied it was not possible to telephone the police when your telephone has been taken away [by BOB]. This is another example of controlling and coercive behaviour.

3.3.3 The couple moved to private rented accommodation in the Wigan area in mid-2013 and STAR was pregnant with Child 1. BOB's brother lived with them and things appeared settled between STAR and BOB for a short time. There is evidence that they were under financial pressure. Their income was derived from benefits and they received monthly food parcels from The Brick Project. It appears, and was confirmed by BOB, that their drug use [cannabis/cocaine] consumed much of their income. BOB's brother moved out and they accrued rent arrears, ending in an eviction notice. Housing intervened, discovered that STAR was well advanced in pregnancy, and provided accommodation treating them as a priority case.

3.3.4 Child 1 was born and there is evidence that the relationship between the couple was still unsettled. However, before the NSPCC referral to GMP and Wigan Children' Services in May 2014, agencies in Wigan had no knowledge or suspicions about domestic abuse. His arrest for domestic abuse in Lancashire was not known to GMP but it could have been easily discovered by them interrogating the Police National Computer [PNC][6] or the Police National Database [PND].[7]

3.3.5 BOB described his relationship with STAR as: "…Overall it was good… we just had problems and we weren't very good at dealing with them. Mine was obvious I was suffering from depression. She did as well, she never went for help. It was good until we moved in together. Even the bad times were good… There was a point when we wanted to leave each other…When Child 1 was born I fell in love with her again".

3.3.6 The DHR panel was conscious that BOB's remarks could not be challenged by STAR. On listening to the full account of the interview with BOB, the panel felt from its independent experience and the available evidence that he was a minimiser who did not take responsibility for his actions.

[6]Police National Computer a national database base holding information on convictions, arrests and vehicles; accessible to all police forces within England, Wales and Scotland.

[7]Police National Database – an information and intelligence database populated by and accessible to all police forces within England, Wales and Scotland.

4. COMMENTARY

4.1 STAR and BOB were young people who came together having shared similar experiences of living in supported accommodation, albeit at different times. BOB was a few years older than STAR.

4.2 STAR came from a loving family who decided that a period living with her grandparents would help her transition to adulthood. This arrangement is not uncommon within families.

4.3 The breakdown in the relationship with her grandparents was caused by generational differences. A date was set for STAR to find alternative accommodation and as it neared she reacted impulsively by taking an overdose of paracetamol. This crisis saw STAR move into supported accommodation where she enjoyed the experience and developed as a person. She left there and moved in with BOB.

4.4 BOB had a period living away from his mother and step-father before moving to the same supported accommodation as STAR. However, they were not resident at the same time. He had a greater involvement with mental health services through several episodes of self-harm. He was never assessed as posing a risk to others. His mother and step-father saw a significant deterioration in him once he started taking illegal drugs.

4.5 STAR and BOB attended the same college but on different courses. They formed a relationship and moved into together. They were given notice to quit by a private landlord because of rent arrears and moved into social housing once it was established STAR was near to giving birth. Neither had sustained employment and relied on benefits. It is known that they frequently used cannabis and sometimes cocaine. This will have consumed some of their income hence the support they received from a foodbank. There were also other indicators of financial pressure such as people demanding repayment of debts they alleged owed.

4.6 BOB's arrest for assaulting STAR in Lancashire in 2013 resulted in a charge of Common Assault. However, STAR withdrew the allegation following what was likely to have been sustained badgering by BOB accompanied with false promises of reform.

4.7 Child 1 was born in spring 2014 and between then and STAR's death there is evidence of an escalation of domestic abuse by BOB on STAR. This trend was not recognised by any agency.

4.8 There were several opportunities to discover that STAR was the victim of coercive and controlling behaviour and physical violence. These were only partly uncovered and in May 2014 a golden opportunity was missed by Greater Manchester Police and Wigan Children's Services to speak with two independent witnesses who having reported their concerns for Child 1's welfare and the domestic abuse between Star and BOB to NSP, were willing to speak with the authorities. The focus of the Police and Children's Services

involvement was on the child welfare aspect of the NSPCC information and the domestic abuse was not given the priority it should have been. This is exampled by the fact that the MoP was not seen or spoken to by either agency.

4.9 That missed opportunity was compounded when police attended a second incident at their home, two months later. The police did not carry out, or follow up on the domestic abuse history of BOB nor did they notify Children's Services and Health Visiting of their involvement and belief that STAR was a victim of domestic abuse.

4.10 The risk assessments done by GMP did not take into account all the information that was available. This case needed a professional to take the initiative and put together a holistic picture of what was happening in the family or call for a multi-agency meeting where information could be shared. Had either of these approaches been adopted, it is possible that STAR would have been identified as a medium or high risk victim.

4.11 STAR's disclosed to her family and friends that BOB was abusing her and swore them to secrecy because she feared BOB and was persuaded by his promises to change. STAR's mother did not know what to do for the best and acceded to STAR's insistence that BOB would mend his ways. STAR was in genuine fear of losing Child 1 should it be known to agencies that she was a victim of domestic abuse, a view continually reinforced BOB.

4.12 Over 65,000 domestic abuse incidents are reported to GMP every year; this represents around 170 incidents a day and about 6% of GMP's total workload. Therefore, the demand on staff in the Public Protection Investigation Unit is substantial and judgements have to be made on which cases require additional thought and checks. The DHR Panel felt that STAR was one of those cases that needed additional scrutiny.

4.13 There is evidence that in the weeks leading to her death STAR was subjected to escalating violence and confided in her mother that she had had enough of the relationship. The DHR Panel does not know if STAR conveyed this directly or indirectly to BOB. What is known is that at the point of separation or soon afterwards the risk of serious harm to victims increases.

4.14 It appeared to the DHR Panel that in the few days before STAR's death the domestic abuse intensified. The assault on STAR that led to facial injuries probably resulted in a loss of consciousness. This is evidenced by the fact that STAR said she woke up fully clothed in a bath of water and did not know how she got there. That incident was a serious criminal offence matter and represented a very high tariff risk factor.

4.15 It is clear that STAR was signaling her unhappiness with the relationship and wanted it to end. STAR told her mother that BOB's behaviour towards her was "belittling", STAR was describing the coercive and controlling element of domestic abuse. The physical violence was also evidence by her black eyes and observations other physical assaults.

4.16 On the day of the homicide STAR accidently knocked over a fish tank and broke it. She asked her mother what to do and also telephoned BOB's mother requesting that she collected BOB from the house as he was getting on her nerves. Whether or not the broken fish tank was the catalyst remains unknown. BOB pleaded not guilty claiming the fatal scissor wound was caused accidently when STAR fell. However, and unanimously, the jury did not believe that account and found him guilty of murder.

4.17 After BOB was found guilty of STAR's murder a national newspaper reported, that an undated note written by STAR in crayon was found addressed to BOB in which she wrote 'I have come to the conclusion that me and you just aren't meant to be.' The police Senior Investigating Officer confirmed the presence of the note and without knowing for certain, believed that BOB has seen it.

4.18 It is well establish through research that risk of serious harm, including death, increases at the time of separation or soon after. In this case STAR and her Mother exchanged messages indicating that the relation with BOB was ending. However, neither STAR nor her mother could be expected to know that this represented an increase in risk.

4.19 Post STAR's death Children's Services worked closely with GMP, the families and courts to ensure that Child 1 was safeguarded and his immediate future secured.

5. LESSONS IDENTIFIED AND GOOD PRACTICE

5.1 Lessons Identified

Lesson 1
It is necessary for agencies to scrutinise referral documents to ensure that pertinent detail is not overlooked.

Narrative:
The NSPCC form completed when MoP reported her concerns for Child 1 contained detailed information on domestic abuse including eye witness testimony. The detail was overlooked by Wigan Children's Services and not acted on by GMP.

Recommendation 1 applies

Lesson 2
Not looking for additional, and ideally, independent sources of information when faced with conflicting evidence can lead to inferior decisions.

Narrative:
This lesson relates to the investigation by GMP and Children's Services into the NSPCC information. Member of Public should have been seen by one or both of the agencies.

Ember of the public and another person had witnessed domestic abuse and their knowledge and testament would have influenced and probably altered the risk assessment.

Recommendation 1 applies

Lesson 3
Agencies who respond to requests for information without knowing the detail of the original referral cannot fully judge the value of their contribution.

Narrative:
Health Visiting did not receive the original referral from NSPCC and when they received feedback from Children's Services and a notification from GMP, were not in a position to evaluate their response.

Recommendation 1 applies

Lesson 4
Family and friends need ready access to information on how to support victims of domestic abuse.

Narrative:
Family and friends had significant knowledge that STAR was suffering domestic abuse and having been sworn to secrecy were left in an unenviable position of not knowing what to do for the best.

Recommendation 2 applies

Lesson 5

Bite marks can be an indication of sexual violence.

Narrative:
BOB bit STAR on her thigh. While this was not known to professionals it is important that professionals involved with victims, or suspected victims, of domestic, know the connection between bite marks and sexual violence.

Recommendation 1 applies

Lesson 6
Failing to gather a comprehensive history of domestic abuse is likely to weaken risk assessments and leave victims vulnerable to further abuse.

Narrative:
In this case there was a growing amount of evidence that BOB was perpetrating domestic abuse on STAR. There would have been benefit to STAR if someone had stopped and thought, "What is happening in this relationship" and then gathered all the available information with which to complete a risk assessment.

Recommendation 1 applies

Lesson 7
Some agencies offering services [in this case The Brick Project] may have tangential information which could help identify financial and other family pressures.

Narrative:
The family received eleven food parcels from The Brick Project, including three when additional provisions were added for a child. Such circumstances provide an oblique opportunity to refer the beneficiaries to other services.

Recommendation 1 applies

Lesson 8
"Healthy Relationship" education may help to reduce domestic abuse.

Narrative:
The DHR Panel debated the need to have bespoke "Healthy Relationship" programmes available to strengthen the work that is done on the subject through more generic programmes.

Note:
An internet search question: "Healthy relationships for young people" produces many links to useful information one of which is www.womensaid.org.uk. This site has the following links.
Bursting the Bubble - Website for teenagers living with family violence.
National Youth Advocacy Service - Information and advocacy service for children and young people up to 24 years.
Fast Forward - Information on drugs and alcohol education for youth.
Respect Not Fear - Website for young people about healthy relationships, with games and activities.
The Site - Support and guidance for young people throughout life.
Young Minds - mental health charity for young people.

Recommendation 3 applies

Lesson 9
Defendants' families can be left isolated follow a homicide.

Narrative
The ACPO policy on "Contact Officers" for defendants' families in domestic homicide cases was not known to either of the Senior Investigating Officers in this case.

GMP recommendation 4 applies

5.2 Good Practice

a. The liaison between Lancashire Children's Services, West Lancashire Homelessness Prevention and Advice Service and The Birchwood Centre prevented STAR from becoming homeless and adding to her vulnerabilities.

b. Wigan and Leigh Homes acted swiftly and allocated the family a property when they realised STAR was pregnant and about to be evicted.

c. Health Visiting used networking to identify the family's new address after temporarily losing contact.

d. The police officer who attended the abandoned 999 call recognised that BOB was exercising control over STAR.

e. While it did not apply in this case an innovative scheme is now in place in Wigan which sees mental nurses deployed alongside police officers to those calls for service which are judged to have a mental health element.

f. The liaison between the police, the Crown Prosecution Service and the Magistrates' Court to impose bail conditions on BOB in support of STAR was judged to be good practice by the Panel.

6. PREDICTABILITY/PREVENTABILITY

6.1 The only DASH[8] risk assessment undertaken by GMP was in response to the 999 call in July 2014. The DASH risk assessment completed on STAR judged BOB posed a Standard risk of causing serious harm to her. The definitions of risk used by GMP are:

- Standard — Current evidence does not indicate likelihood of causing serious harm
- Medium — There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances
- High — There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious

6.2 Therefore, using the Standard definition of risk it was not possible to predict that BOB would cause serious harm to, or kill STAR. However, the DHR Panel felt that the risk faced by STAR was under-assessed because not all the risk factors were identified and taken into account.

6.3 Had the member of the public been seen following the referral from NSPCC to GMP and Wigan Children's Services then the domestic abuse element of the information would have received greater prominence and almost certainly have resulted in a DASH risk assessment. In the professional judgement of the DHR Panel, using hindsight, the risk faced by STAR from BOB at the time of the NSPCC referral would have been medium thereby making predictability more likely.

6.4 The second opportunity to complete a DASH risk assessment came about eleven weeks later with the abandoned 999 call. On this occasion GMP

[8]Domestic Abuse Stalking and Harassment and [so called] Honour Based Violence (DASH 2009)

completed the DASH and judged STAR faced a Standard risk of serious harm from BOB. Again in the professional opinion of the DHR Panel, using hindsight, this was understated and should have been medium. The Standard outcome did not take account of all the risk factors including the historic abuse in Lancashire.

6.5 The DHR Panel very carefully considered its position on predictability and decided that even if the risk assessment had been medium at the time of the NSPCC referral or the abandoned 999 call [May 2014 and July 2014 respectively] there was too much time between then [July 2014] and the homicide to say STAR's death was predictable. The DHR Panel also felt STAR's death was not preventable.

6.6 However, the DHR Panel judged the understating of risk prevented an opportunity for STAR's case to be examined in more detail at MARAC with the probability of producing a plan aimed at lessening her victimisation.

7. RECOMMENDATIONS

7.1 Set out below are the three recommendations from the DHR Panel. They also appear in the Action Plan at Appendix B.

7.2 The Single Agency actions appear in the Action Plan and are not repeated here.

DHR Panel Recommendations

1. That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership use the findings from this DHR in their domestic abuse multi-agency training programmes and specifically highlight the importance of:

   Lesson 1 Scrutinising original referral documents

   Lesson 2 Seeking additional sources of information

   Lesson 3 Sharing full information from referral documents

   Lesson 5 That bite marks on victims can be a sign of sexual violence

   Lesson 6 Poor information gather leads to poor decisions and does not support victims

   Lesson 7 That agencies may hold tangential information of value to other agencies engaged in domestic abuse identification and assessment

2. That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership review their current advice to

family and friends on what to do if they receive disclosures of domestic abuse to determine whether the advice:

- Is still appropriate
- And has it penetrated the community

3. That Wigan Building Stronger Communities Partnership consider whether healthy relationships programmes have a place in reducing domestic violence and if so to determine how such programmes are best delivered in Wigan.

End

Appendix A

Definitions

Domestic Violence

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"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 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

3. *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.

4. *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.

Appendix B

Sexual Bite Marks

"Alternatively, it is well known that assailants in sexual attacks, including sexual homicide, rape and child sexual abuse, often bite their victims as an expression of dominance, rage and animalistic behaviour."

British Dental Journal 190, 415 - 418 (2001)
published online: 28 April 2001 | doi:10.1038/sj.bdj.4800990A look at forensic

dentistry – Part 2: Teeth as weapons of violence – identification of bite mark perpetrators

Webb D A, Pretty I A, Sweet D. Bite marks: a psychological approach. Proceedings of the American Academy of Forensic Sciences Reno, NV, February 2000; 6: 147

Appendix 'C'

Action Plan

DHR Panel Recommendations						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership use the findings from this DHR in their domestic abuse multi-agency training programmes and specifically highlight the importance of: Lesson 1 Scrutinising original referral documents Lesson 2 Seeking additional sources of information	Wigan BSCP: Domestic Abuse Steering Group / Wigan Safeguarding Adults and Children's Joint Training Group to ensure lessons / key training issues are included within review of Domestic Abuse Training package Review to ensure that domestic abuse is incorporated within overall competency framework (children's and adults)	Domestic Abuse Steering discussion and mandate, Training Sub Group incorporate domestic abuse training package refresh and inclusion within overarching competency framework within work plan	Refreshed Domestic Abuse Training package that incorporates key lessons. Children's and Adult's Competency frameworks incorporates refreshed domestic abuse training package	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group) Elaine Lamprell / Nicola Osborne (Joint Chairs Adults and Children's Boards Training Delivery Group)	Refreshed Training Package by April 2016 Incorporation of training package within over-arching children's and adults training competency frameworks by June 2016 First reporting of domestic abuse competency framework to Domestic Abuse Steering Group / Safeguarding Boards September 2016.

	Lesson 3 Sharing full information from referral documents Lesson 4 That bite marks on victims can be a sign of sexual violence Lesson 5 Poor information gather leads to poor decisions and does not support victims Lesson 6 That agencies may hold tangential information of value to other agencies engaged in domestic abuse identification and assessment			and becomes part of both boards performance and quality assurance framework		

2	That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership review their current advice to family and friends on what to do if they receive disclosures of domestic abuse to determine whether the advice: 1. Is still appropriate 2. And has penetrated the community	Wigan BSCP: Wigan Domestic Abuse Steering Group to commission specific needs analysis regarding advice / information for friends and family regarding disclosures. Analysis to incorporate and provide recommendations regarding • victims / friends / families views on current / future content / access / methods. • Assessment of potential needs and demands on partnership services • Quality assured framework for responding to family / friends	Needs Analysis completed Recommendations to BSCP Executive Action Plan (incorporated within overarching Domestic Abuse community capacity programme) agreed and in place with suitable links made to partner agencies corporate Information / Advice policies and strategies	Domestic Abuse Community capacity programme to develop and implement a Domestic Abuse Information and Advice Plan and Framework Quality Assurance / output / performance monitoring / cost benefit analysis for plan regarding increased and earlier reporting of domestic abuse	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group) Joyce Swift (Domestic Abuse Community Capacity Programme lead)	Analysis complete by May 2016 Plan in place by July 2016

		advice • Links to wider corporate Deal for Wigan Programme, / Domestic Abuse Community Capacity Programme / Operations Strive Early Help Programme				
3	That Wigan Building Stronger Communities Partnership consider whether healthy relationships programmes have a place in reducing domestic violence and if so to determine how such programmes are best delivered in Wigan.	Domestic Abuse Steering Group to identify what works / need /opportunities for healthy relationship programmes within refreshed Domestic Abuse Strategy and Action Plan (scoping to form part of strategic needs analysis process)	Strategic needs analysis identifies and recommends suggested approach within broader domestic abuse strategy and action plan	Issue is identified with achievable action plan within Early Intervention Objective in refreshed strategy / action plan	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group)	Domestic Abuse Strategy and Early Intervention objective and action plan in place by June 2016

Single Agency Recommendations

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Clarity to be provided for PPIU specialist staff in relation to what level of checks are required to be completed during an Enhanced Risk Assessment.	Review current policy document/newly revised policy document with regards to what standards of research are expected from staff completing an Enhanced Risk Assessment.	Correspondence update to be provided to the Panel when the policy has been revised and result of the consideration given to what checks are expected and on which GMP databases for each of the risk assessment grading.	Provide clarity to specialist staff when completing Enhanced Risk Assessments and produce a standardised method across the Force to risk assessing domestic abuse incidents.	Detective Chief Superintendent Jardine	30.04.2016
2	Consideration to be given to reviewing the electronic Enhanced	Review the electronic document used for Enhanced Risk	Correspondence update to be provided to the	A revised Enhanced Risk Assessment	Detective Chief Superintendent Jardine	30.04.2016.

	Risk Assessment within the PPI document to make it fit for purpose.	Assessments. Are the questions specific enough? How can the requirement in the policy for an assessment to be completed on both the victim and perpetrator be met if the form allows for research results only on the perpetrator?	Panel when the use of the electronic Enhanced Risk Assessment document has been reviewed.	document or method of recording Enhanced Risk Assessment research results will allow for a more standardised assessment which will include both victim and perpetrator information recorded appropriately.		
3	Enquiries to be made to developing and introducing a flagging system within the PPI OPUS system to enable PPIU triage staff to identify those standard risk PPIs awaiting assessment which have recordable reports of crime attached in order that the can be processed prior to	Liaise with OPUS IT services to ascertain the feasibility of introducing a flagging system as described.	Correspondence update to be provided to the Panel once the enquiries have been completed and the possibility of such a flagging system being introduced is known.	PPIU triage staff will be better placed to process PPI records that have a recordable crime attached to them. These types of PPIs are more likely to require further action by a specialist officer and the earlier	Detective Chief Superintendent Jardine	30.04.2016

	those that do not.			that action can be highlighted and taken the better the service provided to victims.		
4	All SIOs involved in leading a homicide investigation to be reminded to consider the appropriate use of a contact officer to signpost the defendant's family to support agencies available to them.	This matter has already been brought to the attention of the Head of GMP's Major Incident Team (MIT) for discussion at the next MIT managers meeting.	The Panel will be updated from information from the minutes taken at the MIT managers meeting when the subject of contact officers for defendants' families is discussed.	SIOs will be reminded that as per ACPO guidelines relating to family liaison consideration should be given to providing a contact officer for defendants' families to signpost them to support agencies.	Detective Superintendent Jackson	29.02.2016

Wigan CCG						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Draft communication to GP Practices across Wigan Borough to share the following learning: a. Relevance of previous history b. Enquiring about domestic situation c. Recording identity of partner/father at new patient registration	Draft letter to GPs Letter to be tabled for discussion at GP safeguarding Leads Forum	Letter Minutes & Slides	Increased awareness of learning identified from Overview Report	Reuben Furlong	28.02.2016

Wigan and Leigh Homes						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To ensure that all relevant staff have refresher training within three years of attending initial training on domestic abuse	Identify relevant staff and ensure refresher training on domestic abuse included on their individual training plans.	Attendance of relevant staff recorded.	All relevant staff are confident and competent in identifying domestic abuse and the appropriate referral mechanisms	Deborah Morris	To be incorporated within staff training plan 2016/2017.

Bridgewater Community Healthcare NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	An audit of the routine enquiry for domestic abuse by the Health Visiting Service in the Wigan Borough should be undertaken.	An audit of routine enquiry will be undertake across the Wigan Borough	Audit results will be available.	Routine enquiry will be evident on a consistent basis. If routine enquiry not undertaken the reason will be clearly	Helen Case	Completed

				documented e.g. not safe to undertake as partner present.		
2	Staff will be reminded of the risks to adults and children associated with 'toxic trio'	Staff to be reminded of the risks to adults and children associated with toxic trio via i) the Safeguarding Children Newsletter *What's Hot in Safeguarding Children*	Safeguarding Children Newsletter *What's Hot in Safeguarding Children*.	Staff will have an increased awareness of the risks associated with 'toxic trio'	Helen Case	Completed

West Lancashire CCG						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Training session to be offered to the practices involved in this DHR re domestic abuse and violence to ensure adherence to NICE guidance ph50.	1) Discuss with practices 2) Develop training materials 3) Deliver session	Feedback forms Training materials	Increased awareness of issues. Increased detection and referral on for support of those affected.	Dr Linda Whitworth	28.02.16
2	Audit of training needs around domestic abuse and adherence to NICE guidance ph50 in GP practices across the area.	1) Develop audit tool (with help of CCG staff) 2) Disseminate audit 3) collate the results	Audit results	To get a clearer picture of current training needs to help the LSCB/CCGs plan training strategy.	Dr Linda Whitworth	Completed
3	Ensure the practices involved in this DHR have, and adhere to, a DNA policy for children and vulnerable adults,	1) Include this in discussions with practices as in number 1 above	Feedback forms	Additional safety net for children and vulnerable adults.	Dr Linda Whitworth	Completed

	as well as up to date safeguarding children and adults policies.					

West Lancashire Health Centre						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Although staff receive regular updates to their mandatory training at appropriate levels to their roles, it wold appear that domestic violence training / awareness may need to be covered separately	To provide training specifically in domestic violence to all staff at West Lancs Health Centre To contact West Lancs Women's Refuge for help with training Review and update domestic violence policy	E-mail trail of evidence to arrange training meetings. Minutes of meetings Policy document	Improved awareness of presentations of domestic violence and questions to ask during consultations and raise awareness of where to refer women to if they are victims of domestic violence	Dr Sally-Ann Hawkins	31.12.16

		To identify a domestic violence lead for the department	Minutes of meetings			
2	Access to the Medical interoperability gateway (MIG) will improve patient safety as we would be able to access patient's GP records relating to safeguarding concerns rather than relying on GPs to send us alerts when they remember, it would also mean we could access data on patients presenting from out of area.	To finalise discussions with CCG and IG lead and have IT install access to MIG on Adastra system.	E-mail trail Access to computer system to view if required.	Improved awareness of any safeguarding issues known to the patient's registered GP. Also safer prescribing will result from access to patient's PMH and prescribed medication.	Donna Wright	01.03.16
3	Regain access to the Alchemy server	To enable access to patient records stored on the server between 2009-2011	E-mail trail Access to computer system to view if required	To enable reports to be provided in a timely manner to assist multi agency reviews.	Donna Wright	31.12.16

Wigan Children's Services						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	All appropriate correspondence to be saved appropriately on the IT System Liquid Logic. This relates to any information received by the department and any correspondence sent by the department in respect to a family.	Continued clear management oversite, through regular supervision Regular audits to be completed. To identify any areas which require improvement and to ensure quality assurance of cases.	Following a review of the duty service in 2014. Quality of decision making, planning and recording have improved this is evidenced in audits and daily management oversight.	To continue to ensure clear and concise record keeping. To ensure continued quality assurance of recording on cases.	Jayne Ivory, Lynn Fields	Completed

2.	All information to be recorded appropriately within contact records. This to include outcomes and specify clear actions requested of other agencies along with dates for these to be completed. Agencies requested to complete an action to be informed both verbally and in writing. This to be recorded and evidenced within the contact record outcomes.	Clear and concise management oversite on all contacts received by the department. A drive in quality assurance of all contacts. A more robust process of information gathering at the initial contact stage. Regular auditing of cases	Audit of contacts and following actions on 16-17.09.2015 by the Contact and Referral Team. Policy documents	To ensure clear and concise record keeping. To ensure continued quality assurance of recording on cases.	Sharon Oxenham, Lynn Fields	Completed
3	Families to be provided with appropriate information in respect to available support services, when the department are taking no further action. This	Outcome category to be changed on the child's record on the recording of a contact referral. This to have a clear option of	IT system will display new action within the contact outcomes tab on the child's record. To ensure families are provided with the relevant information/advice/signposting.	To allow for clear recording of information/advice provided to the family. To clearly evidence actions,	Lynn Fields, Sharon Oxenham	Completed

	information to be clearly recorded on the IT System Liquid Logic.	advice and professional support or signposting rather than the current option of no further action.		decision making and planning completed by the local authority,		

Wrightington, Wigan and Leigh NHS Foundation Trust [Maternity Services]						
No	**Recommendations**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To ensure opportunities are made to routinely ask pregnant women about domestic abuse.	Routine enquiry checklist devised and a routine enquiry pathway devised.	Maternity guideline updated. Community midwives and antenatal clinic staff trained and confident in using the routine enquiry checklist/using the pathway.	To assist midwives to make enquires regarding domestic abuse and referring on to the relevant support agencies/utilising the pathway.	Sharon Heap Named Midwife child protection and safeguarding vulnerable families	Completed

2	To raise awareness of domestic abuse, recognition and response	A targeted approach to domestic abuse awareness training will be commenced across WWL to include midwives.	Half day training sessions booked for the all WWL staff from January 2016 and staff training figures will be collated and saved on database as evidence.	To ensure that all midwives are trained to recognise the indicators of domestic abuse and can ask the relevant questions to help women disclose their past or current experiences of domestic abuse.	Safeguarding team WWL	Complete and ongoing
3	Audit of routine enquiry by WWL Maternity Services	An audit of routine enquiry will be undertaken by March 2016 Audit results will be available.	Audit results will be available and presented.	Routine enquiry will be evident on a consistent basis.	Sharon Heap Named Midwife child protection and safeguarding vulnerable families	31.05.16