MANCHESTER COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

AF1

OVERVIEW REPORT

June 2016

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

AF1	Victim	White British	29 years of age
AM1	Perpetrator	White British	26 years of age

1.2 In early 2014, AF1 and her partner, AM1, were socialising together in Manchester City Centre. They had a verbal argument during which AM1 punched AF1 who fell to the floor unconscious. He telephoned for an ambulance and AF1 was admitted to hospital. She sustained severe brain injuries and died later, when her life support systems were withdrawn. AM1 was charged with her murder.

1.3 AM1 was tried for the murder of AF1. He initially claimed that she had fallen to the floor in an intoxicated state, but eventually accepted his punch caused her fall and injuries; saying he did not intend to kill her. He was found guilty of murder was sentenced to life imprisonment with a minimum tariff of 16 years.

1.4 The sentencing judge was reported as saying that AM1 would only be released if the Parole Board felt he was no longer a risk to women; adding, "You have in my view a disturbing history of assaulting your partners…"

Source: Local media

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 Introduction

2.1.1 Local strategic governance for domestic abuse and issues linked to the national Violence Against Women and Girls Agenda is held jointly by Manchester Community Safer Partnership [MCSP] and Manchester Safeguarding Adult Board.

2.2 Decision Making

2.2.1 MCSP decided to undertake a DHR this review in line with the Statutory Guidance for the conduct of DHRs, August 2013.

2.3 Agencies Providing Information to the DHR

2.3.1 The following agencies provided Individual Management Reviews (IMR)

- Homelessness MCC
- Independent Domestic Violence Advisory Service MCC
- Greater Manchester Police
- National Probation Service North West [formerly known as Greater Manchester Probation Trust]
- Central Manchester Foundation Trust [CMFT] Midwifery
- NHS England [Manchester] on behalf of GP Services
- Pennine Acute NHS Trust
- MCC Children's Services
- Manchester Mental Health and Social Care Trust
- Northwards Housing

2.3.2 In addition, it was agreed that Victim Support and the Youth Offending Service would provide short reports**.**

2.4 Terms of reference for the review

2.4.1 Terms of reference for the DHR were agreed by the DHR Panel.

- To establish what lessons can be learned from the death of AF1 regarding the way in which professionals and organisations work individually and together to safeguard future victims
- To identify clearly what those lessons are within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- To apply those lessons to service responses including changes to policies and procedures as appropriate
- To contribute to the prevention of domestic abuse incidents and improve service responses for all domestic abuse incidents victims and their children though improved intra and inter-agency working.

2.4.2 In addition, the following case specific terms were agreed.

1. How did agencies identify and assess the domestic abuse indicators in this case, and what cognisance was taken of any historic, mental health needs and/or drug misuse?

2. Were the risk levels set by agencies appropriate and how did agencies keep them under review?

3. What services did agencies provide to AF1 and AM1, and were these timely, proportionate and "fit for purpose" in relation to the identified levels of risk?

4. Did agencies have sufficient focus on understanding AM1s behaviour towards AF1 and did agencies apply an appropriate mixture of sanctions [arrest/charge] and treatment interventions?

5. Did agencies take into account the feelings of AF1 and AM1 about their victimisation and offending, and were those views taken into account by agencies when providing services or support?

6. How effective were agencies in gathering and sharing relevant information, particularly with children services and was any resistance experienced?

7. How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to AF1 and AM1?

8. Were single and multi-agency domestic abuse policies and procedures followed, including MARAC and MAPPA protocols, were these embedded in practice and were any gaps identified?

9. How effective were agencies in the supervision and management of practitioners involved with the response to the needs of the victim and perpetrator, and how effective was this oversight and control of the case?

10. Were there any issues in relation to capacity or resources within agencies and/or the Partnership that affected the ability of agencies to provide services to the victim and perpetrator or work with other agencies?

2.5 Scope of the review

2.5.1 The relationship between AF1 and AM1 was believed to have existed for only five months before her death. However, to ensure that the more recent events were framed against the histories of AF1 and AM1, matters from 2005 onwards were examined.

2.6 Independent Chair of the DHR Panel and Overview Report Author

2.6.1 David Hunter was appointed as the Independent Chair. He has chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Arrangement [MAPPA] Serious Case Reviews. He has never been employed by any of the agencies involved with this DHR.

2.6.2 The overview report author is Cherryl Henry-Leach who is, in the completion of this task, an Independent Practitioner. Cherryl Henry-Leach is employed as a Domestic Abuse Coordinator for a Community Safety Partnership in another part of the country, and is also an Associate for the Coordinated Action Against Domestic Abuse [CAADA], a national agency who hold the lead for MARAC development on behalf of the Home Office. She has not been employed by any of the agencies involved in this review. Cherryl Henry-Leach has completed the Home Office domestic homicide review training packages, including the additional modules on chairing reviews and producing overview reports and also fulfils the criteria set out in the statutory guidance for domestic homicide reviews.

2.7 The DHR Panel

2.7.1 In addition to the Chair and report author, the DHR Panel consists of:

- Domestic Abuse Reduction Coordinator, Manchester City Council [until 17th October 2014]
- Head of Adult Safeguarding and Governance, Manchester City Council [from 17th October 2014]
- Team Manager, Homelessness Assessment, Manchester City Council
- Team Leader, Independent Domestic Violence Advisory Service
- MARAC Co-ordinator Greater Manchester Police
- Senior Probation Officer, National Probation Service North West [formerly known as Greater Manchester Probation Trust]
- Consultant Midwife Lead for DA CMFT
- Team Manager, Children's Services, Manchester City Council
- Designated Nurse Adult Safeguarding, Manchester Clinical Commissioning Group [until 17th October 2014]
- Head of Safeguarding City Wide NHS Safeguarding Team [Commissioning and Quality]
- Senior Policy Officer, Manchester City Council
- Named Nurse Safeguarding Adults Pennine Acute NHS Trust

Note: The Panel did not include a representative from the voluntary section. Independence was secured through the chair and author.

2.8 Parallel Processes

2.8.1 HM Coroner's Inquest was opened and adjourned and subsequent to the criminal verdict will not be re-opened.

2.9 Liaison with Family and Friends

2.9.1 The Independent Chair wrote to the long term foster carers of AF1 and the parent of AM1's. A copy of the Home Office leaflet on Domestic Homicide Reviews was enclosed in this correspondence. The GMP Family Liaison Officer facilitated the delivery of the correspondence to the foster parents. Two close friends of AF1 were also contacted.

2.9.2 AF1's foster mother met with the Chair and report author. The Chair also spoke with AF1's best friend. Their views appear as appropriate throughout the report.

2.9.3 AM1's parents did not respond to the original or follow up letters and the Chair, with the support from the Panel, decided not to pursue them further. They will be written to again before the review is published.

2.9.4 The Chair met with AM1 in prison and his views appear as appropriate throughout the report.

3. BACKGROUND OF AF1 AND AM1

3.1 Introduction

3.1.1 Set out below are the relevant experiences of AF1 and AM1 identified in the IMRs which shows them respectively as the victim and perpetrator of domestic abuse over many years. AF1 was known to have been a victim of three different males with whom she had relationships. Before AF1's relationship with AM1 commenced, he was known to have perpetrated domestic abuse on four of his female partners and also his mother and the Panel agreed he came into the relationship with AF1 as a serial perpetrator. AF1 came as a multiple victim, albeit the nature and degree of her victimisation will be discussed later. AM1 was released from prison in August 2013 and met AF1 in a city centre bar by chance. They formed an immediate relationship and he moved into her home shortly afterwards. AF1's foster mother and friends knew of the relationship, but no agency did.

3.2 AF1

3.2.1 AF1 was one of six siblings and early in her life was placed by Children's Services with foster carers with whom she remained into adulthood.

3.2.2 AF1 became pregnant at the age of 15, and over her lifetime had five children. The Panel are aware from reports received that between 1999 and 2014 AF1 had a number of relationships and some were thought to be abusive. In 2011, AF1's children were formally removed from her care.

3.2.3 AF1 suffered from mental health problems and was diagnosed with Bi Polar [1] in 2013. Her foster mother expressed her belief that this diagnosis came too late in her life to make a difference to the outcome of the proceedings in relation to AF1's children.

[1] Formerly known as manic depression, it is a condition that affects your moods, which can swing from one extreme to another. Source: www.nhs.uk

3.3 AM1

3.3.1 AM1 grew up in a household where he witnessed and was subjected to domestic abuse.

3.3.2 AM1 claimed to have had some history of mental health issues but was never subjected to formal diagnosis.

3.3.3 AM1 was released from prison in 2013 under his own name. Immediately he chose to use his original family name and that is how AF1, her family and social networking friends knew him.

3.3.4 AM1 is known to have abused previous partners prior to his relationship with AF1. He also fathered a number of children. The Panel noted that pregnancy would occur very soon after AM1 entered a new relationship. There is research to support the Panel's hypothesis that this may have been a method AM1 would employ to increase his control over his partners. It is sometimes described as "Reproductive Coercion". [*Miller et al 2010*]

3.3.5 AM1 advised the DHR Chair that he would have benefited from professional support to deal with the root causes of his offending and there was little support for perpetrators of domestic abuse. However, in the IMR provided by GMPT, AM1 is described as demonstrating or having no insight as to the impact of his behaviour on his victims. During the prison interview with the Chair, AM1 minimised his responsibility or blamed his victims.

4. A SUMMARY OF AGENCY INVOLVEMENT

4.1. Manchester City Council Children and Families [CS]

4.1.1 It has been documented earlier in this report that by the time AF1 and AM1 began their relationship [in August 2013], AF1 no longer had care of her children. The IMR provided by this agency confirmed that CS responded to concerns raised by other agencies in relation to the care provided by AF1 to her children and took steps to protect them.

4.2 Independent Domestic Violence Advisory Service [IDVAS]

4.2.1 The IDVAS provides advice, advocacy and support to victims of domestic abuse assessed as being at high risk of suffering serious harm or homicide.

4.2.2 In October 2011, AF1 presented herself to the Manchester City Council Homelessness Service. At this time, the IDVAS worked in partnership with the Homelessness Service to reduce the numbers of homeless presentations where domestic abuse was said to be a causal factor in the homelessness. Under this arrangement IDVAS would undertake domestic abuse risk assessments where domestic abuse was identified as a feature in a person's homelessness. AF1 was assessed by an IDVA because she disclosed domestic abuse, however this perpetrator was a previous partner and was no longer in the country.

4.3 Manchester City Council Homelessness Service

4.3.1 AF1 presented as Homeless on October 2011. She was assessed by the Homelessness Advice and Assessment Centre, and during this assessment AF1 disclosed that she was a victim of domestic abuse [DA]. AF1 advised the service that she had been residing with a family member but that this arrangement had broken down. She also disclosed a history of mental ill health. AF1 presented as a single person whose children had been removed by the local authority.

4.3.2 AF1 was accepted as being homeless and was given temporary accommodation. She was later rehoused by Northwards housing.

4.4 Greater Manchester Police [GMP]

4.4.1 Both AF1 and AM1 were known to GMP.

4.4.2 GMP had attended AF1's home address on a number of occasions due to arguments and domestic incidents. However none of these were during her relationship with AM1.

4.4.3 AM1 was designated a serial domestic abuse perpetrator because he abused previous intimate partners. The IMR states that the "purpose of defining serial perpetrators…is to ensure that the risk a person poses to a victim and that the full extent of a person's offending is flagged to the Crown Prosecution Service when they are arrested for new domestic abuse related offences either with

existing or new partners". [*GMP Tackling Domestic Abuse Policy & Procedure August 2013]*.

4.4.3 Prior to AF1's death GMP had no knowledge of her relationship with AM1 and held no records of any incidents between them. As a result, GMP was unable to make any assessment of domestic abuse issues, mental health needs or alcohol or drug issues in relation to AF1 or AM1. However the IMR highlights relevant learning in relation to the response of the Police and other agencies to high risk domestic abuse perpetrators being released in to the community after serving prison sentences.

4.4.4 The IMR author was provided with information gathered during the homicide investigation that revealed friends and family suspected that AF1 was in an abusive relationship with AM1.

4.5 The Former Greater Manchester Probation Trust [GMPT]

4.5.1 At the time of the events under review, GMPT was part of the National Offender Management Service [NOMS]. GMPT provided services to manage offenders and delivered a range of interventions, including unpaid work, programmes and provision of accommodation in approved premises.

4.5.2 GMPT did not have any involvement with AF1, but had considerable involvement with AM1 from 2005 until February 2013, when AM1 was recalled to prison for breach of his licence conditions.

4.5.3 AM1 was assessed as posing a high risk of serious harm, particularly to female partners. In 2011/12, this was de-escalated to medium risk to members of the public. The IMR notes that this risk level should have remained high due to his past offending and that he had not been out of a relationship very long.

4.5.4 AM1 was released from prison in February 2013 under licence. He breached those conditions and was returned to prison within a few days.

4.5.5 Between AM1's recall in February 2013 and his release in August 2013, his OM updated the Risk Management Plan (RMP) and should have taken the case to a Risk Administration Management Arrangements (RAMA) Meeting. At the time of AM1's release from prison, his OM was absent from work and the case was allocated to someone else. The scheduled RAMA meeting was cancelled and not rearranged. The high level of risk was not effectively managed and this was not identified by the OM or a manager within the service.

4.6 NHS England, Greater Manchester Area Team, General Practitioner [GP]

4.6.1 NHS England's Greater Manchester Area Team is responsible for the commissioning of GP practices.

4.6.2 The IMR commissioned by NHS England on behalf of the three GP practices who had involvement with AF1 and her children, catalogues a number of

safeguarding concerns in relation to AF1's children, who were eventually removed from her care. Also recorded in the records are logs of non-accidental injuries and disclosures of domestic abuse.

4.6.3 AM1 was not registered with a GP in the area following his release from prison and was still registered with a GP in another part of the country.

4.6.4 It is believed by the Panel that AF1 commenced her relationship with AM1 after his release from prison in August 2013. From August 2013 to the date of her death, AF1 had 9 records in her patient notes. A number of these were information sent from the hospital informing of A&E attendances. However during that time, she attended clinics / appointments on 3 separate occasions.

4.7 Manchester Women's Aid [MWA]

4.7.1 MWA provides information in relation to domestic abuse and sexual violence. They also provide advice and support to victims of domestic abuse either by telephone or face to face.

4.7.2 MWA also provides the "Moving On" group which is based on the Freedom Programme. This twelve week programme seeks to increase awareness of domestic abuse, increase resilience and improve self-confidence / assertiveness skills of victims. It is this programme that the IDVA referred AF1 to in October 2011, when it was known as the Freedom Project.

4.7.3 According to MWA records, the programme was not immediately available and there is no record of AF1 attending a course.

4.8 Northwards Housing [HSG]

4.8.1 Northwards Housing is an arms-length management organisation [ALMO]. As such, it is a not for profit organisation managing 13,500 council properties located in North Manchester.

4.8.2 AF1 commenced an unfurnished tenancy with Northwards in May 2012. She was recorded as the sole tenant and did not have any children living with her during the life of the tenancy. The tenancy was initially termed as an introductory tenancy which is defined as "a tenancy which became secure after 12 months", and was, effectively, a trial period to assess how the tenancy would progress. Northwards records indicate that AF1 lived alone at the property and as an introductory tenant she was precluded from allowing another person to live at the address without their permission. Throughout the life of the tenancy, AF1 claimed housing benefit as a sole occupier.

4.8.3 The IMR describes AF1 as managing her tenancy well and that contacts with AF1 focused on property repairs that were linked to the condition or maintenance of the property and these did not cause any concerns to Northwards officers. In the main, these contacts were facilitated through the service's Customer Contact Centre.

4.8.4 Northwards were unaware of AF1s relationship with AM1.

4.9 North West Ambulance Service [NWAS]

4.9.1 NWAS provides emergency and non-emergency pre-hospital medical care to all patients throughout North West Manchester.

4.9.2 Emergency calls made to NWAS are received by the Trust's Emergency Operations Centre [EOC] and an electronically record known as a Sequence of Events [SOE] is commenced.

4.9.3 In relation to AF1, NWAS received two emergency calls, one at the beginning of October 2013 and the other was in relation to the fatal incident that resulted in AF1s death.

4.10 Pennine Acute NHS Trust - North Manchester General Hospital [NMGH]

4.10.1 NMGH is a large NHS hospital located in North Manchester with an accident and emergency [A&E] unit.

4.10.2 AF1 attended the A&E department on three occasions in the months before she died. Her attendances are outlined below:

- **September 2013** – AF1 attends A&E with unnamed friend. Has injury to elbow after reportedly falling whilst on the bus. Prescribed analgesia.
- **October 2013** – AF1 attends A&E with unnamed friend. She presents with serious injuries and claims she has been attached by a group of girls. AF1 is treated and information sent to her GP
- **October 2013** – AF1 attends A&E having been transported by ambulance. She reports a popping sound in her chest and vomiting following the assault a few days earlier. AF1 is X-rayed and discharged with advice to return if symptoms worsen.

4.11 Manchester Mental Health and Social Care Trust [MHT]

4.11.1 MHT provides primary and secondary mental health services to people with severe and enduring mental health problems. This includes inpatient care, crisis support, psychology therapies, out-patient and community mental health service provision.

4.11.2 The IMR provided by this service outlines the contact AF1 had with the service from 2010 to 2013, the majority of the contact taking place in 2011 and 2012. This includes twelve face to face appointments with a psychiatrist, and a further five appointments with the Crisis Resolution Team and additional telephone support from this service in between those appointments.

4.12 Victim Support [VS]

4.12.1 VS is a national charity that supports anyone affected by crime, not only victims and witnesses, but their friends, family and any other people involved. As an independent charity, VS can be approached whether or not a victim reported the crime to the police. At a national level, VS have an agreement in place whereby they receive details for all reported victims of crime, and attempt to contact each victim.

4.12.2 VS received 3 referrals from GMP in relation to AF1, and two were in relation to her being a victim of burglary, one in 2009 and one in 2013. AF1 did not answer many of the calls made to her by VS. On the two occasions she did answer the calls from VS, AF1 ended the call saying she was busy before they could complete a risk assessment or offer support.

4.13 Youth Offending Service, Rochdale [YOS]

4.13.1 AM1 was known to this service in February 2005 following his sentence to a six month referral order for motor related offending.

4.13.2 In June 2005, AM1 was sentenced to a consecutive referral order for an offence of common assault. It is not known who the victim of this assault was.

4.13.4 In August 2005, AM1 committed further offences and so his contact with this service came to an end when he was resentenced to a Community Order.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one of the terms and where this happens a best fit approach has been taken.

5.1 Term 1 - How did agencies identify and assess the domestic abuse indicators in this case, and what cognisance was taken of any historic, mental health needs and/or drug misuse?

5.1.2 Despite contact with several agencies prior to her death, including presentations with serious injuries, AF1 did not disclose domestic abuse. Therefore no domestic abuse risk assessments were conducted. However, the Panel noted opportunities were missed to enquire how AF1 had sustained her injuries and whether she was subjected to domestic abuse.

5.1.3 The Panel noted the three occasions where hospital staff could have created those opportunities and felt this highlighted a need for training, or routine screening around domestic abuse which appears to require improvement within the hospital A&E department. On one occasion, AF1 describes being assaulted the previous evening but that she was intoxicated and had no recollection of events. The Panel agreed that medical staff need further training on the increased risks of abuse faced by younger people who over consume alcohol. Staff also need to explore social factors of patients presenting with recurrent falls. Given that victims of domestic abuse are at increased risk of substance dependency, including alcohol, the training should also include awareness of this link.

5.1.4 There is evidence that AF1's mental health was recognised by GP Practice staff and provided the focus of their care. However, it is clear that AF1 was at an increased risk of experiencing domestic abuse because of her mental illness and background. The Panel also agreed GP Practice Staff missed three opportunities to create the conditions for AF1 to disclose. They could sensitively have probed her attendances at A&E, explored the reasons for her missed medical appointments and established her relationship history in the months preceding her death. The Panel felt that this indicates a need to ensure GP Practice Staff are equipped to recognise indicators of domestic abuse and its links to alcohol misuse and mental health issues in order to respond effectively.

5.1.5 AF1 was known to MHT, and the Panel agrees with the IMR author that the "standard of care given in relation to AF1 was good in that practitioners were sensitive to the needs of AF1 and were knowledgeable of her mental health issues." The Panel also agreed with the IMR author's analysis that "there is little to suggest that practitioners fully appreciated neither the domestic abuse issues [in relation to AF1] nor the impact of AF1's mental health on her children". The Panel noted that MHT missed opportunities to establish any risk of domestic abuse faced by AF1, but also noted that this service had not made domestic abuse training a mandatory requirement for their practitioners. The Panel also noted that AF1 was discharged back to the care of her GP

around the time her relationship with AM1 commenced and so MHT would not have been aware of the relationship. The Panel was satisfied that the MHT IMR makes appropriate recommendations.

5.1.6 Prior to her relationship with AM1 there was one completed domestic abuse risk assessment by the IDVAS in October 2011 and one partially completed domestic abuse risk assessment by VS [which they were not able to complete]. The lack of completed domestic abuse risk assessments undertaken by CS or Health professionals who had contact with AF1 - a person who was known to have experienced domestic abuse in her relationships - indicates that the practise for undertaking routine enquiry to establish if domestic abuse is an identified feature within a relationship, is not fully embedded in the agencies providing information to this DHR.

5.2 *Term 2 - Were the risk levels set by agencies appropriate and how did agencies keep them under review?*

5.2.1 Both GMP and GMPT were aware that AM1posed a high risk of causing serious harm to female partners. They were not aware that AM1 had entered a relationship with AF1. The risk level was appropriate given his offending history and the harm he caused some females in his life. However, a PINS software glitch and a failure by GMPT to implement a RMP meant that the likelihood of AM1 continuing abuse of female partners would remain undetected.

5.2.2 There is evidence that AM1's high risk classification was inappropriately de-escalated to medium risk by GMPT. However, the Panel is satisfied that the reason for this has been addressed by GMPT and so it does not form a recommendation.

5.2.3 The Panel noted that MHT identified that AF1 had anger management issues and posed a risk to others as a result but found no evidence to suggest this information was shared with other agencies. The Panel did not find any evidence to suggest the underpinning issues as to the cause of her anger was explored with her or that the risk she posed was reviewed by MHT.

5.3 *Term 3 - What services did agencies provide to AF1 and AM1, and were these timely, proportionate and "fit for purpose" in relation to the identified levels of risk?*

5.3.1 The Panel agreed that the absence of services provided to AF1 in relation to the domestic abuse she was experiencing from AM1 was significantly influenced by AM1 taking to steps to ensure he did not come under scrutiny of the Police. This may have included AM1 ensuring that AF1 could not access support available to her [e.g. medical appointments], and therefore, disclose any issues of domestic abuse. There is evidence that AF1 disclosed the abuse to her friends, and both her foster mother and her best friend had concerns that AM1 was both isolating AF1 from her social network and coercively controlling AF1. The Panel agreed this highlights a need to ensure members of the public are aware of how to respond to concerns if they are aware that someone they know is being subjected to domestic abuse. AF1's

foster mother also added that there may be a need for GMP to consider how members of the public who are unable or unwilling to access the internet can receive this information. There was some evidence that AF1 disclosed domestic abuse to some service providers but not directly in relation to AM1. The Panel also noted that some of her disclosures were delayed disclosures. However, referrals were not received in relation to these disclosures by domestic abuse support services.

5.3.2 The Panel also noted that it is highly likely AM1 took deliberate steps by using another surname to avoid the possibility of AF1 being made aware of his abusive history and being referred to avenues for support. This was suspected by AF1's foster mother and best friend, who believed that AM1 used this other surname on social media sites to avoid his offending history being discovered by AF1 should she have enquired with the police. AM1 denied this to the DHR Chair, saying he had reverted to his birth name, after having it changed by deed poll to that of his step-father. However, it was striking to the DHR Chair that AM1 knew about and was able to name, "Claire's Law", thereby suggesting that the use of an alternative name could hide his past from a casual enquiry.

5.3.3 It is noted that involvement with AM1 required professionals to challenge his attitudes and behaviour from as early as 2005. This was prior to his attending IDAP and was undertaken without referrals to services that could have offered support to his victims and advised professionals working with him to any changes of his abusive patterns of behaviour. The Panel found no evidence that this was considered until AF5 was referred to MARAC and IDVA. Research indicates that challenging perpetrators of domestic abuse can increase the risk the perpetrator poses to his victim. Best practice recommends that when challenging perpetrators of domestic abuse practitioners should ensure that their victims can access support if they wish to do so, and that the risk posed to them by the perpetrator is monitored.

5.3.4 AF1 was referred to MWA by CS. The Panel noted that AF1 did not receive targeted support from MWA prior to her scheduled commencement on a programme. Targeted support could have encouraged AF1 to remain engaged with her intention to complete the programme. MWA has already recognised this as a learning point for their agency, and so it does not form a recommendation of the Panel.

5.3.5 The Panel noted that AF1's fluctuating mental health and use of alcohol may have impacted on her decision making capacity. There was some agreement that AF1's experiences of domestic abuse may have also impacted on her capacity. The Panel was mindful that the Home Office plans to issue guidance in relation to the impact of sexual violence on a victim's mental capacity and invite the Home Office to consider whether this guidance should also apply to victims of domestic abuse.

5.4 *Term 4 - Did agencies have sufficient focus on understanding AM1s behaviour towards AF1 and did agencies apply an appropriate mixture of sanctions [arrest/charge] and treatment interventions?*

5.4.1 The Panel agreed that with hindsight there was evidence that professionals who were involved with AF1 in the brief period of her relationship with AM1 did recognise indicators that AM1's behaviour toward AF1 was abusive. This is fully explored in the first term of reference.

5.4.2 The Panel also noted that despite AM1's lack of motivation to address his offending behaviour and non-compliance with a variety of sanctions imposed to manage the risks he posed to members of the Public, GMPT still attempted to address his offending behaviour.

5.4.3 The Panel was concerned that as part of his prison sentence planning, AM1 accessed the COVAID programme to deal with his involvement in an affray. The victim of this offence was male and AM1's offending was normally perpetrated against females he was in a relationship with. This programme was designed for individuals who are aggressive and violent after drinking alcohol and therefore involves participants learning anger management strategies to control expressive violence effectively. The Panel agree this was arranged without looking at his offending history as a whole. AM1 was a domestic abuser who employed the use of instrumental violence and already knew how to control his abusive behaviour. Women's Aid and Respect are clear that programmes that are underpinned by anger management strategies are not appropriate interventions for perpetrators of domestic abuse because domestic abuse is a chosen intentional behaviour designed to exert the power and control over an intended victim, normally an intimate partner. The Panel agreed that this was an inappropriate programme for AM1 to undertake.

5.4.4 The Panel also noted that after AF1 met AM1, there were missed opportunities to establish whether she was in an abusive relationship. There were three missed opportunities when she attended at A&E, and one opportunity where GP Practice staff could have explored her circumstances and discussed her recent A&E attendances. However, the Panel also heard from CS that AF1 was in frequent contact with a social worker in relation to her contact with her children and did not disclose her new relationship with AM1. The Panel felt this was a deliberate decision by her given her previous history with CS.

5.5 *Term 5 - Did agencies take into account the feelings of AF1 and AM1 about their victimisation and offending, and were those views taken into account by agencies when providing services or support?*

5.5.1 There is evidence that AF1 attempted to disclose indirectly to medical professionals that she was experiencing domestic abuse.

For example, she said she experienced a "popping sensation in her chest while lying in bed with her partner" and that this *may* have been linked to an assault she experienced a couple of days previously. This was not explored further with her. The Panel felt this demonstrates a lack of awareness as to how victims of domestic abuse can attempt to disclose.

5.5.2 The Panel noted that AF1 attended for emergency medical treatment and that staff responding to her needs did not apply their professional curiosity in relation to domestic abuse which could have resulted in sensitive probing of

the explanations AF1 gave for her injuries. The Panel felt that the application of professional curiosity could have enabled medical staff to create an opportunity for AF1 to disclose her relationship with AM1 and to say whether it was abusive.

5.5.3 The Panel agreed that AF1 would have benefited from frequent contact from an allocated MWA worker from the point of the initial referral. This could have built a trusting relationship with MWA who could have provided regular encouragement to AF1 to attend the programme. It could also have afforded an opportunity for MWA to establish her relationship status. The lack of contact was, therefore, seen by the Panel as a missed opportunity. An allocated key worker could also have undertaken some follow up activity when AF1 did not attend the program. MWA have made a recommendation in relation to this, however the Panel note the positive progress that MWA have taken to address this issue.

5.5.4 The Panel noted the efforts made by GMPT to educate AM1 about the impact his abusive behaviour has on his victims and children who witness the abuse. AM1 did not engage and was actively resistant to any attempts to modify his behaviour.

5.5.5 The Panel considered material that says AF1 was volatile with at least two former partners. There were claims and counter claims of harassment with one partner, much of which was conducted over social media. On another occasion, with a different partner, she was said to have followed him down the street shouting after a verbal argument. The police were involved in both incidents and all parties received appropriate advice from them. AF1 also declared anger management problems and homicidal thoughts to her GP. The Panel considered research that indicates that victims of domestic abuse can appear to initiate domestic abuse and present as an aggressor within the relationship. This has recently become known as violent resistance and has the potential for Professionals to wrongly identify the victim as a perpetrator or primary aggressor in the relationship. One form of co-responsive violence within relationships is referred to as situational couple's violence in which both partners have poor conflict resolution skills and there appears to be no power imbalance within the relationship. This contrasts with domestic abuse in which one partner, the abuser, will exert power and control over another and will utilise coercive control to maintain their dominance within the relationship. [*Johnson 2012*] The following paragraph explains how that phenomenon can be dealt with.

5.5.6 The Panel noted that there was some evidence to suggest that AF1's presentation as a confident and sometimes feisty person may have led professionals working with her to conclude that she was involved in co-responsive violent relationships and not a victim of domestic abuse. When faced with couples who claim that both are equally abusive or violent to each-other, professionals need to screen the relationship to establish if there is a primary victim and primary aggressor. The Panel formed the view that such screening is not embedded in practice and is a lesson learned. It recommends that the MSAB ensures that domestic abuse training incorporates the use of screening tools in line with guidance by Respect.

5.6 *Term 6 - How effective were agencies in gathering and sharing relevant information, particularly with children services, and was any resistance experienced?*

5.6.1 There were examples of good information sharing between agencies. The IDVAS and Homelessness Service shared information effectively and responsively to address AF1's homeless status in 2012. Nursing staff shared information with Approved Premise Staff to prevent AM1 being breached in 2011.

5.6.2 GMP attended several domestic incidents between AF1 and her previous partners. GMP did not refer three of these incidents to CS [2003, 2008 and 2009] which given the low risk assessments was in line with practice at that time. There was an incident in March 2011 which was attended by police. The IMR states that a Domestic Abuse, Stalking and Harassment and "Honour" Based Violence (DASH) RIC was completed and the incident was assessed as standard risk. Details were passed to the Public Protection Investigation Unit (PPIU) and a joint agency strategy meeting was convened.

5.6.3 The Panel noted that failures in GMPT resulted in information not being shared about his release and this was, in the view of the Panel, a missed opportunity to manage the risks he posed.

5.7.1 Term 7 - How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to AF1 and AM1?

5.7.1 Both AF1 and AM1 were white British with English as their first language. AF1 reported to one agency that her faith base was Roman Catholic and she wanted to have one of her children christened. There was no information about AM1's faith.

5.7.2 AF1 had mental health needs which were recognised and administered to. The Panel found no suggestion that AF1 did not have mental capacity in relation to her overall decision making but agreed that there could have been occasions where her capacity to make specific decisions may have been compromised by her mental disorder, her use of alcohol and the impact of domestic abuse. This, in turn, may have reduced her ability to protect herself. The MHT IMR states that AF1 was deemed to have mental capacity when interacting with their staff. The Panel also noted that, with the exception of the referral to MWA for AF1 to undertake the Freedom Programme in 2011, no referrals were received by domestic abuse support services. There was evidence in the IMRs provided that suggested that AF1 had a level of dependence on alcohol. However, there was only one referral to alcohol support services. This suggests that the need for such referrals was not recognised. The Panel agreed that this is a lesson learned and recommends that MSAB ensures its training in relation to domestic abuse includes the need to refer domestic abuse victims to alcohol support services or other specialities as identified through assessment.

5.7.3 The Panel noted that AF1 was experiencing domestic abuse within her early intimate relationships. Her first significant relationship commenced when she was aged 18/19. There is information to suggest that she was experiencing domestic abuse as there was at least one incident reported to both her GP and the Police. Young women aged 16-24 are known to be more likely than other age groups to experience various forms of domestic abuse perpetrated by their intimate partners. There is a need for professionals to ensure that younger women identified as experiencing abuse from their partners are given support to:

- Stay safe from their abusers;
- Recover from their experience of domestic abuse;
- Identify healthier relationship norms; and
- Rebuild their resilience so they are less accepting of domestic abuse within their future relationships.

5.7.4 The Panel agreed there was little evidence that AF1 was given access to such therapeutic support. However, the Panel also noted that the national Young Person's Advocacy Programme has been adopted and is being actively progressed in this area and so have not made a recommendation in relation to this finding.

5.8 *Term 8 - Were single and multi-agency domestic abuse policies and procedures followed, including MARAC and MAPPA protocols, were These embedded in practice and were any gaps identified?*

5.8.1 The Panel found evidence in the IMRs to suggest that agencies have appropriate policies and procedures in place in relation to domestic abuse and there was awareness of the MARAC process. AF1 was not referred to MARAC because she did not undergo domestic abuse risk assessments. This has been addressed under the first term of reference.

5.8.2 In August 2013, at the time of AM1's release from prison his OM was on sick leave. His case was allocated to another OM, but the scheduled RAMA meeting was cancelled and was not rescheduled. Had this meeting gone ahead GMP would have been aware of AM1s impending release. The risk management plan was not implemented and it is unclear why this was the case. The IMR author states that "no defensible explanation has been offered as to why the decision to escalate AM1's risk classification to high before his release was not followed by mandatory referral for a RAMA meeting. The absence of this…led to a lack of effective management oversight of [AM1's] effective safe pre-release planning". The Panel agreed with this analysis and see this as a key missed opportunity to ensure that a RMP was in place when AM1 was released. The DHR Panel endorses the recommendations made by the GMPT IMR author.

5.8.3 The Panel was disappointed to note that ACPO/GMC guidance in relation to knife wounds was not adhered to in October 2013 by physicians attending to AF1's medical needs. The Panel believe this was a missed opportunity as reporting this injury to the Police may have alerted them to AF1's relationship

with AM1. This guidance was not known to all Panel members. The Panel invite the Home Office to re-circulate the guidance nationally. The DHR Panel recommend MSAB address this issue at a local level.

5.8.4 The Panel noted the concern expressed in the IMR submitted by NHS England that highlighted that none of the GP practices involved with AF1 prior to her death had developed a domestic abuse policy. The Royal College of General Practitioners has developed guidance for GP practices who wish to develop a domestic abuse policy. This guidance has been developed with CAADA and is based on the IRIS model [Identification and Referral to Improve Safety]. The GP IMR recommends that it should be mandatory for all GP Practices in the area to develop a domestic abuse policy. This recommendation is supported by the Panel, who also suggest that such policies should include how GPs will:

- provide care for victims and perpetrators
- ensure that the practice has clear referral pathways for victims of domestic abuse
- provide guidance on how to recognise signs and indicators of domestic abuse
- share information
- encourage victims to disclose they are experiencing domestic abuse

5.8.5 The Panel noted that AF1 saw an optician due to blurred vision following an assault. Whilst it was unclear to the Panel if AF1 disclosed that the assault occurred during an incident or episode of domestic violence or abuse, the Panel did query if opticians [and other less obvious health providers e.g. chiropodists] who may come into contact with domestic abuse, or receive disclosures of from victims of domestic abuse, would know how to respond to such instances appropriately. The Panel felt this could be opportunity to ensure early intervention in cases of domestic abuse and it invites the MSAB to explore this further so that it can support such professionals to respond appropriately.

5.9 *Term 9 - How effective were agencies in the supervision and management of practitioners involved with the response to the needs of the victim and perpetrator, and how effective was this oversight and control of the case?*

5.9.1 The Panel noted evidence in the IMRs to indicate there was effective managerial oversight in response to the historic involvement with AF1 and AM1. For example, when AF1 presented as homeless in 2011, the advisors recognised domestic abuse and this triggered an immediate referral to IDVAS who undertook a domestic abuse risk assessment and establishing that AF1's circumstances did not cross the MARAC threshold. The standard of care given to AF1 by MHT was seen, by the Panel, to be good in relation to her mental health needs. Comment has be made previously about the lack of management oversight in GMPT in not spotting that AM1's RMP had not been implemented.

5.10 ***Term 10 - Were there any issues in relation to capacity or resources within agencies and/or the Partnership that affected the ability of agencies to provide services to the victim and perpetrator or work with other agencies?***

5.10.1 The Panel noted that A&E staff who attended to AF1 in the months before she died did not screen her in relation to domestic abuse. This has been addressed under Term 5. However, the Panel also noted that time pressures in what is an extremely busy clinical environment, may have contributed to the staff not enquiring if AF1 was being subjected to domestic abuse. The Panel also noted a similar finding in relation to GP Practice staff and noted that they may not have been aware of AF1's history as a victim of domestic abuse or that her children had been removed from her. However, the Panel does not make further recommendations in relation to these findings as they are satisfied that these have been addressed by the recommendations made by the IMR authors.

5.10.2 The Panel noted that both hospital and mental health services discharged AF1 back into the care of her GP following missed appointments. This was discussed by the Panel who found evidence that discharge correspondence to the GP was not as detailed as it could have been and would have been unlikely to trigger any concern that could have alerted the GP Practice staff to discuss the reasons for those missed appointments. The Panel heard that NHS England is reviewing this with service providers and so the Panel do not make a recommendation in relation to this finding.

5.10.3 The Panel noted that the RAMA meeting, which would have ensured that the risk AM1 posed to his future female partners was shared with GMP, did not proceed due to staff sickness. However, the Panel was satisfied that this has been addressed, and so do not make any recommendations in relation to this.

6 CONCLUSIONS

6.1 AF1 was a young woman who experienced significant upheaval and trauma in her life. She was taken into long term foster care aged about 2 years and later removed permanently from the care of her birth parents. She endured some mental health problems and was later diagnosed with bipolar disorder. She was the victim of domestic abuse perpetrated by different males and her own five children were removed permanently from her care in two tranches. It is now known that the loss of her children had significant impact on AF1's mental well-being.

6.2 The Panel agreed that AF1 was an extremely complex person who presented with many difficulties and had contact with several agencies. However, those agencies often responded to the presenting issue in isolation, as opposed to adopting a best practice model of working with troubled families underpinned by whole family working, an assertive approach and sequencing of interventions.

6.3 The DHR Panel felt that her often described "tough attitude/exterior" and sometimes alleged aggressive behaviour to males and her children was a mechanism she employed to deal with the individual episodes of her historic and current trauma; the cumulative impact of which left her vulnerable to further victimisation. This was her position when she met AM1.

6.3 AM1 came from a household where he witnessed and was subjected to domestic abuse. As he grew up he formed relationships with women and fathered several children to different mothers in various parts of the country. He perpetrated domestic abuse on several of his partners and was also violent in other settings.

6.4 The risks posed by AM1 on his release from prison were not managed due to multiple failures in the systems designed to protect his future partners. It appears the programmes and supervision he received when subject to mandatory court imposed sentences had no impact on his behaviour or attitude to women.

6.5 The couple met by chance in 2013. AF1 came to the relationship with a history of volatile and abusive relationships and AM1 brought an extensive record of perpetrating domestic abuse against female partners.

6.6 AM1 was known to family and friends by a different surname and the DHR Panel thought this was a deliberate action designed to mask his past. AF1's family were shocked to learn of his antecedent history which was outlined after his trial and prior to him being sentenced.

6.7 There were several opportunities for agencies to identify that AM1 and AF1 were in relationship but these were missed. Had they done so, consideration would have been given to disclosing AM1's offending to AF1, thereby enabling her to review the relationship and access support to protect herself. This could have, and most likely would have, included a referral to MARAC.

6.8 There were no reports to any agency of domestic abuse between AF1 and AM1 and, therefore, her homicide did not follow a pattern of known escalation of abuse resulting in death. From this perspective it came as a shock. However, when their histories are viewed longitudinally, the DHR Panel felt the events had a tragic and worryingly familiar outcome.

7 PREDICTABILITY/PREVENTABILITY

7.1 The Panel believed that, given AF1's early family life, mental health and alcohol use, she was at increased risk of domestic abuse from an intimate partner and by extension be more susceptible to a violent death. In this context it was possible to predict that AF1 faced a higher likelihood of suffering really serious harm or even death. It was also likely given AM1's history of violence against women [and others] and the formal risk assessment showing he presented a high risk of causing really serious harm to female partners, that that the chances of him causing the death of a female partner were increased. In this context it was possible to predict that he may cause someone's death. At the time of AF1's death the risk posed by AM1 to female partners was only known to one agency and they were not managing it. However that agency and other agencies did not know AF1 and AM1 were in a relationship, therefore the opportunity to prevent AF1's death was not present.

7.2 Had agencies know about the relationship, a formal disclosure by the police to AF1 of AM1's violent history was very likely. It is known that AF1 knew that AM1 was violent as evidenced by the disclosure she made to a friend that he had assaulted her. However, a police disclosure would have been accurate and revealed the significant risk AF1 faced from AM1. This in turn may have led her to accepting the protective measures of a risk management plan. In this context there would have been an opportunity to prevent AF1's death.

8. LESSONS IDENTIFIED

8.1 GPs and their Practice staff need to be trained, and therefore equipped, to recognise domestic abuse and its correlation to alcohol misuse and mental health issues and respond appropriately in a manner that is holistic to the victims' needs.

8.2 Professionals need to be able to screen for domestic abuse through routine enquiry and then take steps to ensure the risk posed to the victim by the perpetrator is assessed and the victim is supported and signposted to appropriate services.

8.3 There are limitations to what action agencies can take to manage high risk domestic abuse perpetrators who are released into the community at sentence expiry date with no statutory supervision.

8.4 Professionals need to be aware that victims of domestic abuse do not always make direct disclosures and often use tangential language in the hope or expectation that it will be recognised and pursued.

8.5 Local public awareness of the domestic abuse disclosure scheme should be increased to ensure that the public are aware that anyone concerned about someone being a victim of domestic abuse can request a disclosure is made. This should be extended beyond the internet.

8.6 Programmes that are underpinned by anger management strategies are not suitable for domestic abusers.

8.7 Where couples present as employing the use of co-responsive violence, there is a need to ensure that screening takes place to establish the prime perpetrator.

8.8 The knowledge of the ACPO and GMC gunshot and knife wounds guidance is not too well known.

9. RECOMMENDATIONS

9.1 Single Agency Recommendations

NHS England

1. Improve GP awareness of symptoms associated with DVA

2. Disseminate learning from DHR via GP educational meetings, safeguarding meetings, to all practice managers, practice nurses and family planning nurses and via GP training.

3. CCG to explore how A&E and Trusts can share more meaningful data particularly regarding assaults rather than a generic computerised GP letter with only a couple of key words.

4. All GP Practices are mandated to have Domestic Abuse Policies which cover the requirement in respect of assessment including recording relevant social, relationships and medical information, basic safety planning and sign posting to services or referral if required. This is in order to ensure that victims are more readily identified and signposted to support services.

5. For patients who have moved practice and the new GP does not have access to full medical records that they contact the previous GP in a timely manner to obtain information especially in circumstances where the patient is vulnerable.

Pennine Acute Trust

1. Enhance domestic abuse and alcohol abuse training

Greater Manchester Probation Trust

1. In all cases whereby risk is assessed as high the Court report writer if pre-sentence, or the offender manager if escalation occurs within the supervision period, should refer for RAMA.

2. In all high risk cases RAMA reviews to take place a minimum of four monthly if an offender is in the community, or annually [and at least six months pre-release/pre-Parole] if in custody.

3. In all cases where instruction is received from the Parole Board that release will be effected at the Sentence End Date, offender managers ensure effective liaison with relevant agencies to inform their own risk assessment and management of individuals, whilst they remain in custody and upon release.

4. Line managers to implement individual actions plans in relation to OM4 and OM5 to ensure implementation of practice development briefing information via supervision and audit of relevant cases.

5. Offender managers to give consideration to MARAC referral for high risk domestic abuse victims

Greater Manchester Police

1. The Detective Superintendent GMP Force Intelligence Bureau should initiate contact with a senior representative of Saadian Technologies Ltd and seek a formal assurance that the system fault in v3 of PINS which led to a failure to notify GMP of the impending release from prison of a high risk domestic abuse perpetrator has been rectified in v4 of PINS. Subject to the outcome of this enquiry, GMP/ Saadian Technologies should disseminate relevant information internally / externally as appropriate.

Manchester Mental Health and Social Care Trust

1. Review the Domestic Violence and Abuse practice guidelines

2. Review training materials.

9.2 DHR Panel Recommendations

1. That Greater Manchester Police raise the awareness of the Domestic Violence Disclosure Scheme beyond the internet to ensure that anyone who is concerned about their own safety or that of another can request disclosure.

2. That MSAB re-circulate the ACPO and GMC gun shot and knife wounds guidance to its constituent agencies.

3. That the Home Office considers re-circulating the ACPO and GMC gun shot and knife wounds guidance to all Community Safety Partnerships

4. That MSAB constituent agencies inform the Board what processes they have in place to ensure that their staff:

    a. identify victims of domestic violence who make non-direct disclosures

    b. undertake domestic abuse risk assessments, including screen for co-responsive domestic abuse

    c. make referrals to appropriate support services

    d. understand that victims of domestic abuse often present with other problems such as mental health, drug and/or problems and these can deflect attention from domestic abuse that may be occurring

Appendix A - Definitions

1. Domestic Abuse [DA]

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

> "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"

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
>
> 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.
>
> Therefore, the experiences of AF1 fall within the various descriptions of domestic violence and abuse.
>
> The term domestic abuse is used throughout this report.

2. Definition of a Vulnerable Adult

> The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides?" issued by the Lord Chancellor's Department, is a person:
>
> "Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

A consensus has emerged identifying the following main different forms of abuse:

- physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment

  Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm.

  [Source: Section 2 No Secrets Department of Health 2000]

3. <u>Domestic Abuse Risk Assessments</u>

   A domestic abuse risk assessment is best defined as a critical evaluation of information for the purpose of guiding decisions on a complex, public issue. It is recognised that the principle model for assessing risk is the Domestic Abuse, Stalking and Honour Based Violence [DASH 2009] Risk Identification, Assessment and Management Model.

   Currently, two DASH models are in use. The first is the DASH tool developed by CAADA, the Coordinated Action Against Domestic Abuse, a national charity who currently lead, at a national level, MARAC and IDVA development.

   The second DASH tool has been developed by ACPO, the Association of Chief Police Officers.

   Both tools have the same risk thresholds:

   - **High Risk** – There are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious. Serious harm is defined by OASys 2006 as "life threatening and/or traumatic, and from

which recovery, whether psychological or physical, can be expected to be difficult or impossible"

- **Medium Risk** – There are identifiable indicators of a 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 [e.g. loss of accommodation, failure to take prescribed medication, etc.]
- **Standard Risk** - Current evidence does not indicate the likelihood of causing serious harm

DASH guidance for both tools is clear that

- Current events include the most recent or current incident and incidents that have occurred in the last 3 months
- Recent events date back three months from the most current incident/assessment
- Historic events date back 12 months from the most current incident/assessment

In addition, CAADA DASH guidance states that

- 14 positive DASH responses should trigger a referral to MARAC as high risk
- 10 – 14 positive DASH responses should be referred to the IDVA service as medium risk
- Less than 8 positive responses should be considered as low risk
- Professional judgment should be applied, and the assessor should elevate the risk threshold to high if they believe the risk of harm is serious regardless of the number of ticks

There is clear difficulty with assessments in that they are an objective evaluation but made through subjective considerations, consequently they may vary from organisation to organisation and person to person.

However assessments are critical to ensure issues are identified and can be addressed appropriately. They also enable critical services to become involved at an appropriate level, which when linked to information sharing and organisational responsibility, affords protection to the victim and preventative opportunities in respect of the perpetrator.

Inevitably, when organisations differ in the way they identify, assess and determine risk there is a greater chance that potential victims and perpetrators will be overlooked and opportunities to intervene will be missed.

The requirements of the assessment are twofold, firstly those where the victim or perpetrator provides information with regard to domestic abuse, but equally and arguably more so where neither provide that information, but it is suspected.

Although a relatively recent development, CAADA have released guidance that promotes a risk led response to younger victims of domestic abuse. This is accompanied by a DASH RIC, specifically designed for use with victims of domestic abuse aged 16 – 24. A significant differences in the guidance for this DASH RIC is that 10 positive responses should trigger referral to MARAC if the victim is aged 16

or over. It also advises that unknown responses should be considered as positive as this could indicate hidden risks that the victim may not feel able to disclose to the assessor.

4. Multi-Agency Risk Assessment Conference [MARAC]

Multi-Agency Risk Assessment Conferences [MARACs] are regular local meetings where information about high risk domestic abuse victims [those at risk of murder or serious harm] is shared between local agencies. There are currently over 270 MARACs are operating across England, Wales, Scotland and Northern Ireland managing more than 64,000 cases a year.

By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA, a risk focused, co-ordinated safety plan can be drawn up to support the victim. Actions agreed at a MARAC are designed to reduce the risk of immediate further violence and reduce the risk of it happening again in the future.

The need for professional judgement to be applied has been mentioned in the previous section; if a professional has serious concerns about a victim's situation, they should be able to refer the case to MARAC. There are occasions where a case gives rise to serious concerns even if the victim has been unable or unwilling to say what had happened.

5. Multi-Agency Public Protection Arrangements Panels - MAPPA

The Criminal Justice Act 2003 ["CJA 2003"] provides for the establishment of Multi-Agency Public Protection Arrangements ["MAPPA"] in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

MAPPA Guidance has been issued by the Secretary of State for Justice under the CJA 2003 in order to help the relevant agencies in dealing with MAPPA offenders. These agencies are required to have regard to the Guidance [so they need to demonstrate and record their reasons if they depart from it].

MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations. They need to ensure that these are not compromised by MAPPA.

MAPPA categories are as follows:

- Category one – registered sexual offenders

This is someone who commits an offence which comes under the Sexual Offences Act 2003 and they must notify the police of their details. They may have received a custodial sentence, a community sentence or a caution. The nature of the sentence determines the length of the period of registration. They are MAPPA eligible until their registration period expires.

- Category two – violent and other sexual offenders

This is someone sentenced to 12 months custody or more for offences contained in Schedule 15 of Criminal Justice Act [CJA] 2003, the Terrorism Act 2006 or murder. They are MAPPA eligible until the expiry of their sentence. Anyone sentenced to a hospital order with or without restrictions are MAPPA eligible until the responsible clinician or a Mental Health Tribunal decide the order no longer applies.

- Category three – other dangerous offenders

This is based on a professional judgement call. The offender must have a previous conviction or caution that indicates:

- They have the potential to cause serious harm to others
- Their current behaviour is such they may cause serious harm to others, and
- The risks require active multi-agency management at MAPPA level two or three.

Management of MAPPA cases will be at one of the following levels:

- **MAPPA Level 1** – used in cases where the risk posed can be managed effectively by one agency without active or significant involvement from other agencies

- **MAPPA Level 2** – used in cases where the active involvement of more than one agency is required but where either the level of risk or complexity of managing the risk is not so great as to require referral to MAPPA level 3

- **MAPPA Level 3** – used in cases where the offender
    - is assessed by Prison or Probation as being of a high or very high risk of causing serious harm
    - presents risks that can only be managed by a plan that requires senior level input/cooperation due to the case's complexities
    - and/or because the requires high level resources commitment
    - Or exceptional cases not assessed as high or very high risk but the likelihood of media scrutiny or public interest in the management of the case is very high

6. <u>Serial Perpetrator of Domestic Abuse</u>

The Home Office, 2009, defines a serial perpetrator as someone who is alleged to have used/threatened violence against two or more victims that are unconnected to each other [as opposed to repeat offending against the same victim or persons in the same household]. 'Serial' perpetrator has tended to be defined in relation to domestic violence, and thus involving, as victims, individuals who are or have been intimate partners of the perpetrator. However, 'serial' may also be applied more widely to include perpetrators of more than one form of violence against women and girls, where this involves two or more unconnected victims. [Tackling Perpetrators of Violence Against Women and Girls – ACPO Review for the Home Secretary – Home Office 2009 [archived]

7. The Domestic Violence Disclosure Scheme [Claire's Law]

On 8 March 2014, the domestic violence disclosure scheme was implemented across England and Wales. This followed the conclusion of a 1 year pilot in the Greater Manchester, Nottinghamshire, West Mercia and Wiltshire police force areas.

The scheme seeks to ensure that individuals can make informed choices about their relationships, and escape if they wish to do so with tailored support provided by the Police and domestic abuse support services.

The scheme can be accessed in two ways:

Right to ask

Under the scheme an individual can ask police to check whether a new or existing partner has a violent past. This is the 'right to ask'. If records show that an individual may be at risk of domestic violence from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

Right to know

This enables an agency to apply for a disclosure if the agency believes that an individual is at risk of domestic violence from their partner. Again, the police can release information if it is lawful, necessary and proportionate to do so.

Appendix B – Explanation of PINs Malfunction [extract from GMP IMR]

"AM1's record on the PINS database was updated automatically from prison records on 4th August 2013. This database update confirmed AM1's prison release date with a prison discharge address in an area of Greater Manchester, but the address was entered incorrectly on the PINS system. Although the PINS system is available to authorised police officers as a research database and despite AM1's release address being in Greater Manchester this database update alone would not have prompted a response by GMP because the update would not have been viewed without a "trigger" to prompt an authorised PINS user to initiate a search for AM1's current status on the PINS system. This was only one of potentially thousands of PINS records which might be updated on a daily basis The contextual references at paragraph 7.1.3 above, particularly item [b] are relevant here and as such are repeated below.

[a] The last definitive reference in GMP records to AM1 living in the Greater Manchester area was on 20th November 2009 when he was the subject of an intelligence report;

[b] Although AM1's national offending record was documented on the PNC he had not been criminally active in Greater Manchester since 2009 and critically no GMP officers/staff have had any professional involvement with him in the context of domestic abuse since that date; and

[c] AM1's last term of imprisonment was imposed for domestic abuse related offences committed whilst he was living in other parts of the country.

There is a facility within PINS to track individual prisoners The "My Offenders" facility allows authorised officers to track the movements of designated prisoners [including release data], on a daily basis. This is important where, for example, intelligence suggests that a prisoner is likely to re-offend following release. However because AM1 had not been active in GMP since 2009, he was not being actively monitored or tracked by any GMP officers.

Incidentally the discharge address provided by AM1 is/was the home address of an associate… whom AM1 refers to in interviews during the homicide investigation as his 'brother' although the exact nature of their relationship has not been confirmed. Neither has it been possible to confirm from homicide investigation records whether AM1 ever actually took up residence at this address. Anecdotal evidence from the homicide investigation does suggest that he moved into the home of AF1 very soon after his release from prison.

Crucially and in addition to the database update, PINS is programmed to email the GMP Force Intelligence Bureau [FIB] with relevant prisoner release dates. This is the trigger mechanism which prompts GMP to respond to prisoner releases. It is GMP FIB policy, once an email is received via PINS to assess it and then forward a copy of the email to the Operational Policing Hub on the police division where the released prisoner either [a] will be residing or [b] to the police division where the prisoner previously resided. Based on the

PINS database update in respect of AM1 a prisoner release email should have been sent to GMP FIB, who would in turn have forwarded it to the relevant Operational Policing Hub for assessment. A 'Hub' operates on each police division in GMP and it has a central role in police operations, maintaining an overview of and responding to daily demands, threats and risks. The Hub includes senior police managers and operational support teams, including an intelligence assessment desk, a crime desk and an Offender Management Unit. The Hub establishes divisional priorities on a daily basis and directs divisional resources accordingly based on current intelligence threats, operational demands and senior leadership team [SLT] strategic priorities.

The IMR author was keen to establish whether the FIB or GMP had ever received and responded to a PINS email in respect of AM1. Despite this being a well-established and automated process the IMR author could find no reference in GMP's official email system to confirm that GMP had ever received a PINS email regarding the impending release of AM1 in August 2013. Internal checks were initiated with a range of GMP departments. All these checks proved negative.

Offender Management Units [OMU] are local joint-agency teams [Police/Probation] who monitor and manage those individuals resident on a police division who pose a high risk of offending. Each police division in GMP operates an OMU. Staff in the OMU risk-assess and prioritise prolific and persistent offenders [PPO] including prison releases who present the highest risk of re-offending. The relevant Offender Management Unit in the area AM1 took up residence to initially risk assess and monitor AM1 had they been aware of his impending release from prison. When AM1 moved from his discharge address to North Manchester to live with AF1 this responsibility would have transferred to North Manchester Division."

On confirming that FIB or GMP did not receive any emails in relation to the release of AM1, the IMR author pursued the issue with Saadian Technologies who provide and manage the PINS system and from whom the email should have originated. In an email exchange between the IMR author and a Saadian Technologies representative, it was

"confirmed that despite relevant information confirming both a release date and a release address being added to AM1's PINS record, the PINS system [v3] did not send out a notification email to GMP and as a consequence GMP was not notified about AM1's prison release. The explanation given by Saadian Technologies for what they describe as a "system fault" was the fact that historic post-code errors in version 3 of PINS prevented AM1's release address being associated with an Operational Command Unit or OCU, in the proposed release area in Greater Manchester. Saadian did not suggest that the simple spelling mistake of the proposed address would have caused this to occur. Saadian also confirmed that this was a recognised system fault which was rectified by the introduction of v4 of PINS… one week after AM1 was released."

Without any email notification being generated by PINS, the Panel accepted that GMP were unable to risk AM1 prior to his release or implement an offender management plan.

The IMR author also noted that

"AM1 had not been of professional interest to any GMP officers since 2009 and was not tagged on the "My Offenders" facility no secondary email notifications were sent out to specific officers either. This back up contingency is a potentially useful feature of the system which could be utilised by GMP staff to facilitate the monitoring of high risk serial abusers such as AM1…The lack of any secondary email notifications appears to be that tagging under "My Offenders" facility was not recognised as an option by GMP staff in 2009, when AM1 was last criminally active as a domestic abuser in Greater Manchester."

Appendix C – Glossary

ACPO	Association of Chief Police Officers
CAADA	Co-ordinated Action Against Domestic Abuse
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
DASH	Domestic Abuse, Stalking and Harassment and "Honour" Based Violence
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IDVAS	Independent Domestic Violence Advisory Service
IRIS	Identification and Referral to Improve Safety
GMP	Greater Manchester Police
GMPT	Greater Manchester Probation Trust [as was]
MCC	Manchester City Council
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCSP	Manchester Community Safety Partnership
MLSCB	Manchester Local Safeguarding Children's Board
MSAB	Manchester Safeguarding Adults Board
MWA	Manchester Women's Aid
NPS	National Probation Service
PPU	Public Protection Unit
RAMA	Risk Administration Management Arrangements
VAWG	Violence Against Women and Girls
YPVA	Young Person's Advocacy Programme

Appendix D – Further Reading Bibliography

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