MANCHESTER COMMUNITY SAFETY PARTNERSHIP

in collaboration with

MANCHESTER SAFEGUARDING ADULTS BOARD

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim FA 1

Died 23rd July 2011

November 2012

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1. INTRODUCTION

1.1 The following designations have been given to the people involved in this review.

FA 1	Victim	45+ years	Black Caribbean
MA 1	Husband of FA 1	55+ years	Black Caribbean
MA 2	Son of FA 1 and MA 1	18+ years	Black British
FA 2	Friend of FA 1	not known	not known

1.2 FA 1 was estranged from her husband MA 1.

1.3 About 4.15 am on Saturday 23.07.2011 Greater Manchester Police (GMP) received a telephone call from North West Ambulance Service paramedics who were at FA 1's home address treating her for a serious injury. She was taken to hospital but died a short time later. A post-mortem revealed that she died from a single stab wound to the neck.

1.4 MA 1 was arrested and charged with her murder and rape.

1.5 On 26.04.2012 MA 1 was cleared of his wife's murder but found guilty of her manslaughter by an unlawful and dangerous act. He was also found guilty of raping FA 1 on two occasions; one at the time of her death and the other about two months earlier. He was sentenced to 16 years imprisonment.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 Section 4.1 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [the Guidance] gives local Community Safety Partnerships the responsibility for undertaking DHRs. The Manchester Crime and Disorder Reduction Partnership [MCDRP] asked Manchester Safeguarding Adults Board (MSAB) to consider whether the DHR criteria had been met.

2.2 On 16.08.2011 the MSAB Serious Case Review sub-group recommended to the Chair of MSAB that a DHR should be undertaken as the criteria in the Guidance had been met. A day later the Chair accepted the recommendation and the process began.

DHR Panel

2.3 David HUNTER was appointed as the independent chair and author of the DHR and commenced the task of establishing a DHR Panel which consisted of:

- Public Health Manchester from 03.11.2011
- Greater Manchester Police
- A Manchester Housing Association
- Greater Manchester Police
- Manchester Safeguarding Adults Board Manager
- Manchester Women's Aid
- Central Manchester NHS Foundation Trust

Note: The DHR Panel judged that the Manchester Women's Aid representative was sufficiently qualified to deal with the sexual violence aspect of the case when it emerged.

Information Sources

2.4 From the 40 organisations canvassed for information the following agencies provided written material to the DHR Panel:

- Manchester Children's Services
- Greater Manchester Police
- A Manchester Housing Association
- GP medical Centre
- Independent Choices (women's domestic violence help line)
- Central Manchester NHS Foundation Trust
- North West Ambulance Service
- Greater Manchester Fire and Rescue Service

Note: MA 1's GP declined to provide information to the DHR and therefore MA 1's assertion that he told his GP he was violent towards FA 1 and was referred for counselling cannot be verified. That information was disclosed to the independent chair and Adult Safeguarding Manager when MA 1 was seen in prison at the very end of the DHR. The DHR Panel elected not to pursue this given the late stage of disclosure. Some of MA 1's GP history was known to the DHR Panel early because it was contained in third party documents seen by the Panel. In future DHRs, any resistance from GPs to share information will be challenged.

Family and Friends Contributions

2.5 Selected members of FA 1 and MA 1's families were written to informing them that a DHR was taking place and inviting them to contribute. On the advice of the Crown Prosecution Service and the Senior Investigating Officer further contact was held in abeyance until the end of the criminal proceedings.

2.6 Given the very limited contact FA 1 and MA 1 had with agencies it was thought imperative to seek contributions from the families. Accordingly, intense and substantial efforts [letters and telephone calls] were made by GMP Family Liaison Officer [FLO], Adult Safeguarding Manager, the Independent Chair/Author and Victim Support's National Homicide Team to engage the family. MA 2 contributed during a telephone conversation with the Independent Chair/Author on 05.11.2012. Additionally, Greater Manchester Probation Trust was helpful in securing an interview with MA 1 in prison where he was seen by the Independent chair/Author and the Adult Safeguarding Manager on 26.10.2012.

2.7 FA 2, a friend and longstanding work colleague of FA 1's, contributed by way of e-mail exchange with the Adult Safeguarding Manager. FA 2's views and those of MA 1 and MA 2 are included in the report as appropriate. GMP's Family Liaison Officer assisted with the context and background information.

Terms of Reference

2.8 The Terms of Reference section of the report is divided into three parts; Purpose, Time Period and Specific Terms of Reference.

Purpose

The purpose of a Domestic Homicide Review (DHR) is to:

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

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to policies and procedures as appropriate;

and

Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Paragraph 3.3 the Guidance

Time Period

The time period under review is from 23.07.2010 until 23.07.2011; which suitably precedes the known agency contacts of May, June and July 2011.

Specific Terms of Reference

1. What knowledge did your agency have that indicated FA 1 might be a victim of domestic abuse?

2. How and when did your agency share that knowledge with other agencies?

3. How did your agency respond to that shared knowledge and in particular was a risk assessment completed?

4. Was your agency's response to that knowledge or risk assessment in accordance with your agency's relevant policies and procedures, including any multi-agency ones?

5. What services did your agency offer FA 1, were they accessible, appropriate and sympathetic to her needs?

6. What consideration did agencies give to the needs of any children or vulnerable adults within the household?

7. What thought was given to offering services to MA 1?

8. Should the information known to your agency have lead to a different response?

9. What knowledge did FA 1's family and friends have about her victimisation and what did they do with it?

10. How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?

11. Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the victim and to work effectively with other agencies?

12. Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?

13. Did professionals working with the victim have proper supervision and management control and direction?

14. Do any of your agency's policies or procedures require amending or new ones establishing as a result of this DHR, including those covering risk assessment?

15. Is there any key domestic violence research that could have helped professionals' handling of this case?

16. What lessons has your agency learned from this DHR?

17. Was it reasonably possible to predict and prevent the harm that came to the victim?

3. DEFINITIONS

Domestic Violence

Note: In this report the term domestic abuse is used but it has the same meaning as domestic violence.

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

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

3.2 An adult is any person aged 18 years and over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

4. FAMILY BACKGROUND AND CURRENT HISTORY

4.1 FA 1 was a much loved member of a large cohesive family unit many of whom lived close by; seeing each other frequently and providing mutual support. FA 1 had two children from a previous relationship who described her as a loving mother who worked hard for the family. FA 1 was a receptionist in a medical centre for the early part of the day and in the evening worked as a cleaner with two of her sisters at a job centre. She is described as a loving and forgiving person who enjoyed socialising and valued her privacy

4.2 MA 1 was born in the Caribbean and moved with his family to the Midlands when he was twelve years old. He was the second of ten children. In 1974 he formed an eleven year relationship with a woman during which time they had two children. MA 1 was an electrician by trade and a professional musician [steel band] working on cruise ships for six months of the year; generally between October and April.

4.3 FA 1 and MA 1 met in 1989/1990 and he moved to Manchester to be with her. They had one child [MA 2 an adult at the time of FA 1's death] and lived in a housing association property. Up until the beginning of 2011 some family and friends describe FA 1 and MA 1 as the perfect couple with the perfect marriage. It is known from family members that MA 1 exhibited controlling behaviour towards FA 1; a position she seems to have recognised but not overtly challenged. FA 1 will have had her reasons for tolerating MA 1's behaviour.

4.4 During the summer of 2010 FA 1 started to lose a significant amount of weight through fitness and dieting. Whilst FA 1's friends were complimentary of her new look, MA 1 became increasingly concerned and suspected she was seeing another man.

4.5 In October 2010 MA 1 left for his cruise ship engagement. FA 1 complained to friends that MA 1's e-mail and telephone contacts with her were intense and intrusive. He would call her up to five times a day demanding to know where she was. He required her to answer a land line number which he could identify, thereby knowing her whereabouts. This controlling behaviour is typical of domestic abuse perpetrators.

4.6 It was not until the start of 2011 that family and friends of FA 1 and MA 1 began to realise there were problems in the marriage. MA 1 returned home in March 2011 and his relationship with FA 1 deteriorated further when he discovered an unusual amount of activity on her mobile telephone to a number he did not recognise. He managed their mobile telephone accounts and demanded to know the identity of the person she was calling. FA 1 refused to tell him. He persisted in his demands and, it appears, was relentless in his pursuit of "the truth". FA 1 said it was a school friend.

4.7 Around the first two weeks in April 2011 FA 1 told some family members and friends that MA 1 had beaten and injured her. He had demanded to know the identity of the person she was calling. It is alleged he wielded a baseball bat around his head breaking kitchen crockery and furniture. MA 1 locked FA 1 in the bedroom, twisted her arm up her back and held a knife to her throat. FA 1 told him a fictitious name to de-escalate the incident. MA 1 admitted taking a knife from the kitchen to the bedroom and holding it while he demanded to know the identity of her "friend".

4.8 FA 1 told her three children about the incident and against her wishes they confronted MA 1 who acknowledged the incident and tried to explain and justify his actions. He apologised and promised it would never happen again. FA 1 told the children she wanted the relationship to work and they reluctantly respected her request not to take the matter any further or inform the police.

4.9 Over the following four weeks FA 1 and MA 1 continued to live together in a seemingly worsening relationship. MA 1 continued to pursue FA 1 and several of her family and friends in an effort to identify the "other man". FA 1 concluded that the relationship had irretrievably broken down and wanted a separation from MA 1 which he would not accept.

4.10 On an unknown date in May 2011 FA 1 disclosed to family and friends that MA 1 had raped and beaten her following a night out together. MA 1 was jealous of FA 1 after his wife's alleged attention towards a male stage artist. Unusually for FA 1 she did not attend either of her jobs the following week. She told FA 2, a work colleague, about the rape and that her facial injuries prevented her from leaving the house.

4.11 FA 1 told her three children that she had refused their father sex and he became violent and raped her, during which time he bit her face leaving an observed prominent mark. This was seen by a GP when she made a limited disclosure of domestic abuse. The children unsuccessfully tried to persuade their mother to report the attack to the police. It appears she did not want MA 1 to get into trouble and that she was also frightened of him. The details of the attack quickly circulated within the family many of whom spoke to him about it. MA 1 made unsolicited approaches to other family members trying to justify his actions. MA 1 claimed to have disclosed his violence to his GP who referred him for counselling which he said resulted in an initial assessment which he did not follow up on his return from holiday in July 2011. Without knowing what is in his GP record it is not possible to verify his claim. Additionally MA 1 said he told his pastor about his relationship difficulties but not about the violence.

4.12 Because of the attacks on her, FA 1 refused to accompany MA 1 on the holiday and concluded the relationship was over. She also stopped sleeping with MA 1 and asked him to move out or find someplace else for his possessions so he would have no reason to return to the house when his holiday was over. MA 1 resisted the suggestions and placed his belongings in the main bedroom and secured it with a lock. Whilst MA 1 was away FA 1 had the lock removed and liaised with the housing provider about removing MA 1 from the tenancy; disclosing some aspects of the domestic abuse. As his date of MA 1's return drew nearer, FA 1 became increasingly apprehensive about his reaction to events.

4.13 MA 1 returned from holiday on 20.07.2011 and started removing some items from the house. He went to stay with FA 1's mother who lived nearby. On 22.07.2011 MA 1 was due to sign the tenancy over to FA 1. He declined when he visited the housing provider. FA 1 arranged for MA 1 to visit her at the house later that evening and took the precaution of having her sister present. FA 1 told MA 1 that the relationship was over and they should get on with their lives separately. He was indisposed to accept this and left the house to go to a party. FA 1's sister remained with her until about mid-night. MA 1 returned to the house a few hours later in the early hours of 23.04.2011, let himself in with a key, raped and killed FA 1.

4.14 FA 1 and MA 1 were not known to the police prior to FA 1's death, save for a single incident when a window was broken in their house. MA 1 was abroad at the time and the incident is not judged to be relevant to the DHR. Two previous partners of MA 1 told the police that he had been violent to them. Those matters were not reported to the police at the time.

5. SIGNIFICANT EVENTS AND THEIR ANALYSIS

5.1 Introduction

5.1.1 There were only six relevant contacts with agencies which are listed below and given a shorthand narrative description. Thereafter each significant event is expanded

upon and where appropriate, immediately followed by a critical analysis which draws on the IMRs and the deliberations of DHR Panel members.

5.1.2 The information provided by GMP, Children's Services and Central Manchester University Hospitals NHS Foundation Trust does not contain "Significant Events". However, some of their information was used to inform the analysis.

5.2 List of Significant Events

Date	Event
17.05.2011	FA 1 disclosed Domestic Abuse [bite mark] to GP
01.06.2011	MA 1 disclosed mutual violence in his "online" housing application
06.06.2011	FA 1 disclosed domestic Abuse to her housing provider
08.06.2011	FA 1 told the housing provider she wants MA 1 to move out
21.06.2011	FA 1 sought marital counselling referral from GP
22.07.2011	MA 1 saw housing provider and failed to sign tenancy over to FA 1
23.07.2011	FA 1 stabbed and died

5.3 Significant Event: FA 1 disclosed Domestic Abuse including bite mark to GP

5.3.1 FA 1 visited her GP on 17.05.2011 and asked to see a female doctor. One was not available until later that day and she was seen by a male GP and a GP trainee registrar. FA 1 complained of lower back pain and disclosed that she was having domestic problems with MA 1. She reported being bitten on her face by him over the weekend. When asked for more detail FA 1 became tearful saying, "I don't want to talk about it". She was offered an appointment with a female doctor and signposted to the domestic violence help line and the police. The GP did not carry out a domestic violence risk assessment as there was no requirement to do so; nor is it practical that they will do so in the future because of the very limited time allocated to each patient.

Analysis:

5.3.2 The consultation was conducted by a GP [GP 1] in the presence of a trainee GP. The IMR author notes that the trainee GP judged FA 1 was not happy and elicited the domestic abuse disclosure from her. That was good work and supportive of FA 1. Bite marks are associated with sexual violence and this aspect was not explored by the GP. Domestic violence training in Manchester does not generally cover this topic. "Human bite marks are frequently found on the victims of violent and sexual crimes, i.e., serial murder, rape, and child abuse". * This was the first time an agency recorded FA 1 as suffering domestic abuse and it presented a significant opportunity to help her.

* Webb DA, Forensic implications of biting behaviour: a conceptually underdeveloped area of investigation. J Forensic Sci 2002; 47(1):103–106.

5.3.3 The GP quite properly offered FA 1 the services of a female doctor and also sign-posted her to a domestic abuse help line and the police. It might be that FA 1

would have disclosed more to a female GP, as suggested by her request to see one. The GP could have discussed the case with the practice safeguarding lead to determine if there were other ways to help FA 1 or asked if she would like to see a female practice nurse if one was available. Additionally the GP could have sought advice from PCT Safeguarding Specialists. There is no mention in the GP IMR of whether the sexual violence associated with bite marks was recognised. In an ideal world a risk assessment would have been completed. The risk assessment model in use at the time was: CAADA DASH Risk Indicator Checklist (Coordinated Action Against Domestic Abuse, Domestic Abuse Stalking and Harassment).

5.3.4 The IMR records that the GP Practice was unaware of the CAADA risk assessment tool and had not received any safeguarding adult or domestic abuse training; adding, "This [training] is considered to be a need that goes beyond this practice and has in fact been recognised as a national issue in relation to GPs".

5.3.5 Since then the GP practice has received training in Identification and Referral to Improve Safety- IRIS- and is now part of the IRIS project in Manchester.

5.3.6 IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The target patient population is women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

5.3.7 IRIS is collaboration between primary care and third sector organisations specialising in DVA. An advocate educator is linked to general practices and based in a local specialist DVA service- Manchester Women's Aid. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices.

Source: www.irisdomesticviolence.org.uk

Note: An evaluation of IRIS concluded:

"The IRIS programme is likely to be cost effective and possibly cost saving from a societal perspective. Better data on the trajectory of abuse and the effect of advocacy are needed for a more robust model".

Source: bmjopen.bmj.com 02.07.2012 Angela Devine et al

5.3.8 In the absence of a risk assessment, the DHR Panel at its meeting on 03.11.2011 completed a CAADA risk assessment based on the facts known to the GP and other agencies at the time. The exercise generated a score of 9. A score of 14 or more [or professional judgement] is needed before the case can be referred to MARAC [Multi Agency Risk Assessment Conference].

Notes:
Manchester now has a domestic abuse assessment and referral form which was not in place at this time and it clarifies that if a MARAC referral is not appropriate then Manchester Women's Aid can follow up the case. If this is refused then the Domestic Abuse Helpline number should be offered at a minimum.

MARAC: Multi-Agency Risk Assessment Conferences are meetings where information about high risk domestic abuse victims (those at risk of homicide or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year. Source: www.caada.org.uk

5.4 Significant Event: MA 1 wrote 'mutual violence' in his "online" application

5.4.1 MA 1 made an on line application for re-housing on 01.06.2011 in which he stated that he and FA 1 has been violent towards each other.

Analysis:

5.4.2 There is no more information available about this disclosure and the housing provider appears not to have spotted its significance, or initiated any action. The housing provider representative on the DHR Panel felt that should such a comment appear again its importance would be spotted. This confidence stems from updated protocols and staff training.

5.4.3 There is no evidence that FA 1 was ever violent towards MA 1, and MA 1's use of the phrase, "mutual violence" is probably evidence of his minimisation and avoidance of responsibility.

5.5 Significant Event: FA 1 disclosed domestic Abuse to Housing Provider

5.5.1 On 06.06.2011 FA 1, a joint tenant with MA 1, disclosed to the housing provider that she had been the victim of domestic abuse in April 2011 and in May 2011 and that the latter abuse required hospital treatment. She was not prepared to suffer a third violent incident and wanted re-housing along with their adult son. FA 1 informed the housing provider that she told MA 1 she wanted to separate. FA 1 added she was not concerned about her safety.

5.5.2 It appears MA 1 did not accept her friendship with the other man was platonic. MA 1 assaulted her in April 2011. They had been sleeping in separate rooms since. They were not talking and FA 1 felt more settled when MA 1 was away from home.

5.5.3 FA 1 had told MA 1 that she wanted their relationship to end and set a deadline requiring him to move out of the house on his return from his holiday in June 2011. The housing provider gave her a "useful telephone number leaflet", advice on housing options and the practical option of having a "flight bag" prepared. The housing provider advised FA1 to seek independent legal advice from a solicitor and advised her that they could obtain an injunction against MA1.

5.5.4 Additionally, the housing provider facilitated a telephone call to Independent Choices, a local help line for female victims of domestic violence, who provided her with:

- legal advice on housing
- information on injunctions

- telephone counselling
- contact details for Women's Aid, the police and a solicitor.

Analysis:

5.5.5 The housing provider responded appropriately and complied with its domestic violence policy. They seemed reassured by FA 1 that she was not concerned for her safety. The DHR Panel felt that the housing provider placed an over reliance of FA 1's perception of her safety. At the time of FA 1's death the housing provider was not completing CAADA DASH which it now does. It is recognised that women are in greater danger of violence from male partners at the point of separation. The housing provider acknowledges it should have recognised this and referred FA 1 directly to Women's Aid or a similar victims' organisation.

5.5.6 FA 1 had set a deadline for MA 1 to move from the property which appears to be in conflict with her request to the housing provider on 06.06.2011 for rehousing. The DHR Panel felt this contradiction in thinking probably reflected the turmoil in FA 1's life at that time and should have been recognised as a point of inconsistency and explored further. MA 1 told the DHR author and MSAB Manager that FA 1 had originally wanted to move out and she was offered priority rehousing but she then decided to stay in the marital home as it was near to her mother. MA 1 said that he then approached the housing provider to ask if he could take this accommodation in her place but was told he was a lower priority for rehousing and that he must find private tenancy. The housing provider reflected that it was probably a little over-influenced by FA 1 views and would now be more questioning of victims so that the most appropriate services and advice could be offered. However, this approach has to be balanced against taking control of the situation away from the victim.

5.5.7 MA 1 broke his tenancy agreement when he assaulted FA 1 and this aspect is considered later in the report.

5.5.8 There is no trace within FA 1's medical records that she received hospital treatment at Central Manchester Foundation Trust, or any other hospital, for the May 2011 domestic abuse. The DHR Panel felt that ideally the housing provider might have asked the nature of the injury and at which hospital she was treated.

5.5.9 The housing provider was praised for having good domestic abuse Policies and Procedures in the Audit Commission Housing Association Inspection Report – February 2007 – Housing Management Services.

5.6 Significant Event: FA 1 told Housing Provider she wants MA 1 to move out

5.6.1 On 08.06.2011 FA 1 visited the housing provider and requested they help her remove MA 1 from the house or alternatively move her. The housing provider contacted MA 1 by telephone. MA1 was told that he was in breach of his tenancy and he should find private rented accommodation. He admitted hitting FA 1 and expressed regret for his actions. MA1 was 'surprised by the call'.

5.6.2 Thereafter on 08.06.2011, there were several telephone calls between the housing provider FA 1 and MA 1 updating the pair on the housing situation. It appears that FA 1 was going to stay with her mother until MA 1 went on holiday on 21.06.2011.

5.6.3 On 09.06.2011 FA 1 informed the housing provider that she was still at her mothers and MA 1 was planning to move from their house. On 15.06.2011 FA 1 telephoned the housing provider to report that MA 1 had agreed to sign the tenancy over to her and he would be attending the office to do so. FA 1 said she was "ok". On the same day the housing provider asked MA 1 whether he had found alternative accommodation. He reported it was too expensive. MA 1 was advised to call Homefinder to check on his application.

Analysis:

5.6.4 The above exchanges demonstrate thoughtful liaison between the housing provider and their tenants. The housing provider could have sought injunctive relief excluding MA 1 from the property.

5.6.5 The housing provider explained in its IMR that it took no legal action against MA 1 for breaching his tenancy because it appeared, "although estranged, there was a degree of cooperation between the couple and FA 1 did not want to take such action". An injunction would have required the support of FA 1. The housing provider say the wishes of domestic abuse victims are generally paramount and they were following that policy line; being reassured that the situation between the couple was tolerable.

5.6.6 The DHR Panel debated whether refraining from injunctive action was in the best interests of FA 1 who at this point [early June 2011] seemed resolved to end the relationship and in summary concluded:

5.6.7 This event highlighted the need for those working with MA 1 to see how his needs could be met rather than just telling him to sign the tenancy over and making him homeless which was likely to greatly increase the risk to FA 1. The housing provider suggested that they could perhaps have been more proactive in helping him find alternative housing. The Panel also noted that some agencies have to work with perpetrators of domestic abuse on issues without specific training in relation to managing risk and this needed addressing. The Panel also noted that the zero tolerance approach which is generally adopted for domestic abuse needs to be balanced with looking at the holistic needs of perpetrators such as their mental health, substance misuse, employment, housing needs etc with a view to tackling the problem from both ends.

Note: In March 2012 training in working with domestic abuse perpetrators was commissioned by the DA forum and 80 participants including the housing provider attended. The MSCB and MSAB protocol is also being updated to reflect this need and therefore a recommendation is unnecessary.

5.7 Significant Event: FA 1 sought marital counselling referral from GP

5.7.1 On 21.06.2011 FA 1 visited her GP [GP 1] and reported "family problems with her husband". FA 1 had been advised by Relate of an eight week wait for an appointment and she asked whether the GP could provide counselling sooner. The GP was doubtful if a referral from the GP practice to counselling services would be quicker and advised FA 1 to make an appointment with Relate. No other actions are recorded on FA 1's medical record.

Analysis:

5.7.2 GP 1 was aware of the 06.06.2012 consultation with GP 2 during which FA 1 disclosed domestic abuse. GP 1 "understood" that the patients focus was to continue the relationship with the help of counselling. The DHR Panel thought that the GP could have used this opportunity to sign-post FA 1 to agencies specialising in supporting victims of domestic abuse [e.g. Women's Aid/Victim Support] so that FA 1 could access support during the eight week waiting period.

5.7.3 The DHR Panel heard that Relate and the domestic abuse sector recognise that disclosing issues in front of a partner could increase the risks. Relate mitigate this by screening at an initial assessment. Where domestic abuse is disclosed they offer support to the victim and a voluntary perpetrator programme for the abuser. Marital counselling is only likely to be effective if the abuse has already been addressed, for example through a successful completion of a perpetrator programme. The IRIS project which has now been introduced to this practice would promote a more appropriate referral pathway.

5.8 Significant Event: MA attended the Housing Provider; left without assigning tenancy

5.8.1 At 12.05 pm on Friday 22.07.2011 MA 1 attended at the housing provider apparently to give up his tenancy. He left without signing, saying he wanted to seek legal advice and that the paperwork was wrong. It was noted that MA 1 appeared sullen. The housing provider updated FA 1.

5.8.2 At the same time the housing provider called MA 1 and he agreed to return to the office before 4.30 pm to sign the paperwork. FA 1 was updated with this development. At 2.30 pm MA 1 called the housing provider to discuss his rehousing application. MA 1 said he would call the housing provider back on Monday to discuss this further.

Analysis:

5.8.3 The above events took place 12 to 18 hours before FA 1's death. There is no suggestion from the DHR Panel of cause and effect. They are included to show that the pressure may have been building on MA 1 because of his growing realisation that FA 1 was determined to end the relationship and that he would have to leave home.

Note: There is no doubt that FA 1's was resolved to ending the relationship with MA 1. This can be further evidenced by her sister's account that on the evening of 22.07.2011, FA 1 told MA 1 in plain terms that the relationship was over and they should get on with their lives separately. The DHR Panel noted that the sister was present because FA 1 did not want to be alone with MA 1.

5.8.4 With hindsight it is easy to say that the housing provider should have pursued injunctive relief on behalf of FA 1 and in support of its own domestic abuse policy. The housing provider made their decision based on what they judged to be in the best interests of FA 1 having listened to her wishes and would have required her consent to proceed. It is not possible to say whether injunctive relief would have altered the situation or outcome.

5.9 Domestic Violence Protection Notices and Orders [DVPN] [DVPO]

5.9.1 The following information is included because of its potential relevance to this case.

5.9.2 Sections 24-33 Crime and Security Act 2010 enabled three police forces, including GMP, to take part in a DVPN and DVPO one year pilot beginning on 30.06.2011. * The DVPN can be issued by a police superintendent and prohibits a person from doing whatever is specified in it. It aims to provide immediate and emergency relief for victims of domestic violence where the alleged perpetrator has not been charged with an offence. An application for a DVPO must be made to a Magistrates' Court within 48 hours.

* The pilot has been extended until 30.06.2013.

5.9.3 S24 (2) says:

A DVPN may be issued to a person ("P") aged 18 years or over if the authorising officer has reasonable grounds for believing that –
(a) P has been violent towards, or has threatened violence towards, an associate person, and
(b) the issue of the DVPN is necessary to protect that person from violence or a threat of violence by P.

5.9.4 Breaches of the DVPN are arrestable and the person is taken before a Magistrates' Court who will consider the breach as part of the DVPO application.

5.9.5 Whilst the pilot did not begin until 30.06.2011 [about three weeks before FA 1's death] neither the housing provider nor the GP practice were aware of it and therefore could not discuss its potential usefulness with FA 1.

5.9.6 The housing provider received training from GMP on DVPNs on 14.10.2011.

6. ANALYSIS AGAINST THE TERMS OF REFERENCE

6.1 Introduction

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

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

6.2 *What knowledge did your agency have that indicated FA 1 might be a victim of domestic abuse?*

6.2.1 Only two agencies had real knowledge that FA 1 was a victim of domestic abuse; the housing provider and the GP practice. This knowledge was gained through self disclosure by FA 1 and on one occasion by MA 1. Independent Choices had one anonymous telephone contact with FA 1 [facilitated by the housing provider] and gave appropriate advice to FA 1.

6.3 *How and when did your agency share that knowledge with other agencies?*

6.3.1 The housing provider and the GP practice did not share the disclosures with any agency. Both acknowledge they could and probably should have. However, it is not clear if either agency gathered sufficient information on the nature and extent of the domestic abuse. If they did it was not recorded. There is no evidence that FA 1 told either agency that she had been raped which may have prompted them to consider the issue differently. FA 1 might have made such a disclosure had she been seen by a female GP. However, she did not take up the offer to see one later the same day.

6.4 *How did your agency respond to that shared knowledge and in particular was a risk assessment completed?*

6.4.1 At the time of the events it was not the housing provider's practice to complete risk assessments. Since then, but not as a direct result, the housing provider does complete risk assessments and is a referring agency to MARAC. The GP practice was unaware of the CAADA risk assessment tool and staff were not trained in adult safeguarding or domestic abuse. Since then the GP practice has taken part in the IRIS scheme which will benefit victims of domestic violence. The housing provider was unaware of the DVPN scheme. It has since received training on the scheme.

6.5 *Was your agency's response to that knowledge or risk assessment in accordance with your agency's relevant policies and procedures, including any multi-agency ones?*

6.5.1 The GP practice advice to FA 1 was limited and they missed two opportunities to consider a risk assessment and/or signpost her to other domestic violence support services, albeit it after the initial disclosure it did signpost post her to services. The practice did not have a domestic abuse policy or procedure. The housing provider gave appropriate advice and sign-posted FA 1 to services. They also facilitated a call to a help line which provided useful advice. There was never any multi-agency meeting or discussion about the case. The housing provider did however follow their agency procedures which have been updated since the events. MSAB did not have multi agency procedures for domestic abuse at this time although MSCB did. MSAB and MSCB will have a joint domestic abuse protocol by the end of March 2013 which will apply to all agencies that are signed up to the work of the two safeguarding boards.

6.6 *What services did your agency offer FA 1, were they accessible, appropriate and sympathetic to her needs?*

6.6.1 The GP Practice offered a listening ear but was not able to facilitate access to counselling any quicker than the eight week wait for a Relate appointment. The DHR Panel felt that whilst having to wait this length of time was the reality, it did nothing to support FA 1, who was looking for more immediate help and that help may have been more appropriate from a domestic abuse service.

6.6.2 The DHR Panel felt the housing provider could have taken a more positive line and sought injunctive relief on behalf of FA 1. This would have put her in control of MA 1's access to the home. However, the housing provider believed that FA 1 was looking to save the relationship and this understanding in addition to lack of the necessary consent led them to hold off. Thereafter the housing provider was supportive of FA 1 and ensured she was kept informed of events relating to MA 1's termination of the joint tenancy. They explained her tenancy rights, including the episode where MA 1 had locked his belongings in a bedroom. Solving MA 1's

accommodation needs was an important part of supporting FA 1 and the housing provider might have been more creative in the solution. For example it could have considered offering MA 1 a tenancy in another of its properties, albeit that was well outside its standard approach to perpetrators of domestic abuse.

6.7 *What consideration did agencies give to the needs of any children or vulnerable adults within the household?*

6.7.1 Neither the housing provider nor the GP practice recorded that they had explored this area. Both will have known from their records that FA 1 did not have children less than 18 years of age, but do not appeared to have asked about other childcare or vulnerable adult responsibilities.

6.8 *What thought was given to offering services to MA 1?*

6.8.1 FA 1's GP practice appears not to have considered offering services to MA 1, following her disclosures. MA 1 said in interview that he disclosed his violent behaviour to his GP and was referred for counselling. The DHR Panel was denied access to his GP records and therefore cannot verify if his account. However, given MA 1's minimisation of his domestic abuse, it is thought unlikely that he provided a candid explanation. The housing provider gave MA 1 advice on how to find alternative accommodation following his breach of the tenancy agreement. The case never got to the point where a multi-agency plan to tackle the issues, may have considered services for MA 1.

6.9 *Should the information known to your agency have lead to a different response?*

6.9.1 The GP practice missed the significance of the bite mark which MA 1 inflicted as part of an assault on FA 1. Has its relevance been recognised it may have prompted the practice to refer to another agency or probe deeper into the issues. However, at the time the GP practice was not familiar with domestic violence risk assessment.

6.9.2 Injunctive relief against MA 1 would have laid down a firm marker and supported FA 1 by allowing her the time and space to decide on her future, without the pressure brought about by MA 1's domiciliary status. The DHR Panel recognised that this needed the cooperation of FA 1 who was unwilling to give it for fear of getting MA 1 into trouble, a position consistent with her refusal to involve the police. Additionally, the housing provider could have considered using Sanctuary Scheme for FA 1 to make her safe in her home.

6.10 *What knowledge did FA 1's family and friends have about her victimisation and what did they do with it?*

6.10.1 It is clear that FA 1 revealed to her three adult children and other family members that MA 1 was violent and had raped her. This emerged from the police investigation into FA 1's death and was confirmed by MA 1. The children confronted MA 1 who apologised for his actions, promising they would not be repeated. They tried to persuade FA 1 to contact Police but she refused because she did not want to get MA 1 into trouble. FA 1 was after a trouble free solution to a relationship which she saw as over, but MA 1 saw as recoverable.

6.10.2 At one point MA 1 left the marital home to stay with FA 1's mother, albeit she was in hospital. The DHR Panel felt this move reflected the family's wish to respect FA 1's decision not to involve the police. On the evening before she died, FA 1 asked her sister to be present before explaining to MA 1 that the relationship was over and they should go their separate ways.

6.10.3 FA 2 was seen in her capacity as a friend of FA 1. FA 2 thought a zero tolerance approach to domestic violence was best saying, "make the first time the last time". She wondered whether victims could tell the police so they could impress on perpetrators that their actions were domestic abuse, but stop short of arrest and process if this was what the victim wanted. She described FA 1 as a forgiving woman and it was sometimes difficult for family and friends to "interfere" in relationships in case the couple wanted reconciliation. FA 2 thought FA 1 was safe but felt strongly that the locks to the house should have been changed to deny MA 1 independent access. Unfortunately, the housing provider was unable to do this whilst MA1 was still a tenant.

6.10.4 FA 2 was also FA 1's supervisor at one of her employments. The DHR Panel wondered whether all employers should have domestic violence polices and made a recommendation for MSAB to consider the point.

6.11 *How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?*

6.11.1 The family reluctantly agreed with FA 1's wish not to report the domestic abuse to the police. FA 2 told the DHR Panel that she felt the police should have been told but was persuaded by FA 1 not to do so because she felt safe. Victims, family and friends are not always best placed to accurately judge the risks involved in domestic violence. For example it is known amongst professionals that risk increases significantly at the point of separation. Had an agency used the risk indicator checklist it may have alerted FA 1 to the risks commonly faced by victims of domestic abuse. This reinforces the need for agencies to make referrals to domestic abuse specialists.

6.12 *Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the victim and to work effectively with other agencies?*

6.12.1 The GP Practice reported at least an eight week wait for access to counselling services for FA 1. There is no fast track procedure to counselling. This GP Practice does not employ counsellors and given the competing demands within GP practices, counselling is not generally seen as a priority.

6.13 *Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?*

6.13.1 FA 1 and MA 1 self categorised as Black Caribbean/Black British. The two agencies with relevant contact have well established equality and diversity policies and there is no evidence to say that the services provided or offered were any different because of FA 1's ethnicity. FA 1 is also described as Catholic and all agencies should remember that support may be available from faith groups.

6.13.2 When FA 1 visited the GP practice on 17.05.2011 she originally wanted to see a female doctor. One was not available until later that day and she agreed to see a male GP in the presence of male GP trainee registrar. It is known that FA 1 did not disclose that she had been raped and was reticent to provide detail of the domestic abuse. Had a female doctor been immediately available the disclosure may have been fuller. The GP practice was unable to meet FA 1's immediate requirement or suggest the alternative of a female practice nurse, had one been available.

6.14 *Did professionals working with the victim have proper supervision and management control and direction?*

6.14.1 FA 1's disclosure to the GP was made to a GP trainee registrar and the GP Consultation Observation Tool [COP] was completed. GPs are independent practitioners and as such are not managed. The attending GP did not seek advice from the GP practice lead on adult safeguarding.

6.14.2 The housing provider reports in its IMR that:

"Officers managed the situation on a day to day basis. Appropriate advice and assistance was sought from managers when necessary. The case was discussed by practitioners with the Neighbourhood Manager and the Supported Housing Manager who is the organisational lead on Domestic Abuse".

6.14.3 The DHR Panel noted the comment and concluded the decisions made by staff had the support of their managers who must therefore also bear responsibility for any learning points arising from the housing provider's contact with FA 1 and MA 1.

6.15 *Do any of your agency's policies or procedures require amending or new ones establishing as a result of this DHR, including those covering risk assessment?*

6.15.1 The housing provider and the GP practice have already amended their policies around risk assessment and are now better placed to support victims of domestic abuse. In the case of the housing provider, they now have a policy for referring cases to MARAC. Exposure to the DHR process has enabled the housing provider to identify previously unknown victims of domestic violence living in their properties. Support for them has been offered through MARAC.

6.15.2 MSAB and MSCB will have a joint domestic abuse protocol by the end of March 2013 which will apply to all agencies that are signed up to the work of the safeguarding boards.

6.16 *Is there any key domestic violence research that could have helped professionals' handling of this case?*

6.16.1 "When a woman reaches the point of separating from her spouse, she may feel intensely vulnerable during the unpredictable transition to a new life. Aside from the more extreme dangers -- women leaving violent or abusive spouses are at greater risk of being severely assaulted or even killed by their ... partners immediately after a separation, according to forensic psychotherapist Adam Jukes -- a period of bereavement and uncertainty awaits her as she moves away from her former identity. Reliable and consistent emotional support becomes inestimably valuable".

Source: www.ehow.co.uk

Women are at greatest risk of homicide at the point of separation or after leaving a violent partner.

Source(Lees, 2000). www.womensaid.org.uk

6.16.2 Therefore it is essential that professionals know of the heightened danger when formulating risk and devising risk management plans.

6.16.3 The GP did not appreciate the significance of the bite mark caused by MA 1 when he abused FA 1.

6.16.4 Human bite marks are frequently found on the victims of violent and sexual crimes, i.e., serial murder, rape, and child abuse...

Source: Journal of Forensic Sciences: Webb DA, Sweet D, Hinman DL, Pretty IA. Forensic implications of biting behaviour: a conceptually underdeveloped area of investigation. J Forensic Sci 2002;47(1):103–106.

6.17 *What lessons has your agency learned from this DHR?*

6.17.1 **The Housing Provider has learned:**

- The need to focus on the victim as well as the perpetrator and consider the impact of any actions taken.
- The need to focus on support mechanisms and housing advice as well as legal action and tenancy enforcement to both parties where appropriate.
- The need to consider how staff can influence the victim so that they continue to be the centre of decision making and are aware of heightened risks such as 'separation'.

6.17.2 **The GP Practice has learned:**

- The Trainee GP's skills in eliciting information and providing support illustrate good practice.
- What could be learnt is how to deal with situations like this and of proper recording and flagging of the patients' notes to make others in the practice aware, whilst maintaining confidentiality.

  Note: The DHR Panel heard that improvements to the "recording and flagging" have been made since the DHR began.
- A discussion with the Safeguarding Lead within the Practice would have been ideal if not essential.
- Advice could have been sought from PCT Designated Nurse
- Lack of awareness of the domestic abuse guidelines and use of risk assessment tool within the practice was poor and therefore the seriousness of the problem was missed.

- The provision of counselling service is poor and there are lengthy delays in accessing what is available.
- Practice staff require training on adult safeguarding and domestic abuse.
- Practices need to have contact details for domestic abuse support organisations.

Note:

On 24.05.2012, the Royal College of General Practitioners launched new guidance to support GPs and their teams in recognising and responding to domestic violence.

The guidance includes key principles to help GPs and healthcare staff respond quickly and effectively to patients who disclose domestic abuse. These include:

The practice manager should build strong partnerships with local domestic abuse services and ensure domestic abuse training for the practice team.

The practice should establish a domestic abuse care pathway, so that the team understands the correct process for identifying abuse, responding to disclosure, risk assessment, referral and information sharing.

Direct referral to a domestic abuse service for further assessment of any patient disclosing abuse to a clinician should take place. Some practices may develop an internal referral route to a practice nurse or other health professional with additional domestic abuse training who will conduct the specialist assessment.

Domestic abuse should also be addressed by the local strategic lead for the clinical commissioning group.

The guidance also includes resources to help the practice team, including a process map for responding to domestic abuse and a services directory.

Source: www.rcgp.org.uk

6.17.3 **The DHR Panel felt the following lessons could also usefully be learned by partner agencies:**

- Initially, victims may not fully disclose the extent and nature of domestic abuse. Therefore, there is a need for professionals to obtain a full account of the domestic abuse at the first opportunity so that a comprehensive risk assessment and risk mangement safety plan can be drawn up in support of the victim. At this stage victims are likely to want help and if this opportunity is missed the victim may not, for a number of understandable reasons, continue to disclose. These reasons may include: lack of trust, fear of perpetrator and embarrassment.
- Victims of domestic abuse presenting with bite marks might have suffered sexual violence. Non-specialist domestic violence professionals should be alert to this link. Had FA 1 been able to see a specialist domestic violence or sexual worker, the significance of the bite mark and other risk factors were very likely to have been identified and a support plan considered.

- The holistic needs of perpetrators should be considered in addition to the victim's, thereby forming the optimum approach in each case. This may include criminal and civil justice routes to manage perpetrators' risks. In the long term support can be offered around housing, education, employment, substance misuse and debt. Where necessary these can be used in conjunction with perpetrator programmes if they are available. Such support would be in addition to the needs of the victim who should be consulted. Agencies should consider throughout whether risk to the victim is increasing while any perpetrator intervention is being offered.

- Publicity campaigns for domestic abuse need to target families and friends so they can direct victims to support services.

- The GP's refusal to provide information on MA 1 prohibited an important area from being reviewed.

6.17.4 The other agencies contributing to this review [paragraph 2.4] have no lessons relevant to the terms of reference.

6.18 *Was it reasonably possible to predict and prevent the harm that came to the victim?*

6.18.1 Four groups knew that FA 1 was the victim of domestic violence: the GP, the Housing Association, her work colleague and the family. Only the family and friend/work colleague knew that FA 1 had also been raped. FA 1's family and friend/work colleague reluctantly conceded to her wish not to involve the police. Neither the GP nor Housing Association considered a referral to MARAC. Had a risk assessment been completed by either of them the numerical referral threshold of 14 would not have been met. The DHR Panel's retrospective assessment showed that without the knowledge of sexual violence, the professional threshold criteria would not have been met.

6.18.2 Therefore the DHR Panel concluded that on the information known outside the family, it was not reasonably possible to predict or prevent the death of FA 1. The person responsible for FA 1's death was MA 1, as determined by the court on 26.04.2012.

7. GOOD PRACTICE

7.1 The Trainee GP spotted something amiss with FA 1 and was able to draw out a limited disclosure and signpost her to domestic abuse support agencies. The housing provider kept FA 1 well informed of progress when MA 1 left their office angry. It explained the options of injunctions and other support and facilitated FA 1's telephone call to the Domestic Abuse Helpline.

8. CONCLUSIONS

8.1 FA 1 disclosed to her family and friend in the spring of 2011 that she was the victim of domestic violence and rape at the hands of MA 1. FA 1's adult children and other family members confronted him. He tried to explain and justify his actions, and undertook not to repeat the domestic abuse. However, at that time the matters remained within the family and intervention from agencies was not possible. It

appears FA 1 did not want the authorities involved and sought self resolution. She did not want to get MA 1 into trouble with the police.

8.2 There was a limited disclosure to a male GP in May 2011, which may have been fuller had a female GP been immediately available as was FA 1's wish. FA 1 did not disclose she had been raped and the possible sexual connotations of the bite mark inflicted on her by MA 1 were not recognised by the GP. Had they been, further sensitive probing may have elicited a fuller account. FA 1 was offered an appointment with a female GP and signposted to the police and domestic abuse help line. However, a risk assessment was not completed, in common with the GP custom at the time, nor will they be completed in the future. However the IRIS programme, which the GP Practice is involved with, should see GP's making appropriate referrals to support agencies. Therefore the opportunity to support future victims of domestic violence will be enhanced, albeit too late for FA 1.

8.3 On 01.06.2011, MA 1 disclosed "mutual violence" in his online application to the housing provider for re-housing. The domestic violence issue was missed. Less than a week later, FA 1 disclosed two episodes of domestic abuse to the housing provider. The disclosure did not refer to the rape. FA 1 wanted re-housing. Appropriate advice was given to FA 1 and the housing provider helpfully facilitated a telephone call to Independent Choices who also provided practical advice. However, a risk assessment was not completed because at the time it was not the housing provider's practice to do so. FA 1 told the housing provider she felt safe but the organisation should have recognised that victims are not always best placed to make this judgment. That was difficult in the absence of a risk assessment policy but could have been achieved by discussing the case with a domestic abuse specialist.

8.4 Thereafter FA 1's attitude to MA 1 seems to have hardened and she wanted to end the relationship. FA 1 returned to the GP practice wanting quicker access to counselling than the current eight week wait for an appointment with Relate. She was advised that counselling through the GP route was not likely to be quicker and to pursue the Relate route. Whilst that was the case, it did nothing to support FA 1 or reduce the risk she was facing and another opportunity to assess her risk and needs was missed.

8.5 The housing provider continued to negotiate with MA 1 to make FA 1 the sole tenant of the house. The housing provider might have sought injunctive relief for FA 1 which excluded him from the property because he had broken his tenancy agreement through inflicting domestic abuse on FA 1. The housing provider could not pursue this as FA 1 withheld her consent. In the absence of any other independent evidence to support an application, she would have been required to attend court. In addition to this, the incident happened more than six weeks before the disclosure, making the granting of a 'without notice' injunction less likely. The injunctive relief would have supported FA 1 and given her control of an important aspect of the relationship and not necessarily hampered reconciliation, particularly if MA 1 was sincere in his claims to change. The housing provider acknowledges that it was not aware that risk increased at the point of separation.

8.6 MA 1's claims to have disclosed his violence to his GP cannot be verified because access to his medical records was denied by the GP. MA 1 went on holiday and on his return in late July 2011 he refused to sign over the tenancy to FA 1, telling the housing provider he needed more information. On the evening before her death FA

1, supported by her sister, told MA 1 that the relationship was finally over. He returned a few hours later, raped and killed her. This reinforces the point of victims being at greater risk when separation happens.

8.7 FA 1 probably did not appreciate the danger she was in and that the risk to her increased as separation became a reality for MA 1. An experienced domestic abuse professional would have known this, alerting FA 1 to the dangers and developed a risk management plan to deal with the separation. It is not possible to say if such action would have prevented her death. FA 1 did not want to involve the police because she did not want MA 1 to get into trouble. Her family and friends respected her choice and it appears reluctantly stayed silent.

8.9 MA 1 was a person whom two previous partners claimed was violent to them. This was unknown to the police, FA 1 or her family. MA 1 exercised significant control over FA 1's life which turned to violence in 2011 when he suspected her of forming a liaison with another man. MA 1's persistent harassment of FA 1 over the identity and nature of the liaison saw him violently assault her. FA 1's determination to end her relationship with MA 1 placed her in unrecognised danger which ended with her death on 23.07.2011.

8.10 In a statement at the end of the trial, FA 1's family said:

"No sentence in the world could ever give us back our mother. The sentence of 16 years passed today is of no comfort to us and we are simply left numb. It does however provide some form of closure for us, her children, and the rest of the family in so far as everyone now knows the truth of what MA 1 did to our mother. We can now finally allow our mum to rest in peace."

9. RECOMMENDATIONS

9.1 Single Agency

9.1.1 The GP Practice

1. GP practice, with the support of NHS Manchester, to identify a Safeguarding Lead and for the Lead to complete duties according to the Safeguarding Children Toolkit.

2. Ensure all staff are aware who the Safeguarding Lead is and of their own role in respect to Safeguarding Children, Adults including Domestic Violence.

3. Improve record keeping in the practice. Guidelines to be produced to include when to record and when more detail is essential.

4. GP Practice to undertake a Significant Event Analysis (SEA) to enhance learning.

5. Safeguarding Lead to ensure the practice is fully compliant with children and adult including domestic violence safeguarding training.

6. Share findings of the Serious Case Review report with:

NHS Manchester/ Clinical Commissioning Group (CCGs),

Mental Health commissioning colleagues

Child and Adult Safeguarding colleagues

7. Generic competencies in GP Training that relate to risk assessment and management are applied in safeguarding situations and demonstrated to their supervisors

9.1.2 The Housing Provider

1. Introduce steps in procedure to review perpetrator management
2. Introduce steps in procedure to evaluate risk to victim
3. Introduce steps in procedure to make victim aware of crisis points

9.2 The DHR Panel

1. That MSCB and MSAB develop a Domestic Abuse Protocol to promote the referral pathway for victims of domestic abuse, including sexual violence and recommendations on best practice for those who work with perpetrators of domestic abuse including sexual violence. All agencies likely to identify victims and perpetrators of domestic violence, including GP practices and housing associations, should be included.

   The rationale for this recommendation stems from neither the GP or Housing Association had knowledge of the referral pathways following FA 1's disclosure. Sexual violence is included because it was present in this case, albeit unknown to any agency.

2. That all agencies should promote the take up of domestic abuse training for their front line staff to ensure that they recognise risk, [including the significance of bite marks as a possible indicator of sexual abuse] assess risk and respond appropriately to disclosures of domestic abuse. Training should also be offered in how best to work with perpetrators of domestic abuse.

   Bite marks are associated with sexual violence and the GP missed the significance of this injury. Likewise, the increase of risk at the point of separation was not appreciated by the Housing Association or the GP. While MA 1 was not the subject of services to manage his domestic violence, few professionals outside of the National Probation/Prison Service are likely to have the skills to engage effectively with perpetrators and change their behaviour thereby lessening the risk they present.

3. That the Manchester Domestic Abuse Forum should consider a publicity campaign to target family and friends of victims of domestic abuse to direct them to support services and enable them to know how to support those who confide in them.

   FA 1's family and her work colleague/friend knew that she was the victim of DV, and in her family's case, also of rape. Their immediate thoughts were to report MA 1 to the police, but FA 1 forbade them. Had they known about

services for DV victims they might have urged FA 1 to see a specialist DV worker who would have recognised the risk issues

4. That MSAB and MSCB consider whether all employers should have domestic abuse policies.

   FA 1's friend and work colleague's employer did not have a specific policy that provided guidance to staff on what to do if someone you worked with [and in this case supervised] disclosed domestic violence.

END OF REPORT DHR FA 1

November 2012