Safer Lincolnshire Partnership

Domestic Homicide Review

The homicide of Zara

Age 33 years

Died May 2016

Independent Overview Author: Marion Wright

Date: April 2018

DHR – KDCNH/16

1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Zara in May 2016. It examines agency responses and contact with Zara, aged 33 years, her husband Stefan, aged 32 years and their daughter, aged 5 years, at the point of Zara's death. In order to protect the identity of the victim and the perpetrator in line with national guidance the names Zara and Stefan are given as pseudonyms (as the family of the victim have not yet responded to the request to contribute to the review there has not been an opportunity to agree the pseudonyms with them). Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the family or community and whether there were any barriers to accessing support.

1.3 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways 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 upon, and what is expected to change as a result.

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

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure D.A. is identified and responded to effectively at the earliest opportunity.

- Contribute to a better understanding of the nature of domestic violence and abuse and

- Highlight good practice.

1.4 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on the 13th April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being killed by her estranged husband at her home. The Home Office criteria for reviews includes "a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by:

a) A person to whom he or she was related or with whom he or she was or had been in an intimate relationship."

It is recognised that a domestic abuse incident, which results in the death of a victim, is often not a first attack and is likely to have been preceded by psychological, emotional abuse, coercive control and possibly other physical attacks.

1.5 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies for their contribution and for their significant time, openness and commitment.

1.6 DHR 2016H Review Panel Members

Marion Wright	Independent Overview Report Author / Chair
Karen Shooter	Lincolnshire County Council Domestic Abuse Manager
Rick Hatton	Lincolnshire Police
Sarah Norburn	Lincolnshire Police
Roz Cordy	Lincolnshire County Council Children's Services
Elaine Todd	United Lincolnshire Hospital Trust
Claire Tozer	South West Lincolnshire Clinical Commissioning Group
John O'Connor	Lincolnshire County Council, Children's Services (Education)
Barbara Mitchell	Lincolnshire Community Health Service
Donna Brewer	The Borough Council
David Harding	GP Representative
Jane Keenlyside	West Lincolnshire Domestic Abuse Service

Zoe Rodger-Fox	East Midlands Ambulance Service
Pat Armitage	CAFCASS

Panel Support Members.

Toni Geraghty	Legal Services, Lincolnshire Advisor to the Panel
Ben Rush	Panel Administrator, Lincolnshire County Council
Teresa Tennant	Panel Administrator Lincolnshire County Council

1.7 To reinforce the impartiality of this report it is confirmed that the Independent Chair / Independent Overview Author, referred to as The Author, is not employed by any Lincolnshire agency in any other capacity and has not previously had any direct involvement in this case. Neither has she had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair / Author is a retired Assistant Chief Officer of Probation with 33 years' experience. She had strategic lead for Public Protection including Domestic Abuse and had been involved in working with offenders who commit crimes of D.A. both through individual and group work. The Author was responsible for the management of the introduction of MARAC, in 2009, into the area in which she worked. The Author has undertaken many training courses in relation to Domestic Abuse and the pattern of behaviour this involved. The most recent event attended was the Domestic Homicide Review Workshop developed by AAFDA (Advocacy After Fatal Domestic Abuse) and Standing Together in May 2017. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and writing numerous Domestic Homicide Reviews. The Author has had a special interest in Domestic Abuse throughout her career having first undertaken a placement with Erin Pizzey at Chiswick Women's Aid in 1975.

1.8 Both the agency review panel members and the Individual Management Review (IMR) report authors who have provided agency evidence considered by the review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.9 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake a DHR once Stefan was charged with the murder. The Home Office was informed of the likelihood of a DHR following the notification by the Police to the Chair of the Safer Lincolnshire Partnership of the death. The DHR review panel first met on 24th November 2016 where it was confirmed that a DHR would be undertaken and the process was started. However, at that stage, Stefan was denying the charge of murder. Therefore, the proceedings were postponed until March 2017.

1.10 The trial took place in April 2017 and Stefan was convicted of the murder of Zara and was sentenced to 23 years' imprisonment. The Judges sentencing remarks were obtained. They referred to the fact that Zara had suffered a brutal assault resulting in several facial fractures and a traumatic brain injury. Zara was dragged to the bathroom where she was drowned by holding the shower head against her whilst it was emitting water. In an attempt to cover his tracks, to dispose of the body and to ensure that he was not detected as the murderer, Stefan set a fire which could have resulted in further death or injury to others living in the block of flats and who were present at the time. The Judge commented in his sentencing remarks that Zara was plainly caused suffering before death took place." You and she had separated. She had found another man and you were jealous and angry about that and you felt humiliated that man was sent to prison but your wife indicated that she would wait for him. There was also the question of residence of your daughter, whom you both loved dearly, and the question of her residence was something that was subject to court proceedings. Your wife had been acquitted of the charge against her of perverting the course of justice and so she was in a position to offer a home to your daughter and you were plainly concerned about that. You have been found guilty of murder by the jury on compelling evidence and I detect not a shred of remorse in your body".

1.11 The Coroner' Office has been informed of the DHR process and has been notified of the Court result. Following a conviction for murder, unless a family member specifically requests an inquest takes place, the Coroner accepts the verdict of the Crown Court and takes no further action. In this case, no request was made by a family member.

Circumstances that led to the review being undertaken

1.12 Zara lived alone in a first floor flat in Lincolnshire. She was a Latvian national who had settled in Lincolnshire in 2007.

1.13 On a Friday afternoon in May 2016, Lincolnshire Police were informed by Lincolnshire Fire and Rescue that the body of a female had been found in a first floor flat. A workman working outside had alerted the Fire Service that there was a fire in the property. A slow burning fire was discovered on the staircase of the property which had resulted in the flat being covered in a thick layer of black soot. In the bath was the naked body of a female, later identified as Zara. Although she was covered in soot, it was apparent she had suffered head injuries.

1.14 The scene was examined and a pool of blood was found in the lounge. There appeared to be a trail of blood leading from the lounge into the hallway. There was no plug in the bath, however what looked like pieces of toilet roll had been stuffed into the plughole and from the level of the line of soot, it appeared there had been 3 – 4 inches of water in the bath at the time the room filled with smoke.

1.15 A post mortem examination revealed that Zara had significant injuries to her face and to the back of both arms. There was no soot in her airways indicating that she

had died before the bathroom had filled with smoke. The Home Office Pathologist recorded the cause of death to be drowning and blunt force head injuries.

1.16 Zara's estranged husband, Stefan, was initially seen on the day of the murder when he said he had been to Zara's flat the previous night. He stated they had shared a bottle of whiskey after which they were intimate. He said he left the flat around 2 am and walked home.

1.17 Evidence was obtained that conflicted with this account and Stefan was arrested on the suspicion of murder. During the Police interviews, he maintained that when he left Zara she was alive and well. He was released on bail pending further enquiries.

1.18 Four days later, Stefan was rearrested due to additional evidence being available, including CCTV footage and telephone details which showed he did not leave Zara's flat till much later than he had said. He was charged with murder. He continued to deny any involvement in the offence, however, he was convicted by a jury, following a trial, in April 2017. At the time of writing, Stefan had still not accepted responsibility for his offending behaviour.

Scope of the review

1.19 The scope of the review will include information available on Zara the victim, Basia her daughter and Stefan the perpetrator, the victim's estranged husband and father to Basia, between 17th January 2011 and the 20th May 2016. This is the period between agencies first having relevant information and the murder. However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their IMR. As well as the IMRs, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR), whether internal procedures were followed, whether on reflection they were considered adequate, arrived at a conclusion and where necessary, made a recommendation from the agency perspective. Quality assurance was provided for IMR's by individual commissioners, the legal representative for the Panel, the Review Panel and by the Chair and Report Author. The review panel analysed the IMRs for themes and issues which were discussed in a meeting.

Terms of Reference (TOR)

1.20 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed: -

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects? Was the victim's perception of danger canvassed?

d) Did the agency assess the risk they posed to each other in light of the separation (because as we know people are more at risk when they are separating/have separated and there is a loss of children/custody issues)?

e) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

f) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information or patterns of behaviour and whether they were acted upon it?

g) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

h) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

i) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

j) Were any issues of disability, diversity, culture or identity relevant?

k) To consider whether there are training needs arising from this case

l) To consider the management oversight and supervision provided to workers involved

m) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

Methodology

1.21 The Review Panel was convened by the Safer Lincolnshire Partnership (SLP) and included representatives from the relevant agencies and the Independent Chair and Overview Report Author. The Review Panel commissioned a chronology and IMRs from each agency. Family members and friends were contacted to make a contribution.

1.22 A total of five meetings were held with the Review Panel. The first was to consider information available, to agree that a DHR was appropriate and to consider the Terms of Reference. The second was to commission the IMR's. The third meeting was to consider information contained in the IMRs, to identify gaps and to seek further information as appropriate. The third meeting was also attended by the report authors and enabled agencies to present their information and give time for others to ask questions and make comment. The fourth and fifth meeting considered the draft overview report and ensured that it fairly and accurately represented the information of those agencies that contributed.

1.23 In order for agencies to prepare their contribution they were asked to consider contact and practice in providing a service measured against agency policy and procedures and to identify any shortfalls or indeed where current policies or procedures required improvement. Agencies sourced and reviewed a range of information from a variety of systems and interviewed some staff shown to have had direct involvement with Zara and Stefan.

1.24 The agencies completing IMRs and the profile of their involvement with the individuals were as follows: -

Organisation	Author	Involvement
Lincolnshire Police	Steve Bell Regional Review Unit	Responded to telephone calls and visits from the victim and the perpetrator Attended home addresses in response to alleged offences and concerns. Attended the scene of the murder and made an arrest and prosecuted the murder case.
United Lincolnshire Hospitals NHS Trust	Elaine Todd Named Nurse	Provided care for Zara between January 2011 and

	for Safeguarding Children and Young People	November 2013 via three separate attendances to the A and E Department
GP Practice Lincolnshire Clinical Commissioning Group	David Hardy Practice Manager and Practice Deputy Safeguarding Lead at the Medical Centre	Provided GP services and healthcare between 2008 until 2016 for the victim and 2010 to 2016 for the perpetrator and their daughter.
Lincolnshire Community Health Services	Jill Anderson Head of Safeguarding	Provided Health Visiting and School Nurse Service to victim and daughter between November 2010 and May 2016.
Education Services Lincolnshire County Council	Jill Chandar-Nair Inclusion and Attendance Manager Senior Liaison Manager for Education with Children's Services	Provided Pre-School and School Services from September 2014 to May 2016
Lincolnshire County Council Children's Services	Johan Hague Consultant for Lincolnshire County Council Children's Services since 2014	Provided a response to 13 contacts between January 2011 and 2016.
CAFCASS	Helen Abbotts	Provided the Family Court with reports and advice concerning a Child Arrangements Order for court hearings in March and May 2016.

1.25 A summary report was received from West Lincolnshire Domestic Abuse service (WLDAS) in relation to the IDVA Service provided in connection with a Multi-Agency Risk Assessment Conference (MARAC) in August 2011 where Zara was injured. The abusers were her brother-in-law and his brother. WLDAS manages the IDVA Service. The MARAC is organised under the auspices of Lincolnshire County

Council and MARAC information was considered and agreed by Lincolnshire County Council Safer Communities Lead.

1.26 A summary report was received from EMAS who provided ambulance response to the victim on four occasions between 2011and May 2016. There was one telephone response to Stefan.

1.27 A summary report was also received from The Borough Council in relation to Council Tax and two contacts with Stefan in May 2016. Contact was made with the letting agency who rented the property to Stefan. Liaison took place with the Cambridgeshire Prison Intelligence Officer regarding the 5 weeks Zara was remanded in custody at HMP Peterborough in September 2015. However, there is no intelligence regarding Zara making any disclosures regarding suffering Domestic Abuse.

1.28 Children and Family Court Advisory Support Services (CAFCASS) were contacted and a request made via The Family Court Judge to provide disclosure of the private law papers detailing information about their contact with Zara and Stefan. These were provided in August 2017 and an IMR was submitted in November 2017.

1.29 Information was provided by Lincolnshire Fire and Rescue Service. Having been called to the scene of the murder in May 2016, on arrival a female casualty was found to be deceased. The post mortem has since determined it was not a fire related death. In these circumstances, no further involvement was required in the DHR.

1.30 In preparing the Overview Report the following documents were referred to:

1) The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and Revised Guidance 2016.
2) The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Authors.
3) Call an End to Violence Against Women and Girls HM Government published 25th November 2010. Updated 2016.
4) Barriers to Disclosure - Walby and Allen 2004.
5) Incidents of Abuse before Domestic Abuse is reported to the Police - Jaffe 1982
6) Home Office Domestic Homicide Reviews - Common Themes Identified and Lessons Learned November 2013.
7) Women's Watch 2012 – 2013. Special Euro-Barometer by the European Commission.
8) Coercive Control - Professor Evan Stark
9) Agency IMRs and Chronologies.
10) Understanding Risk and Vulnerability in the context D.A. – College of Policing.
11) United Nations Human Rights Information for Latvia and Lithuania.
12) Victim Blaming Gracia 2014.
13) Domestic Homicide review case Analysis. Standing Together. – Nicola Sharp-Jeffs, Jess and Liz Kelly 2016.
14) Domestic Homicide Reviews. Key Findings from Analysis. December 2016.

15) Census Information on the relevant town in Lincolnshire 2011 as reported in The Independent Newspaper.

16) Child First. Nineteen Child Homicides. Women's Aid.

17) Joint Targeted Area Inspections. Domestic Violence Services Should Focus on the Perpetrator.

18) Living in Fear. Stalking and Harassment Thematic Inspection by HMIC and HMCPSI.

19) The Revised Practice Direction12J: Child Arrangements and Contact Order: Domestic Violence and Harm. Article by Marie Crawford barrister at Becket Chambers

1.31 Where confidential information has been detailed in relation to Zara and Stefan, it has been gathered and shared in the public interest and in line with the expectation of the National Guidance for the conduct of DHRs.

Family and Others Contact

1.32 Following contact with family in the UK by the Police Family Liaison Officer to explain about the DHR, the victim's sister and friends were contacted offering them the opportunity to contribute to the review. The Author spoke on the telephone to two of Zara's friends and her sister and agreed to follow up the call with a home visit to discuss matters in person. Despite many telephone calls at different times and different days of the week together with messages left, there was, unfortunately, no further response from any of those contacted. A letter was sent to Zara's sister but again there was no response. Had family and friends been involved it would have added richness and detail to the understanding of Zara's experiences and her life. Once the draft Overview Report was completed, her sister was contacted again to offer her the opportunity to consider the Overview Report and comment on the content prior to publication again there was no response to the calls made and letter sent. Zara`s parents live in Latvia, they are elderly and it was advised that there should not be direct contact with them but only via Zara`s sister which has not been possible as referenced above.

1.33 The Author contacted Stefan's Offender Supervisor in the prison to explain to him the process and purpose of the DHR and to ask him to discuss it with Stefan. This was followed by a letter to both Stefan and the Offender Supervisor to offer and encourage involvement in the DHR process. There was no response from Stefan. Further contact with the Offender Supervisor confirmed that Stefan had received the letter but had indicated that he did not wish to engage with the DHR process.

Basia's Perspective

1.34 There was an acrimonious dispute between the parents about the care and custody of Basia their daughter. Prior to the homicide, Basia's views were canvassed by the School and by CAFCASS. She was seen, by the School staff, to have a close relationship with her father and indicated to both agencies that she wanted to stay with him rather than her mother. She intimated that she did not feel safe with her mother and was scared of her mother's new boyfriend. She said she was happy

with her father and wanted to live with him. Whether this response was influenced by the time she spent with her father whilst her mother was in custody and his attitude towards her mother is not fully known. Prior to the breakdown of the marriage the HV recorded that Basia was seen to have a close relationship with her mother and her mother was considered to be an attentive appropriate parent. It was the view expressed by Zara to CAFCASS that Stefan was manipulating their daughter's thinking to ensure he obtained custody. Basia has indicated that she misses her mother and understands, to some degree, that her father is responsible for her mother's death. Basia has written to her father to ask for an explanation of why he hurt her mother. At the time of writing, Stefan had not responded to that specific issue. He does write to Basia but at the moment she is said to be very angry with him.

1.35 Contact was made with Basia's Social Worker to ask her to explain to Basia about this review in an age appropriate way and to explore whether she would like her thoughts represented in the review. Basia does not talk a great deal about her experiences and her loss at this stage. Understandably, she is concerned with her immediate future and whether that is to be in Latvia or in the UK. She is keen to stay in the UK.

1.36 Basia has referred to witnessing her father hitting her mother with a chair. In terms of the review, she "wants to make sure that nobody else's Daddy kills their Mummy". Despite her age, this would indicate a level of understanding of the main purpose of this review and a desire to protect others from the experiences that she has suffered.

1.37 The Author has discussed with the Social Worker the importance of a copy of the review, when it is published, going into Basia's file for future reference. It is hoped that when older, if she wished, Basia could have access to the report and to understand that that those professionals who had contact with her parents, explored their contact from every angle to try and learn for the future how to better to protect people like her mummy and herself.

1.38 Subjects included in the scope of the DHR: -

Victim - Zara – Estranged wife of the perpetrator.

Perpetrator - Stefan – Estranged husband of the victim.

Basia - Daughter of the victim and perpetrator.

2 Background Circumstances of the Case

2.1 Information suggests that Zara and Stefan met in Lincolnshire in 2008. Both had come to the UK to find work and improve their life opportunities. Zara was from Latvia and Stefan was from Lithuania. These two countries are neighbouring Baltic States. There is a significant Eastern European Community in Lincolnshire to which they belonged.

2.2 Zara's sister and family also live in Lincolnshire and it is reported that they were very close and supportive of each other. Zara's parents continue to live in Latvia and

Stefan's mother resides in his home country of Lithuania. His father is no longer alive.

2.3 The couple married in 2010 and their daughter, who was their only child, was born in November 2010. The couple both worked in the food industry, Zara in fruit and vegetable packing and Stefan in a bakery. The couple lived in privately rented property in Lincolnshire, moving on two or three occasions to other houses in the same vicinity.

2.4 The couple first came to the attention of agencies for a safeguarding concern in January 2011 when Zara had called an ambulance. She was distressed. The baby was seven weeks old and Zara referred to her crying a lot and that she was short of sleep. The baby had woken Stefan and this caused an argument and there was physical contact between the adults which involved pushing. The hospital observed appropriate parenting by Zara.

2.5 Zara went to stay with her sister but the couple quickly reunited. They were seen by a Health Visitor, the next day, when all was reported to be well.

2.6 There was an incident, in July 2011, where Zara had minor injuries following her brother-in law smashing a window. There was a Multi-Agency Risk Assessment Conference (MARAC) in August 2011, due to a high risk assessment of Domestic Abuse (D.A.) by the Police. However, there was no ongoing contact as Zara did not wish for involvement.

2.7 There was nothing of further significance known until May 2015, when Zara reported to her General Practitioner (GP) that she was in a new relationship. Following this disclosure, there was concern raised by Stefan via the child's Pre School, Children's Services and the Police, relating to Zara's new boyfriend, her alcohol use and her care of Basia. Basia was living with Zara at this time. In the main, this concern was considered to be malicious and without supporting evidence. The couple had separated and it was acrimonious.

2.8 In September 2015, two males were seriously assaulted. Zara's boyfriend was one of the individuals arrested and later convicted of the assault. A few days later, Zara, herself, was arrested and remanded in custody charged with perverting the course of justice in that she assisted the offenders. She was remanded in custody for five weeks. She was acquitted of the charges in May 2016. Her remand in custody meant that her daughter went to live with her father, Zara's estranged husband. On her release on bail, Stefan would not let Zara have custody or contact with their daughter.

2.9 The school were concerned for Basia's well-being, given the conflict between the parents, and there were various communications between the School, Children's Services and the Police. There were allegations and counter allegations by the couple about the quality of care for Basia.

2.10 During April and early May 2016, Zara made five calls to the Police complaining of alleged offences including theft, criminal damage and of stalking and harassment

she thought had been committed by Stefan. She disclosed he had been violent, previously, and she was afraid of him. There were no charges brought. He was spoken to by the Police on one occasion.

2.11 Zara had initiated proceedings via the Family Court to resolve the conflict over care and custody of their child. There was a Court hearing seven days before Zara was murdered, with custody granted to the father and indirect contact by Zara. She had been acquitted of all criminal charges four days before.

2.12 The following week a workman reported a fire at a multi-occupancy block of flats. The Ambulance and the Police were called. Zara's body was found in the bath. Stefan reported that he had been with her the night before, (this was his birthday), but he insisted he had left her safe and well. Discrepancies in his reporting of events were found. He was charged and, following trial, was convicted of Zara's murder, in April 2017, and sentenced to 23 years' imprisonment.

Victim Information

2.13 Zara was born and brought up in Latvia, one of her parents two daughters. She moved to the United Kingdom, as did her sister, in 2007. There is reference to her going back to Latvia for holidays, to visit her parents and taking her daughter with her.

2.14 According to her work manager she was a hard worker and was in regular employment in the fruit and vegetable packing industry. The manager for the agency for whom she worked recalls her being reliable and friendly. She had lots of friends and was popular. He was aware of the conflict over the custody of Basia but was not aware of any D.A. It is reported that Zara spoke reasonable English and did not require an interpreter.

2.15 Child Health Visiting records indicate Zara was a good mother. She sought advice, when appropriate, concerning her daughter's development and acted upon that advice. Health Visiting witnessed a positive mother child relationship and there were no direct concerns regarding her care. Following allegations, by Stefan, of Zara drinking and beinginappropriately intimate in front of the child, Basia was put on the school' s vulnerable child register. This meant the school paid extra attention to her development and well-being. There was never any evidence that the allegations, made by Stefan were true but are likely to have been said to discredit Zara and increase the likelihood of him gaining custody of his daughter.

2.16 Whilst Zara never sought advice or support from D.A. Support Services, her friends refer to knowing that there were difficulties in the relationship and that Stefan could be "crazy". They felt that Zara went to the Police for help when she reported the five alleged offences of theft, criminal damage, stalking and harassment and they felt the Police ignored her and let her down. She allegedly asked some friends to try and capture Stefan's negative behaviour on their mobile phone cameras so that she would have some evidence to give to the Police so they would believe her and take action.

2.17 In terms of Zara's experiences before she came to the UK, it is likely life would have been difficult especially as a woman. Latvia was occupied by the Soviet Union between 1940 and 1991 and has suffered transitional difficulties since then. Many gender equality laws remain unimplemented. According to a survey undertaken by the European Commission, most Latvians think women should be housewives, take care of the children and do the shopping. Men are the breadwinners. There are no shelters for women victims of violence, coupled with widespread tolerance for Domestic offences. Many women suffer violence in the family and seek neither legal or social assistance. They prefer not to speak about it. There is general distrust by the public towards law enforcement institutions in Latvia, with the majority unwilling to report matters feeling no action would be taken. However, Zara did spend almost ten years in the UK before her death and was therefore exposed to a different culture. Whilst she continued to live in an Eastern European immigrant community, she did take the brave step of going to the Police for help in relation to Stefan's behaviour.

Perpetrator Information

2.18 Stefan came to England in 2008. His mother continues to live in Lithuania, his father is deceased. There is very little information held regarding Stefan.

2.19 He worked nights in a bakery near to his home. However, at the time of the murder, he was unemployed. Zara told CAFCASS that Stefan lost his job due to his heavy alcohol use but this was unsubstantiated.

2.20 After the relationship with Zara broke down, he lived independently, and shared his home with three other people who originated from Lithuania. Despite Stefan having informed agencies that he had employed the services of a childminder to care for Basia at night, information available to the panel during the review was that the people that he lived with cared for the child. Just days prior to the incident of 20th May 2016, Stefan visited the Borough Council to say he was in rent arears at the privately rented home where he lived and he said he feared he would be evicted and made homeless. In terms of him keeping sole custody of his daughter, this must have been a huge concern for him, given that his estranged wife had a stable home, was working, and had now been acquitted of the criminal charges that had been hanging over her.

2.21 Lithuania, Stefan's country of birth, had a higher rate of D.A. in comparison to other European countries. During a survey in 2010 for the Eurobarometer organised by the European Commission to gather information, 86% of respondents agreed that the "provocative behaviour of women" was the cause of violence against women. This was the highest percentage of victim blaming of all the European countries surveyed and significantly higher that the European average of 52%. 48% of Lithuanians surveyed knew people who had been abused.

2.22 It is not known what views Stefan held about this issue and the information included is to give a flavour of what experiences may have influenced his attitudes.

3 Chronology

3.1 The Chronology of agency contact with Zara and Stefan is attached at Appendix A.

3.2 The chronology of contact and services provided spans a six-year period, covering the length of time from the first identification of any concerns about this family. This was in January 2011, when Zara was distressed following an argument with and pushing by Stefan. There was some limited contact, later, in 2011 and then no relevant information from agencies until the breakup of the marriage in the summer of 2015. Following this there is information from Education, Children's Services and the Police. Other than the referral to MARAC relating to an incident involving family members and not Stefan in 2011, there was no contact with D.A. agencies.

Synopsis of Significant Events

A synopsis of critical events is attached at Appendix B.

4 Individual Management Reviews

Agency Overview and Analysis

4.1 East Midlands Ambulance Service (EMAS)

The Summary Report was prepared following address checks of the various properties where the family members lived. There was a review of the services provided to the named individuals using a variety of service records and information systems.

4.1.1 From January 2011, EMAS recorded four contacts in relation to Zara and one in relation to Stefan and none relating to Basia. Three of Zara's contacts are relevant for the purpose of this review. The fourth was for a non-related illness. The one call in relation to Stefan was relevant.

4.1.2 In January 2011, there was a 999 call from Zara who reported she was going "mad". On arrival, she informed the ambulance crew that she had a seven-week old

baby who had cried and woken up her partner, the father of the baby. She reported this had started an argument between them and physical contact in the form of pushing took place. No injuries were recorded and she was conveyed to hospital.

4.1.3 In July 2011, EMAS received a 999 call reporting Zara had a facial injury. Her sister's estranged husband had smashed a window nearby and she was injured by some glass. The wound did not require transportation to hospital.

4.1.4 In October 2011, Stefan rang EMAS and reported he had been assaulted by his wife, alleging she had hit him on the head with a champagne bottle and that he had a headache. Despite attempts to contact him by the clinical assessment team this was unsuccessful. Police were notified and later confirmed he did not require an ambulance.

4.1.5 On analysing the responses of EMAS to these events, it is recognised with the benefit of hindsight, that in the first case there should have been a safeguarding referral to support Zara and to assess whether the baby was at risk. On the second occasion, there was no evidence of professional curiosity being exercised in discussing the reported D.A. and whether Zara would have consented to signposting for advice and support in. In terms of the call relating to Stefan, a DV referral was not activated. These were missed opportunities to refer on to other agencies. On both occasions involving Zara, there was a male at the property. However, the crew did not record the actual name of the male at the scene. There has been significant work within EMAS to improve practice in relation to the Domestic Violence agenda.

4.1.6 The last contact with EMAS was in May 2016, when assistance was requested by the Fire Service to provide support at a home fire where it was reported that a person was present. When EMAS arrived at the scene, it was recognised that "life was extinct" and EMAS had minimal intervention in order to help preserve the crime scene.

4.1.7 It is recognised that the first Domestic Violence and Abuse Policy was ratified in 2012 and was rolled out during safeguarding training to all frontline staff during 2012 – 2013. This was after the D.A. incident identified in this review in 2011 took place.

4.2 <u>United Lincolnshire Hospitals NHS Trust (ULHT)</u>

In preparing the IMR, the medical notes for Zara and Basia were sourced and analysed. ULHT holds no records in relation to Stefan. No medical staff were

interviewed as part of the process as documentation reviewed by the Author offered the level of clarity required to understand the extent of their involvement.

4.2.1 Within the scoping period, Zara's and Basia's association with ULHT was via three separate attendances, each to the A&E department. Two relating to Zara were for non- relevant medical issues.

4.2.2 Records indicate that, in January 2011, both Zara (and Basia, who was 7 weeks old), attended A&E via an ambulance, in a distressed state. Zara reported having "domestic problems" and that Stefan had pushed her. Zara said Stefan had called an ambulance as he thought that Zara had taken an overdose. Zara denied she had taken an overdose. This is different information from that which EMAS had recorded about who made the telephone call to the ambulance service. EMAS refers to it being Zara who called for the ambulance. However, she did report that she was exhausted, having not slept for days due to her baby crying and feeding at night. Zara disclosed financial issues in that she was on maternity leave and her partner was not contributing to household bills. A&E contacted the family GP who was unavailable due to being busy with a patient at the time. Liaison with Children's Social Care was undertaken and a Common Assessment Framework (CAF) referral was completed in order to initiate support for Zara and Basia. Safety planning was discussed with Zara, she reported that she intended to stay with her sister for additional support. The HV made contact the following day as a result of the CAF.

4.2.3 Basia's second attendance was on 24th December 2011, due to her being described as generally unwell. The booking did not progress to assessment due to the family leaving before Basia was seen by nursing and medical staff. A lack of access to available documentation prevented the IMR author from clarifying with whom Basia attended and the reason for the failure to wait.

4.2.4 On the 19th December 2012, Basia attended an outpatient eye clinic. An operation was scheduled but the condition resolved itself and the procedure was no longer required. Basia was discharged back into the care of her GP with evidence of a letter to the GP confirming this.

4.2.5 At the January 2011 contact, there were no concerns relating to Zara's capacity to care for Basia. Stefan was not present and therefore, staff were not able to assess his capacity to care for Basia.

4.2.6 Staff responded well to this incident and recognised possible indicators of compromised parenting capacity and documented interaction between mother and baby. At this period of time D.A. processes were not fully embedded and practised within the Trust and there was no standalone D.A. policy and protocols. However, staff did recognise both Zara's and Basia's vulnerabilities and initiated support via

liaison with Social Care via a CAF referral and via Health Visitors. All members of ULHT staff are now required to undertake training in relation to the identification and management of D.A. disclosures. Consequently, should patients attend in similar circumstances today, there would be an expectation that such attendances would be managed in accordance with these processes.

4.2.7 Apart from Zara's January 2011 attendance, Trust documentation provides little insight into her relationship with Stefan. During all but one attendance, she attended alone but reported Stefan as her next of kin.

4.2.8 Interrogation of the ULHT system suggests that in March 2014, a referral was received from Stefan's GP requesting an Orthopaedic review. The referral did not progress to an appointment as a referral was considered inappropriate and declined. The GP was informed accordingly.

4.2.9 Documentation suggests the family's native language was Russian. There was no evidence to suggest that their understanding of English was such that staff members were required to use interpreter services to support their consultations and assessments.

4.3 Lincolnshire Community Health Services (LCHS)

In order to prepare this IMR, the Author reviewed electronic health visiting and school nurse records held in respect of Basia and Zara. A contact in an out of hours setting was also recorded in relation to Zara and the electronic records in relation to this were also sourced and reviewed. An interview took place with the named Health Visitor for the scope period.

4.3.1 On the 17th January 2011, the Health Visitor (HV) was notified by a staff nurse in A&E that Zara had attended with her daughter and concerns were that Stefan had been aggressive. The HV made an appointment to see Zara at her sister's on 24th January 2011. However, this meeting did not take place as Zara, Stefan and their daughter attended the Child Health Clinic at the GP's Surgery the following day on the 18th January 2011. The HV asked the couple about arguments within the family home. The incident was dismissed by the couple as a disagreement. The couple appeared happy and affectionate with each other, which was a consistent presentation, and there had been no previous indicators of D.A. within their relationship. The HV did not arrange a follow up meeting with Zara independently as the couple stated they wished to come to the clinic with their daughter. She did not explore, further, the D.A. reported nor did she provide any information regarding support services, she considered that this was inappropriate as Stefan was present and to discuss D.A. may have increased risk to Zara. This was recognised as a missed opportunity to explore further the allegation of D.A. and make an

assessment and consider risk management and safety strategies and signposting on to support services.

4.3.2 In discussion with the IMR author, the HV identified the changes in her practice in the six years since 2011. Now, she would always attempt to see the victim independently to assess the risks, complete a DASH risk assessment and provide additional advice and support. This in line with the policy changes and is now reflected in all routine practice.

4.3.3 There were a further eleven clinic contacts between the HV team and the family from 19th January 2011 and 23rd August 2011. There were no further disclosures of D.A. and no concerns were identified.

4.3.4 On the 5th September 2011, the HV received notification that Zara had been identified as a victim of D.A. within a MARAC meeting held on 23rd August 2011. The incident involved her brother-in –law smashing a window and some of the broken glass cut Zara's eye and face. The HV undertook a home visit to see the couple, where it was explained who the perpetrators were and that it did not involve Stefan. Zara had been concerned that the men may return and cause more harm. The HV, appropriately, contacted the Lead Nurse Domestic Abuse LCHS and the Deputy Named Nurse for Safeguarding LCHS to query this information. The HV had also received information that Basia was subject to a Team Around the Child (TAC) plan. This was checked and found to be incorrect. In response to this information and the concerns it raised, the HV arranged a targeted two-year developmental assessment for Basia which would be done face to face rather than by questionnaire. This was good practice. The assessment was completed in February 2013 when good interaction between Basia and her parents was observed. The 0-19 team had regular contact with the family over and above that offered within the universal core service as parents utilised the community clinic regularly. There was no evidence to suggest ongoing D.A. and there were no further concerns.

4.3.5 Basia's case was transferred to the School Nurse on the 24th July 2015 which is routine practice prior to a child commencing school in the following September. The HV, appropriately shared the concerns regarding the two known incidents of D.A. in 2011. This is good practice.

4.3.6 Although English was not the family's first language, their English was good and there was no need for an interpreter during contacts. They engaged well and there was regular contact with the family over and above that offered within the Universal service, as the parents utilised the community clinic regularly and constructively.

4.4 General Practice

To prepare the IMR, Zara's, Stefan's and Basia's medical records were scrutinised and the case was discussed at one of the Clinical Management Meetings to see if any of the staff who treated any of the family members could remember anything that they did not record in the medical records. All three family members were registered at the same practice and were seen by different practice staff for a range of routine illnesses and conditions.

4.4.1 Zara was registered at the General Practice from 13th August 2008 until she died. She was seen by members of the practice clinical staff forty-four times. This would appear average for her age and the length of time registered.

4.4.2 According to her medical notes, Zara did not identify suffering any D.A.to the surgery. There were entries in her daughter's records of the visit to hospital on 17th January 2011 where Zara alleged D.A. There had been an argument and pushing and as a result a referral to CAF and the HV Service was made. The follow up visit, the day after, was recorded indicating that there were no ongoing concerns. There was no specific letter regarding this incident recorded on Zara's GP medical record as at that time if a letter from A and E was received administrative staff entered the basic information only into the medical records. In this case, it was written "acute stress reaction - victim of domestic violence".

4.4.3 There was also an entry in the record by the HV who had seen Zara, Stefan and Basia following the MARAC in September 2011. "Both state they have a strong relationship. The D.A. incident related to her sister and no D.A. reported within the family home". No further action was felt appropriate.

4.4.4 In May 2015, she told the GP she had a new partner and in January 2016 she requested a blood test to check for drug abuse as she was in a "tug of war" with her ex-partner to see her daughter. She said that she had equal parenting share but her ex-partner was unwilling to let her see her daughter unless she could prove she had not taken drugs. The GP explained that there were no clinical grounds to do the test if she had not taken drugs. She was advised to attend the Drug and Alcohol Rehabilitation Service. She attended but they also refused to do the test. She was advised to see a Solicitor.

4.4.5 With hindsight, the Practice recognised that a visit from Zara to the Practice, in May 2015, may have been suspicious. Zara had reported that she had tripped over the cat and fell down the stairs, two weeks previously, and had back and knee pain. Zara attended with a friend who acted as a translator which is in contrast to her contact with other agencies where it was said she did not require a translator at the time, there was no reason to disbelieve her explanation and she was treated for her

symptoms and no further action was taken. As a result of this review, and recognising that they could not identify who had attended with Zara, the Practice have decided in future to make a note of who is attending with each patient.

4.4.6 Where there has been D.A. concerns in the past and a patient attends with an injury, albeit with a non D.A. explanation, it would be good practice for the clinician to use professional curiosity to explore whether the individual feels safe in their relationship at home or considers themselves at risk in any way.

4.47 The General Practice have developed monthly safeguarding meetings which helps all clinical staff to be aware of ongoing cases of concern. Any new cases are introduced at the next meeting. If a case requires immediate attention of staff, the Practice Manager will task all staff so that they are aware of the issues. This is considered to be good practice.

4.5 <u>West Lincolnshire Domestic Abuse Service (WLDAS).</u>

To prepare the summary report for the DHR, the author from WLDAS accessed the MODUS system which is a multi-agency electronic system developed for use by agencies involved in dealing with D.A. survivors, children and alleged perpetrators. The system is government approved and is used across the UK by Domestic Violence Agencies, Local and Regional Councils and the Probation Service. The documentation in relation to the case where Zara was recorded as a high risk victim was analysed. WLDAS manage the IDVA Service, the responsibility for the development of the MARAC lies with Lincolnshire County Council.

4.5.1 The case was submitted by the Lincolnshire Police Domestic Abuse Officer as a MARAC referral. The perpetrators were her brother-in –law and his brother. Zara had been present at the incident on the 30th July 2011 that was reported to the Police. There was a DASH risk assessment for the other victim of the incident but no separate DASH assessment linked to Zara and although there were separate MARAC referrals for her and the other victim, the information was the same on each referral. Where there are multiple victims each is treated individually with separate risk assessments. Zara's was not the primary victim but considered to be the secondary victim.

4.5.2 The Independent Domestic Violence Advisor Service (IDVA), managed by WLDAS, liaised with the Police officer submitting the case to MARAC. The IDVA had, on two separate occasions prior to the case being heard, left messages on Zara's phone. (The meeting is a regular twice monthly meeting to share information regarding D.A. cases which have been identified as high risk. The main aim of the MARAC is to reduce the risk of serious harm or homicide and to increase the safety, health and well-being of the victims, including adults and their children). There had been no

response from the messages and it was reported that there had been no direct intervention with either Zara or the other victim. Subsequently, as the main risk was considered to be to the other victim, this case was closed by The IDVA Service due to disengagement of the client and therefore, there was no opportunity to facilitate a joint meeting between the Police and Zara. This was in line with procedure at the time.

4.5.3 Whilst the IDVA Service did not make contact, there was information sharing between the Police, Probation, IDVA and Health Visiting in respect of managing the risk presented to Zara as she did not wish to engage with IDVA. The risk management in relation to the other victim was pursued but is not relevant to this review. To follow up the concerns, the Health Visitor, as the trusted professional, visited Zara's home address and interviewed both Zara and Stefan together. Stefan assured the HV that neither of the named perpetrators were welcome at his home. Stefan had not been involved in any way in the incident. In order to ensure there was future further assessment, the HV arranged a targeted two-year development review for Basia which involved face to face contact. This was undertaken in February 2013.

4.5.4 It is now expected practice that a separate MARAC referral and a separate DASH are required for each individual case referred to MARAC even if it reflects a similar incident. If the victims do not respond to contact from the IDVA, they will make every effort to work with the referring agency to explore avenues to reduce risk. The IDVA will update the victim after MARAC with any actions and safety plans unless there is a better suited agency involved at the time.

4.5.6 The other victim was considered the target in this incident. There was ongoing work undertaken in line with appropriate safety planning to protect her and her children. As Zara was supported by Stefan and did not continue to consider herself at risk, there was no ongoing action other than the follow up by the HV which appears appropriate in the circumstances.

4.6 <u>Education</u>

The information for the IMR was gathered through e-mails, telephone and face to face meetings between the IMR Author, The Head Teacher, the Interim Head Teacher, the School Designated Safeguarding Lead and the Head of School. All school records were available at the meeting. As Basia had been placed on the school's vulnerable child register from September 2015 until November 2015 there was a detailed summary of events and actions. There was no involvement with the Education Welfare Service or the School Nurse other than for routine checks (height, weight and hearing).

4.6.1 Basia attended pre-school from 2nd September 2014 until 17thJuly 2015. She attended eighteen hours a week in line with her early year's entitlement. She started at the linked Primary School on the 2nd September 2015. Both pre-school and school understood that the parents were separated and that, initially, Basia was living with her mother. Prior to 15th September 2015, Basia was brought to pre-school and school by her mother or her father. This changed to her being brought by her father when Zara was remanded in custody on 15th September 2015.

4.6.2 There were three safeguarding referrals made, one by pre-school and two by school. The first by pre-school was in relation to an incident on 4th June 2015. Zara had been phoned by pre-school as her father had turned up to see Basia. Zara attended the pre-school and the couple went outside. Raised voices were heard which lasted about 15 minutes, afterwards they both left and the child stayed at pre-school.

4.6.3 The second safeguarding referral was made by primary school on 15th September 2015 due to a number of concerns including, witnessing a disagreement between the parents the day before, knowledge that the mother had been arrested for involvement in a serious violent crime, Basia's alleged fear of Zara's new boyfriend, the inability to contact the mother (she had been remanded in custody that day) and erratic arrangements for collecting Basia from school.

4.6.4 The third safeguarding referral, also made by the primary school, was on the 5th November 2015, when Zara went to school to collect her daughter. Zara had been in custody from 15th September 2015 and was released on 22nd October 2015. The school were concerned that Basia had not seen her mother since she was arrested. They contacted the father who arrived and the parents left together. There were no specific concerns regarding the interaction between the parents.

4.6.5 None of the safeguarding referrals met the criteria for Social Care intervention but resulted in both pre-school and school putting actions in place to ensure Basia's safety. These actions included an Early Help Assessment (EHA) and safe and well checks conducted by the school and Police. The EHA reported that Stefan had sought advice from a Solicitor and he was going to apply for urgent custody rights should Zara be released from custody. The school witnessed a positive relationship and special bond between Stefan and his daughter and she had told the school she was happy staying with her father.

4.6.6 Stefan informed the assessment that he was worried that Basia had witnessed aggression and inappropriate behaviour from adults who were under the influence of drugs and alcohol whilst in the care of her mother. Also, her father reported she had displayed behaviour which indicated she had witnessed her mother and her boyfriend having an intimate relationship. There was no evidence that the child was displaying any behaviour that wasn't in line with her age and development reported

by the school. A plan was agreed with the father regarding actions he needed to take including seeking legal advice and ensuring Basia attended school regularly.

4.6.7 Basia was put on the vulnerable children's register at school on the 4th September 2015, due to the concerns the father had raised. The child also stated she did not feel safe with her mother. The Vulnerable Children's Register is specific to this School and relates to its local safeguarding practice. Parents are informed that the child is on the register.

4.6.8 There were times when the school advised Zara to seek advice from Children's Services and a Solicitor when she expressed concerns over how her daughter was being cared for when staying with her father.

4.6.9 The pre-school and school both recognised that the parents did not have a good relationship and that both had concerns about how their daughter was cared for by the other, with allegations and counter allegations of substance misuse and inappropriate behaviour. As time went on, they were aware that the parents were in dispute over the custody of their daughter. However, they did not witness anything between the parents or from what the child said, that indicated that it was an abusive relationship. The arguments the school witnessed were said to be heated but not abusive. Zara did not indicate verbally or through her behaviour that she felt in danger and was not perceived as a victim. It was understood that the parents had little or no communication.

4.6.10 When the school did not have a full picture of the situation, they exercised professional curiosity. This included contacting the Police at the point when Zara had been arrested to enquire about living arrangements for Basia and again when Zara was released from custody. Zara had asked school to keep her informed of Basia's progress. It was agreed that they would contact her at certain points. However, during a telephone contact in December 2015, the staff felt her response was inappropriate and this process was stopped. Zara's use of English language was not as proficient as Stefan's which may have led to some misinterpretation.

4.6.11 The school shared information, as appropriate, with Children's Social Care and the Police and were tenacious in ensuring their part in the safety and well-being of Basia. They demonstrated a holistic approach to the needs of the family by offering Early Help Assessment and advice to both parents, at different times, regarding their expressed concerns.

4.7 <u>Lincolnshire County Council Children's Services (CSC)</u>

The IMR Author accessed the electronic care file, had conversations with the Social Worker and the Team Around the Child (TAC) advisor in order to prepare the IMR.

4.7.1 There were a total of thirteen contacts recorded on the case file. The first was in January 2011, when Zara attended the hospital after what she reported was a verbal altercation with Stefan and allegations of pushing. Zara was said to look very down. The HV was informed and Zara was seen and was going to keep herself safe by staying with her sister. A CAF was completed and it was recognised that the HV could convene a Team Around the Child (TAC) if concerned. In the circumstance, the Children's Services outcome was "no further action indicated".

4.7.2 The next contact was over four years later on 4th June 2015, when Stefan called Children's Services to advise that he had concerns about his daughter as he and her mother had split up a few weeks previously. There were a number of allegations made about the care mother was giving. Also that Zara was taking drugs and had mental health issues and that her boyfriend had a history of offending in Lithuania. The outcome was that as there was no substantiation for the allegations. The issues had only come to light after the couple separated, and as there had been no concerns known to HV or Children's Services since 2011, Stefan was given advice and guidance about obtaining legal advice and seeking support.

4.7.3 There was a contact from the pre-school on the same day which reflected the same concerns, Stefan informed Children's Services he had been to the pre-school and shared the same information. A decision was made to request the pre-school centre to complete an EHA and if relevant proceed to a TAC. Due to lack of engagement by either parent the EHA was not completed on this occasion and therefore did not proceed to a TAC. The EHA is a voluntary intervention and can only proceed with parent's consent.

4.7.4 On the 11th June 2015, a contact was received from the Police notifying Children's Services of a D.A. incident that took place on the 10th June 2015. The incident was said to be verbal, that Basia was present at the incident and was seen by an attending Police Officer. The incident was assessed as a standard risk and police had no concerns Lincolnshire Children's Services (LCS) in the joint protocol with Lincolnshire Police on managing D.A. identification and referrals where children are involved or resident in the household, advises that notification of incidents will be taken as information only until there are three such notifications in a rolling year or there are other referrals. As such the response was considered appropriate by the IMR Author.

4.7.5 A contact was received by Children's Social Care (CSC) on the 15th September 2015 from the primary school. On the 4th September 2015, Stefan had informed the school that the child lived part time with both parents. He advised them of a range of concerns he had about the mother's care of their daughter including that Zara could be aggressive towards her daughter and that Basia was afraid of Zara's new

boyfriend. School had tried to arrange an after school meeting with Zara but she had not turned up. The father informed the school that he thought she had been arrested along with her boyfriend. The father stated that it was his intention to keep Basia with him from then onwards. School confirmed they had no concerns and the child had not made any disclosures. As there was no evidence from the detail given that the new boyfriend presented a risk, it was suggested the school plan a home visit to the mother. Whilst this did not meet the threshold for a CSC assessment, the School were advised EH Services may offer help and support.

4.7.6 On the 18th September 2015, a referral was received from the Police Central Referral Unit (CRU) that Stefan had visited the Police Station in relation to concerns about the safety of himself and his daughter following the arrest of Zara for a serious offence. He repeated some of the previous allegations about Zara being involved with drugs and inappropriate in front of Basia. Stefan advised he was seeking custody of his daughter through the courts and identified he may need help with parenting. The Police also advised CSC that Zara was in a relationship with a violent offender who had been charged with attempted murder. Zara's brother-in-law was also charged with involvement in the crime.

4.7.7 CSC sent information through to the Early Help Team to ask them to contact the father to discuss what help and support was needed. There were felt to be no risks to Basia as her mother was remanded in custody. Police were requested to notify and re refer if the mother was released on bail.

4.7.8 On the 24th September 2015, the school contacted CSC as they were aware the mother was in custody and was one of the people arrested in connection with an attempted murder. The school were unsure what other support they could provide and had been in contact with the Police for guidance. The school were informed, if the mother was released on bail and attempted to take Basia. CSC were to be notified to consider if there was a role for them.

4.7.9 On the 28th September 2015, information was sent to the school to request support via an EHA and that an arrangement had been made with Stefan to discuss this. The EHA was completed on the 2nd October 2015 with an agreement to proceed to TAC. An initial TAC meeting was arranged for 16th October 2015.

4.7.10 According to CSC, the TAC appeared to be in existence between 2nd October 2015 and 5th May 2016. However, this was not the case. When a D.A. incident occurred on the 10th May 2016 and information was sent to the lead practitioner at school, the school sent a response advising that, although an EHA was completed, Stefan felt, at the time, support via TAC was not necessary and therefore Basia was not open to TAC. School advised that they monitored for Basia`s wellbeing.

4.7.11 On the 5th November 2015, the school made a second safeguarding referral, as Zara had been released on bail and turned up at school asking to take her daughter. Counter allegations were made about Stefan using alcohol and she was being refused contact with her daughter by Stefan. Stefan was informed about Zara's attendance and went to the school. He said the Police had visited the night before as Basia had not been in school. He had thought they had been asked to attend by school but it was by Zara's request. The School were recommended to tell the father to seek legal advice. CSC did not consider that this case met the threshold for CSC involvement. It was noted that there was a TAC in place, which was incorrect, but no notification had been sent to confirm that a TAC had not taken place.

4.7.12 On the 8th February 2016, a request for information was made by CAFCASS which was provided.

4.7.13 On the 5th May 2016, a contact was received from the Police informing of a D.A. incident on the 2nd May 2016. The incident was reported as verbal and that Basia was not present. CSC were still under the impression that Basia was open to TAC and subsequently, notified the lead practitioner at school of the D.A. incident. It was later learnt that the information about TAC being open was misleading and that the TAC was never undertaken and was closed after the EHA in October 2015.

4.7.14 On the 21st May 2016, the Police contacted CSC and informed them about the death of a female which was later confirmed as Zara. Stefan was being interviewed as a suspect and the Police were using Police Powers to Protect to request a foster placement which was provided that night.

4.7.15 Although there were a number of contacts from pre-school, school, Stefan, concerns expressed by Zara, and the Police, including two D.A. notifications and three CSC referrals, CSC did not consider the concerns, met the threshold for a CSC assessment, but advised that support be offered through an early help assessment and team around the child.

4.7.16 The CSC recording system still recorded that there was a TAC open from October 2015 to May 2016. This was not clarified by the School when they made a CSC referral on the 5th November 2015 seeking advice and support.

4.8 <u>Lincolnshire Police</u>

The East Midlands Special Operations Regional Review Unit undertook the IMR on behalf of Lincolnshire Police. Research was undertaken on the Police National

Computer, the Police National Database Niche Crime Recording System, NSPSIS, Command and Control System, Genie, the Intelligence Search Engine, CATS, the Care Administration and Tracking System (which is a database for child protection, adult abuse and high risk Domestic Abuse matters) VISOR, the Violent and Sex Offenders Register. The reviewing officer has reviewed all the records that feature the subjects of this review and included details of all those of a D.A. nature on the chronology of agency involvement.

4.8.1 On the 17th January 2011, EMAS called requesting Police attendance, as a female was alleging she had been abused by her husband, over the past two days. There was a seven-week old baby in the home. Zara and the baby were taken to hospital. Stefan was described as being very tired having just finished a night shift. The incident log was endorsed that no offence had been committed. There was no mention as to the nature of the abuse and it would appear no further enquiries were made into the allegations. A DASH risk assessment was not completed and there is no record of the Child Protection Register being checked and the incident was not referred to the Public Protection Unit for child safeguarding issues to be addressed. The Force Control Room (FCR) classified the incident as inconsiderate behaviour. Further enquiries could have been made into Zara's comment to EMAS staff that she had been abused by her husband over the past two days and, if necessary, a DASH risk assessment completed. The DASH system had been introduced in 2010 and was in its early days of implementation.

4.8.2 Following the incident on the 30th July 2011, when Zara was injured by breaking glass due to her brother-in –law breaking a window, the case was referred to MARAC and Zara was seen by the Domestic Abuse Officer (DAO). The DAO gave basic advice and followed it up with a further visit. Safety planning was completed in line with expectation and there was no ongoing contact with Zara.

4.8.3 On the 16th October 2011, a call was received from EMAS informing the Police that a male had been assaulted by his wife. Stefan was the victim and Zara was the alleged assailant. Following several attempts to contact Stefan, he was finally seen by the Police late that evening. The incident was updated stating that Stefan said he had been very drunk that morning and that he had fallen over which is how he hurt himself. He said Zara had not touched him and it was a misunderstanding. A DASH risk assessment was not completed and the FCR classified the incident as anti-social drunken behaviour.

4.8.4 On the 10th June 2015, Stefan phoned the Police saying he was outside his ex-partner's home and could see his daughter lying on the settee but she was not responding. He said there were cans of drink around and she was alone in the home and he could get no reply. When the Police attended, they spoke to Zara who was inside the home and had not been drinking as Stefan had suggested. Basia was seen by the officers and was safe and well and there were no concerns. The incident log recorded that the report appeared to be malicious and that Stefan was being a nuisance to Zara.

4.8.5 The officer completed a DASH which recorded the couple had separated and there was conflict over access to the daughter and that Stefan wanted full custody. All the other questions on the DASH were answered No. The risk level was graded standard i.e. current evidence does not indicate the likelihood of serious harm. A sergeant recorded on the log that he agreed with the grading and that no further Police action was required. On the 11th June 2015, the PPU CRU informed CSC of this incident by e-mail.

4.8.6 On the 12th September 2015, two men were badly beaten in the locality. Several males, including Zara's boyfriend, were arrested for causing grievous bodily harm. The boyfriend received 18 years' imprisonment, later reduced to 16 years, for his part in the assault. On the 13th September 2015, Zara was arrested on suspicion of assisting the offenders in that she disposed of blood stained clothing and transported the offenders to another location. She appeared in Court on the 15th September 2015, where she was remanded in custody. She was later released on bail on the 22nd October 2015.

4.8.7 On the 17th September 2015, Stefan contacted the Police to say he was concerned for the safety of himself and his daughter, who was now living with him, following Zara having been charged with assisting the offenders. He said Zara was in a relationship with a violent criminal and that Basia had witnessed Zara and her boyfriend taking drugs and being intimate. He was worried, if granted bail, Zara may try and take Basia from him.

4.8.8 On the 17th September 2015, the officer submitted a Stop Abuse Form and on the 18th September 2015, a referral was made to CSC setting out the concerns. The risk assessment on the referral was graded as high due to the circumstances of the offence with which she had been charged.

4.8.9 On the 4th November 2015, Zara telephoned the Police and said she had concerns for Basia who was living with Stefan. She said Stefan was preventing Zara from seeing her daughter and she was concerned because Stefan drinks heavily and gambles a lot. An officer attended and saw Stefan and Basia. Both were safe and well and the officer described the living conditions as fine. A DASH was not completed and the FCR classified the incident as concern for safety. CSC were not informed of this incident. The officers satisfied themselves that the child was not at risk and they deemed a DASH was not necessary nor was there a requirement to inform CSC. However, it would appear from CSC information that CSC had specifically requested that the Police inform them and re refer if the mother was granted bail. There was a lack of information sharing at this point.

4.8.10 On the 12th February 2016, the officer submitted a Stop Abuse Referral form to PPU CRU. He had done a bail check at Zara's address. Zara had informed the officer

there were plans for Basia to move in with her in the near future. He was aware of the previous referral to CSC in which it was suggested that Basia could be at risk if she was returned to Zara due to the nature of the offence she had been charged with. He graded the risk level as medium as the child was with her father. The CRU considered the information on the Stop Abuse form and decided there was no requirement to inform CSC and the report was logged for information on this occasion. The rationale for that decision is not recorded. It would appear to be an omission in information sharing not to have informed CSC that the mother was of the view that the child would be returned to her and, potentially, there was an increase in perceived risk.

4.8.11 On the 21stth April 2016, Zara phoned the Police to report that her daughter's bicycle had been stolen overnight, from the garden of her home address. She stated that she suspected that her ex-husband had taken it. She had received an odd call from him the previous day which made her think he was responsible. She also said he had mental health issues. The reviewing officer spoke to the investigating officer, who said he did not visit Stefan to ask him about the cycle because there was no evidence to support Zara's suspicion he was responsible. The Force Control Room (FCR) applied THRIVE Principles to the call. THRIVE stands for Threat, Harm, Risk, Investigation, Vulnerability, Engagement. The model is used to assess the appropriate initial Police response to a call. It allows forces to service the needs of each victim and puts officers where they are needed most. A letter was sent to Zara informing her that the crime was to be filed as resolved, no suspect, investigation complete.

4.8.12 The Crime Management Bureau finalised the crime on the basis of information submitted by the investigating officer on a Mobile Data Terminal (MDT) that no suspect had been identified, house to house, CCTV and scene searches were completed and there were no further meaningful lines of enquiry.

4.8.13 On the 27th April 2016, Zara called at the Police Station and reported that, overnight, superglue had been applied to the driver's door of her car whilst it was parked close to her home address and the she was now unable to open the door. A sergeant completed an initial investigation assessment and tasked out further work for an officer. An officer visited Zara and the incident was recorded as a crime and on the crime report it referred to the fact that Zara had previous issues with her ex-partner but there were no witnesses to place him as a suspect. Therefore, Stefan was not seen and a DASH was not completed. Various further enquiries were made including house to house, CCTV and scene searches. On the 10th May 2016, a letter was sent to Zara informing her that the crime was to be filed as resolved, no suspect, investigation complete. On the 14th May 2016, the crime occurrence log was updated by a sergeant that enquiries were complete, the identity of the suspect unknown and the victim had been updated.

4.8.14 On the 29th April 2016, Zara called at the Police Station again and reported that for the second time, superglue had been applied to her car door and on this occasion it was the passenger door which had been glued shut. THRIVE principles were

applied. When visited, Zara informed the officer that this was the second time that glue had been put on her car door and the third occasion in a week that she had been the victim of a crime. It was recorded in the incident log that "the caller believes husband (separated) is responsible but has no proof." There were no witnesses identified and there was no CCTV evidence.

4.8.15 This was the third incident in eight days, however, the investigations did not identify a specific suspect and therefore Stefan was not spoken to, which could have been considered. The incident was not recognised as being D.A. Therefore, a DASH risk assessment was not completed.

4.8.16 It was the 6th August 2016 before this third crime was finalised as resolved, no suspect, investigation complete. This was three months after the crime was reported and two and a half months after Zara's murder. It is not known why this crime took so long to finalise.

4.8.17 At the time of reporting the theft of the cycle and the second offence of criminal damage, Zara informed officers that she believed Stefan was responsible for two of the crimes. Following the second report, the incidents could have been linked, recognised as possibly involving D.A., stalking and harassment offences and investigated as such. Furthermore, Zara was awaiting trial for attempting to pervert the course of justice in relation to a serious assault involving members of an organised crime group. Although there was no specific evidence, the officer could also have investigated the possibility that the three offences were committed either by Stefan or someone connected to the organised crime group. The response lacked robustness, in identifying the risk of harm, recognising Zara's vulnerability and engaging her in terms of her protection.

4.8.18 On the 2nd May 2016, Zara, once again, contacted the Police and said she was having ongoing problems with her ex-husband. He had followed her to her sister's house and was taking photographs of her car. She told the officer who attended that she did not know why he was there, but while outside, he had been videoing her and asking her to come outside. She said his actions had scared her. She explained they were getting divorced and there was to be a court hearing on the 13th May 2016 to decide custody of their daughter. The officer told Zara that he would visit Stefan and tell him to stop all contact as it was unwanted.

4.8.19 The officer visited Stefan who said that Zara had posted a tee shirt for his daughter through his door. Stefan said he was trying to return the tee shirt as it was the wrong size. He said the reason he was filming the visit was because Zara had made false allegations against him before and he wanted to protect himself. The officer told Stefan that Zara was alarmed by his actions and advised him that any further contact should be made through Solicitors.

4.8.20 Zara, later, contacted the Police to say that Stefan had posted the video recording of the above visit on Facebook. The same officer visited Stefan and told him that his behaviour was unnecessary and that the video did show the number plate of Zara's car. Stefan apologised and deleted it and said that he would no longer contact Zara. Zara was informed of the action taken.

4.8.21 A DASH was completed in which it was recorded that Zara had separated from Stefan within the past year and there was conflict between them over custody of their daughter. She said she had suffered physical violence from Stefan in the past and was frightened of him being violent towards her again. Details of her allegations of violence were not recorded in the DASH. She described Stefan as a very jealous person who had had problems in the past year with alcohol. The risk level was graded as standard. A supervisor agreed with the grading adding that it appears to be a couple experiencing difficulties as they go through a divorce – No offences have been disclosed and advice given to both parties regarding how to conduct themselves in the future.

4.8.22 As the three offences the week before had not been recognised and recorded as D.A., stalking and harassment, the pattern of abuse that was developing was not seen and Stefan was not identified as a suspect. Had it been, this may have been seen as a pattern of behaviour that was escalating, rather than no offence committed. Also, given the frequency of the incidents, the history of violence, the fear of danger expressed by the victim together with the increasing risk related to the custody battle, this was an escalation in risk and if a full assessment of all the factors had been taken into account, the risk may not have been seen as standard.

4.8.23 On the 11th May 2016, Zara visited the Police Station in connection with regaining property that had been held by the Police in relation to the offence of perverting the course of justice of which she had been acquitted on the 9th May 2016. She was told, should she have any problems, she should contact the Police.

4.8.24 Later, on the night of the 11th May 2016, Zara telephoned the Police to say that Stefan had been to her address and had posted the present, she had delivered for her daughter, back through her letterbox. She said she was nervous of the situation and was worried Stefan knew where she lived. She informed the Police that he had left and was advised to call back if he returned. Later, an officer attended and ascertained that there had been no further contact or verbal communications between Zara and Stefan and no offences had been committed. Zara was given advice regarding obtaining a non-molestation order. There is no record of Stefan having been spoken to about this incident.

4.8.25 A DASH risk assessment was completed and it was recorded that Zara felt frightened and that she did not know why Stefan was at her address. (This may have been a misunderstanding caused by language barriers as the incident log had said Stefan was returning a present). She reiterated that there was conflict between

them regarding the custody of their daughter and she was frightened Stefan may inflict further injury or violence upon her. Again, there were no details recorded of what previous injuries or violence had been inflicted upon her. The risk level was graded as standard and a supervisor agreed with the grading adding that no offences had been disclosed. There was no order in place preventing Stefan going to Zara's address and Stefan had not attempted to make contact with Zara. Had this DASH been notified to CSC, this would have amounted to three notifications in a rolling twelve months and triggered consideration for a CSC assessment. The consideration is an automatic process, however, if criteria for assessment is not met, the team would close the case without assessment taking place.

4.8.26 Had the possibility, that the incidents of the 2nd and 11th May 2016 were connected to the theft and criminal damage, been recognised and investigated it may have become apparent that a pattern of stalking and harassment was taking place and offences were being committed. There was a failure to recognise the growing risk and to consider a safety plan for Zara to refer her on to other agencies and provide information on D.A. support services. This was the third DASH in a 12-month period and it did not reflect the increasing risk that is evident with the benefit of hindsight.

4.9 <u>The Borough Council Housing Department</u>

4.9.1 Zara was registered for Council Tax at the address where her body was discovered in May 2016. She was registered for this address from 16th January 2016. This was a privately rented property.

Stefan registered for Council Tax at the address where he lived with Basia from the 30th November 2015 to the 22nd June 2016.

4.9.2 Stefan visited the Council Offices on the 12th May 2016, saying he was likely to be made homeless and that he had a 5-year-old daughter. He had received a notice to quit the property, by the 3rd June 2016, for none payment of rent. He informed the council that he had issues with his former partner and they were in Court the day after on the 13th May 2016 regarding custody of their daughter. He was advised about the action he should take regarding eviction which was in line with policy.

4.9.3 Contact was made by DHR Author with the letting agency to gather any relevant information. The letting agency were not aware of any domestic difficulties at the address and there had not been any complaints or reports of concerns from neighbours.

4.10 <u>Children and Family Court Advisory and Support Services (CAFCASS).</u>

4.10.1 When the DHR panel became aware of the involvement of CAFCASS in this case, permission was sought from the Family Court for CAFCASS to share relevant information relating to their contact with Zara, Stefan and Basia. CAFCASS provided disclosure of the private law papers detailing some information and as a result an IMR was requested and was provided in November 2017.

4.10.2 In January 2016, Zara had made an application to the Court for a Child Arrangements Order in relation to spending time with Basia and having Basia to live with her. This was precipitated by Zara being remanded in custody in September 2015, at which time Basia had gone to stay with her father Stefan. On Zara's release from custody in October 2015, Stefan would not allow Zara to have any contact with her daughter. They had previously shared Basia's care between them depending on their patterns of work.

4.10.3 CAFCASS provided the Court with a safeguarding letter for the first hearing on the 1st March 2016 which identified that enquiries were incomplete and further assessment was necessary. A Case Analysis Report was prepared for the next hearing date in May 2016. The report was based on interviews with Zara, Stefan and Basia and information provided by the Police, Children's Services and Basia's School. The report provided advice to the Court in the form of assessment, professional judgement and concluded with recommendations.

4.10.4 In the first telephone interview in February 2016, Zara raised a number of concerns and allegations with the CAFCASS worker. This included that there had been domestic violence in her relationship with Stefan and on at least seven occasions. Basia was present, witnessed it and had become distressed. This information was shared with the Family Court Judge in the Safeguarding Letter of 1st March. Zara also, later, referred to harassment and stalking by Stefan post separation and that she had moved home to stop the harassment but he had tracked her down.

4.10.5 Police information, at the time, stated that there were two outstanding criminal matters against Zara. One for battery, dated May 2015, where it was alleged Zara had assaulted a female and one for assisting an offender, who was charged with attempted murder, and thereby perverting the course of justice.

4.10.6 The case was allocated to a CAFCASS Practice Educator together with a student. Given the information shared by Zara, the student was advised to seek an enhanced Police check and to explore Zara's insight to her offending. The Safe Lives tool was to be used when interviewing Zara in relation to the D.A. she had raised. This, in fact, did not happen and the Safe Contact Indicator tool was used instead. The Safe Lives tool would have been useful in providing evidence that the D.A. risk had been fully covered.

4.10.7 The records of the interview and Court reports identified the history of their relationship, its breakdown and subsequent allegations and counter allegations of their abilities as parents. Stefan alleged concerns in relation to Zara's alcohol abuse, substance misuse, mental health and domestic violence with him as a victim. He said that Basia feared her mother and that she had been exposed to inappropriate behaviour.

4.10.8 Zara made counter allegations about Stefan's D.A., alcohol use and mental health and allowing a drug dealer to live in his home. Both parties rejected the allegations made against them.

4.10.9 The fact that Zara was in a relationship with a man who had been charged with a serious violent crime and that she was implicated was a clear concern for her judgement and her immediate ability to care for her daughter. There had been no concerns about her ability to care for her daughter prior to this. The circumstances and Zara's response to these concerns became a dominant factor in the case analysis and, to some extent, appears to have eclipsed the significance of the allegations made by Zara of D.A.

4.10.10 The enhanced Police check undertaken by CAFCASS does not appear to have requested or included any specific information about D.A. in the parent's relationship. The request for information from CAFCASS to the Police did not reference any timescales or indicate any specific incidents of D.A. However, a tick box for D.V. and emotional harm under a section entitled "possible areas of concern "was completed. There is a line in the request form which also enables the Police to disclose any other information they considered relevant. In line with the protocol between the Police and CAFCASS, Police checks are destroyed on case closure, so were not available when the IMR was prepared. There was no reference to CAFCASS having received police D.A. information or verification of Zara`s alleged abuse in the court report.

4.10.11 When interviewed at School, Basia indicated that she liked living with her father and described why she did not want to return to her mother. When Zara became aware of her daughter's views, Zara expressed concern that Stefan was manipulating Basia, which may have been the case, and pleaded with the worker to see Basia again but this was felt unnecessary.

4.10.12 There were evident discrepancies in some of what Stefan was saying E.g. in relation to the indirect contact that had been in place since March by way of written communication and gifts from Zara to Basia and Basia's response to this. Also the CAFCASS report quotes Stefan in that he says Zara refused to take a drugs test. This review has shown that this is was incorrect. Zara made attempts to have a drugs test by approaching her G.P. and being advised to go to a drugs agency for

the test, which she did, but this was refused as she did not use drugs. In turn, there was felt to be a lack of understanding and awareness by Zara in relation to the risk presented to Basia by her relationship with her new partner and her alleged involvement with the criminal activity surrounding him and the lack of a safe network of people surrounding her. In terms of the criminal cases against her, the battery charge was not proceeded with due to lack of reliable evidence, and she was acquitted of the charge of perverting the course of justice on 9th May 2016.

4.10.13 Despite the outcome of the criminal court case, the report recommended that Basia live with her father and in the absence of an opportunity for appropriate supervised access at the time, only indirect access was to take place between Zara and Basia. It was suggested that if indirect contact was maintained and Zara could show she was able to keep her daughter safe and free from risk, she should reapply for a Child Arrangements Order in six months' time.

4.10.14 The outcome of the hearing must have been devastating for Zara and may have reinforced her victimisation and reinforced to Stefan the power of his control over Zara. It is recognised that abusive father's use child contact as a means to further abuse their ex partners. It may be that the Family Court process, in some way, challenged Stefan's power and control and thereby increased the risk to Zara from Stefan and she was murdered just days after the hearing. CAFCASS referred to having had some experience of "spite killings" via previous Serious Case Reviews where one parent has killed another during or after proceedings. However, this case does not fit the general picture of such cases which have tended to focus on a scenario whereby the perpetrator had "lost "in court. In this case, Stefan had effectively "won ".

4.10.15 Whilst there had been safeguarding checks with the Police, there does not appear to be any information reported regarding the previous recorded incident of D.A. in 2011 and 2015 where a DASH assessment had been completed. The pattern of coercive control which had continued after the relationship had officially ended and resulted in five Police call outs in April and early May 2016 prior to the Family Court hearing, were not specifically referenced or recognised as coercive control. There was reference in the report to Zara's allegation of physical abuse and harassment from Stefan, but they were not explored in detail.

4.10.16 There did not appear to be any investigation of or reference to the harm potentially caused to Basia by the alleged D.A. Her experiences of D.A. did not appear to have been explored with her. Since her mother's death she has referred to the violence perpetrated by her father to her mother that she had witnessed.

4.10.17 The overriding concern during the child arrangements order process appear to have been Zara's choice of a new partner and the allegation of her putting her child at risk due to this relationship. Stefan had, via his contact with the Police, School and CSC, successfully painted a very damaging picture of Zara. The fact that D.A.

involves a very serious and significant failure in parenting in failing to protect the child's carer and emotional wellbeing, was not obviously explored or subject to any recommendation to the Court.

4.11 Family Court Practice Direction 12J.

4.11.1 Since this case was before the Family Court in May 2016, a revised Family Court Practice Direction, which would appear relevant, came into force in October 2017. Practice Direction 12J Child Arrangements and Contact Order: Domestic Violence and Harm followed a review of practice by Justice Cobb. Judges were urged to ensure that the Practice Direction (P.D.) is properly complied with and that the Judicial College provide high quality training in D.V. to all Family Judiciary as recommended in the Cobb Review.

4.11.2 P.D.12J was originally implemented in 2008 because of concerns about child homicides in response to the first Women's Aid report entitled "29 Child Homicides". The review was commissioned after the publication in January 2016 of the influential Women's Aid report entitled "Nineteen Child Homicides". What must change so children are put first in child contact arrangements and the Family Courts?

4.11.3 Of all the recommendations made by Mr Justice Cobb, there are two that would appear to be particularly relevant to this case.

1. The Government and Senior Leaders in the Family Courts and CAFCASS need to take action to bring about cultural change within the Family Court system to ensure that the safety and wellbeing of the child (ren) and non-abusive parents are under stood and consistently prioritised.

2. Children's experiences of D.A. and its impact on them should always be fully considered by the Family Court Judiciary with an acknowledgement that post-separation abuse is commonly experienced by non-abusive parents.

4.11.4 Part of the conclusions reached by those involved in the P.D.12J consultation process were that the basis of the problem is the poor professional understanding by the Family Courts i.e. Judges and Magistrates of the nature and impact of D.A. and one of the main recommendations of the review was for specialist training and ongoing professional development for the Judiciary. A further addition is also that when the Court takes steps to obtain information available locally, to assist the parties and the child, this is now to include "Local Domestic Abuse Support Services".

4.11.5 The barrister writing the article about P.D.12J argued that the reference to professional understanding should include CAFCASS given the importance of their input and the courts reliance on their advice. The Courts are directed to follow CAFCASS recommendations or give reasons why they are not. Hopefully, the recommendation for a specialist risk assessment by an accredited agency will assist all those involved.

5 Terms of Reference Analysis

5.1 Examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects or given rise to other concerns or instigated other interventions.

5.1.1 There were two historic D.A. incidents. One on 17th January 2011 which involved an argument and allegations of Stefan pushing Zara. There was a referral from the hospital via CAF to Social Care and also liaison with the HV who visited the couple and considered at that point that no further intervention was necessary. It was considered to be a heated argument and the relationship was back on track. This was not explored further with Zara on her own, no information regarding support services was provided and a DASH was not completed. Practice has developed considerably since then. The couple were seen regularly by the HV at the clinic and there were no further concerns. They were noted to be very affectionate with one another.

5.1.2 Following an incident, in July 2011, where Zara was hit by broken glass from a window smashed by her brother in law, there was a MARAC. The other victim was confirmed as high risk . Neither victim engaged with the services offered by the IDVA and again the HV, as the trusted professional, saw Zara and Stefan at home and was assured the incident did not relate to their relationship, which was accurate. A targeted two year developmental assessment for their daughter was arranged in response to the abuse concerns to enable face to face follow up contact. This was undertaken and there were no further concerns.

5.1.3 The family situation deteriorated significantly after the couple separated in April 2015 and there was a custody dispute regarding their daughter. There were allegations and counter allegations of inappropriate parenting behaviour, some of it malicious. Despite a DASH being completed by the Police in June 2015, there was no allegation of domestic violence and agencies viewed it as a custody dispute rather than D.A. The real concerns came as the Child Arrangements Order court date approached on the 13th May 2016. Zara shared, with CAFCASS, she had been a victim of D.A. previously which had continued following the breakdown of her marriage and that her daughter had witnessed some of the violence. For their part, CAFCASS felt she did not make it clear she had ongoing concerns at the time of the court hearing. However, it is recognised by many agencies that custody disputes increase risk where D.A. is involved. It is possible Zara did not make her

situation clearer as she may have been frightened to disclose her concerns in case it led to reprisals from Stefan and had negative implications for the care of Basia. The revised P.D.12J assists the Judiciary, Government and CAFCASS to bring about cultural change within the Family Court system to ensure that the safety and wellbeing of the child and non-abusive parents are understood and consistently prioritised.

5.1.4 Despite her past cultural experience in Latvia, where there may be limited expectation of support from the Authorities for D.A., Zara contacted the Police on five occasions between the 21st April 2016 and 11th May 2016 to report offences of theft, criminal damage and stalking and harassment. She disclosed previous violence and shared her fear of Stefan. The first three incidents were not recognised by the Police as D.A. and were not investigated as such, despite Zara clearly suspecting her husband was responsible for two of the incidents. Seen in isolation, they were not serious crimes, but together formed a pattern of D.A. and stalking and harassment that warranted concern and intervention. No intervention or information was provided about D.A. support services, although the Police did recommend to Zara she consider a non-molestation order.

5.2 <u>When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about the potential indications of Domestic Violence and Abuse and aware of what to do if they had concerns about a victim or a perpetrator ? Was it reasonable to expect practitioners, given their level of training and knowledge to fulfil their expectations ?</u>

5.2.1 In 2011, the Ambulance Service, whilst recognising the incident as D.A. did not make a D.A. referral or safeguarding referral for the child, who was seven weeks old at the time. This was prior to their D.A. policy and subsequent change in practice which would now include an expectation of a referral on.

5.2.2 In January 2011, the hospital had no standalone D.A. Policy, they have since developed one. Despite this, the staff did recognise the vulnerability of the mother and the child, initiated support via a CAF and discussed safety planning with the mother. The hospital, now, has a policy which covers D.A. and they would expect all attendances to be managed in accordance with the relevant process.

5.2.3 In 2011, the HV responded to the concerns raised via the hospital and CAF. The HV saw the couple and made an assessment that no further action was necessary at the time. A targeted face to face two year assessment rather than an assessment via questionnaire was arranged to monitor the situation. This is good practice. Since then, all HVs have had DASH and MARAC training and practice has improved as a result. The HV would now make every effort to see the individual victim on their own and explore safety issues and provide support service information in line with policy expectation.

5.2.4 A copy of the A&E report from January 2011 was sent to the GP Surgery for inclusion in the health records of Zara and Basia. However, prior to 2013, the GP may not have seen the A&E report as administrators would have been responsible for identifying key detail and including it in the records. Since 2013, all A&E reports are fully scanned into medical records and since 2015, there is a monthly safeguarding meeting where concerns are shared and all practice staff are expected to follow up concerns with patients and ask questions to make sure patients are safe.

5.2.5 Pre-school and School were sensitive to the needs of the subjects. Basia was placed on the School's Vulnerable Child Register. Education were aware there was conflict in the family and a bitter custody dispute. They did not recognise there was D.A. They offered information and support to both parents including about legal advice and an Early Help assessment. Staff had had training in recognising D.A. but they did not see the relationship of Zara and Stefan as abusive and did not see Zara as a victim. Many of the recognised barriers to disclosure of D.A. and to accessing services are likely to have been a feature for Zara. These include cultural differences, shame and embarrassment, fear of reprisals and fear for the implications for the care of her daughter. It was only in the weeks immediately prior to her death that Zara disclosed to the Police and CAFCASS her experiences of D.A. Basia was asked about what she wanted in connection with her parents and her wishes were followed.

5.2.6 CSC, whilst aware the family were in conflict, did not consider Basia`s needs met the threshold for intervention in relation to a Social Care assessment. EHA and TAC were offered but the TAC was not taken up by Stefan. The two DASH completed by the Police, in May 2016, meant there were three recognised D.A. incidents in a twelve month rolling period which should have triggered a consideration for a CSC assessment. However, as Basia was not living with her mother and was not present when the incidents leading to the DASH occurred in May 2016, the third DASH assessment was not forwarded to CSC and they were unaware of its existence.

5.2.7 The Police recognised some of the incidents as D.A. and three DASH were completed, one in June 2015 and two in May 2016. When Zara disclosed previous violence and that she was afraid, there was a lack of professional curiosity and information gathering to identify the nature of the violence and fear and to respond by providing information regarding help, support and protection or consideration of investigation and charge. They did respond well to concerns about the child and undertook safe and well checks and referred to CSC on occasions. Officers had had DASH training and it was reasonable to expect them to have been able to identify that stalking and harassment could have been taking place after the report of the theft of the cycle and the following superglue incidents.

5.2.8 CAFCASS identified that, in many respects, they felt the issues raised in this case are reflective of many of the private law cases they manage. Zara shared that she

had been a victim of physical D.A., witnessed by her daughter, which had continued in the form of stalking and harassment after separation. However, there was no request detailing specific incidents or timescales made by CAFCASS to the Police to support or refute these allegations. A tick box for concerns about D.A. and emotional harm under a section entitled "possible areas of concern" was completed. There is a line in the request form which also enables the Police to disclose any other information they feel is relevant. The Safe Lives tool suggested for use is considered the most appropriate assessment where D.A. is alleged, however, in this case it was not used and a Safe Contact tool was used instead. Whilst it is recognised in the Joint Targeted Area Inspection "D.A. is the most common factor where children are at risk of serious harm ". D.A. does not appear to have been considered as a risk factor for Basia and there was no referral of the D.A. information to the relevant local authority. The CAFCASS worker was a student but was supported and supervised by a Practice Educator and on occasions a service manager.

5.3 <u>When and in what way were the victim wishes and feelings ascertained and considered? Were the subjects informed of the options or choices to make informed decisions? Were they signposted to other agencies and how accessible were those services to the subjects? Was the victim's perception of danger canvassed?</u>

5.3.1 EMAS have no recorded evidence that the crew discussed with Zara, the potential D.A. in 2011, which is recognised as a missed opportunity. As it was not discussed, no options or choices were offered to her and no signposting onwards. Since 2011, significant work has been completed within EMAS in relation to the D.A. agenda and changes in practice have been made.

5.3.2 Other than the incident in January 2011, Zara made no disclosures of D.A. until April and May 2016, when she contacted the Police. The August 2011 MARAC did not involve Stefan but did provide D.A. advice and support service information. It is recognised the incident of January 2011 could have been explored further by HV and the Police and independent contact made enabling her wishes and feelings to be explored further and signposting onwards as appropriate.

5.3.3 Via the MARAC process in August 2011, Zara was offered contact and advice from the IDVA but chose not to pursue this as it was her brother-in-law who was the perpetrator and her injury was coincidental.

5.3.4 Education did not witness anything to indicate the relationship between Zara and Stefan was abusive. Zara did not indicate that she was in any danger and was not therefore provided with D.A. options or choices. She was advised to take legal advice regarding the custody dispute for her daughter. School had a much closer working relationship with Stefan, and Basia was seen as preferring to be with her father. School found Zara's attitude difficult in December 2015 and therefore no longer responded to her wish to have regular information about her daughter's

progress. Alternative methods of communication could perhaps have been explored such as written communication, text, or e-mail to help maintain the link.

5.3.5 Basia`s life experiences, although subject to many alleged concerns, was never fully explored with her. Stefan and Zara were offered advice and guidance at different times. Issues of risk to Basia were seen to be from Zara and her relationship with her new boyfriend and involvement with the offence of which she was later acquitted. The risks to Basia relating to the alleged D.A. were never fully assessed and led to an assumption Basia was better off with her father.

5.3.6 CAFCASS prepared a Family Court Report regarding custody of Basia. The outcome of the 13th May 2016 hearing was that full care of the daughter was awarded to the father and only indirect contact was awarded to Zara with a suggested review in six months' time. This was opposing Zara's wishes and gave power to Stefan and further isolated Zara from Basia. CAFCASS explained that there was a Court Order in place that directed Stefan to facilitate the indirect access. However, this had been in place since March 2016 and he had failed to abide by some of the terms prior to the May 13th 2016 hearing. As it was an open case and still going through the court process, there was the option for Zara, with her solicitor, to refer any obstruction to access back to Court.

5.3.7 Zara disclosed to CAFCASS that she had been the subject of physical abuse from Stefan during their marriage and of stalking and harassment since their separation. This information appeared to have been viewed as part of the allegations and counter allegations present in many child arrangement disputes. Zara's perception of ongoing danger did not appear to be canvassed by CAFCASS, nor was she or her daughter signposted to other agencies for support or safety advice. The revised P.D.12J states that when the Court takes steps to obtain information locally to assist the parties and the child, this is now to include local D.A. Support Services. Stefan had successfully painted a damning picture of Zara as a mother and this, together with her criminal charges, for which she was later acquitted, appear to have influenced the perception of her as a vulnerable victim.

5.3.8 Zara made, at least, five reports to the Police of concerns about Stefan's behaviour, three of which involved the clear commission of crime. The other two reports concerned stalking and harassment. As there was no proof that Stefan was the perpetrator of the theft and damage no action was taken against him. Latterly, Zara shared with the Police that she had suffered violence from Stefan in the past and was frightened. This was not explored further. Information was given about a non-molestation order but no information was provided at this time about D.A. services and support or consideration of a multi-agency assessment and response to consider a safety plan.

5.4 Did the agencies assess the risk they posed to each other in the light of the separation? (because we know people are more at risk when they are separating or have separated and there is a loss of children or custody issues)

5.4.1 The separation and custody battle between the couple was not known to several of the agencies who did not have contact during 2015 / 2016 including Health Visiting, EMAS and the Hospital.

5.4.2 The GP had been informed that Zara had a new partner in May 2015, but not that the Zara and Stefan had separated. This information was given about the custody conflict by Zara when she requested a drug test in January 2016 as her husband would not allow her access to her daughter unless she could prove she was not using drugs. This information, alone, did not alert the GP to the increasing risk posed. However, there was also a lack of professional curiosity in terms of asking if Zara was safe, bearing in mind there had been some history of D.A. in 2011 and the separation and custody disputes are known to increase risk.

5.4.3 The School knew Basia's parents were separated when she joined the School. During assessments of Basia's needs by the School, the relationship between the mother and father was always discussed however D.A. was not considered as there was no evidence to suggest that D.A. was an issue. It was understood that the parents had little or no communication. The School referred Basia to CSC on two occasions following their growing concerns. These were in September 2015 following Zara's arrest and again in November 2015, when Zara was released and there were concerns raised by Stefan that she may try and take Basia from school. Stefan had represented Zara as a risk to the care of Basia. Her remand in custody for a serious offence, of which she was later acquitted, reinforced the concerns and blurred the view of Zara as a victim of D.A.

5.4.4 CSC report that they had little information about the adults as a couple, and it was not until the murder of Zara that CSC were made fully aware of all the details of the private law application made by Zara to have her daughter returned to her care.

5.4.5 After the murder, Stefan indicated that he and Zara had been considering a reconciliation. This was disputed by Zara's sister who advised that Zara was seeking a divorce and had reached the Decree Nisi stage, but Stefan had refused to sign the papers.

5.4.6 By the time the murder occurred, the couple had been separated for twelve months. Each incident identified by the Police, to be of a D.A. nature, had been risk assessed by the attending officer. All the incidents were considered standard risk. As the Police viewed each incident in isolation and failed to identify the three offences in April 2016 could be stalking and harassment offences, they did not

recognise the cumulative picture of increasing risk as the custody issue and the potential loss of the child, reached the climax of a Court Hearing on the 13th May 2016.

5.4.7 **"**The impending potential separation of the father from his child, caused by the mother's application to the Court, was a piece of information that should have heightened awareness of practitioners to her vulnerability and should have been seen as a change in circumstances that increased the risk ". (Nineteen Child Homicides by Women's Aid). However, CAFCASS did not appear to recognise the increased risk of separation and child custody conflict in this case.

5.5 <u>What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been made in an informed and professional way?</u>

5.5.1 All reports of crimes and concerns about Zara's and her estranged husband's behaviour provided an opportunity for assessment and decision making by the Police. Reports of incidents became more frequent from April 2016 and were indicative of an escalation of D.A. in the form of stalking and harassment. The three offences in April 2016 were not recognised as D.A. Had they been identified as such this may have impacted on the level of risk applied on the 2nd and 11th May, and influenced the interventions and outcomes provided in relation to Zara's safety.

5.5.2 Each of the thirteen contacts listed in the CSC case file provided an opportunity for assessment and decision making. They were all assessed by those employed to screen contacts who look at past history, however the pattern of Stefan's coercive, controlling behaviour in relation to painting a negative picture of his wife as a parent and not allowing his wife to see their daughter was not recognised as D.A. but seen as part of the custody dispute. The view was that the case did not meet the threshold for CSC assessment.

5.5.3 CSC had recorded that there was a TAC in place, but this was incorrect. Had this been known at the time, decisions may have been made to refer for further help and assessment.

5.5.4 There were a number of occasions when a safe and well check was made in relation to Basia. The School contacted external agencies, where relevant, to gather information to inform the process. A joint home visit was done with the police as there was no recognition of D.A., it was not considered a factor in this case. Stefan was seen as a positive factor and Zara seen as presenting greater risks. The School were unaware of the five incidents in April and May 2016, leading up to the custody case being heard at Court. Had there been a multi-agency discussion and assessment at that time, this important information could have been shared and a

clearer picture gained. However, the case did not meet the criteria for referral to MARAC and there is no other forum identified to which cases with a lower risk rating could have been referred.

5.5.5 In 2011, the hospital assessed the concerns relating to Zara's allegation of pushing and referred onwards via CAF for Social Care and HV input. HV and the Ambulance Services have identified that, in 2011, there was a missed opportunity to explore further with Zara, D.A. and signpost on for support and services as necessary.

5.5.6 During the assessment by CAFCASS to advise the Family Court on child arrangements, the Safe Lives Assessment tool was not used as suggested. Had it been, it is recognised by CAFCASS that it would have led to evidence of a more comprehensive assessment of the risk associated with D.A.

5.6 Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in this case? This includes whether professionals analysed any relevant historical information and patterns of behaviour and whether they acted upon it.

5.6.1 In many incidents reported to the Police, appropriate professional curiosity was exercised. However, there were exceptions.

5.6.2 Officers attending the three incidents reported by Zara in the eight-day period at the end of April 2016, could have investigated Zara's allegations that Stefan was responsible for the offences reported which may have identified a pattern of stalking and harassment towards Zara. The fact that there was no evidence available to make him a suspect meant that incidents were not seen in the context in which Zara may have experienced them. On the 17th January 2011, officers failed to explore the allegation by Zara that she had been abused by Stefan over the past two days.

5.6.3 Regarding the 2nd and 11th May 2016 incidents, the officer recorded that Zara had suffered physical violence from Stefan in the past and that she was frightened of him being violent towards her again. No details were recorded on either risk assessment of what and when the previous violence was. Lincolnshire Police have, recently, equipped officers with Mobile Data Terminals (MDT) and 90% of DASH assessments are now completed using MDTs. Improvements have been incorporated into the DASH in that further details must be added in a number of areas including where violence has previously been committed to the victim by the suspect. Also if stalking and harassment applies to the incident, eleven extra questions appear on the MDT which the officer must complete.

5.6.4 Several of the contacts, made by Stefan, to School, Police CAFCASS and CSC, included allegations of either poor parenting or risks to Basia from her mother. Basia was not seen by anyone but the School until CAFCASS involvement. Neither parent was interviewed to assess their parenting ability as the allegations did not meet the threshold for a safeguarding assessment.

5.6.5 The School were aware of the domestic arrangements and put in the appropriate actions to secure the safety and well-being of Basia. Where the School did not have the full picture of the situation they were professionally curious. This included taking action to contact the Police and CSC for information and advice and on two occasions undertaking home visits to establish the situation. This was good practice.

5.6.6 The GP could have exercised greater professional curiosity in relation to Zara's request for drugs test to prove to her estranged husband that she was not using drugs. The husband would not let her have contact with her daughter until she could prove this. Some exploratory questions may have uncovered the impossible situation Zara was caught in and that there had been violence in the past and that the controlling behaviour was continuing despite separation.

5.6.7 HV missed the opportunity to exercise greater professional curiosity back in January 2011. Following the August MARAC a face to face follow up two-year assessment was targeted. There were no other concerns or disclosures made. The information about the D.A. incidents in 2011 were appropriately shared with the School Nurse during the transition of service.

5.6.8 Having interviewed Zara, Stefan and Basia regarding the Child Arrangements Order, CAFCASS also considered information from the Police, School and Children's Social Care in order to analyse the family history and patterns of behaviour. No specific D.A. information was requested from Police by CAFCASS regarding Zara`s allegations, a tick box for D.V. and emotional harm under a section entitled possible areas of concern was completed. There does not appear to be any evidence to suggest Basia's experience of the alleged D.A. was explored or analysed. The recorded focus of the interview with Basia was the difficulties in her relationship with her mother and her positive view of her father. With the benefit of hindsight and evidence of Stefan's coercive control towards Zara, it is likely that as Zara suggested, he could have manipulated Basia into being negative about her mother to support the picture he wished to portray. The revised P.D.12J which came into force in October 2017 included a recommendation that children's experiences of D.A. and its impact on them should always be fully considered by the Family Court Judiciary.

5.7 <u>Were the actions of agencies in contact with all the subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?</u>

5.7.1 Back in 2011, the A&E Nurse appropriately shared concerns regarding D.A. with the HV as did the HV with the School Nurses. The HV remained alert to the risk of D.A. throughout her involvement with the family.

5.7.2 In 2011, the Ambulance Service did not refer on in connection the allegations of abuse. However, this was covered by the actions of the Hospital and practice has developed and the changes are identified in the changes section.

5.7.3 There was a lack of recognition of the pattern of abuse including Stefan using contact with their daughter as a means of controlling Zara together with alleged previous violence with stalking and harassment after the relationship had ended. There was advice given by the Police regarding a non-molestation order in 2016 and in 2015, advice to seek legal advice about care and custody of Basia. There was no advice or support given to Zara regarding D.A. services available.

5.7.4 Despite the pattern of Stefan making allegations of Zara's inability to care properly for Basia, there was no formal risk assessment by CSC as Basia remained in Stefan's care.

5.7.5 Three DASH were completed and were all graded as standard. Had the allegations of theft and criminal damage been recognised as D.A. and the stalking and harassment identified, this may have altered the perceived level of risk.

5.7.6 It is likely that Zara felt vulnerable and isolated and unsupported by professionals as referred to by her friends.

5.7.7 Research would suggest, having been the victim of violence in her relationship with Stefan, it is more likely that her subsequent relationships could have elements of D.A. The details of her relationship with her new partner and his relationship with Basia was never fully explored. Basia did suggest to CAFCASS she felt her mother's new boyfriend did not like her and would shout at her a lot.

5.7.8 It is not known that if the third DASH completed on the 12th May 2016 had led to a CSC notification, whether it would have met the threshold for assessment however it would have automatically resulted in a referral and would have been considered for an assessment by the area team who have the autonomy to close the referral if they feel it does not meet the threshold. CSC were under the impression that there was a TAC in place, had they known the this was not the case, they may have referred for further early help and assessment.

5.7.9 The School action which related to the welfare of the child was appropriate relevant and effective. No agency recognised the coercive control present in Stefan discrediting Zara and by using the child to control her by refusing contact unless she did as he said e.g. the drugs test. CAFCASS assessed that it was not in Basia`s interest to have direct contact with her mother until her mother could ensure she was no longer involved in criminal activity and could show awareness of the risks she presented to her daughter. Zara had been acquitted of the offence at this stage. There was no suggestion that Stefan should change his thinking and behaviour which appears to overlook the risk associated with the allegations of D.A. that were witnessed by the child.

5.8 Did the Agencies have Policies and Procedures for Domestic Abuse? and Safeguarding and were assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to MARAC or other Multi-Agency Fora?

5.8.1 Lincolnshire Police Force's policy and procedures mirrors national policy and guidance. The updated version has been in place since September 2013. It is a comprehensive policy which contains detailed procedures for dealing with concerns about D.A. including procedures for DASH risk assessments. Lincolnshire Police has a stalking and harassment policy based on the ACPO / NPCC latest guidance (2009). This is currently under review with the College of Policing. HMIC and HMCPSI have also completed a thematic inspection of stalking and harassment crime across all forces with publication of their findings in July 2017. The thematic report "Living in Fear" contained 22 recommendations directed to the National Police Chiefs Council, the College of Policing, the Crown Prosecution Service and Chief Constables. Four recommendations directed to the Chief Constables include ensuring stalking investigations are improved, to ensure all victims of stalking and harassment are protected and that there is compliance with National Stalking Protocol.

5.8.2 Zara reported three incidents to the Police between the 21st and 29th April 2016, two of which she believed her estranged husband was responsible. No DASH were completed. The investigation did not identify Stefan as the suspect or recognise that a pattern of D.A. was emerging. The victim was not subject to a MARAC other than in 2011, as whenever a DASH risk assessment was completed, the level was standard which did not meet the threshold for referral on. Had the three other DASH been completed and the pattern of stalking and harassment identified, the risk may have been considered greater than standard which may in turn led to a multi-agency discussion.

5.8.3 Lincolnshire County Council Children's Services have a joint policy and procedure for D.A. and Safeguarding involving the police. The third DASH was completed by the Police on the 12th May 2016, seven days before Zara's murder. This was not notified to CSC as the Police considered there were no children involved. Had CSC

received this, it would have met the threshold of 3 standard D.A. notifications in a rolling 12 months and therefore would be referred for consideration for a Social Care assessment.

5.8.4 The role of the CAFCASS Family Court Advisors in private law proceedings is to carry out initial safeguarding checks in response to court applications and to advise the court on safe management of cases. CAFCASS has no statutory powers to investigate concerns. Where it is believed a child is suffering, it is expected the worker refers the information to the relevant local authority. The Domestic Abuse guidance is included in Practice Direction 12J Child Arrangements and Contact Order: Domestic Violence and Harm. "Women's Aid Nineteen Child Homicides (Bristol: Women's Aid 2016) recommended that all family courts are aware of and fully implement Practice Direction 12J. A Domestic Abuse Practice Pathway was developed and launched by CAFCASS in September 2016 and has been subject to ongoing training in 2017. The revised Family Court P.D.12J identifies that the Court must "have particular regard to any allegation or admission of harm by D.A. to the child or parents."

5.8.5 The School had an up to date Safeguarding Policy which was in line with the Local Authority Model Policy. There was no requirement for the School to have a D.A. policy at this time. However, the School had the expertise, through the designated Safeguarding Lead, to complete an assessment had it been required.

5.8.6 There was referral to a MARAC in 2011 following Zara being injured by broken glass when her sister's husband smashed a window. There was a separate MARAC referral but no Dash linked to Zara. A separate DASH for each referral is now required.

5.8.7 In 2011, the General Practice Safeguarding Policy was very basic and it did not give instructions on how to deal with D.A. reporting. The policy was completely rewritten, in 2013, to include much more detail on how to deal with different reports. There was a record via the HV of the MARAC in 2011 but details were not copied to the GP Practice and is not in any of the medical records.

5.8.8 The LCHS Safeguarding Children's Policy was available throughout the period of scope and it incorporates D.A. LCHS had a nurse lead for D.A. and she attended the MARAC meeting on the 23rd August 2011. The HV did not identify any concerns regarding D.A. outside any of the incidents in 2011 and therefore there was no requirement for risk assessments to be completed.

5.8.9 In 2011, ULHT did not have a stand-alone D.A policy or protocols. However, staff members recognised a need and instigated support via an alternative route. In 2015, the Trust created and published a Policy to support disclosures from patients

and staff members experiencing D.A. Consequently, should patients attend in similar circumstances today, there would be an expectation that such attendances would be managed in accordance with these processes.

5.8.10 The EMAS D.A. Policy was ratified and disseminated across the agency in April 2012. Staff have received ongoing training and updates in relation to developing practice.

5.9 Did action or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided or relevant enquiries made in the light of assessments given? What was known or should have been known at the time?

5.9.1 As the DASH risk assessments were all considered to be standard, there was no referral on by the Police for multi-agency consideration or to develop a risk management plan. There is no evidence of support or D.A. services being offered to Zara as the situation deteriorated in 2016 other than about seeking legal advice regarding the custody issues and on seeking a non-molestation order. Had Stefan been considered a suspect, enquiries in relation to the three reports of crimes and the allegations of stalking and harassment may have uncovered relevant information in relation to domestic abuse and the increased risks presented to Zara and prompted greater concern and response.

5.9.2 The referral to CSC did not meet the threshold for intervention in the form of a CSC assessment. An Early Help assessment was offered via the School and support offered e.g. exploration of free school meals. Stefan refused further contact via a TAC. Both were voluntary interventions and require parent's agreement. However, it is acknowledged at the time, that CSC were under the impression that a TAC was in place and help and support provided.

5.9.3 The actions taken by the School related to the assessment of the needs of Basia. For this purpose, services offered and enquiries made were appropriate. The role of D.A. in the family and particularly coercive control was not recognised. Stefan had taken steps to influence those professionals involved, that Zara presented a risk to Basia and the child was better in his care. This remained unchallenged as Zara was unable to have contact with Basia and present an alternative position. This behaviour was effective in controlling Zara's role as a mother.

5.9.4 Despite Zara's disclosure of abuse to CAFCASS, it appears this was seen as a separate issue from that of the welfare of Basia. That Stefan was likely to be using the family courts and child contact as a vehicle to continue to abuse Zara was not recognised. There is no evidence that CAFCASS referred Zara on for support and a finding of fact concerning D.A. was not seen as necessary. P.D.12J recommends

the use of a specialist risk assessment by an accredited agency to help improve the accuracy and understanding of the risk involved.

5.9.5 It has already been recognised that there was a missed opportunity for assessment in January 2011, by HV and to refer on by the Ambulance Service. Due to the lack of engagement by Zara following the MARAC appropriate services were not canvassed with her and the HV followed up the concerns by a home visit and a targeted 2-year assessment regarding Basia.

5.10 Were procedures sensitive to diversity, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerability and disability necessary? How accessible were the services for the victim and the alleged perpetrator?

5.10.1 It was recognised that Russian was the first language of this family and that Stefan had a better command of the English language than Zara, but both were able to communicate to a significant level.

5.10.2 It is recognised by the Police that there are improvements to be made in building better relationships with the Eastern European communities in the part of Lincolnshire in which this family lived. A specific Police Officer who is of Polish origin has been assigned to build trust with this community and increase the reporting of crime.

5.10.3 When considering how accessible services were for Zara, there appears to be little evidence of consideration by agencies involved, of the cultural differences between Latvia, Lithuania and the UK and how this may have impacted upon her disclosure of D.A. and accessing help. There had already been reference to the fact that Latvians, at least, do not openly discuss D.A. Shame and embarrassment are likely to have been a feature for Zara. She was a capable woman who had the courage to leave her home and settle in a new country; admitting to being a victim may not have come easily to her.

5.10.4 Fear may have been a significant barrier, fear of repercussions and fear of not being believed. Her suggested links to serious crime and the allegations by Stefan of her poor parenting, drug use etc. would, no doubt, have impacted greatly on her self-esteem and self-confidence and would had given her first-hand experience of being vulnerable to not being believed.

5.10.5 Zara's immigration status may also have been a barrier and the fear if she was found guilty of the crime, she may have been deported. She may have not wanted

to draw any more attention to herself and her situation. Victim blaming was already an issue for her in terms of the campaign Stefan had mounted to discredit her as a parent and alert others to her poor judgement in becoming involved with her new partner.

5.10.6 In May 2016, Zara told the Police she was afraid of Stefan and that he might be violent again and cause her injury. With hindsight, the greatest fear of all for disclosure for Zara may have related to the implications for Basia. Had Zara been found guilty and sentenced to imprisonment and Stefan recognised as someone responsible for significant D.A., what would happen to Basia. Zara was in a very complex situation, had she accessed D.A. services, it may have helped her to unravel her situation and to prioritise her safety.

5.10.7 Neither adult would have been considered vulnerable in line with the “no secrets” definition of a vulnerable adult or the Care Act 2014 definition of an “Adult at Risk.”

5.10.8 Basia was identified as a vulnerable child by the School due to her parent’s separation and conflict, her mother’s imprisonment and the allegations and counter allegations made. Basia was constantly monitored by the School to ensure she was safe and developing appropriately.

5.10.6 It is unknown whether Zara was aware of D.A. support services locally. Such support is limited in Latvia and this may have affected her expectation of what was available. He first recourse was to the Police for assistance. Locally, she did have a good network of friends and her sister from whom, it is hoped, she gained some support during this crisis period in her life.

5.11 <u>Consider whether there are any training needs arising from the case.</u>

5.11.1 The lessons learned from this case should be fed back to frontline staff as appropriate. Specifically, the importance of gathering all information and looking for patterns of behaviour rather than viewing each incident in isolation.

5.11.2 Education identified the importance of ongoing training on offer and bulletins that remind schools to adequate training on D.A. is in place.

5.11.3 EMAS use a blended approach to training varying training methods over a three-year period. EMAS deliver face to face training, then an education booklet, followed by an E learning package. From April 2017, all EMAS staff will complete an E

learning package and assessment around safeguarding and Domestic Violence and Abuse. This will be used as a training needs analysis and themes will be pulled from this DHR and used in the assessment and training during 2018 – 2019.

5.11.4 In September 2016 CAFCASS launched a new practice guidance to improve the response to allegations of D.A. during the family court process. The Domestic Abuse Practice Pathway has been subject to implementation and training in 2017.

5.11.5 Police identified that they should consider using the reported pattern of events in this case E.g. theft of cycle and two offences of criminal damage as a learning exercise during any future force wide training, particularly D.A. stalking and harassment and wider vulnerability training.

5.11.6 There is another DHR underway in the Lincolnshire area where controlling and coercive behaviour was a key factor in Domestic Abuse. The D.A. resulted in the death of the perpetrator's wife, his daughter and culminated in him killing himself. A range of learning has been identified and recommendations will be made.

5.11.7 The recommendations from that review include convening a range of practitioner events, across the county, highlighting the effect of controlling and coercive behaviour and also the increased risk posed at the time of separation. As well as county wide awareness training, the review suggests a nationwide publicity campaign concerning the significance of controlling and coercive behaviour. It also suggests the SLP: -

a) Should ensure that each statutory agency within their area provides assurance that its strategic safeguarding leads are able to ensure all frontline staff can recognise the signs and symptoms of this specific form of D.A.

b) Ask the CCG to issue a guidance note to all GP practices in their area, highlighting the need to ask questions overtly about D.A. and to ensure they have up to date knowledge of coercive control as a form of D.A. This action has already taken place and was part of a safeguarding newsletter to General Practices.

5.11.8 A previous DHR in the county identified the significance of cultural difference and expectation in dealing with D.A. It recommended that through the County D.A. protocol and training, practitioners are made aware of the need to consider the effect of cultural differences of those suffering D.A. to improve understanding and service delivery.

5.11.9 In the light of these recommendations already having been made, they will not be repeated as a recommendation from this DHR.

5.11.10 P.D.12J identifies the need for high quality training in D.V. to all Family Judiciary as recommended in the Cobb Review.

5.12 Consider the management oversight and supervision to the workers involved.

5.12.1 Police Officers would be expected to deal with the majority of the incidents contained in this review without requiring advice, guidance and supervision. Supervision was provided in that on every occasion when a DASH risk assessment was completed, a supervisor added their comments and verified the grading of risk. Sergeants should also monitor incidents attended by their staff and ensure, wherever necessary, a DASH risk assessment is completed.

5.12.2 The crime report in relation to the criminal damage to Zara's car on the 27th April 2016, was submitted through a sergeant who endorsed the report that enquiries were complete and that the identity of the suspect was not known. The sergeant should have recognised that the criminal damage offence was linked to the theft of the cycle six days earlier and both offences may have constituted D.A. The reviewing officer has discussed the matter with the Detective Superintendent responsible for investigative standards who has arranged for the officers and their supervisors involved in the theft of the cycle and the criminal damage to be given suitable advice.

5.12.3 The management of Child Protection and Safeguarding concerns within the School is exemplary as judged by Ofsted in March 2017. The regular review of vulnerable children has ensured that management had a clear oversight and that staff are supported and confident in making decisions.

5.12.4 The GP now has monthly safeguarding meetings which helps keep all clinical staff aware of ongoing cases. Any new cases are introduced at the next meeting. If a case requires immediate attention of all the staff, the Practice Manger will task staff so they are aware of any problems.

5.12.5 Safeguarding supervision and group safeguarding supervision was available to the 0 – 19 years' corporate team throughout the scope period. As the HV did not have any ongoing concerns in relation to the family, this case was not discussed within supervision.

5.12.6 This case was allocated, by CAFCASS, to a final year student Social Worker, who was coming towards the end of her placement. There was an experienced Practice

Educator involved who regularly met and reviewed the case with the student. The Service Manager had attended some of the sessions. The issue of the student using the inappropriate assessment tool, Safe Contact, rather than the Safe Lives tool together with the fact that specific D.A. information was not requested from the Police, did not appear to have been identified by the Practice Educator until the IMR was completed.

5.12.7 The CAFCASS Service Manager has reflected on whether this case should have been allocated to a student and has concluded that it was appropriate. The allocation was in line with specific guidelines included in the CAFCASS Handbook which refers to the suitability and complexity of cases. The team has reviewed how they decide which cases are allocated to students, using the guidelines, to give more consideration to the individual skills of the student.

5.13 Did any restructuring during the period of the review have an impact on the quality of the service delivered?

5.13.1 No agency identified any restructuring during the period under review which might have had an impact on the quality of the service delivered.

6 Lessons Learned.

6.1 Whilst there were two recorded incidents of D.A. in 2011, this family remained below the radar for agency involvement, other than in a very limited way, until four years later in 2015. They then came to the attention of the agencies following the breakdown of their relationship, separation and conflict over custody of their daughter. It is recognised that in January 2011 and May 2016, there was a lack of professional curiosity to explore with Zara the nature of the allegations she made of abuse, to undertake a full assessment based on her perceptions of fear and danger, to consider her safety and signpost her on to D.A. agencies for support as appropriate. There was also a lack of professional curiosity at other times, including from the GP when Zara requested a blood test to prove to her estranged husband that she was not using drugs, as he would not let her have contact with her daughter without this proof. There were no exploratory questions on the underlying problem in their relationship and the response focused on the presenting issues of the drug test

6.2 The first of three DASH risk assessments was completed in June 2015, the other two were in May 2016. They were all considered standard risk and related to verbal harassment and malicious allegations by Stefan. The danger surrounding the non-physical coercive controlling behaviour and intimidation went, largely, unrecognised and the risks remained below the threshold for intervention. Stefan used his custody of their daughter to control Zara and used false allegations of her poor parenting

and behaviour to discredit and undermine her in the eyes of professionals e.g. Zara was unable to have regular contact with her daughter, only seeing her twice between September 2015 and her death in May 2016. It is critical to recognise the risk factors associated with coercive control and take steps to ensure victims are aware of the dangers and for agencies to refer to specialist D.A. services for intervention.

6.3 Generally, agencies did not see the relationship as abusive. Whilst certain behaviour exhibited by Stefan was seen as malicious e.g. ringing The Ambulance Service and Police in June 2015, when he could not get his daughter to answer the door, there was little consideration of the risk this non-violent behaviour presented. In the main, the risks to their daughter were seen as a result of Zara's behaviour and her new relationship which were the subject of Stefan's allegations. Stefan was seen, by the School and potentially Children's Services and the Police, as providing the more consistent and appropriate parenting. It is important agencies are aware that for perpetrators to make false allegations against victims, in relation to care of children, is a recognised pattern of behaviour in abusive relationships and should be considered as such.

6.4 In April 2016, the Police did not recognise the three offences, of theft of the cycle and criminal damage to Zara's car, were linked and amounted to a pattern of escalating risk behaviour. Whilst Zara indicated that she suspected that her estranged husband was responsible for the offences, she had no proof. Stefan was not seen in relation to four of the five allegations made in April and May 2016. Had he been seen, the concerns regarding the risk he presented may have been more fully explored and further action taken.

6.5 Events were, largely, viewed in isolation and the emerging pattern of escalation in Stefan's abusive behaviour was not seen. Had the links been made, this may have increased the identified risk assessed via the two DASH completed in May 2016.

6.6 In 2015, there was activity with a variety of agencies following the breakdown of their marriage and separation. As a result, their child was placed on the Vulnerable Child Register by the School to monitor her well-being. This was seen as good practice. However, despite the activity between Education, CSC and the Police, there was a lack of joined up working between these agencies to fully understand the dynamics of the family and Zara was never seen in relation to the many concerns regarding the care of their daughter, until the Child Arrangement Order in April 2016.

6.7 Despite three referrals from Education to CSC asking for a Social Care Assessment, this case did not meet the threshold for such an assessment. It was considered the concerns were related to the dispute over custody of the couple's daughter and an Early Help Assessment and a TAC intervention were offered but not proceeded with. It should be recognised that where there is an abusive

relationship, separation and potential loss of the child, the risk to the victim is significantly increased.

6.8 There was a communication difficulty between the School and CSC in relation to the TAC. CSC were under the impression the TAC was in place from October 2015 to May 2016. However, the TAC never started as Stefan did not consider it necessary. Had CSC been aware there was no ongoing help and support involved with the family, they may have viewed the allegation by Stefan of his daughter witnessing her mother's inappropriate behaviour differently and become involved in undertaking an assessment.

6.9 Consistent and comprehensive record keeping is crucial in ensuring appropriate continuity of care and an integrated response. This is a recommendation in relation to the recording and communication in connection with the TAC.

6.10 In the circumstance of her being unable to have contact with her daughter due to Stefan's controlling behaviour, Zara asked School to keep her, regularly informed of her daughter's attendance and progress. It was agreed the School would ring her to do this. When contacted, the School found Zara's curt response inappropriate and discontinued the arrangement. An alternative form of communication, via text or letter, could have been considered to enable an ongoing and important link with her daughter.

6.11 Whilst the family's first language of Russian was not seen as a barrier to accessing services, the potential cultural barrier in this minority community of victim blaming attitudes and the expectations of the stereotypical role of women may have been. Fear concerning immigration status, shame and embarrassment and the fear of the child being removed from the parents may all have played their part in restricting disclosure and accessing services.

6.12 Although there were some concerns of varying degrees felt by Education, CSC, CAFCASS and the Police, none met the threshold for intervention and Zara was not recognised as a victim of D.A. in the form of jealous surveillance, coercive control and harassment. As concerns did not meet threshold for current multi agency involvement there was an absence of a co-ordinated response to fully understand the risk involved and to provide an intervention to protect her and her daughter.

6.13 The impending separation of the father from his child, caused by the mother's application to the Court for contact, was a piece of information that should have heightened the awareness of practitioners to her vulnerability and an increase in risk.

7 Conclusions

7.1 Both Zara and Stefan, independently, came to the UK from Latvia and Lithuania to pursue a better life with new opportunities. They met in 2009 and married in 2010, with their first and only child being born later that year. The first allegation of abuse was recorded in January 2011 when there was limited involvement with statutory agencies that fell short of an assessment and intervention and the couple appeared to resolve their difficulties. Prior to 2015, the contact with HVs suggested the couple had a close and effective relationship and that Zara was a caring and appropriate mother.

7.2 Zara's sister lived near to her in Lincolnshire and they provided each other with help and support reportedly having a close and caring relationship. Zara kept in touch with her parents in Latvia visiting in the holidays. Locally, she had a network of friends who also came from Eastern Europe. It is considered that D.A. is more prevalent in Latvia and Lithuania and it is, generally, considered more acceptable. The legislation to condemn it and support networks to manage it being less developed than in the UK.

7.3 The couple both worked in the food industry, working shifts and long hours. They rented houses and moved on a couple of occasions but within the same Eastern European community.

7.4 The relationship ended in the spring of 2015, according to Zara, in part, due to violence in the relationship. Zara met a new boyfriend. Initially, she retained custody of her daughter, although there was conflict with Stefan from the outset as he wanted sole custody of Basia. As a result, Stefan made what were viewed as malicious allegations to the School, CSC CAFCASS and the Police, about Zara's inappropriate parenting. These allegations are not uncommon in disputed custody cases the Police did undertake safe and well checks in relation to the child and there were no concerns. The School placed the child on the Vulnerable Child Register. Agencies saw the problem as one of conflict over custody arrangements and did not consider that D.A. may have been an issue.

7.5 Zara's new partner and others were involved in a serious assault on two men. In May 2016, he was convicted and sentenced to 18 years' imprisonment. Zara was arrested and charged with perverting the course of justice in that she assisted the offenders by giving them a lift in her car from the crime scene. She was remanded in custody for five weeks which presented Stefan with the opportunity to take control of the custody of their daughter. Although Zara was remanded on bail in October 2015, Stefan would not return their daughter to her or let her have any contact.

7.6 Unable to see her daughter, Zara took legal proceedings to try and gain access and custody of Basia. As the Court date of the 13th May 2016 neared, there became a pattern of her becoming the victim of crime and harassment from Stefan. Whilst

Zara told the Police that she thought Stefan was responsible for the offence of theft and an offence of criminal damage, the Police consider there was no evidence to make him a suspect in their enquiries. They were seen in isolation, even though they happened within an eight-day period, and they were finalised without Stefan being interviewed.

7.7 In early May 2016, Zara reported to the Police that Stefan was following her and taking video recordings and that he called at her home uninvited. She disclosed that she was frightened by his actions and that he had been violent towards her in the past and she feared he may be violent again. There were two DASH risk assessment s which were both considered standard risk. Zara was advised about a non-molestation order but no D.A. support services information was given and there was no evidence of exploration of her fears or the previous violence to fully understand the risks presented.

7.8 On the 9th May 2016, she was acquitted of the charges against her and on the 13th May 2016, there was a Family Court hearing regarding the custody arrangements for Basia. The allegations Zara made to CAFCASS about her being the victim of DA were not fully investigated and were seen as allegations and counter allegations not unusual in contested child arrangements orders. The outcome was custody to Stefan and only indirect contact to Zara. This must have been a terrible blow to Zara and a reinforcement of the success of the controlling behaviour by Stefan.

7.9 The 19th May 2016 was Stefan's birthday. In the evening the couple were seen together, on CCTV footage. The next day, Zara's body was found in the bath at her home following a report of a fire which had been set on the stairwell of her property. Zara had multiple injuries and had been drowned. Stefan was interviewed in connection with her death and was later charged and convicted of murder. In 10th April 2017, following the trial, he was sentenced to 23 years' imprisonment.

7.10 Agencies, in general, did not recognise D.A. in the form of Stefan's controlling behaviour and stalking and harassment and the risks it presented to Zara and, in turn, Basia. There was a clear escalation in Stefan targeting Zara prior to her death, with five incidents in a four-week period. Whilst it was not reasonable for any agency to predict the tragic events that were to occur, had there been some co-ordinated intervention, there may have been the opportunity to manage and reduce the risks.

8 Changes Already Taken Place

8.1 EMAS

8.1.1 Domestic Violence and Abuse training was included within the Safeguarding Think Family agenda delivered in 2011 / 2012 and in 2014 / 2016 and was a core training subject in 2012 / 2013. Staff have been provided with the skills to recognise D.A. and signpost individuals to the appropriate services. EMAS will continue to include D.A. updates on a yearly basis as part of safeguarding training.

8.1.2 During the educational year 2016 / 2017, a safeguarding workbook was compiled for completion by all staff members. This included a chapter on D.A. This will be quality assessed in 2017 / 2018.

8.1.3 EMAS are currently looking at developing D.A. pathways to directly refer victims to support services.

8.1.4 EMAS has been involved in a significant number of DHRs due to the large geographical area covered. Learning that is already identified includes naming of the alleged perpetrators and other witnesses on the patient report form (PRF). Therefore, this will not be subject to a recommendation in this review.

8.2 ULHT

8.2.1 All staff are now required to undertake training in relation to the identification and management of D.A. disclosures including nationally recognised methods of risk assessing and referral signposting.

8.2.2 In 2015, the Trust created and published a policy to support disclosures from patients and staff experiencing D.A. This can be accessed by all staff. In addition, documentation by ULHT Midwifery Services now contain a direct question in relation to D.A. which is asked at the initial booking and at regular intervals throughout the antenatal period.

8.2.3 The Safeguarding Team is represented at monthly A&E paediatric interface meetings, thereby facilitating prompt discussion with departmental leads should issues relating to safeguarding be identified.

8.2.4 Given the Authority's difficulty to source and secure copies of the A&E attendance records for Basia (which are stored off site under contract with a Records Management Company) the issue has been escalated to the relevant members of the Trust's Senior Management and Executive Team and also to the Contract Manager for the Records Management Company. It has been requested they

review this situation whilst suggesting that the Record Management Company consider reviewing their processes for tracking records accordingly.

8.3 Lincolnshire Community Health Service (LCHS)

8.3.1 LCHS implemented D.A. training as a mandatory safeguarding programme in 2013 / 2014 and all staff were required to attend this. The training included risk assessment and referral to MARAC, professional curiosity and how to ask the D.A. questions.

8.4 The General Practice.

8.4.1 The Practice Safeguarding Policy was rewritten in 2013 to include much more detail on how to deal with different incidents reported to the practice.

8.4.2 The practice now has monthly safeguarding meetings which helps to keep all clinical staff aware of ongoing cases. Any new cases are introduced at the next meeting. If a case requires immediate attention of all staff, the Practice Manager will task all staff so they are aware of the issues.

8.4.3 Since the beginning of 2016, the practice now records a message on the front of the medical record to warn the clinician that there are certain conditions. This would include safeguarding concerns. The practice is exploring whether this can be an icon or symbol that can appear on every page of the medical record rather than just on the first page, to remind staff of the relevant issue.

8.5 Lincolnshire County Council MARAC

8.5.1 A separate MARAC referral and a separate DASH are required for each individual case being referred to MARAC, even if it reflects the same incident experienced by different parties.

8.6 West Lincolnshire Domestic Abuse Service (WLDAS)

8.6.1 The IDVA Service, when there is consent, will make every effort to contact the victim and, if safe to do so, will write a letter offering them the service. If no consent is available, the IDVA Service will make every effort to work with the referring agency to explore avenues to reduce risk.

8.6.2 Where there is consent from the victim for contact, the IDVA Service will update the victim, after MARAC, with any action and safety plans unless there is a better suited agency involved at the time. This is now recorded on each client record on the MODUS MARAC case system.

8.7 Lincolnshire County Council Children's Services

8.7.1 The Team Manager in CSC will ensure that contacts containing allegations of a child witnessing sexual activity are considered for a referral for Social Care assessment and the rationale recorded.

8.8 Lincolnshire Police

8.8.1 Lincolnshire Police have recently equipped officers with Mobile Data Terminals (MDTs) and 90% of DASH risk assessments are now completed by officers using an MDT. Improvements have been incorporated into the DASH risk assessment on the MDT in that further detail must be added in a number of areas including whether a victim states he or she has previously been a victim of violence committed by the suspect. Also, if an officer identifies that stalking or harassment applies to the incident, then eleven extra questions appear on his or her MDT which the officer must complete.

8.8.2 In July 2017 HMICFRS released "Living in Fear" an inspection report into police service response to stalking and harassment. Lincolnshire Police are investing in and undertaking a programme of work which includes the creation of a new role of a stalking and harassment project worker. This role will deliver specific officer training alongside Paladin which is a lead organisation in this field, it will involve working with a survivor of stalking to raise the profile in the county and to lead a criminal justice partners workshop which agreed to form a multi- agency scrutiny group on this issue. Lincolnshire Police also ceased the use of PINs with immediate effect and is awaiting further national developments to take forward in the county.

8.9 CAFCASS

8.9.1 The CAFCASS team have reviewed how they follow the specific guidelines in the handbook concerning case allocation to students, to consider the complexity and suitability of cases to match the individual skill of the student.

8.9.2 A Domestic Abuse Practice Pathway was developed and launched by CAFCASS in September 2016 and has been subject to ongoing training in 2017.

8.10 Family Courts

8.10.1 The new P.D.12J October 2017 makes a number of recommendations concerning child arrangements and contact orders, D.V. and harm, focussed upon improving the safety and wellbeing of the child(Ren) and non-abusing parent.

9 Recommendations

9.1 EMAS

9.1.1 From April 2017, all staff will be required to complete an E Learning Package and self-assessment around safeguarding and D.A. This will be used as a training needs analysis. Themes will be taken from this review and used in the assessment during 2017 / 2018.

9.1.2 EMAS will implement the lessons learned from this review as part of a continuing engagement with the safeguarding agenda.

9.2 The General Practice.

9.2.1 Clinical staff are to record the name and relationship of people attending with the patient.

9.2.2 The General Practice to agree an icon or symbol for safeguarding concerns to be included on the top right of the medical record. This will be added to all medical records where there is a safeguarding concern by the end of October 2017.

9.3 Community Safety Partnership

9.3.1 Ensure all staff in lead agencies are able to understand the power and control dynamics of D.A. and are able to recognise coercive control.

9.3.2 All relevant agencies to be informed of the learning from this review in relation to the risk associated with D.A. perpetrators making false accusations about their ex-partner's ability to parent and using child contact arrangements as a means to further control and abuse their ex-partner.

9.3.3 In line with the agreed process, all lead agencies to be reminded to inform the TAC Administration Support Team within Children's Social Care when a TAC ends.

9.3.4 To approach NHS England to request that the National Medical Computer System includes a nationally agreed icon or symbol for safeguarding concerns that would appear on every page of the medical record rather than the front page alone.

9.4 Lincolnshire Police

9.4.1 Lincolnshire Police should consider using the reported pattern of events in this case, (theft of a cycle and two offences of criminal damage) as a learning exercise during any future force wide training, particularly Domestic Abuse, Harassment and Stalking training and wider vulnerability training to evidence the importance of looking at the pattern of offending rather than viewing incidents in isolation.

9.5 CAFCASS

9.5.1 To ensure all staff assess allegations of D.A. thoroughly in line with agency Domestic Abuse Practice Pathway guidance provided.

Marion Wright

Independent Author

10. Glossary of Terms

A&E	Accident and Emergency Department

CAF	Community Assessment Framework
CAFCASS	Children and Family Court Advisory Support Services
CCGs	Clinical Commissioning Groups
CRU	Central Referral Unit (Police)
CSC	Children's Social Care
CSE	Child Sexual Exploitation
SLP	Safer Lincolnshire Partnership
DA	Domestic Abuse
DAO	Police Domestic Abuse Officer
DASH	Domestic Abuse Stalking and Harassment and Honour Based Violence
DHR	Domestic Homicide Review
DV	Domestic Violence
DVA	Domestic Violence and Abuse
EHA	Early Help Assessment
EMAS	East Midlands Ambulance Service
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
HMP	Her Majesty's Prison
HV	Health Visitor
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Report
LCHS	Lincolnshire Community Health Service
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MDT	Mobile Data Terminal
NHS	National Health Service
PD	Practice Direction
PPU	Police Public Protection Unit
TAC	Team Around the Child
THRIVE	Threat Harm Risk Investigation Vulnerability and Engagement
TOR	Terms of Reference
ULHT	United Lincolnshire Hospital Trust
VISOR	Violent and Sex Offenders Register
WLDAS	West Lincolnshire Domestic Abuse service