Salford Community Safety Partnership

Domestic Homicide Review

Overview Report

‘Steven’

Died August 2019

Chair David Hunter
Author Ged McManus

February 2022

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Steven[1], a resident of Salford prior to his murder in August 2019. The DHR panel would like to offer their condolences to Steven's family on their tragic loss.

1.2 Steven's former wife supported his sons whilst Steven was on life support in hospital and was part of the decision to turn off life support when medical advice indicated that course of action. Steven's sons and his surviving sister consented for his former wife to represent them by taking part in the review. She provided the following tribute on behalf of his family.

1.3 Tribute to Steven

'He was a gentle giant with a heart of gold, he was full of life and laughter. Steven would help anyone and give them his last penny, he loved all animals, he had the most amazing smile and his laughter was infectious. He was an amazing dad, a treasured brother and fantastic husband. He is missed each and every day and his memory will live on through his family forever'.

For anyone suffering domestic violence.

'To anyone reading this, please seek help, speak to family or friends or a doctor, anyone who you can confide in. Don't feel embarrassed or ashamed you've done nothing wrong. There is help and support there for you and once you make that first step things will get better and you will get the help and support you desperately need, please don't suffer in silence, your life is important too'.

1.4 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 community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

[1] A pseudonym for the victim selected by the DHR panel.

1.5 For approximately twelve months before his murder Steven lived with Roland's (a juvenile) [2] mother Karen[3]. He had moved into her home where she lived with Roland, his young cousin and two other children. Although he appeared to others to be living with Karen, Steven maintained a tenancy on his own home for some months and applied for rehousing in his own name in May 2019. The application gave his own address and did not mention Karen or Roland.

1.6 There was tension amongst different parts of the family, for example Karen's adult daughter asked the police for a 'Clare's law' disclosure (DVDS)[4] in relation to Steven. Roland's two younger siblings were removed from the home by their father (Karen's estranged husband) and there was an investigation by Children's Social Care under section 47 of the Children Act 1989.

1.7 On the day of Steven's murder an argument broke out between Steven and Roland. This became physical and Roland stabbed Steven in the head with a kitchen knife. On the arrival of police and paramedics, Karen tried to protect Roland by telling them that another man had stabbed Steven and left the house.

1.8 Steven was taken to hospital but died from his injury the following day. Roland was arrested and charged with his murder. Karen was also arrested and charged with Perverting the Course of Justice.

1.9 Roland pleaded not guilty to Steven's murder and claimed that he had acted in self-defence. After a two week trial he was found guilty of murder and detained at Her Majesty's Pleasure (the youth equivalent of life imprisonment). He has to serve a minimum of 11 years imprisonment before he can be considered for release. Karen who had been granted bail did not appear in court and a warrant was issued for her arrest. She was later arrested and sentenced to eighteen months imprisonment for Perverting the Course of Justice.

1.10 The review will consider agencies contact and involvement with Steven, Roland and Karen from 16 February 2018, until Steven's murder in August 2019. This time period was chosen as it was several months before Steven and Karen were believed to have met and encompassed important life events for Roland. The panel agreed to extend the time period a week beyond the homicide in

[2] A pseudonym for the perpetrator selected by the DHR panel and agreed with the victim's family

[3] A pseudonym for the victim's partner and perpetrator's mother selected by the DHR panel and agreed with the victim's family

[4] Domestic Violence Disclosure Scheme https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

order to incorporate any safeguarding issues after the homicide if that became appropriate. Background information prior to the terms of reference period was also available to the panel and is used in the report for context.

1.11 The intention of the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.12 **Note:**
It is not the purpose of this DHR to enquire into how Steven died. That is a matter that has already been examined during Roland's trial.

2 TIMESCALES

2.1 This review began on 31 October 2019 and was concluded on 16 December 2020 following consultation with Steven's family. The panel met on 31 October 2019 and decided on which agencies needed to complete Independent Management Reviews. Its next meeting was scheduled for 18 March 2020 when the panel would have reviewed the Independent Management Reviews (IMR's)[5]. This meeting was cancelled by restrictions in place as a result of the corona virus. The panel did not therefore meet to review the IMRs. However IMR queries were raised within subsequent virtual meetings.

A decision was taken that the author should produce a draft report which would then be reviewed by the panel. The first draft of the report was reviewed by the panel in a meeting conducted using Microsoft Teams video conferencing on 2 June 2020. A new schedule for the review was agreed and three further meetings took place by video conference.

2.2 On 28 July 2020, the last scheduled meeting of the panel took place following which an updated version of the overview report was produced and shared with the panel. The report was then shared with Steven's family on 14 September 2020.

2.3 On 22 October 2020, the author of the report spoke to Steven's ex-wife who represented his sons and his sister. The family requested an amendment to the report which removed information that they considered personal to them. They also provided information in relation to Roland's actions which were unknown to the author of the report. After a further request for information from the police investigation this additional information in the form of text messages found on Roland's mobile phone has been confirmed and is now contained in the report.

2.4 Steven's family wished to make comment on the report in three other areas.

1. The family thought that Steven's admissions to hospital with head injuries and his later attendance to see his GP when he complained of low mood were red flags for abuse and should have been recognised as such.
2. Steven lived in a three bed flat and after the two other people living there left he fell into rent arrears as he was unable to pay the 'bedroom tax'. His family thought that if he had been moved to a one bedroom flat at this point then problems would have been avoided as he would not have built up the arrears that led to his eviction. They also think that it may

[5] IMRs are the reports submitted by agencies to the review.

have been in part the pressure of his housing situation which caused him to move in with Karen.

3. The family's view is that Steven's relationship with Karen was at the root of the issues between Steven and Roland. Their view is that when Karen began paying attention to Steven, Roland became jealous and this led to the animosity that Roland felt towards Steven. The family would have liked to see Karen make a contribution to the review.

2.5 After amendments were made to the report at their request the family were provided with a copy of the updated report. The family did not then engage further in the process and after consultation with their Victim Support homicide worker it was confirmed that the family no longer wanted to be involved. Nevertheless, the DHR chair will write to the family before publication and invite them to read the report. The DHR panel were provided with the updated report and agreed with the amendments that had been made. The process was concluded in December 2020.

3 CONFIDENTIALITY

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 The report uses pseudonyms in order to protect the identity of the victim, perpetrator, and perpetrator's mother.

4 TERMS OF REFERENCE

4.1 The purpose of a DHR is to

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

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

Apply these lessons to service responses including changes to inform national and local 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 that domestic abuse 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.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.2 Timeframe under Review

The DHR covers the period 16 February 2018 to September 2019. See 1.10 for rationale.

4.3 Subjects of the review

Steven age 52: Victim
Roland age 17: Perpetrator
Karen age 48: Partner of victim, mother of perpetrator

4.4 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that may have identified Steven as a victim of domestic abuse, and Roland as a perpetrator; what was the response?

2. What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Steven as a perpetrator of domestic abuse, and Roland as a victim; what was the response?

3. What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Karen as a victim and/ or perpetrator of domestic abuse; what was the response?

4. What influence did Roland's age have on your agency's dealing with him relevant to the terms of reference?

5. What barriers existed that may have prevented Steven from seeking help for his domestic abuse victimisation?

6. What barriers existed that may have prevented Roland from seeking help for any domestic abuse offending?

7. How did your agency respond to any potential child safeguarding indicators when dealing with domestic abuse involving Steven and Roland?

8. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Steven and Roland?

9. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Steven and/ or Roland, or on your agency's ability to work effectively with other agencies?

10. What learning has emerged for your agency?

11. Are there any examples of outstanding or innovative practice arising from this case?

12. Does the learning in this review appear in other domestic homicide reviews commissioned by Salford Community Safety Partnership?

5 METHODOLOGY

5.1 Following Steven's murder, formal notification of the homicide was sent to Salford Community Safety Partnership by Great Manchester Police on 1 September 2019. A screening meeting took place on 18 September 2019, where it was agreed to conduct a Domestic Homicide Review. The Home Office was then informed.

5.2 At the first DHR panel meeting an action was raised to discover whether the case had been screened by Salford Safeguarding Children Partnership to determine if it met the criteria for a child safeguarding practice review. On 25 November 2019, the Salford Safeguarding Children Partnership held a case review meeting and determined the circumstances did not meet the threshold for a child safeguarding practice review. The meeting did identify several points it felt would benefit from examination by the domestic homicide review. These are considered in Terms of Reference 2 and 4.

6 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES AND WIDER COMMUNITY

6.1 Family

6.1.1 The DHR Chair wrote to Steven's family inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet. The letters were personally delivered by the police Family Liaison Officers.

The DHR chair wrote to Karen (the perpetrator's mother) in prison inviting her to contribute to the review and included the Home Office and AAFDA leaflets. She did not reply.

The DHR chair was unable to establish reliable contact details for the perpetrator's siblings and cousin and made a decision, supported by the DHR Panel, not to pursue engagement with the perpetrator's extended family.

6.1.2 As set out at paragraph 1.2, Steven's family were represented by his former wife who agreed to speak to the author of the review and provided the tribute at paragraph 1.3. She also provided much of the biographical information which is set out in paragraph 13. Victim Support provided support to her as required.

6.1.3 In addition to the information at paragraph 13 Steven's family were able to provide information that was not known to agencies.

6.1.4 Steven met Karen in a pub whilst he was playing darts. Whilst it is uncertain exactly when, this was sometime in summer 2018. Karen quickly began spending time at Steven's flat where she would stay for several days at a time.

6.1.5 Steven shared his three bedroomed flat with his son and a friend. When the friend moved away he found it difficult to keep up with the rent. His son also moved out which made things more difficult.

6.1.6 Steven's family say that they feel he was being bullied by visitors to the flat who they believe were associates or family of Karen's. For example the walls of the flat were covered in offensive graffiti.

6.1.7 After Steven suffered a head injury in September 2018 he effectively moved in with Karen. Steven's family do not believe his 'accidental' explanation for his head injury and believe that he was assaulted by a family member or associate of Karen.

6.1.8 During the period when Steven was not living in his flat there continued to be reports of anti-social behaviour from the flat. Steven's family believe that the

flat had been taken over by Karen's family or associates resulting in noise and other complaints. This displays some of the features of "Cuckooing", where criminal gangs target the home of vulnerable people to be used for criminal practices, with victims often left with little choice but to cooperate. The practice is named after the parasitic nest stealing practices of the cuckoo bird.[6]

6.1.9 Steven maintained a relationship with his sons for some months, for example meeting them to go bowling or to the cinema but after a while he began to let them down and their relationship became more distant. He became guarded in what he said and in the last few months of his life he was not in touch with his family. They believe that if Steven had been suffering from abuse he would not have said anything and would have kept it to himself as he did not like being on his own.

6.2 Steven's Friend

6.2.1 During the course of the criminal investigation the police made contact with a friend of Steven's who no longer lived in the Salford area. The friend was not seen as part of the DHR process.

6.2.2 The friend said that after the break-up of a relationship in 2017, he had moved into a spare bedroom at Steven's flat and had lived there for about a year. Steven's son also lived in the flat for some of the time. The friend moved out after around a year but kept in touch and visited Steven from time to time. During these visits Steven told him that he had met Karen. During one visit the friend saw a bag of white powder which he assumed was illicit drugs and spoke to Steven about it. Steven told him that the bag belonged to another man who had visited the flat. There is no information on whether Steven used drugs. It would be speculative to suggest that the later deterioration in his physical appearance was caused by drug use. As will be seen later in the report it appears Steven and Roland disapproved of potential drug use within the home.

6.2.3 The friend then moved away to a distant part of the country and the men did not keep in touch. About four weeks before Steven's murder his friend visited Salford and went to the flat to see him. He found the flat empty but after making enquiries with neighbours he visited Steven at Karen's house. The friend found that Steven was subdued and not his normal self. He looked 'rough' and had lost weight. Steven did not want to invite his friend into the house so they drove to a local retail park where the friend bought a mobile phone for Steven and

[6] Spicer, Moyle and Coomber (2019) The variable and evolving nature of Cuckooing as a form of criminal exploitation in street level drug market. Trends in organised crime.

told him to get in touch if he needed anything. Over the next few weeks the friend rang Steven but the phone was never answered.

6.2.4 Around ten days before Steven's murder, the friend visited him at Karen's house again. Steven answered the door but was unusually unwelcoming and asked, 'What do you want'. The friend noticed that Steven had a cut on his eyebrow and that his bare feet were dirty. When asked what was wrong Steven said 'Karen doesn't like you', his friend thought that this was a strange comment as he had never met Karen. A man and woman were standing behind Steven in the doorway. Steven's friend left and did not see him again.

6.3 The Perpetrator

6.3.1 The independent chair of the review wrote to Roland in prison to invite him to take part in the review. Following this there were further communications with prison staff who were supporting Roland. However, after a number of discussions on the subject with prison staff Roland initially declined to take part in the review.

6.3.2 Roland did however agree to speak to his criminal justice worker. Roland was complimentary about the services that he had been engaged with at the Gypsy Wagon Heritage Project[7] and Salford City College. He said that he could remember speaking to a social worker and felt that he did not have any particular needs at that time. Through conversations with his criminal justice worker Roland later agreed to speak to the author of the review.

6.3.3 A prison transfer and restrictions on visiting as a result of the corona virus meant that arranging to speak to Roland was not possible for several months. However, prison staff were helpful in arranging a video meeting between Roland and the report's author when that became possible in late August 2020. Roland's comments to the author are repeated without judgement and no enquires have been made as to their efficacy.

6.3.4 Roland said that he was introduced to Steven soon after Karen and Steven had met. Roland could not remember exactly when this was but knew it was after Steven had been in hospital with a head injury (September 2018).

6.3.5 Roland said that he was wary of Steven and found him physically intimidating although at first thought that they had got on. As Steven and Karen's

[7] Members of the Salford Irish Traveller community, Salford Children's Services and Salford Community Leisure took part in a three year project to build a traditional Bill Wright-style Bow Top Gypsy wagon. They worked with a local Irish Traveller master craftsman, learning traditional skills of wagon making which have been passed down over many decades. They also learnt about the lifestyle, culture and traditions of life and survival on the road.

relationship progressed Roland said that Steven became more aggressive verbally and this escalated into physical abuse, towards Karen, on a number of occasions. Roland said that he attempted to intervene to protect his mother during some incidents but that he then got on the wrong side of Steven and their relationship deteriorated.

6.3.6 Karen began spending time outside the home and was working informally for a friend although Roland did not know what this involved. The result though was that Roland and Steven spent much of the time together in the house. Roland said that he spent most of the time in his room playing games on his Xbox, only coming out to get food. Although he was trying to avoid Steven this led to further friction, for example there were arguments when Roland had only made food and drink for himself and not for Steven as well. On one occasion Roland said that this resulted in Steven throwing a cup of tea over him.

6.3.7 Roland was aware that Steven had two sons but thought that they had fallen out and were not in touch. He was aware that a friend of Steven's had bought a mobile phone for him and said that this was a cause of conflict with Karen as the purpose of the phone was to assist in something criminal that Steven and his friend were planning. There is no evidence the telephone was provided for other than altruistic reasons.

6.3.8 Professionals had observed that the home was historically kept in a very tidy and spotlessly clean state. However, photographs taken at the time of Steven's murder show that the house was very untidy with accumulations of clothes and rubbish right around the house. Roland said that after his two younger siblings were moved to live with his father Karen's behaviour changed. For example she started hoarding and often bought clothes and toys for the younger children in the hope that they would be returning to live with her at some point. This was compounded when Steven was evicted from his flat and moved all of his possessions into the house.

6.3.9 Roland said that he had been really unhappy and now wished that he had told someone about what was happening. In hindsight he thought that this could have been the police, a social worker, someone at college or a relative. He didn't tell anyone as it had been ingrained into him that the family sorted out its own problems and he was never to call the police. He acknowledged that he had called the police on one occasion to report that his brother had assaulted him but he had later bitterly regretted calling them.

6.3.10 Asked what he would say to anyone else in the same position Roland said 'Just tell someone'.

It is known that a person's experience in their formative years can impact on their later behaviour. It could not be determined whether Roland's childhood experiences contributed to the murder of Steven.

Adverse Childhood Experiences [ACE]

It is not known whether Roland endured Adverse Childhood Experiences [ACE][8] which are defined as 'highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity.'

Impact of ACEs

Just like attachment, experiencing ACEs can have an impact on our future physical and mental health, and often ACEs can be barriers to healthy attachment relationships forming for children. Some of the effects of ACEs on our physical and mental health are:

- An increase in the risk of certain health problems in adulthood, such as cancer and heart disease, as well as increasing the risk of mental health difficulties, violence and becoming a victim of violence.
- An increase in the risk of mental health problems, such as anxiety, depression, and post-traumatic stress. 1 in 3 diagnosed mental health conditions in adulthood directly relate to ACEs.
- The longer an individual experiences an ACE and the more ACEs someone experiences, the bigger the impact it will have on their development and their health.

Some of the other things exposure to ACEs can impact, are:

- The ability to recognise and manage different emotions.
- The capacity to make and keep healthy friendships and other relationships.
- The ability to manage behaviour in school settings.
- Difficulties coping with emotions safely without causing harm to self or others.

[8] Source: https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

7 CONTRIBUTORS TO THE REVIEW/ AGENCIES SUBMITTING IMRS[9]

7.1	**Agency**	**Contribution**
	Greater Manchester Police (GMP)	IMR
	Salford Youth Justice Service	IMR
	Salford Child and Adolescent Mental Health Service (CAMHS)	IMR
	Salford Ethnic Minority and Traveller Achievement Service (EMTAS)	IMR
	ForHousing	IMR
	Salford Housing Options	IMR
	NHS Salford Clinical Commissioning Group (CCG)	IMR
	Salford Royal NHS Foundation Trust	IMR
	Salford Children's Services	IMR
	Salford Youth Service	IMR

7.2 As well as the IMRs, each agency provided a chronology of interaction with Steven, Roland and Karen including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Steven, Roland or Karen or any involvement in the provision of services to them. The exception to this is EMTAS where the small numbers of staff meant that the IMR author had personal knowledge of Roland and Karen. The IMR author had knowledge of Roland and Karen because the EMTAS service had received a referral from Roland's primary school for some additional educational support which he was eligible for because of his Irish Traveller/ English Gypsy heritage. The IMR author was the lead Traveller Co-ordinator across the City at this time but did not support Roland directly. The IMR was quality assured by another senior member of staff and the DHR panel accepted that this was a reasonable and proportionate approach.

[9] Independent Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Steven and/or the perpetrator.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Steven, Roland and Karen and any other action taken.

7.4 It should also provide an analysis of events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

7.5 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.6 The IMRs in this case were of good quality and focussed on the issues facing the subjects of the review. They were quality assured by the original author, the respective agency and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

8 THE REVIEW PANEL MEMBERS

David Hunter	Independent Chair
Ged McManus	Author
Roselyn Baker	CSP Manager
Alison Troisi	Detective Sergeant Greater Manchester Police
Jane Anderson	Housing Options
Andrea Patel	Salford CCG
Kay Davidson	Salford Youth Justice Service
Jacqueline Marsh	Greater Manchester Mental Health NHS Foundation Trust (GMMH)
Emma Ford	Head of Safeguarding Salford Children's Services
Mark Fitton	ForHousing
Dawn Redshaw	Salford Women's Aid
Tim Rumley	Salford Youth Service
Gail Winder	Salford Royal NHS Foundation Trust
Chris Howl	Salford City Council Policy and Equality Officer
Natalie Stables	Salford Ethnic Minority and Traveller Achievement Service
Mary Fenner	Salford Child and Adolescent Mental Health Service (CAMHS)
Rhys Dower	LGBT Foundation Manchester[10]

10 LGBT Foundation is a national charity delivering advice, support and information services to lesbian, gay, bisexual and trans communities.

9 AUTHOR AND CHAIR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the Chair and Author were separate persons.

9.2 David Hunter was appointed as the DHR Chair. David is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service. He did not serve in Greater Manchester.

9.3 Ged McManus, another independent practitioner assisted the independent Chair and wrote the report. He has chaired and written previous DHRs and Safeguarding Adult Reviews. He is currently the Independent Chair of a Safeguarding Adult Board in the north of England (not Greater Manchester) and was judged to have the skills and experience for the role. Prior to becoming an independent practitioner he served for over thirty years in the police service. He did not serve in Greater Manchester.

9.4 Neither independent practitioner has conducted previous work in Salford and they are both entirely independent of any agency involved in the review.

10 PARALLEL REVIEWS

10.1 An inquest was opened and adjourned immediately following Steven's murder. The Coroner decided on 27 May 2020, that the inquest hearing was not to be resumed following receipt of notification of the conclusion of the criminal trial, a provision made available under Schedule 1 of the Coroners and Justice Act 2009.

10.2 There are no other parallel reviews to this case. See paragraph 5.2 for an explanation of why there was not a child safeguarding practice review.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process.

11 EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** (for example an age group would include “over fifties” or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range).
- **disability** (for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act).
- **gender reassignment** (for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act).
- **marriage and civil partnership** (for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic).
- **pregnancy and maternity**
- **race** (for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens).
- **religion or belief** (for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be).
- **sex**
- **sexual orientation** (for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex

from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So a gay man and a lesbian share a sexual orientation).

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:

(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 Steven was white male of British Heritage, and a non-traveller. Any abuse towards him may not have been seen as domestic abuse; but more as anti-social behaviour and low value criminal damage.

It can be argued that Steven entered a cultural environment he knew little about. That fact alone may have added to any other vulnerabilities he was experiencing. For example, in 2019 Steven sustained a known head injury. Later that year he complained to his GP of memory loss and low mood. He was medicated for his low mood which appeared to have its origins in the earlier head injury. These matters may well have added to his existing vulnerability of living in an unfamiliar cultural environment where he faced hostility from the perpetrator.

11.3 Roland was of dual heritage English Gypsy and Irish Traveller.

Roland had expressed to support workers that he thought he was bisexual. He had briefly attended an LGBT group and attended a PRIDE march. He later expressed his regret at making the disclosure. It is unknown if any of this information was known to his family.

The following research extract offers some insight into the complexities faced by members of the LGBT community.

'Many lesbian, gay, bisexual, and transgender (LGBT) people from Gypsy Roma and Traveller communities sadly experience homophobia, which is similar to many other cultures. Many hide their sexual identity because they fear rejection by their family and community, others because of their religious beliefs.

There is no empirical research or statistics to evidence the hidden problem of homophobia within the Gypsy Roma Traveller communities against their own LGBT community. From our own casework and engagement with the wider Gypsy Roma Traveller (GRT) NGO sector and various other stakeholder groups, we know this is a real issue within the GRT community, however it is

still rarely talked about.

The shame and guilt inflicted on LGBT community members has and can force many to live their lives in denial, in secret, fearing for their health and wellbeing.[11]

11.4 Roland was invited to join the Heritage Lottery Project Wagon project because of his Gypsy/Traveller Heritage, and it was an opportunity to try and engage him back into some kind of structured educational experience after he had been Electively Home Educated for several years.

11.5 Karen had lived a settled lifestyle for several years. The following information based on research illustrates the experience and associated difficulties faced by women from the traveller community.

No reliable statistics are available regarding prevalence of domestic abuse in Gypsy + Traveller communities, however a 2007 study in Wrexham found that 61% of married English Gypsy women and 81% of married Irish Traveller women interviewed had experienced direct domestic abuse .

While many incidents of domestic abuse are perpetrated by husbands and intimate partners, other family members may be perpetrators of domestic abuse.

Domestic abuse is accepted as normal for many women. A pilot project in Leeds found that many women from the Gypsy and Traveller community who accessed their training were surprised to learn that many behaviours they took for granted were actually forms of domestic abuse.

Research suggests that domestic violence may first commence in some incidents when a family moves into a house and tensions arise as they experience isolation, discrimination, financial hardship and depression. Anecdotal evidence suggests that domestic abuse occurs particularly when women become more economically or politically active outside of the home while traditional male roles are less easy to sustain thus challenging traditional gender roles.

There is a strong belief within the Gypsy and Traveller community that marriage is for life. Divorce is rarely acceptable and women who do leave their husband often experience shame and discrimination, or have to leave the community entirely:

[11] Source: https://travellermovement.org.uk/advocacy-support/lgbt

Anecdotal information suggests that insecurely accommodated or nomadic women experiencing violence will often put their family first, prioritising the need to maintain a home over their own health and well-being.

A lack of awareness about domestic abuse and the services available to help victims means that women often feel that leaving an abusive relationship is not an option.

Barriers to Leaving an Abusive Relationship:
If a woman leaves her husband, she may have to leave her whole community, which can mean leaving her culture and way of life and facing the prejudice of the settled population alone'.[12]

11.6 Domestic homicide and domestic abuse in particular, is predominantly a gendered crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, according to the Office of National Statistics homicide report;

"There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner

Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims).

Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women).

11.7 An additional problem besetting women from the travelling community is Patriarchy; a system of social organization characterized by male dominance.

'Women's role in Gypsy and Traveller communities:
The National Traveller Women's Forum (Ireland) (NWTF) sets out the position as follows:

[12] www.equalityhumanrights.com/en/file/6231/download?token=XyDGlOUh

Traveller women play a central role in Traveller society. In the domestic sphere, they assume responsibility for child rearing, care of the home and the welfare of both their immediate and extended families. Similar to women in the settled community, they are often the key point of contact with frontline service providers such as GPs, social workers, local authority personnel with responsibility for accommodation, schools, etc. In this context, the well-documented existence of institutional discrimination and prejudice directed at GRT is more likely to affect Traveller women than Traveller men…

Broadly speaking, gender roles are clearly divided in the Traveller with distinct divisions between experiences, expectations, decision-making authority and the sense of value associated with each sex. In the main, and undoubtedly with exceptions, men are the dominant grouping, with more access to power, control and decision-making authority'.[13]

11.8 No one outside the household had a clear picture of what was happening. Steven's friend suspected something but did not know what. The panel discussed whether Steven being male (sex) and older meant that what was happening to him was either less understood or dismissed as a different form of violence but could not come to a conclusion. The panel recognised that Steven was different from the rest of the household as he was not from the travelling community.

[13] https://travellermovement.org.uk/phocadownload/userupload/Women/Briefing-paper-on-GRT-women-March-2017_2017.03.07_final.pdf

12 DISSEMINATION

12.1 The following people/organisation will be furnished with a copy of the report prior to publication.

- Steven's family,
- Home Office,
- Salford CSP and its constituent agencies.

13 BACKGROUND, OVERVIEW AND CHRONOLOGY

13.1 INTRODUCTION

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid some duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is from documents provided by agencies and the family and material gathered by the police during the homicide investigation.

13.2 Steven

13.2.1 Steven was the oldest of four siblings and was born in the Manchester area. His mother died when he was nine years old and together with his siblings he spent much of his childhood in foster care. When his father started a relationship with a new partner, Steven and his siblings went back to live with their father but the arrangements broke down and they spent time in foster care again. Steven's father passed away when Steven was fifteen. On leaving foster care Steven was provided with a flat by the local authority and became independent.

13.2.2 Steven met his wife when he was twenty four, they got married in 1995 and had two children together. As a young man he worked at a DIY store but injured his leg when he fell from a loading bay and did not work after that.

13.2.3 The couple separated in August 2015. Steven moved into his son's flat and then lived with his brother for some time before obtaining a flat with ForHousing in December 2016. His oldest son and a friend moved in with him. At around this time Steven attended hospital seeking treatment for injuries on two occasions. On the first he said he had walked into a door and the second that he had stabbed himself in the leg whilst doing DIY. These attendances were before Steven met Karen.

13.2.4 On 31 August 2018 Steven was admitted to hospital suffering from a bleed on the brain. He was treated and discharged on 7 September 2018. He said that he had lost his balance and hit the back of his head on a door some days previously and had fallen into a brick wall before that. Steven told his family the same story about his head injury, but they think that he may have been assaulted as there were rumours circulating to that effect. No assault was reported and there is no evidence that Steven was assaulted.

13.2.5 On 17 September 2018, Steven was admitted to hospital following a bicycle accident which resulted in a fall down an embankment. On examination he had sustained a head injury. A subconjunctival haematoma[14] was evident to the right eye, however Steven explained that this injury was sustained from a fight with a friend after drinking four cans of lager. Steven remained as an inpatient for observations and was subsequently discharged on 20 September 2018. The head injury continued to cause Steven problems and he sought help from his GP for low mood and loss of memory.

13.3 **Karen**

13.3.1 Karen is of English Gypsy heritage. She has been married twice and had three children in each relationship. The relationship with her second husband, Roland's father, broke down in the Summer of 2018 and it seems that she formed a relationship with Steven soon after.

13.3.2 Karen's three older children to her first marriage did not live in the family home and maintained independent lives. She was in touch with her older son and one of her daughters who did visit the family home but was estranged from another daughter.

13.3.3 Karen lived in the family home with her second husband and the three children of that relationship until the Summer of 2018, when the relationship with her husband broke down and he left. Roland was the oldest sibling living in the house, being 16 in 2018.

13.3.4 Karen had a history of not attending her own medical appointments and sometimes did not take her children to their medical appointments. Her GP attempted to engage Karen in medication reviews but after many attempts to engage her were unsuccessful Karen was deleted from the GP's list in June 2019.

13.4 **Roland**

13.4.1 Roland was referred to CAMHS by a school nurse in July 2014, aged 12 because of angry outbursts at school and home. At school he was reported

[14] Subconjunctival haemorrhage is one cause of a red eye. It is caused by a small bleed behind the covering of the eye. It can look alarming but it usually causes no symptoms and is usually harmless.

by teachers to pick up chairs to throw them and use racist and sexist language, although he could be polite and well-mannered at times.

13.4.2 Roland was seen by CAMHS (sometimes with Karen) for ten sessions between January and May 2015. A cognitive assessment was completed during two of these sessions that indicated that Roland's ability was largely in the average range, but with difficulty with the coding subtest, which uses skills similar to those used in handwriting, and is a measure of Processing Speed. Teacher assessments described Roland as fidgety in class and easily distracted, and he started to be home schooled. Hyperactive and distractible behaviour was observed in clinic. Karen reported impulsivity, e.g. with roads, not able to cross safely, also that she had difficulty putting in boundaries regarding behaviour, computer use and sleeping. Work was agreed with Roland and Karen on his anxiety using Cognitive Behavioural Therapy (CBT). Some improvement was reported over time with separation from Karen, sleeping independently and with going out in crowded places. Roland was referred for an opinion regarding ADHD[15] in May 2015 and did not attend further appointments. Roland was offered another appointment and subsequently attended appointments between December 2015 and April 2016 to address his possible ADHD, ongoing sleeping problems and behavioural difficulties.

13.4.3 Roland stopped attending school in December 2014 and became home schooled (Elective Home Education {EHE}). The panel heard that Roland's school and EMTAS tried hard to prevent Roland going into EHE through on-going dialogue, phone calls and home visits. The panel were told that it is not an uncommon occurrence for the families of secondary aged Gypsy and Traveller children to opt for EHE. Children who are being home educated are visited once a year by a local authority officer. The author of the DHR was given access to reports compiled after annual visits by the EHE Coordinator. The reports were positive and highlighted that Roland had access to work books and a computer. He enjoyed reading and focussed on English and maths.

13.4.4 From February 2016 to September 2018, Roland attended the Gypsy Wagon Heritage Project, this involved him in developing practical skills, for example sanding and painting as well as personal development such as giving a presentation to others.

13.4.5 In 2017, Roland attended an LGBT group and received support from a youth worker who specialises in work with LGBT young people. Roland went on a

[15] Attention Deficit Hyperactivity Disorder

Pride march with young people from Salford LGBT group. Between January and June 2018 Roland attended the Salford Youth Council once a week. During this time he disclosed that he was bisexual. Roland had a series of fallouts with peers in the group. He later disclosed to a youth worker his regret over disclosing that he was bisexual.

13.4.6 In September 2018, Roland started a college course (Multi Trade Skills entry level) at Salford City College. He presented at college as a mature individual and was selected as class representative for the college student council due to his balanced views and ability to interact well with others. He interacted well with staff and students and presented as a polite and balanced young man. Roland's attendance at college was poor and Karen was invited to attend college to discuss this and an isolated incident of poor behaviour. She declined to attend the meeting.

13.4.7 After Christmas 2018, Roland's attendance at college reduced further and attempts were made to reengage him or find an alternative form of education or training. In March 2019 Roland returned to almost full time attendance at college for two weeks and worked to complete his entry Level 3 qualification. He worked closely with his tutors to complete the relevant workbooks and attained the level 3 qualification. He reported a minor illness on 19 March 2019 and did not attend college again. This meant he missed the last two weeks of the course but had already completed the qualification. Although Roland's attendance was poor it did not stand out amongst a challenging cohort of students where attendance is generally sporadic for some students. Roland was eligible and was invited to enrol on the Multi Skills level 1 course for September 2019. Steven's murder happened before Roland needed to enrol.

13.5 **Steven, Karen and Roland**

13.5.1 The DHR panel do not have definitive information around when Steven and Karen began a relationship. Steven's family told the author of the review that he had met Karen in a pub whilst he was playing darts and began a relationship with her. Initially she would stay at his flat for several days at a time, although it is likely that sometime in September 2018, Steven began staying with Karen at her house for at least some of the time. He maintained his own tenancy until June 2019, when he was evicted due to rent arrears. When presenting to the Housing Options Service at that time he said he was staying with a friend and gave Karen's address.

13.5.2 On 14 October 2018, Roland contacted the police and reported that his older brother had 'head-butted' him and may have broken his nose. This was said

to be because Roland had called their sister a whore. On police arrival Roland and Karen did not want to make a complaint. A DASH[16] risk assessment was completed which recorded a standard risk. A crime was recorded but no further action was taken. Roland's older brother was said to have been at the house because he didn't like Karen's new boyfriend (Steven) who she had been seeing for four weeks. Two days later a social worker visited Roland at home to follow up on his report to the police that he had been assaulted by his brother. Roland said that he had lied to the police. He said that he was out walking the dog and got into a dispute with three young people who were calling him fat and one of these 'head-butted' him. He returned home and his brother was making fun of him, saying that he should have defended himself. Due to this Roland said he phoned the police and said that his brother had 'head-butted' him. (Roland told the report's author that he had in fact been assaulted by his brother but that he now thought it was an accident and regretted calling the police).

13.5.3 On 15 October 2018, Roland's father removed the younger siblings from Karen's care after collecting them from school. The school made a safeguarding referral due to the children not receiving appropriate medical attention. Some days later their father reported that one of the children had made comments suggestive of abuse. A strategy meeting, regarding the younger siblings, held the following day decided that the threshold for an enquiry under Section 47 Children Act 1989[17] was met and that enquiry was initiated. Domestic abuse was not a factor in the decisions made.

13.5.4 On 15 October 2018, Karen's adult daughter contacted the police asking for information about Steven under the DVDS. Karen was said to be aware of the application. The case was assessed and it was decided that insufficient grounds existed for a disclosure to be made and Karen's daughter was informed. Karen was handed a 'non-disclosure letter'; this set out that an enquiry under the DVDS had been made and that nothing was to be disclosed.

It is not known what prompted Karen's daughter to make the DVDS request.

Additional enquiries with Greater Manchester Police reveal that the original form is no longer available and in any event the reasons for the DVDS request are not specifically recorded.

[16] Domestic Abuse, Stalking and Honour Based Violence. www.safelives.org.uk
[17] Section 47 places a duty on a local authority to investigate … if they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

13.5.5 On 2 November 2018, a strategy meeting took place following the enquiry under Section 47 Children Act 1989. The outcome was that no evidence had been identified to support any concerns of abuse. It was identified the presenting risks raised from school and health professionals had been substantiated but there were now no ongoing concerns due to Roland's father having custody of the younger children.

13.5.6 On 8 November 2018, A Children and Families Assessment on Roland (and a relative who is not a subject of the review) was completed as part of the section 47 enquiry, it concluded there were no safeguarding concerns or outstanding support needs for Roland (or the relative) and the case was closed. Roland was to continue to be offered pastoral support at college and EMTAS were to continue to support the whole family. This was inaccurate as the role of EMTAS was to support children's education not whole family support.

13.5.7 On 15 November 2018, an Anti-Social Behaviour noise nuisance complaint was received by ForHousing about loud music and arguing coming from Stevens's flat. Steven failed to attend appointments to discuss these concerns.

13.5.8 On 18 March 2019, a neighbourhood housing officer visited Steven at his flat and completed a property inspection. This followed a failed visit on 6 February 2019 when someone was in but refused to come to the door.

13.5.9 On 16 May 2019, Steven registered with Salford Home Search. He gave his current address as his flat and said that he was looking to move to a one bed property as his current accommodation was too big and he was unable to afford the shortfall in the rent and was therefore in rent arrears. The application did not list any other people to be housed with him.

13.5.10 On 2 June 2019, Karen registered with Salford Home Search. She gave the family home as her current address and said she had lived there since 2010. The application listed Roland as living with her and moving with her, but not Steven.

13.5.11 On 3 June 2019, Steven was evicted from his flat due to rent arrears. The following day he presented to Salford Housing Options Service. He refused an offer of accommodation and said that he could stay with a friend (he gave Karen's address).

13.5.12 Karen also presented to Salford Housing Options Service on 4 June 2019, she said that her private sector landlord had issued her with a notice to terminate her tenancy however she did not have the notice with her.

13.5.13 The case was closed on 8 July 2019, when Karen did not follow up and did not answer a telephone call. The chair of the review wrote to the landlord inviting their contribution to the review but no reply was received.

13.5.14 Steven and Karen did not mention each other on their separate housing applications and the two applications were not linked.

13.5.15 On 12 July 2019, Steven attended his GP complaining of low mood he was accompanied by Karen who became upset and left. Steven was prescribed Mirtazapine[18].

13.5.16 On 31 July 2019, Steven attended his GP complaining of low mood and memory loss which was attributed to his head injury a year earlier. He was prescribed fluoxetine[19] and referred for counselling and the Salford Memory Assessment service and given an appointment in two weeks.

13.5.17 On 28 August 2019, Steven attended his GP to follow up the appointment of 31 July 2019. He said he had missed his last scheduled appointment as he had been at a funeral in Ireland. He was asked to continue on fluoxetine and attend again in two weeks.

13.5.18 On 30 August 2019, a friend of Karen's visited her at home. Roland overheard part of a conversation and accused his mother of taking drugs. Steven became involved in the argument which developed into a physical confrontation between Steven and Roland during which Roland stabbed Steven in the head with a kitchen knife inflicting the fatal wound.

13.5.19 Examination of Roland's mobile phone during the police investigation showed that throughout July and August Roland sent text messages to his mother and others which were extremely hostile towards Steven. Examples include:

[18] Mirtazapine is an antidepressant medicine. It's used to treat depression and sometimes obsessive compulsive disorder and anxiety disorders

[19] Fluoxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). It is often used to treat depression, and also sometimes obsessive compulsive disorder and bulimia. Fluoxetine helps many people recover from depression, and it has fewer unwanted effects than older antidepressants.

‘Don't be widdin to no one especially ***** but yesterday mam was arguing with “Steven” because his mate ***** came to see him and took him off to Tesco to get him a phone so they can keep in touch and the fene[20] asked him if he wants to move down there and stay with him so let wasn't pleased “Steven” pointed in my face and said ''and you don't get involved either'' so I boxed the face off him and he thought that night he had a bleed on the brain again because it felt the same lol my hands abit swollen and I can't bend one of my fingers xx.’

‘Again I just wanted to make it clear that I won't put up with no fucking shit u can't deny you have wanted to do it since day one and he needed it back then for the shit he said to yous anyway so in my eyes he's needed his jaw spinned for time lol x.’

‘I feel like stabbing him up and finally fucking out an end to this because I can’t fucking cope looking at the fene he disgusts me’.

Other texts included information that indicated Roland had assaulted Steven.

‘I swear on ***** life I feel like going down stairs stabbing him up and finally fucking out an end to this because I can't fucking cope looking at the fene he disgusts me.’

‘I just want to put him out and fuck him off but we all know Mam would just go back to him when she can do 10x better the only time he'll ever fuck off is when he's dead and that's exactly what I'm on about.’

‘He's the lowest of the low and he's in my fucking living room.’

13.5.20 Photographs on Roland’s phone showed a picture of Steven asleep with a penis drawn in marker pen on his face. The DHR panel felt that behaviour fell under the definition of domestic abuse.

13.5.21 Part of Roland’s motivation as described in his text messages was jealousy of the time and attention his mother gave to Steven as well as anger at the loss of Roland’s younger siblings from the house.

13.5.22 During his trial Roland claimed he was acting in self-defence. He also claimed diminished responsibility, with his legal team saying he was suffering from an abnormality of mental functioning at the time. A psychiatrist for the defence said Roland was on the autistic spectrum.

[20] Irish slang for boy or boyfriend

13.5.23 The court heard that Roland worked on odd jobs and went to college when he was sixteen for a period before leaving. Most of his days were said to be spent watching films and playing on his Xbox.

13.5.24 Counsel for the prosecution said that Roland, was 'not comfortable' with the relationship between Steven and Karen, and that there had been 'friction' between them. Roland claimed that Steven had been abusive to him and Karen.

13.5.25 After a two week trial, the jury found Roland guilty of murder. Schedule 21, Criminal Justice Act 2003 sets out the sentencing start points where a person is sentenced to a mandatory life sentence. In the case of a youth (such as Roland) the sentencing start point is twelve years before a person can be considered for parole. Roland was sentenced to life imprisonment with a minimum tariff of eleven years.

13.5.26 A table containing important events which help with the context of the DHR can be found at Appendix A. This table is a combined chronology of events and provides an efficient reference to locating items of particular interest to the reader.

14 ANALYSIS

14.1 What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Steven as a victim of domestic abuse, and Roland as a perpetrator; what was the response?

14.1.1 No agency held information during the timeframe of the review that specified Steven was a victim of domestic abuse or that Roland was a perpetrator.

14.1.2 Following Steven's murder a number of statements were obtained from neighbours by the police. These statements provide information regarding an incident in early August 2019, when a male fitting the description of Roland was seen with a baseball bat at the door of the family address refusing to allow two people, believed to be Karen and Steven, into the property. Several witnesses reported hearing the man with the bat shouting 'Why have you picked him over me.' 'You're not touching her again'.
Others stated that Roland and Steven were always at 'Loggerheads'.

14.1.3 This information was not known to the police or any other agency at the time and only came to light as a result of the police investigation into Steven's murder.

14.1.4 Steven's GP practice is part of the IRIS[21] project. The practice had no knowledge of current or historic domestic abuse and no referrals were made. During the review timeframe Steven presented with significant injuries. A routine enquiry should have taken place into how these injuries occurred. The significant head injury resulting in the subdural haematoma could have been indicative of a self-harm injury in the context of mental ill health or alcohol consumption rather than an assault. It could also have resulted from domestic abuse. This was not explored with Steven by the GP practice.

14.1.5 The GP safeguarding lead for the practice has confirmed that male victims of domestic abuse are recognised by the practice and routine enquiry is made as appropriate. In Steven's case his history of mental health and alcohol issues was considered a more likely explanation and therefore domestic abuse was not explored. Steven's family felt the GP(s) who saw Steven for low mood and memory loss should have asked him about domestic abuse and not attributed Steven's concerns to his head injury.

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[21] The IRIS project is an evidence based model to support the identification of domestic abuse within Primary Care. This involves training health professionals to identify health indicators of DVA, supports enquiry about domestic abuse and identifies clear referral pathways to local domestic abuse services.

14.1.6 Steven attended Salford Hospital (Salford Royal NHS Foundation Trust) for treatment to injuries on a number of occasions within the timeframe of the review. Explanations about the causes of his injuries were thought to be legitimate. There was therefore no enquiry with him regarding the possibility of domestic abuse. Steven's family believe that hospital staff should have been suspicious of the explanation given by Steven and think it is very likely his injuries were inflicted by another person(s). The DHR panel noted that a single agency action requires Salford Hospital to develop and embed the Primary Care response to domestic abuse. This approach includes recognising that males can also be victims of domestic abuse.

14.1.7 Roland had a history of angry outbursts, for example picking up a chair to throw it and this was one of the reasons for his referral to CAMHS as a twelve year old.

14.1.8 Whilst attending Salford Youth Council during the time frame of the review Roland sometimes had difficulty communicating appropriately with his peers. In the Youth Council online discussions Roland felt he had been made a show of when he attempted to initiate a relationship with a young woman, which was rejected. The summary of the conversations online indicated Roland was prone to outbursts in the language he used and in some of his comments made threats of violence towards other young people.

14.1.9 The information that was known to agencies about Roland's behaviour and tendency towards threats was in the context of adolescent behaviour. Roland was supported by CAMHS before the review period. He was both supported and challenged by youth workers about his behaviour towards peers. Roland was seen as a young person who was struggling with his identity and sexuality and how others in his family and the Traveller community would respond to him. His behaviour was not considered to be in the context of domestic abuse and there was no information to indicate that Steven was a victim of domestic abuse from Roland.

14.1.10 The Crown Prosecution Service policy guidance on coercive control states[22];

Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs

[22] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next.

14.1.11 On the evidence available to it the panel did not think that Steven had been subject to controlling and coercive behaviour by Roland. Paragraph 14.3.2 reflects on how Steven may have been impacted by Karen's behaviour. The DHR Panel thought Roland's act of drawing a penis on Steven's face and photographing it was abusive and demeaning. The act by itself, or together with other aspects of Roland's behaviour, did not amount to controlling and coercive behaviour.

14.2 **What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Steven as a perpetrator of domestic abuse, and Roland as a victim; what was the response?**

14.2.1 No agency had any information during the time period of the review that indicated Steven was a perpetrator of domestic abuse or that Roland was a victim of domestic abuse by Steven.

14.2.2 Steven is recorded as both a victim and perpetrator of domestic abuse. Following an incident in 2015, he was referred to MARAC as a high risk perpetrator. The incident had involved making serious verbal threats. Incidents prior to the timeframe of the review are not analysed in detail as they did not feature Roland or Karen.

14.2.3 On 14 October 2018, Roland reported to the police that his brother had 'head-butted' him and broken his nose. The incident was attended and correctly updated as per the Greater Manchester Police Domestic Abuse Policy (2015). This policy is currently being reviewed due to recent changes in structure

The definition of Domestic Abuse is:

> Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

The definition treats people aged 16 or over as adults, and Domestic Abuse involving 16 and 17 year olds is recorded. These cases are also Child Protection matters, where relevant procedures should be followed under Section 17 and 47 of the Children's Act (Child in Need or Child at Risk of Significant Harm).

14.2.4 The attending officer completed a DASH risk assessment which assessed the risk as Standard, as such the officer had the authority to file the incident after completing the relevant updates. The DASH contained only one positive answer as Roland refused to answer most questions. The officer requested that the matter be referred to Children's Services due to the fact that the victim, Roland, was 16 years old at the time of the incident. A referral was completed however the police did not request a strategy meeting. Working Together 2018, states that when there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving the local authority, the police, and health. A strategy meeting on 16 October 2018 was arranged by Children's Social Care as a result of the police referral although it had not been requested by the police. The police IMR author states that in hindsight, having reviewed the incident log and taking into consideration the victim was a child who had been assaulted, this incident could have been risk assessed as MEDIUM.

14.2.5 All medium and high-risk incidents are reviewed by a specialist officer and an enhanced risk assessment completed. This officer would then agree or alter the risk level set by the attending officer. Actions could have included safeguarding the victim, visiting to action safeguarding or making telephone contact. The need for a domestic abuse marker at the address on police computer systems would have been considered. A review by a specialist may have also noted the need for a strategy meeting.

14.2.6 On 15 October 2018, Karen's adult daughter contacted the police asking for information about Steven under the DVDS. Karen was said to be aware of the application. The case was assessed and it was decided that insufficient grounds existed for a disclosure to be made and Karen's daughter was informed. This decision does not seem to have fully taken into account that Steven was judged to be a high risk domestic abuse perpetrator and had been referred to MARAC in 2016. Part of the recorded rationale was that 'It appears that during the heat of an argument he likes to make verbal threats'. (This related to the incident which warranted referral to MARAC). The decision maker concluded that were insufficient other risk indicators to merit a disclosure. The police IMR author concluded that there was enough information to warrant a disclosure and that this could have been done as part of the Section 47 process. The panel supported this view.

14.2.7 On 16 October 2018, a social worker visited Roland at home to follow up on his report to the police that he had been assaulted by his brother. Roland said that he had lied to the police. Roland said that he was out walking the dog and got into a dispute with three young people who were calling him fat and one of these 'head-butted' him. He returned home and his brother Steven was

making fun of him, saying that he should have defended himself. Due to this Roland said he phoned the police and said that his brother had 'head-butted' him.

14.2.8 The panel were told that Roland had a high BMI[23] score and long history of weight issues. Those who knew him thought that this contributed to feelings of low self-worth and difficulties in making positive friendships with peers. Conversely the pastoral lead at the college Roland attended said that Roland's weight did not appear to have any impact on his relationships with others at the college. [It is now known Roland had been assaulted by his brother].

14.2.9 The police were asked to attend a strategy meeting on 16 October 2018, in relation to Roland and his two younger siblings. The reason for the meeting was to consider medical neglect in relation to the younger siblings, the assault on Roland and concerns regarding Karen using drugs and alcohol with Steven. Further concerns were raised by the father of the younger children (Karen's estranged husband) regarding abuse. A further strategy meeting took place on 2 November 2018. The meeting recorded that Steven was a victim of historical Domestic Abuse and did not record that he was also a high-risk perpetrator and that he had a 'Stalker' flag. A High-Risk Domestic Abuse Perpetrator marker is added to a nominal file for 12 months and a day from the MARAC and had automatically been weeded in 2016 from Steven's file but would have been available on a more detailed examination of the record.

14.2.10 The officer attending the strategy meeting on behalf of GMP states that he did not believe that Roland had lied regarding being assaulted by his brother and as such he did not update the crime report.

14.2.11 The minutes of the strategy meeting of 2 November 2018, were not recorded on police systems until 12 November 2018. The minutes of the strategy meeting of 16 October 2018 were not recorded on police systems until the fact that they had not been recorded was discovered by the police IMR author. This meant that the DVDS application was dealt with in isolation as the officer tasked with that issue did not have information about the strategy meetings available to them. Had the two processes been joined up then any potential disclosure could have been discussed in the strategy meetings in the whole context of the issues facing the family at that time.

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[23] The body mass index (BMI) is a measure that uses height and weight to work out if a person's weight is healthy.

14.2.12 Salford City College where Roland was enrolled on a Multi Trade Skills course provided pastoral support to him during some of the time period of the review but were not made aware by Roland or any agency of Karen's relationship with Steven and Steven's role in the family setup. Roland told staff at the college that he was upset because his father had taken the younger siblings to Ireland and that he was worried about his mum (Karen) because she was upset about losing the two younger children.

14.2.13 No agency possessed information which indicated that Steven was a perpetrator of domestic abuse towards Roland.

14.3 **What indicators of domestic abuse, including controlling and coercive behaviour, did your agency have that may have identified Karen as a victim and/ or perpetrator of domestic abuse; what was the response?**

14.3.1 Karen had been known historically to the police as a victim of domestic abuse in relation to three recorded incidents between 2004 and 2007. The perpetrator being family members.

14.3.2 She was recorded as a perpetrator on one report in 2007 in relation to her daughter and again on the 25 October 2018, when her second husband reported malicious communications. During his initial call, Karen's second husband stated that he had been a domestic abuse victim for the last 20 years. The DASH report records that her second husband stated that Karen had been violent to him in the past and that she had previously stopped him from seeing family and friends. The panel thought that this information was relevant to the DHR as it may be indicative of a pattern of behaviour given the information from Steven's family and friend that he had become distant and broken off contact with them.

14.3.3 Police information shows Karen was a victim and perpetrator of domestic abuse well over a decade ago.

14.3.4 On 21 April 2019 Karen attended the Accident and Emergency department of North Manchester General Hospital (Northern Care Alliance NHS group) accompanied by Steven. She said that she had fallen from a bike that day and had injured her head and hand. A wound to her head was glued and she was given a follow appointment for the fracture clinic. Karen did not attend the fracture clinic. The injury was considered to be consistent with the explanation given and there was no enquiry into the potential for domestic abuse. The panel discussed that in the circumstances described an enquiry into the possibility of domestic abuse would have been appropriate. This has been recognised as an area for development by the relevant safeguarding

practitioners and has led to a single agency recommendation for Salford Royal NHS Trust.

14.3.5 Following Steven's murder, the police investigation team spoke to witnesses who stated that historically they had heard Karen shouting abuse at Roland. One described hearing 'You're a fat bastard, nobody wants you, I hope you die, you gay fat bastard.' This was not reported to the police or any other agency by either Roland or a third party. The panel felt that on the face of Karen's comments her conduct amounted to emotional abuse (child abuse). The comments could have amounted to domestic abuse if they were after Roland's sixteenth birthday as the Government definition of domestic abuse applies to over sixteens. The panel member representing the LGBT Foundation told the panel that 'outing' a person's sexuality without their consent in this way could have a serious negative impact on them and that the words could have amounted to a hate crime.

14.3.6 No agency was in possession of information that indicated Karen may have been either a victim or perpetrator of domestic abuse in her relationships with Steven and Roland.

14.4 **What influence did Roland's age have on your agency's dealing with him relevant to the terms of reference?**

14.4.1 Roland's age was considered in the outcome of the Children and Families Assessment completed by a social worker on 8 November 2018. Due to Roland's age it was considered he was able to offer himself some level of safety. Safety planning had been completed with Roland, and the social worker was confident he understood the plan identified, and had a mobile phone should he need to implement the safety plan. No concerns of Roland being neglected were identified during the assessment, he was able to ensure his own self care needs were met around personal grooming, ensure he was fed and ensure he was well presented.

14.4.2 The assessment concluded there were no safeguarding concerns or outstanding support needs for Roland and the case was closed. Roland was to continue to be offered pastoral support at college and EMTAS were to continue to support the whole family. This was inaccurate as the role of EMTAS was to support the younger children's education not whole family support.

14.4.3 Although the ongoing involvement of EMTAS was part of the rationale for closing the case, in fact EMTAS had no further involvement with Roland other

than a single telephone call to invite him to an event which he did not attend. EMTAS were not aware of their presumed continuing involvement in the case.

14.4.4 The step down to universal services could have been strengthened by the multi-agency group. The understanding of the role of EMTAS could have been strengthened at the point of social care step down, to ensure the roles and supports were clear following social care ending their involvement. Good practice is to ensure that roles and responsibilities are clear following step down so that the needs of the child can be supported and monitored, clear timescales should be set within a SMART (Specific, Measurable, Achievable, Realistic, Timely) plan detailing the ongoing work and interventions required to enable a consistent level of identified support to continue.

14.4.5 The Children and Families Assessment offered an understanding of Roland's current needs, views, wishes and feelings. Areas of the assessment could have been improved to ensure the analysis was further evidence based, including the utilisation of the social care tools for assessing neglect. The conclusion of the assessment was that support was to continue through the provision of universal services. If the outcome had been that a more targeted approach through Team Around the Family (TAF) or child in need was required, this would have provided a further, short term level of coordinated multi-agency planning and intervention. The impact of this is that the family dynamics may have been better understood due to this level of involvement. Given there were no safeguarding concerns referred back to social care between case closure and the incident leading to this DHR, it is unlikely that any further social care involvement at that time would have altered events.

14.4.6 The incident of assault that Roland reported to the police was treated appropriately by the police based on Roland's age in that it was treated as a child protection matter as well as a crime and an appropriate referral was made to Children's Services. The incident should have led to the police requesting a strategy meeting which did not happen. However, Roland's case was discussed in the strategy meetings that took place on 16 October 2018 and 2 November 2018.

14.4.7 Salford City College where Roland was enrolled was informed of the incidents by the social worker, which ensured that staff were able to approach Roland and offer him pastoral support. He utilised this by attending support sessions and visiting the pastoral team office daily, when in college. Roland did not disclose any concerns relating to himself but expressed concern about his younger siblings. He did not disclose that Steven had moved into the family home and staff at the college had no knowledge of Steven.

14.5 **What barriers existed that may have prevented Steven from seeking help for his domestic abuse victimisation?**

14.5.1 Prior to his murder Steven was not known to any agency as a domestic abuse victim within his relationships with Karen and Roland.

14.5.2 The Respect Men's advice line, toolkit for work with male victims of domestic abuse[24] contains the following information on 'toxic masculinity' which may result in men being less likely to report instances of abuse.

14.5.3 The term 'toxic masculinity' is interpreted by many as an accusation that all men behave in an abusive and aggressive way. To avoid being misunderstood and to make clear that there are many expressions of masculine ties, rather than a single and uniform expression, we prefer to use the term, 'harmful masculinities' or 'harmful expressions of masculinities' in this context.

These expressions of masculinities often adhere to the typical gendered expectations that men are: aggressive; violent; unemotional and dominate their relationships with women and children. It identifies 'feminine' traits such as compassion, empathy and the ability to express your emotions as weakness. A man or boy displaying these traits may be laughed at or encouraged to suppress their emotions, which may lead to higher rates of violence, risk taking behaviours and suicide.

Men and boys are often led to believe that being depressed, feeling emotional pain, being bullied, feeling suicidal, experiencing eating disorders, being abused are 'feminine' issues and that 'real men' do not have them. This can leave men suppressing their pain, lacking the ability and security to talk about their emotions and to lash out in what they perceive 'acceptable' masculine ways such as substance abuse and violence.

The weaponisation of masculinity is the culture that shames men from emotional displays or displaying any form of feminised 'weakness' and sets the stage for men to act violently towards others.

As previously mentioned, men report experiencing many of the forms of abuse experienced by female victims of abuse, however an additional complexity is the weaponisation of masculinity in forms of abuse. By this we mean the use of somebody's masculinity and undermining of the societal perception of men.

[24] https://mensadviceline.org.uk/wp-content/uploads/2020/01/Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf

Perpetrators might use the expectation of gendered roles to abuse, this might take any of the following forms.

If you were a real man you wouldn't put up with this,
If you were a real man you'd provide better for your family, and
If you were a real man you would be able to satisfy me sexually.

14.5.4 There are many published studies which identify the barriers to disclosure faced by victims of domestic abuse. The reasons identified are fairly consistent. One study by The Victim Support report 'Surviving Justice' 2017[25] report includes the following barriers and their percentage frequency.

Barriers to reporting	% citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.5.5 Aggressive behaviour appears to have been normalised within the household. Examples include a man with a bat threatening Karen and Roland. Roland being 'head-butted' by his brother and Karen being abusive to Roland. Within that context it may have been difficult for Steven to report any abuse he suffered before his murder.

14.5.6 Safelives [26] in their 2019 report, Safe and Well: Mental Health and Domestic Abuse, say 'There is a strong association between having mental health problems and being a victim of domestic abuse. Mental ill health is also a risk

[25] https://www.victimsupport.org.uk/wp content/uploads/documents/files/VS_Survivor%E2%80%99s%20justice.pdf

[26] A UK charity dedicated to ending domestic abuse, for everyone and for good

factor for abuse perpetration'. Steven was being treated by his GP for low level mental health issues.

14.5.7 It is well established that all forms of domestic abuse are under reported. Studies have shown that parents are understandably particularly reluctant to disclose or report violence from their child.[27] Whilst Steven was not Roland's father his position in the household placed him as a de facto step-father.

14.5.8 Steven's family noted that he lived in a three bed flat and after the two other people living there left he fell into rent arrears as he was unable to pay the 'bedroom tax'. His family thought that if he had been moved to a one bedroom flat at this point then problems would have been avoided as he would not have built up the arrears that led to his eviction. They also think that it may have been in part the pressure of his housing situation which caused him to move in with Karen. The DHR panel noted that Steven's landlord had, and has, in place policies that deal sympathetically with victims of domestic abuse. The family's view at 1.3 encourages victims of domestic abuse to tell someone about it. A disclosure to the landlord would have seen them support Steven. As this was not known to Steven it could be construed as a barrier. Steven cannot be 'blamed' for his silence and the recommendation at 17.5 is aimed at ensuring that advice on domestic abuse is widely available.

14.6 **What barriers existed that may have prevented Roland from seeking help for any domestic abuse offending?**

14.6.1 There is no information that any agency knew or suspected that Roland was abusing either Steven or Karen. As described at paragraph 14.1.2 the police investigation has shown that neighbours witnessed disturbances which may have amounted to domestic abuse.

14.6.2 Steven moved into the family home soon after Roland's parents had split up. There is evidence that other family members were at least initially unhappy about this and this may have influenced Roland.

14.6.3 Whilst engaged in the youth council, LGBT groups and the Gypsy Wagon Heritage Project, youth workers were aware of Roland's anger in his online comments, and support and help was offered. Roland's changing view of the acceptability of his sexuality to himself and his perception that his family, particularly the males, would not accept his sexuality meant he did not take up the support of the LGBT groups he could have. Roland rejected support because it appeared he found it hard to be himself and live with his sexuality and how this went against his family's views of such matters. Whilst youth

[27] Condry and Miles 2014

workers were not aware of any domestic abuse offending, they did offer support to Roland and a sympathetic ear from three different youth workers in three projects.

14.6.4 The DHR panel thought it was unlikely that Roland would have recognised any of his behaviour as domestic abuse. Roland had been out of mainstream schooling for several years and he would not therefore have benefitted from mainstream Personal Social and Health Education which may touch on healthy relationships and domestic abuse.

14.6.5 A briefing published by the South East Wales Women's Aid consortium funded by the Equality and Human Rights Commission (October 2010) found that 'Cultural and social taboos exist amongst all Travelling groups against involving the police when violence occurs'. The EMTAS representative on the panel pointed out that in the experience of her service in Salford some Travellers, for example Travelling Show people did contact the police to report issues when appropriate.

14.7 **How did your agency respond to any potential child safeguarding indicators when dealing with domestic abuse involving Steven and Roland?**

14.7.1 No agency had any domestic abuse involving Roland and Steven reported to them. Other child safeguarding issues are discussed at paragraphs 14.2 and 14.4

14.8 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Steven and Roland?**

14.8.1 See section 11

14.9 **Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Steven and/ or Roland, or on your agency's ability to work effectively with other agencies?**

14.9.1 **Greater Manchester Police**

In the opinion of the IMR author there were two capacity and resource issues which impacted on the safeguarding response to the incident on 14 October 2018 and the Domestic Abuse incident reported by Karen's estranged husband on 25 October 2018.

The officer located in The Bridge attended a strategy meeting on 16 October and 2 November 2018, yet did not update the IT systems until 12 November 2018 with the strategy meeting minutes. These had not been read or checked for accuracy.

Police response resources from 25 October 2018 were very limited and thus the incident log was delayed until 8 November 2018.

Availability of resources is an issue for every emergency and safeguarding organisation on a regular basis. The IMR author is aware that GMP does everything within its power to ensure that resources are prioritised and used appropriately but the impact of budget and resource cuts experienced by the organisation in the past years has meant that inevitably there will be occasions where resources will be stretched to the point where providing an acceptable level of service is not possible.

14.10 **What learning has emerged for your agency?**

14.10.1 **Children's Services**

Ensuring assessments are consistently evidence based and fully address the exploration of the presenting risk and what this means to the individual child taking into account wider environmental issues which may impact upon the child's lived experience. Ensuring assessments are consistently evidence based, utilising the appropriate tools to support practice. These should take into account wider environmental issues which may impact upon the child's lived experience.

14.10.2 **Greater Manchester Police**

Recording of Information.
During the IMR author's work, it became apparent that it is not unusual for Children's Services to request a strategy meeting in person at The Bridge as the Social Work Duty team and police are co-located there. This is usually followed up with an email request for audit purposes, at which point a PPI (Public Protection Investigation) document would be created or updated. PPI's are now replaced with Care Plans (CAPS).

The officer present at the strategy meeting on 16 October 2018 cannot account for the reason that it is not documented on GMP systems believing that it was an oversight and a capacity issue at the time.

This has been fed back to district and the current process ensures that strategy meeting requests must be received via email at which point a 'CAP'

document (Care Plan) will be created. This will be actioned to supervision to allocate thereby ensuring management oversight in relation to every strategy meeting requested.

Strategy Meetings.

At the first strategy meeting only CSC and GMP were present. Education and Housing were present as well as CSC and GMP at the second. Health representation was not present even though there were significant concerns around missed health appointments. School had also raised concerns. Appropriate partners are essential in order to make informed decisions. Working together 2018 states, that the purpose of a strategy meeting is to;

- Share available information,
- Agree the conduct and timing of a Criminal Investigation,
- Decide whether enquiries under Sec 47 of the Children Act should be instigated,
- To determine any short term actions to determine what further information is needed, and
- To consider Legal thresholds.

None of these tasks were documented.

The GMP representative at the meetings was a Police Constable who although had child protection experience, had never completed the Initial Crime Investigators Development Programme or Child Abuse Investigators Course.

A 'Learning from Reviews' presentation was provided to staff from The Bridge and Complex Safeguarding Team. District Senior Leadership Team have been made aware of potential training needs of Bridge staff. A senior GMP (Investigation and Safeguarding Review) ISR3 review officer has been made aware regarding the training needs for The Bridge staff (Multi Agency Safeguarding Hub).

Line Management Oversight.
As the strategy meetings were not documented within GMP there was no management oversight within GMP. District Senior Leadership Team have been made aware and action agreed that CAP plans will be actioned to supervision for closure or allocation.

Accuracy from Strategy Meeting Minutes.
The minutes from the 2018 meetings were only obtained by GMP as a result of this safeguarding review. They are inaccurate - Mother's partner's name is incorrectly recorded and the information from GMP suggests that Steven is a domestic abuse victim, there is no information with regard to the fact that he is indeed a domestic abuse perpetrator and was referred to MARAC in 2015.
I have been informed that the minutes from meetings are not often shared or checked upon their receipt. As above this issue regarding capacity of the staff has been raised with the district SLT and the ISR 3 review team.

DVDS process.
Due to the fact that a Section 47 investigation had been initiated on the 16 October 2018, this would have negated the need for this application. However, the officers completing this process would have been unaware of this as it was not recorded.

14.10.3 **GP Practices**
Consideration for non-attendance to appointments for adults should be further explored. It is acknowledged that there may be a host of reasons why this may occur but the link with controlling and coercive relationship will be emphasised within IRIS training.

When a child is home schooled Primary Care are now informed by the 0-19 services as per policy and guidance. This guidance was not in place when Roland became home schooled in 2015. Primary Care records are now flagged with relevant 'read code'. These identify to the GP practice the children who are home schooled and provide an opportunity to invite home schooled children into the GP practice for an annual review. This ensures at least one agency has an opportunity to assess health related issues. The 'read code' was not on Roland's medical records because the policy was not in place at the time he became home schooled.

14.10.4 **Salford Youth Services**
An area of learning for the Youth Service is to be more persistent with seeking to engage a young person, like Roland, where there is internal conflict about his sexuality, culture and family. On several occasions a youth worker offered via text message to meet or support, as it was clear, Roland was experiencing internal conflicts and if he could have continued to attend the LGBT groups to gain the peer and worker support this may be benefited him. 1:1 support from a worker via a referral through The Bridge may have resulted in Roland receiving more support with the issues he was experiencing around his sexuality and family.

14.11 **Are there any examples of outstanding or innovative practice arising from this case?**

14.11.1 **Salford CCG – GP practice**

GP Practice 2 did not routinely record who attended appointments with either Roland or Karen. This means it is difficult to tell from the records who accompanied Roland and Karen to appointments. This has been explored with the GP practice and they fully acknowledge this. The Practice have embedded a system which is regularly audited to ensure that all patients, no matter their age, have a 'read code' automatically added to ensure the system records if they attend alone or if someone is in attendance. Audits are completed on all clinical staff to monitor compliance to this system change.

14.12 **Does the learning in this review appear in other domestic homicide reviews commissioned by Salford Community Safety Partnership?**

14.12.1 Previous Domestic Homicide Reviews conducted in Salford have been considered and the specific learning in this review has not previously been recognised.

15 CONCLUSIONS

15.1 Steven met Karen during the Summer of 2018 and they quickly began spending time together, initially at his flat and eventually at Karen's family home when Steven moved in.

15.2 Steven had lived in his flat with his one of his sons and a friend. His friend moved away earlier in 2018 and his son also moved out. During the following months Steven's contact with his sons reduced and then stopped altogether. Steven's family feel that he was bullied and intimidated by Karen's family and cite graffiti in his flat and rumours of an assault as their reasons for this belief. The family's view is that Steven's relationship with Karen was at the root of the issues between Steven and Roland. Their view is that when Karen began paying attention to Steven, Roland became jealous and this led to the animosity that Roland felt towards Steven. The family would have liked to see Karen make a contribution to the review.

15.3 On 31 August 2018 and again on 17 September 2018, Steven was admitted to hospital with a head injury. Steven claimed that the injuries were as a result of accidents but also said on the second occasion that he had been in a fight with a friend.

15.4 It seems that it was around this time that Steven moved into Karen's family home. His flat continued to be used by unknown others and was a source of noise nuisance complaints.

15.5 In October 2018, a series of incidents occurred which brought Steven, Karen and Roland to the attention of agencies.

- Concerns were raised about Roland's younger siblings who had missed a number of medical appointments.
- Roland reported an assault by his older brother.
- Karen's adult daughter contacted the police asking for information about Steven under the Domestic Violence Disclosure Scheme.
- Roland's father removed the younger siblings from Karen's care and the school made a safeguarding referral. A strategy meeting regarding the younger siblings resulted in a Section 47 Children Act 1989[28] enquiry the outcome of which saw them remain with their father.

[28] Section 47 places a duty on a local authority to investigate … if they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

15.6 Appropriately, there were two strategy meetings in relation to his younger siblings and Roland. No evidence was found to substantiate the suggestion of abuse in relation to the younger children. In early November 2018, a children and family's assessment in relation to Roland concluded that there were no ongoing concerns and his case was closed to Children's Social Care. The social worker recorded that there would be ongoing support from EMTAS but that was not accurate and there was no ongoing support in place for Roland.

15.7 In October 2014, Roland stated during a CAMHS assessment that he was 'always on the edge and ready to fight'. He appeared sensitive to threat and had a very swift fight or flight response causing him to be angry and aggressive. He did not attend school after December 2014 and was "home educated", but did attend the Gypsy Wagon Heritage Project for two years from 2016 where he gained basic skills and personal development. From January to June 2018, Roland attended the Salford Youth Council once a week. During this time he disclosed that he was bi sexual and later told a youth worker that he regretted his disclosure.

15.8 Although Roland's background presents a turbulent picture, when he attended Salford City College from September 2018 to March 2019 he was observed to be a mature individual and was selected as class representative for the college student council due to his balanced views and ability to interact well with others. Roland was well known to the pastoral team at the college but he did not disclose to them Steven's presence in the family and his discussions focussed on the removal of his younger siblings.

15.9 After the incidents of October 2018, agencies had little contact with the family. In April 2019 Karen attended a hospital Accident and Emergency department with a hand and head injury which she said had been caused by a fall from a bike. In late May/early June, Steven and Karen both applied for housing separately and did not mention each other on their housing applications. In July and August 2019 Steven visited his GP complaining of low mood and was prescribed anti-depressant medication.

15.10 Whilst nothing was reported to agencies, the police investigation into Steven's murder found evidence of conflict in the family which was not reported to the police. Steven's family noticed a change in his behaviour in that his contact with them diminished and a friend saw that he had lost weight and was not his normal self. By the time of his murder in August 2019, Steven appears to have lost contact with his existing family and friends. The DHR panel did not have clear information on why this was the case. It is possible that this was a choice Steven made. However, on reading the report Steven's family strongly disagreed that he would have made this choice as he had always been very

‘family-oriented’. It is also possible that he was under some pressure from Karen and her family to restrict contact with his family and friends that he had known before starting the relationship with Karen.

15.11 Text messages to others recovered from Roland’s phone show that he felt angry and hostile towards Steven.

15.12 On the day of Steven’s murder an argument quickly led to a physical confrontation between him and Roland in which Roland stabbed him inflicting a fatal injury. There is no record of Roland being in contact with any agency after his last attendance at college in March 2019. He would have been eligible to enrol again at college the week following Steven’s murder.

15.13 It seems that Steven and Karen’s relationship was initially unpopular with her family, for example her adult daughter instigated a DVDS application and her adult son was said to be visiting because he was unhappy about the relationship between Karen and Steven when Roland reported an assault in October 2018. However, the family in effect became invisible to agencies after October 2018 and there were no further incidents which raised concern.

15.14 During Roland’s trial, the prosecutor said that Roland was not comfortable with the relationship between his mother and Steven and there had been friction between them. At his trial Roland gave evidence that during an argument with Steven he picked up his phone to call his brother to come and “sort Steven out”. Immediately following this was the physical confrontation in which Steven was killed.

16 MULTI AGENCY LEARNING DEVELOPED BY THE DHR PANEL

16.1 Narrative

The focus of the strategy meetings was on Roland's younger siblings and Roland appeared to have been marginalised. Additionally, the strategy meetings did not include a health representative which meant decisions were made on inferior information and analysis.

Learning

Agencies should apply existing guidance (Working Together to Safeguard Children 2018) appropriately in order to maximise the benefit of multi-agency working.

Recommendation 1

16.2 Narrative

Roland's case was finalised by Children's Social Care in the expectation that there would be ongoing involvement from EMTAS. This was not the case and EMTAS had no ongoing arrangement with Roland within their agreed working practices.

Learning

A full understanding of the role of other agencies at the point of step down from social care is vital, to ensure appropriate supports are in place for children and families.

Recommendation 2

16.3 Narrative

There was unreported conflict in the household during 2018/2019 which led to Steven's murder.

Learning

Adolescent to Parent Violence and Abuse is under reported by victims and may not always be considered or recognised by professionals.

Recommendation 3

16.4 **Narrative**

The panel heard that help in dealing with Adolescent to Parent Violence and Abuse is available to families through the Salford Children's services Early Help offer but that the programme is not well known or publicised. The Salford Youth Justice Team provides a later stage intervention programme for families who are struggling with Adolescent to Parent Violence where the young person is in the criminal justice process.

Learning

Information about services has to be freely available in order for the public and other agencies to make best use of those services.

Recommendation 4

16.5 **Narrative**

People outside the household were aware of problems, for example abusive behaviour. This finding is consistent with many other DHRs.

Learning

The panel felt that this illustrated a cultural acceptance of domestic abuse within some neighbourhoods of Salford and that action was required in order to address the cultural issue. This may need to go beyond publicity as Salford CSP already conducts extensive publicity around domestic abuse. The issue was identified in the Salford Domestic Abuse Needs Analysis, produced in June 2019 and a set of actions intended to change attitudes and behaviours is identified in the accompanying Salford Tackling Domestic Abuse Plan 2020 – 2030.

Recommendation 5

16.6 **Narrative**

The panel recognised that there is a lack of evidence that routine enquiry is embedded in all agencies as standard practice and should review the policies on routine/targeted enquiry.

Learning

The partnership should receive assurance that the role and practice of routine/targeted enquiry is embedded within all domestic abuse training.

Recommendation 6

17 RECOMMENDATIONS

DHR Panel

17.1 In order for strategy meetings to be consistently good, practice standards including appropriate management oversight of strategy meetings should be developed and implemented into multi-agency practice, utilising the support of Salford Safeguarding Partnership. Salford Community Safety Partnership should be assured by its constituent partners that the work has been completed and implemented.

17.2 Agencies should give assurance to Salford CSP that where workers are reliant on other agencies to provide support following their conclusion of a case, a full understanding of the other agencies' involvement is documented and a SMART plan is developed.

17.3 Agencies should give assurance to Salford CSP that their workers have access to the Home Office information guide on Adolescent to Parent Violence and Abuse (APVA) and that it is included within Domestic Abuse training.

17.4 Salford Community Safety Partnership should review the referral pathways and direct access by the public to programmes tackling Adolescent to Parent Violence and make them more accessible to other agencies and the public.

17.5 Salford Community Safety Partnership should receive an update on the Salford Tackling Domestic Abuse Plan 2020 – 2030 and assure itself that the actions intended to change attitudes and behaviours are robust and on track.

17.6 Salford Community Safety Partnership should receive assurance that the role and practice of routine/targeted enquiry is embedded within all domestic abuse training.

Appendix A – Table of Significant Events

Date	Event
July 2014 – July 2017	Roland saw the Community Pediatrician service with obesity, significant behavioural difficulties and issues relating to self-esteem. He was displaying violent behaviour, outbursts, defiant nature and difficulty following instructions posing potential risk to a vulnerable pupil on one occasion. The School Health Advisor made a referral to CAMHS around the same time and Roland was assessed by them in October 2014. Roland said that he was "always on the edge and ready to fight". He appeared sensitive to threat and had a very swift fight or flight response causing him to be angry and aggressive.
16.1.18. - 5.6.18.	Roland attended the Salford Youth Council once a week. During this time he disclosed that he was bi sexual. Roland had a series of fallouts with peers in the group.
15.6.18.	Roland had a conversation with a youth worker in which he said he regretted his disclosure that he was bi sexual.
February 2016 to Sept 2018	Roland attended the Gypsy Wagon Heritage Project, this involved him in developing practical skills, e.g. sanding and painting as well as personal development e.g. giving a presentation to others.
20.7.18.	Roland attended his GP surgery with a sensitive physical health issue. Due to this his father was asked to leave the room. Disclosed following this he had been sexually active.
31.8.18.	Steven was admitted to hospital suffering from a bleed on the brain. He was treated and discharged on 7.9.18. He said that he had lost his balance and hit the back of his head on a door some days previously and had fallen into a brick wall before that.
17.9.18	Steven was admitted to hospital following a bicycle accident which resulted in a 15ft fall down an embankment. On examination Steven had sustained a head injury. A subconjunctival haematoma was evident to the right eye, however Steven explained that this injury was sustained from a fight with a friend the other day after consuming 4 cans of lager. No loss of consciousness was reported at the time of the bicycle accident. Steven remained as an inpatient at SRFT for observations and was subsequently discharged on 20 September 2018.
4.10.18.	Breach of tenancy case opened as Steven failed to allow access to inspect balcony condition. Case closed 10.4.18 as access gained and rubbish removed.
12.10.18.	Health visitor reports concerns about Roland's younger siblings. The outcome was a Team Around the Family to continue to support Karen.

14.10.18.	Roland contacted the police and reported that his older brother had 'head-butted' him and may have broken his nose. This was said to be because Roland had called their sister a whore. On police arrival Roland and Karen did not want to make a complaint. A DASH risk assessment was completed which recorded a standard risk. A crime was recorded but no further action was taken. Roland's older brother was said to be at the house because he didn't like Karen's new boyfriend (Steven) who she had been seeing for four weeks.
15.10.18.	Karen's adult daughter contacted the police asking for information about Steven under the Domestic Violence Disclosure Scheme. Karen was said to be aware of the application. The case was assessed and it was decided that insufficient grounds existed for a disclosure to be made and Karen's daughter was informed.
15.10.18.	Roland's father removed the younger siblings from Karen's care after collecting them from school. The school made a safeguarding referral due to the children no receiving appropriate medical attention. Whilst with their father he reported that one of the children had made comments suggestive of sexual conduct from an adult male (Steven)
16.10.18.	Strategy meeting re younger siblings. Threshold met for Sec 47 enquiry (section 47 Children Act 1989).
16.10.18.	A social worker visited Roland at home to follow up on his report to the police that he had been assaulted by his brother. Roland said that he had lied to the police. Roland said that he was out walking the dog and got into a dispute with three young people who were calling him fat and one of these 'head-butted' him. He returned home and his brother Steven was making fun of him, saying that he should have defended himself. Due to 'head-butted' him.
25.10.18	Roland's father contacted the police to report that he was receiving threats via a false Facebook account which he alleged had been set up by Karen. A DASH risk assessment recorded a medium risk.
2.11.18.	Strategy meeting and outcome to section 47 enquiry. No evidence had been identified to support any concerns of sexual abuse. It was identified the presenting risks raised from school and health professionals had been substantiated but there were no ongoing concerns due to Roland's father now having custody.
8.11.18.	A Children and Families Assessment on Roland and ***** was completed, it concluded there were no safeguarding concerns or outstanding support needs for Roland and ***** and the case was closed. Roland was to continue to be offered pastoral support at college and EMTAS were to continue to support the whole family.
15.11.18.	An ASB noise nuisance complaint received by ForHousing about loud music and arguing coming from Steven's flat. Steven failed to attend

	appointments to discuss these concerns. The case was closed on 5.6.19 following Steven being evicted for rent arrears on 3.6.19.
17.11.18.	The police received a call to say that Roland and ******* had been locked in the house without food. On police attendance this was found to be a hoax call.
6.2.19.	A neighbourhood housing officer visited Steven at his flat. Someone was in but refused to come to the door.
18.3.19.	A neighbourhood housing officer visited Steven at his flat and completed a property inspection.
21.4.19.	Karen attended the Accident and Emergency department of North Manchester General Hospital (Northern Care Alliance NHS group) accompanied by Steven. She said that she had fallen from a bike that day and had injured her head and hand. A wound to her head was glued and she was given a follow up appointment for the fracture clinic. Karen did not attend the fracture clinic. There was no enquiry into the potential for domestic abuse.
16.5.19	Steven registered with Salford Home Search. Current address was ***** and had lived there since 21.12.16. He was looking to move to a one bed property as his current accommodation was too big and he was unable to afford the shortfall in the rent and was therefore in rent arrears. The application did not list any other people to be housed with him.
2.6.19	Karen registered with Salford Home Search. Her current address was ***** and she had lived there since 10.08.10. The application listed Roland *****, son, and *****, as living with her and moving with her. Application was never made active.
3.6.19	Steven was evicted from his tenancy due to rent arrears.
4.6.19.	Steven presented to the Housing Options Service in Salford having been evicted for rent arrears by ForHousing from ***** the previous day. He had a TORTS (Interference with Goods) Act 1977 Schedule to advise that his belongings were still in the property and he needed to arrange for removal by 01.07.19. Steven did not meet the statutory criteria for placement into temporary accommodation however, he was offered a referral for accommodation under ABEN (A Bed Every Night), scheme. Steven refused the referral as he said he could stay with a friend at (Karen's address) for the time being.
4.6.19	Karen presented to the Housing Options Service as her private sector landlord had issued her with a notice to terminate her tenancy at ****** however she did not have the notice with her. Karen said that there were two children to be rehoused with her, Roland and (relative

	not subject of review). She said that she would prefer to stay in the Irlam area.
4.6.19.	Karen was deleted from the practice list at her GP surgery after many attempts to engage her had failed.
8.7.19	A Housing Options Advisor, rang Karen as she had still not provided a copy of the notice from her landlord but there was no answer so the case was closed.
12.7.19.	Steven attended his GP complaining of low mood he was accompanied by Karen who became upset and left. Steven was prescribed Mirtazapine.
31.7.19.	Steven attended his GP complaining of low mood. He was prescribed fluoxetine and referred for counselling and the Salford Memory Assessment service and given an appointment in two weeks' time.
28.8.19	Steven attended his GP to follow upon the appointment of 31.7.19. He said he had missed his last scheduled appointment as he had been at a funeral in Ireland. He was to continue on fluoxetine and attend again in two weeks' time.

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