

BURY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

SUMMARY OVERVIEW REPORT

Victim MA 1

February 2015

CONTENTS

	SECTION	PAGE
1.	Introduction	3
2.	Establishing the Domestic Homicide Review	4 – 5
3.	Family Background	6
4.	The Facts	7 - 10
5.	Commentary	11
6.	Lessons Identified	12
7.	Predictability/Preventability	13
8.	Recommendations	14 - 15
Appendix A	Definition of Domestic Abuse	
Appendix B	Agency Lessons Identified	

1. INTRODUCTION

1.1 The principal people referred to in this report are:

MA1 : The Victim

MA2 : The Perpetrator

FA1 : Victim's partner and Perpetrator's Mother

1.2 In 2012 MA2 telephoned Greater Manchester Police [GMP] to say that MA1 was threatening him and being violent towards his mother [FA1]. A short while later North West Ambulance Service called GMP to say that MA1 had been stabbed; he died later that day in hospital.

1.3 MA2 was charged and convicted of murdering MA1 and sentenced to life imprisonment with a minimum tariff of 12 years.

1.4 The trial Judge remarked:

'I am in no doubt whatever that MA1's death occurred after he had drunkenly attacked your mother and you had restrained him in an upstairs bedroom, where he had also threatened you with violence ... you have been convicted of a murder charge because you went too far in dealing with his aggression.'

Source GMP

1.5 This DHR is unusual in that MA1 was not a victim of a domestic violence perpetrator. It was established during the criminal trial that MA1 and FA1 were involved in a domestic incident. MA2 intervened and exceeded legitimacy in protecting his mother.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

Decision Making

- 2.1 Initially, the Bolton Community Safety Partnership decided that the criteria for a DHR were met and began collating material. It became apparent that the history of the case lay within Bury and the agencies there held substantial information. It also transpired that the family had been living in Bolton for just six months. The Bolton and Bury Community Safety Partnership Leads and Domestic Violence Co-ordinators agreed it would be appropriate for Bury Community Safety Partnership to lead on the DHR. The Home Office Domestic Violence Unit was informed.

DHR Panel

- 2.2 David Hunter was appointed as the Independent Chair and Author. He was judged to have the appropriate experience and independence to conduct the DHR.

DHR Panel Members

- 2.3 The Panel members were:

Ann Christopher	Pennine Acute NHS Trust
Nigel Elliott	Greater Manchester Probation Trust
David Fowler	Bury Council
Janice France	Greater Manchester Probation Trust
Mark Granby	Greater Manchester Police [GMP]
Maxine Lomax	NHS Bury Clinical Commissioning Group
Claire Paynter	Bury Children's Social Care
Anita Pearce	Six Town Housing
Eileen Scarratt	GMP
Amanda Smith	Pennine Care NHS Foundation Trust Mental Health Services
Bridget Thomas	Pennine Care NHS Foundation Trust Community Services
Liz Shingler	Bury Children's Social Care Youth Offending Service
Joyce Carroll	DHR Administrator

Agencies Submitting Individual Management Reviews [IMR]

- 2.4 The following agencies submitted IMRs.

Children's Social Care
Children's Social Care Youth Offending Team
Connexions
GMP
Greater Manchester Probation Trust
Housing Choices
Pennine Acute NHS Hospitals Trust
Pennine Care NHS Foundation Trust Community Services
Pennine Care NHS Foundation Trust Mental Health Services
Six Town Housing

Notification/Involvement of Families

- 2.5 FA1 and MA1's mother were written to informing them that a DHR was taking place and inviting them to contribute. It was agreed these letters and the Home Office Domestic Violence leaflet for families would be delivered by GMP Family Liaison Officers. MA1's mother and step-father contributed to the review and were seen twice by the independent chair/author. MA2 was seen in prison after his conviction.
- 2.6 Significant efforts were made by the independent chair and AAFDA [Advocacy After Fatal Domestic Abuse: Registered Charity 1125973] to involve FA1. However, all attempts were unsuccessful and the report was published without the contents being shared with FA1.

Terms of Reference

Purpose of a DHR

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

[Paragraph 7 Multi-Agency Statutory Guidance for the Conduct of DHR 2013]

Timeframe

- 2.8 03.08.2004 until the homicide; the start date was selected to coincide with MA2's referral to Child and Adolescent Mental Health Services [CAMHS].
- 2.9 Agencies were requested to complete a précis of any material predating 03.08.2004 which they judged relevant to the purposes of this DHR and include them as a narrative at the beginning of Section 4 of their IMRs.

Appendix A contains the Government's definition of domestic abuse.

3. FAMILY BACKGROUND

3.1 Introduction

- 3.1.1 The sources of information in the following paragraphs are from the IMRs and the families of MA1 and FA1.

3.2 MA1 Victim

- 3.2.1 MA1 was one of three siblings. He is described by his mother and step father as enjoying school and in particular art. He was popular with his peers and had lots of friends. He studied A level art and technical drawing. MA1 worked in warehousing with periods of unemployment. He was a qualified fork lift truck operator. His passion for cooking led him to train in the south west before returning north to begin life as a parent.
- 3.2.2 His mother and step father describe him as a, kind, generous, confident and peaceful person who enjoyed a social drink but did not abuse it. He enjoyed golf and would do anything for anyone. He was a good son to them. They had never known him to be violent; he would walk away from confrontation and stay silent.
- 3.2.3 At times MA1 felt low because his contemporaries were forging their lives and moving on. He felt left behind and was unable to find employment opportunities to match his artistic skills.
- 3.2.4 In 2011 MA1 met FA1 and moved in with her in 2012. MA1's family thought the relationship was not suitable for MA1 saying they were concerned about the age difference, but recognised that he preferred older women.

3.3 MA2 Perpetrator

- 3.3.1 MA2's childhood can fairly be described as very difficult. He wanted his mother to be happy and knew that she was the victim of domestic abuse from several partners. He witnessed many such incidents and was injured during some of them.
- 3.3.2 MA2 moved out of the family home in 2009 and stayed with members of his extended family. He also presented himself as homeless on two occasions. He formed a non-lasting relationship which resulted in one child.
- 3.3.3 MA2 described his relationship with MA1 as good, except when the latter had been drinking. MA2's siblings told him that MA1 was involved in domestic incidents with his mother. He also saw her with injuries which she explained as accidents. It was not until the day he intervened in the confrontation between MA1 and his mother that he actually witnessed any domestic violence between them. MA2 feels his reaction to the assault on his mother by MA1 was conditioned by his generally negative experiences of life.

4. THE FACTS

4.1 Introduction

- 4.1.1 The material in this narrative section is arranged in time periods. The victim MA1 does not feature until October 2011. The next two paragraphs place some context around the preceding events.
- 4.1.2 Very little was known to agencies about the victim [MA1] which contrasts sharply to the abundance of information known about the offender [MA2]. In the period under review MA1 had just three contacts with services, whereas MA2 had multiple interactions, many of them as a child. These interactions revealed that MA2 had a problematical childhood which continued during his transition into young adulthood. The domestic abuse within MA2's family was not always dealt with appropriately by agencies. The services offered to protect MA2 were examined in a separate review initiated by Bury Safeguarding Children Board's, Serious Case Sub Group.
- 4.1.3 The life experiences of MA2 almost certainly influenced his actions on the night he killed MA1. Therefore they are relevant to the review, but the DHR Panel was keen to ensure they did not overshadow it.
- 4.1.4 The DHR Panel selected, for each period, what it considered to be representative examples of missed opportunities to support/influence MA2. All the interactions with MA1 are examined.

4.2 August 2004 to February 2009

- 4.2.1 GMP attended 18 domestic violence incidents between FA1 and her partner MA4, and several more involving other family members. There are 25 references to alcohol abuse, most of which were recorded by GMP.

Examples of Missed Opportunities to Support/Influence MA2

- 4.2.2 MA2 was involved with CAMHS from August 2004. In May 2005 he was diagnosed with Attention Deficit Hyperactivity Disorder [ADHD] and during the following years was treated with increasing doses of medication. His behaviour was noted to be variable. CAMHS had difficulty engaging with MA2's mother but did not look for alternative sources of information such as the school health practitioner or the GP. MA2's was discharged from CAMHS when he reached 18 years of age.
- 4.2.3 In 2006 MA2 was engaged with the YOT having received a three month referral order for criminal damage. The YOT had information about the family dynamics that was shared with GMP but not with Children's Services. There is no record of any action being taken by any agency in relation to the YOT information.
- 4.2.4 MA2 called GMP in 2007 to report that MA4 had assaulted him during a domestic incident with FA1. GMP recorded crimes of criminal damage and assault on MA2. MA4 was arrested and the Crown Prosecution Service took no further action against him because FA1 and MA2 would not cooperate.
- 4.2.5 GMP referred the incident to Children's Services but did not refer it to MARAC even though the risk faced by FA1 was high.¹

¹ MARAC: Multi-Agency Risk Assessment Conferences are meetings where information about high risk domestic abuse victims (those at risk of homicide or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. www.caada.org.uk

- 4.2.6 It appeared that while MARAC had been operational in Bury since March 2007, professionals' knowledge of the systems and processes was underdeveloped and therefore the case was not referred. Children's Services did not complete an Initial Assessment as was required following three domestic violence incidents in twelve months. Both agencies acknowledge their response was not good.
- 4.2.7 Six Town Housing [STH] was involved with FA1 for several years and dealt with many complaints from neighbours about anti-social behaviour originating from the family. Eventually the family had its tenancy terminated. STH missed some opportunities to share information with other agencies including Children's Services.
- 4.2.8 In 2008 MA2 contacted GMP reporting that MA4 had assaulted him and his mother; the police noted that both adults were drunk. FA1 suffered significant facial injuries. MA2 was punched on the head and chest by MA4 who was later charged with assaulting them. The risk assessment judged that MA4 posed a low risk of causing serious harm to FA1. The matter was referred to Children's Services. The DHR Panel felt the risk assessment significantly understated the risk posed by MA4 and faced by FA1 and MA2.
- 4.2.9 FA1 and MA2 attended Accident and Emergency at hospital and were treated for the above injuries and discharged. The child protection issue was not recognised and therefore no referral was made to Children's Services. That was a clear breach of hospital policy.
- 4.2.10 It is fair and reasonable to say that MA2's life was beset by significant difficulties the causes of which he had limited influence over. There is no record of a problem solving approach to the family's many, varied and complex needs. No professional seems to have considered the cumulative impact of the issues on MA2's well-being and consequently did not look for a solution.

4.3 February 2009 to October 2011

- 4.3.1 The involvement of agencies with the family during this period was significantly less than the previous one. MA2 stayed with his family and his girlfriend's family, and presented himself as homeless in September 2009 and May 2011.
- 4.3.2 In 2009 MA2 had his ADHD medication reduced and it was noted he was:
 - more irritable
 - had difficulty sleeping
 - socially isolated
 - lacked motivation/lethargic
 - suicidal thoughts associated with low mood
 - recent undisclosed superficial self-harm
 - clinically depressed

- 4.3.3 In June 2009 MA2 was arrested and charged with possession of an offensive weapon; half a house brick, which he was going to use as weapon. There does not seem to have been a particular target in mind, other than it was noted he was eying up passers-by.
- 4.3.4 The first reference to MA1 appears during this period. In 2010 MA1 was convicted of attempting/permitting or suffering the production of cannabis on his premises and dishonestly using electricity. MA1 claimed an element of coercion in committing the offence. He was sentenced to six months imprisonment suspended for two years and a requirement to do 100 hours unpaid work. This brought him under the supervision of GMPT. He completed his community work without any difficulties.

4.4 November 2011 to Death of MA1

First Domestic Violence Incident FA1 - MA1

- 4.4.1 In 2012 GMP dealt with a verbal argument between MA1 and FA1. A GMP officer completed a Domestic Abuse Stalking and Harassment risk assessment [DASH]. FA1 declined to answer 25 of the 27 screening questions. The level of risk was assessed as "standard" meaning the current evidence did not indicate the likelihood of serious harm. This was based on the officer's professional judgment and is reasonable.

Second "Domestic Violence Incident" FA1 - MA1

- 4.4.2 In 2012 GMP received an abandoned silent "999" call. The call taker heard an argument between a male and female. The call was traced to Address 1. GMP telephoned MA1 [at Address 1] who said his six year old daughter had been playing with the telephone. No sounds of a disturbance were heard. A police patrol called at the house ninety minutes later but did not get a reply. The log was endorsed with: "History of domestics at this address".
- 4.4.3 At 8.51 a.m. the same morning an officer called at Address 1 and saw FA1 and MA1 who appeared to be the only people present. They were both safe and well and claimed to have no idea why the police had attended. MA1 explained that his daughter from a previous relationship had stayed the night and may have dialled "999" accidentally. This is known to be wrong as MA1's daughter was a home with her mother.
- 4.4.4 The officer noticed that MA1 had a cut on the bridge of his nose which he claimed happened when he fell over. He was asked in private whether he had been assaulted but denied it. There is no suggestion that MA2 caused the injury.

Other Relevant Matters

- 4.4.5 MA1's mother and step-father told the DHR independent chair/author that MA1 had told them that he had made a decision to move out of the house and live with a friend as the relationship with FA1 was not working out. MA1 was waiting for a friend to collect him and his belongings as he did not want to leave without them, fearing FA1 would obstruct their later retrieval.

Events Leading to Fatal Assault on MA1

- 4.4.6 MA2 told the DHR independent chair/author that he had no difficulty with MA1 living in the family home and that they got on well apart from when MA1 was drinking.
- 4.4.7 On a Friday evening MA1, FA1, MA2 and two other adults went to a local public house to watch football. All, apart from MA2 were drinking. Later that evening they purchased beer and vodka, returned to Address 1 and continued drinking at which time MA2 joined in. The two adults went home leaving the family members alone. FA1 went upstairs leaving MA1 and MA2 downstairs. The female adult returned after a row with her partner and spoke with MA1 and MA2. FA1 came down stairs and challenged MA1 about the presence of the female friend in the house. FA1 went upstairs followed shortly by MA1. Sounds of shouting and thudding were heard and MA2 ran upstairs to intervene in what he believed was an assault on his mother by MA1. The adult female then ran upstairs and observed MA2 holding MA1 in a headlock. MA1 and MA2 went downstairs. FA1 followed and discovered MA1 with a wound to his neck. It appeared that MA2 had confronted MA 1 with a knife and stabbed him. By this time it was the early hours of Saturday morning.
- 4.4.8 MA2 was arrested on suspicion of assaulting MA1. MA1 had alcohol levels which equate to being moderately drunk. No alcohol or drugs were detected in MA2's sample taken some 19 hours after his arrest. He told a police officer and a doctor that he had consumed about five to six cans of lager. FA1 stated she had about three pints of lager in the pub and felt a bit tipsy. At home she shared half a bottle of vodka with the adult female and went to bed drunk.
- 4.4.9 MA2 said to the DHR chair/author that having been assaulted previously when he intervened to protect his mother from domestic violence, he did not want the same to happen again and that was the reason for "defending" himself against MA1. MA2 readily acknowledges that his childhood experiences of domestic violence shaped how he reacted to the incident between FA1 and MA1.

5. COMMENTARY

- 5.1 Much of this DHR has out of necessity focussed on MA2's formative years in an attempt to describe the environment and understand the issues which shaped and influenced his actions in 2012.
- 5.2 The DHR Panel felt MA2's childhood and young teenage years were beset by complex and enduring issues. These included living in a home where alcohol was abused and domestic violence was a frequent event. Added to that were his health and behavioural problems. The family was also evicted. MA2 was the victim of physical abuse by some of his mother's partners which went unrecognised by professionals, despite there being many opportunities for intervention. No agency spotted the cumulative impact of events within and around the family and thus no multi-agency planning happened. Had it taken place the opportunity for change would have been far greater.
- 5.3 The impact of domestic violence on FA1 and MA2 was not recognised and in particular any links it may have had to MA2's behaviour were not explored. Some positive work was done with MA2 but he reverted to a chaotic lifestyle which continued into adulthood. The stabilising impact of parenthood did not work for him and his relationship with his partner broke down. However, MA2 must also bear responsibility for his behaviour. He did not have a psychotic mental illness and therefore had real choices to make.
- 5.4 MA1 entered a relationship with FA1. He moved in with her and MA2 in 2012. He did not have a history of being involved with domestic abuse. It appears from MA2's account that he got on well with MA1, a position that only deteriorated when MA1 and FA1 drank too much. The theme of domestic violence set against a background of alcohol abuse runs through the entire review period. In some ways it is quite remarkable that MA2 did not abuse alcohol given his exposure to it. He was a frequent user of cannabis and occasional user of class A drugs, albeit no traces were found in the samples taken from him post arrest.
- 5.5 MA1 became entangled in a physical altercation with FA1 which was witnessed by MA2. There is no evidence to say that MA2 specifically targeted MA1, it was simply that he saw MA1 being violent to his mother and looked to protect her.
- 5.6 A separate review which will concentrate on the child protection aspects of the case.
- 5.7 Finally, the DHR Panel concluded that the weaknesses identified within agencies did not contribute towards the death of MA1. Had those weaknesses not existed MA2 would have been given a greater opportunity to change. It is not possible to say he would have altered his behaviour, there are just too many variables, including the passage of time.

6. LESSONS IDENTIFIED

6.1 DHR Panel

Lesson 1

Narrative

GMP recorded MA1 as the primary victim of domestic violence and FA1 as the secondary victim following a verbal only argument in 2012. Neither of them chose to disclose all the issues. Additionally, MA1 denied being a victim of domestic violence when he was seen with a cut to his nose on a separate occasion in 2012.

Lesson

The lesson is that victims of domestic violence do not always reveal to agencies their status as victims and this makes it very difficult for accurate risk assessment and appropriate services to be offer. Consequently, agencies should look for wider sources of information when they are concerned about hidden or undisclosed domestic violence cases.

Lesson 2

Narrative

Chaotic use of alcohol continues to feature in domestic violence and in this case was prevalent before MA1 moved in with FA1 and MA2. However it is said, "Alcohol does not cause domestic violence, but there is evidence that where the domestic violence exists, alcohol is often present.

Source: Grasping the Nettle: alcohol and domestic violence Revised edition, 2010 Sarah Galvani, University of Bedfordshire

Lesson

The lesson is that agencies should recognise the impact of alcohol abuse when assessing risk in domestic violence cases.

6.2 Single Agency

Seven agencies reported relevant Lessons Identified: Children's Services, GMP, GMPT, YOT, Pennine Care NHS Foundation Trust, Pennine Acute Hospitals NHS Trust and STH. These are mainly tangential to the purposes of the DHR, but nevertheless are included at Appendix B for transparency and learning. Some agencies identified examples of good practice but none of them were directly related to the DHR.

7. Predictability/Preventability

- 7.1 MA1 was not known to any agency as being a physically violent person and was described by his mother and step-father as peaceful. There is some evidence that there was domestic abuse between him and FA1.
- 7.2 There is no evidence that prior to the homicide that MA2 was the perpetrator of domestic abuse; all the evidence suggests he had been a victim domestic abuse on several occasions.
- 7.3 MA1 had one known domestic violence incident [non-physical] with FA1 and one suspected domestic violence incident with her. He was recorded as the primary victim in the first incident and assessed as facing a standard risk. The suspected domestic violence incident was judged not to meet the domestic violence definition and therefore never enter the risk assessment process.
- 7.4 Despite their brief history, it is reasonable to say that there might be further domestic incidents between MA1 and FA1. It is not believed that MA2 witnessed any domestic violence between them. He did suspect it was happening.
- 7.5 It was predictable that MA2 would intervene to protect his mother from any domestic violence he witnessed. This is evidenced by his history of having done so despite being assaulted himself. MA2 did not have a history of being violent towards people, other than in the protection of his mother. Given that MA2 lived in the same house as FA1 and MA1 it is likely that at some time he might witness domestic violence and intervene.
- 7.6 On balance, the DHR Panel thought that it was predictable that FA1 would be the victim of domestic violence. Given her history of victimisation the DHR Panel also felt that FA1 would either be involved with pre-emptive or retaliatory behaviour against those who threatened her. It was also predictable that MA1 would be caught up with incidents of domestic violence with FA1 when they were in drink.
- 7.7 MA2's intervention in such violence was predictable and his history of arming himself with weapons for self-protection, meant that it was not surprising he might turn to them when faced with an older and bigger person. He said his experiences of being assaulted by domestic violence perpetrators influenced how he reacted to MA1. It was not predictable that the outcome of MA2's involvement would be fatal for MA1.
- 7.8 The DHR Panel considered that whilst it was predictable that MA2 would defend his mother, the three year gap between his previous intervention meant that it was not reasonable to expect any agency to have predicted or prevented his actions in attacking MA1 with fatal results. His level of assessed risk, albeit some years ago, did not indicate he could commit serious harm to anyone.

8. RECOMMENDATIONS

8.1 Introduction

- 8.1.1 This DHR was completed in 2013 and publication was delayed while legal advice was sought on its content. Bury Community Safety Partnership is now satisfied that the DHR Panel and single agency recommendations have been completed in the intervening period; they are however, set out below for transparency.

8.2 DHR Panel

- 8.1.1 That Bury Community Safety Partnership should ensure that its multi-agency domestic violence training establishes or reinforces the following aspects of domestic violence:

1. That in order to produce accurate risk assessments, including service planning, it is necessary to gather information from a wide range of sources and not just rely on self-reporting which is often misleading because of denial or limited disclosure.
2. That "low risk" is not the same as "no risk".
3. That alcohol is an important feature in many domestic violence cases and professionals should take cognisance of it when working with victims and perpetrators.

8.3 Single Agency

- 8.3.1 The DHR Panel did not think it would be useful to repeat the non-direct domestic violence recommendations from agencies IMRs, feeling they would clutter and maybe confuse a DHR with a child serious case review. The following single agency recommendations were thought relevant to the DHR.

GMP

- 8.3.2 That the Head of the Public Protection Division clarifies the policy and procedure for the completion of enhanced risk assessments in relation to domestic abuse, stalking and harassment incidents where the initial level of assessment is "standard".

Children's Services

- 8.3.3 Ensure that the DASH risk assessment is routinely used and that consideration is given to MARAC referrals where necessary.

GMPT

- 8.3.4 In all case of domestic abuse ensure there is contact with police Domestic Abuse and Safeguarding Unit to ascertain prior contact and establish ongoing risk information sharing.

Pennine Care NHS Foundation Trust

- 8.3.5 To ensure that there is direct enquiry in relation to domestic abuse within risk assessments.

Pennine Acute Hospitals NHS Trust

8.3.6 Enhance domestic abuse and alcohol abuse training

Youth Offending Team

8.6.7 The YOT must ensure that proper analysis is made of information that informs planning and decision making.

END OF SUMMARY OVERVIEW REPORT

February 2015

Appendix A

DEFINITION of DOMESTIC VIOLENCE

The Government definition of domestic violence against both men and women is:
[2004]

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

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

Notes:

1. GMP use the above definition which has been agreed between the Government and The Association Chief Police Officers [ACPO]
2. On 01.03.2013 the Government definition of Domestic Violence changed to:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to the following types of abuse: psychological: physical: sexual: financial: emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

MA1 was in a relationship and living with FA1. Also living in the same house was MA2. Therefore, it is appropriate to refer to MA1 and MA2 as family members.

APPENDIX B

Agencies' Lesson Identified

1. Children's Services

1.2 Introduction

- 1.2.1 The significant practice deficits highlighted in this case occurred before 2010 and had already been identified by the agency via the auditing activity in place since 2009. Further issues were identified during the Serious Case Review of Child D in 2011 (published 2012) and the agency's contribution to the Trafford Domestic Homicide Review of L and K in 2012 (to be published). The following details the issues identified by this review *[in bold italics]*, when they were previously identified, what action has been taken in response to these and what outstanding action is recommended.

Ensuring appropriate responses to referrals and that enquiries are undertaken when there is evidence of a likelihood of significant harm. The thresholds in operation in the Social Work team were identified to be too high in 2009. The team was strengthened in relation to management and staffing levels in 2010. Thresholds have been audited internally and also externally by Ofsted, demonstrating that this has been addressed. This is an area that needs continued close monitoring.

Ensuring referral to the MARAC is considered where necessary and that DASH risk assessment is completed where appropriate. Action to address this has already been completed. The outstanding need is to monitor the extent to which this is used in practice and take remedial action as needed.

Ensuring information and participation of key agencies is sought within initial assessments and strategy discussions and lack of recording of dates members seen. These issues have also been highlighted within audits of practice and were addressed in 2010. The practice was to routinely confine strategy discussions to the police and social care. A practice change was made and further on scrutinising recording of assessments. Both subsequent audits and Ofsted inspections of the Duty and referral function in 2010, 2011 and 2012 have evidenced that changes have been embedded.

GPs, Education providers and probation are notified when Domestic Abuse incidents take place but where no further action is taken by Social Care. This has been addressed by the revision to the Domestic Abuse Information Sharing Protocol ratified in February 2013 which is now operational. Monitoring to ensure this remains operational is required.

The need for "healthy scepticism" and "respectful uncertainty": Concerns about quality of assessments were identified in an extensive audit of Child Protection cases in 2009. The department has invested heavily in risk assessment training which has included the importance of synthesising information from different sources and in testing out different hypotheses and not taking what is said on face value. Training in relation to undertaking assessments from an independent consultancy was undertaken with all Social Work staff in 2010, and this was repeated in 2012 and further, a new risk assessment model was adopted in 2013 in which all staff have

been trained. Consultant Social Workers have been appointed in 2012 to support Social Work practice directly through consultant, mentoring and training delivery. All Safeguarding Board courses have also been updated to include the issue of addressing “disguised compliance” in response to national serious case review findings and the 2009 audits. Follow up audits undertaken in 2011 and 2012 show improved practice. This is also evident in the intervention with FA3 in 2010/11. Given the training work undertaken, it is recommended that the only further action is to disseminate the findings of the review to practitioners with particular emphasis on questioning information and testing hypotheses, and upon the vulnerability of teenagers.

2. GMP

If local deviations from Force policy on Enhanced Risk Assessments are considered necessary, arrangements should be made with the policy holder to review the policy ensure consistency across GMP or approval for the local practice.

3. GMPT [as was]

GMPT’s lessons are around the management of MA4’s case but one recognises that information gathering meant that the child protection issues for MA2 were not identified and acted on.

4. YOT

Good assessments can only be achieved after gathering and sharing all the relevant material, including child protection issues, thereby ensuring the analysis leading to case and decision making, is properly founded.

5. Pennine Care NHS Foundation Trust [CAMHS]

To ensure that there is direct enquiry in relation to domestic abuse within risk
To ensure when information is received in relation to serious domestic abuse that this is shared and clarified with the police, children’s services and community health services.
To provide a briefing to front line staff in CAMHS in relation to domestic abuse and emotional abuse
To ensure that staff are made aware of the availability of multi-agency training on domestic abuse.

6. Pennine Acute Hospitals NHS Trust

When information is not shared with other agencies it can hinder them in identifying all the issues in a case thereby weakening the analysis, assessment and provision of services.

7. STH

STH acknowledges that it should have contacted more agencies when deciding how best to deal with FA1 as a tenant. The lesson is that not gathering all relevant information may hinder decision making. The DHR Panel heard that STH practice has changed since 2008 and therefore a recommendation is not needed.