Manchester Community Safety Partnership

Domestic Homicide Review Report:

‘Sarah’

Author: Tony Blockley

Amended by Officers from Manchester City Council

Version 11

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1. Introduction

1.1. The Circumstances that led to this Domestic Homicide Review (DHR)

1.1.1 This Domestic Homicide Review Overview Report is about Sarah, a 38-year-old mother, who died in Manchester, in August 2015 after having been severely assaulted and strangled by her husband.

1.1.2 Sarah was from another European country. She lived in Manchester with 48 year old Adam but frequently spent time working abroad. She had a 14-year-old son from a previous relationship who sometimes stayed with them.

1.1.3 'Sarah' is a pseudonym chosen by the victim's sister. She has participated in this review and the panel would like to extend its sincere condolences to her for her sad loss. The panel would also like to thank her for the courage and the dignity she has displayed throughout this DHR process. Her support has been invaluable and has greatly assisted the panel to view events through Sarah's eyes.

1.1.4 'Adam' and 'Robert' are pseudonyms chosen and agreed with the individuals.

1.1.5 After a trial at Manchester Crown court, Adam was found guilty of murdering Sarah. He was sentenced to life imprisonment with a recommendation that he must serve 17 years and five months before the question of his parole can be considered.

1.1.6 During the court proceedings, the judge said:

"…her family and friends…provided her with encouragement and support. You, by contrast, became increasingly irritated, frustrated and resentful and you sought to undermine her confidence and to control her."

"On all the evidence I have heard I am satisfied that this attack occurred against a background of controlling and sometimes aggressive behaviour by you…you came to resent her success and her friendships and those she met…you were jealous of her being the focus of attention and praise and of her meeting people when she was working away from home."

1.1.7 Adam had been convicted on two previous occasions before he murdered Sarah. On the first (which happened in Manchester but wasn't reported to Greater Manchester Police), Adam was reported as saying words to the effect "You are not leaving me. Now there is only one solution; first you die, then I die. I kill you. Now you die'". During the second incident it was reported that, 'Whilst JM was pressing tightly over her mouth and nose he said to [Sarah] words similar to "Now you die." He was convicted in

another European country and sentenced to 90-days imprisonment in respect of both offences.

1.1.8 Sarah and Adam met sometime during 2011. A friend of the couple, Adult C, provided evidence that at first the relationship between them appeared to be good, but Adult C soon realised that Adam was volatile and that he would often 'explode in anger', even at the slightest thing.

1.1.9 Sarah told Adult C in the months before her death that she was frightened of Adam and was planning to leave him. She also talked about the incident abroad when Adam had been arrested for assaulting her and that he had been sent to prison for it.

1.1.10 Adult D, another acquaintance of Sarah, said that during a meeting in March 2015, Sarah had told her in confidence that she wanted to end her relationship with Adam, although she did not tell her why.

1.2. The lead-up to Sarah's death

1.2.1. The immediate chain of events that ultimately led to Sarah's death in the early hours of 30th August 2015, were as follows:

1.2.2. On 27th August 2015, Adult D stayed overnight at Sarah's and Adam's home. The following morning, she heard doors banging and Sarah and Adam swearing at each other. She said the couple argued two or three times a day throughout her stay with them.

1.2.3. Two days later, after Adam had said he was going to prepare a meal for everyone, he arrived home apparently already in a bad mood. When Sarah said she had already prepared a meal, he was so angry that he smashed a bottle of milk on the floor. Adult C said Sarah was "frozen in fear".

1.2.4. When she had the opportunity, Adult D asked Sarah if her husband was suffering from some sort of mental illness. She replied on the lines of, "Does he look normal to you?"

1.2.5. During the evening, Adult C tried to talk to Adam about his behaviour and at one-point Adam did ask Adult C to go with him into the garden so that they could talk. He appeared serious and as if he was going to talk about his problems, but then his tone changed and he made light of the situation.

1.2.6. Adult C decided to leave around 10pm and as he was going, Adam asked if he would drop him of at the local church, which he did. Just over an hour later, Sarah telephoned Adult C to ask if he knew where her husband was. Adult C said he had dropped him off at the church.

1.2.7. Later that night, Sarah went upstairs and woke Adult D to tell her that Adam had come home drunk and said that she didn't feel safe. Adam also went upstairs, saying, "It's not true, everything she's just told you." He then took Sarah's laptop.

1.2.8. Adam then told Sarah to get out of the house. He was screaming and threw himself at her and they both fell down the stairs. He was punching Sarah and also started to strangle her. Adult D shouted at him to stop and said, "You're going to kill her", to which Adam said, "I want to kill her."

1.2.9. Adult D then ran to a neighbour's house to ask them to call the police and while he was doing so, Adam went into Robert's bedroom and tried to strangle him. The child managed to push Adam away with his legs and escape.

1.2.10. At 12.43am on 30th August 2015, Robert rang the police on the 999 system and said Adam had strangled his mother and that she was unconscious.

1.2.11. An ambulance was called and police officers were sent to the scene. When the police arrived, they found Adam in one of the upstairs bedrooms and arrested him. He said such things as "Kill me please" and "You pay for tonight in your next life". Later, at the police station, he said, "I can't remember anything other than waking up here."

1.2.12. The ambulance crew took Sarah to hospital, where sadly she died at 2.05am the same morning. Sarah had multiple injuries to her head and neck. She had also been strangled.

1.3 Establishing the Domestic Homicide Review

1.3.1 On 6th October 2015, the Community Safety partnership met to discuss the case and duly determined that a DHR should be undertaken. The Home Office was notified the following day.

1.3.2 The Review commenced with the first Panel meeting, held on 24th November 2015. The overview report was presented to the CSP Board on 28th February 2017 and submitted to the Home Office in July 2017.

1.4 DHR Panel Chair / Overview Report Author

1.4.1 Tony Blockley, an Independent Chair and report author was appointed by the Manchester Community Safety Partnership. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPA and was responsible for all public protection

issues when he was head of crime in a UK police force. He has been involved in numerous DHRs, serious case reviews and MAPPA reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Manchester Community Safety Partnership) and is a Senior lecturer in criminology at the University of Derby.

1.5 The Review Panel

1.5.1 The Domestic Homicide Review Panel on behalf of Manchester Community Safety Partnership agreed the formation of the overview panel comprising of agencies that had contact with Sarah and Adam during the period under review. Other agencies were also invited, including a representative providing specialist domestic violence advice.

1.5.2 The DHR Review Panel consisted of:

Name	**Organisation**
Tony Blockley	Independent Chair and Author
Michelle Hulme	Policy Specialist, Community Safety Team, Manchester City Council
Georgina Agoglia	Business Support, Manchester City Council (1st panel meeting only)
Leanne Conroy	Policy Officer, Safeguarding in Educatiion Unit, Manchester City Council
Delia Edwards	Domestic Abuse Reduction Co-ordinator, Manchester City Council
Joanne Simpson	Service Manager, Independent Choices
Sarah Khalil	Designated Nurse for Safeguarding Adults, Clinical Commissioning Group
Ann Christopher	Named Nurse, Safeguarding Adults, Pennine Acute Trust
Anna Buchanan	Detective Inspector, Greater Manchester Police
Jenny Patterson	Safeguarding Lead for Education, Manchester City Council

1.6 Scope of the review

1.6.1 The DHR panel determined that the review should focus on the period between 1st November 2012 and 30th August 2015, the date of Sarah's death. The starting point reflected the first occasion that agencies had any information that domestic violence and abuse featured in Sarah's life.

1.6.2 Comment: After Sarah's murder, agencies became aware that she had been assaulted by Adam elsewhere in Europe and that there had been other

incidents in Manchester that had gone unreported. Further comment will be made of this later in the report.

1.7 Terms of reference

1.7.1 The purpose of the review was to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which Greater Manchester 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.

1.7.2 The review aimed to address:

- Whether the incident in which Sarah died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Sarah or her family and friends in reporting any abuse in Manchester or elsewhere, including whether they knew how to report domestic abuse should they have wanted to?

- Whether there were opportunities for professionals to 'enquire' as to any domestic abuse experienced by Sarah that were missed.

- Whether Adam had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Sarah or Adam that were missed.

- Whether there were any training or awareness raising requirements necessary to ensure a greater knowledge and understanding of

domestic abuse processes and/or services in the area covered by the Manchester Community Safety Partnership.

- Giving appropriate consideration to any equality and diversity issues that appear pertinent to Sarah or Adam e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

1.8 The review identified the following general areas for consideration:

1.8.1 **Family engagement**

- How should friends, family members and other support networks and, where appropriate, Adam, contribute to the review and who should be responsible for facilitating their involvement?

- How should matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for it.

1.8.2 **Legal Processes**

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

1.8.3 **Research**

- How should the review process take account of previous lessons learned from research and previous DHRs?

1.8.4 In order to reach a view on whether Sarah's death could have been predicted and/or prevented, the IMR authors were asked to include information on, and analysis of, all the following issues:

1.8.5 **Multi agency responsibility**

- Was Sarah or Adam subject to a MARAC/MAPPA?

- Was Adam subject to a Domestic Violence Perpetrator Programme (DVPP)?

- Did Sarah have any contact with a domestic abuse organisation or helpline?

- Whether Sarah or Adam were 'vulnerable adults'

- Whether there were any issues in communication, information sharing or service delivery between services.

1.8.6 **Individual agency responsibility**

- Was the work in Sarah's case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

- What were the key relevant points/opportunities for assessment and decision-making in Sarah's case in relation to her and Adam? What was the quality of any multi-agency assessments?

- Was the impact of domestic violence on Sarah recognised?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Could the homicide have been anticipated (predicted?) or prevented?

- Was there learning in Sarah's case that would improve safeguarding practice in relation to domestic violence experienced by the parents or guardians of children at risk?

- Is there learning in relation to the effective communication, information sharing and risk assessment for all those children's services involved in Manchester, including any good practice that can be built upon?

1.8.7 **Specific considerations for this review**

- Adam had been convicted elsewhere in Europe and had been prosecuted by those authorities. What were the circumstances and

was/should that information have been shared? If the information had been shared what would have been the agency response?

- Was Robert's school aware of DV and/or did they attempt to find out the cause of his concerns?

- Was Adam's mental health considered by agencies? Were there any referrals for mental health issues?

- Were there referrals to children's services relating to Robert? If not, why not?

- Were risk assessments referred appropriately?

1.9 Participating agencies and requirements

1.9.1 The following agencies were asked to provide chronological accounts of their contact with Sarah and with Adam.

- Greater Manchester Police
- Pennine Acute NHS Hospitals Trust (North Manchester General Hospital Accident and Emergency)
- Manchester Mental Health & Social Care Trust
- Manchester Clinical Commissioning Groups (GP)
- North West Ambulance Services
- Robert's school

1.9.2 Each agency was required to report the following:

- A chronology of interaction with Sarah and/or Adam
- What action was taken and to provide an analysis of those actions
- Whether internal procedures were followed and if those procedures were appropriate in light of the death of Sarah
- Conclusions and recommendations

1.10 Parallel processes

1.10.1 There was a thorough police investigation into the circumstances of Sarah's death culminating in the trial of Adam. He was found guilty of her murder and was sentenced to life imprisonment with a recommendation that he serves a minimum of 17 years and five months before being considered for parole.

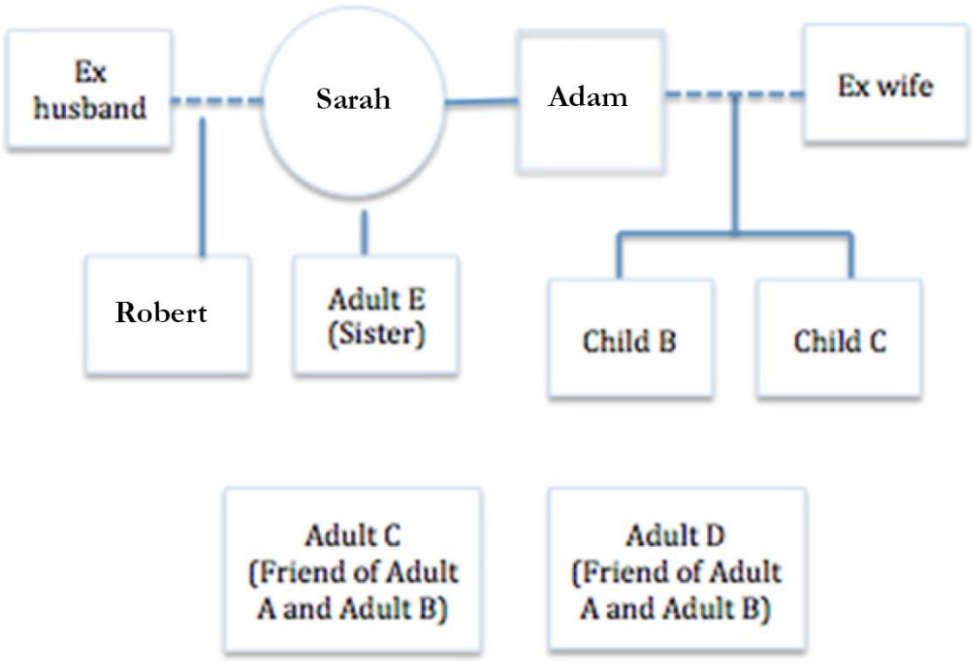
1.10.2 Sarah's death was referred to the Coroner and as yet no inquest has taken place. The Coroner has requested a copy of the report to determine

whether to resume the investigation and inquest in accordance with S.11 and sub section S.1 (2) (a) of the Coroners and Justice Act 2009.

1.11 The involvement of family members

1.11.1 The DHR Panel would like not only to extend its sincere condolences to Sarah's family, but also to express its gratitude to them for their support and for the courage and dignity they have displayed throughout the process.

1.11.2 Family composition



1.11.3 Sarah's family have been contacted during the review and her sister, Adult E, has kindly spoken with the author. A summary of what she said can be found in the next section of this report.

1.11.4 Adult E explained that their mother is unwell and is 'hardly coping'. She does not speak English. Adult E asked that her mother not be contacted as part of the review. When she feels her mother is strong enough she will speak to her about it. She has no contact with her father.

1.11.5 Friends of Sarah have also been invited to participate in the review but to date, none have acknowledged the request or expressed a desire to take part.

1.11.6 Adam responded positively to an invitation to participate in the review and arrangements were made for the Chair to visit him in prison. However, when the Chair visited the prison, Adam refused to see him.

1.12 Contribution of Sarah's sister (Adult E)

1.12.1 Adult E said she was reasonably close to Sarah but added that she led a hectic life performing around the world.

1.12.2 She described their childhood and said that their father was violent towards their mother. She feels that as a consequence, they became tolerant of domestic violence and abuse from an early age.

1.12.3 Adult E felt that the longer Sarah was exposed to the abuse from Adam, the more normal it became to her. Adult E described it as 'losing its borders.' She said that Sarah tried to justify the abuse as a means of managing it and that she even joked about it on one occasion when she said, "He's going to kill me one day."

1.12.4 **Comment**: A report by Unicef (2006) found that, 'Children who live with and are aware of violence in the home face many challenges and risks that can last throughout their lives. There is increased risk of children becoming victims of abuse themselves.[1]

1.12.5 Adult E also thought Sarah joked about the abuse to distance it from reality and because of the perceived shame attached to it. She also thought that in some way Sarah thought she deserved it.

1.12.6 Adult E said that in the beginning of the relationship Adam 'seemed like a nice guy' and that he idolised Sarah. He was already married and Sarah was 10-years younger than him.

1.12.7 She said that Sarah was not a strong person but she did have a strong personality and that she was very driven in her career. She added that she (Adult E) thought that was a challenge for Adam.

1.12.8 She also said that Adam arranged Sarah's work and managed her website, so Adult E thought he was able to control her that way.

1.12.9 Adult E said that occasionally Adam would call her to complain about Sarah's behaviour. She told him that it was none of her business, although she did not expand on this.

[1] Unicef (2006), Behind Closed Doors, The Impact of Domestic Violence on Children; https://www.unicef.org/media/files/BehindClosedDoors.pdf

1.12.10 Adult E and Sarah spoke regularly over the phone and on Skype. Adam was always present. He would not let Sarah talk in her first language, insisting she spoke in English. Even when the sisters met in a café, Adam would turn up. Adult E commented that their father had displayed the same controlling behaviour when they were younger.

1.12.11 Adam's previous wife had not been a creative person like Sarah. His previous relationship had apparently been very routine based, structured and clear, everything Sarah was not. Adult E said that Adam did not understand Sarah; she was very different and Adult E felt her sister would be trapped by such a routine. Sarah was very much a free spirit, being creative, playing music, painting and writing poetry; she did not want a settled life restricted to one home and one country, she wanted more than that.

1.12.12 Adult E was specifically asked whether her sister was aware of services that support victims of domestic abuse and if she had known about them, whether she would have accessed them. She did not know if Sarah was aware, but was quite adamant that Sarah would not have sought support even if she had known it was available. That was mainly because of Sarah's perceived shame of it all and because she was a private person who thought she could manage the situation herself.

1.13 What the agencies knew prior to Sarah's death

1.13.1 **Sarah**

1.13.2 Agencies had limited knowledge of Sarah before her death. It is now known that she had been the victim in a number of incidents of domestic violence perpetrated by Adam; some had been reported, but most had not come to the attention of the agencies.

1.13.3 **Adam**

1.13.4 Adam had been involved with Greater Manchester Police (GMP) after Sarah had reported his abuse. He had never been arrested for any offences, as on every occasion there was no evidence upon which to support a prosecution.

1.13.5 Adam had been arrested elsewhere in Europe in 2012 for domestic assault against Sarah. This included an offence in Manchester in November 2012 that had not been reported to GMP at the time. He was convicted and received a 90-day custodial sentence in 2014.

2. Chronology of events

2.1. 21st November 2011

2.1.1 On 21st November 2011, Sarah saw her GP complaining of 'low mood'. The notes recorded that Sarah, 'Lives with her partner and who was also employer – decided to have a baby together a year ago, Patient was 12 weeks pregnant when [Adam] suddenly dumped her via e-mail and fired her too and went back to [Europe]. Had a termination last Thursday…Guilt over termination. Thoughts of self-harm, no plans or intent.' She was prescribed sleeping tablets and given numbers for counselling.

2.1.2 **Comment**: This was a potential opportunity to enquire about her relationship and whether she had been subjected to domestic violence and/or abuse.

2.2 23rd November 2011

2.2.1 On 23rd November 2011, a 'cause for concern' notification was sent from North Manchester General Hospital to the GP. Sarah had attended the Accident and Emergency department on 20th November 2011 and left Robert, who was 10, at home alone. She was experiencing abdominal pain and bleeding following a fairly recent termination.

2.2.2 **Comment**: The IMR states that the practice manager telephoned Sarah but there was no answer. Information sent from A&E to the GP suggested that the school nurse may want to talk to the doctor directly.

2.2.3 It is expected practice if a child is home alone and not on child health or the GP system the school nurse would discuss this in their safeguarding supervision and seek advice regarding whether they should refer to children's social care. The notes do not detail the outcome of this.

2.3 September 2012

2.3.1 In September 2012, Robert's school became aware that Sarah had met Adam and were in a relationship, but they did not know they were married. The notes relating to Robert indicate that his behaviour had begun to deteriorate around this time and his concentration levels were not as they should have been.

2.4. 18th November 2012

2.4.1 During the morning of 18th November 2012, Adam went to the Accident and Emergency department of the North Manchester General Hospital with

Sarah. He said he was feeling depressed and claimed to have had a 'blackout' the night before. Sarah told the triage nurse that Adam was suicidal. They both said that they were having frequent arguments and fights.

2.4.2 Adam told the nurse that he had suffered from depression previously and had been treated for it in Europe. He also admitted to having struck Sarah.

2.4.3 An accident and emergency doctor saw him and referred him to the psychiatric liaison nurse for an assessment. Manchester Mental Health and Social Care Trust provided this service (see also 2.4.11 below).

2.4.4 Analysis

2.4.5 Both Sarah and Adam said they were having frequent arguments and fights and he had admitted to striking Sarah. There is nothing in the notes that domestic abuse was considered or questioned. This was an opportunity to engage both Sarah and Adam to assess any risk. Both Sarah and Adam should have been spoken to separately to allow for any disclosures that may have taken place.

2.4.6 There is nothing to indicate any consideration was given to any children in the relationship. Enquiry and professional curiosity regarding children is essential to ensure there is no further harm within the relationship and impacting on children. Whilst the review recognises that not every relationship will have children, or provide the information it is important that there is an opportunity to enquire.

2.4.7 A short time after the initial attendance, Sarah returned to the accident and emergency department alone. She told staff that she had been involved in a domestic incident with Adam during which she had been pushed over and had injured her arm. Sarah had a graze to her lower arm, which was cleaned and dressed. She was then discharged. During this attendance she did not say she had been to the accident and emergency department earlier that day with Adam.

2.4.8 **Comment**: There was no record at the hospital of Sarah having been to the Accident and Emergency department earlier that day. The recording system within the accident and emergency department is based on patient details, therefore only Adam's details were recorded.

2.4.9 No enquiry was made about the nature of the violence and therefore no assessment of the level of risk was made. This was not expected practice following a disclosure of domestic violence and represents a missed opportunity to engage with Sarah about domestic violence.

2.4.10 No enquiry was made as to whether Adam had caring responsibilities for any children or whether there were any children in the household.

2.4.11 Manchester Mental Health & Social Care Trust was only involved with Sarah and Adam on one occasion, as a result of a referral from North Manchester General Hospital accident and emergency department on 18th November 2012.

2.4.12 During the assessment they would appear to have been seen together and there was disclosure of domestic violence and abuse.

2.4.13 The records of the appointment show:

> […] Adam reports to [Redacted] because he has none of his prescribed medication left he was becoming depressed and edgy, leading him to hit his partner, [Sarah].
>
> [Sarah] informed [redacted] it was the first time the [perpetrator] had ever hit her.

2.4.14 **Comment:** The reason for their attendance was to obtain more medication. This resulted in the clinicians dealing with the presenting issue and even though violence had been disclosed, the possibility of domestic abuse wasn't considered. In light of the disclosure, both parties should have been spoken to separately to establish the full facts. The Panel felt that the social class of the couple and them being clear, possibly assertive, about their reason for attending the hospital [needing more medication]; may have influenced the response they received from the practitioner.

2.4.15 A publication by The British Psychological Society highlights how, 'We are all prone to a variety of unconscious psychological biases and errors.'[2]It goes on to look at different types of bias, including cognitive bias. It goes on to say, Confirmation bias can have a huge impact on the quality of decision-making across many professions.' This is essentially where people seek to prove what they want to believe rather than seeking evidence to the contrary.

2.4.16 Research by Walby and Allen (2004)[3] found that, 'among women subject to domestic abuse (non-sexual threats or force) in the last year, the average number of incidents was 20, while 28% experienced one incident only. Thirty-one percent of female victims had not told anyone, other than the person carrying out the survey, about the worst incident of domestic violence that they had suffered during the last year.

2.4.17 No risk assessment was undertaken despite domestic violence being disclosed and this should be seen as a missed opportunity to engage with Sarah and Adam.

2.4.18 Following this appointment, a letter was received by the registered GP from the hospital.

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[2] https://www1.bps.org.uk/system/files/Public%20files/Comms-media/Making%20better%20decisions.pdf

[3] Walby S and Allen J, (2004): Domestic Violence, Sexual Assault and Stalking: Findings form the British Crime Survey, Home Office Research, Development and Statistics.

2.4.19 The letter described their attendance at the North Manchester General Hospital accident and emergency department as follows:

'[Adam] feels depressed and edgy, leading to his hitting his partner'. The nurse at accident and emergency has documented in relation to [Adam] hitting her '[Sarah] was understanding about this and claimed it was the first time he had ever hit her.' [Adam] was asking for more medication, escitalopram for depression was prescribed by GP out of hours' service.'

The letter went on to discuss the children from Adam's previous relationship. The GP wrote on the letter 'to come in and discuss letter'

2.5 20th November 2012

2.5.1 On 20th November 2012, a different GP in the practice spoke to Sarah and Adam together. Sarah and Adam described an argument they had two days previously. The notes recorded that 'both were angry, when she attempted to leave she was dragged back in and sustained carpet burn allegedly, doesn't not feel this was an assault, nothing like this has ever happened before, she doesn't want to involve the police'.

2.5.2 The GP prescribed citalopram (an anti-depressant) and referred her to Primary Care Mental Health team.

2.5.3 Adam's notes stated, 'lost child* and father last year-more depressed since. Breakdown on Saturday. Feels anxious, unsure of cues. No suicidal ideation at present. Alcohol 10 units/week. Advised to use citalopram to help stabilise mood as this has helped in the past and kept him calm. Any further incidents need to be reported to relevant authorities. Happy with plan.'

*During the course of the review, the panel found no evidence that Adam had lost a child and believed that this was in reference to Sarah's pregnancy that was terminated

2.5.4 The GP did not appear to have considered the letter of 18th November 2012, which had identified a number of risk factors relating to domestic violence and abuse and Adam's mental health.

2.5.5 **Comment**: It is not known whether the GP was aware of the letter and the review has been unable to ascertain an answer. There is a possibility that the GP saw this as a mental health issue and did not recognise the situation as domestic abuse. Whatever happened, it amounted to a missed opportunity to engage with Sarah and Adam regarding domestic violence and abuse and to assess Adam's mental health.

2.5.6 It is not appropriate to speak with a victim in the presence of a potential perpetrator when there is any suggestion of domestic abuse being involved. The GP should have spoken to Sarah on her own and explained what domestic abuse is and what support were on offer. There was also an

opportunity to engage with Adam and to discuss options to address his behaviour.

2.5.7 Additional consequences of these missed opportunities were that no risk assessment and/or safety planning was completed and there was no enquiry raised about the safeguarding of the couple's children.

2.5.8 The important role that GPs can play in identifying domestic abuse has been recognised in this and other DHRs conducted in Manchester. As a result of this, all Manchester GPs have now received Identification and Referral to Improve Safety (IRIS) Training. All GPs can refer patients disclosing domestic abuse to an Advocate Educator and there is ongoing support, monitoring and auditing to ensure the effectiveness of this approach.

2.6 28th November 2012

2.6.1 On 28th November 2012, Sarah and Adam were in Europe. Sarah reported to the local police that Adam had assaulted her. She told police that Adam had pressed his hands over her nose and mouth so that she had difficulty breathing.

2.6.2 The Greater Manchester Police Force Major Incident Team discovered from a European police report that the incident had followed an argument between the couple about the obtaining of a broadband service for their house in Manchester. Separately Sarah had not been well and when she attempted to leave their flat to see a doctor, Adam pulled her into the bedroom and threw her onto the bed.

2.6.3 He then covered Sarah's mouth and nose with his hand and repeatedly told her she was going to die. Sarah eventually managed to calm Adam down by saying that she loved him. Only then did he let her go. Sarah then went to the bedroom window and shouted for help; Adam grabbed her again and suffocated her using his body-weight to hold her down.

2.6.4 Eventually, Adam calmed down again and Sarah was able to leave the flat and go to see her doctor. She went to the doctor initially then decided that she was going to report the incident to the police and went to the local police station instead.

2.6.5 She also told the European police about an incident that had taken place at their home in Manchester on 18th November 2012.

2.6.6 Sarah returned home from an evening out with Robert at around 10.30pm. She knocked at the door for a long time before Adam opened it. Adam was angry and asked, 'Don't you have a key?' An argument began between

Sarah and Adam. Sarah said that she couldn't take any more and she walked away to a nearby bus stop. Adam followed her to the bus stop. She told police in Europe, 'he carried me like a doll under his arm'. She said that he grabbed her with one arm under her arms and dragged her towards the apartment. Halfway there, Adam lost his grip and she fell to the ground. Adam then grabbed her coat and dragged her into the apartment 'like a bag'. Sarah sustained an injury to her left forearm as a result of being dragged.

2.6.7 Back at the address Adam dragged Sarah into the bedroom threw her onto the bed and pressed his stomach and chest area over her face so that she couldn't breathe. He also pressed his hand over her mouth and nose. Sarah managed to roll over and Adam pressed her head into the pillows and the mattress several times. He said, "You are not leaving me. Now there is only one solution, first you die, then I die. I kill you. Now you die". She told European police how Adam held his hands on her face on and off, so that she could get her breath.

2.6.8 Sarah told European police that Robert was with Sarah and he saw her being carried and dragged into the apartment. Sarah put Robert to bed before the incident continued.

2.6.9 Eventually Adam fell asleep. Sarah said that when she woke up, she woke Adam up and asked him what had happened. He said he couldn't remember any of it as he'd been very drunk. She told police that he was very sorry and the she gave him an ultimatum to either go to the police or to Accident and Emergency. Adam chose to go with Sarah to the hospital (see also section 2.4).

2.6.10 **Comment:** This incident was not reported to the Greater Manchester Police at the time.

2.6.11 The local European police arrested Adam on 28th November 2012. He told the police that Sarah was very difficult to live with and her behaviour was very erratic.

2.6.12 He was charged with two counts of assault and two counts of threats to kill.

2.6.13 **Comment:** Because Adam was a relevant national, legislation allowed for him to be processed through the local court for the first assault even though it had occurred in Manchester.

2.6.14 The court case was adjourned several times as Adam was not well enough to attend court, but on 4th September 2013, he pleaded guilty to all four charges and was sentenced to 90-days imprisonment.

2.6.15 **Analysis**

2.6.16 These were two significant incidents, both of which identified several high-risk domestic abuse factors, including strangulation, suffocation and threats to kill. Adam had attempted to strangle Sarah at least twice, threatening to kill her in the process and he had also referred to Sarah leaving him, which was again another high-level risk factor.

2.6.17 None of this information was communicated to the police in Manchester or any other UK authority. There is nothing to require the proactive sharing of such information between countries. Had there been, the information may have informed future incidents and during Adam's imprisonment, support could have been offered to Sarah. The opportunity may also have been taken to engage Adam in addressing his behaviour.

2.6.18 **Comment:** The Review Panel has been unable to ascertain whether support was offered to Sarah or Adam in that country.

2.7 **8th February 2013**

2.7.1 On 8th February 2013 Sarah attended a follow up appointment from the original on 20th November 2012 and her record was endorsed, 'much better now, doesn't need meds, doesn't feel depressed, unpredictability of work/gigs can have impact on work but coping well. Supported well from partner'.

2.7.2 **Comment:** There was no reference to the previous appointment in November 2012 or the letter and no questions were asked about the relationship and/or domestic violence or mental health issues. Again, the panel felt that this was a missed opportunity.

2.8 13th February 2013

2.8.1 At 00.08am on 13th February 2013, a member of the public contacted GMP via the 999 system to report that a man and a woman were arguing in the street and that the man had hit the woman.

2.8.2 The police attended and the officer updated the control room that it was a domestic incident and one or both had consumed alcohol. After a short while the officer updated the control room again stating 'There is a couple having a verbal argument. No assault - female not making any complaints. Alcohol a Factor. 1 – 27'

2.8.3 **Analysis**

2.8.4 The incident was coded as being domestic related which prompted an automated Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment to be created (DASH)[4]

2.8.5 The purpose of the form is to:

- To help front line practitioners identify high-risk cases of domestic abuse, stalking and 'honour'- based violence
- To decide which cases should be referred to the Multi Agency Risk Assessment Conference (MARAC) and what other support might be required. A completed form becomes an active record that can be referred to in future case management.
- To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour-based' violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpin the most recognised models of risk assessment.

2.8.6 Guidelines in the GMP 'Domestic Abuse Policy and Procedure' document state that for standard risk cases, a letter to the victim should be sent, but it appears that did not happen. Enquiries have been made by the IMR author to check the reason for this but no definitive answer was available.

2.8.7 At approximately 00.30am on 13th February 2013 Adam attended the North Manchester General Hospital Accident and Emergency department telling staff that he had a history of depression and that he was having frequent arguments with Sarah. He was very upset and tearful when seen by the triage nurse and kept repeating that he was being "treated like shit" by Sarah. He left without being seen.

2.8.8 Even though a doctor had not seen Adam, a letter was sent to his GP informing them that he had been at the hospital but had left prior to treatment. This is an example of good practice.

2.8.9 **On 14th February 2013**, the GP received a letter from a fertility clinic about Sarah and Adam's recent attendance there. The letter provided information that was contrary to that given to the GP on 18th November 2012, in that it referred to Sarah having conceived but miscarried in 2011.

[4] The DASH risk assessment was developed by Laura Richards on behalf of the Association of Chief Police Officers (ACPO) in partnership with 'Safelives' – formerly Coordinated Action Against Domestic Abuse (CAADA).

2.8.10 **Comment:** Receipt of this correspondence, coupled with the disclosure of domestic violence and mental health issues, could have triggered an enquiry by the GP. It is acknowledged that the information came in the form of a letter but there is nothing to suggest the GP contacted Sarah for an appointment.

2.8.11 It is inappropriate to include the contents of this letter.

2.9 22nd May 2013

2.9.1 On 22nd May 2013, the GP practice received a letter from the Primary Care Mental Health Team saying that Sarah had opted not to engage with referral into the service. Within the referral information from the GP it stated that Sarah 'has also been having problems in relation to her partner.'

2.9.2 **Comment**: This was a good example of information sharing. (The letter also highlighted potential domestic abuse and should have initiated professional curiosity to establish what 'the problems' were).

2.9.3 The reasons for non-engagement can be varied and it is recognised that there is a freedom of choice, however Sarah's non-engagement could have been a consequence of the controlling and coercive behaviour of Adam. Recognising this should have triggered further examination of the circumstances, enquiries with the Primary Care Mental Health Team could have been made and an opportunity generated to invite Sarah to an appointment.

2.10 6th November 2013

2.10.1 Just before midnight on 6th November 2013, Sarah telephoned GMP and reported that Adam appeared to be "Out of his mind". She said Adam had been out and when he had returned he did not have his house key. He started to damage the garden fence and was attempting to get into the house by forcing the front door. Sarah also said Adam had a similar breakdown previously.

2.10.2 Sarah went on to say that she was too frightened to let Adam into the house and that there was a 12-year-old child (Robert) in the house and she wanted to keep the situation as calm as possible for his sake. She told the operator that Adam was asking her to let him in the house and he had said "Either you stop this shit or you are out of here tomorrow". Sarah then told the operator that Adam was walking across the road to the Metrolink station.

2.10.3 The police operator recorded that she could hear a male speaking in the background; he sounded distressed and was speaking in a foreign language that she could not understand.

2.10.4 A minute later, Adam rang the police on the 999 system saying he had been locked out of his house by his wife and she had been treating him badly for some time.

2.10.5 The operator thought Adam had been drinking and recorded that he was getting himself worked up. She tried to calm him down but he appeared to take no notice of her. Adam stated that he just wanted to collect his possessions and then leave. At midnight, he said, “Forget it” and terminated the call.

2.10.6 When the police got there, Sarah told them that Adam had been out drinking all day and she had refused to let him back in the house when he had returned home drunk. Adam then damaged the front-door lock. Sarah said she had not been physically assaulted but had called the police because she was scared.

2.10.7 The incident was closed using a closing code that identified it as domestic-related involving alcohol and that there had been a child present. The computer automatically generated a form to enable the officer to record the DASH risk assessment. The outcome of completion of the DASH was a medium risk assessment, upon which the officer forwarded the PPI to the Medium Risk Domestic Abuse Incidents Queue, for further specialist assessment. The definition of medium risk (at the time) was: ‘*There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances e.g. failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse’*.

2.10.8 The risk assessment had contained seven positive responses from Sarah to questions about:

- Whether Sarah was very frightened
- Whether she was in fear of further violence
- If Adam was controlling or excessively jealous
- If Adam had ever threatened to kill Sarah or anyone else
- Whether Adam had problems with alcohol, drugs or mental health
- If Adam had ever threatened/attempted suicide
- Whether Adam had ever been in trouble with police or had a criminal history.

2.10.9 **Comment**: One question asked whether Adam had ever attempted to strangle, choke, suffocate or drown Sarah. Sarah said he had not, which is contrary to what is now known.

2.10.10 **Analysis**

2.10.11 The officer recorded that alcohol and children were a factor in the incident, but when spoken to as part of this review, she accepted she had not actually seen the child (who was upstairs). The officer accepts that she should have made a physical check on the child.

2.10.12 The officer added that during the last year or so, much more training had been provided about how to deal with domestic abuse incidents and risk assessments.

2.10.13 **Comment:** Over the last two years GMP's approach to tackling domestic violence and abuse has placed much greater emphasis on safeguarding issues relating to the victim and any children, positive action being taken against any perpetrator, the importance of risk assessments and the requirement to involve partner agencies in cases where referrals are appropriate.

2.10.14 The answers Sarah provided for the risk assessment indicated the presence of the 'toxic trio'[5] of alcohol, drugs and mental health issues, which are known as escalating factors in the risk posed to victims of domestic abuse.

2.10.15 Why Sarah did not mention the fact that Adam had previously strangled and suffocated her remains a mystery, but had GMP known about the imprisonment of Adam abroad the officer may have been able to encourage Sarah to disclose more information.

2.10.16 The risk assessment gave positive indications relating to alcohol, drugs and elements of Adam's mental health and also to Adam's criminal history including threats to kill. In those circumstances, it would appear that the correct risk assessment should have been 'high'.

2.10.17 The DASH form was sent electronically to the medium risk queue to be assessed by a specialist PPIU domestic abuse officer.

2.10.18 GMP guidance to officers at the time stated that if having carried out a phone conversation with the victim they request a home visit or a face-to-face contact, then it must be arranged. Victims should also be signposted to appropriate support services and be provided with advice and support.

2.10.19 On 7th November 2013, the specialist PPIU domestic abuse officer recorded that an enhanced risk assessment (ERA) had been completed and the risk level had been reduced to standard.

[5] Cleaver, Aldgate and Duncan, (1999), Children's Needs - Parenting Capacity: The Impact of Parental Mental Illness, Problem Alcohol and Drug Use and Domestic Violence on children's development, The Stationery Office, London

2.10.20 **Comment:** The re-grading of risk assessment is a common practice and is within the current policies of GMP.

2.10.21 The decision to re-grade raises challenges for the person making the decisions as they are not fully aware of the circumstances, furthermore the question whether there should have been any communication with Sarah to involve her in the decision making process.

2.10.22 The electronic record mentioned that there had been one previous verbal incident in February 2013 and that no offences had occurred. The domestic abuse officer said that although she reduced the risk assessment to standard, she had not documented the rationale behind the decision. She also stated that, in her opinion, there was no requirement for further contact with the victim and she was under the impression that contact from a specialist officer was not always required in standard risk cases.

2.10.23 **Comment:** Had the risk assessment carried out by the attending officer resulted in Sarah being assessed as being at high risk of harm, and that assessment had been subsequently concurred with by the PPIU officer, the outcome would have been a referral to MARAC. She would also then have been allocated an Independent Domestic Violence Adviser and been offered support and advice on safety planning.

2.10.24 The HMIC report, 'Everyone's Business: improving the police response to domestic abuse[6]', found that, 'While the police service has an agreed risk assessment form, DASH (which stands for domestic abuse, stalking and harassment), the extent to which it is used by responding officers and the way in which it is used, vary significantly from force to force. There is often a poor understanding on the part of officers of the factors for risk assessment. Too often the completion of the DASH form is seen as a compliance exercise rather than one that is necessary to protect the victim. The measure of a successful police response to a domestic abuse incident should not be whether a form has been filled in. It should be whether the officer has correctly identified the level of risk, has taken appropriate action to keep the victim safe as a result and has obtained or protected evidence necessary for an appropriate prosecution.'

2.10.25 Throughout his time at school Robert never disclosed any difficulties at home and never discussed that Sarah and Adam argued. There was no suggestion that he had witnessed any form of domestic abuse.

2.10.26 However, the school records show that between November 2011 and June 2015, Robert attended the school nurse on 10 separate occasions. The reasons for attending included; not sleeping, headache due to not sleeping

[6] HMIC, Everyone's Business: Improving the police response to domestic abuse, 2014

for two nights, sore shoulder and painful ankle due to a fall in the playground banged cheek on a door, hurting his eye with a baton, burn to a finger, headache and shoulder ache and feeling tired and stressed and stomach ache due to not sleeping. It should be noted, that Robert was attending the school as a boarder and this could have resulted in him seeing the school nurse more frequently than he might had he been attending on a day-to-day basis and returning home.

2.10.27 In September 2015, Robert was a reported as being involved with a small group of boys who had been reading about depriving the body of oxygen to achieve a natural high.

2.10.28 At the final appointment in June 2015 Robert said that he had been feeling stressed for a few weeks. He described the main reason as the amount of workload, academic and music, lack of concentration and thinking people are going to say something bad when they talk to him. He said that he was organised with his workload but just didn't have enough time. He also couldn't concentrate as he was distracted by what else he had to do expectations and the demands of the school. A counselling appointment was booked for Robert to help with stress management and talk about breathing exercises. He subsequently cancelled this counselling appointment and when asked if he wanted to make another one said he didn't.

2.10.29 **Comment:** The school and the school nurse were unaware of domestic abuse in the home. In hindsight Robert's behaviour did change around the time that Adam started to live with Robert and his mother, including Robert staying at the school as a boarder. Whilst this is only clear now it is important that in the future, consideration is given to the wider family environment that affects children's behaviour.

2.10.30 Whilst we cannot be certain, it is possible that some of these presentations were due to Robert witnessing domestic incidents involving Sarah and Adam. It is known that Robert was present and witnessed some of the incident on 18th November 2012 and on 6th November 2013.

2.10.31 A report by CAADA (now Safe Lives) in 2014[7] found that, 'Children are at greater risk of direct harm if they are exposed to domestic abuse. Almost two-thirds (62%) of the children who were exposed were also directly harmed.' It went on to say, 'Exposure to domestic abuse causes serious physical and psychological harm to children. Amongst other impacts, over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school, and nearly two-thirds (60%) felt responsible for negative events. In addition, based on direct reporting by the children, at intake only around half knew how to keep themselves safe (56%) or get

[7] CAADA, February 2014, In Plain Sight: Effective help for children exposed to domestic abuse.

help (62%), a quarter (24%) did dangerous or harmful things, around half were often unhappy (46%), worried (52%) and/or angry (43%), and half (55%) found it difficult to sleep.'

2.10.32 The panel felt that the school should become familiar with possible indicators of domestic violence and abuse that children may display, so that professionals can enquire about their home life, try to establish the true cause of any worries and ensure children and adults can be supported as soon as possible where domestic abuse or other concerns are identified.

2.10.33 Since September 2017, Operation Encompass has been introduced across Manchester. This process involves police officers attending domestic abuse incidents where children are present sharing information about the incident with their school. This is done in a timely manner so that the school is made aware and there is the opportunity for a range of overt and silent support measures to be considered and implemented for the child (or children) concerned without delay.

2.11 1st August 2015

2.11.1 At 8.34pm on 1st August 2015, Sarah contacted the police on the 999 systems. She said her husband had "gone a bit mad" and was being verbally aggressive. She was scared so she had left the house. The call taker created a FWIN (Force Wide Incident Number) and recorded that it was unknown if alcohol was a contributory factor, no drugs were involved, no weapon had been seen and the husband had been in prison previously for domestic abuse. This information was given to the call taker by Sarah.

2.11.2 **Comment:** The incident was correctly graded as a 'priority' grade 2, which means the police should attend within one hour of the call being made.

2.11.3 The incident was delayed a number of times without any rationale, which meant the officers did not arrive until 9.39pm – one hour and five minutes after the original call. In the meantime, at 9.01pm, Adam had contacted the police complaining that Sarah had been making a noise and he wanted her to leave. He said they had argued about his children playing their musical instruments. He added that he owned the house and he wanted her to leave.

2.11.4 The incident was closed having been classified as domestic related with a child present. As before, the computer automatically generated a GMP form to enable the officer to update the DASH risk assessment.

2.11.5 Sarah told the police that there were children in the household and that Adam had been sent to prison two years previously for domestic violence

against her. She declined to answer five of the risk assessment questions. The non-response should have been seen as significant and should have been taken as a disclosure; this suggests a lack of professional curiosity.

2.11.6 Sarah had been outside the house when the police arrived and she told them that her husband had gone mad and had been arguing with her for no reason. He had shouted in her face and told her to leave the address. Sarah confirmed that no offences had taken place, no assault or damage had occurred and whilst she had been outside the property, Adam had started to throw items of her property out of the door.

2.11.7 The officers spoke to Adam who said he could no longer deal with his wife. He said he paid the bills and did all the housework and that he received no help from her. Adam's two children (Child B and Child C) were also present but apparently, they could not speak English.

2.11.8 One of the officers spoken to as part of this review described Adam as acting in a very eccentric manner and like a 'typical musician who had a high level of artistic talent, but acted in an unconventional way.'

2.11.9 **Comment:** It is important that professionals do not assess individuals based solely on their appearance. This 'bounded rationality' can create cognitive limitations within the risk assessor. This decision could be seen as excusing Adam's behaviour and not recognising the behaviour as being abusive.

2.11.10 The HMIC report, Everyone's Business[8] states that, 'Response officers have varying levels of skills and experience. They are often under pressure to deal with incidents as rapidly as possible, so they can be available to respond to other emergency and priority calls. They may attend a range of different incidents on the same shifts which require a different approach or level of empathy (for example breaking up a fight in a public place). Officers will carry personal views and bias (often reinforced by their experiences as police officers or indeed in their own personal lives and by the views of their colleagues) that they bring to these incidents, which can have an impact on their approach and attitudes.'

2.11.11 The officers were told of Adam's previous offending but it did not trigger any further enquiry. Had it done so, the police would have been aware of his previous offending and the manner of it, which would have identified high risk factors.

2.11.12 Sarah was asked if she needed any property from the house that evening and she asked for her mobile phone. Adam told the officer that because he

[8] HMIC, Everyone's Business: Improving the police response to domestic abuse, 2014

had paid for the phone, she could have the SIM, but he would keep the handset.

2.11.13 She left the address and the police advised her not to return until the following day. They told her that if she needed anything she should call them. She was also told if she was going to return for more of her belongings and she wanted police to attend with her, they would do so.

2.11.14 The officer stated that Sarah was happy to leave the house and did not appear in any great distress, although she was concerned for her piano, which she thought her husband might damage. Sarah explained that she was a musician.

2.11.15 Sarah confirmed that the two children at the house were her husband's, but that she did have a son (Robert), who was in the city with friends. The officer offered to assist in collecting Robert for her, but she said she would make her own arrangements.

2.11.16 The officer also recorded results of her RARA (Remove, Avoid, Reduce and Accept) risk assessment as follows:

- 'Remove – Both parties were dealt with separately and accounts were obtained when separated. [Sarah] was removed from the area with a family friend to stay at their address for the evening in order for both parties to calm down.

- Avoid – [Sarah] is going away again tomorrow for work purposes. Has been advised to call Police should she require assistance when returning for her belongings.

- Reduce – DASH completed. Further support declined by both parties. Appears to be a marriage breakdown.

- Accept – DASH completed as standard risk. Both parties separated, no offences disclosed.'

2.11.17 The toxic trio risk assessment was also recorded which indicated that alcohol, drugs and mental health issues were not contributory factors to the incident. The officer did record that Sarah had said Adam had been in prison approximately two years previously for domestic violence related offences.

2.11.18 The officer commented during this review that in hindsight she might have graded the incident as a medium risk due to the comment by Sarah about Adam's previous offending history, although this was not explored at the time.

2.11.19 Another officer who had attended the incident said that in hindsight they might have tried to speak to Adam's children through an interpreter just to check there were no safeguarding issues.

2.11.20 It is pertinent to note that although Sarah was the victim, she was the one who had to leave the house. Although she said she was content to stay elsewhere, it would seem the onus was placed on her to move rather than Adam. This is a regular theme in other DHR's across the country and it may be a consequence of the Remove aspect of the RARA process.

2.11.21 **Comment:** There is no power to remove a perpetrator from an address except to satisfy a Domestic Violence Protection Order. According to the records this was not considered and in the circumstances it may not have been appropriate, but it is important that officers consider all available options.

2.11.22 It is noted that no offences were disclosed and that Sarah had not made any criminal complaint. It is also recognised that there was no independent information to suggest a crime had been committed and therefore it was not even possible to consider a 'victimless' prosecution.

3. Addressing the terms of reference

3.1 Family engagement

3.1.1 **How should friends, family members and other support networks and, where appropriate, Adam, contribute to the review and who should be responsible for facilitating their involvement?**

3.1.2 Sarah's sister has taken part in the review and her assistance has been very helpful. She was initially contacted by email and subsequently spoken to over the phone as she is living elsewhere in Europe. She has requested that her mother not be contacted because she is devastated by Sarah's death.

3.1.3 Since the review has been completed and the report finalised, an email was sent to Sarah's sister address to discuss the content, however this email and subsequent attempts to contact has remained unanswered

3.1.4 Several of Sarah's friends have been invited to participate in the review, however none have responded to the letters that were sent to them. On completion of the review they will again be contacted by letter to see if they will participate.

3.1.5 Robert's father has been spoken to. He has asked that Robert is not contacted at this time and the review respects his wishes. As mentioned previously, Adam responded positively to an invitation to participate in the review and arrangements were made for the Chair to visit him in prison. However, when the Chair visited the prison, he refused to see him.

3.2 Publication and Media Interest

3.2.1 **How should matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it.**

3.2.2 As indicated earlier, since the review has been completed and the report finalised, an email was sent to Sarah's sister's address to discuss the content, however this email and subsequent attempts to contact has remained unanswered

3.2.3 The Community Safety Partnership will publish the report and the partnership will address any media enquiries on behalf of all the agencies involved.

3.3 Legal Processes

3.3.1 **How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?**

3.3.2 The Coroner has requested a copy of the report on completion of this review to determine whether to resume the investigation and inquest in accordance with S.11 and sub section S.1 (2) (a) of the Coroners and Justice Act 2009

3.3.3 **Does the review panel need to obtain independent legal advice about any aspect of the proposed review?**

3.3.4 Nothing has come to light during the review to suggest the need to seek independent legal advice.

3.4 Research

3.4.1 **How should the review process take account of previous lessons learned from research and previous DHRs?**

3.4.2 Previous DHR's have been scrutinised during this review to elicit best practice. Research was extended to include academic sources including: Kemshall (2013), Walby and Allen (2004); Bain (2008); Munro (2007); Nash (2010); Brandon et al (2009); Barry (2009).

3.5 Diversity

3.5.1 **Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability and faith that may require special consideration?**

3.5.2 Nothing has emerged during the review that would indicate there were any issues of equality and diversity. Both Sarah and Adam were fluent in English. However, they did not originate from the UK and may not have been as aware of local services as other citizens who have grown up here.

3.6 Multi agency responsibility

3.6.1 **Was Sarah or Adam subject to a MARAC/ MAPPA?**

3.6.2 Neither Sarah nor Adam was subject to MARAC or MAPPA. There was nothing in the review that would indicate either would be suitable for MAPPA. On the information known to UK agencies, Sarah was not considered to be at high risk of harm requiring a MARAC referral, however if the information from Europe had been shared then she may have been.

3.6.3 **Was Adam subject to a Domestic Violence Perpetrator Programme (DVPP)?**

3.6.4 Adam was not subject to a mandatory perpetrator programme, however there were some missed opportunities to provide him with information about voluntary schemes that he could have engaged with if he had wanted to.

3.6.5 **Did Sarah have any contact with a domestic abuse organisation or helpline**?

3.6.6 There is nothing in this review that suggest that Sarah engaged with a domestic abuse organisation or helpline. Her sister does not believe she did and Sarah never discussed the abuse in that much detail with her.

3.6.7 There were a number of missed opportunities to provide information directly to Sarah regarding available services. On the occasions GMP attended incidents of domestic abuse; 13th February 2013, 6th November 2013 and 1st August 2015 officers could have provided information relating to support services, but there is nothing to suggest they did.

3.6.8 On 18th November 2012, Sarah and Adam attended North Manchester General hospital accident and emergency department and disclosed that Adam had been violent. They could have been provided with information about relevant services but there is nothing that suggests they were.

3.6.9 Whilst at A&E, both Sarah and Adam were seen by Manchester Mental Health & Social Care Trust. They disclosed that Adam had been violent because he had ran out of his medication. Again, they could have been provided with information about available support services, but there is nothing that suggests they were.

3.6.10 On 20th November 2012, Sarah and Adam attended the GP practice together where they discussed an assault, which the GP does not appear to have recognised as domestic abuse. The GP discussed matters with the two of them together, which is not good practice. The opportunity to signpost both of them to victim and perpetrator services was not taken.

3.6.11 **Consideration should also be given as to whether either Sarah or Adam were 'vulnerable adults' and that local safeguarding arrangements would apply.**

3.6.12 Neither Sarah nor Adam were 'vulnerable adults' within the definition of the No Secrets guidance[9] or adults at risk of harm, within the definition of the Care Act 2014.[10]

3.6.13 **Were there any issues in communication, information sharing or service delivery, between services?**

3.6.14 Information held by police in another European country was not shared with GMP. Adam had been convicted of domestic violence on two separate occasions in another European country and received 90-days imprisonment. GMP were not made aware of these incidents until after the homicide, even though one of them had taken place in Manchester. Had GMP been aware of these previous incidents and the severity of the abuse, then it is possible that the risk would have been assessed as higher triggering a different response.

3.6.15 There are a few issues relating to the extent and detail of information that was shared between agencies in Manchester. Whilst general information was shared, there were opportunities for greater detail to have been obtained that could have provided a better understanding that were missed.

[9] Department of Health, No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

[10] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

3.6.16 On 18th November 2012, when Sarah and Adam attended the North Manchester General hospital Accident and Emergency department, Adam was immediately referred and seen by the mental health liaison nurse at the hospital. This is another example of good practice.

3.6.17 However, no information was provided to staff that indicated domestic violence was an issue and no risk assessment was completed. If it had been, the information could have been of assistance to the mental health team and other professionals.

3.6.18 On 18th November 2012, a letter was received at the GP practice detailing information obtained by the Mental Health Liaison Nurse in the Accident and Emergency department from Sarah and Adam. They both attended the practice two days later and the content of the letter was discussed. The GP was a trainee and appeared to accept what the couple said at face value. Domestic violence, and the impact of it on the victim did not appear to have been recognised.

3.6.19 The incident attended by GMP on 6th November 2015 was originally assessed as medium, but was then downgraded by the specialist officer to standard. If it had remained at medium, an automatic referral would have been made to children's services and further information provided to Sarah regarding other support services that were available.

3.6.20 This same assessment does not appear to have taken account of the 'toxic trio' that had been identified during the DASH risk assessment.

3.6.21 On 1st August 2015, the information provided by Sarah should have resulted in a medium risk assessment triggering the response highlighted above. Adam's previous offending history was not examined and had it been, it would highly likely have resulted in a medium risk assessment.

3.6.22 On 13th February 2013, Adam attended the accident and emergency department and left before any assessment or treatment could be provided. This was communicated to his GP and is an example of good practice and communication.

3.6.23 On 22nd May 2013, the GP practice received a letter from the Primary Care Mental Health Team relating to an assessment of Adam, which included information about his health, background issues and elements of domestic abuse. Again, this is an example of good practice and information sharing.

3.6.24 Sarah attended the hospital a short time later on her own. She disclosed domestic violence and she had visible injuries. There was no risk

assessment and nothing to suggest this information was shared with partners.

3.7 Individual agency responsibility

3.7.1 **Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?**

3.7.2 There were some instances when work in Sarah's case was not consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards. When the couple attended the accident and emergency department disclosing domestic violence, they were not spoken to separately and no risk assessment was completed. Similarly, when they attended the GP practice and again disclosed violence in their relationship, there was no safe enquiry, they were not spoken to separately or arrangements made to do this and no assessment of risk was conducted. During the incident on the 1st August 2015, when GMP attended the address, they did not physically check on the welfare of the children or grade the risk.

3.7.3 On 18th November 2012, Sarah and Adam attended the North Manchester General Hospital accident and emergency department together where they disclosed violence in the relationship. No safe enquiry or risk assessment took place and the actions of staff contravened current policy and expected practice. Later that same day, Sarah presented alone disclosing violence in the relationship it wasn't explored with her. No recognition of domestic violence or risk assessment took place and she wasn't given any information on support available. Again, the actions of staff contravened current policy and expected practice.

3.7.4 On 18th November 2012, a member of the Mental Health Liaison Team from the Manchester Mental Health & Social Care Trust saw Sarah and Adam in the accident and emergency department. Violence in the relationship was disclosed and no assessment or further action/information was obtained; this was not within expected standards.

3.7.5 Following the visit to the hospital on 13th February 2013, Adam attended the hospital and disclosed potential domestic violence and abuse; there was no safeguarding consideration for Sarah although Adam left the hospital before any treatment. This information relating to the attendance at the hospital was shared with the GP but there is nothing to suggest any GP follow up. This practice was consistent with expected standards.

3.7.6 The GP spoke with Sarah and Adam together on 20th November 2012. This is not consistent with the practice policy and procedures that say individuals in these circumstances should be seen separately.

3.7.7 **What were the key relevant points/opportunities for assessment and decision making in this case in relation to Sarah and Adam? What was the quality of any multi-agency assessments?**

3.7.8 As already mentioned, there were missed opportunities to conduct risk assessments by GMP, North Manchester General Hospital, Manchester Mental Health & Social Care Trust and the GP. It should also be noted that GMP were not privy to the information from Europe and Sarah responded differently on different occasions.

3.7.9 Circumstances did not arise where a multi-agency assessment would have taken place.

3.7.10 **Was the impact of domestic violence on Sarah recognised?**

3.7.11 The impact was not fully recognised in all contacts with Sarah. There was a failure to recognise the possibility of barriers to reporting abuse including coercion, control, minimisation, fear and shame.

3.7.12 North Manchester General Hospital, Manchester Mental Health and Social Care Trust and the GP all failed to speak to Sarah and Adam separately following a disclosure of violence. This indicates that they did not recognise the impact of domestic violence and abuse on Sarah and in particular the coercive and controlling behaviour that we now know was present within their relationship.

3.7.13 GMP was aware of some of the violence but Sarah minimised the true extent of it. While conducting the risk assessment, the officers appear to have focussed on the questions rather than utilising professional curiosity and recognising the wider signs of abuse. There were occasions when Sarah did not answer questions but this did not appear to raise any concerns as to why that was the case.

3.7.14 **Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?**

3.7.15 The review has highlighted a number of discrepancies between assessment and actions being taken. There were a number of occasions when different actions would have created different outcomes, but is not possible to assess whether this would have reduced or increased the levels of risk towards Sarah.

3.7.16 **Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?**

3.7.17 It is difficult to assess management accountability in Sarah's case. Certainly there were appropriate decisions in line with policy, specifically within GMP. There were opportunities to discuss Sarah and Adam within the GP surgery and with the trainee's supervisor or safeguarding lead that were not taken.

3.7.18 There was some management accountability identified with the North Manchester General Hospital accident and emergency department and Manchester Mental Health & Social Care Trust, however assessments were not completed appropriately.

3.7.19 **Could Sarah's homicide have been anticipated or prevented?**

3.7.20 There is nothing to suggest that Sarah's homicide could have been anticipated or prevented.

3.7.21 There were indications of Adam's abusive during his contact with the accident and emergency department, GMP and the GP, but these instances were sometimes minimised and not fully recognised and on some occasions not recognised at all.

3.7.22 Following Sarah's death, the police investigation uncovered more information concerning his behaviour that demonstrated a controlling and jealous nature. The trial judge commented:

"On all the evidence I have heard, I am satisfied that this attack occurred against a background of controlling and sometimes aggressive behaviour by you… you came to resent her success and her friendships and those she met… you were jealous of her being the focus of attention and praise and of her meeting people when she was working away from home."

3.7.23 Was there learning in this case that would improve safeguarding practice in relation to domestic violence experienced by the parents or guardians of children at risk?

3.7.24 There were occasions when Robert, Child B and Child C were in the house when domestic violence and abuse took place. This report has identified the need for greater awareness of adopting safeguarding practices for children in such circumstances.

3.7.25 As mentioned earlier, Manchester has since introduced Operation Encompass which is where information about incidents attended by police is shared with schools, in order that they are aware of the incident, and potential impact on their pupil(s) when they arrive for the next school day and have the opportunity to consider and put in place a range of overt and silent support measures. Robert's school is signed up to participation in Operation Encompass.

3.7.26 **Is there learning in relation to the effective communication, information sharing and risk assessment for all those children's services involved in Manchester, including any good practice that can be built upon?**

3.7.27 This review is unable to determine whether this is the case as information was not shared with Children's Services.

3.8 Specific considerations for this review

3.8.1 **Adam had been convicted elsewhere in Europe and had been prosecuted by those authorities. What were the circumstances and was/should that information have been shared? If the information had been shared would that have potentially changed agency responses?**

3.8.2 The incidents abroad and in the UK were similar in that Adam had strangled and suffocated Sarah.

3.8.3 The panel is of the opinion that the information about his offending and his conviction should have been shared, but accept there is no statutory obligation or current process to do so.

3.8.4 It is difficult to assess what impact the lack of information sharing had. With it, there would probably have been a different response by GMP in line with their policy. That would have involved direct engagement with Sarah after the incident(s) and she would have been provided with information about support services. In the event of a high-risk assessment this would have triggered a referral to MARAC and the abuse would have been managed within a multi-agency setting.

3.8.5 **Was Robert's school aware of domestic violence and/or did they attempt to find out the cause of his concerns?**

3.8.6 Robert's school was not aware of domestic violence or abuse within the family. There were a number of occasions where Robert presented to the nurse because he hadn't slept or due to minor injuries. There were not frequent enough to give cause for concern. There were also some behavioural issues that were identified by school. School had arranged for

Robert to have a counselling session in respect of them, but he cancelled it. The school did not follow this up.

3.8.7 The school has reflected on Sarah's death and reviewed their involvement with the child. Hindsight has alerted them to possible changes in his behaviour around the time Sarah and Adam began living together. As a result, practices and process relating to examining changes in behaviour and following up on cancelled counselling appointments have changed.

3.8.8 **Was Adam's mental health considered by agencies? Were there any referrals for mental health issues?**

3.8.9 Issues relating Adam's mental health were recognised during a visit to the North Manchester General Hospital Accident and Emergency department on 18th November 2012. He was referred to a mental health liaison worker from Manchester Mental Health & Social Care Trust who saw him there.

3.8.10 Following the receipt of the letter from the hospital on 20th November the GP saw Sarah and Adam together. They discussed the incident two days previously with the GP. It was recorded that 'both were angry when she attempted to leave she was dragged back in and sustained carpet burn allegedly, doesn't not feel this was an assault, nothing like this has ever happened before she doesn't want to involve the police'.

3.8.11 The GP also discussed Sarah's depression and prescribed citalopram (anti-depressant) and referred her to Primary care Mental Health team. In Adams notes is says …'Breakdown on Saturday. Feels anxious, unsure of cues. No suicidal ideation at present. Alcohol 10 units/week. Advised to use citalopram to help stabilise mood as this has helped in the past and kept him calm. Any further incidents need to be reported to relevant authorities. Happy with plan.'

3.8.12 On 6th November 2013, the DASH risk assessment identified positive responses to the questions relating to the 'toxic trio', but there was no consideration of Adam's mental health and no referral made by GMP.

3.8.13 **Were there referrals to children's services relating to Robert? If not, why not?**

3.8.14 There was an opportunity to refer Robert to Children's services when GMP attended the domestic incident on 6th November 2013. Similarly they could have referred Child B and Child C when the attended the incident on 1st August 2015. However, the officers did not contravene contemporary policy relating to standard risk incidents.

3.8.15 When Sarah and Adam attended North Manchester General Hospital Accident and Emergency department together and individually, there was no risk assessment and no enquiry regarding the family and any children, hence no assessment of children's welfare was undertaken.

3.8.16 Similarly, when Sarah and Adam attended the GP practice, no risk assessment was undertaken and no enquiry regarding the family and any children was made. As a consequence, no referral was made to Children's services.

3.8.17 The lack of referral by these agencies has been captured in the lessons learned in the review and in the individual agency recommendations.

3.8.18 **Were risk assessments referred appropriately?**

3.8.19 Where risk assessments were conducted they were managed appropriately and in compliance with the respective agency processes and guidance. However, there were several opportunities to conduct risk assessments, which were missed, and had certain of those risk assessments arrived at different ratings, they may have triggered referral into multi-agency procedures for safety planning and support; these instances have been discussed in-depth throughout this report.

4 Overall analysis

Analysis has been completed within the body of the report. This section summarises the information and learning identified.

4.1 Greater Manchester Police

4.1.1 Greater Manchester Police were involved in several incidents where Sarah presented as the victim. The officers who attend the incidents were not aware of Adam's offending elsewhere in Europe. This meant that relevant background information indicating the severity of risk wasn't taken into consideration when risk assessments were conducted.

4.1.2 Several incidents took place when children were in the house. There is a need to recognise the impact on children of domestic abuse and all necessary steps should be taken to protect them, including making appropriate referrals. It is vital that they are seen physically to ensure their safety and well-being.

4.1.3 GMP have an established risk assessment process, however it is important that officers recognise and understand what they are told and the assessment can be adjusted as necessary. This is important when information relating to the 'toxic trio' or other risk factors is identified.

4.1.4 There is a responsibility for all officers engaged with dealing and managing domestic abuse that they probe responses to ensure they fully understand the issues and allow for further disclosure. In the event of a refusal to answer questions, this should be regarded as a positive indicator in assessing the risk.

4.2 Pennine Acute NHS Hospitals Trust (North Manchester General Hospital Accident and Emergency)

4.2.1 Both Sarah and Adam presented at the Accident and Emergency department together and separately. On these occasions, disclosures were made regarding domestic violence, however staff appeared to accept explanations given that this was the first time it had happened and were complicit in assisting Adam to obtain more medication. There was a lack of professional curiosity, the couple were not spoken to separately and the possibilities of minimisation, coercive control and a pattern of domestic abuse was not considered.

4.2.2 There is a need to ensure that staff are aware of the nature and wide range of abusive behaviours such as emotional abuse, psychological, financial and sexual abuse. Professionals also need to consider the wider family environment, particularly with regard to any children in the household and consequential safeguarding referrals.

4.2.3 The ability of staff to ask questions and exercise an appropriate level of professional curiosity regarding children is essential to ensure that action can be taken to prevent further harm.

4.2.4 It is important that staff are able to recognise the impact of perpetrator behaviours on a victim and it is important that wherever possible, they are seen separately and privately. This would allow for potential further disclosure and for the completion of risk assessments.

4.2.5 During the visits to the hospital there does not appear to be any recognition of domestic violence, although violence in the relationship was disclosed. This should be seen as learning for the staff to be aware of the wider circumstances together with the presenting issues.

4.2.6 Attendance at hospital is mainly voluntary and in most cases the hospital cannot restrain patients from leaving. It is important that the information provided at the time is captured, recorded and shared wherever this is possible. This may be the only time this information is available.

4.3 Manchester Mental Health & Social Care Trust

4.3.1 Violence in the relationship was disclosed and this was not recognised or recorded as domestic violence by the nurse. It appears that when an incident of violence was disclosed, this was treated as a mental health issue, requiring a mental health response rather than the possibility of domestic abuse being explored. The panel felt that professionals focussed on and responded to the presenting issue, without considering the potential for other issues to be prevalent.

4.4 Manchester Clinical Commissioning Groups (GP)

4.4.1 Both Sarah and Adam attended the same GP surgery. On one occasion they visited together and during some of that appointment, violence was disclosed. It is important that GP's are aware of the signs and impacts of domestic violence and abuse and are confident to be able to act on them, particularly with regard to speaking to patients alone and confidentially. This also provides an opportunity to furnish information to victims and perpetrators on services that can address their needs.

4.4.2 It is important that GP's are aware of risk in domestic violence cases and the recognised high risk factors:

- Threats to kill
- Strangulation
- Separation
- Pregnancy (not applicable to this DHR)
- The use of knives and guns (not applicable to this DHR)

4.4.3 This will allow them to make any relevant notes onto their system and ensure other staff is able to make the appropriate risk assessment.

4.4.4 This information should be shared wherever necessary. It would also allow for the consideration of children in a household who may be witnessing domestic violence and abuse. It is the responsibility of the GP in such cases to refer to appropriate services as part of the wider safeguarding obligation.

4.4.5 Patient records can readily identify information relating to domestic abuse. This includes the use of flags but GP's require awareness to ensure information is not missed or overlooked and to activate flags. Domestic abuse training and awareness within GP practices is essential to achieve this.

4.4.6 Not engaging with services or not telling professionals the full information can be a matter of choice, however it can also be as a result of the victim being controlled by their abuser. It is important to recognise and consider this possibility when dealing with patients.

4.5 Robert's school

4.5.1 Robert's school was not aware of anything specifically to suggest domestic violence or abuse was happening within the family home. With hindsight there is some learning relating to changes of patterns of behaviour that may be indicators of domestic violence within families.

5. Lessons to be learned from the review

5.1 A challenge for the review was to determine the impact of the lack of knowledge regarding the previous offending history of Adam. Had GMP been aware of Adam's offending elsewhere in Europe and the conviction for an offence in Manchester, this could have affected their response and subsequent outcome.

5.2 Whilst the review acknowledges this as a point of learning and raises the issue as a national recommendation there is little the review or GMP can influence.

5.3 Risk assessments are an integral part of safeguarding. It is important that all agencies understand the risk factors associated with domestic violence and abuse and where necessary ensure an assessment is completed without making any assumption it has already been done. This applied to North Manchester General Hospital Accident and Emergency, Manchester Mental Health & Social Care Trust on 18th November 2013 when both Sarah and Adam attended the hospital and again for North Manchester General Hospital when Sarah attended the hospital independently a short time later. Following this attendance, Sarah and Adam attended the GP practice on 20th November 2013 when domestic abuse was not identified and services were not offered.

5.4 Throughout this review there has been much comment about the use of risk assessments – or the failure to utilise them. Risk assessments are a useful tool in determining the levels of risk relating to the victim, however there are a number of limitations and they should only form part of the assessment process. The risk assessments that were completed were done in isolation, in response to the presenting complaint and lacked consideration of causal patterns or other factors that may influence the response, such as fear, shame, coercion and controlling behaviours.[11] [12]

5.5 Information for the assessment is provided by the victim who may not reveal the full extent of the violence or abuse. This may be due to a number

[11] Kemshall, H., Wilkinson, B. and Baker, K. (2013). Working with Risk: Skills for Contemporary Social Work. John Wiley & Sons.

[12] Carson, D. and Bain, A. (2012). Professional risk and working with people. London [etc.]: Jessica Kingsley

of issues including minimisation, fear, lack of trust or other coercive and controlling behaviours by Adam. Professionals should recognise there are multiple barriers to reporting abuse and there should be a suitable level of professional curiosity to understand those barriers.

5.6 It is important that a risk assessment is not a mechanistic approach and creates an over-reliance on procedures that are easy to explain. Equally important is the recognition by the person undertaking any risk assessment that their own cognitive biases may influence their assessment of risk. Certainly officers from GMP excused Adam's behaviour on one occasion due to his 'eccentricity' and it is possible that they were influenced by the socio-economic position of the couple.

5.7 As described in paragraph 2.4.15 earlier, it is recognised within current research that cognitive biases of those completing the risk assessments can influence their conduct of this process. The panel felt that this could have been the case when Sarah and Adam attended A&E, saw the mental health liaison and when they attended the GP together; they were dealt with for the presenting issues and there was no consideration of ongoing domestic abuse.

5.8 Within the review there is evidence that professionals considered the presenting issue but did not recognise or consider the wider issues of domestic abuse. This was the case within the accident and emergency department and with the GP.

5.9 There were occasions when Sarah did not answer risk assessment questions. This did not appear to have raised any concerns or further enquiries by the assessors. Any failure to answer questions or provide a response should be viewed as a positive indicator and assessed accordingly.

5.10 There should be a clear understanding of the components of risk to a victim. This extends beyond completing the risk assessment but highlights the need to understand risk factors.

5.11 It should also include a thorough understanding of the 'toxic trio', as already discussed and the impact on any assessment. This was particularly relevant to the risk assessment by GMP on 6th November 2013 and 1st August 2015.

5.12 There should be clear policies relating to engagement with victims to ensure they are spoken to independently and in confidence. This did not happen within the North Manchester General Hospital Accident and Emergency Department, Manchester Mental Health & Social Care Trust or the GP' practice.

5.13 The impact of domestic abuse on children is well documented (see paragraph 2.10.31). The empirical evidence suggests that growing up in an abusive home environment can critically jeopardise the developmental progress and personal ability of children[13] [14] the cumulative effect of which may be carried into adulthood and can contribute significantly to the cycle of adversity and violence. Exposure to domestic violence may have a varied impact at different stages, with early and prolonged exposure potentially creating more severe problems because it affects the subsequent chain of development.[15]

5.14 It is important that professionals consider the welfare of children when responding to incidents of domestic abuse and ensure they are acknowledged, engaged in appropriate discussions, that they are listened to and their well-being is considered during decision making processes.

[13] Martin, S. G. (2002). Children exposed to domestic violence: Psychological considerations for health care practitioners. Holistic Nursing Practice, 16(3), 7–15

[14] McIntosh, J. E. (2002). Thought in the face of violence: A child's need. Robertbuse and Neglect, 26, 229–241

[15] Cunningham, A., & Baker, L. (2004). What about me! Seeking to understand a child's view of violence in the family. London, ON: Centre for Children & Families in the Justice System

6. Conclusions

6.1 Since this review was commenced, revised guidance for the completion of domestic homicide reviews has been published and there is no longer a requirement to consider whether the homicide was predictable or preventable. However, as this review commenced before the new guidance was issued, such consideration was given. The review has not identified any opportunities to predict the death of Sarah; and therefore no opportunities to prevent it.

6.2 It appears that Sarah had suffered domestic violence and abuse for a number of years at the hands of Adam.

6.3 Adam was a controlling and jealous man whose anger often came to a head when he did not get his own way. That has been evidenced on several occasions throughout this review.

6.4 According to Sarah's sister, Sarah felt she could control the abusive relationship she was in. During the weeks prior to her death, Sarah was in the process of separating from Adam, although none of the agencies that were involved with her knew that.

6.5 It is impossible to assess whether Sarah was aware of domestic violence and abuse services or whether she would have engaged with those services had she known. Her sister does not think she would have done.

6.6 Consideration should always be given to the wider family where domestic violence and abuse occurs. Children are vulnerable and agencies should do everything to engage them and protect them.

6.7 Opportunities were missed by a number of agencies in their dealings with Sarah and Adam to enquire further about their relationship, and to exercise a greater degree of professional curiosity.

7. Recommendations

7.1 National

7.1.1 There should be consideration of developing a process whereby information about high-risk domestic abuse offenders is shared across international boundaries.

7.2 Community Safety Partnership

7.2.1 The partnership should disseminate the learning from this DHR.

7.3 Greater Manchester Police

7.3.1 To ensure that officers probe information provided by victims in relation to previous domestic abuse. This is particularly important in relation to incidents in other areas and the need to complete relevant checks, for example, the Police National Database (PND).

7.3.2 To ensure that all officers who have contact with victims of domestic abuse understand the importance of providing relevant helpline and support signposting. When it has been done, a record should be made as to what information has been provided to the victim.

7.3.3 To ensure that supervisors make proper use of an up to date induction package for newly appointed domestic abuse specialists when they start in post.

7.3.4 To ensure that whenever children are present during incidents of domestic abuse they are communicated with, listened to and their welfare considered.

7.4 Pennine Acute NHS Hospitals Trust (North Manchester General Hospital Accident and Emergency)

7.4.1 To conduct regular audits to ensure patients identifying signs of domestic abuse are supported appropriately.

7.4.2 To ensure that DVA training includes good practice around interviewing the victim and perpetrator separately.

7.4.3 To ensure that safe enquiry is conducted in the event of domestic abuse disclosure, regardless of whether the victim is the patient or partner, friend or relative accompanying them.

7.4.4 To carry out a risk assessment for any person disclosing domestic abuse in line with MSAB/MSCB guidelines

7.4.5 To ensure that lessons learned from this DHR are cascaded to staff as appropriate.

7.5 Manchester Mental Health & Social Care Trust

7.5.1 To ensure that DVA training includes good practice around interviewing the victim and perpetrator separately.

7.5.2 To ensure that safe enquiry is conducted in the event of domestic abuse disclosure, regardless of whether the victim is the patient or partner, friend or relative accompanying them.

7.5.3 To carry out a risk assessment for any person disclosing domestic abuse in line with MSAB/MSCB guidelines

7.5.4 To cascade lessons learned from this DHR to ensure that clinicians consider the full facts rather than just responding to the presenting issue, e.g. domestic abuse as well as mental health issues.

7.6 Manchester Clinical Commissioning Groups (GP)

7.6.1 To improve GP awareness of symptoms and behaviour associated with DVA through IRIS training

7.6.2 To disseminate learning from the DHR via Safeguarding Newsletter, CCG Website.

7.7 North West Ambulance Services

7.7.1 To ensure that awareness raising with staff takes place in relation to the consideration of immigration status and to be curious why a patient may not have a GP.

7.8 Robert's school

7.8.1 The school should take action to ensure that staff are familiar with the possible indicators of domestic abuse and the impact on the child.

7.8.2 The school should consider accessing Healthy Relationships Awareness sessions for pupils, which looks specifically at domestic abuse and relationships.

7.8.3 To review the effectiveness of changes to the system where Deputy Head Pastoral reviews all counselling appointments every week to check who has attended and who hasn't. There should be a system of follow-up as necessary.

7.8.4 To ensure that all records relating to children are accurate and visits to the school nurse are included in the Head of House Meeting Minutes

7.8.5 To ensure that where children are concerned with their workloads, a referral is made to their personal tutor to discuss and plan support.

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