SAFER STOCKPORT PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW

OVERVIEW REPORT

SUBJECT: MS

DATE OF DEATH : 4TH FEBRUARY 2012

INDEPENDENT AUTHOR: MAUREEN NOBLE

CONTENTS

1. SCOPE OF THE REVIEW

On the night of 3rd February 2012 an incident took place at Address 1 that resulted in the subject of this case, who will be referred to as MS, dying from his injuries on 4th February 2012 at NHS FT2.

The incident and subsequent death of MS resulted in a referral to the Safer Stockport Partnership from the Greater Manchester Police Public Protection Investigation Unit (PPIU). This referral proposed that the case met the criteria for undertaking a Domestic Violence Homicide Review (DVHR). The Safer Stockport Partnership (SSP) held an initial scoping meeting on 29th February 2012 and concluded that a DVHR should be undertaken.

This decision was approved by the Home Office on 1st March 2012 and a panel of senior officers from local agencies was formed to scope the key lines of enquiry and oversee the review. An Independent Chair and Author were appointed in line with Home Office guidance.

The overview report was commissioned by the Safer Stockport Partnership (SSP) under the statutory guidance to local Community Safety Partnerships into conducting a Domestic Violence Homicide Review detailed in section 5 of this report.

2. KEY INDIVIDUALS

The table below lists the key individuals in this case. They have been anonymised for the purposes of the DVHR in line with statutory guidance.

Family Member Known As	Relationship to Subject	Address at time of incident
MS	Subject (date of death 04.02.2012)	Address 1 Also registered at Address 2
AF1	Common Law Partner/Cohabitee	Address 1
Child 1	Child of AF1	Not living at Address 1 **
Child 2	Child of AF1	Not living at Address 1 **

** It should be noted that whilst AF1's children were members of the household during the first part of the period under review, neither were present during the 6 weeks leading up to the incident or at the time of the incident itself. Child 1, who was age 17 at the time of the incident had moved out of the family home in December 2011. Child 2 who was age 13 at the time of the incident had been removed to another address by his birth father in November 2011.

3. INCIDENT LEADING TO THE DEATH OF MS

On 3rd February 2012 at 23.04 hours Greater Manchester Police (GMP) received numerous telephone calls from various persons living in close proximity to Address 1 (AF1's home address) stating that there was a person on fire in the street.

He died from his injuries on 4th February 2012.

4. CRIMINAL INVESTIGATION AND PROCEEDINGS

AF1 was arrested and charged with the murder of MS on 5th February 2012. She appeared at Stockport Magistrates Court on 6th February 2012 where she was further remanded in custody to appear at Manchester Crown Court on 7th February 2012.

On 7th February AF1 appeared in court on a charge of murder. AF1 entered a plea of not guilty.

A trial date was set at 9th July 2012 and proceedings commenced at Manchester Crown Court on that date.

On 20th July 2012 at Manchester Crown Court AF1 was found not guilty of murder and cleared of all charges.

On 27th July 2012 Her Majesty's Coroner issued a Form 120 and 121 to the Home Office showing the trial outcome as 'Murder – defendant acquitted – inquest not resumed'. The cause of death was recorded as 'burns – immolation and products of combustion'.

SECTION 2 – THE DVHR PROCESS

5. PURPOSE DEFINITION AND PROCESS

This Domestic Violence Homicide Review was conducted under guidance contained in Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004).

The guidance states '*Domestic Homicide reviews are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate'.*

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

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

The definition of domestic violence used in this report is in line with the Home Office definition revised in September 2012 the Home Office as follows:

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

- ***psychological***
- ***physical***
- ***sexual***
- ***financial***
- ***emotional***

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

"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and

intimidation or other abuse that is used to harm, punish, or frighten their victim."

**** This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.***

5.1 Review Panel Membership and Meetings

An independent Chair and Author were appointed in line with the Home Office guidance. The review panel met on six occasions between 4th May and 7th November 2012.

The Independent Chair stood down in August 2012 to take up a new post outside of the Borough. A critical reader with experience of chairing DVHRs was therefore employed to comment on the final draft of the overview report as a quality assurance measure.

Lynn Merillion	**Independent Chair – until August 2012***
Transformation Manager	**Adult Social Care, Stockport MBC**
Service Manager	**Children's Social Care, Stockport MBC**
Head of Safeguarding	**Stockport MBC**
Strategic Manager	**Community Safety, Stockport MBC**
Designated Nurse	**NHS Stockport**
Senior Probation Officer	**Greater Manchester Probation Trust**
Chief Inspector	**Greater Manchester Police**
Branch Crown Prosecutor	**Crown Prosecution Service**
In Attendance: **Maureen Noble** **Community Safety Officer, Domestic Abuse**	 **Independent Author** **Stockport MBC**

5.2 The Period Under Review

The panel agreed that the relevant timeframe of the review would be from 1st March 2011, when MS and AF1 resumed their relationship and began cohabiting at Address 1, to 3rd February 2012, the date of the incident that led to the death of MS (in total a period of 11 months). It was agreed that all information contained in Individual Management Reports (IMRs) should be confined to this period. However if deemed to be of significance by the IMR author the panel would take into account any historical information presented in IMRs. This overview report therefore contains information that pre-dates 1st March 2011.

5.3 Timescale for Completion of the Review

The initial target date for completing the review was set at 31st August 2012 however it was noted that other factors, particularly the progress of the criminal proceedings, may affect the panel's ability to complete the review by this date.

The panel suspended work between 20th July and 4th August in order to consider the outcome of the criminal proceedings and any impact this may have on the status of the review.

As stated earlier, following the outcome of the court proceedings, guidance was sought from the Home Office who advised that the DVHR should continue on the basis a serious incident had occurred that warranted review. On 4th August this guidance was accepted by the Safer Stockport Partnership and the review resumed.

In addition to the delay resulting from the criminal proceedings it was necessary to allow a longer timescale for the completion of a report from HM Courts Service (HMCTS).

5.4 Securing Family Involvement in the Review

At the start of the review process a family member was notified that a DVHR was being conducted.

Following extensive discussion the review panel decided that it would not be appropriate to invite Child 1 to participate in the review due to fact that she was cited as a witness for the prosecution in the case against AF1. The Panel also felt that Child 1 would have experienced significant trauma as a result of the incident and the trial. The panel therefore concluded that it would not be in Child 1's best interests to involve her in the review.

The criminal proceedings and attendant media interest necessitated a delay in pursuing a contribution from MS's family as it was considered insensitive to approach MS's family during and immediately after the trial. The panel therefore decided to wait until after the trial had ended to make further contact with the family.

Despite attempts to engage MS's family, the review panel was unable to secure this.

The panel acknowledge that the absence of family involvement represents a gap in our understanding of MS's experience as a victim of domestic violence.

Later in this report the panel make observations and a recommendation about the importance of engaging family members in DVHRs and some of the barriers that may exist to so doing.

The panel discussed inviting the perpetrator to contribute to the review. However the panel concluded that this course of action would not be followed.

5.5 Documentation and Other Sources of Information

The following documentation was used in the Review.

- Individual Management Reports from the agencies listed in Section 8
- A combined Health Overview report
- Home Office Guidance on conducting Domestic Homicide Reviews
- Greater Manchester Police Policy on Domestic Homicide

- A multi agency integrated chronology was produced that provided a sequential record of agency involvement.
- Supporting research and information as cited in the body of the report. **NB This overview report is not based on academic research and the panel did not undertake literature or effectiveness reviews as part of the review process.**

The panel is indebted to Advocacy After Fatal Domestic Abuse (AAFDA) for advice and guidance in relation to engaging family members in the DVHR process.

5.6 Specific Terms of Reference/Key Lines of Enquiry

The panel asked IMR authors to address the following key lines of enquiry in their agency reports:

1. How did your agency respond to knowledge that there was domestic abuse in this family and in particular was the CAADA[1] risk indicator checklist completed and consideration of whether the victim should be referred to MARAC[2]

2. What services did your agency offer to the victim of domestic abuse were they accessible, appropriate and sympathetic to her / his needs?

3. Was the impact of alcohol assessed or suitably recognised? What action did your agency take in identification and dealing with the causative factors including alcohol mis-use.

4. What safety planning was offered to the victim / family members including referral to specialist domestic abuse services?

5. What thought was given to offering services to the perpetrator of the victim's domestic violence?

6. What knowledge did the victim's family and friends have about her / his victimisation and what did they do with it?

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

8. Were issues with respect to safeguarding (children and adults) adequately assessed and acted upon?

[1] Co-Ordinated Action Against Domestic Abuse – DASH Risk Assessment Tool – standard multi agency tool used to assess the risk associated with domestic abuse.

[2] Multi-Agency Risk Assessment Conference - each GM Local Authority Borough has a MARAC.

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

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

11. Was it reasonably possible to predict and prevent the harm that came to the victims and what lessons has your agency learnt from this DHR?

12. Are there any diversity issues that need to be considered?

SECTION 3 – UNDERSTANDING THE CASE

6. BACKGROUND AND EVENTS

6.1 Background

MS and AF1 had known each other for approximately ten years and had maintained an 'on/off' relationship during this time. They lived together at Address 1 from around March 2011 to the date of the incident.

Between 25th July 2011 and 18th January 2012 MS held a tenancy at Address 2. This tenancy was ended by Stockport Homes on 18th January 2012 following a period of rent arrears. It appears that MS never actually lived at Address 2 and that for the entire review period he was living with AF1 at Address 1.

AF1 has two children from a previous relationship. Both children lived at Address 1 during part of the period under review. However neither Child 1 nor Child 2 was a member of the household when the incident leading to MS's death occurred.

MS has three children from two previous relationships. These children were not part of the household at any time during the review period and are therefore not the subject of consideration in this review.

The relationship between MS and AF1 was at times volatile and violent with alcohol misuse acting as an aggravating factor in disputes and other offences, some of which pre-dated the period under review.

6.2 Diversity Issues

MS was diagnosed with inflammatory arthritis in 2007. This condition affected his mobility and caused joint pain however MS was not registered disabled. There is no evidence or suggestion in any of the material presented in this review that MS's physical health and mobility issues contributed to the domestic violence that he experienced in his relationship with AF1.

MS was categorised as a vulnerable person by police following a domestic violence incident of which he was the victim that took place on 24th August 2011.

Following assessment by Stockport Adult Social Care (ASC) under the criteria contained in the Stockport All-Agency Safeguarding Policy MS did not meet their vulnerable adult criteria.

There are no other specific issues in relation to diversity identified in any of the case material.

6.3 Events Occurring In the Review Period

6.3.1 Events in March 2011

MS resumed his previous relationship with AF1 and began cohabiting with her and two children.

6.3.2. Events in April 2011

On 15th April 2011 a housing application was received by Stockport Homes from MS stating that he was living with his previous partner and they were joint tenants. MS's application stated that he needed re-housing due to "relationship breakdown", that he and his partner (not AF1) were not on speaking terms and that living in that situation was creating an atmosphere for their children.

6.3.3. Events in May 2011

No events are recorded as taking place.

6.3.4. Events in June 2011

No events are recorded as taking place.

6.3.5. Events in July 2011

On 2nd July 2011 Police were called to an incident at 02.01 when MS rang saying that, following a domestic argument with AF1, he had been ejected from Address 1 and was seeking re-entry in order to recover his possessions. The police log records that he sounded very intoxicated and aggressive stating that if no police patrol arrived quickly 'there would be a murder'.

The police response to the call was delayed by approximately 1 hour and 40 minutes and when officers attended the house was in darkness and there was no response from the occupants. Police visited the house again at 08.48 hours and found MS leaving the house and AF1 unwilling to engage with officers. There is no record of whether either of the children was present at this incident.

On 20th July 2011 MS viewed a property at Address 2 as a prospective tenant and subsequently took up the tenancy on 25th July 2011. However, as referred to throughout this report it is unlikely that MS ever resided at Address 2.

6.3.6. Events in August 2011

On 20th August police received a report from the previous partner of MS that she had been receiving 'threatening' phone calls from MS and AF1 in relation to access to MS's children.

The officer dealing with the incident judged that no offence had been committed as there was no evidence of threat and no further action was taken.

Police were called to Address 1 on 24th August by MS reporting that he had been kicked in the face by AF1 and that AF1 had bitten his ear. This injury was seen by police officers who attended the scene however it appears that MS did not seek medical treatment for it.

Police officers attending the scene found both parties intoxicated and witnessed scenes of verbal abuse and violent behaviour. Child 1 was noted on the police log as being present at the incident. Ultimately the officer attending had to forcibly remove AF1 and restrain her with handcuffs. AF1 was arrested and taken to a police station.

A written statement was taken from MS in which he stated that earlier in the evening he had been drinking at a local pub with AF1. MS said that when they returned home an argument developed in which AF1 became verbally aggressive and physically violent.

AF1 was charged with an offence of common assault and was bailed to Address 1 with conditions not to contact MS (it appears however that AF1 and MS continued to reside at Address 1 together). As MS was registered as living at Address 2 no further checks were undertaken up by any agency as to whether MS and AF1 were continuing to live together, despite this being in contravention of the bail conditions.

A Domestic Violence (DV) marker was entered onto the police operational computer in relation to Address 1 in order to alert call handlers and officers to the propensity for violent domestic incidents at the property. MS was referred to Victim Support as a vulnerable adult who had experienced domestic abuse

The following day MS presented at the police station wishing to retract his statement stating that *'he didn't want AF1 to lose her job, he would not be continuing the relationship and he was not intimidated by AF1'*. The case was discontinued by police but Public Protection Investigation Unit (PPIU) recorded details of the incident.

The case came to court on 31st August 2011. AF1 pleaded not guilty and the case was adjourned for trial on 7th October 2011.

Victim Support attempted to contact MS by phone on 31st August but the person on the phone (believed to be MS) refused to identify himself.

6.3.7. Events in September 2011

On 1st September 2011 Victim Support made a follow up call to MS during which he declined any support saying that he did not feel 'at risk' from AF1. MS also declined an invitation to complete the CAADA risk assessment.

On 2nd September 2011 MS wrote to the court indicating that he wanted the charges against AF1 to be dropped. This correspondence was sent to the Crown Prosecution Service and Witness Care Unit on 13th September 2011. According to CPS MS was a reluctant witness and made a retraction statement on 16th September 2011.

On 28th September CPS applied for a witness summons to require MS to attend the trial. This was granted the same day and was served by a police officer to Address 2. However, it appears that MS did not receive this summons due to him not residing at Address 2.

On the 10th and 27th September police received further contacts from MS's previous partner reporting abusive phone calls being received from MS and AF1. An officer from the PPIU conducted a risk assessment and rated the risk as standard. A victim letter was sent to MS's previous partner.

On 28th September, five weeks after the incident of 24th August had occurred PPIU sent a Vulnerable Adult referral form by fax to the Adult Social Care contact centre. Adult Social Care staff screened the referral of MS for action against the vulnerable adult criteria which was not met. This referral also included information about Child 1's presence at the incident and her date of birth. ASC therefore passed the referral to Children's Social Care on 29th September however there is no documented record in ASC of this taking place.

Children's Social Care recorded the referral as being received on 29th September when it entered their workflow. Children's Social Care did not however fully process this referral on the 'CareFirst' system resulting in there being no record of the referral. This was attributed to human error and resulted in no action being taken in relation to the DV incident on 24th August.

6.3.8. Events in October 2011

The trial of AF1 for alleged common assault opened on 7th October however the court was informed that MS had not attended to give evidence. On further investigation Address 2 appeared abandoned, MS could not be reached on the phone and there had been no other contact from him. There had been no request to adjourn the case to another day; CPS offered no evidence and the charge was therefore dismissed by the court.

On 31st October 2011 MS registered with a new GP and completed a new patient registration form which included alcohol screening. MS reported that he consumed 16 units of alcohol per week with 8 or more units being consumed at any one time. This information was reviewed by the practice nurse and discussed with him and represents a very thorough approach to alcohol screening. On the basis of self report information no concerns were noted. MS also reported that he had no 'caring' responsibilities.

6.3.9. Events in November 2011

On 9th November 2011 just after 01.00 police received a call from AF1 at Address 1 who 'sounded intoxicated' stating that MS had her car keys and was refusing to allow her to leave the house. The officer ascertained that children were present in the house. Police attended and spoke to Child 1 and Child 2 who that said AF1 and MS had been drinking all evening. AF1 wanted to drive to the shop and MS had removed her keys to stop her.

At 02.22 that same day police received a recall from Child 1 saying that AF1 was drunk and screaming at child 2 and that child 2 was 'very scared'. A police officer returned to the

address where both children asked if they could be removed from the premises and taken to their grandparents who lived nearby. The children were removed to the grandparents address.

Eleven days later on 20th November at 01.00 whilst AF1 was driving her vehicle she collided with a police van on a public highway. A police officer approached AF1's vehicle and requested that she await a traffic patrol to routinely administer a breath test. AF1 attempted to leave the scene and officers attempted to restrain her whereupon AF1 became very aggressive and abusive, this caused officers to place AF1 in a secure cage in the rear of the police van. A short time later AF1 provided a breath test which proved positive, causing her to be arrested under Section 4 of the Road Traffic Act. AF1 was charged and bailed to appear before Stockport Magistrates on 8th December 2011.

The following day, 21st November 2011, Children's Social Care received notification from GMP of the incident that had taken place on 9th November. The contact form stated that neither Child 1 nor Child 2 were present at the incident, although this was not the case as both were present and had requested to be removed from Address 1.

The CSC Contact Centre Team Manager escalated the referral to the Duty Team Manager who reviewed the information and decided that it did not meet the threshold for referral to Level 3 as it was believed, based on the police notification, that the children were not present at the incident. The incident was therefore classified as Level 2 i.e. 'not requiring further assessment'. As a result no strategy meeting was held and the incident was referred to the Stockport Family Pathway in line with recommended practice.

On 24th November AF1 attended a counselling appointment with RELATE to whom she had been referred by her employer, Stockport MBC, for six counselling sessions. She attended a further five counselling sessions until the case was closed on 19th January 2012.

On 25th November 2012 a senior practitioner from CSC checked with police regarding the safety of the Address 1 for a home visit. The check indicated that it was safe for staff to visit the address but noted that MS is 'in fear' of AF1.

On 30th November 2011 the police check information was added to the LAGAN system and the case was allocated to MOSAIC through the Stockport Family Pathway system.

On that same day police received a 999 call from MS saying that there had been a 'physical' dispute at Address 1 involving himself and AF1. Police attended and found both parties to be heavily intoxicated and unable to give an account of what had happened. MS was removed to his sister's address.

Two hours later AF1 re-called the police saying that she wanted to make an allegation of assault against MS however, when officers arrived at Address 1 AF1 became abusive and was unwilling to co-operate. It was noted on the police log that no children were present however this incident was referred to Children's Social Care (CSC) and school nurses.

6.3.10. Events in December 2011

On 1st December police were called by Child 1 to attend Address 1. She informed them that she was going to remove her property as she was moving out of the address and that she

anticipated resistance. Police later received another phone call from Child 1 saying that there had been no resistance to allowing her to remove her possessions and there was no need to attend.

The following day a further call was received from Child 1 reporting that MS was preventing her from removing her property from Address 1. Police attended and completed a DASH risk assessment which was set at standard. Child 1 was assisted in safely removing her property.

MOSAIC Young People's Service received a referral via the Support Families Pathway on 5th December (relating to the incident that took place on 9th November) in respect of Child 2 which included information on possible domestic abuse and alcohol misuse. Three days later MOSAIC sent a voluntary 'engagement' letter to AF1 offering a family based intervention. It appears that MOSAIC perceived AF1 to be the victim of domestic violence on this occasion.

AF1 appeared at Stockport Magistrate's Court on 8th December. This appearance was in connection with the offence of driving with excess alcohol committed on 20th November when AF1's vehicle collided with a police car. AF1 pleaded guilty to the offence and was sentenced to a six month community order with a curfew requirement for twelve weeks from 9pm to 5am each day at Address 1. She was disqualified from driving for two years, offered a Drink Drive Rehabilitation Course (which she undertook and completed) and ordered to pay £85 costs.

Following the court hearing the outcome of the case was input to the court IT system. This generates an automatic update to the Police National Computer. The information contained was that the curfew was to be electronically monitored by G4S. For this to be initiated a separate email is required to G4S giving details of the court's order. When the information is received by G4S the Court should then request a delivery receipt as part of the message. This is retained as part of the court records.

The court outcome was not entered onto the system and as a result the sentence was not carried out. **This significant error did not come to light until officers from Stockport Community Safety Unit contacted G4S as part of this Domestic Homicide Review.**

On 14th December 2011 the GP surgery received MS's previous notes which referred to MS presenting with a problem in relation to alcohol misuse in June 1999. (MS attributed the problem to financial and marital difficulties).

On 15th December MOSAIC school based service attempted contact with Child 2 via his school however it became apparent that Child 2 had not attended school since 21st November 2011 due to residing with his birth father in another Borough. This absence was later followed up by Children's Social Care with Education Services.

On 28th December, around four weeks after the last recorded domestic incident at Address 1 police received a call from AF1 saying that MS had broken into the house and was damaging property.

Officers attended and arrested MS for damage to the front door. Both MS and AF1 were heavily intoxicated. Officers later returned to Address 1 to gather evidence and interview

AF1 however, they found her to be obstructive, refusing to answer questions that would enable them to undertake a DASH risk assessment.

The police log relating to the incident was closed as code C06 indicating that it was a criminal damage incident. Supplementary codes D62 and P01 were also used identifying the incident as also being a 'domestic incident' involving adults where a suspect had been arrested. A specialist domestic violence investigator made contact with AF1 by phone and then by a home visit and a witness statement was taken. AF1 was given the direct number for the Stockport PPIU.

MS was processed as a suspect and after admitting the offence of criminal damage received an adult caution. The application of the closure code D62 (domestic violence) enabled the PPIU at Stockport to identify and evaluate the incident. However no referral was made for AF1 as a victim of domestic violence.

6.3.11. Events in January 2012

As AF1 did not take up the offer of voluntary engagement with MOSAIC the case was closed by them on 6th January 2012.

At 22.07 on 6th January Police received a 999 call from AF1, she was 'very upset' and asked for police to attend Address 1. A log was opened as a code D05 (domestic incident) and officers attended within 10 minutes. They found both MS and AF1 heavily intoxicated, a verbal altercation had occurred and AF1 had asked MS to leave but he had refused. MS was directed to leave the premises which he did and no offences were disclosed.

The log was closed as code D62. A CAADA DASH risk assessment was attempted however AF1 refused to give most of the details required to enable a referral to take place. The risk level was set to standard and a 'victim letter' was sent to AF1. A referral was also made to Children's Social Care (CSC). The PPIU log was drawn to the attention of a supervisor because there had been seven previous call-outs in 2011.

CSC received the report of this incident on 12th January (six days after the incident). At this time it was known by CSC that Child 2 was living elsewhere although his whereabouts were not on record. The incident report prompted CSC to look into the whereabouts of Child 2 and they established that he was living with his father in another borough. CSC continued to liaise with schools and CAFCASS regarding Child 2's education and an application for a residency order.

On 18th January 2012 MS's tenancy at Address 2 was terminated by Stockport Homes. MS had built up rent arrears and contact was attempted on numerous occasions to resolve this. On every occasion attempted contact with MS was unsuccessful either by home visit, letter or telephone.

On 19th January AF1 attended the final counselling session with RELATE and the case was closed.

6.3.12. Events in February 2012

On 3rd February AF1 consulted her GP on an unrelated health issue which was not deemed to be pertinent to this review.

On the same day at 23.04 hours GMP received a number of calls from various persons living in close proximity to Address 1 stating there to be a person on fire in the street. MS died of his injuries on 4th February 2012.

7. SYNOPSIS OF AGENCY INVOLVEMENT

IMRs were initially requested from the agencies listed below. A Health Overview report was also requested containing information from the GP of MS; the GP of AF1, Child 1 and Child 2; School Nursing Services; North West Ambulance Service and NHSFT2.

A comprehensive multi-agency chronology was compiled including information from all agencies that had had contact with the victim.

Following further scrutiny of the review documentation an IMR was requested from G4S. This IMR was received on 19th June 2012. Information contained in the G4S report led to a full IMR being requested from Her Majesty's Courts Service (HMCTS) which was received on 22nd August 2012. As outlined above the requirement for this additional IMR led to a delay in the timescale within which the Review Panel could conclude its work and produce a final overview report.

A brief synopsis of key involvement taken from each IMR is provided below. Agency information is presented in alphabetical order.

7.2 Crown Prosecution Service (CPS)

CPS had two contacts with MS and AF1 the first of which related to the alleged assault by AF1 upon MS on 24th August 2011 for which CPS took the decision to prosecute on the same day. AF1 was charged with common assault and appeared at Stockport Magistrates Court on 31st August 2011. A not guilty plea was entered and a trial date fixed for 7th October 2011.

According to the CPS report MS was a reluctant witness and made a retraction statement on 16th September 2011. A witness summons was applied for and granted to call MS to give evidence. MS did not attend court as it is unlikely that he received the summons. Attempts were made to contact MS at his registered home address (Address 2) but he appeared not to live there. The case against AF1 was subsequently dismissed by the court due to a lack of evidence.

The second contact related to AF1's court appearance on 8th December relating to a driving offence committed in November. AF1 pleaded guilty to this offence and appeared at Stockport Magistrates Court on 8th December 2011. AF1 was made subject to a 6 months Community Order with a 3 months electronic tag/curfew (ending on 29th February 2012)

and was disqualified from driving for 2 years. This sentence was not carried out due to a notification failure in the HMCTS system.

7.2.1. Comment on Professional Practice

CPS operated to expected levels of practice in handling contacts with MS and AF1. With regard to the summons for MS to appear as a witness, this was issued by CPS and delivered by a police officer to MS's registered address. MS was not living at the address however he did not make this known to CPS, Victim Support or the police.

As far as can be ascertained by the review panel the summons was never received by MS. There is an agency agreement between GMP and CPS for police to follow up unresponsive victims however this agreement was not acted upon on this occasion.

7.2.2. Agency Actions Arising From IMR

No single agency actions were identified by CPS.

7.3 G4S (Offender Supervision Agency)

G4S was not originally asked to provide an IMR. A brief background to the service is included below to provide a context for understanding the process of sentence management.

7.3.1. Background to the service provided by G4S

G4S is the contractor responsible for the electronic monitoring of offenders on behalf of the Ministry of Justice in the North West region. They monitor individuals as part of bail conditions, prison licence conditions or as part of community sentences.

All curfew notifications issued by supervising courts are sent to a central inbox. The majority of orders are received by email sent to the relevant address. However, some orders are received by fax; the faxes are automatically converted to an email and arrive in the same inbox.

On receipt of a new curfew notification, G4S is contractually required to attend the curfew address to install the monitoring equipment. This visit must be completed during the hours of curfew. The equipment will send an alert to the monitoring centre in response to any key events including the following:

- if a subject is absent during the hours of curfew; if the tag or monitoring unit are damaged;
- if power to the unit is lost or the unit is moved; if the mobile signal required to communicate events is lost.

7.3.2. Agency Involvement

The G4S IMR states:

'On Friday 13th July 2012 G4S was informed (by Stockport Community Safety Partnership as part of the DVHR) that AF1 had been made subject to a Community Order with a single requirement of a 3 month electronically monitored curfew by Stockport Magistrates Court on 08th December 2011.

As the monitoring contractor for the North West region, G4S would have been responsible for managing the curfew in this case. G4S has performed a full search of the monitoring system using the individual's details (name, date of birth and address) which confirmed that there is no record of an order for AF1.

A further search was conducted of all curfew orders received in December within the email inbox used for all electronic monitoring notifications sent to the organisation. There is no record of an order received for the above person from the court'.

7.3.3. Comment on Professional Practice

G4S acted within expected levels of practice as they were unaware of the sentence.

7.3.4. Agency Actions Arising from IMR

No single agency actions were identified by G4S.

7.4 General Practitioner – MS

During the period under review MS consulted his GP on four occasions. On 15th September 2012 during a consultation for smoking cessation MS was given a routine screening for alcohol consumption which he reported to be 20 units per week which is below the recommended maximum for an adult therefore no concerns were noted.

On 31st October 2011 MS registered with a new GP and completed a new patient registration form. This included a self-report of consumption of 16 units of alcohol per week. MS did report that he consumed eight or more units at any one time. This information was reviewed by the practice nurse and discussed with him and represents a very thorough approach to alcohol screening. However, on the basis of self report information no concerns were noted. MS also reported that he had no 'caring' responsibilities.

On the 14th December 2011 the GP surgery received MS's previous notes which showed that in June 1999 had received an alcohol detoxification treatment programme.

7.4.1. Comment on Professional Practice

Professional practice was to the expected standard in relation to MS's presenting issues. Previous alcohol misuse was given consideration in assessments however the GP did not offer screening for domestic abuse linked to alcohol misuse.

7.4.2. Agency Actions Arising from the IMR

No single agency actions were identified by MS's GP

7.5 General Practitioner – AF1

The GP was the only health agency that was actively involved with AF1 during the review period.

AF1 was seen by a number of GP's who each dealt with presenting issues but did not appear to link with previous consultations. AF1 may have chosen to access different GP's or, if all her appointment requests were 'last minute', then being able to access the same GP for each consultation would be difficult to achieve and is not specific to this case.

There is no record of AF1 ever consulting her GP in relation to issues of domestic abuse or of alcohol misuse, despite a long documented history in other agency reports. AF1's GP reports that, from the health issues presented by AF1, there was no reason to suspect that either domestic abuse or alcohol misuse were problems for her. AF1 presented with low level depression, anxiety and anger. The treatment offered was appropriate for the presenting problems however further enquiry or screening for domestic abuse did not take place.

AF1 consulted her GP on the day of the incident that lead to MS's death however it was deemed that this was on an unrelated health issue and therefore not pertinent to this review.

7.5.1. Comment on Professional Practice

AF1's GP responded appropriately to all presentations and consultations and managed AF1's care in line with expected practice. There is no record of enquiry about the root cause of depression, anxiety and anger which is a missed opportunity in relation to identifying domestic abuse and/or alcohol misuse as contributory or causative factor.

7.6 Greater Manchester Fire and Rescue Service (GMFRS)

GMFRS provided a brief IMR to the review panel. The IMR stated that GMFRS had no contact with either MS or AF1 until they were called out to the incident on the night of 3rd February.

GMFRS stated that further information relating to the incident on 3rd February 2012 could not be made available due to ongoing criminal proceedings.

Following the conclusion of the trial of AF1 further information was requested by the panel and was received on 22nd August 2012 this included greater detail on the emergency call-out, attendance at the scene of the incident and response time which has been incorporated into this report. GMFRS also provided witness statements from two witnesses who were present at the scene. These witness statements were presented in the criminal case but are not included in this overview report.

7.6.1. Comment on Professional Practice

GMFRS acted within expected practice and standards.

7.6.2. Agency Actions Arising from the IMR

No single agency actions were identified by GMFRS.

7.7 Greater Manchester Police

Greater Manchester Police provided a comprehensive and detailed report to the Review Panel.

The IMR detailed numerous contacts with both MS and AF1 dating back to September 1997 and August 2000 respectively. The terms of this review confine analysis to the period 1st March 2011 and 3rd February 2012, however, reference is made to incidents pre-dating this review period.

7.7.2. Police Contact Prior to the Review Period

Both MS and AF1 were known to the Police prior to the period under review. Prior to 1st March 2011 AF1 had twenty previous contacts with the Police and MS had had five previous convictions for nine offences. Many of these contacts involved alcohol, violence and domestic abuse with both parties being both perpetrator and/or victim.

7.7.3. Police Contact in the Review Period

During the review period there were fourteen separate contacts involving MS and AF1 recorded by Police, the first being on 2nd July 2011 and the last on 3rd February 2012.

Three of these contacts relate to MS's previous partner who had received abusive phone calls and texts from MS and AF1. These incidents were properly discharged by police officers.

One contact took place on 23rd November when AF1 contacted police to say that her previous partner was refusing to return Child 2 following an access visit, saying that AF1 was unfit to look after him. Police followed up the call with Child 2's father and satisfied themselves that child 2 was safe.

Five of the contacts at Address 1 were coded domestic incidents where AF1 and MS were physically violent towards each other, on two occasions AF1 was the complainant and on three occasions MS was the complainant. Throughout the various contacts with the AF1 and MS police officers had not been able to fully complete the 'DASH' risk assessments due to both of their unwillingness to co-operate in the process.

Two contacts were with AF1 in relation to driving offences.

Two contacts were made by Child 1 when she asked for police assistance in removing her property from Address 1.

The final contact at Address 1 was to attend the incident on 3rd February 2012 that lead to the death of MS.

7.7.8. Comment on Professional Practice

Greater Manchester Police generally acted within expected standards of practice. However, there were three occasions where practice fell below expected standards.

With regard to the incident on 2nd July 2011 despite the incident code being listed as D05 the log was not suitably graded for response and no patrol attended until 03.45 hours by which time MS was not present and there was no response at Address According to GMPs policy this incident should have been graded at least level 2 or at the highest level.

The five week delay in referring to Children's Social Care following the incident on 24th August 2011 is unacceptably long and added to a lack of attention or urgency in addressing the needs of Child 1 and Child 2 who were exposed to domestic violence with frequency and severity.

Although police offered AF1 support via the PPIU following the incident on 28th December they did not make a referral to victim services for AF1.

7.7.9. Actions Arising from IMR

An action in relation to stalking and harassment is set out in the attached single agency action plan.

7.8 Greater Manchester Probation Trust (GMPT)

Greater Manchester Probation Trust provided a brief IMR that required further detail to enable the panel to judge their involvement in the case.

GMPT had no contact with MS within the timeframe of the review. They did have previous contact when MS was subject to a Community Rehabilitation Order which was completed in June 1998.

AF1 was not known to GMPT although the agency was aware from Stockport Magistrates Court that on 8th December 2011 AF1 was made subject to a Community Order with a 12 week curfew requirement for an offence of driving with excess alcohol. This sentence was imposed without a pre-sentence report being requested from GMPT.

7.8.1. Comments on professional practice

Practice was within expected standards.

7.8.2. Actions Arising from the IMR

No single agency actions were identified by GMPT.

7.9 HER MAJESTY'S COURTS SERVICE (HMCTS)

The panel requested an IMR from HMCTS following analysis of the multi-agency chronology. This IMR was received on 22nd August 2012. It provided brief details of HMCTS involvement with AF1 and focused on two contacts that took place during the review period.

The first contact was for the alleged offence of common assault that took place on 24th August 2011 as referred to above. On the trial date of 7th October the court was informed that MS had not attended to give evidence. On further investigation MS's registered address appeared abandoned, MS could not be reached on the phone and there had been no other contact with him. There was no request to adjourn the case to another day. The CPS offered no evidence and the charge was dismissed by the court.

The second contact was in relation to AF1's charge of driving a motor vehicle with excess alcohol. AF1 appeared at Stockport Magistrates' Court on 8th December 2011. She pleaded guilty. The sentence given was a six month community order with a curfew requirement for twelve weeks from 9pm to 5am each day at Address 1. AF1 was disqualified from driving for two years, offered a Drink Drive Rehabilitation Course (which she undertook and completed) and ordered to pay £85 costs.

The sentence was not undertaken due to a failure in the notification system as set out below.

7.9.3 Comment on Professional Practice

HMCTS generally operated within expected practice. A breach of court procedure occurred in relation to AF1's sentence for driving with excess alcohol. A member of staff from the courts administrative team failed to send to G4S notification of a curfew order for monitoring purposes. This was in breach of the courts procedures but which was not picked up until enquiries were made as part of the DVHR.

HMCTS has conducted an investigation into the circumstances of the breach. The investigation also highlighted that in August 2011 a manager who no longer works for HMCTS stopped the requirement to request and retain a delivery receipt as part of the communication with G4S. This was contrary to specified procedures. The change was challenged as part of a quarterly assurance check of the courts internal procedures and reversed with immediate effect.

7.9.4 Agency Actions Arising From the IMR

HMCTS has conducted an internal enquiry into the systems fault caused by human error. No further agency actions are identified.

7.10 MOSAIC

MOSAIC is a young person's drug and alcohol service which offers a range of support to children, young people and families affected by substance misuse. The service works with children and adults.

The service received a referral via the Support Families Pathway on 5th December.2011 in respect of Child 2 which included information on possible domestic abuse and alcohol misuse.

On 8th December 2011 MOSAIC sent a voluntary engagement letter to AF1 offering a family based intervention. MOSAIC school based service attempted contact with Child 2 on 15th December however Child 2 had not attended school since 21st November 2011 due to residing with father.

The case was closed by MOSAIC on 6th January 2012.

7.10.1. Comment on Professional Practice

MOSAIC operated within expected practice. It would have been good practice to enquire further about the status of AF1 in relation to the domestic violence incident on 9th November as it appears she was assumed to be the victim rather than a possible perpetrator.

7.10.2. Agency Actions Arising from the IMR

MOSAIC have identified no actions arising from the review.

7.11 School Nursing Service

The service has two recorded contacts in relation to family. The incident on 9th November 2011 and the incident that occurred on 30th November 2011 where MS was cautioned for an alleged assault on AF1 was referred to school nursing services.

The Community Safeguarding Children policy 2010 contains a flow chart which details a pathway for Health Visitors and School Nurses to follow on receipt of the police referral. There is no evidence that the practitioner assessed the information as, on two occasions, there was no documentation as per the agency guideline. The guideline was partially followed as CSC were contacted. This appears to be practitioner failure rather than an absence of policy and guidelines. This failure to follow the guideline could not be deemed to contribute to the ultimate outcome as the information received by the SN was that AF1 was the victim. School Nurses to not provide a direct service to adults and would not have undertaken a CAADA risk assessment.

The chronology indicates that the time between the domestic abuse incidents occurring and the details being entered in Child 2's Child Health Records in two cases was over a month after the event. This was because of late notification of the incidents to Children's Social Care by the police.

7.12 Stockport MBC Adult Social Care

Adult Social Care (ASC) provided a clear and comprehensive IMR.

ASC had had previous involvement with MS during 2007 when he was referred to hospital for investigations which resulted in a diagnosis of inflammatory arthritis for which he received outpatient treatment.

During the period under review Involvement with MS was confined to a single referral from Greater Manchester Police received on 28th September 2011. This referral was in response to the domestic violence incident involving AF1 and MS that took place on 24th August 2011.

ASC deemed that MS did not meet the criteria for vulnerable adult status as set out in Stockport's Safeguarding Policy. However information was passed to Children's Social Care as children were present in the household.

ASC had no contact with AF1.

7.11.1. Comment on Professional Practice

The assessment and outcome were in line with expected practice however there is a learning point regarding a common definition of vulnerability across agencies which appears in the recommendations section of this report.

7.11.2. Agency Actions Arising from the IMR

An agency action plan is contained in section 12 of this report.

7.12 Stockport MBC Children's Social Care (CSC)

The first IMR produced by Children's Social Care required further detail on their involvement with the Child 1 and Child 2 who were living with MS and AF1 during part of the review period. The second IMR was received within the requested timescale and provided a full record of involvement and analysis of practice.

7.12.1. Contact Prior to the Review Period

Prior to the review period both Child 1 and Child 2 were the subjects of Domestic Violence police notifications made to Children's Social Care. There were 12 such notifications between 2002 and 2008 which involved AF1 and four different adult males, indicating a long history of domestic abuse in the family.

During 2006, 2007 and 2008, it was considered that the referrals met Social Care threshold. Three Initial Assessments [seven day assessment] were conducted in response to incidents of domestic abuse. On each occasion the Initial Assessment did not recommend a Core Assessment or the issues were not deemed to warrant a Child Protection Case Conference.

7.12.2. Contact in the Review Period

The IMR from CSC documents thirteen separate actions and contacts in relation to Child 1 and Child 2.

The entries are drawn from the LAGAN and CareFirst system, the first of which relates to the alleged common assault domestic violence incident that took place on 24th August and was not notified by Police until 28th September. The second entry is on 21st November and relates to the domestic violence incident that took place on 9th November and the actions arising from it.

There are five further entries between 25th November and 8th December relating to the referral to MOSAIC of AF1 and Child 2.

A further record on 22nd December relates to the domestic violence incident that occurred on 30th November which again was the subject of late notification.

On 12th January 2012 there is a contact regarding the domestic violence incident that took place on 6th January where no children were present.

Of the remaining contacts/entries four relate to liaison with Young People's Services in relation to Child 2's school absence, residence with his birth father and subsequent residency proceedings.

The final entry relates to notification of the arrest of AF1 for the murder of MS.

7.12.3 Comment on Professional Practice

There are several instances of human error in recording information that lead to missed opportunities for assessment, referral and escalation of the case. The family were rarely viewed in a holistic way and the cumulative impact of recurrent domestic abuse and alcohol misuse were not given full consideration. In some instances this is attributable to poor quality information being received by CSC, particularly from GMP, in relation to children being present at incidents of domestic violence and to unacceptably long delays in referral following domestic violence incidents.

Liaison and information sharing between CSC and Education in relation to Child 2 was initially poor and a lack of knowledge about the whereabouts of Child 2 between the two agencies is unacceptable.

7.12.4. Agency Actions Arising from the IMR

An agency action plan is contained in section 12 of this report.

7.13 RELATE

AF1 was referred to RELATE for six counselling sessions by her employer Stockport MBC. AF1 attended the first counselling session on 24th November 2011 and attended all five subsequent counselling sessions until the case was closed on 19th January 2012.

The RELATE IMR indicates that 'current domestic abuse' was not referred to in the sessions but that 'past domestic abuse committed against AF1 by a previous partner was briefly referred to but that AF1 did not wish to discuss it in any detail'. In addition the report states that AF1 did not discuss any alcohol issues in her counselling sessions.

7.13.1. Comment on Professional Practice

The RELATE IMR, although brief, demonstrates expected practice by professionals. RELATE informed the panel that they have undertaken an independent internal review of their processes and involvement as a result of the criminal case and have found no areas for concern.

7.13.2. Agency Action Arising from the IMR

No agency actions have been identified.

7.14 Stockport MBC Services for Young People

On 29th November 2011 the CCIS (Client Caseload Information System) database recorded a contact from the Head of Year at Child 2's school. The Head of Year expressed concerns regarding Child 2's absence from school following conversations with Child 2's father. The Head of Year was advised that the absence should be recorded as 'unauthorised' and that

further advice should be sought as Child 2 was residing with his birth father in another Borough in Greater Manchester.

There followed nine further records on the CCIS database between 29th November 2011 and 13th January 2012 relating to Child 2's ongoing absence from school.

The school wrote to Child 2's father regarding absences and transfer to another school but there is no contact with AF1 and no explanation of this omission. Children's Social Care eventually established Child 2's whereabouts and liaison took place regarding Child 2's school transfer.

7.14.1. Comment on Professional Practice

Professional practice meets the expected standard however liaison and record keeping should be improved in relation to school absences and transfers.

7.14.2. Agency Actions Arising from the IMR

No single agency actions were identified.

7.15 Stockport Homes

Stockport Homes is an Arms Length Management Organisation which manages the Council's housing stock, delivering services which include homelessness, housing allocations, rent recovery, tenancy and estate management, Anti social behaviour and support services.

On 15th April 2011 a housing application was received by Stockport Homes from MS stating that he was living with his previous partner and they were joint tenants. MS's application stated that he needed re-housing due to "relationship breakdown", that he and his previous partner were not on speaking terms and that living in that situation was creating an atmosphere for their children.

On 20th July 2011 MS viewed a property at Address 2 as a prospective tenant and subsequently took up tenancy on 25th July 2011.

MS got into rent arrears and contact was attempted on numerous occasions to resolve rent arrears. On each occasion contact was unsuccessful either by home visit, letter or telephone. On 18th January 2012 the tenancy was terminated.

7.15.1. Comment on Professional Practice

Stockport Homes operated with expected levels of practice and have demonstrated a willingness to learn from the review

7.15.2. Agency Actions Arising from the IMR

Stockport Homes have made changes to their pre-tenancy questionnaire based on the findings of this review.

7.16 Victim Support

Victim Support received two referrals from the police regarding assaults on MS. The first referral related to an assault made by a known offender upon MS when he attempted to intervene in a dispute and is not relevant to this review.

The second referral related to the alleged assault by AF1 that took place on 24th August 2011. Victim Support attempted to contact MS by phone on 31st August but the person on the phone refused to identify themselves.

On 1st September 2011 Victim Support made a follow up call to MS where he again declined any support saying that he did not feel 'at risk' from AF1. MS also declined an invitation to complete the CAADA risk assessment.

7.16.1. Comment on Professional Practice

Victim Support provided the expected level of service in relation to domestic abuse referral.

7.16.2. Agency Actions Arising from the IMR

No agency actions have been identified.

7.17 General Comments on the Quality of IMRs

There was good compliance with regard to completing IMRs. All agencies who were asked to produce an IMR did so within the timescale set down by the Review Panel.

The Safer Stockport Partnership ran a Domestic Abuse IMR training session prior to the first review panel meeting. However not all agencies were able to attend.

The IMR received from AF1's GP on 9th July 2012 was written by the GP himself and no independent person had access to the records, unlike MS's GP report which was written independently of the practice.

AF1's GP initially refused to share information with the review panel as he stated that he had been advised that he did not have a statutory obligation to do so. The source of this advice is not known. The matter was referred to the Primary Care Trust Caldecott Guardian who advised the GP to seek consent from AF1 to disclose relevant information and if consent was refused then consideration should be given to disclosing the information in the public interest.

AF1 requested access to the report prior to it being shared with the panel. The report submitted was approved by AF1.

SECTION 4 – WHAT DO WE LEARN FROM THE REVIEW

8. RESPONSES TO THE TERMS OF REFERENCE/KEY LINES OF ENQUIRY

IMR authors were asked to consider twelve key lines of enquiry in their reports. A summary of responses and key points is given below.

8.1.1. TOR 1: How did your agency respond to knowledge that there was domestic abuse in this family and in particular was the CAADA risk indicator checklist completed and consideration given of whether the victim should be referred to MARAC?

Of the agencies involved with the subject and wider family Greater Manchester Police, Children's Social Care, Adult Social Care, School Nursing, Victim Support, CPS and HMCTS were aware that domestic abuse was taking place within the family.

The responses from Health Agencies are included in the Health Overview section of this report. It is of note that neither MS's nor AF1's GP felt it necessary, based on presenting conditions to undertake any form of domestic abuse screening or questioning. AF1's GP did not enquire as to whether her presentation with low level depression, anxiety and anger were related to possible domestic abuse.

School Nursing Services did not act upon information they had received in relation to domestic abuse. Whilst it is unlikely that actions by the School Nursing Service would have changed the outcome of the case, there is learning to be gained in relation to good practice in safeguarding children exposed to domestic abuse and adherence to policy and procedure.

Victim Support offered MS a CAADA risk assessment on two occasions but this was declined by MS. MS told Victim Support that he was not afraid of AF1.

Greater Manchester Police flagged MS as a vulnerable adult following the incident on 24th August 2011 and referred him to Adult Social Care. This referral did not take place until 29th September 2011 a period of five weeks after the incident. MS did not meet the criteria for classification as a vulnerable adult under the Stockport All Agency Safeguarding policy.

The GMP dashboard risk rating for incidents involving MS and AF1 never rose above a 'standard' level, thus the case was never referred to MARAC.

8.1.2. TOR 2: What services did your agency offer to the victim of domestic abuse. Were they accessible, appropriate and sympathetic?

MS was offered specific domestic abuse services by Greater Manchester Police and by Victim Support. It is not possible to say whether these services were accessible, appropriate

and sympathetic from the material seen within this review as there is little information from the victim and no information from the victim's family as to why MS did not choose to take up the service. It is however evident that these services acted to expected levels of practice in making and receiving referrals and in contacting the victim.

MS did not consider himself to be a victim of domestic abuse however national research shows that male (and female) victims often conceal abuse and deny its negative impact. The question of whether services would have responded differently had the victim been female has been raised by the Review panel. From the information available it would be speculative to say that there is evidence that a female victim would have received a different level of service.

From the information reviewed it appears highly likely that AF1 was also a victim of domestic abuse. Whilst AF1 is not the subject of this case there were missed opportunities to intervene with AF1 as a victim.

8.1.3. TOR 3: Was the impact of alcohol assessed or suitably recognised? What action did your agency taken in identification and dealing with the causative factors including alcohol misuse.

The impact of alcohol is a significant factor in this case, however, the majority of agencies either

- were unaware of alcohol misuse as a factor in the relationship between MS and AF1
- did not sufficiently assess or consider alcohol misuse in their response to incidents
- were aware of alcohol misuse but missed opportunities to offer interventions

CPS recognised alcohol as an aggravating factor in the offence committed by AF1 on 20th November 2011 and offered AF1 a Drink Driving Rehabilitation Course which she undertook.

Greater Manchester Police were aware of alcohol misuse as a contributory factor in relation to domestic abuse and AF1's driving offences, however, AF1 was not offered an alcohol assessment or brief interventions programme by GMP or referred to any other agencies for alcohol interventions.

GMP also failed to initiate a LADO** (Local Authority Designated Officer) referral in relation to AF1's offences.

MS's second GP offered a thorough alcohol screening however the self-report information of low risk alcohol consumption did not lead them to undertake any further assessments.

Children's Social Care was aware that AF1 misused alcohol as they were notified of a number of domestic abuse incidents where alcohol was cited as an aggravating factor. Following the incident on 9th November CSC referred Child 2 and AF1 to MOSAIC via the Stockport Family Pathway. As MOSAIC is a voluntary engagement service when AF1 did not take up the offer of an appointment the case was closed with no further action being taken.

8.1.4. TOR 4: What safety planning was offered to the victim/family members including referral to specialist domestic abuse services?

Greater Manchester Police identified MS as a vulnerable person following the alleged assault that took place on 24th August 2011. This resulted in a referral to Adult Social Care and to Victim Support. MS did not wish to complete the CAADA risk assessment and refused services from Victim Support who were therefore unable to provide support services.

AF1 was offered a DASH risk assessment on several occasions however this was declined with only a partial risk assessment being undertaken on one occasion.

No other safety planning was offered to the family by any agency.

8.1.5. TOR 5: What thought was given to offering services to the perpetrator?

There is no evidence that consideration was given by any agency to offering services to either AF1 or MS as perpetrators of domestic violence.

It is apparent that the school nursing service and MOSAIC made assumptions about AF1 being the victim of domestic violence rather than as a perpetrator.

8.1.6. TOR 6: What knowledge did the victim's family and friends have about victimisation and what did they do with it?

The panel discussed family involvement at length and attempted to involve a family member at the start of the review and again after the outcome of the trial. This proved to be unsuccessful. Therefore the panel did not have an understanding from friends or family regarding victimisation.

8.1.7. TOR 7: How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?

Information was shared appropriately between services in relation to known incidents of domestic abuse upon the victim. The victim did not engage with specialist domestic abuse services (i.e. Victim Support). In the absence of involvement from the family in the review it is not possible to comment upon their knowledge of the victim's experience of domestic abuse.

8.1.8. TOR 8: Were issues with respect to safeguarding (children and adults) adequately assessed and acted upon?

MS was identified as a vulnerable adult by Greater Manchester Police and referred to ASC, however, as stated elsewhere in this report the criteria for vulnerable adults status differs across agencies and MS was not deemed to be a vulnerable adult by ASC.

There were a number of missed opportunities in relation to safeguarding children. Considering the historical issues relating to violence and alcohol greater significance should have been given to the referral made to Children's Social Care on 9th November 2011 when the referral was passed to the Stockport Family Pathway rather than progressing to initial assessment. It is evident that the two further referrals received on 30th November 2011 and 6th January 2012 were considered Level 2 threshold and managed through the Stockport Family Pathway.

On the Police referral form to Children's Social Care it is stated that Child 1 and Child 2 were 'not ordinarily resident'at Address 1 despite other reports stating explicitly that one or both of the children lived there. This information was not cross-referenced on every occasion and therefore led to a lack of due consideration of whether or not the children were living at the address.

The Children's Social Care chronology on the family had not been updated since 2006. The absence of an up to date chronology is likely to have impeded decision making in this case as the history dating back to 2002 of violence and alcohol was not taken into account.

8.1.9. TOR 9: Were there issues in relation to capacity or resources in your agency that impacted upon the ability to provide to the victim and to work effectively with other agencies?

In general terms issues of capacity and resources were not cited as impacting on any agency's ability to provide a service to the victim and to work with other agencies.

Of note are comments from Children's Social Care Services who highlight the volume of referrals coming from GMP through the CareFirst system.

GMP also highlights changes to the divisional structures in relation to Public Protection Unit.

8.1.10. TOR 10: Do any of your agency's policies/procedures/training require amending or new ones establishing as a result of this DVHR, including those covering risk assessment and information sharing?

None of the agency IMRs identifies any policy/procedures and training issues however contributing agencies have been asked to ensure that communication and risk assessment procedures are quality assured on a regular basis.

8.1.11. TOR 11: Was it reasonably possible to predict and prevent the harm that came to the victim and what lessons have your agency learnt from this DVHR?

It is the overall conclusion of the panel that the incident that occurred on the night of 3rd February 2012 could not have been predicted by any agency who had contact with MS.

If communication within and between agencies had been of a higher standard the risks presented by AF1 and MS to each other and to Child 1 and Child 2 would have been more clearly seen and could have been acted upon. On more than one occasion agency information sharing was untimely, inaccurate and unrecorded.

8.1.12. TOR 12: Identify any diversity issues raised as part of this case?

MS was diagnosed with inflammatory arthritis in 2007 and suffered acute pain as a result. This impacted his mobility and he had previously had aids fitted in his accommodation. No other diversity issues were identified by agencies.

The issue of being a male victim of domestic abuse was considered by the panel to be a diversity issue which will be captured in the recommendations.

9. FINDINGS

There is considerable learning emerging from the case across the agencies participating in the review and in the wider context in relation to the conduct of Domestic Violence Homicide Reviews.

The review has identified seven key themes upon which agencies should focus in relation to learning, these are:

- Male victims of domestic abuse
- Female perpetrators of domestic abuse
- Safeguarding children
- Alcohol misuse
- Vulnerable adults
- Criminal Justice System
- Family involvement in DVHRs

9.1. Finding One - Male Victims of Domestic Abuse

According to the British Crime Survey (2010-11) in 4 women and 1 in 6 men will be affected by domestic abuse during their lifetime.

National research shows that male victims are three times (10%) more likely **not** to tell the police they are victim than a female victim (29%) and only 4% of male victims will tell a health professional compared to 19% of female victims *(Home Office British Crime Survey 2010-11).*

Over the last three years reporting of domestic abuse incidents in Stockport has increased year on year. 6120 incidents were reported to the police in the period April 2010 to March 2011 with 1084 of these being recorded as crimes.

During the year 2010-2011 Stockport Without Abuse (SWA) received over 1161 referrals for assistance and provided support to 978 females and 183 males. They also supported 116 children indirectly and gave advice to 240 people through the local Helpline.

Of the 1084 recorded crimes associated with domestic abuse, there were 943 victims (757 females and 186 males) of whom 103 were repeat victims. Over the last three years Stockport has seen a significant increase of male victims reporting crimes.

According to agency reports it is not uncommon in cases of domestic violence for victims to withdraw their allegations, thereby preventing the case from going to court. This occurred in relation to the incident that took place on 24th August 2011 where MS subsequently withdrew allegations as he 'did not want AF1 to lose her job and he said he was ending the relationship'. GMP and Victim Support demonstrated good practice in working with the victim however MS did not wish to complete the CAADA risk assessment and the ultimate decision to withdraw from the case rested with him.

In this instance Victim Services issued a summons for MS to provide evidence at court which was delivered to MS's registered address however as MS did not reside at this address it appears that this summons was never received by him. There was no follow up by police or Victim Services as to (a) whether the summons had been received or (b) why MS did not appear at court as a witness. This lack of follow up is a missed opportunity to engage MS in support services in relation to his experience as a victim of domestic abuse. It is unlikely that this would have resulted in the case progressing to trial but could have provided a further opportunity to engage MS in victim support services. CPS has recognised this gap and has improved their witness summons handling procedures as a result of this review.

It is well documented that in this case both adult parties displayed violent and aggressive behaviour toward each other which was often exacerbated by alcohol intoxication and on at least one occasion MS was the perpetrator of domestic violence upon AF1. As AF1 never completed a DASH risk assessment it is not possible to say with certainty that she was a victim of domestic abuse.

MS was identified by GMP as a vulnerable adult experiencing domestic abuse and was referred to appropriate services and there is no evidence that MS was treated by differently by services as a male victim of domestic abuse. Current risk assessment tools are someone weighted towards female victims and there appears to be a presumption by some agencies in this case that AF1 was the sole victim.

The risk rating for domestic violence incidents in this case never rose above 'standard' despite the escalation in the frequency of incidents between August and November 2011. Thus the case did not meet the criteria for referral to MARAC.

9.2. Finding Two - Female Perpetrators of Domestic Abuse

There are limited programmes locally and nationally for perpetrators of domestic violence and virtually no programmes specifically targeting women.

It is recorded in several IMRs that MS did not perceive AF1 to be a threat saying that he was not afraid of her and that on the occasion she assaulted him on 24th August this was because she was drunk. AF1 was not identified as a perpetrator of domestic violence by any agency other than GMP.

AF1 was not offered any service in relation to either perpetration or victimisation. Without the insight of family members the review panel were unable to clearly understand both MS and AF1's roles as behaviours as victim(s) and perpetrator(s).

Research suggests that female perpetrators are often acting in response to violence and intimidation from a violent male partner (Hester et al 2010). Given the lack of information available on AF1 as a perpetrator it would be speculative to draw conclusions about perpetrator roles in the relationship. It is apparent from the material seen that MS and AF1 were at times violent and aggressive towards each other.

9.3. Finding Three - Safeguarding Children

Whilst MS is the subject of this review it is important to recognise that both Child 1 and Child 2 were exposed to domestic abuse. Both children lived at Address 1 with MS and AF1 during part of the review period, although both had moved to other addresses before the incident leading to the death of MS.

The frequency and severity of incidents, particularly in the period between 2nd July 2011 and 9th November 2011 did not trigger multi-agency action to safeguard the children. They were never the subject of strategy meetings as the family did not meet the Children's Services thresholds for intervention. This was due to delays in referral, inaccurate information sharing, systems failures and human error.

AF1 was employed by a local school therefore the first domestic violence incident where children were recorded as present, along with the drink driving incident should have resulted in a referral by the Police to the Local Authority Designated Officer (LADO). This referral did not take place. This is a missed opportunity to add to the understanding of risk and vulnerability in the family and any potential risks that AF1 may have presented in her employment.

9.4. Finding Four - Alcohol misuse

The relationship between alcohol misuse and domestic violence is the subject of much discussion and some disagreement *(Alcohol Concern Factsheets – June 2010).* Research shows that alcohol misuse can impact on the boundaries between victim and perpetrator (Hester M et al, 2008) and this appears to have been borne out in this case.

In this case there are many examples of the negative impact played by alcohol misuse as a major factor in the often violent relationship between MS and AF1. Alcohol misuse featured in the domestic disputes attended by GMP, in the driving offences committed by AF1 and in allegations of harassment by MS's previous partner.

MS had a history of alcohol misuse and had received rehabilitative treatment in 2000. However it is apparent that MS continued to drink heavily on occasion and that this exacerbated violence and aggression between himself and AF1. MS was not assessed as requiring alcohol interventions either by his GP or by police who attended incidents where MS was intoxicated. The panel saw no evidence of AF1 suffering physical violence at the hand of MS however it would be inappropriate to rule out the possibility that domestic violence in the relationship was mutual.

Opportunities to assess AF1's alcohol misuse in the Criminal Justice system and its impact upon AF1 and MS were missed. There is no evidence of an alcohol treatment assessment being undertaken when AF1 was arrested for driving with excess alcohol on 20th November 2011, nor did HMCTS recognise that alcohol assessment and screening may have proved worthwhile in addressing AF1's alcohol misuse and associated criminal and violent behaviour.

AF1 did not present to her GP with alcohol or domestic abuse issues, despite a long history of both. It is reasonable to conclude that the GP could not have known about either of these issues unless directly consulted by the patient. AF1 did consult her GP in relation to low level depression and anxiety and anger issues however the GP did not link this with possible alcohol misuse or domestic abuse and therefore did not screen AF1 for either. The extent of both alcohol misuse and violence by AF1, which is well documented by other agencies, raises questions about the need for improved information sharing with General Practitioners.

9.5. Finding Five - Vulnerable Adults

Although MS was categorised as a vulnerable adult by the Police following the domestic violence incident that occurred on 24th August 2011 the criteria used for this classification is not shared by other agencies.

The assessment and intervention criteria within agencies differ markedly and this can lead to confusion in identifying and acting upon any perceived or known risks.

9.6. Finding Six - Criminal Justice System

Following the court hearing on 8th December 2011 the process for communicating the sentence from HMCTS to the provider (G4S) failed. Consequently the sentence was never applied.

It would be speculative to suggest that the application of the sentence would have affected the outcome of this case however had the sentence been applied AF1 would have been subject to curfew and been electronically tagged at the time of the incident on 3rd February 2012.

9.7 Good Practice and Early Implementation

All agencies involved in the review have demonstrated a willingness to implement learning as the review has progressed. This is excellent practice and indicates that victim protection and safeguarding are given a high priority within local services.

Since the commencement of the review the following changes have taken place:

- Claire's Law introduced on sharing information about DV perpetrators
- Changes to the CareFirst/LAGAN system in CSC resulting in more robust recording and information sharing
- The Stockport Homes pre-tenancy risk assessment form completed at viewing has been amended to establish if potential tenants have any medical problems in addition to mental health, drugs and alcohol
- CPS has improved its witness care arrangements
- RELATE have conducted an internal enquiry and implemented the findings
- HMCTS has conducted an internal enquiry into communicating sentencing outcomes and quality assuring responses.

9.8. Wider Learning

The DVHR process is relatively new and unfamiliar to many agencies. Aspects of the Health economy, particularly General Practice, were slow to respond to the request for the provision of IMRs and questioned the statutory nature of the DVHR requirement. Following input from the Director of Public Health and Designated Safeguarding Lead compliance with the statutory requirement was achieved.

Compliance with the review was excellent with agencies working together to contribute to a robust review process. This was particularly enhanced by the leadership and direction shown by the Community Safety Partnership and the dedicated resource offered by the Strategic Manager for Community Safety and the Domestic Abuse Coordinator.

Agencies involved in this review are to be commended for the time, energy and effort that they invested in ensuring that the review was conducted within the parameters of the Home Office guidance and for the willingness they have shown towards the early adoption of learning as the findings of the review emerged.

9.9 Family Involvement in DVHRs

Despite efforts to engage a key family member in the DVHR process the review did not have the benefit of family input. The panel recognises that this presents a gap in seeing the events through the eyes of the victim.

When the first attempts at involving the family proved unsuccessful guidance was sought from AAFDA. The panel have reflected that involving a third party advocate at an earlier

stage in the review may have resulted in greater success in engaging the family and would recommend that future reviews involve such agencies at an earlier stage in the process.

It is the panel's view that the guidance in relation to DVHRs should be strengthened in relation to family involvement and practical consideration should be given to any legal constraints that may restrict family involvement.

10. SUMMARY

It is the view of the review panel that the incident that lead to the death of MS could not have been predicted by any agency involved in this review.

The review has highlighted key issues of local and national significance when dealing with intimate partner domestic violence. The separation of the role and behaviour of perpetrator and victim has been difficult in this case, particularly as neither of the intimate partners were ever fully screened or assessed as perpetrator or victim during the 12 month period under review.

The impact of alcohol misuse by the intimate partners in this case is considered to be a significant factor in the volatility of their relationship. Whilst there is inconclusive research evidence about the relationship between domestic violence and alcohol misuse as a causative or aggravating factor, it is the view of the panel that alcohol misuse fuelled an already difficult and disharmonious relationship. Despite this neither party sought any support or interventions with their use of alcohol and only one agency put in place an alcohol intervention (an alcohol rehabilitation driving course).

Risk assessments relating to safeguarding Child 1 and Child 2 were inadequate and communication between agencies particularly the police and Children's Social Care was inconsistent. This, coupled with poor record keeping and review by Children's Social Care, meant that the children were never the subject of a safeguarding strategy meeting. Rather the case was referred on a voluntary engagement basis to MOSAIC via the Stockport Families Pathway.

The systems failure in HMCTS meant that the sentence given to AF1 following an offence for drink driving was not implemented thereby leaving AF1 without supervision. Had this sentence been implemented AF1 would have been subject to an electronic tag and curfew at the time that the incident took place.

In summary, there were several missed opportunities for assessment and intervention. It is not possible to say with certainty whether these missed opportunities would have changed the ultimate outcome of the case. The review panel's recommendations are formulated on the basis that the changes in practice recommended in this review will result in a safer system for victims of domestic violence and their families.

11. RECOMMENDATIONS

1. Greater Manchester Police should put in place quality assurance measures to ensure that domestic violence referrals involving children are timely and directed to the appropriate department as set out in PPIU standards (2012) including compliance with LADO requirements.

2. The Adult Safeguarding Board should develop a clear and commonly understood multi-agency definition and language in relation to vulnerable adults.

3. The Safer Stockport Partnership should ensure that family involvement in future Domestic Violence Homicide Reviews is prioritised.

4. The Drug and Alcohol Action Team Joint Commissioning Group should review the local alcohol strategy to ensure that all agencies have a clear and achievable service policy in relation to assessment, referral and feedback in cases of domestic abuse.

5. The local Health and Wellbeing Board should review the feasibility of establishing a referral system between GMP and General Practice where domestic abuse and alcohol misuse present significant risk to individuals and families.

6. The Stockport Domestic Abuse strategic group should review its policy and practice in relation supporting male victims of domestic abuse and make any necessary changes.

7. The Stockport Domestic Abuse strategic group should bring forward its plans to strengthen responses to intervening with perpetrators of domestic abuse. This should link to the work currently being done by Manchester DV forum to develop a shared approach to perpetrator interventions.

8. HMCTS should put in place quality assurance system for notification and implementation of sentencing outcomes.

9. The Local Criminal Justice Board should review the process of setting curfew arrangements to ensure that perpetrator curfews are not imposed at the same address as that of the victim.

12. BIBLIOGRAPHY

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AAFDA – Advocacy After Fatal Domestic Abuse

Greater Manchester Police – GM Policy on Domestic Violence

13. GLOSSARY OF TERMS, ABBREVIATIONS AND ORGANISATIONS

AADFA : Advocacy After Fatal Domestic Abuse

ASC : Adult Social Care

CAADA : Co-Ordinated Action Against Domestic Abuse

CAADA DASH RISK ASSESSMENT : Standard risk assessment tool used by multi-agency partnerships to assess the risk of domestic abuse

CAFCASS : Child and Family Court Advisory and Support Service

CPS : Crown Prosecution Service

CSC : Children's Social Care

DOMESTIC ABUSE/DOMESTIC VIOLENCE: These terms are used interchangeably throughout the report and are defined on page 5 of the overview report.

DVHR: Domestic Violence Homicide Review

G4S: Private sector provider of Criminal Justice Services contracted to provide electronic monitoring.

GMFRS: Greater Manchester Fire and Rescue Service

GMP: Greater Manchester Police

GMPT: Greater Manchester Probation Trust

HMCTS: Her Majesty's Courts Service

LAGAN: Stockport Metropolitan Borough Council's Case Management System

LADO: Local Authority Designated Officer

MARAC: Multi-agency Risk Assessment Conference

Multi-agency group responsible for risk rating, monitoring and overseeing cases of domestic abuse. Each Local Authority area has a MARAC.

MOSAIC: Stockport's Young People's Drug and Alcohol Service

NWAS: North West Ambulance Service

PPIU: Public Protection Investigation Unit (part of Greater Manchester Police)

RELATE: National charity providing relationship counselling and other services

SSP: Safer Stockport Partnership