Manchester Community Safety Partnership

Domestic Homicide Review

Executive Summary: Victim S

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1. INTRODUCTION

This Domestic Homicide Review examines agency responses and support given to the victim (S) a resident of East Manchester, prior to the point of her death on the 18th June 2013. This report also considers agency involvement with the children of the victim following her death, in particular, decisions in relation to the children's safeguarding needs.

The review will consider agencies contact and involvement with the victim (S) and the perpetrator (PS) from September 2012 until August 2013.

The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

On the 18th June 2013 Greater Manchester Police received a report that a woman had died at Address A. Police Officers attended and found the body of a woman later identified as S. The post mortem revealed that S had died of stab wounds to the chest.

A man, PS, was charged with the murder of his partner S. Given the circumstances of the death, a multi agency Screening Meeting took place on the 26th June 2013 to discuss the case and to determine if the criteria were met for a Domestic Homicide Review. A formal decision that a Domestic Homicide Review should be undertaken was made on the 31st July 2013 by the Community Safety Partnership.

This Domestic Homicide Review was held in compliance with legislation (Section 9 Domestic Violence, Crime and Victims Act -2004). The review follows Home Office Guidance for the conduct of multi-agency Domestic Homicide Reviews. All personal data, other than the name of the Overview Report author and has been fully anonymised. This is in order to comply with Home Office guidance for Domestic Homicide Reviews.

Members of the Review Panel, representing all of the key agencies, would like to express their deepest sympathy to members of the family for their loss in such tragic circumstances.

2.0 Terms of Reference

The terms of Reference of the Review were as follows:

General

1. 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.

2. 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.

3. To demonstrate how those lessons will be applied to service responses including changes to policies and procedures

4. To demonstrate how agencies are contributing to the prevention of domestic violence and how service responses have improved for all domestic violence victims, their children and other relatives, through improved intra and inter-agency working.

5. To determine if there was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with best professional practice. If evidence was not recognised what was the reason for this?

6. To determine whether any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved.

7. To determine whether the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

8. To identify whether the victim had been referred or should have been referred to a Multi-Agency Risk Assessment Conference (MARAC).
9. To establish what contact the victim had with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

Case Specific

10. Were practitioners sensitive to the needs of the victim, children and perpetrator including in the aftermath of the incident leading to the death of the victim, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfill these expectations?

11. Did the agency have single / multi-agency policies and procedures in place for dealing with concerns about domestic abuse, including DASH risk assessment and risk management and were those assessments correctly used in the case of this victim / perpetrator?

12. Were appropriate lines of enquiries made in relation to domestic abuse, given what was known about the family at the time?

13. Did the agency comply with domestic violence protocols agreed with other

agencies including any information-sharing protocols?

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

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

16. How did agencies ascertain the wishes and feelings of S with regards to her relationship with her daughter? Was the victim informed of options /choices to make informed decisions and were her views taken into account when providing services or support?

17. Is it reasonable to assume that the wishes of the victim should have been known? Were they signposted to other agencies?

18. Was anything known about the perpetrator? For example, were they being managed under MAPPA or any other services?

19. Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?

20. Were procedures and provision of services sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? How does your organisation support and engage with victims from ethnic communities and were issues relating to the Polish community addressed adequately? Was it known if the family had adequate support systems including economic support within the community?

21. Were senior managers or other agencies and professionals involved at the appropriate points?

22. How accessible were the services for the victim, perpetrator and children within the family?

23. Are there other domestic homicide cases locally that give additional insight into ways of working effectively with victims of domestic violence?

24. Are there any issues in relation to training, management, supervision or capacity of resources within your agency that affected your ability to provide services to the victim, S, and her family or to work with other agencies?

25. To what degree could the homicide have been accurately predicted and prevented?

26. Were the children recognised as victims, not just witnesses, and was there an appropriate response to their safeguarding needs? Were the risk assessments associated with their placement in Poland adequate?

2.1 Agencies contributing to the Review

Seventeen agencies were contacted to ascertain whether they had any knowledge of / involvement with S or any of her family members. Of those agencies, seven were asked to complete an Individual Management Review (IMR) due to their involvement. These were:

- Manchester Children's Services
- Central Manchester University Hospitals NHS Foundation Trust
- The Black Health Agency (BHA) – A voluntary organisation
- Early Intervention Team
- Greater Manchester Police
- Manchester Education Service
- Pennine Acute Hospitals NHS Trust

There was minimal information held by the family General Practitioner on S and the children. As such an IMR from the GP Practice regarding S and the children was not sought although access to the information was requested. This information was made available and contributed to the comprehensive chronology. The General Practitioner, following advice from their professional body, was unwilling to release information on the perpetrator, PS, without their consent. NHS England was contacted to seek their assistance in resolving this matter. At the time of completion of this Review there had been no response from NHS England.

2.2 Parallel Proceedings

At the commencement of this Domestic Homicide Review the partner of S, PS, was awaiting trial for the murder of S. The trial was concluded during the course of the review. PS pleaded guilty to the murder and was sentenced to life imprisonment. There were no other parallel proceedings.

2.3 Hindsight

The Overview Report has sought to reduce the influence of hindsight bias by considering how decisions were made and actions taken at the time.

2.4 Approval

The Overview Report was considered by the Community Safety Partnership on the 21st January 2014 and the findings and recommendations agreed. The Safeguarding Children Board considered the Report on the 13th March 2014 and the Adults Safeguarding Board considered the Report on the 17th March 2014. The findings and recommendations were agreed by both Boards.

2.5 Involvement of the Family

The Chair of the Domestic Homicide Review Panel wrote to the victim's family (through the children's maternal grandmother and DS1) outlining the purpose and process of the Review and seeking any contribution from maternal grandmother. A commitment was made to share information from the Review with maternal grandmother, DS1 and where appropriate other family members prior to publication of the Review.

3. THE FACTS

3.1 Family Structure

The Family structure is set out below.

NAME	AGE	RELATIONSHIP TO SUBJECT	ADDRESS
S	32	Subject	Address A
PS	40	Partner of Subject and father of DS3 and SS	Address A
DS1	15	Daughter of Subject	Address A
DS2	14	Daughter of Subject	Living with Maternal grandmother in Poland
SS	6	Son of Subject and PS	Address A
DS3	4	Daughter of Subject and PS	Address A
DD1	1	Daughter of DS1 and Granddaughter of Subject	Address A

Other significant family members:
MS - maternal grandmother (living in Poland)
PD1 – father of DD1 (living in Poland)

3.2 The Homicide

At the time of the murder, the victim S lived in privately rented accommodation in East Manchester with her partner, PS, and three of her children, DS1, SS and DS3. Also living in the family home was the baby daughter of DS1 (DD1). The family had been living at this address since September 2012. A further child DS2, was living with the maternal grandmother in Poland.

The victim, S, met the perpetrator around 2005. S had been sent to prison, in Poland, for a short period and PS was also an inmate at the same prison. During this period maternal grandmother had custody of DS1 and DS2.

The first child of S and PS (SS) was born in 2007 and the couple married at the beginning of 2008. Their second child (DS3) was born in 2009.

During the summer of 2011, S, PS and their two children (DS3 and SS) moved to live in London. After a few months in the UK they moved to Manchester. The two oldest children, DS1 and DS2 remained in the care of their maternal grandmother in Poland. During 2012, DS1 became pregnant. At that time she was 14 years of age. Her mother, S, returned to Poland and brought DS1 back to Manchester with her. DS2 remained in the care of her maternal grand mother.

As the perpetrator, PS, pleaded guilty of murder at trial, witness accounts in relation to the murder was not materially contested. As such there is a reasonable presumption that the account is accurate.

Around 18.00 hours on the 17th June 2013, the family was all present at the home address. The parents (PS and S) started to argue because S told PS that she intended to leave him. PS was reported, in a witness statement, as telling S that he would kill her and the children and then himself if she left him. During the evening PS left the house on two occasions, returning with bottles of beer, which he proceeded to drink with S.

The argument appeared to subside, and by 22.00 hours, family members had all gone to bed. DS1 was awoken around 01.00 hours by the sound of her mother's voice shouting that she (DS1) should run away as PS had done something to her (S's) hand.

DS1 bolted her bedroom door, but PS forced his way in and pinned DS1 down by her throat. She was released after a while and managed to move to the upstairs landing where she saw her mother, S, lying partially in the bathroom and the hallway. DS1 was physically prevented by PS, from going to her mother's aid.

All of the children were placed in a bedroom until the morning. PS was heard cleaning the bathroom. In the morning PS asked DS1 what she intended to do. Fearing for her own safety and the safety of the other children she made an undertaking to PS not to tell anyone what had happened that night.

DS1 did convince PS that she needed to go to a nearby supermarket to buy milk and provisions for her baby. PS left the house with all of the children and they visited another store and the GP surgery but DS1 did not tell anyone about the incident. When the family entered the supermarket DS1 managed to engineer a situation where PS stayed outside the store with SS and DS3. DS1 located a member of staff, who she knew to be a Polish speaker, and disclosed what had happened to her mother.

The Police were contacted at 10.17 hours by the store employee and attended the store, commencing an urgent search for PS and his two children who had not remained outside. Other Police Officers attended the home address and forced their way into the premises. The lifeless body of S was found in the bathroom at 10.25 hours. At 10.57 the Police located PS together with SS and DS3 in the street, approximately three miles away from the home address. PS was arrested on suspicion of murder and the two children taken into Police protection. DS1 and DD1 had already been taken to the Police station in the interests of their safety and protection. All of the children were reunited at the Police Station.

A post mortem examination was undertaken on the 18th June 2013, by a Home Office forensic pathologist. The examination concluded that S died as a direct consequence of a single stab wound that had penetrated the soft tissues of the right anterior chest wall and divided the right subclavian artery and subclavian vein. There was also partial division of the nerves supplying the right arm.

PS was later charged with the murder of S and false imprisonment of the children. He subsequently entered a guilty plea to the murder but not guilty in respect to the false

imprisonment charge. PS was found guilty of murder on the 11th October 2013, and sentenced to life imprisonment. The false imprisonment charge was allowed to "lie on file". The Judge ordered that PS serve a minimum tariff of eighteen years and four months before being considered for parole.

4. Agency Involvement

Between 17th October 2012 and 17th June 2013, a number of agencies had involvement with S and/or her family. Initial contact was with a midwife specialising in teenage pregnancy who contacted Children's Services as the family had arrived from Poland on 18th September 2012, with their daughter DS1 who was 14 years old and 37 weeks pregnant.

Communication took place between the school and the midwife to consider the most suitable support for DS1 in terms of her education. There was also communication between the allocated Midwife and the health safeguarding team, with regards to the baby's father who was 17 years of age and was living in Poland.

There was a birth notification from Pennine Acute Hospitals on the 27th October 2012. Satisfactory health screening allowed discharge from hospital for mother and baby on the 30th October 2012.

Following the birth of the baby on 27th October 2012, there was involvement / contact with a number of different agencies. The family was referred to the Black Health Agency, on the 29th October 2012, by the New Arrivals Team. Children's Services First Response Team was contacted by the Safeguarding Midwife from North Manchester General hospital. Apart from the age of the mother, DS1, it was clarified that there were no other concerns.

During November 2012, there were contacts with several agencies including health, education and the Black Health Agency in order to provide advice, get the children (including DS1) into school and to help and support the family to integrate into the local community.

The health visitor also undertook a primary birth visit on the 27th November 2012 which included health promotion advice, feeding, safe sleeping and handling and clinic attendance. Within this visit, domestic violence was discussed and assessed. DS1 were seen alone when issues about domestic violence were assessed. There was no indication of low mood, smoking, taking drugs or domestic violence. DS1 indicated that she was well supported within the family.

There were further contacts with the Health Visiting Service in December 2012 and January 2013 including a number of home visits. There was also some contact with the Black Health Agency who were supporting the family with accessing benefits, liaison with schools and rent arrears. A home visit from the Black Health Agency on 19th December noted that the family appeared to be in financial difficulty and S had requested help with clothes for the baby.

On 22nd January 2013, DS1 started school, initially part-time.

On 15th February 2013, there was an incident where DS1 stole a teacher's mobile

phone. The school stated that this incident was reported to the police. During this incident, DS1 informed the interpreter "her stepfather treats her differently to her siblings and she is struggling to buy things for herself and her baby". This was the first indication that there were some tensions within the family.

On 22nd February 2013, the Black Health Agency referred S to Children's Services as she had no money to buy milk and food. She was also referred to the local church mission for support.

On 27th February 2013 DS1 sent a message to school via another pupil. Part of the message said that she (DS1) is "not happy at home and step dad and mum were having arguments". DS1 was spoken to about it being inappropriate to use other pupils to relay messages. The wider issue however of DS1 being unhappy at home does not appear to have been addressed. This is examined in more detail in the Analysis section of the full report.

By March 2013, it was evident that there were significant tensions between S and DS1. A multi-agency meeting took place because S had disclosed that DS1 had said she was going to kill herself and the baby. S was also critical of DS1's care of the baby. The meeting resulted in a referral to Children's Services. A Social Worker was allocated the case on 13th March and an initial assessment commenced. A number of home visits / contacts took place and there were significant concerns that DS1 was on the 'verge of care' due to the situation becoming untenable.
There was little improvement and in April due to concerns that DS1 might be depressed, she was referred to Child and Adolescent Mental Health Services (CAMHS).

In April 2013, there were a couple of arguments between S and DS1 that resulted in Greater Manchester Police becoming involved.

During a home visit on 8th May 2013, early intervention workers witnessed a major argument between S and DS1. By the end of the visit, things had calmed down.

Despite ongoing contact with a number of agencies, there was no knowledge of domestic abuse taking place between S and PS. Agency involvement was initially around providing support to DS1 as a new teenage mum and helping S and her family settle into the local community and access appropriate services. As time progressed, there was increasing evidence of tension between S and DS1. As a result, involvement from agencies shifted to support S with managing DS1's behaviour, preventing DS1 from entering the care system, and supporting DS1 with caring for her daughter.

5. Conclusions / Lessons Learnt

Although this is a Domestic Homicide Review, much of the focus of the review is on the welfare of the children and in particular the relationships between S and DS1 and the parenting capacity of DS1. There was no indication that there were difficulties in the relationship between S and PS except for the incident where DS1 sent a message to school via another pupil stating that she was, "not happy at home and step dad and mum were having arguments". The panel felt that this was a missed opportunity to explore what was happening at home with DS1 and ask her about domestic violence.

There no suggestion that there had been any previous concern about domestic violence until information was obtained from the children's maternal grandmother after the murder had taken place.

This raises some issues about recognition of domestic violence and whether it should be screened as a standard by all agencies as a core element of the assessment process. Two agencies, BHA and Community Health did raise the issue of potential domestic violence with DS1 and S respectively (as a screening measure). Although both denied there was any domestic violence in this case, the screening at least may serve to raise awareness with potential or actual victims about agency support and willingness to intervene.

This is particularly important in the case of new arrivals to the UK, who are likely to be unaware of the support services available to victims of domestic violence and be uncertain about how to seek help.

Understanding the dynamics and how signs of domestic abuse may be manifested is a complex task requiring considerable sensitivity and skills. Detecting often, subtle indicators also requires professional curiosity in wanting to make sense of why events or incidents may be happening. There were, for example, some quite significant indications of aggressive behaviour within the family, including threatening with a hammer. There were also some elements of the family constellation that were never explored properly. There was no real explanation, for example, why DS2 and for a time DS1 were being cared for by their maternal grandmother

Some of this should have been explored through the Core Assessment process and a key learning point from this Review is that assessments need to be much more thorough, systematic and analytical if they are going to be used as an effective tool in planning interventions.

There were weaknesses in all of the assessments undertaken by Children's Services. In particular the Core Assessment completed in May 2013 did not include information about the family history, or family dynamics any information about PS or any information about the relationship between PS and S. This meant that assumptions about the nature of family problems were made without the benefit of a proper analysis.

There were some potential problem areas in undertaking assessments in this case. An interpreter was required in order to facilitate communication and this may have had a constraining impact on the development of a relationship between family members and the assessing social worker. There may also have been some cultural issues that limited the subject matter that family members were willing to discuss. Whilst these language and cultural issues may have been present, there are also clear indications that the assessment focused largely upon presenting issues, namely, the parenting capacity of DS1 and the relationship between DS1 and S.

The evidence overall from this, and other Reviews on a national basis, is that there are significant practitioner skills deficits in undertaking good quality assessments. With new guidance and a more flexible approach to assessments recently introduced (Government Guidance - Working Together 2013), there is an ideal opportunity for agencies to develop systems to promote good quality assessments.

There are a number of families coming to the UK where concerns will arise because of possible or actual family violence. Trevena (2009) and the Home Office (2011), for example, estimate that over 700,000 Polish economic migrants have come to Britain since 2004, when Poland made accession to the European Union. There are significant challenges in assessing the level of risk within these families when there are concerns about family violence. Some of the key factors are:

- The dependency on interpreters who may be unfamiliar with domestic violence or have a different cultural perspective of family violence
- The problems associated with obtaining information about the family history or previous incidents of family violence. This was particularly pertinent in this case. This is a national problem that should be brought to the attention of the relevant Government Departments.

Given these significant challenges, the Adults Safeguarding Board and the Children's Safeguarding Board should review practice guidance on working with families and individuals who have recently arrived in the UK. This review should consider:

- The use and training of interpreters
- Cross country communication in accessing and sharing information
- Dissemination of information to new arrivals in the UK about services related to domestic and family violence
- Core skills necessary in working with families from diverse cultures.

Overall, there was only limited agency involvement whilst the family was living in Manchester. There was no indication from any agency involvement that there were serious tensions between S and PS or that there was a history of domestic violence. Although this tragic event was not predictable or preventable there are some significant lessons from this Review that can help to improve work with children and their families.

7. Recommendations

7.1 Overview Report Recommendations

1. The Local Safeguarding Children's Board and Adults Safeguarding Board should ensure that all agencies have in place effective screening mechanisms for domestic violence. This includes training for staff to ensure they are aware of the possible signs of abuse, and understand the importance of enquiring in a sensitive and safe way; and are familiar with the barriers that may prevent victims from disclosing the abuse.

2. The Local Safeguarding Children Board should audit and review standards, including the skills necessary for undertaking assessments of children in need and their families. Front line practitioners need to be able to recognise the subtle signs of domestic abuse and other potential safeguarding issues and feel confident and able to exercise professional curiosity in the course of their duties.

3. The Local Safeguarding Children Board should develop and issue good practice guidance on the management of cases when children who are looked after might move from the UK to another country.

4. The Local Safeguarding Children Board and the Adults Safeguarding Board should review guidance on work with "newly arrived" families and individuals. This review should consider the elements identified in Section 6.13 of this Report.

5. The Community Safety Partnership in collaboration with the Safeguarding Children Board and the Adults Safeguarding Board should review guidance on domestic violence within families where the alleged perpetrator is under 16 years of age.

7.2 Individual Management Review Recommendations

It should be noted that there are relatively few recommendations from the Individual Management Reviews. This reflects the limited involvement of agencies with the family and the fact that the only significant issues to emerge were the relationship between S and her daughter, DS1 and also the parenting capacity of DS1.

Manchester City Council Early Intervention Team

1. Review the recording policy to include a synopsis/overview at the start of the recording.
2. If a case is jointly worked, the agency must be clear around the role of the supporting worker.
3. Supervision with manager/supervisor should be reflective and ask the "why" question.
4. Quality assurance of Manchester Common Assessment Framework to ensure a whole family approach is taken and the assessment is signed off by family members.
5. Implementation of a risk identification screening tool (including domestic violence).

Manchester City Council – Children's Services

1. There is no clear guidance to support practitioners who are involved in moving children from the UK to relatives abroad

BHA for Equality and Health in Social Care

1. Amend information sharing consent form.
2. Amend initial assessment to include domestic abuse specifically to the assessment.
3. Ensure quality case notes.
4. Arrange Domestic abuse training course.
5. Update safeguarding policy.
6. Share Revised Policy

Central Manchester University Hospitals NHS Foundation Trust

1. Single agency domestic abuse training for key professionals to become mandatory across the organisation.