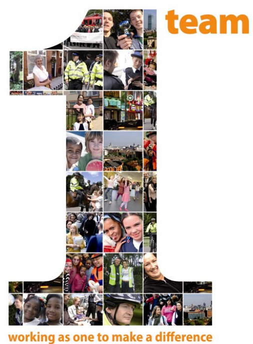

Manchester Community Safety Partnership

Domestic Homicide Review

Overview Report: Victim S

Author: Dennis Charlton

Date: January 2014

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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 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 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.

1.1 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?

1.2 Independence of the Review

The author of the Domestic Homicide Review Overview Report was Dennis Charlton. He is an Independent Consultant in Child Protection with substantial experience in safeguarding children. Mr. Charlton is a former Assistant Director of a local authority Children's Service. He has undertaken a number of Serious Case Reviews both as an Overview Report author and also Chair of SCR Panels. He has also been the author of a number of Critical Case Reviews and an Adults Serious Case Review. He is accredited to undertake SCR's using the Social Care Institute of Excellence (SCIE) systems approach. He holds a professional qualification in Psychiatric Social Work.

The Overview author also acted as Chair of the Domestic Homicide Review Panel.

All of the Individual Management Reviews were undertaken by experienced managers, who had no direct management responsibility for the case.

1.3 Membership of The Domestic Homicide Review Panel

	Independent Chair and Overview Report author
	Lead Nurse (Safeguarding). Central Manchester Foundation Trust
	Domestic Abuse Reduction Coordinator. Manchester City Council
	Safeguarding Manager, Education. Manchester City Council
	Head of Adults Safeguarding and Governance Manchester City Council
	Early Intervention Team, Team Manager
	Chief Executive Officer, Women's Aid
	Designated Nurse Adult Safeguarding NHS
	Designated Nurse Adult Safeguarding NHS
	Detective Inspector, Greater Manchester Police
	Team Manager, Children's Services
	Team Manager, Routes Project
	Head of Safeguarding, Pennine Acute NHS Trust

1.4 Agencies contributing to the Review

The following agencies were contacted in order to identify if they had any involvement with the family.

- NHS Citywide Safeguarding Team
- Manchester North, Central, South Clinical Commissioning Groups
- Greater Manchester Police
- Manchester City Council Community Alcohol Team
- Sexual Assault Referral Centre
- Manchester Women's Aid
- Greater Manchester Probation Trust
- Manchester Mental Health and Social Care Trust
- Manchester Rape Crisis Team
- Manchester Action on Street Health
- Routes Project
- Manchester City Council Adults Safeguarding Service
- Manchester City Council Children's Safeguarding Services
- Manchester City Council Drugs and Alcohol Strategy Team
- Manchester City Council Property Information/ Benefits Enquiries
- Victim Support
- Manchester City Council Education Services and schools that the children attended

Of these agencies, seven were asked to complete an Individual Management Review.

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.

1.5 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.

1.6 Methodology

At an early stage in the review process agencies that had been involved with the family were identified and asked to produce Individual Management Reviews, based on the terms of reference. In producing Individual Management Reviews, staff working with the family were interviewed as appropriate, as detailed in the

Individual Management Reviews. All confidential information regarding the family was made available for the purposes of this review (in the public interest) and this information fully contributed to the Review. Each individual agency was also asked to produce a chronology. This information was used to develop a comprehensive chronology.
The Individual Management Review Reports were examined and analysed by the Overview Report author.
Authors of the Individual Management Reviews were invited to meet with the Domestic Homicide Review Panel in order to clarify any issues relating to the Individual Management Reviews. This also served as an additional quality control mechanism as well as Senior Managers from each organisation signing off their respective agency Individual Management Reviews.

Individual Management Reviews were requested and compiled by the following seven agencies:-

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

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

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.

1.7 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.

2. THE FACTS

2.1 Family Structure and Chronology

The Family structure is set out in the table 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)

2.2 Family Background

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 grandmother.

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.

2.3 The Homicide

Around 6pm on the 17th June 2013, the family was all present at the home address. 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 10pm, family members had all gone to bed. DS1 was awoken around 1am 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 10.17am 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 10.25am. At 10.57am 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.

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 convicted 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.

3. AGENCY INVOLVEMENT

3.1 Agency Involvement based on Comprehensive Chronology

This section outlines the involvement of agencies that have contributed to the review process with the family and the interactions of agencies with one another.

The first point of contact between agencies and the family was on the 17th October 2012, when the midwife (Midwife1), specialising in teenage pregnancy, contacted Manchester Children's Services (First Response Team) as the family had arrived from Poland on the 18th September 2012, with their daughter DS1, who was fourteen years old and thirty seven weeks pregnant. Children's Services were advised that an interpreter would be necessary in communicating with the family. This contact was not progressed to a referral and as such was not sent on to a social work team.

There was liaison between school 3 (a specialist provider of education for pregnant school girls and teenage mothers who require alternative school provision) and the "New Arrivals Team" and also between school 3 and Midwife 1 to consider the most suitable support for DS1 in terms of her education. This led to arrangements being made for a joint home visit by the Midwife and the "designated person' from school 3.

There was communication between the allocated Midwife and the health safeguarding team, confirming that DS1 arrived from Poland with her family on the 16th September 2012 and was approximately 37 weeks pregnant. The information indicated that the baby's father was 17 years of age and was living in Poland.
The notes conclude that further investigation is required under Section 47 of the Children Act. There was no indication of a referral to Children's Services at this time.

There was a birth notification from North Manchester General Hospital (Pennine Acute Trust) on the 27th October 2012. This indicated that DS1 had given birth at 38 weeks gestation. The birth weight was 3.53 kg. Satisfactory health screening allowed discharge from hospital for mother and baby on the 30th October 2012. DS1 was noted to be breastfeeding and the baby was well. A follow up neonatal blood screening, on the 1st November 2012 was normal.

There were a number of parallel activities and communications between agencies around the time of the birth. The family was referred to the Black Health Agency, on the 29th October 2012, by the New Arrivals Team. The Black Health Agency is

a voluntary organisation that works with minority groups. 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.

The teenage pregnancy midwife contacted the health visitor on the 7th November 2012 to advise that the family would require a Polish interpreter. There were no concerns reported in relation to DS1's care of the baby although S, the baby's maternal grandmother, was undertaking a lot of the care. There were some issues reported in relation to breastfeeding although the baby was putting on weight.
There was some information about the family background. The partner of S (PS) had been living in the UK for 12 months, with S travelling back and forth between Poland and the UK. DS1 had remained in Poland in the care of her maternal grandmother. The teenage pregnancy midwife also reported that Manchester Children's Services had been contacted but had no concerns.

There were a series of health related referrals and appropriate information shared between health professionals between the 12th and 14th November 2012. The health visitor for example was informed that DS1 was a 14 year-old mother from Poland.
DS1 was also seen for contraceptive advice on two occasions (14/11/12 and 19/11/12). DS1 was given advice regarding the law in the UK relating to sex under 16 years of age (the age of consent in Poland is 15 years of age). After discussion with managers it was agreed that no further action would be taken in relation to this issue. This is explored in more detail in the Analysis section.

There were also a number of contacts with the family through the Education Service during this period. On the 24th October 2012 the Head Teacher of school 3 sent notification of DS1 to the Education Admissions Team advising that DS1 was currently a child missing education. The school had already sought and obtained information from the International New Arrivals Team about available translation services.

A joint visit to the family home took place on the 20th November 2012 with the Midwife and Designated Person for School 3. It was agreed that DS1 would aim to commence School 3 after a period of maternity leave of 18 weeks. There was also liaison between School 3 and the International New Arrivals Team during November 2012 confirming that a worker had been allocated. This was particularly relevant because of the communication problems and is discussed in more detail in the Analysis section.

An application had been received by the Education Admissions Team in mid November 2012 in relation to SS and DS3. This application was processed under normal admissions protocols and an offer of a place was sent, at an early stage, to S. As the Admissions team did not initially receive a reply a further letter was sent to S in relation to the offer. By mid December S had made contact to accept the school place and it was agreed that SS would commence his placement at school 1 on the 8th January 2012. This start commenced successfully with both parents supporting the admission to school. The school Designated Person

reported that School 1 had no concerns about SS or the family.

The family was visited by a Polish speaking BHA practitioner on the 27th November 2012. An initial assessment was undertaken, establishing the family structure, arrival into the UK and needs. The family view at this point was they would like a larger house, needed support to apply for various benefits, wanted to meet other Polish people in the community and find a local church. They also wanted information on leisure facilities. An appropriate action plan was established, based upon the identified needs of the family.

The health visitor also undertook a primary birth visit on the 27th November 2012. It was established that the home was a three bedroom privately rented property with DS1 sharing a bedroom with DD1 who had a cot in the room. This primary birth visit included health promotion advice, feeding, safe sleeping and handling and clinic attendance. Within this visit, domestic violence was discussed and assessed. DS1 was seen alone when issues about domestic violence were discussed. There was no indication of low mood, smoking, taking drugs or domestic violence. DS1 indicated that she was well supported within the family DS1 had not received any contact from the father of a baby, a 17-year old living in Poland.

DS1 and her baby attended the baby clinic on the 7th December 2012. A Polish interpreter was present in order to support DS1 It was noted that there was a satisfactory weight gain. The baby was feeding well but reported to be vomiting large amounts after feeds. The baby was seen by the GP regarding the vomiting on the same day. Overall the baby was reported as “well looking”.

There was a further visit by the health visitor accompanied by a student health visitor on the 18th December 2012. It is standard and good practice for a student health visitor in training to be supported by a qualified health visitor, who acts as mentor and offers professional guidance. An interpreter was present. DS1 was seen with her baby. Also present during the visit was her stepfather (PS) and her younger sibling DS3. The home was noted to be “tidy and warm”. The bedroom was visited to assess sleeping conditions.
It was ascertained that Connexions had been contacted to provide assistance to DS1 regarding her benefits and additional support.
It was also noted that DS3 had been experiencing muscle spasms that had been occurring for the last two-three months. This was referred to the General Practitioner. PS expressed concern regarding DS3’s dry skin – a prescription was given for topical and bath treatments with instructions on use. PS also reported that a referral had been made to the community dentist due to concerns that DS3 has protruding front teeth because of dummy use.
It was identified that DS1 appeared to need more support with the care of her baby and that DS1 was holding the baby appropriately and the baby was clean and well dressed.

Overall DS1 was recorded as appearing happy and did not express concerns about low mood. She appeared clean and well dressed but also appeared underweight and pale. It was noted that bonding appeared better than the previous visit.

DS1 had been in contact with the father of her baby and there was a possibility that he might visit her in the future.

There were a number of interventions around mid December by the BHA practitioner. There was a home visit on the 17th December 2012 in which various benefits were discussed and also liaison with primary school (School 1) in relation to education for SS. There was a further home visit by the BHA practitioner on the 19th December 2012 with the focus on applying for various benefits, liaison over school admissions and managing rent arrears. It was noted that the family appeared to be in financial difficulty and that S was requesting help with clothes for the baby. Subsequently there was liaison with the owner of the property in relation to the rent arrears.

There was a follow up home visit by the health visitor on the 19th December 2012. All of the family members were present. It was noted that the baby (DD1) appeared content, clean and nicely dressed and using a dummy. It was not possible for DD1 to have her BCG vaccination that day because she was poorly. The family was noted to be very friendly and welcoming although their use of English was limited. It did not appear that an interpreter was present during this particular visit.

There were a series of interventions in January 2013 in relation to the children starting school. There was a home visit by the Designated Person at School 3 to discuss DS1 starting school. This was followed up with a visit by DS1 to School 3 and a starting date of 22nd January 2013 was determined. An interpreter was identified to assist DS1 at school.
SS was admitted to School 1 on the 8th January 2013 and transferred to School 2 on the 11th February 2013.
In all of the interactions with family members during this school admission phase, there were no indications of any wider concerns about relationships within the family.

There was also ongoing contact with the family from the health visitor during January 2013. There was a home visit on the 21st January 2013 by the health visitor. S and DS3 were also present. DS1 reported that her boyfriend (father of the baby) had recently visited her and wanted to continue the relationship with her and the baby.
DS1 reported that she wanted to return to Poland but would have to finish her education first.
There were no concerns expressed about the baby who now slept on her back in a Moses basket
S asked if DS1 could be left alone with the children. It was agreed that DS1 could be left for a short while with her baby but should not also have the responsibility of caring for her siblings.
This was the first occasion when there was some acknowledgement of friction between mother and daughter.

The baby was observed to be very settled, clean and nicely dressed. The baby was reported as smiling, feeding well and waking for a feed at night.
There were no obvious social concerns noted. The home was clean, warm and

comfortable although PS was not currently working and the family was claiming benefits. There was some discussion about DS3 "shaking" which S said was related to attention seeking behaviour. DS3 also had dry skin and appropriate advice regarding use of prescribed emollients was given.

There was liaison between the School 1 and the school health nurse in relation to SS who had recently started school. There were no attendance issues and he was reported to be "a lovely boy".

In addition to health and education support, the family was also given practical support with various benefit claims. On the 11th January 2013 the BHA Practitioner delivered housing benefit and council tax benefit forms to the family. Application had also been made for free school meals.

On the 14th January 2013 DS1 visited her proposed school (School 3). This was viewed as a successful visit and she started this school on the 22nd January 2013 initially on a part time basis. An interpreter was allocated to support DS1 within the school setting. There were no initial reported concerns at either school in relation to DS1 or SS.

There was an incident on the 15th February 2013 when DS1 stole a teacher's mobile phone. DS1 had taken the mobile to a local shop and paid for it to be unlocked. The mobile was retrieved and School 3 reported the theft to the Police. The school reported that a Police Officer came into school to speak with DS1 about the possible consequences of her actions. It was not possible to corroborate, from Police records, that this visit to school by a Police Officer took place.
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. This incident seems to be referred to in the BHA IMR as being on the 14th February 2013. This is unlikely as both the Education and Health records show the incident to have been on the 15th Feb.

On the 18th February 2013 the baby (DD1) was brought to hospital at the request of the GP. She was seen with her mother and diagnosed as having a chest infection. An interpreter was present throughout the examination and DD1 was discharged home later that day with appropriate medication inhaler and saline drops. A referral was made to the Children's Community Nursing Team. This was followed up by a home visit from the Children's Community Nursing Team on the 20th February 2013. The baby (DD1) was seen. DS1 was also present as was S. It was recorded in the case record that there were no concerns with DD1 who appeared bright and alert. A full assessment was completed. There does not appear to have been an interpreter present during this visit.

There were indications of some financial hardship within the family during mid February 2013 with some rent arrears (housing benefit had been delayed). This seems to have come to a head on 22nd February when BHA referred the family to Children's Social Care. At that point, S stated that she had no money for food and milk for the children. S was also unable to access a crisis loan. There was also a

referral from BHA to the local Church Mission for support for the family.
On the 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.

A meeting (referred to as a Multi Agency Common Assessment Framework Meeting in the BHA IMR) took place on the 12th March 2003. Present at the meeting were BHA, School 3 representative and the Health Visitor. An interpreter was present at the meeting. It was agreed to refer DS1 to Children's Social Care because S had disclosed DS1 had threatened to kill herself and the baby. There were also disagreements between S and DS1.

It was clear from the meeting that there were considerable tensions between S and her daughter DS1. S was critical of DS1's care of her baby. It also emerged that DS1 had in the past chosen to live with her maternal grandmother. Overall there was a view that the family dynamics and DS1's behaviour may be a risk to the baby. The referral to Children's Services was entirely appropriate in these circumstances. This is explored in more detail in the Analysis section.

The case was allocated to a social worker (SW1) on the 13th March 2013 and an Initial Assessment commenced. This is the first stage of the assessment process under statutory guidance for the Assessment of Children and their Families. There were particular concerns being expressed at this stage that DS1 would need support in managing her baby. There were also concerns about tensions between DS1 and her mother S. The initial home visit on the 19th March 2013 was not productive because the social worker was accompanied by a male interpreter and DS1 would not speak in front of a man.

This was followed up with a home visit on the 20th March 2013. DS1 alleged that her mother had hit her and taken her mobile phone. A decision was made not to progress to a Strategy Meeting. This is a meeting of Police and Children's Social Care, along with other appropriate professionals to determine if further enquiries need to be made because a child is suffering or likely to suffer significant harm (Section 47 Children Act 1989). In this case there was felt to be no evidence of any injury. This is explored in more depth in the Analysis section.

On 21st March 2013, S requested assistance from Children's Services in managing DS1. She said that DS1 had threatened her with a hammer during an argument. There is no record of any response to this alleged incident from Children's Services. It is recorded that the Initial Assessment commenced by the allocated social worker on the 19th March 2013 was completed on the 22nd March 2013. Records show that the Initial Assessment documentation was left blank except for the Analysis section. This is unsatisfactory and is addressed in the Analysis section.

There were a considerable number of concerns being generated between agencies, at this stage, about DS1's parenting capacity. The Early Intervention

Team recorded on the 20th March 2013 that S had said that DS1 had threatened to harm herself and the baby. BHA was contacted by S saying that DS1 was terrorising the family. There is a documented record from Community Health (21st March 2013) that states DS1 had threatened S with a knife. This documented incident may be confused with the hammer incident (recorded on the 21st March 2013 by Children's Services). There were clearly a number of tensions within the family that were bordering on, if not actual domestic violence incidents. These tensions related to the relationship between S and DS1. There was no suggestion of any conflict between S and PS.

There was also a referral from the allocated social worker to the Early Intervention Team. This is a local authority managed service providing support to pregnant women or families who have children under five years of age. The focus of work requested was:

- Support for basic care of DD1 as DS1 was struggling to consistently care for DD1
- Support with managing DS1's behaviour
- Support for S with claiming her child benefit and tax credit as she had not received them since applying in September 2012

The case was allocated to a student social worker, new to the service, and a Family Support Worker. An Initial home visit took place on the 11th April 2013

By the 21st March there was a discussion between the allocated social worker and the Team Manager of Families First. This consultation considered requesting intensive support from Families First as DS1 appeared to on the "verge of care". This suggested that there was a growing acknowledgement that the situation in the family home was becoming too unstable to be tenable. Families First is a Manchester City Council specialist children's social care service, providing intensive short term support for families where there are problems, including behavioural problems, there are indications from the records that Families First were unable to offer an immediate service but could offer intervention in the near future. Although the records are not clear, it appears that a formal referral to Families First was not made. Presumably this was because the situation seemed to be calmer during the later stages of March 2013.

The process of completion of the Initial Assessment on the 22nd March did seem to calm some of the tensions between S and DS1 with DS1 acknowledging that her mother had not hit her but had pushed her away when she (DS1) had been threatening. The analysis seemed to be focused on the relationship between mother and daughter. A core assessment was recommended. This is a further stage of more in depth assessment looking at domains including the family and environmental factors, the parenting capacity and the child's developmental needs.

Progress in the relationship between S and DS1 continued through the early part of April 2013 with BHA reporting that DS1's behaviour had improved since intervention from Children's Social Care. A referral was made to the Early Intervention Team by Children's Services to offer family support.

There were some concerns expressed however stemming from a health visitor visit to the family home on the 11th April 2013. S expressed concerns that DS1 may be depressed. A referral was made to Child and Adolescent Mental Health Services following this observation. There was also concern expressed by S that DS1 can have mood changes and will shout and swear. Concern was expressed that DS1 was planning to go to Poland with her baby for a holiday but wanted to stay there. There was discussion between the allocated social worker and health visitor following these expressed concerns.

There was a meeting at School 3 on the 22nd April 2013 with the health visitor, allocated social worker and DS1. Generally DS1 was happy about the arrangements at the nursery for the care of DD1. She did express some unhappiness about the health visitor talking more to her mother about the care of DD1 than herself.
DS1 said that there were very few arguments at present between herself and her mother. There were some suggestions that S was not happy with the Early Intervention Team having contact with DS1 at the family home although DS1 was adamant that her preferred choice of location contact was at the family home. There were also indications that DS1 did not wish to commence counseling with CAMHS.

On the 23rd April 2013 there was contact with the family from the Early Intervention Team. Work was undertaken with DS1 around establishing a sleep pattern and routine for DD1. DS1 informed the student social worker and the family support worker that S did not want the Early Intervention Team to visit the family home. DS1 was clear that she wished the contact to continue in the family home. There does not appear to have been any further exploration of this issue with the wider family and this is addressed in the Analysis section. DS1 also informed staff that there had been a Child in Need meeting held the previous day. The issue of communication between professionals is addressed in the Analysis section.

On the 27th and 28th April 2013 there was contact with the Police when DS1 contacted the Police from a telephone kiosk, via a Polish telephone interpreter, to complain that her mother was making threats to her. Police Officers attended the family home; S, PS and all of the children were present. As none of the family spoke English the discussions were made through Language Line Solutions via a remote Polish interpreter over the loudspeaker of the Police Officer’s mobile phone.

It was established that S and DS1 had been involved in an argument resulting in S confiscating her daughter’s mobile telephone. The dispute seemed to have been resolved and as no allegations of a criminal nature were reported no further action was taken in relation to any criminal offence. Although the incident did not meet the criteria of a domestic violence incident, the attending Police Officer referred the details to the divisional Public Protection Investigation Unit because of the apparent vulnerability of DS1 and DD1.

The following day, DS1 contacted the Police, again through Languageline, from a

telephone kiosk, reporting that PS had thrown her mobile telephone in the bin and was at the house shouting and swearing. DS1 was advised to remain at the telephone kiosk where Police Officers would meet with her. Police Officers arrived eleven minutes after the initial telephone call but DS1 was no longer present. A visit to the family home did not locate DS1 or DD1 and as there was no indication of any ongoing disturbance the incident was closed as a continuation of the events of the previous evening and requiring no further Police action. Whilst there was no indication of ongoing disturbances it may have been prudent to ensure that DS1 was directly engaged before deciding no further action was required.

On the 30th April 2013, DD1 was brought to hospital at the request of the GP. She was seen with her mother and diagnosed as having a chest infection. An interpreter (Polish speaking nurse) was present throughout the examination. DD1 was discharged home with appropriate medication and advice for DS1.

On the 30th April 2013 Children's Services records show that DS1 reported that she had argued with her mother. DS1 would not say what the argument was about but claimed that her mother was making up allegations about her (DS1's) care of DD1. The allocated social worker contacted S by telephone and S made a number of assertions about DS1's poor standards of care for DD1. She also said that DS1 wanted to leave home and had asked for the child benefit so she could afford to visit Poland.

The Core Assessment undertaken by Children's Services was completed on the 1st May 2013. It identified a number of tensions between DS1 and S that increased risk for DD1. The conclusion at this stage was that the Early Intervention Team should continue with their intensive involvement with DS1 and the family. Some concerns were also noted by the nursery, in early May 2013, about DS1 not following advice about care of DD1. Issues regarding the thoroughness of the Core Assessment are commented on in more detail in the Analysis section.

On the 7th May 2013 the nursery contacted Children's Services as DD1 had a bruise on her right cheek. This led to a medical examination, under child protection procedures, at North Manchester General hospital. An interpreter was present during the examination. It was noted that the baby appeared well cared for and was growing well. The explanation given for the injury was that the baby had fallen onto a wooden floor with a dummy in her mouth. It was thought that this explanation was consistent with the injury and DD1 was discharged home with her mother. There was appropriate communication about this incident between all of the agencies involved with DS1 and DD1.

PS attended North Manchester General hospital by ambulance on the 8th May 2013 because of chest pains and breathing difficulties, although these symptoms appear to have dissipated by the time of his arrival at hospital. A "friend' of PS who translated via the telephone said that PS had been suffering a lot of stress recently. PS also reported that he had experienced anxiety attacks in the past. The medical examination did not detect any problems and he was discharged home with advice to go to his GP if symptoms persisted.

When the Early Intervention team workers visited the family home on the 8th May 2013 there was a major argument between S and DS1. This seems to be because S was angry that she had been excluded from the medical examination of DD1. Although the argument was reported as being volatile, S and DS1 had calmed down by the end of the visit and DD1 did not appear upset by the raised voices. This is explored further in the analysis section.

During the visit by the Early Intervention Team on the 8th May 2013, some of the discussion with DS1 took place in her bedroom as DS1 wanted to speak in private. She informed workers that she had an appointment for counseling but thought her mother would laugh at her for wanting counseling. She was also critical of her mother's standards of parenting.

There was a further home visit by the Early Intervention Team workers (student social worker and family support worker) on the 16th May 2013. An interpreter was present and the focus seemed to be on the development of DD1. DS1 reported some health concerns such as DD1's sleep pattern and loose stools and dry skin. This information was shared with the health visitor. DS1 informed workers at this meeting that the family was visiting Poland for a week in the very near future.

There were suggestions documented in the Early Intervention Team records that a conversation took place between the Early Intervention Team student social worker and a social worker from Children's Services (dated 4th June 2013) that the family would be returning from Poland on the 6th June 2013. It was clear however from other sources that S and PS were back in the area on the 5th May 2013. School 3 confirmed on the 18th June 2013 that DS1 had stayed in Poland longer than expected but had returned to school "the previous week". It was noted that DS1 had seemed upset in school recently.

On the 18th June 2013 the police were contacted by an employee at a supermarket to say the DS1 had come into the supermarket and informed a Polish-speaking employee that her mother had been killed by PS. Immediate action was taken by the Police, as outlined in Section 2 of this Overview Report.

3.2 The Welfare of the Children in the aftermath of the homicide

On the 18th June 2013 a Strategy discussion between Police and Children's Services took place leading to the children being placed together with Polish speaking foster carers. This allowed a culturally, linguistically appropriate placement and is commented on in the Analysis section.

Maternal grandmother (living in Poland) and maternal uncle (living in London) were contacted and immediately made arrangements to travel to Manchester. On the 20th June 2013 arrangements were made for maternal grandmother and maternal uncle to have unsupervised contact with the children and an assessment of maternal grandmother as a potential carer for the children was commenced. Enquiries were also commenced as to support services for the children in Poland.

On the 24th June 2013 all four children moved into a hotel with maternal grandmother and maternal uncle. This meant that the children were no longer

"Looked After" by the local authority. As they had only been looked after for five days the formal reviewing system for all looked after children had not commenced.

On the 25th June 2013 Children's Services e-mailed the Polish Embassy to request information about maternal grandmother. There was no request for information about maternal grandmother's partner or adult son, who were also living in the household in Poland.

On the 26th June 2013 the Polish Embassy responded that maternal grandmother had been in trouble with the Police 10 years earlier and had "received a punishment". The Children's Services Team Manager took the view that maternal grandmother cared for DS3 under the equivalent of a Special Guardianship Order and had therefore been assessed as a suitable carer; therefore there had not been safeguarding concerns. This rationale is commented on in depth in the Analysis section.

On 28th June 2013 a children's social worker, in Poland, informed Children's Services that maternal grandmother and her partner were unemployed and did not have access to benefits. Maternal grandmother cared for DS3 and their own child. It was confirmed that should the children return to Poland, they would be offered support around their recent traumatic experience and support to move to a bigger property.

On the 2nd July 2013 the Police informed Children's Services that eleven years ago maternal grandmother had been in a violent relationship and had stabbed her partner. He subsequently died from his injuries. Maternal grandmother was arrested but not charged as the offence was regarded as self-defence. The Police also advised that maternal grandmother had been assessed by social services in Poland as being a suitable carer for the children in her care.

On 5th July 2013 the children returned to Poland with their maternal grandmother and maternal uncle. There is no record of Social Services in Poland being informed of this arrangement. Contact with the family was maintained through the Police family Liaison Officer. There has been no contact with the family by other agencies in Manchester.

4. ANALYSIS OF THE INDIVIDUAL MANAGEMENT REVIEWS

4.1 Greater Manchester Police

The author of the Individual Management Review (IMR) was afforded full access to all records and documentation relating to the case. The author is a member of the specialist team undertaking reviews of cases, including Serious Case Reviews and Domestic Homicide Reviews. As such they have a degree of expertise in collating and analyzing information in serious and critical cases. The IMR author is independent of any direct involvement in the case.

Most of the information for this IMR was drawn from Greater Manchester Police Integrated Computer System which securely holds data for the majority of incidents managed by Greater Manchester Police.

The author also interviewed four members of staff in the course of compiling the IMR. These interviews took place with two Detective Sergeants from the Public Protection Investigation Unit for the North Manchester division and two family Liaison Officers attached to the murder investigation.

Police involvement with S and the family was relatively brief. Up until seven weeks before the incident that led to her death, neither S, or any other member of her immediate family group had come into any form of recorded contact with Greater Manchester Police. There was one incident, recorded by other agencies, on the 5th February 2013, when DS1 was reported to have stolen a mobile phone from a member of the teaching staff at school. Some agency records state that a Police Officer was involved in dealing with the incident. The author for this IMR was unable to confirm Police involvement in this incident.

There were five separate contacts between Greater Manchester Police and the family. The first was on the 27th April 2013 when DS1 contacted the Police from a telephone kiosk via a Polish-speaking interpreter, complaining that her mother (S) had taken her mobile phone from her following an argument between S and DS1. Police Officers attended the family home where all family members were present. The dispute appeared to be resolved prior to the arrival of the Police and seemed to centre on DS1 refusing to do household “chores”. S was described as expressing the view that although DS1 was a mother, she was still only 15 years of age, therefore she (S) retained the right to discipline her. The house was in “good condition” and checks on the welfare of the other children indicated that they were safe and well. It was ascertained that Social Services were involved with the family. Although the exact reason for Social Services involvement was not established, it was presumed that it was because of the age DS1 and the fact that she was a teenage mother.

This was a reasonable position for the Police to take. They had responded to the complaint, been satisfied that the dispute was not of a serious nature, and had taken the opportunity to check on the welfare of DD1 and the wider family members. There were also crucially no offences. Although this incident did not meet the criteria of a domestic violence incident, the attending Police officer referred the details to the Divisional Public Protection Investigation Unit (PPIU) because of the apparent vulnerability of DS1 and DD1. This was good practice and indicated a sound appreciation of wider issues of vulnerability.
As this was the first incident of contact with the family the PPIU created a record of the incident but took no further action.

As none of the family members spoke English, all communication was conducted through LanguageLine Solutions via a remote Polish interpreter, over the loudspeaker of the Police Officer’s mobile phone. This was an appropriate measure taken to facilitate communication in these circumstances.

The following day (28th April 2013), DS1 again contacted the Police from a public telephone kiosk via a Polish-speaking interpreter. On this occasion, DS1 alleged that PS had damaged her mobile phone and thrown it in the bin. He was said to be shouting and swearing. DS1 who was with DD1 was advised to remain at the

telephone kiosk where Police Officers would meet her. Although Police Officers arrived at the telephone kiosk within eleven minutes of the initial call, DS1 was no longer present. A visit to the family home did not locate DS1 or DD1 and there was no evidence of an ongoing disturbance.

This incident was closed as it was considered a continuation of the incident that had occurred the previous evening and it was considered that no further intervention was required by the Police.
Although the rationale for this decision is understandable, it would have been prudent to locate DS1 and DD1. There were some indications that the incidents, whilst being relatively minor, may have suggested wider tensions in the family.

The next involvement of the Police with the family was on the 7th May 2013, when a referral was made to the Police by Manchester Children's Services. This concerned possible harm or neglect to DD1 who had presented at the nursery with facial bruising. Information from Children's Services suggested tensions between S and DS1 over the care of DD1.

The Police and Children's Services agreed to hold a Strategy discussion, which took place later that day. Strategy discussions are used as a mechanism for determining actions that are required when there is a reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. Following the Strategy discussion, a medical examination of DS1 was undertaken. The findings of the medical examination established that the bruising was likely to be accidental. It was also recorded that the Early Intervention Team, who were actively involved with DS1 in her care of DD1 were content with the way DS1 was engaging with her baby. DS1 and her baby were discharged from hospital.

All of the professionals agreed at this stage that there was no requirement for Police involvement. This was an appropriate judgment given the evidence of the medical examination and the view of those directly involved with DS1 and DD1.

On the 8th May 2013 the Police received an emergency call from LanguageLine phoning on behalf of PS who was experiencing chest pains. This call was immediately and appropriately passed on to the Ambulance service and no further action was required of the Police.
It is possible to speculate that the different events of the previous referrals indicated growing tensions within the family, however, the presentation of this particular contact clearly had immediate medical significance and the decision to pass on the call to the ambulance service was the correct action.

The next point of contact for the Police, with the family, was on the 18th June 2013. These events are fully explored in Section 2 of this Overview Report. It was clearly crucial that the Police located the children (SS and DS2) and secured their safety as well as detaining the perpetrator. When the children were found the Police acted correctly in securing their safety through Police Protection Orders. It was extremely important, given the harrowing circumstances, that all of the children were reunited as soon as possible and this occurred at the Police Station where all four children were taken. The Police IMR emphasizes the importance of ensuring the safety and welfare of the children.

There was evidence of considerable sensitivity, as outlined in the Police IMR, that these were four very vulnerable and isolated children, in a foreign country without the support of parents or family. Police Officers from the Public Protection Investigation Unit, with specialist skills in child protection were initially detailed to deal with the welfare of the children. There was very early liaison with Manchester Children's Services and a speedy response in social work involvement. Two, specialist family liaison Police Officers were identified to deal exclusively with the welfare of the children. An approved Polish speaking interpreter was immediately engaged to assist the children at the Police station.

At the point of the children being reunited only DS1 was aware that their mother was dead and as such as well as being a victim was an important potential witness to the murder. Police investigators identified the dilemma of DS1's status as both witness and victim. At an early stage, it was identified that there was a maternal uncle who was working in London. The children's maternal grandmother was also notified and was making immediate arrangements to come to Manchester. There was clearly considerable coordination of activities required and the Police IMR highlights how this was conducted in a sensitive and careful manner.

When the maternal uncle and maternal grandmother arrived in Manchester, they were able to provide the Police and Children's Services with background information. The Police IMR includes relevant contextual information from these sources. In interviews with the maternal grandmother, she voluntarily revealed that twelve yeas ago she had spend time on "remand " in Poland having been the victim of prolonged domestic violence culminating in her stabbing her husband to death. A subsequent investigation by the Polish authorities found there was no case to answer.

The Police IMR also covered background information showing that maternal grandmother recalled an awareness of violence between S and PS shortly after they were married. Maternal grandmother noticed bruising on S's body and saw she had a black eye on one occasion. S had reportedly informed her mother that PS was short tempered and would beat her on occasions. During the period that S was living in the UK she maintained regular contact with her mother, telling her that the relationship with PS was deteriorating and that she was considering leaving him. S later disclosed to her mother that she had met a Polish man based in the Netherlands and was intending to go and live with him. This information, contained in the Police IMR correctly states that the background information from maternal grandmother was the first indication that there was a history of domestic violence within the family.

The Police IMR also indicates that there was agreement between the Police and Children's Services that the children had a close bond with their maternal grandmother and that it was in the children's best interests to return to Poland in the care of their maternal grandmother. The Police IMR also comments on the ongoing contact between Police family liaison officers and the family. In one relatively recent communication from maternal grandmother some of the problems facing the children's grandmother are articulated, suggesting worries on

the grandmother's side that the Polish authorities may take the children away from her, that housing conditions are not good, the financial situation is not good and she is struggling to come to terms with the loss of her daughter.

Overall the Greater Manchester Police IMR is sensitively written and demonstrates a very good understanding of the vulnerability of the children. It offers a full picture of the information held by Greater Manchester Police and is clear about actions taken and decisions made. The IMR does not contain any recommendations and as such has no action plan. Whilst this may be slightly unusual, it reflects the limited involvement of the Police with the family (until the point of the murder). Actions taken by the Police, following the murder, were appropriate and marked by an appreciation of the children as victims. The Police IMR takes the view that the murder was not predictable or preventable.

4.2 Manchester City Council Children's Services

The author of the Children's Services Individual Management Review is not involved in the line management of any of the social work staff or managers involved in the case. The author is an experienced manager and practitioner with a good understanding of child welfare and safeguarding issues.
All documentation and records relating to the family were made available to the IMR author. Case notes, "Episodes" or uploaded documents are all contained in the electronic record held by the local authority Children's Services. Sources of information were contained in the chronology. The IMR referred to the Terms of Reference of the Domestic Homicide Review throughout the Report.
The Team Manager (TM1), was interviewed by the IMR author for the specific purpose of this IMR. All of the social workers involved with the family, at various levels, had left the employment of Manchester City Council and were unavailable for interview.

Children's Services direct involvement with the family began in March 2013 following a referral by the Teenage Pregnancy Reintegration Manager. Prior to this contact there had been referrals in October 2012, and in February and March 2013. The October referral was made by the Teenage Pregnancy Midwife as the family had recently arrived and the 14-year-old daughter, DS1 was pregnant. This referral was dealt with by the contact centre and passed to the International New Arrivals Team.

The two referrals in February and March 2013 were for financial assistance and were not progressed, although the IMR does comment that a further referral for financial assistance would have prompted an Initial Assessment in Children's Services.

The IMR outlines the referral on 13th March 2013 as containing two elements. First an assessment of DS1's parenting capacity because of some concerns emerging about her care of DD1. Second an assessment of the relationship between DS1 and her mother S, in order to determine the support required for S in caring for DS1.There is evidence from the IMR that the Initial Assessment was not completed to a reasonable standard and this was acknowledged in the IMR.

The Core Assessment, completed on the 1st May 2013 was deficient in a number of areas. The assessment focused on the relationship between S and DS1 with an emphasis on DS1's parenting capacity. There was no attempt to explore wider issues within the family, including family history and relationships, or the dynamics within the family. In particular PS remained a peripheral figure, barely mentioned in the assessment.
In all, from the point of allocation to a social worker (SW1) on the 13th March 2013 there were two home visits to undertake the initial assessment on the 19th and 20th March 2013. There was also a multi-agency Case Planning meeting held on the 22nd April 2013 (not attended by S or PS). There was a referral from Children's Services to the Early Intervention Team for support for the family in March 2013. Apart from this involvement Children's Services appear to have taken a very passive line in relation to involvement with the family. There was one incident in particular where S alleged that DS1 had threatened her (S) with a hammer (21st March 2013). The IMR expresses the view, correctly, that this was a violent episode and it would have been good practice to assess the risks to the baby and other children in the household.

The IMR does address the interventions and decision-making process following the murder. There were clearly urgent attempts to safeguard all four of the children and promote their welfare. Enquiries were made with Child and Adolescent Mental Health Services in relation to counseling, The Polish Embassy was contacted to request information about maternal grandmother and arrangements were made for the children to stay with their relatives in a hotel in Manchester.

The principle that the children should be looked after, as a long-term arrangement, in Poland, by a relative with whom they had close bonds was sound. There were, however, a number of issues, identified by the IMR, in relation to the assessment, that raise questions about the depth of information used in making the decision to let maternal grandmother return to Poland with the children in her care.
Information that was unavailable at that stage included:

- Information about the offence committed by the children's maternal grandmother.
- The current relationship of the children's maternal grandmother and whether there were any issues regarding domestic violence.
- The adequacy of the living arrangements for the children. The children's maternal grandmother lived in a two-bedroom apartment with two adults and two children. Once the children arrived there would be nine people living in the apartment.
- There was no information about financial support or support from family and the community.
- There was no information about how the children's education and health needs would be met.

There are, as the IMR points out, lessons to be learned about guidance for practitioners who are involved in moving children from the UK to relatives abroad, particularly in relation to the required standard of assessment and checks for children who are looked after by the local authority.

The IMR states that the murder was not predictable or preventable. There was one individual agency recommendation from this IMR. The Overview Report author is of the opinion that a further recommendation relating to the possible failure to respond to the alleged violent incident on the 22nd March 2013 is required. It was unclear from the records if a home visit was made by the allocated social worker to investigate this incident. The lack of recording about the response to this incident is clearly unsatisfactory. There is also the need for a recommendation relating to the quality of assessments. These issues are explored in more detail in the Overview Analysis related to the Terms of Reference.

4.3 Manchester City Council Early Intervention Team IMR

The Early Intervention Team IMR author is a Team Manager within the Early Intervention Service. They were not involved with this case and had no managerial responsibility for any of the practitioners involved with the case. The Early Intervention Team provides family support to pregnant women or families who have children under the age of five years.
All documentation relating to the case, held by the Early Intervention Service was made available to the author. This included all of the case notes recorded by the student social worker and the family support worker.
The author interviewed the student social worker, the family support worker and the Early Intervention Team Coordinator.

The IMR summarises the involvement of the Early Intervention Team from the first referral to the agency on the 21st March 2013. In all four home visits were undertaken by the student social worker and the family support worker. They were accompanied by a female Polish-speaking interpreter on each occasion. The major focus of intervention was on helping DS1 in her parenting role. This included advice on sleep management and developing a routine for DD1.

The IMR is critical of some of the recording standards and also states that the focus of intervention was on DS1 and her daughter DD1 when it should ideally have been more proactive in engaging S and taking a whole family approach.

The IMR comments on some of the opportunities for further exploration of issues and a lack of professional curiosity with officers failing to ask the ‘why’ questions.

The IMR refers to an incident where DS1 comments that S did not want the Student Social Worker and Family Support Worker to visit her at the house. Whilst the Student Social Worker and Family Support Worker offered to meet her elsewhere, they didn’t appear to ask the reason for this or discuss this with S. Discussing this with S could have been a good opportunity to engage her in the support plan and understand more about the relationship dynamics.

During another home visit, DS1 asked to meet with the Student Social Worker and Family Support worker in her bedroom during which she disclosed that she had an appointment for counseling. The Student Social Worker and Family Support Workder did not ask her about why she felt she needed counseling and

appeared to make assumptions.

There was one occasion noted in May 2013 when there was a ferocious argument, in the presence of the student social worker and family support worker, between S and DS1. It was noted that the baby, DD1, witnessed the argument but did not seem distressed by the raised voices. This should really have led to some consideration about the reasons why DD1 was not distressed and the possibility that such arguments were regular occurrences.

Overall, the IMR, suggests that there was no clear indication of domestic violence and that the murder could not have been predicted or prevented. There were five individual agency recommendations from this IMR. All of these recommendations aimed at improving delivery of services are appropriate.

4.4 Central Manchester University Hospital Trust IMR

The author of the IMR is an experienced manager with no practitioner or managerial involvement with the case. The author has substantial experience of safeguarding children issues.
The author of the IMR had access to all documentation and case records held in community health services. This documentation consisted of:

- Children's Community Health records incorporating social information relating to all family members
- Manchester Safeguarding Children Team (Community) file
- Manchester Child Health system
- Computer records held by Palatine Contraception and Sexual Health Service
- The lead health visitor from the time of DD1's birth was also interviewed.

The IMR indicates that the family became known to Community Health Services from November 2012 following notification by the midwife to the health visitor following the birth of DD1. It was known at that time that DS1 had been in the country for a period of about six weeks.

The other children were seen and as they were awaiting school allocation, the health visitor coordinated all health assessments, support and intervention. It was identified that both DS1 and DD1 required multi-agency case planning, as they were children in need by virtue of DS1's age as a young mother and the vulnerability of DD1 and DS1.

The IMR outlines that the majority of community health related contacts took place at the family home and were planned visits with an interpretation service booked in advance. There was also evidence of two clinic visits by DS1 in relation to DD1. The IMR also notes that DD1's immunisations were completed although there had been two failed to attend and once cancelled appointment.

The IMR states that records indicate an excellent level of support being offered to the family, with appropriate use of an interpreter. There was limited information about the adults in the household although both were stated as being available in planned contact with community health services.

The IMR also outlines that there were no indicators of domestic violence, either reported within the family or from partner agencies, although community health records indicate that routine screening questions about domestic violence were asked in line with standards expected from a Primary visit (first assessing visit).

It is clear within the IMR that when tensions were described within the family, they appeared to be because of the relationship between DS1 and S. DS1 was recorded as being verbally abusive to S and had allegedly threatened S with a knife (it is probable that this has been erroneously recorded and relates to the incident in March 2013 when DS1 is alleged to have threatened S with a hammer). The IMR does identify concerns that DS1 had allegedly threatened to kill herself and her baby. There were also reports that DS1 had been physically violent to her boyfriend (the father of DD1) when he visited from Poland.

The IMR also comments on the high standard of liaison between health related services and also with other external agencies. There were also appropriate referrals to other services including Child and Parent Support Services, Sure Start and Connexions. Community health records were maintained to a high standard, recording assessments, interventions and communications with other agencies.

The IMR offers the opinion that the murder could not have been predicted or prevented. There was one recommendation from this Individual Management Review relating to Domestic Violence training being given mandatory status for all appropriate staff in the organisation. This is an appropriate recommendation.

4.5 Pennine Acute Hospitals NHS Trust IMR

The IMR author is a named Nurse for Safeguarding Adults with experience of safeguarding issues. The author has no line management responsibilities for any practitioner involved in this case and has had no personal involvement in the case.

The IMR author had access to all records and documentation held by the Trust. These were records from the Electronic Patient Administration System, Electronic Accident and Emergency Records, medical Case Notes
There was no indication from the IMR that any staff were interviewed.

In all there were seven occasions of contact for family members with the hospital. DS1 was seen at North Manchester General hospital on the 17th October 2012 when she attended clinic to register for antenatal care. A Polish-speaking interpreter was made available, as it was known that DS1's first language was not English. DS1 was seen by the Teenage Pregnancy midwife and within two days DS1 had an ultra sound scan and was reviewed by a doctor. She delivered a normal healthy baby on the 27th October 2012 and was discharged home on the 30th October 2012.

The IMR outlines that DD1 was seen at hospital on the 18th February 2013 and diagnosed as having a chest infection. She was discharged home later that day with appropriate medication.

DD1 was also brought to hospital on the 30th April 2013. She was reported to have been coughing. A diagnosis of possible viral infection was made and as the baby appeared well cared for and was not distressed she was discharged home after examination. As the IMR states, these interventions were appropriate.

The IMR details the occasion on the 7th May 2013 when DD1 was examined at hospital at the request of the allocated social worker regarding a bruise on her right cheek. The notes indicate that the baby appeared well cared for and was growing appropriately. The explanation for the bruising was consistent with the presentation and the baby discharged.

The IMR notes that PS attended hospital on the 8th May 2013 via an ambulance. He reported that he had experienced chest pains but this had been resolved by arrival at the hospital. PS reported that he had suffered anxiety attacks in the past and nothing wrong was found on examination. He was discharged home.

The final contact was on the 18th June 2013 when DS1 was brought to hospital, accompanied by female Police Officers and a social worker. DS1 was complaining of abdominal pain. This was the day when DS1 reported the murder. The IMR outlines that she was fully examined and there was no evidence of injury but muscle relaxant medication was prescribed.

On all of the occasions family members were seen at hospital, interpreters were used. These were staff from the hospital who were Polish speaking.

There were no recommendations for action from the findings of this IMR. This was appropriate given the limited involvement with the family.

4.6 Black Health Agency for Equality in Health and Social Care IMR

BHA were involved with the family between 29th October 2012 and 2nd April 2013. The initial referral was made by the New Arrivals Team. The focus was on supporting the family in the community, helping to claim benefits and accessing education.

The author of the IMR has had no direct involvement in the management of practitioners working with the family.
All records relating to the family were accessed. There was no indication that any records were missing or not accessible. In addition one practitioner (Practitioner 1) was interviewed.

In all there were six home visits to the family. As the Practitioner (Practitioner 1) is Polish speaking, an additional interpreter was not required. The allocation to a Polish speaking worker was, as indicated in the IMR, a very positive measure and allowed a good relationship to develop with the family without the constraints sometimes experienced through the use of interpreters.
As well as the home visits there was evidence of frequent contacts with other agencies, both on a practical level, in relation to benefits as well as liaison to express concerns in relation to the relationship between S and DS1 and also the parenting capacity of DS1.

There was no indication throughout the involvement of BHA that domestic violence was an issue in relation to PS and S, or that there was any historical evidence of domestic violence within the wider family. The Initial Assessment undertaken by BHA did not specifically address domestic violence however this was raised by the Practitioner, with S responding that "they had arguments like everybody else but no issues with domestic violence". The IMR states that, 'Only S was involved in the initial assessment', however it is not clear whether PS and other family members were present in the house at the time. The member of staff had knowledge and experience of domestic abuse and the indicators. The assessment was looking to identify needs across a whole range of areas. Being asked about domestic abuse as part of a wider assessment of need may not create the right environment for someone to disclose domestic abuse. In addition to this, learning from other DHRs has found that victims rarely disclose domestic abuse during a first meeting and therefore it maybe necessary for frontline officers to look for possible signs and to ask these questions again, once they have started to build a relationship. In addition to this, BME victims can face additional barriers to disclosing domestic violence and abuse.

There are indications from the IMR that much of the focus of work, understandably was aimed at helping S to navigate the different cultural and systems challenges she was facing such as claiming benefits, changing schools, making application for a nursery place. This focus changed in emphasis around March 2013 with allegations and counter allegations between S and DS1. The service was decommissioned on the 2nd April 2013 and had no further involvement with the family. The IMR expresses the view that had it not been for this decommissioning, the service would have continued their work with the family, as there was still a valuable role to play.
In all there were 5 recommendations. All were aimed at improving record keeping, screening of domestic violence and updated training for staff on domestic violence. The recommendations were appropriate.

4.7 Manchester City Council Education IMR

The IMR author is an Education Caseworker within the Education Casework Team. The IMR author has had no direct involvement with this case and has no managerial responsibility for any of the Education staff involved with the family. The IMR author used to compile the IMR was accessed from the following sources.

- Case notes from School 3
- Copies of attendance certificates in relation to SS and DS1
- Admissions and transfer notes from the Admissions Team
- Interview with the Designated Person (School 2)
- Interview with the Designated Person (School 3)
- Telephone conversation with the manager of the Admissions Team.
- There were not thought to be any records missing or inaccessible.

The IMR focuses on the admission of DS1 to School 3 and the admission of DS3 to School 1 and subsequent transfer to School 2. SS also started at school during the same period. The IMR indicates a sensitive and well-coordinated approach,

with an appreciation of the language needs of the children and family. The integration of DS1 into a specialist education resource was carried out with considerable care and planned around DS1's needs.

The IMR refers to an incident on 15th February 2013 at the school, where DS1 stole a teacher's mobile phone. DS1 informed the translator that her stepfather treats her differently to her siblings and she is struggling to buy things for herself the baby. It is not clear whether DS1 was asked what she meant by this or whether there was any further discussion.

On 27th February 2013, there was an incident referred to in the IMR where DS1 sent a message to school via another pupil where she mentioned that she was not happy at home and that her stepdad and mum were having arguments. It seems that the member of staff spoke to DS1 and advised her not to use other pupils to relay messages. However the panel felt that it was not clear whether DS1 was asked more about the arguments at home and felt that an opportunity may have been missed to explore this further with her.

The IMR notes that School 3 identified problems in the relationship between DS1 and S at a relatively early stage and arranged a multi-agency meeting on the 12th March 2013. This meeting gave further evidence of the relationship difficulties between DS1 and S leading to a decision to refer the family to Children's Services. The IMR indicates, correctly that this was an appropriate referral.

The IMR describes an incident on 7th May 2013 where school staff noticed bruising on DD1's cheek and due to this followed routine safeguarding procedures. DD1 was taken to hospital where her injury was examined. The IMR states, *"S had been angry with DS1 for giving out family details at the hospital and both S and PS had screamed at her for doing this".* There was no evidence that DS1 was asked more about this and why they were angry.

The IMR reports that once DS3 and SS had started school there was minimal contact with S and PS apart from the daily drop off and collection of the children at school. Other than the message relayed via another pupil, referred to at paragraph 4.60, there was no indication of any problems in the relationship between S and PS. School 3 were aware of tensions between DS1 and S but were not aware of any issues between S and PS. There was no knowledge of domestic violence.
There were no recommendations from this Individual Management Review.

5. KEY ISSUES ARISING FROM THE REVIEW WITHIN THE CASE SPECIFIC TERMS OF REFERENCE

This section analyses the involvement of agencies in the context of the Case Specific Terms of Reference. The General Terms of Reference are addressed throughout the Overview Report.

5.1 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?

In the aftermath of the homicide, there was considerable and urgent activity to protect the children (DS1 and DD1) who were first located and were immediately made the subjects of Police Protection. The perpetrator, who was with SS and DS3, was located within just over thirty minutes after the initial emergency call to the Police, and the children were taken into Police protection. There was awareness that the children had experienced a traumatic event and they were reunited as speedily as possible.
Effective liaison between Police and Children's Services meant that the children were placed together in a Polish speaking foster placement and there were urgent efforts made to contact the children's maternal grandmother and maternal uncle in the knowledge that support from the family was essential for the children.
There were no clear indicators and no disclosures of domestic violence in this case, largely because there had been limited agency involvement with the family. There was the incident where DS1 sent a message to school via another pupil where DS1 mentioned that she was not happy at home and that her stepdad 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. That said, there was no guarantee that she would have disclosed any violence or abuse.

There was also the occasion where the Student Social Worker and Family Support Worker witnessed a major argument between S and DS1. DD1 was present at the time and did not appear to be distressed. The Panel agreed with the IMR author that this should have been explored further.

5.2 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?

All of the agencies had multi agency policies and procedures in place for dealing with domestic violence. These policies and procedures are actively promoted by Manchester Safeguarding Adult Board and Manchester Safeguarding Children Board.
Two of the agencies, Community Health Services and BHA, as part of their initial assessment screening, specifically addressed issues of domestic violence. BHA was reassured by S that domestic violence was not occurring in the family. Community Health Services were reassured by DS1 that there was not domestic

violence within the family.
Children's Services Initial and Core Assessments were of poor quality and such did not adequately address family relationships. There were some subtle indications of tensions and a potential for violence within the family. This was identified as being due to relationship problems between S and DS1 when it may have been indicative of a more embedded culture of aggression within the family. Similarly there were some identified financial pressures on the family and it was noted that PS controlled the finances within the family. This may have indicated coercive / controlling behaviour but this was not explored further.

The scale of domestic violence is such that all agencies should address the possibility that it is occurring in families. A recent crime survey of England and Wales (2011/2012 data) indicates that 2 million people in the UK experience sexual assault, violence, threats or abuse at the hands of a partner or family member. Of these victims, 1.2 million are women and 800.000 are men.

5.3 *Were appropriate lines of enquiries made in relation to domestic abuse, given what was known about the family at the time?*
One of the significant problems in this case was that there was very limited information available about the family. Agencies were effectively dealing with the family as a "new case" without the benefit of historical information that may have offered some insight into the family dynamics. There were opportunities to gain more information, particularly through the Core Assessment process and other agency assessment processes. It is evident, however from the Children's Services IMR, that background historical information was not collected and there was insufficient analysis of the family dynamics. This is a common feature of findings on Serious Case Reviews and is best summarised by the work of Brandon et al (2008) "*assessments are based on the systematic collection of information and evidence, including making systematic observation. An assessment needs to be made in the context and developmental processes that have shaped children, parents and their families".*
Information collected by the Police, in the aftermath of the murder, suggested there was significant historical information about domestic violence in the wider family. The children's maternal grandmother, for example killed her partner (the father of S), after being the victim of protracted domestic violence. Presumably S would have been exposed, as a child, to this domestic violence.
The children's maternal grandmother, in the aftermath of the death of S, gave information that S had informed her (the children's maternal grandmother) that PS was short tempered and would beat her on occasions. The children's maternal grandmother also reported that S had met another man and was intending to go and live with him.

There were clearly, with hindsight, some serious tensions in the relationship between S and PS. There were however no clear indications from the involvement of agencies with the family that there were any concerns about this relationship. Factors that are probably relevant are:

- The presentation of family problems was very much seen to be the relationship between DS1 and S and the parenting capacity of a young mother. This effectively became a "mindset" in agency thinking without other avenues being considered.

- There was very limited background historical information, because the family was "new" to UK agencies.
- Assessments, particularly the Children's Services assessment, did not explore the family history adequately.

5.4 Did the agency comply with domestic violence protocols agreed with other agencies including any information-sharing protocols?

There was no evidence that any of the agencies failed to comply with domestic violence protocols in this case. Domestic violence was never identified as an issue until after the homicide and there was no indication that it was a factor within the family.

All of the agencies were aware of domestic violence protocols and were able to give examples of how they were used in their agencies.

There were some problematic issues identified in relation to age thresholds for initiating domestic violence procedures. DS1 was 14 years of age when she first came to live with her mother and family in the UK. After an initial settling in period, there were a number of tensions between S and DS1 that emerged. This escalated and at one stage S reported that her daughter had threatened her with a hammer. She also reported that DS1 had threatened to kill herself and her baby. These reported incidents were not investigated properly. There is even some doubt from the records if the reported incident involving a hammer was investigated at all.

There is a possibility that this incident was not taken as seriously as it should have been because the alleged perpetrator was a child and the alleged victim was an adult. Had the alleged perpetrator been over the age of 16 years. This clearly would have met the threshold of a domestic violence incident. The implication, in a wider sense, is that there is a substantially less serious response given to violent acts or threats of violence if the alleged perpetrator is below the age of 16 years. **This issue is addressed in Recommendation 5.**

5.5 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?

There were a number of occasions when assessments were undertaken with the family. These include, the initial assessment by BHA, the community health assessment and the Children's Services led Initial and Core Assessment. There was also consideration by agencies about the need to undertake an assessment under the Common Assessment Framework guidance (CAF). These are assessments undertaken when a case has not reached the criteria for Children's Services intervention, but the complexity inherent in a number of different agencies involved with a family suggests that there is a need for multi-agency assessment and planning.

The Core Assessment was inadequate, focusing on the relationship between DS1 and S without exploring wider family dynamics and relationships. There was very little engagement with PS or any understanding of his role in the family.

The Core Assessment led to a decision to support the family through the Child in Need process. This effectively meant that the major focus of work was on DS1's parenting capacity and her relationship with her mother, S.

There are two significant contributory factors that are likely to have impacted on the Children's Services Core Assessment. The practitioner SW1 was newly qualified and as such would have needed considerable support in undertaking an assessment of a complex case. The evidence suggests that the Core Assessment was "signed off" by the Team Manager when there were significant deficits in the assessment. There was no consideration, in the assessment, of the family history, the extended family, the relationship between PS and S or the relationship between PS and DS1. There was also no consideration of the other children in the family and why, for example DS2 was being cared for by maternal grandmother in Poland.

There is a checklist available for Team Managers outlining key issues that need to be addressed before an assessment is "signed off". This checklist was not used and this may indicate that there are some systemic weaknesses in quality assurance within the Children's Services assessment processes. This is addressed as a recommendation.

5.6 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?

All of the risk management plans were based on an understanding that the primary risks were in relation to the care of DD1 by DS1. Services were offered, appropriately, to support DS1 in her role as a young mother. There was, however no objective evidence, other than reports from S that DS1 was not caring for her baby adequately. These reports were clouded by allegations about poor parenting by S and DS1 about each other. It would have been important in the assessment of DS1's care to have some direct observation of her care of DD1. There was no indication that this took place on a planned basis.

When there were concerns identified about a bruise to DD1's cheek, a medical examination took place after the local authority had followed Section 47 Children Act guidance. This was good practice in safeguarding DD1.

There was no indication from the various assessments that domestic violence in relation to S and PS was a factor in the family life. It would have taken considerable professional curiosity to unearth this. It would have required, for example, a good understanding of the historical context of the relationship and the current nature of the relationship. There was no indication from the direction of work being undertaken with the family that there would have been more insight gained about their relationship.

5.7 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?

All of the agencies working with the family were aware of tensions between S and her daughter DS1. There was, in particular, an appreciation that although DS1 was a mother she was also a child.

Agencies identified the wishes of S through discussion with her. There are for example a number of documented references to discussions with S about her role

and responsibilities in relation to DS1.
There was however a lack of depth in agency understanding about the relationship between DS1 and S. There is no evidence that agencies understood why DS1 and DS2 were being cared for by maternal grandmother, in Poland, prior to DS1 becoming pregnant and moving to her mother's care. Nor is there any indication of any focused planned work with S and DS1 jointly to help resolve relationship problems.
The main area, which became dominant, was consideration of the respective roles of S and DS1 in caring for DD1. Although this was an important issue in the relationship, it did tend to deflect agencies from a wider understanding of the conflicts between DS1 and her mother.
There was one particular incident in March 2013 when S reported that DS1 had threatened her with a hammer. There is no indication from the records that this was ever investigated or if the issue was addressed with DS1. There were also allegations from DS1 (March 2013) that her mother had hit her. Taken together these allegations and counter allegations may have led to thinking about the general atmosphere within the family home and the propensity for aggression from family members. In working with complex family relationships there is a need for practitioners to carefully reflect on the presentation of behaviour within the family. Children who are violent in interpersonal relationships, for example, have often been exposed to environments where aggression is commonplace.
There was very little evidence that the reasons why DS1 had been cared for by her maternal grandmother (DS2 was still in the care of her maternal grandmother) and the difficulties inherent in DS1 effectively joining a "new" family.

5.8 Is it reasonable to assume that the wishes of the victim should have been known? Were they signposted to other agencies?
There was no indication from the victim that she was experiencing domestic violence. Her wishes in relation to other concerns about DS1 were known and respected.

5.9 Was anything known about the perpetrator? For example, were they being managed under MAPPA or any other services?
There was very little information known about the perpetrator. This may have been partly because the family was "new" to the different agencies; it was also because the various assessments did not adequately explore his role within the family and the nature of relationships within the family.
On a national basis, Serious Case Reviews have commented on the failure to engage meaningfully with adult males in families. This Domestic Homicide Review echoes those findings.
There was no indication that PS actively sought to avoid professionals. There was at least one occasion when he called at the social care office seeking a loan because of financial pressures. The indications are much more that he was not considered to have much relevance to the focus of work being undertaken with S, DS1 and DD1.

There are key learning points about working with families that have newly arrived in the UK, about the importance of collecting and analysing historical and contextual information. This will pose considerable challenges for agencies, which should not be underestimated. One the lessons, however, from this Review, is

that had pertinent information been available about the family history it may well have led to a different interpretation and different understanding of what was happening in the family.

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

The victim had not disclosed that there was domestic violence within the family. One of the agencies, BHA had specifically asked S about domestic violence, as part of their screening process but S denied abusive experiences within the family. Other DHRs have identified that victims are not likely to disclose during an initial meeting and that BME victims face additional barriers to making a disclosure.

5.11 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?

All of the agencies involved with the family were sensitive to the linguistic needs of the family. It was noted at an early stage of involvement that the family were Polish and spoke very little English. To overcome the language and communication difficulties, the BHA, who was offering support to the family, used a Polish-speaking worker who was able to communicate directly with the family members. This worker was also very experienced in work with domestic violence victims. Children's Services used a Polish speaking female interpreter, with the exception of the first home visit when a male Polish-speaking interpreter was unsuccessfully used (DS1 felt too inhibited in speaking about personal issues in front of a male). Similarly the health visitor and midwife used an interpreter.

Efforts by school to support DS1 through attaching an interpreter to her class were helpful.

On the occasions when family members attended hospital, Polish speaking interpreters were made available. The Police used Languageline to communicate with family members when they were called to the family home in April 2013.

There was limited reference, in the IMR's, to the constraints and problems in using interpreters. There is some evidence, for example, that some families feel reluctant to speak openly, in front of translators, about sensitive issues. There are also possibilities that translation may "lose" some of the intended emphasis of discussions.

There is also a very real factor in that a major tool used by practitioners is the empathetic relationship developed between practitioner and service user. It may be that the presence of a translator inhibits the development of this relationship. There is also an additional factor in that translators may be unfamiliar with difficult areas of family behaviour such as domestic violence or child abuse and may not be sensitive to recognising nuanced messages family members may be giving

about problematic activities. **This is addressed within Recommendation 4.**

There was less evidence that cultural issues were addressed. An early assessment by BHA identified that the family wanted a larger house, needed support in claiming benefits, wanted to meet other Polish people and to find a suitable church and leisure facilities for the children. At the point of the homicide, however, there was a picture presented of the family still being relatively isolated. There is nothing mentioned in any of the IMR's about family activities, for example, and DS1 still seems to have no friends in the community. There is a well established Polish community in Manchester and it would have been reasonable to expect the family to have developed tangible cultural connections, either through their own initiatives or through signposting by the various agencies involved with the family.
It may be that because of the decommissioning of BHA in early April 2013, there was less emphasis on cultural issues.

5.12 Were senior managers or other agencies and professionals involved at the appropriate points?
There was involvement of managers across agencies to varying degrees. BHA ensured that a Project Manager was available to offer guidance during supervision.

Community Health Services had access to a dedicated Safeguarding Team and Health Visitor1 brought the case very appropriately to Safeguarding supervision.

There was involvement by a Children's Services Team Manager throughout the case. Although, as observed earlier, they did not follow guidance on the use of a checklist before "signing off " the Initial Assessment.

The only agency reporting capacity or resource constraints was Children's Services. Because of a significant restructuring taking place in that agency and high referral rates, the Team Manager was unable to offer the usual level of oversight in the case. This may, in part, account for the poor quality of the assessments although as indicated in the Overview Report there is a strong likelihood that the standard of assessments is a more systemic problem.

5.13 How accessible were the services for the victim, perpetrator and children within the family?
All of the services involved with the family were readily accessible, as indicated by the frequency of contact and the relative ease the family members had in contacting services. Communication and accessibility was aided considerably by the use of Polish speaking interpreters. It was particularly helpful that the practitioner from the Routes Project supporting the family was Polish speaking.

5.14 Are there other domestic homicide cases locally that give additional insight into ways of working effectively with victims of domestic violence?
Other cases in Manchester have identified additional barriers that BME victims of domestic abuse may face that prevent them from disclosing the abuse. This can include cultural barriers, language barriers, knowing how and where to access services, financial status, immigration status etc.

This is an unusual case in that there were no indications of domestic violence in relation to S and PS. One of the key lessons coming from this case is the need to "dig" beneath the presentation of tensions within families and to always be sensitive to the potential for domestic violence.

5.15 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 S and her family or to work with other agencies?
There were no capacity or resource issues identified by the majority of agencies; although that position needs to be seen in the context of there being relatively limited agency involvement with the family over a short period of time. These events also took place at a time of considerable organisational change within agencies that may have impacted on capacity.
Pressure of work within Children's Services at the time seems to have had an impact in this case on the satisfactory completion of the Initial Assessment process and the monitoring of the allocated workers interventions with the family. It seems probable that this case was not an isolated example of an inadequate assessment being undertaken.

There are both training and skills development issues identified in the work of Children's Services. Although there are potential dangers in drawing more general conclusions from one specific case, there are indications of a deficit in skills in assessment and a lack of understanding of assessment models. There were so many basic elements missing from the core assessment that effective intervention would have been problematic.

There is ongoing training on Domestic Violence on a multi-agency basis. It would be helpful for this training to be reviewed and updated in the light of lessons from this Domestic Homicide Review.

5.16 To what degree could the homicide have been accurately predicted and prevented?
There was no indication of domestic violence in relation to PS and S, nor any indication that there were difficulties in the relationship between them. None of the historical information about domestic abuse in Poland was known and there were no allegations or suspicions about domestic violence occurring in the UK. In these circumstances, the homicide could not have been accurately predicted or prevented.

5.17 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?
The events of the 17th and 18th June 2013 were tragic and traumatic for the children. When immediate safeguarding interventions were made in respect of SS and DS3 on the morning of the 18th June 2013 they were reunited with DS1 and DD1 as soon as possible. Although there was recognition that DS1 was a potential witness, there was also a very clear understanding that she, and the other children were also victims. It was necessary to interview DS1 as her stepfather was detained in custody on suspicion of murder, however, because of

the children's vulnerabilities two specialist child protection Police officers were assigned, almost immediately, to look after the welfare of the children. Early liaison with Children's Services also meant that a social worker was able to attend the Police station and support the children. Records of the Police involvement throughout this phase suggest that there was considerable sensitivity shown towards the children, particularly DS1 as a key witness.
Early enquiries by Children's Services, were made to Child and Adolescent Mental Health Services (CAMHS) regarding emotional support for the children. It was a sensible step to seek expert advice in these circumstances.

The children were all placed together that evening with Polish speaking foster carers. This was clearly an important placement both in terms of culture and shared language. It was particularly important that the children were placed together given the acute and traumatic separation from their mother.
It was also important that contact was established with maternal uncle and maternal grandmother, arrangements being speedily put in place for them to see the children.

When maternal grandmother and maternal uncle arrived in Manchester it was agreed (20th June 2013) that they could have unsupervised contact with the children, an assessment of maternal grandmother as a potential carer for the children being undertaken by SW2. There is no evidence, from the records that this assessment was completed. There was a balance between meeting the children's emotional support needs and ensuring that adequate checks were undertaken. In these unique circumstances, it is understandable why decisions were made to optimise the children's contact with their relatives; however, the viability assessment of maternal grandmother did need to be completed for the local authority, to fulfill its responsibilities. It is likely that the balance between assessment of risk, and ensuring extended family support for the children was lost in the tragic circumstances of these events.

The decision to move all of the children into a hotel with their maternal grandmother and maternal uncle meant that the children were no longer looked after by the local authority. This did mean that the children were placed in the care of relatives before Police checks or background information from Poland was obtained. The Polish Embassy was contacted by Children's Services on the 25th June 2013 and requested to provide background information on maternal grandmother. Contact with the Polish Embassy offered the opportunity to obtain information on all of the adult members of the household in Poland, including maternal grandmother's partner and maternal grandmother's adult son, who was living in the household. This was an oversight, probably caused by the unusual nature of the situation.

When information came back from the Polish Embassy on the 26th June 2013, it indicated that maternal grandmother had been in trouble with the Police ten years previously and "had received a punishment". There appear to have been assumptions made that because the children's maternal grandmother cared for DS2 under the equivalent of a Special Guardianship Order there could not have been any safeguarding concerns. There is no documented evidence to support these assumptions.

A social worker from Poland made contact with Manchester Children's Services on the 26th June 2013. They informed Children's Services that maternal grandmother and her partner were both unemployed and did not have access to benefits. Social Services in Poland gave financial support to the family for the care of DS2 and their own child.

On the 2nd July 2013 Manchester Police advised Children's Services of information relating to the children's maternal grandmother. This was significant information in that it disclosed that the children's maternal grandmother had been previously in a violent relationship and had stabbed her partner, leading to his death. Maternal grandmother was arrested but not charged, as the offence was viewed as self-defence. The Police advice also stated that the children's maternal grandmother had been assessed by Social Services in Poland, as an appropriate carer for the two children in her care. Although the allocated social worker asked for this information from the Polish authorities, they were informed that this would need to be requested through the Courts and the family wanted to return to Poland as soon as possible.
Police information about the two adult males living with maternal grandmother was not requested (maternal grandmother's partner and her adult son).

The evidence from observations of the relationship between the children's maternal grandmother and the children was that there was a warm and caring relationship. There was a period of two weeks when maternal grandmother cared for the children in a hotel in Manchester and there was clearly a bond between the children and their maternal grandmother. There was also agreement between the Police and Children's Services that the children should be allowed to return to Poland.

There were some very real dilemmas in the management of this case in the aftermath of the murder. It was vital that the children were supported as fully as possible and all of the evidence suggests that their placement with Polish speaking foster carers and the arrangement for their maternal grandmother and maternal uncle to support the children in the UK was appropriate and child focused.
It was also right that the children's maternal grandmother should have been considered as a viable carer for the children and as Polish citizens, the children's long term needs were more likely to be met in the care of relatives where there was an established bond.
It seems likely, from available information, the decision when to let the children return to Poland was genuinely intended to help them to settle in a supportive and familiar environment following their traumatic experience. Also residing in a hotel for the four children, their maternal grandmother and maternal uncle was also not an ideal situation. There were however some very basic checks that should have been completed, prior to the children moving to Poland.

The risk assessment, prior to the children returning to Poland, failed to seek or obtain basic checks on significant adults who would be living in the household with the children. There were two adult males living with the children's maternal grandmother and Police checks were not made in relation to either of these

people. Whilst there was a perceived and understandable urgency about allowing the children to return to Poland as speedily as possible, these very basic checks should have commenced and been completed prior to the children's move. It should be noted that the checks on maternal grandmother did not commence until the 24th June 2013 and were returned, through the Polish Embassy on the 26th June 2013. This implies that there would not have been significant delays if checks had been requested, at the same time, on maternal grandmother's partner and her adult son.

Guidance in *Working Together* is clear that:
Where a child becomes looked after the assessment will be the baseline for work with the family. Any needs which have been identified should be addressed before decisions are made about the child's return home. An assessment by a social worker is required before the child returns home under the Care Planning, Placement and Case Review (England) Regulations 2010.
It would have been more appropriate to hold an urgent review whilst the children remained looked after in foster care and made suitable planning arrangements for the proposed move to Poland. This could have included a risk assessment and suitable checks and liaison with the Polish authorities. It would also have encouraged and up to date picture of health and educational needs that could have been shared with the Polish welfare services.
Arrangements for the children having very intensive and close contact with the maternal grandmother and maternal uncle could have been maintained whilst safeguarding the welfare of the children.

There was no evidence that the Polish Social Services were informed about the timing when the children were returning to Poland, nor any evidence that they were updated about the emotional needs of the children. This suggests there are important lessons to be learned about cross national communication and information sharing.

6. 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 message from DS1 sent to school via another pupil in February 2013, where she said that she was, *'not happy at home and step dad and mum were having arguments'*. It was certainly not known that S was a victim of 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 who 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**

addressed in Recommendation 1.

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. It is now known through information provided by maternal grandmother that both S and DS1 had witnessed domestic abuse. There were other risk factors associated with domestic abuse identified such as, threats to kill / threats of suicide, financial difficulties, depression and anxiety, requests for help from statutory agencies. 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. There was also information that DS1 had left school in Poland in 2011 due to behavioural issues, although there doesn't seem to be any further information about this. Frontline practitioners did not consider the whole family picture and focused their attention on the presenting issue of DS1 as a teenage mum and her relationship with S.

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.

Assessments in Children's Services are led by government guidance contained in *Working Together to Safeguard Children (2010).* This guidance was updated in March 2013 with essentially the same messages about assessment being a dynamic process and the main components of a good assessment being the interaction between:

- The child's development needs, including whether they are suffering or likely to suffer significant harm;
- Parents' or carers' capacity to respond to those needs;
- The impact or influence of wider family, community and environmental circumstances.

There were substantial 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. This is a common feature in assessment work that has been commented on by a number of researchers (Rose 2001) (Cicchetti and Valentino 2006).

There was also no evidence of any professional challenge to the conclusions of

the Core Assessment or of significant multi-agency collaboration during the assessment process.

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 social worker leading the assessment was also newly qualified and there may have been some resource issues with a structural reorganisation taking place at the time.

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. **This is addressed in Recommendation 2.**

There is a significant learning point with regard to the age threshold for defining domestic violence incidents. Under current guidance relating to child protection, acts of aggression towards children by their carers would be managed within child safeguarding procedures. Similarly intimate partner or family member incidents of controlling, coercive or threatening behaviour, including violent behaviour, of those over 16 years of age, would be managed under domestic violence procedures. There is a lack of clarity, however, when acts of coercion, controlling or threatening behaviour within families are carried out by those less than 16 years of age. The incident reported about threatening with a hammer, for example was probably not treated as seriously as it should have been, partly because the age of DS1 (15 years at the time) excluded the definition of the incident as that of domestic violence.

This lack of clarity has the potential for causing confusion about the level of response required of practitioners in cases of violence within families perpetrated by young people under the age of 16 years. **This is addressed in Recommendation 5.**

There are also significant learning points in relation to the children's move to Poland. In the absence of any clear guidance to what were very unusual and tragic circumstances, decisions were made to return the children to Poland, in the care of their maternal grandmother. There was very clearly a dilemma. On one hand it was important for the children to be in as secure and familiar an environment as possible. Observation of their relationship with their maternal grandmother strongly suggested that there were affectionate and genuine bonds. On the other hand there were responsibilities to ensure that the children were moving to a safe environment.

There should, however, have been basic criminal checks completed on the partner and adult son of maternal grandmother before the children moved to Poland. This would not necessarily have delayed the move if the checks were done alongside those of the children's maternal grandmother.
It would be unfair to be too critical of the decision making at the time in these difficult circumstances. It is clear however that guidance is necessary to aid decision making when children, who are looked after by the local authority, cease to be accommodated and are cared for by relatives in another country. **This is addressed in Recommendation 3.**

Allied to the previous issue, and also the assessment process, 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.

This is addressed as Recommendation 4.

Despite the agency involvement whilst the family was living in Manchester, there was no indication from any agency 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).

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 organization.

Appendix 1

RESEARCH SOURCES

Brandon, M et al (2008) *Analysing child deaths and serious injury through abuse and neglect.* Department for Children, Schools and Families. London, UK.

Cicchetti, D and Valentino, K (2006) *An Ecological Transactional Perspective on Child Maltreatment* in *Developmental Psychopathology: Risk, Disorder and Adaptation. Wiley. New York.*

HM Government (2010 *Working Together to Safeguard Children.* Department for Children, Schools and Families. London.

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Rose, W (2001) *Assessing children in need and their families: background and context.* In J Horwath (ed) *The Child's World: assessing children in need.* Jessica Kingsley. London.

Travena, P (2009) *New Polish Migrants to the UK: A Synthesis of Exiting Evidence.* Centre for Population Change. Economic and Research Council.