THE EXECUTIVE SUMMARY OF A DOMESTIC HOMICIDE REVIEW UNDER SECTION 9 OF THE DOMESTIC VIOLENCE CRIME AND VICTIMS ACT 2004

IN RESPECT OF THE DEATH OF A WOMAN

'Binesh'

SUMMARY PRODUCED BY PETER MADDOCKS

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Summary of the circumstances and processes of the review

1. This report examines the response of organisations and the appropriateness of professional support given to the 35 year old female victim referred to as Binesh for the purpose of this review who was a resident of Stockport prior to her death in August 2014. The review has considered the extent and quality of contact and involvement with Binesh and the 36 year old male perpetrator who was her estranged husband from the 1st June 2013 to the date of death. He was convicted of manslaughter in late 2015 and was sentenced to life imprisonment with a requirement to serve a minimum of 15 years. Binesh was, and the perpetrator is, British Asian Bangladeshi and Muslim. English is the spoken language.

2. The regional ambulance service was summoned to Binesh's home in the early hours of the 18th August 2014. She was found unconscious on the floor of her bedroom. She was taken to hospital but died from her injuries five days later on the 23rd August 2014. The perpetrator was arrested at the scene initially on a charge of assault and subsequently with murder and was remanded into custody.

3. The circumstances of the death were reported to the chair of the Stockport Community Safety Partnership. It was agreed that the criteria for a domestic homicide review were met at a meeting of the domestic homicide review scoping meeting on the 6th October 2014 and the chair of the Safer Stockport Partnership endorsed the recommendation with a target date for completion by May 2015. Although a draft report was completed by May 2015, the delays in the criminal prosecution required the timetable to be extended. The final report and this executive summary were published after the Home Office evaluation was completed in May 2016.

4. The methodology of the review complies with national guidance for the conduct of a domestic homicide review. This includes identifying a suitably experienced and qualified independent person to lead the review and to provide an overview report for publication.

5. The domestic homicide review panel met on three occasions between December 2014 and August 2015. The draft overview report was presented to a meeting of the Safer Stockport Partnership in August 2015 to enable work on action plans to be approved. The report was finalised when the independent reviewer was able to speak with a relative of Binesh after the conclusion of the criminal trial in late 2015.

Organisation	**Job title**
Greater Manchester Police	Detective Sergeant (Serious Sexual Offences Unit)
NHS England	Patient Experience Manager

NHS Stockport Clinical Commissioning Group	Named Nurse Safeguarding Children
Stockport Metropolitan Borough Council	Head of Service Children's Social Care
Stockport Metropolitan Borough Council	Deputy Head of Service Community Safety Unit
Stockport Metropolitan Borough Council	Service Manager Children's Social Care
Stockport Metropolitan Borough Council	Manager Children's Safeguarding
Stockport Metropolitan Borough Council	Head of Social Care
Stockport Metropolitan Borough Council	Head of Safeguarding
Stockport Metropolitan Borough Council	Community Learning Mentor Cultural Issues
Stockport NHS Foundation Trust	Child Programme Team Leader
Stockport Self Help Service	Lead Officer
Stockport Women's Centre	Business and Development Manager
Tameside Metropolitan Borough Council Education	LADO[1] and Safeguarding Advisor for Education Services[2] in Tameside
Tameside Metropolitan Borough Council	Named Nurse
Victim Support	Service Delivery Manager

6. The panel was attended by the Officer for Domestic Violence from Stockport Metropolitan Borough Council. The panel co-opted specialists to provide specific advice as required. For example the Stockport Ethnic Diversity Team were consulted in regard to issues of culture, ethnicity and religion and provided advice to the panel and the authors of individual management review reports.

7. A family liaison officer provided the point of contact between the review and the family and facilitated the arrangements for the independent reviewer to speak with Binesh's relative after the criminal trial had been completed.

8. A routine request for information was made to local organisations at the outset of the review to establish what contact and information there had been with Binesh, the perpetrator or their two children.

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[1] LADO is the local authority designated officer and is described in national guidance (*Working Together to Safeguard Children*). The LADO role applies to paid, unpaid, volunteers, casual, agency or anyone self-employed and they capture concerns, allegations or offences emanating from outside of work.

[2] Binesh was employed by Tameside Metropolitan Borough as a teacher and taught at the school attended by both of her children.

9. Eleven organisations had contact of information and are listed below. Seven of those organisations provided an individual management report (IMR) as described in national guidance. These are described as full reports. The four other organisations had less contact or involvement that did not justify a full report and these services provided information in a short report. The full reports required organisations to provide a detailed account and analysis against the terms of reference set for the review which are included as an appendix.

    i. CAFCASS (full report in regard to the private law proceedings in 2014);

    ii. Central Manchester University Hospitals NHS Foundation Trust (short report in relation to historical treatment and provided emergency hospital care following the fatal assault);

    iii. Greater Manchester Police (notification of homicide and a full report about historical contact and then response to disclosure of rape in April 2014 and criminal investigation of Binesh's death[3]);

    iv. NHS England in regard to the GP (full report about provision of general medical care to the family);

    v. North West Ambulance Service (NWAS) (short report in regard to the emergency response to Binesh's fatal injury);

    vi. Pennine Care NHS Foundation Trust (short report about contact with Child 1);

    vii. Primary School (full report about Binesh's employment and the education for Child 1 and Child 2).

    viii. Stockport Children's Social Care and Safeguarding (children's social care services) (full report in regard to an assessment and provided a report in regard to the private law proceedings in 2014);

    ix. Stockport NHS Foundation Trust (short report in regard to school nursing services);

    x. Self Help Services (full report about an assessment of the perpetrator's mental health in August 2014);

    xi. Victim Support (full report in relation to burglary in November 2013 and then following Binesh's disclosure of rape in April 2014);

[3] Not all of the police contacts described in the agency police review and chronology are referenced in this report; some such as a burglary are not relevant to the domestic homicide review.

10. Binesh was a qualified teacher and worked in a school in a neighbouring local authority. The perpetrator does not have higher education qualifications and has a history of casual employment.

11. Research and evidence from other domestic homicide reviews consistently show that victims will delay disclosing information about abuse. Binesh had begun telling colleagues at school about some of the circumstances of her relationship with the perpetrator although it was April 2014 before the police were contacted by Binesh to report emotional and physical abuse. Binesh did not want the perpetrator to be prosecuted and hoped the abuse would stop. This is also consistent with many victims of domestic abuse who feel they cannot engage with criminal justice and statutory procedures.

12. The first contact with children's social care services occurred in the same month although was as the result of a request for an assessment and report in regard to a private law application that had been made by the perpetrator for a prohibited steps order (which was not granted). Binesh disclosed longstanding emotional abuse and an increasing level of control by the perpetrator. It was on the same day and after this visit by CSC that the perpetrator contacted children's social care services and the police to report that Binesh and the children were missing and saying that he thought she had gone to a relative's home where the perpetrator was attempting to prevent the children visiting through the prohibited steps order application.

13. Binesh also told the GP about having suffered years of emotional abuse during a medical consultation for a sore throat. The school had also been told at other times about verbal arguments and the children having witnessed a physical assault on the victim. Significantly, the school had been confident that Binesh was dealing with the situation and was taking steps to protect the children and herself.

14. At the end of April 2014 Binesh reported being raped by the perpetrator. Binesh was unwilling and unable to agree to be video interviewed or to make a formal statement and declined contact with the specialist sexual abuse referral centre. This presented difficulties for the police in collating important evidence and conducting an effective investigation. Although Binesh's behaviour might appear counter intuitive it is not unusual for victim's to face very significant internal and external inhibitors to engaging with the police and other services. For example, some people saw Binesh's education and being articulate and confident as indicators that she could take appropriate action. Conversely, for a victim who is educated, has status through their professional role and with family and friends they can have a sense of misplaced shame that such abuse should be happening to them.

15. There were misunderstandings on the part of individual police officers that because of the allegation that Binesh's circumstances would be discussed at the MARAC (multiagency risk assessment conference). This did not happen because Binesh was not assessed as being at the highest risk of domestic abuse.

Key issues arising from the review

16. Consistent with the evidence from research and other reviews, Binesh lived with abuse for several years without talking to anybody including her family. The reasons for victims to not disclose what is happening, and especially for an educated and articulate woman such as Binesh can be complex. Binesh's relative felt that a contributory factor could have been Binesh knowing that the family had expressed their doubts about the relationship with the perpetrator and had opposed the marriage. The family felt it was not a good match in regard to the difference in educational achievement and employment for example. This may have inhibited Binesh in confiding with her family.

17. Binesh was an educated, intelligent and articulate woman and victims who share a similar background have a sense of disbelief and dissonance about how they could possibly be a victim. A corollary to this was that her colleagues felt that Binesh had the capacity and ability to deal with the abusive relationship. Domestic abuse has an impact on victims at many different levels. It is emotionally and physically damaging and erodes self-image and resilience.

18. Binesh suffered financial and sexual coercion. She disclosed some of this from April 2014 onwards but could not engage with the police in pursuing a prosecution. The reasons were not articulated and again from the evidence from research and domestic homicide reviews, the inhibitors can be multiple and varied. As with all victims, Binesh hoped the abuse would cease. The motivation for the perpetrator refusing to accept the separation have not been fully articulated. He was reliant on Binesh's income, incurred debts and continued to coerce Binesh into sexual relations. He sought to isolate her from the relative he knew she visited. He verbally and physically abused Binesh in front of the children.

19. Whilst recognising that Binesh's inability to co-operate with a police investigation in regard to the rape allegation was an obstacle it appears that professionals collectively had an insufficiently developed awareness about victim and perpetrator behaviour at key moments. Assessments and enquiries, whether for the purpose of criminal investigations or to safeguard victims and children have to be informed by an awareness of the factors that can inhibit and influence the behaviour of victims. Professionals need to have the capacity to develop appropriate strategies to help overcome the obstacles. A victim who is not co-operating in a robust plan of safety is in itself an indicator of risk and should not be treated simply as preventing any further action of any description.

20. Binesh's behaviour was not unusual for a victim in regard to keeping information hidden for so long, feeling unable to support a criminal investigation or in leaving and returning to the family home.

21. The only time that the perpetrator was the subject of any imposed control was when he was made the subject of the police bail that prevented him from residing with or having contact with Binesh. The bail was imposed after Binesh made the initial statement about the rape although lapsed when she was unable to go further with the police investigation. Other legal avenues for example in seeking a non-molestation and occupation order were not used and there is not a record of anybody advising Binesh about this course of action.

Conclusions and recommendations

22. Any meaningful analysis of the complex human interactions and processes for decision making that characterise multiagency work with adults vulnerable to domestic abuse has to understand why things happen and the extent to which local systems help or hinder effective work to prevent and stop domestic abuse.

23. The process of undertaking the review has already generated learning across several services and therefore it is of doubtful quality to take an unduly forensic approach of dealing with every detailed aspect; such an approach leads to over complicated and ultimately less effective action plans and strategies. The fact that the final overview report will be a public document also means that the full content is available for relevant training and development to promote continued learning across all services.

24. The key points of learning relate to:
    a) Recognition and understanding about domestic abuse
    b) Risk assessment
    c) Role of universal services
    d) Domestic abuse as a safeguarding issue for children
    e) Policy and training

Recognition and understanding about domestic abuse

25. The domestic abuse strategy in Stockport identifies gaps and inconsistencies within early intervention and prevention services and recognises the importance for workforce development.

26. Professionals need to distinguish between the controlling and coercive behaviour that constitutes domestic abuse and other behaviour that reflects marital or relationship difficulties and tensions. Although separation and divorce are difficult and distressing experiences especially for children that can be ameliorated by strategies such as mediation and support, it is domestic abuse that represents a

distinct and different attitude, behaviour and threat that requires clarity in its recognition, definition and response by professionals. It requires having the knowledge, skill and sensitivity to actively look for signs and symptoms of domestic abuse given the barriers that face victims in disclosing it.

27. The Greater Manchester Domestic Abuse Procedures emphasis that workers in all agencies need to be in a position to identify and receive disclosures about domestic abuse and be prepared to ask direct questions. GPs are one group of professionals who will be recipients of information and was the case for Binesh and the perpetrator. Schools or employers more generally can also be other recipients of information.

28. Domestic abuse is when someone in a close relationship behaves in a way that causes the other person physical, mental, or emotional damage. It doesn't have to be physical violence. It includes any incident of threatening behaviour. Domestic abuse can be psychological, physical, social, financial or emotional and this is reflected in the amendments to national definitions of domestic abuse issued in September 2012 to reflect the legal protections set out in the Equality Act 2010.

29. The extent to which Binesh was suffering emotional, physical and sexual coercion (and how this affected her behaviour) was not clearly enough recognised by any of the services. If it had been there would have been better opportunity to have understood the behaviour of both perpetrator and victim particularly from April 2014 onwards. It would have given greater confidence in key interactions with Binesh at school, with the police and with children's social care services.

30. The quality of professional's response influences the likelihood of victims engaging with strategies and action. Victims will not want to leave their home and the disruption of familiar routines and places for adult victims and for children often requires contemplation and involve decisions to subsequently return. Victims will also be concerned and fearful of an escalation in abuse and violence; this was clearly the position for Binesh.

31. Individuals who return to violent or abusive situations require more help not less. Returning home and a familiar situation should be seen as a normal response to separation and part of the process of longer term change. Victims and their children will be under a great deal of emotional and psychological stress. An up to date risk assessment should be completed in these circumstances.

32. Binesh had been discussing the domestic abuse with work colleagues at school from the summer of 2013. Victims of domestic abuse who are in employment or training may either disclose information as Binesh did or work colleagues may observe other indicators such as evidence of physical injury or Binesh being controlled in terms of

contact in or outside of the workplace. It is for this reason that organisations should have policies about domestic abuse and how employees can be supported.

33. The fact that Binesh was a teacher should have given an enhanced level of professional workplace knowledge within the school about domestic abuse compared for example to a commercial or manufacturing enterprise. Domestic abuse is an issue that affects individuals across all social and economic groups be they a victim or a perpetrator. This case shows that employers and work colleagues might well be the people who victims talk to about domestic abuse. Clear policies in regard to responding to an employee who is either a victim or a perpetrator of domestic abuse will assist in responding appropriately.

34. Domestic abuse is a safeguarding issue for children and it will be a teacher or primary health worker who is more likely than any other professional to observe or receive information indicating that a child is living in a household with domestic violence. In order to do this, school staff and the school designated safeguarding lead in particular have to participate in training and development that enable them to have the skills and ability to identify signs of abuse and what needs to be done.

35. The domestic homicide review has highlighted that in this school there had not been the level of training required to enable them to effectively respond to the disclosures by Binesh or identify the safeguarding issues in regard to the children. All of the discussions were undertaken on the basis of empathetic support much as a friend might provide rather than bringing the level of professional perspective and action required.

36. The school (and other services) relied too much on Binesh being able to resolve the situation in spite of the evidence that the perpetrator had no intention of agreeing to a separation or allowing Binesh to leave the relationship. Better participation in appropriate training and the development of awareness would are more likely to promote a better understanding about crucial interactions; for example that when the perpetrator was making allegations about the relative it was part of a strategy to isolate Binesh.

37. At no stage did the school, and in particular the designated safeguarding lead consider initiating a CAF as a precursor to more intensive involvement or making a referral to children's social care services ideally with the cooperation of Binesh. The involvement of other statutory services would have provided opportunity for an earlier assessment of the children's circumstances and conceivably would have introduced other sources of advice and help that could have included the use of civil law measures such as a non-molestation order.

38. The response by the police relied unduly on Binesh cooperating with criminal investigations. It is not evident that there was sufficient understanding about the reasons that victims very often will report abuse and violence but are reluctant to formalise statements or undergo forensic procedures. The response to the allegation of the rape took little account of seeking other evidence that included the previous history.

39. The fact that much of the information held by different professionals remained within their organisational silos hampered anybody having a good enough overview. The police and children's social care services had separate disclosures about domestic abuse within a 48 hour timeframe at the beginning of April 2014 although neither service was aware of this at the time. The police sent a routine notification through to children's social care services a month later.

40. All of the services relied on Binesh being able to take sufficient protective action for herself and for the children. The extent to which Binesh felt ashamed of being a victim of domestic abuse partly as a result of being a professional educated and articulate woman was not appreciated.

Risk assessment

41. The overall approach to risk assessment did not appear to appreciate the degree to which a disclosure of domestic abuse and/or an attempt to leave an abusive relationship would represent an increased rather than decreased level of risk to a victim. Binesh left the house when she became aware that the perpetrator had found notes and evidence that she had been talking to the police.

42. This did not feature to any significant level in any risk assessment. There was high reliance on the perpetrator complying with his bail conditions and when this ended after the decision was taken that no further action could be taken there was no explicit risk assessment or sharing of information with children's social care services. There was insufficient attention to the circumstances, needs and voice of the children and the impact on them of being witnesses to domestic abuse.

43. The importance of assessment actively seeking out and considering the views, wishes and feelings of children appropriate to their age and understanding and analysing the implications for their immediate and longer term safety and well-being is a recurring theme in reviews.

44. Victims can also minimise the degree of risk. Some of this reflects a desire to manage the response by professionals and fearing consequences. Some of it is a lack of knowledge and understanding about the nature of coercion and control.

45. None of the professionals appeared to advise Binesh to seek a non-molestation and occupation order. This may have reflected a reliance on the bail conditions imposing controls on the perpetrator although ended when Binesh felt unable to support follow up action after the initial allegation of rape.

46. The confusion about whether the case was to go to a MARAC appeared to have given Binesh some reassurance. In fact the case was closed to both the police and to Victim Support.

47. The inability of Binesh to accept contact with the SARC (sexual abuse referral centre) removed the opportunity for specialist professionals to talk with Binesh. If she had been able to take that step it would have opened up opportunities to encourage and support Binesh in a plan that involved the criminal justice services and the development of a safety plan. There is no recorded reason for why Binesh did not want to have involvement with SARC.

48. The absence of any significant mental health or any evidence of substance misuse probably contributed to an overall optimism that Binesh was not at high risk from the perpetrator.

Role of universal services

49. The value and importance of professionals working in universally accessible services has been reinforced by this review. The first and most persistent disclosures were at school and the GP practice was also receiving information from both Binesh and the perpetrator.

50. The extent to which these services do not have clear enough policy and protocol and the absence of focussed curiosity and ability to ask direct questions is an important learning point.

51. The Royal College of General Practitioners published guidance to help staff working in general practices to respond effectively to patients experiencing domestic abuse[4]. The guidance describes key principles to help develop domestic abuse policy which includes the role of a senior and designated person for domestic abuse, establishing a domestic abuse care pathway and the training requirements for the whole team including clinical and non-clinical staff. The same guidance also highlights the importance for a strategic lead from within the clinical commissioning group. The Royal College of General Practitioners also endorse the IRIS (identification and referral to improve safety) commissioning guidance published by The University of Bristol.

[4] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

52. The Royal College of General Practitioners also provide through the internet website access to the Violence Against Women and Children e-learning course which enables GPs and other primary care professionals to improve their recognition of and response to patients suffering from violence.

53. The Tameside agency report describes training provided to school in that borough and acknowledges that schools need to access this facility. The education service in Stockport has not been a party to the review given the children were not attending a Stockport school. However the learning identified in regard to ensuring there are clear arrangements in place for a designated safeguarding lead who has sufficient knowledge of domestic abuse and there are clear arrangements in place to ensure teaching and non-teaching staff are able to recognise potential signs and symptoms of domestic abuse and are able to respond appropriately is relevant to Stockport and indeed other areas.

Domestic abuse as a safeguarding issue for children

54. The local domestic abuse procedures highlight that research makes clear links between domestic violence and abuse and the abuse and neglect of children and also found more than half of serious case reviews. 30 per cent of children screened through the local multi agency safeguarding hub (MASH) in Stockport show domestic abuse as the predominant issue.

55. The physical, psychological and emotional effects of domestic abuse and violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may act out the aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under stress. Several of the children displayed symptoms of stress that with hindsight were not identified or understood at the time. The symptoms of stress that can been seen in children living in households where there is domestic abuse and violence include:

    a) Withdrawal
    b) Aggression or bullying
    c) Tantrums
    d) Vandalism
    e) Problems in school, truancy, speech problems, difficulties with learning
    f) Attention seeking
    g) Nightmares or insomnia
    h) Bed-wetting
    i) Anxiety, depression, fear of abandonment
    j) Feelings of inferiority
    k) Drug or alcohol abuse

l) Eating disorders
m) Constant colds, headaches, mouth ulcers, asthma, eczema

56. There are no reports of any of the above symptoms being present for Binesh's children although their distress about arguments and witnessing assaults on Binesh are clearly recorded. The school the children attended is rated as good by Ofsted. A good school is one source of resilience for children dealing with traumatic events in their lives although it is important that this is not allowed to mask the significance of domestic abuse on children's emotional as well as physical well-being.

57. Neither the police nor children's social care services initiated a strategy meeting because the children were not regarded as being at risk of significant harm. This judgment was largely influenced by the way Binesh interacted with both of these services and appeared to be taking steps to protect her children. The inability to engage with the police and the SARC, returning to the home where the perpetrator insisted on remaining, the ending of bail for the perpetrator and no other legal sanction being in place were indicators that the children could and would be exposed to further abuse.

Policy and training arrangements

58. None of the services have referred to any specific policies in regard to domestic abuse either in regard to looking after employees who are victims of domestic abuse as well as policies for helping patients, pupils and service users. The Crown Prosecution Service (who were not participants in this review) have as an example of good practice developed guidance for employees in that service suffering domestic violence.

59. The NHS accountability and assurance framework described in *Safeguarding Vulnerable People in the Reformed NHS* published in March 2013 by the NHS Commissioning Board makes clear an expectation that GP practices have a safeguarding lead. 35 of the 48 GP practices in Stockport actively participate in the quarterly safeguarding briefings. These have included information about domestic abuse as well as having input from the specialist sergeant from the police domestic abuse team.

60. The Greater Manchester Child Protection Procedures do not make a clear and specific reference to the importance of recognising and understanding the impact of domestic abuse as a source of harm for children. Although the procedures include reference to domestic abuse as an indicator of abuse and it is included in the section that deals with children in specific circumstances it gives little specific advice and guidance on what should be done either in identifying potential signs and symptoms (for example through children's behaviour) or following more specific disclosures for example.

61. Multi agency training in regard to the impact of domestic abuse is included in the Stockport Safeguarding Children Board annual programme. There is e-learning on domestic abuse awareness provided through delivered the Virtual College which is accessed through licence. This has a cost implication for any professional or services outside of the local authority. The decision was made last year to stop delivering the classroom based sessions because of dropping attendance and to move to the online learning package. No information was available about who was participating in this level of training.

62. The reliance on e-learning to deliver training on complex areas of work such as domestic abuse are being highlighted in other reviews. E-learning provides limited opportunity to develop the level of cognitive awareness necessary to recognise evidence of coercion and to understand the barriers that face victims in making disclosures or engaging with strategies.

Recommendations

1. NHS England should clarify that NHS Stockport Clinical Commissioning Group have a professional lead for domestic abuse which is clearly identified in that post holder's job description. The lead should represent the clinical commissioning group at the strategic forum in Stockport that oversees the domestic abuse strategy.

2. NHS England and Stockport Clinical Commissioning Group should ensure that all GP practices in Stockport have been made aware of the guidance issued by the Royal College of General Practitioners and encourage them to ensure that there is a written policy for the practice and the role of the safeguarding lead in respect of domestic abuse that complies with *Safeguarding Vulnerable People in the Reformed NHS 2013*.

3. NHS England and Stockport Clinical Commissioning Group should encourage clinical and non-clinical staff in GP practices to complete relevant training which for members of the Royal College of General Practitioners (RCGP) includes the Violence Against Women and Children e-learning course.

4. The Stockport Community Safety Partnership should develop a model policy statement that can be used by employers setting out guidance on responding to employees experiencing domestic abuse and that it is promoted through local employer organisations that include the chamber of commerce and professional associations.

5. The safeguarding advisor for schools in Tameside and Stockport should ensure that all schools have a written policy in regard to domestic abuse and

that domestic abuse is written into the role of their safeguarding or designated senior professional.

6. The Stockport Safeguarding Children Board should ensure that the local audit of arrangements under section 11 of the Children Act 2004 and any data collated under section 175 of the Education Act 2002 (governing and responsible bodies for schools complying with safeguarding responsibilities) incorporate data and information on domestic abuse from schools and early years settings.

7. The Stockport Safeguarding Children Board should ensure that specific guidance on the recognition of and response to children affected by domestic abuse and violence is included in local safeguarding policies, procedures and training.

8. Stockport Children's Social Care Services and the Greater Manchester Police should ensure that when their professional staff are responding to information or referrals about domestic abuse that a clear record is made of advice and action to promote the safety of the victim and any children and any contingency arrangement or plans.

9. The Stockport Community Safety Partnership should seek clarification from the Greater Manchester Police public protection and investigation unit about the role and use of diary appointments in regard to contact from domestic abuse victims.

10. The Stockport Community Safety Partnership should review with the Stockport Children Safeguarding Children Board the level and effectiveness of training for professionals in regard to domestic abuse and seek further information about single agency training and development.

11. The Stockport Community Safety Partnership should review with the Stockport Safeguarding Children Board the availability and effectiveness of training and development in regard to cultural awareness and understanding and implications for working with victims vulnerable to domestic abuse.

Terms of reference

a) What contact did agencies have with family members?

b) What services did agencies offer to the subject and other family members? Were these services accessible, appropriate and sympathetic to the presenting needs?

c) Did any agency have knowledge of domestic abuse in this family? If so, how was this knowledge acted upon?

d) What safety planning was offered to Binesh and/or family members including referral to specialist domestic abuse services?

e) What (if any) services were offered to the perpetrator of domestic abuse?

f) What knowledge did Binesh's family and friends have about domestic abuse within the family composition and what did they do with it?

g) How did agencies, family members and friends deal with any confidentiality issues Binesh might have requested of them?

h) Were there any specific diversity issues relating to the subject/family?

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

j) Were there issues in relation to capacity or resources in any agency that impacted the ability to provide services to Binesh and to work effectively with other agencies?

k) Was information sharing within and between agencies appropriate, timely and effective?

l) Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?

m) Do any agency's policies / procedures / training require amending or new ones establishing as a result of this case?

n) Was it possible for any agency to predict and prevent the harm that came to Binesh?

o) Is there any other information that maybe relevant to this review?