For Publication

DOMESTIC HOMICIDE REVIEW

‘SCOTT’

OCTOBER 2015

REPORT PRODUCED BY PETER MADDOCKS

INDEPENDENT AUTHOR

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For Publication

Contents

Introduction

1. The report begins by expressing the sincere sympathies on behalf of the Safer Stockport Partnership who commissioned the review and the people who contributed information or worked on the review. We understand that Scott's death had a profound impact on his family.

2. This domestic homicide review (DHR) examines the response of organisations and the appropriateness of professional support given to 45-year-old Scott, a resident of Stockport prior to his death in October 2015, due to fatal wounds inflicted by Lena, his then 48-year-old partner.

3. In addition to agency involvement, the review also examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community, and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

4. The key purpose of undertaking DHRs 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.

5. The review considers the contact and involvement by different professionals and organisations with Scott and Lena as well as with Scott's previous long term partner, Susan. The timeline for the review is from July 2011 until October 2015. It was in July 2011 that the police recorded the first incident of domestic abuse.

Timescales

6. The review originally began in December 2015 although was suspended at the request of the Crown Prosecution Service and the police until after the criminal trial had been completed in November 2016.

7. The review was completed when the draft report was presented to the Safer Stockport Partnership in May 2017. Lena was given leave to appeal her sentence and this was heard in August 2017 when her sentence was reduced.

Confidentiality

8. The findings of a domestic homicide review are confidential. Information is available only to participating officers/professionals and their line managers.

9. Professionals are referred to by their roles such as independent domestic violence advocate (IDVA), GP, police officer, teacher or social worker for example. The services that were involved are described in paragraph 24.

Methodology and terms of reference

10. The circumstances of Scott's death were reported to the chair of the Stockport Community Safety Partnership. It was agreed in December 2015 that the criteria for a domestic homicide review were met.

11. A domestic homicide must review the circumstances in which the death of person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship, or been a member of the same household as themselves.

12. 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.

13. The initial scoping agreed the list of services who would be asked to provide an individual management report if their involvement was significant; for services who had very brief contact a shorter statement of information was requested.

14. This initial tranche of individual management reports (IMR) was commissioned before the first meeting of the panel in March 2016 and had a completion date was initially set for June 2016.

15. This schedule was revised following the first meeting of the panel in March 2016 when additional agencies were identified as needing to provide information for the review. There were also delays in the criminal trial which was postponed until late October 2016.

16. The Crown Prosecution Service (CPS) had been consulted by the police on charging issues relating to previous incidents of domestic abuse but because of their role in the criminal process, they were unable to disclose or provide information until the completion of the criminal trial. Additionally, the police had referred their contact with Scott just a few weeks prior to the fatal assault to the Independent Police Complaints Commission (IPCC).

17. The fact that several family members were also material witnesses in the criminal proceedings prevented information being sought from them until the trial had been completed.

18. The CPS requested a delay to the DHR in April 2016 on the basis that none of the family members could be approached for information prior to the completion of the court proceedings and needing to postpone work on an IMR on behalf of the CPS.

19. Agencies contributing reports or information to the domestic homicide review used the following terms of reference to provide information and analysis for the domestic homicide review.

    a) What contact did agencies have with family members?

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

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

    d) What safety planning was offered to the victims/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 family and friends have about domestic abuse and what did they do with it?

    g) How did agencies, family members and friends deal with any confidentiality issues the victims 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 agencies that impacted on their ability to provide services to the victims 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 of the agencies 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 the homicide victim?

o) Any other information relevant to this review

Involvement of family, friends, work colleagues, neighbours and the wider community

20. A letter was sent to Scott's family via his sister who was their chosen point of contact for the review. This letter was sent via the police family liaison officer in early 2016. The family confirmed they wanted to have contact and would provide information. This had to be postponed until early 2017 after the criminal proceedings had been concluded at the request of CPS given that family members were scheduled to provide evidence in the court proceedings. The author of this report had the first meeting with Scott's sister in January 2017. Information was provided to the family about advocacy services including Advocacy After Fatal Domestic Abuse.

21. Scott's family say that they had no information from either Scott or from Lena to indicate that there was domestic abuse and felt strongly that this had only been alleged by Lena after the fatal stabbing.

22. A letter was given to Susan in the summer of 2016 to ensure that she was also informed of the review. She was also provided with advice and information about advocacy support. It was at this stage that it became apparent that there would be information relevant to the work of the review regarding Susan's contact with the police and other services reporting incidents of domestic abuse before she and Scott separated. At that stage, Susan confirmed that she wanted to provide information for the review although this had to be postponed until after the trial. When the author contacted Susan after the trial she agreed to meet in January 2017. The first meeting was postponed when Susan and one of her children became poorly. Susan was going to be accompanied and supported by a worker from the local Women's Aid service. A further date to meet was scheduled although at that stage Susan felt unable to keep the appointment or to provide any information or take part in the review. She explained this in a text to the author on the 30th of January 2017. Susan has received a copy of the draft report as has Scott's family. None of Susan's children wanted to provide information for the DHR.

23. After Lena had been sentenced and sent to prison the author wrote to the prison governor requesting access to Lena for the purpose of the review. This letter was sent in December 2016. No response was forthcoming from Lena or from her adult child.

Contributors to the review

24. The scoping meeting identified the services who had contact or knowledge about the Scott and/or Lena or Susan. Most of the organisations were required to complete an individual management review (full report) whilst other organisations who had less significant involvement provided a short report.

    a) Crown Prosecution Service (CPS) provided information in a letter following which they were asked to provide a full report in regard to the legal consultations with police on charging decisions regarding Scott in September 2011 when Susan reported being assaulted and again in September 2015 when domestic abuse allegations were made by Lena; a report has not been provided;
    b) Greater Manchester Police (notification of homicide and a full report about the previous contact regarding disclosures of domestic abuse by Susan and Lena and the management of firearms certification for Scott);
    c) Manchester Children's Services (children's social care services) (full report in regard to contact and referrals regarding domestic abuse disclosures by Susan in 2011 and subsequent assessment);
    d) Manchester Early Help HUB (full report in relation to the assertive outreach work in regard to the youngest child on health and school-related needs);
    e) Manchester Education Service (full report in regard to Scott and Susan's younger children);
    f) Manchester IDVA (independent domestic violence advocacy) service; (full report in regard to Susan's disclosures of domestic abuse);
    g) Manchester Mental Health and Social Care Trust (report completed under the serious incident framework regarding services to Lena and a shorter report regarding a three-week contact in 2011 with Scott);
    h) Manchester Clinical Commissioning Groups (CCG) (provided a full report in regard to relevant patient contact by the GP practice which coincidentally was where Scott, Lena, Susan and the children were all registered)[1];

[1] The individuals were registered for different lengths of time. Scott was registered in 1997, Susan was registered in 1998 and Lena was registered in 2006.

i) North West Ambulance Service (NWAS) (short report in regard to emergency response to Scott's fatal injury);
j) Victim Support (full report in relation to domestic abuse of Susan by Scott in 2011);
k) Community Housing Group (full report in relation to Susan making a disclosure of domestic abuse which included assistance in accessing legal advice and upgrading security at the family home).

25. The National Centre for Domestic Violence was asked to provide a summary of information regarding telephone-based legal advice to Susan to prevent harassment by Scott. No information was provided by that service despite follow up requests.

26. The initial collation of information from agencies identified that Susan had made an application to revoke a Non-Molestation Order made against Scott in late September 2011 only weeks later in early November 2011. None of the services was party to providing advice or help regarding that revocation. The independent reviewer sought legal advice regarding disclosure of information submitted to the court to revoke the order which required a formal 'C2' application for a judicial decision as to whether information should be released. The purpose of the proposed application was to seek clarification as to whether the court sought any information about whether Susan was being subjected to coercion or control by Scott in making that application. The application could not be made until after the criminal proceedings had been completed. The information collated by the review from different organisations describes how Scott had continued to exert pressure on Susan through contact with the children and friends and on one occasion entered the house without permission in the middle of the night.

27. This procedure required Susan to be notified of the application and to be a party to the process. Susan was also a potential witness for the criminal proceedings that were postponed from March 2016 until October 2016. CPS requested that no approach was made to any of the relatives or witnesses and therefore it would have been inappropriate to have initiated a separate legal process without being able to speak with and explain the purpose to Susan.

28. The panel decided in December 2016 that the DHR should not be delayed any further with an application for release of court information relating to the Non-Molestation Order revocation. At that time the reviewer expected to speak with Susan in January 2017 although as described elsewhere Susan felt unable to meet. Relevant learning is highlighted in the final chapter including issues for national policy.

The review panel membership

29. The first meeting of the panel was in March 2016. Two further meetings of the panel were held in April and June 2016 before the meetings were suspended until the criminal trial had been completed in November 2016. The panel met in December 2016 and for the final time in February 2017. CPS was invited to participate as panel members but did not attend.

Organisation	**Name, job title or role**
Alliance for Positive Relationships[2]	Amanda Dewson, Manager
Greater Manchester Fire and Rescue Service	Paul Starling Borough Manager Stockport and Tameside
Greater Manchester Police	Alison Troisi Sergeant Specialist Protective Services
National Probation Service (North West Division)	Richard Moses, Head of Stockport and Tameside, National Probation Service (North West Division)
Manchester City Council	Michelle Hulme, Policy Specialist, Community Safety Team
NHS England	Louise Davison, Designated Nurse Safeguarding Adults Citywide Team (Commissioning and Quality)
NHS Stockport Clinical Commissioning Group	Andria Walton Designated Nurse for Adult Safeguarding who was replaced by Sue Gaskell (Designated Nurse Safeguarding Children) for one of the panel meetings
NHS Stockport Clinical Commissioning Group	Julie Parker, Head of Safeguarding/Designated Nurse Safeguarding Children
Stockport Metropolitan Council	Ged Sweeney, Manager Children's Services
Stockport Metropolitan Council	Nuala O'Rourke Head of Safeguarding and Learning
Stockport Metropolitan Council	Steve Skelton Head of Policy, Performance and Reform
Stockport Metropolitan Council	Rachel Smith, Manager, Community Safety Unit
Stockport Metropolitan Council	Elaine Alkin Neighbourhood Officer and business support to the review in attendance
Independent chair of the panel	Peter Maddocks

[2] The APR partners include Stockport Women's Centre and Stockport without Abuse from the voluntary sector domestic abuse specialist services and is about preventing domestic abuse and looking at different methods to support families. This includes working with men, women and families who are involved with domestic abuse incidents.

The author of the overview report and statement of independence

30. Peter Maddocks is the independent chair and overview report author for this domestic homicide review. He was commissioned in February 2016. He has over forty years' experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council (HCPC). He undertakes work throughout the United Kingdom as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has completed domestic homicide reviews with other community safety partnerships in England. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales. In compliance with national guidance, he has used the online toolkit and online learning provided by the Home Office. He has also participated in training in relation to serious case reviews including the use of systems learning as developed by SCIE (Social Care Institute for Excellence) in regard to serious case reviews and participated in masterclass training for independent reviewers. He has undertaken one domestic homicide review previously in Stockport. He has never been employed by any of the organisations participating in the review, has not held elected office the borough or in Manchester and has no personal or other relationship with any individual who has a professional or elected position in the borough or in Manchester.

Parallel reviews

31. The Independent Police Complaints Commission (IPCC) investigated the circumstances of the contact the police had with Lena and Scott between the 30th September 2015 and the 13th October 2015 after Lena had reported being the victim of domestic abuse from Scott[3]. The independent reviewer requested, and was granted, interested party status to the IPCC investigation and was provided with information including a copy of the IPCC report to assist with the collation of learning for the domestic homicide review. The IPCC investigation concluded that police officers did not cause or contribute to the death of Scott and could not have reasonably predicted the murder of Scott. The investigation made one recommendation that Greater Manchester Police (GMP) should ensure that the Public Protection Investigation Unit (PPIU) handbook was updated to reflect the changes in working practices that had already been developed.

32. Lena received care and treatment from specialist mental health services since 2006 although was never a detained patient. Although she has presented with symptoms including self-harm and impulsive behaviour (in regard to self-harm)

[3] The referral to the IPCC was made by the Greater Manchester Police because of the recent contact with Lena and Scott. The IPCC has been subsequently replaced by the Independent Office for Police Conduct.

as well as auditory hallucinations[4] (these were about low self-esteem and Lena thinking she should be dead rather than any instruction or prompting to cause harm to others) she has never been diagnosed as presenting a risk to a third party including intimate partners.

33. The review was advised that statutory investigations were to be conducted in compliance with the NHS England Serious Incident Framework and the Department for Health Guidance EL (94) 27 and LASSL (94) 4. Following discussion between the NHS officers and the independent reviewer, it was agreed that it was appropriate for the reviews to be completed independently of each other[5]. The trial judge was clear in stating that the history of mental health was not relevant to the circumstances of the fatal assault.

Equality and diversity

34. The three adults and the respective children are all white British and English is their language of communication. According to the independent domestic abuse advocate (IDVA), Scott and Susan both had good reading and writing skills. No information is provided about Lena by any service in regard to these aptitudes.

35. All three adults had a degree of mental ill-health with Lena having the most extensive and complex needs. This, combined with her use of alcohol, was an indicator of additional vulnerability. She also appeared to have few friends and did not work.

36. Scott experienced less severe episodes of depression that appeared to be reactive in nature when dealing with his feelings regarding separation from his children. He was a user of alcohol and drugs.

37. Susan experienced some episodes of depression which were subject of consultation and support from the GP.

38. Lena was subjected to domestic abuse in a previous relationship.

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[4] Auditory hallucinations are false perceptions of sound. They have been described as the experience of internal words or noises that have no real origin in the outside world and are perceived to be separate from the person's mental processes. They can be experienced for example as instruction to harm a third party or as in this case can be experienced as reinforcing a negative self-image or that other people have a negative attitude or view.

[5] The statutory guidance describes serious incidents in the NHS as being acts or omissions occurring as part of NHS-funded healthcare (including in the community) that result in the unexpected or avoidable death of one or more people and which includes homicide by a person in receipt of mental health care within the recent past. https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/

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Dissemination

39. The following organisations and people receive a copy of the overview report. This is in addition to Scott's family and Susan.

Panel Members

Alliance for Positive Relationships	
Independent Consultant	Chair and Author of Report
NHS England	Patient Experience Manager
NHS Stockport (CCG)	Designated Nurse for Safeguarding Children
Greater Manchester Fire and Rescue Service	
Greater Manchester Police	Detective Sergeant – Serious Case Review
Greater Manchester Probation Trust	
Manchester City Council	Policy Specialist Community Safety Team
Stockport MBC – Community Safety Unit	Deputy Head of Service
Stockport MBC – Children Social Care	Head of Service
Stockport MBC – Children's Safeguarding	Manager
Stockport MBC	Head of Policy, Performance and Reform
Stockport NHS Foundation Trust	Named Nurse Safeguarding (CCG)

In attendance at the Panel:

Stockport MBC – Community Safety Unit	Officer for Domestic Violence
Manchester City Council	

Report Authors

Children's Social Care and Safeguarding,	Manchester City Council
Greater Manchester Police	
Manchester Early Years HUB	
Manchester Education Service	

Manchester IDVA

Manchester Mental Health and Social Care Trust

Manchester Children's Social Care Services

NHS Foundation Trust - Nursing

Manchester Clinical Commissioning Group - GP

North West Ambulance Service (NWAS)

Manchester Clinical Commissioning Group

Victim Support

Wythenshawe Community Housing Group

Safer Stockport Partnership Board

Greater Manchester Fire Service

Greater Manchester Police Crime Commissioners Office

Greater Manchester Police Service

Guinness Housing Partnership Association

Home Office

Independent Consultant

Member of Parliament

National Probation Service

Solutions SK

Stockport Council

Stockport Councillors

Stockport Homes

Stockport NHS

Stockport NHS Foundation Trust

Transport for Greater Manchester

Victim Support

Background information (the facts)

40. Scott and Lena were in a relationship from 2011. Scott was 45 years old when he died and Lena was 48 years old. Lisa had one child aged 29 years old. According to Scott's family, Lena and Scott had never cohabited. Scott stayed at the property on a regular basis although he was not permanently resident or a joint tenant at the property. Their relationship began while Scott was still living with Susan aged 47 years old in 2015. Scott and Susan had lived together for 24 years until their separation in 2011 after Susan found out about Scott's relationship with Lena which had been taking place for several months. Scott and Susan had four children aged 24, 22, 18 and 12 years respectively.

41. Scott's family live in Greater Manchester. Lena's family also live in Manchester. In 1998 Lena reported being a victim of domestic abuse and an offence of assault was prosecuted against the previous partner who was found not guilty. Lena had alleged that she had been burnt by a domestic appliance during an argument. The archived record of the offence and court decision provides no further detail.

42. In September 2011, Scott went to his GP with his sister to report that he was the victim of domestic abuse from Susan. The GP diagnosed depression and a referral was made to the local mental health crisis resolution home treatment service. They provided support to Scott until October 2011. This was the only recorded report of Scott being a victim of domestic abuse and neither Scott nor any other person made a report to the police.

43. Lena has received care and support from mental health services since May 2006. She has a history of psychotic depression and low mood. Although the mental health services were aware that Lena was in a relationship they had no details about Scott.

44. Prior to the fatal assault, Lena had only come to the attention of services in regard to domestic abuse as a victim rather than as a perpetrator. In September 2015. Lena disclosed being assaulted by Scott and that she had tried to leave the relationship several times. This contact with Lena and Scott less than a month before the fatal stabbing was the subject of the referral to IPCC previously described.

45. None of the services had much information about Scott and Lena's relationship. The most information recorded prior to the homicide was when the police responded to a third party report of a domestic argument between Scott and

Lena in September 2015. The third-party was a neighbour who had been asked by Lena to call the police after she had been assaulted by Scott given she did not have her own mobile phone.

46. Lena was convicted of murder and sentenced to life imprisonment. The jury heard evidence regarding Lena's mental health but expert witnesses said that her illness was not a factor in regard to the circumstances of Scott's death. Lena's sentence was reduced upon appeal in 2017

Chronology

47. There were five recorded incidents of domestic abuse reported to the police about Scott in regard to Susan between August 2011 and September 2012. The first incident in August 2011 was a 'silent' mobile phone call to the emergency call handler who was able to identify the mobile telephone number and linked it to Susan and resulted in police officers being dispatched. Susan declined to engage with a DASH assessment and the case was closed by a specialist DVA (domestic violence and abuse) detective six days later.

48. Three weeks later Susan phoned the police to report that Scott had been 'verbally aggressive' the previous evening and had made threats to kill her. Susan had left the house with her youngest children and had stayed at a friend's home. The police were told that Scott had firearms (for which he had a firearms certificate). Scott was subsequently detained and his firearms were removed temporarily. He was found to have more ammunition than his firearms certificate had permitted and he admitted the offence. Susan declined to participate with the DASH assessment and withdrew her statement about any threats to kill. The DASH was closed at the standard (lowest) level of risk threat assessment and Scott's firearms were subsequently returned to him.

49. Two weeks later in mid-September 2011, Susan reported to the police that she had been struck on her face by Scott. By the time a police officer arrived Scott had already left the property. The police officer recorded that Susan had blood on her mouth and teeth and that the youngest child had witnessed the assault. No separate statement or account about what the child had seen was recorded. Susan confirmed that she would support a prosecution. Scott was arrested and denied assaulting Susan saying that he had been struck by Susan. The CPS declined a charge. Scott declined to allow a referral being made to a local perpetrators service by the police. It was only occasioned when such a referral was apparently considered and it was never followed up. The case was closed by a specialist detective the following day.

50. The landlord housing association made a referral to the MARAC in September 2011 after Susan had told them that she was frightened of Scott and that he

might carry out his threats to kill and to assault the children. Susan had told the landlord that Scott was controlling and trying to dictate where she could go. Susan also reported that Scott was drinking heavily.

51. The police issued a Domestic Violence Protection Notice and a referral was made to Victim Support who allocated a worker to follow up with Susan and other services. A referral was also made to children's social care services.

52. In late September 2011, Scott went to his GP with his sister to report that he was the victim of domestic abuse from Susan. The GP diagnosed depression and a referral was made to the local mental health crisis resolution home treatment service. They provided support to Scott until October 2011.

53. Susan was supported in making an application for a Non-Molestation Order in September 2011 which was granted and was served on Scott.

54. The IDVA (Victim Support and Independent Domestic Violence Advocate) service maintained contact with Susan. A discussion at MARAC (multi-agency risk assessment conference) In October 2011 resulted in no further actions on the understanding that Victim Support would remain involved along with children's social care.

55. In early November 2011 during a routine support phone call by Victim Support, Susan reported having been to court to have the Non-Molestation Order revoked. None of the services had been aware of that application or was asked to provide information to the court.

56. The following day Susan consulted the GP about symptoms of depression during which she talked about a history of domestic violence during the relationship. This was not disclosed to any other service.

57. In December 2011 there was increasing concern about Susan and Scott's youngest child in regard to poor school attendance and challenging behaviour.

58. In March 2012 a neighbour of Lena contacted the police to report a disturbance at Lena's home. Police officers were deployed and detained Scott and Lena's adult son. It was reported that the two men had never got on. The DASH was completed with all 28 questions being refused answers. Lena nor her adult son have provided information for the DHR or about their relationship with Scott.

59. By the summer of 2012, the concerns were such that a further referral was made to children's social care services requesting an assessment in June 2012. An initial assessment was completed which mentions domestic abuse as background information but is not enquired into or analysed.

60. Scott reported having symptoms of depression to his GP in June and July 2012 and that he missed his children. In July 2012 Susan told the police that she was being harassed by Scott via mobile phone messages. One of the messages

was to 'make sure your fire alarm works'. Susan told the police that she had an injunction which she did not and the police were not aware that the Non-Molestation Order had been revoked the previous year by Susan.

61. Scott was arrested for harassment; he acknowledged that he had sent 'numerous text messages' claiming this was only to ask after the welfare of his children. He was cautioned. Scott's firearms certificate was revoked and his firearms were removed because of his further harassment of Susan.

62. There was further phone contact in August 2012 through one of the children.

63. In early September 2012 during a routine contact from a Victim Support officer, Susan reported having woken in the middle of the night a couple of weeks previously to find Scott standing at the foot of her bed. He still had a key to the property. Although Susan was encouraged to report this to the police no information was provided to the police. The locks were changed by the landlord service.

64. In January 2015 there was a further referral by the school to children's social care services about Scott and Susan's youngest child who had health needs; this was the fifth referral in the timeline for the review. Concerns were focussed on poor school attendance, poor socialisation, health needs and Susan's mental and emotional health. A parenting assessment was requested but the MASH allocated it for support through the Assertive Outreach service who work with families at risk of breakdown. A second referral from the school in early February 2015 was declined. A consultant paediatrician made a referral in May 2015 to children's services.

65. A social work assessment in July 2015 included discussions with Susan who raised concerns about Scott's use of drugs when he was saying that he would look after the youngest child. There was a child protection conference in August 2015 and the public law outline procedure was started as a precursor to potential care proceedings. Scott died before any further action was developed.

66. In late September 2015, a neighbour contacted the police to report a domestic disturbance at Lena's home. Lena had gone to the neighbour's property to report that she had been assaulted by Scott and did not have her own mobile phone to call for assistance.

67. Scott had left Lena's property by the time the police officer had arrived. He was later arrested at his mother's home for assault and criminal damage. A DASH assessment and statement recorded that Lena had been in a relationship for four years and arguments had been escalating for two years. She disclosed that Scott drank heavily and used cocaine. She reported being physically assaulted and that she had tried to leave the relationship several times. This is the only record about Lena and Scott's relationship by any agency.

68. There were 16 positive responses on the DASH. Although the police agency report described the DASH as providing a very comprehensive update with detailed explanations of the replies the assessment was graded as a medium risk. The agency report author for the police commented that the risk assessment indicated a high level of risk. The DASH recorded that Lena felt frightened, isolated and depressed and she stated that domestic abuse was occurring two or three times a week. It included information about Scott having been diagnosed with depression in the past, that there was domestic abuse with a previous partner and that he drank and used cocaine. A specialist officer reviewed the case but had not changed the risk category. If the category had been increased to high a referral to MARAC should have followed. A recommendation is made to the Greater Manchester Police at the end of this report.

69. Lena felt isolated from family and friends and did not want her family to know that she had been a victim of domestic abuse; she felt ashamed. The police officers arranged for Lena to be issued with a mobile number to call for help. This was not a TecSOS device[6].

70. Scott was interviewed by the police and a file was submitted to the CPS for a charging decision. The CPS solicitor reviewed the case in early October 2015 to determine if a charge should be made or not. The case was proposed criminal damage and actual bodily harm alleged by Lena against Scott. According to the CPS file note, Lena had stated that Scott had assaulted her and damaged her front door. The solicitor recorded that Lena had no visible injury although she had reported having been punched hard enough to have been knocked to the floor. A neighbour who made the call to the police had seen Lena but had not noted an injury to Lena. Both Lena and Scott had been drinking and, according to the CPS solicitor's note, there was no previous history of abuse or violence between the couple; this was incorrect.

71. The CPS solicitor had a copy of a domestic abuse history report dated 1st October 2015. According to the police officer working in the prisoner processing unit the domestic violence history included the history with Susan and the previous incident should also have been included in the history provided. The CPS solicitor also had a copy of the DASH assessment that recorded that Lena felt, 'frightened, isolated and depressed' and that domestic abuse was occurring 'two to three times a week and that she was not aware that he had hurt anybody else, including previous relationships'.

72. The solicitor concluded that the absence of visible injury was inconsistent with the level of the allegation and was a 'one-on-one allegation' and there was insufficient evidence to support a decision to prosecute. Scott provided an explanation for the damage and the injuries sustained. His account was

[6] TecSOS provides immediate connection to the police at the touch of a button 24/7.

assessed to be at least as plausible as that of Lena. There was no independent evidence and as such the reviewing lawyer determined that the case failed on evidential grounds. The review requested further information from CPS to clarify the detail of information that the CPS solicitor had; no further information has been forthcoming.

73. An application for a Domestic Violence Protection Order (DVPO) was considered by the police but considered not required because it was the 'first instance, minimal previous, and both live in separate areas'. This decision is analysed in the following chapter; it is apparent that Scott's history was not factored into the decision making, appeared to give little or no regard to the DASH assessment and the fact that the two parties lived in different geographical areas does not in itself prevent harassment or coercion.

74. Three days after the CPS review in early October 2015, a detective in the specialist domestic abuse team updated the PPI document[7] which added a summary account of the incident and noted that Scott had crimes for domestic abuse against Susan including details about the Non-Molestation Order and Domestic Violence Protection Order made in 2011. It was also noted by the specialist officer that there was an intelligence record about Scott having his firearms certificate revoked due to the domestic abuse in regard to Scott's previous partner (Susan). The same officer went on to record that '*this is the first reported DV incident to the police. Marker on the address, a letter sent with our details and also telephone contact with the victim (Lena) offering her advice. NFA DVU'*. A text message was subsequently sent to Lena asking her to make contact with the specialist officer saying that the officer needed to '*speak with you before I can close the incident'*.

75. Lena subsequently went to a local police station to return the mobile phone provided by the police; Lena left a message saying that she '*was in a much better place now and does not need any further support'.* This contact with the police was the subject of a routine referral to the IPCC when a death has occurred after recent police contact.

Overview

76. This domestic homicide review is unusual in that the victim of the homicide was the perpetrator of abuse and violence with the two women he had an intimate relationship with and one of whom killed him. Scott's family were aware that in regard to both relationships there had been conflict but did not regard him as a perpetrator of domestic abuse. They feel very angry about the death of Scott and about the relationship with Lena whom they hold responsible for the

[7] The PPI is a computer based data system within the public protection investigation unit which collates information and intelligence about incidents that have public protection or safeguarding implications.

collapse in his relationship with Susan. They describe how they had felt that it was Lena who exploited the relationship with Scott. They say that Lena never complained about any abuse (and neither did Scott). This is at some variance with the evidence of contact and recording with services provided to the DHR.

77. A fortnight before Scott was fatally stabbed by Lena she had reported being assaulted by Scott. A DASH assessment by the police officers who responded to that incident recorded information from Lena that she was being subjected to domestic abuse on two or three occasions per week. She reported feeling frightened, isolated and depressed. Lena has suffered poor mental health over several years and has received support and treatment from the local mental health and social care trust. During the DASH assessment, Lena also told officers that Scott drank alcohol and used drugs including cocaine. The DASH was risk assessed at a medium level. Lena was provided with a mobile phone to report any further concerns.

78. The details of the assault were passed to the Crown Prosecution Service (CPS) who declined a charge on the basis that Lena's description about the severity of the assault was not corroborated by the evidence of an injury or independent witnesses. No further action was taken by the police and Lena returned the phone reporting that 'she was in a much better place now'.

79. Lena had been the victim of domestic abuse in a previous relationship several years previously. That was the subject of a criminal court hearing although the court was not convinced that an offence had occurred.

80. Prior to his relationship with Lena, Scott lived with Susan with whom he had four children. The youngest child has significant health issues and disability and education, health and social care services have had considerable involvement providing support. There have also been assessments completed by the children's social care services on more than one occasion and formal plans including a child in need had been used.

81. The only occasion when Scott was reported to be a victim of domestic abuse was to the GP and to the mental health team who became involved through the GP referral after he had presented with depression. His account is at significant variance to the information that was disclosed for example to the police. The mental health service, nor the GP practice who were given information by the service, took any action in regard to the allegations that Scott and his sister made that Susan was a perpetrator of domestic abuse and that there were children in the household.

82. Until this domestic homicide review, none of the services had a complete record of information relating to incidents of domestic abuse. All of the services had information about domestic abuse in regard to Scott's relationship with Susan.

Significantly, despite more than one statutory child care assessment by Manchester children's social care services, a child protection conference that should have had information from all the respective agencies and a child in need plan, the history and significance of domestic abuse were not enquired into as part of those processes.

83. Susan secured a Non-Molestation Order in 2011 although went back to court in the same year to have it revoked. That decision was made without any service being asked to provide information. The police were not aware of the revocation.

84. The review highlights the importance of professionals, particularly in services such as education primary and specialist health having the curiosity and capacity to inquire into the circumstances of adults and children when there is evidence or disclosure about domestic abuse.

85. The review highlights the importance of perpetrator engagement and support is embedded in the overall response to domestic abuse.

Analysis of professional decision making and practice

Contact and knowledge about domestic abuse

86. The circumstances described and analysed by this domestic homicide review challenge the usual categorisation of there being a 'perpetrator' and a 'victim' of domestic abuse. Responses by organisations and the provision of services often categorise on this basis and focus on separating the intervention between a victim and a perpetrator.

87. Although abusive or violent behaviour is always the responsibility of the person (male or female) who commits it, this review invites reflection about the complexity of factors that can be at the heart of intimate violence. Research is showing that not all intimate violence is the same and it does not always spring from a common cause or objective. It is a fact that many fatal domestic homicides have occurred at the point at which the homicide victim has been leaving an abusive and controlling relationship. This tragic homicide appears to have elements of what is often referred to as situational abuse or violence.

88. Situational abuse or violence occurs when a couple has a conflict which turns into arguments that escalate into emotional and possibly physical violence. It often involves both partners as opposed to being the control and coercion by one partner over the other. The violence can escalate as it did in this case with severe and catastrophic consequences. Alcohol or drugs, poor anger

management and communication issues can be implicated. Alcohol plays a significant role in being a source of conflict and escalating violence. According to one researcher[8] 40 per cent of couples characterised by this type of abuse and violence comprises once incident such as a slap or push that horrifies the partners sufficiently to deal with it and it does not reoccur; it serves as a 'wake-up' to deal with problems in the relationship. Of the remainder, there is chronic violence ranging from a few incidents that may or may not be reported to the police or another service to more chronic arguing that escalates to violence. Access to any form of a weapon is an additional and significant risk factor.

89. Recognising domestic abuse and exploring its characteristics is therefore essential in providing safety and developing the most effective interventions.

90. The first disclosure of domestic abuse was in 2011 by Susan. The DASH in September 2011 and other assessments and a consultation with the GP in November 2011 indicate that there had been a long time horizon of several years that was never satisfactorily inquired into after allegations of abuse had become increasingly disclosed. Susan did not want to participate in the review and therefore it has not been possible to explore this with her.

91. Victims face many barriers to disclosing domestic abuse and both Susan and Lena had reported postponing contact with the police. Lena described feelings of shame that isolated her from friends and family. She had left an abusive relationship several years previously and had supported a court prosecution of the former partner that resulted in no conviction. Both women described in statements and/or DASH assessments prior to Scott's homicide of trying to end the relationship with Scott and the extent to which they were subjected to ongoing harassment by Scott. Susan clearly struggled in caring for a child with additional and significant needs and the children were also upset by the separation of their parents.

92. The police were the first service to receive information about domestic abuse when they investigated the silent mobile phone call in August 2011. The police were proactive in identifying the location of the registered mobile phone user (Susan) and ensured a uniformed officer was deployed to check on her safety and of the children.

93. Action taken by the police included completing a DASH which Susan declined to cooperate with; this is not unusual and a victim should not be blamed if they display such reluctance to participate. This can appear to be counter-intuitive

[8] Johnson, M. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence: The North-eastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE cited in a Policy Briefing from Tavistock Relationships http://www.tavistockrelationships.ac.uk/images/uploads/policy_use/policybriefings/Situational_Couple_Violence_Nov_2016__FINAL.pdf

although it is not untypical of many victims who for varied and many reasons have to confront barriers in speaking out about the abuse that they are suffering. The police officers established that one of Susan's children had learning difficulties and had been present during the incident. The closing summary categorised the incident as a 'verbal only' and that there was no prior history of *reported* domestic abuse.

94. The IMR from the police comments that as a minimum, in compliance with policy at the time, a letter should have been sent to Susan with contact details and advice about sources of support. This was not done. This at least in part might reflect a mindset that it was an isolated and a 'verbal' argument. No other service was made aware of the contact. There was no record made of any physical check of the child or provide any account of their views, wishes and feelings. Because there was no sharing of information with children's services there was no opportunity to establish if the family were already known; the reference to the child's learning disability infers that they could have already been identified as a child in need[9].

95. The second incident of domestic abuse reported to the police in August 2011 represented an escalation of concerns given this involved Scott's threats to use his registered firearms unless the family left the house in the early hours of the morning. Susan did not contact the police for several hours after staying at a friend's home with her children. It was during the subsequent enquiries that Susan referred to Scott's relationship with Lena being the catalyst for the incident. As with the first incident barely three weeks previously, no referral or information was sent through to any other service. The two children who had been in the house when Scott made the threat to harm Susan were aged 8 and 14 years at the time, both of whom are described in the police record as having 'disabilities'.

96. The third incident a fortnight later in September 2011 resulted in Scott being issued with a Domestic Violence Protection Notice (DVPN) which meant that although the CPS solicitor refused a charge of assault there was an automatic referral to the Victim Support service. The IDVA and landlord service were also aware of the incident and the IDVA and landlord service helped Susan instruct a solicitor to apply for the Non-Molestation Order which was made later that same month. In this regard, there was effective sharing of information between relevant services and Susan was advised and supported in seeking the Non-Molestation Order. There was an inherent reliance on Scott complying with the court order and Susan reporting any breaches to the police.

97. The contact with Susan appears to have been discussed at a MARAC meeting although none of the services has a written record other than no further action was required. The MARAC referral was made by the landlord service.

[9] Section 17 of the Children Act 1989 designates disability as a criteria for a child in need.

98. Scott, Lena and Susan were patients at the same GP practice which is one of the first of 16 trained GP practices in Manchester that has had an IRIS (identification and referral to improve safety) domestic abuse service provided since December 2013[10] and therefore postdates Susan's early disclosures about domestic abuse in 2011 via the letter from the mental health services and from Susan when she consulted a GP in November 2011 about depression as a result of the separation from Scott who Susan reported was emotionally and physically abusive towards her.

99. Susan's consultation with the GP disclosed a longer-term history of emotional and physical abuse exacerbated by alcohol and drugs and mental illness. The circumstances for referring Susan for cognitive behaviour therapy (CBT) are not explicitly described although it is recorded that Susan has confirmed that domestic abuse services were involved[11]. In regard to Lena, the GP was not made aware of any domestic abuse until after Lena had killed Scott.

100. None of the services with the exception of IDVA were made aware of the revocation of the Non-Molestation Order and that service was only made aware by Susan after the court hearing. The police were clearly still working on the assumption that an order was still in place when the fourth contact with the police in July 2012 by Susan reported harassment by Scott over a two week period. Scott was given a 'simple caution' and referrals were made to children's services and Women's Aid. Given Scott's history, the decision to administer a simple caution is difficult to reconcile or the absence of action to enforce the Non-Molestation Order (that would have highlighted the revocation process eventually). The fact that there appears to be no system of the courts routinely advising the police either about applications to revoke or the outcomes is a gap discussed in the final chapter.

101. It is also significant that the CRHT were told an entirely contradictory account by Scott regarding the domestic abuse where he described himself as being the victim. Accepting the information at face value at least merited further consideration regarding the children who continued to live with Susan who was being accused of being a perpetrator of domestic abuse.

102. Manchester children's services allocated a social worker to complete a statutory assessment in June 2012. There is no evidence of enquiries to establish if domestic abuse was a factor in the range of difficulties being presented by Susan and Scott's two younger children.

[10] IRIS is an exemplar project that aims to improve identification and action by primary health practitioners in regard to domestic abuse.

[11] www.nhs.uk describes cognitive behavioural therapy (CBT) as a talking therapy that can help patients manage their problems by changing the way they think and behave. Its most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.

103. In August 2012 the school received information from Susan that she had been in contact with the police having been harassed by Scott. This information was not shared outside of the school. Children's services had a referral from the police in August 2012 and were aware of the MARAC discussion. In September 2012 the chance encounter between the school-based social worker and Susan which included Susan referring to waking in the night to find Scott at the bottom of her bed was not shared with anybody else.

104. A further referral to Manchester children's services in January 2015, a CAF in April 2015 and a further assessment by a social worker in June 2015 all apparently were conducted in the absence of any information or discussion about domestic abuse.

105. The first record of harassment made by Lena in August 2012 did not involve Scott but rather harassment by one of Scott and Susan's children who was apparently motivated by wanting Scott to return to Susan and the family home. There is no information recorded about Susan's views or the circumstances that were causing the child who was over 18 to make these calls. No other service was aware of the contact.

106. The second record of contact between Lena and the police in March 2013 was a third party report of the argument involving Lena, her adult son and Scott. The police record of the contact refers to the two men have never got on with each other although the nature of the conflict was not clarified. No other service was aware of the contact (and there were no reasons for any other service to have been notified about this incident).

107. The third contact between the police and Lena in September 2015 was the first disclosure by Lena about Scott's abuse and harassment towards her. The police clearly recognised this as an incident of domestic abuse, risk assessed Lena as being at medium level and were proactive in giving Lena access to a mobile phone and to sources of help.

108. Lena wanted Scott to be charged for assault although the charge was refused by a CPS solicitor on evidential grounds and without apparent awareness of the antecedents. A DVPN was not issued either. No referral was made to IDVA or to Victim Support despite Lena having acknowledged her isolation from friends and family and feeling ashamed about being a victim of domestic abuse. Scott's history of harassment of Susan had also been recorded and was also a matter of record in regard to the prior incidents involving Susan.

Assessment of safeguarding concerns

109. The extent to which there was evidence of control and coercion was poorly identified and enquired into particularly in regard to incidents and information reported by Susan.

110. There is little recorded evidence generally about the implications of domestic abuse for the children of Susan and Scott or being sufficiently addressed by any of the agencies and to ensure that the children's views, wishes and feelings along with the impact of domestic abuse being considered in assessments by any of the services.

111. The police policy requires enhanced risk assessments by specialist officers when children are parties to the incidents of domestic abuse. Their role is to check the risk assessments and to decide whether referrals to other agencies are required. The IMR author could not find evidence recorded about what checks were made in regard to who made the first call in August 2011 or about any of the other children.

112. There was no referral to children's social care services although there were a referral and help was provided to Susan in securing a Non-Molestation Order. Susan and Scott's youngest child was subject of a child protection plan at the time of Scott's death. The risk that was the focus of the plan related to the serious health concerns and Susan's capacity to meet these needs. Domestic abuse was never identified as a factor in any of the statutory assessments. It is not clear if it was ever referred to in any of the CAF, child in need or strategy meetings.

113. The occasions when a referral was made to specialist domestic abuse services in regard Susan resulted in a risk assessment in regard to home security and there was good support given in advising and assisting Susan to secure a Non-Molestation Order.

114. Since April 2010 the police have had a policy that is explicit about physically checking on the welfare of children that they are safe and well. Details must always be taken of any children who are present during an incident. The police IMR comments that although checks may have been completed they were not clearly recorded. Further complications arise when the adults for various reasons are minimising the level of abuse and violence that children are witnessing either directly or indirectly; for example, a parent might have concerns about what action statutory services will take in regard to their children; for example, fearing that their child will be removed from their care or their family be subjected to unwelcome scrutiny and monitoring. It was one of the younger children made the phone call to the police on the first incident which makes the absence of any child-specific record more significant. The reliance on physical evidence such as visible injuries to determine the level of abuse and violence can misdirect professionals from making risk assessments and

deciding what a 'safe and well' check means for individual children. The subsequent reports that Scott was trying to contact Susan through the children also merited greater attention and reflection. It seemed to be a significant factor in Susan deciding to revoke the Non-Molestation Order.

115. The police IMR comments about the concern that there was no recorded evidence of specialist officers making contact with Susan to provide support and information and to assess the safeguarding concerns for the victim and any dependent children. The incident involving threats to kill were frightening for Susan and for the youngest children in particular who were aged 8 and 14 years respectively at the time.

116. Disclosures about domestic abuse made to the police by Susan and Lena were subject to risk assessments although in Lena's case the assessment of risk only involved the police, and occurred less than a month before her fatal assault on Scott. Lena answered all of the questions that are set out in the DASH assessment describing feeling 'frightened, isolated and depressed'. She also made clear that domestic abuse was occurring on a regular basis (two or three times a week). Lena said that she did not know if Scott had any previous history of domestic abuse although was aware that he had been in trouble with the police through threatening his ex-partner; this does not mean that she had detailed information. The police officer who completed the DASH arranged for Lena to be issued with a mobile phone to ensure that she was able to call for advice, help and support if necessary. Having assessed her as being at medium risk followed the policy of referring the information to the specialist police officers in the public protection investigation unit. The DASH assessment should have identified high risk given the 16 positive answers.

117. Although it is apparent that the police officer paid attention to the views, wishes and feelings of Lena and encouraged the completion of the risk assessment and noted that in regard to Scott there had been *'previous DV with ex-partners'* it did not appear to take account that Scott had been the subject of a Non-Molestation Order in his previous relationship and neither was it apparently considered by the prisoner processing unit or by the CPS when making decisions or in any other action. The RARA (reduce, avoid, remove, accept) risk assessment by the arresting officer included Lena's statement that her '*relationship with Scott is over. She wants nothing more to do with him'*. The decision to leave a relationship following domestic abuse represents a heightened risk for the victim and particularly when there was a history of continued harassment with previous partners.

118. In addition to completing a DASH, the police should consider what other action is appropriate to address risk which includes the issuing of a Domestic Violence Protection Notice and whether sharing information under the Domestic Violence Disclosure Scheme (Clare's law).

119. The police officer considered and decided not to take further action under those measures. The reasoning was that there was no independent evidence, no 'young children' were involved and it was the first incident in this relationship and there was nothing outstanding from the previous history. Although the police officer provided their reasoning about a decision taken in good faith, even without the benefit of hindsight the reasoning shows a limited appreciation about domestic abuse which extends more widely than a single officer or agency. Lena had described previous unreported incidents which resonate with the evidence cited earlier that victims very rarely report abuse and violence on the first incident and are susceptible to ongoing harassment.

120. This is well understood by those who work with the victims of domestic abuse. It is less well understood by people who have limited training and experience in this area and can lead to inappropriate and risky decision making.

121. The assessments did not have any information about Lena's mental health history over several years as a vulnerable adult who was also prone to self-harm. This, together with her use of alcohol and drugs along with the domestic abuse compounded the level of risk.

122. This meant that the risk assessment was primarily focussed on the immediate 'in-the-moment' presentation of information which still resulted in the risk assessment being graded as a medium level. The fact that Lena was observed to have sustained no significant physical injuries was influential in how decisions were made about whether Scott should be issued with a Domestic Violence Protection Notice or processed for court. It gave a little account of emotional and psychological harm. The absence of independent witnesses, no young dependent children being present in the household and the incident being regarded as the first episode of violence all contributed to the level of the response being de-escalated and releasing Scott from custody without any charge or a prevention notice being issued.

123. A specialist police officer attempted to have contact with Lena to tell her about Scott's release although was only able to leave messages for her.

124. When Lena subsequently returned the mobile phone less than two weeks after the incident to the police at a local police station it followed the decision to not take any action at all in regard to Scott. No information had been provided to Lena about Scott's history of domestic abuse. The Domestic Violence Disclosure Scheme (DVDS), allows the police to disclose information to victims of domestic abuse if they believe it would help the victim make decisions about their own safety or the safety of any other members of their family[12]. The reason

[12] Since the 8th March 2014 members of the public a 'right to ask' police where they have a concern that their partner may pose a risk to them or where they are concerned that the partner of a member of their

for not disclosing any information was influenced by Lena stating that as far as she was concerned the relationship was over. Lena also confirmed when the DASH was completed in late September 2015 that she was aware that Scott had been 'in trouble with the police' because of threats to his ex-partner.

125. There was an absence of curiosity on particular occasions such as when Susan disclosed going back to court to revoke the Non-Molestation Order. This appeared to be the result of Susan feeling pressurised by Scott through the children to remove restrictions although the absence of Susan's participation in the review has meant that this has not been explored with her.

126. The revocation was made without any information being sought by the court from any service. The application to revoke the Non-Molestation Order did not involve any of the services and gave no opportunity to provide updated advice or assessment to the court. The review has had no evidence that requests for information were made by the court before deciding to revoke the order.

127. The implied threats of causing a fire were not risk assessed with the fire and rescue service who were not asked to complete such an assessment.

128. As with Lena, there was a tendency for the responses to be too focussed on the here-and-now and not showing better anticipation about the level of support that a victim of domestic abuse is likely to require. Both Susan and Lena faced great difficulties in leaving the relationship with Scott. He displayed a capacity to continue contacting both women and in the case of Susan to use the children to exert emotional pressure. Arguably, the application to revoke the Non-Molestation Order was a product of this emotional pressure. Lena had suffered domestic abuse in a previous relationship and had cooperated with a prosecution that was not proven. Victims who make disclosures of abuse that do not result in an effective outcome can be deterred from making disclosures in the future.

129. The second incident of domestic abuse involving the threatened use of firearms by Scott was clearly prioritised for a response that involved a strategy for locating and arresting Scott and seizing his firearms along with ammunition. This involved the deployment of specialist police officers. The police officer completed a vulnerable person update on the FWIN (force-wide incident number) which included using a closing code of G07 (concern for safety 17 and under) which ensured that the information was reviewed by specialist child protection officers including the DASH assessment that was indicating a medium level of risk.

family or a friend may pose a risk to that individual. The initiative is named after 36-year-old Clare Wood who was murdered by her ex-boyfriend in 2009 in Greater Manchester.

130. The incident resulted in Scott being sanctioned for exceeding the level of ammunition he was licenced to own. Susan's decision to remove herself and the children from the home had avoided a fatal escalation and arguably Scott had recognised he was at risk of escalating the incident. The UK has one of the most stringent systems of controlling firearms which means that incidents of familicide are far lower than countries with less gun control. Regrettably, there have been incidents of fatal domestic homicides involving licenced firearms in other parts of the UK.

131. The decision to refuse a charge of assault was influenced by Susan not reporting the incident when it was ongoing and the absence of injury and erroneously believing this had been the first incident of domestic abuse.

Knowledge and information about the perpetrator of domestic abuse and services offered

132. Lena is the perpetrator of the fatal assault upon Scott that caused the domestic homicide review to be commissioned. She had previously been recorded by the police as being the victim of domestic abuse in the relationship with Scott and in an earlier long-term relationship. She was never reported or had allegations made against her of being a perpetrator of domestic abuse. Therefore the focus of this section is upon services that were offered to Scott as a reported perpetrator of domestic abuse in his relationship with Susan and with Lena.

133. Scott was offered a referral to a perpetrator service when the police had the first contact with him in 2011. It was not followed up and he was not subsequently referred to any services in regard to any of the subsequent incidents of domestic abuse. Although he was the subject of a Non-Molestation Order and a Domestic Violence Protection Order in 2011 these are civil law measures. He was never prosecuted, and other than a caution in 2011, he was never subject of any sanction under criminal legislation.

134. The CRHT mental health service that provided support to Scott in late 2011 was told by him about domestic abuse (although Scott reported it as being a case of malicious allegations by his ex-partner). Scott also reported making efforts to revoke the 'restraining order' (which strengthens the sense that he was actively seeking to influence and secure the revocation of the Non-Molestation Order). Scott also reported that his firearms certificate had been recently revoked. None of this was the subject of any consultation for advice with a safeguarding specialist in that service.

135. There is a fine ethical and legal distinction to be observed by mental health professionals in providing confidential care for patients and recognising when information that suggests an enhanced level of risk requires further follow up within and outside the service. Since 2012 the MMHSCT has overhauled the safeguarding arrangements across the Trust and established 14 MARAC marshals across the service to provide advice in regard to domestic abuse. The

MARAC is intended to deal only with the highest levels of risk from domestic abuse. It is the rigour of enquiry that is given to information and disclosures about domestic abuse that are critical in helping to develop a more complete record of evidence and insight to inform judgments about risk level. The service has implemented domestic abuse training since 2015. Recognising the significance of the information that is indicating domestic abuse having implications not just for the immediate care and treatment of the primary patient and particularly when there are children and other factors to be considered that may aggravate the risk level is a learning point.

136. Substance abuse and mental ill-health are factors that often aggravate domestic abuse; they are not the cause of domestic abuse. The only service that Scott accessed was in regard to his depression. When Scott sought help in regard to his depression in September 2011 he was presented as being the victim of domestic abuse. Neither the GP nor the CRHT made any contact with any other service and were not asked to provide information by other agencies when those services conducted assessments particularly in regard to the children.

137. That particular information as it was presented to the two services did not indicate a direct threat of harm to any child from Scott although the disclosure during the initial visit by the CRHT included an allegation that Susan was the perpetrator of abuse and still had the care of the children. This information deserved further attention as did the disclosure that Scott had access to a firearm; for example, a discussion with a safeguarding professional. There is no evidence to support the allegation that Susan had assaulted Scott who was interviewed by the police in regard to the incidents of domestic abuse that were reported by Susan.

Services offered and provided to the victims of domestic abuse

138. Susan and Lena both received a response from police officers when they reported domestic abuse; on the first occasion when a call was made on Susan's phone nothing was said to the call handler who made sure that a follow up was made by police officers when the phone number was linked to Susan's address. This was made possible by the phone being registered to a user at a particular address. This, of course, is not a facility that is available to victims who use pay-as-you-go phones.

139. Susan and Lena have both had significant involvement with different services. Susan was supported in making an application for a Non-Molestation Order and upgrading security at the family home. Some of those measures were undermined for example when Scott was allowed to retain a key for the property. Services such as Victim Support provided ongoing help and advice which was mainly conducted by telephone through regular contact. An effort

was made to arrange face-to-face meetings although these were cancelled by Susan. Susan has accessed support more recently though since the death of Scott.

140. Lena's main support has been through mental health services and the involvement has been significant and for several years. She disclosed that she was isolated and depressed although it is not apparent that information about the extent of mental illness or involvement by mental health services was revealed during the DASH assessment. Police officers are not required to make the inquiry. No referrals were made to specialist services in regard to domestic abuse and the mental health services were not provided with any information. The risk assessment did not identify Lena's history of mental ill-health and vulnerability.

141. There was no direct assessment or enquiry into the needs, views and wishes of Susan's youngest children. There was a reliance on Susan having taken steps to protect herself and the children (which she had done although faced pressure and difficulty in maintaining). Any strategy that only relies on the victim taking action is never sufficient on its own. The children's distress at the separation of their parents, and the removal of their father from the family home was never explored or sufficiently understood by social workers completing statutory assessments and neither was the evidence of ongoing coercion.

142. By the time a statutory assessment under the Children Act 1989 was being completed in relation to the child in need and later the child protection plans, the significance of domestic abuse had been lost and was apparently being treated as a historical issue. Treating domestic abuse as historical and relying on victims to protect themselves and their children creates the latent conditions in which risk can be minimised and the impact on children's emotional as well as physical safety is poorly understood. The domestic abuse was not investigated as part of the child's assessment or of the parenting assessment of Scott.

Other issues

143. Lena has been a patient of mental health services over several years, has also been a habitual user of alcohol and drugs.

144. Alcohol does not cause domestic violence and abuse, but there is evidence that where domestic violence exists, alcohol is also often a factor that will exacerbate the incidents and severity.

145. Research suggests that adults with mental health problems are more likely to abuse drugs or alcohol; people who abuse drugs have a markedly increased lifetime occurrence of diagnosable mental health issues and there are strong

links between intimate partner violence and both 'drinking in the event' and 'problem drinking' more broadly.

146. There is evidence that a victim's increasing alcohol consumption heightens their risk of becoming a victim of crime or violence. In relation to domestic violence, in particular, a British study found that victims of domestic "assault" had higher levels of alcohol consumption than non-victims and that the risk of violence increased with increasing levels of drinking[13].

147. For service users the problems associated with using alcohol and living with domestic abuse is;

a) The challenge of seeking some kind of change or improvement in their lives;

b) Often have a history of emotional, sexual and physical violence or abuse as a child and/or adult;

c) Are isolated in terms of self and family;

d) History of denying or minimising the problems/suffering they face;

e) Live with a sense of shame, stigma and covering up;

f) 'Relapse'; returning to alcohol use or to an abusive partner;

g) Live with insecurity about their housing or the home environment;

h) Contact with legal, medical, and criminal justice systems;

i) Live with the potential for serious harm or death without intervention.

148. The implications for professionals are that they are frequently working with people in crisis. They will often face ambivalence from the person they are trying to help and they will also know that change is hard to achieve.

[13] Mirrlees-Black, C. (1999), Domestic Violence: Findings from a new British Crime Survey self-completion questionnaire, London, Home Office Research Study 191, HMSO; also cited by Alcohol Concern's information and statistical digest Grasping the nettle: alcohol and domestic violence, June 2010, which also provides references for the other studies cited.

Capacity and resources

149. The capacity of services is highlighted in some of the agency reports. The high incidence of domestic abuse across Greater Manchester represents a significant workload for services such as the police and the specialist domestic abuse agencies in responding to the needs of victims. It also represents a significant workload for services such as health and social care even when it is not identified or diagnosed as a factor in the presentation of need. The prevalence of domestic abuse is higher than is recognised and recorded by agencies and is demonstrated in this review. Even when it was being disclosed for example by Susan, the significance was insufficiently understood for example in the conduct of statutory assessments under the Children Act 1989 in relation to her children.

150. Greater Manchester Police dealt with 13,399 domestic abuse-related crimes in the 12 months to the end of August 2013; there were 4,478 assaults relating to domestic abuse, 1,667 incidents of harassment and 353 sexual assaults.

151. The volume of domestic abuse incidents has an influence on judgements and decision making. For example, the decision of no further action by CPS used to be reviewed by an inspector but this policy was not sustainable due to the number of incidents being dealt with. The decision of no further action by CPS if disputed by the officer dealing with the case is brought to the attention of the duty inspector for review and appeal with CPS. A decision made by the police to no further action an investigation must be ratified by the duty inspector.

152. In the PPIU where specialist police officers receive the PPI reports the procedures to state that a detective sergeant must actively review and manage medium risk cases although because of the volume of cases the working practice is that specialist domestic violence officers can finalise the medium-risk cases themselves. This was implemented in September 2015.

153. The specialist detective sergeant reviewed the incident reported by Lena in September 2015 and made a judgement that a DVPN was not appropriate because Lena and Scott did not live together; they also believed that the domestic violence disclosure scheme did not apply because Lena had declared the relationship to be over. There is no reference to Scott's previous history which was relevant to consider.

154. If a DVPN had been issued it does not mean that this would have prevented the subsequent events resulting in Scott's death. The point of learning that will be well understood by specialist domestic abuse practitioners, in particular, is that separation is a time of elevated risk and victims of domestic abuse for many and varied reasons are not always able to maintain a separation.

155. Victim Support became involved when the referral was made to MARAC and at that stage, the IDVA did not have the capacity to allocate. Victim Support described their role as a holding service maintaining regular contact with Susan. A great deal of their contact was by telephone. They offered face-to-face meetings although these were declined or cancelled by Susan. It is noted that in 2012 they had not had the capacity to deal with the level of referrals and although the holding arrangements referred to in earlier sections no longer apply the service have reported limited capacity to provided significant follow up to victims.

156. The Manchester IDVA service is under-resourced against the CAADA recommended guidelines for caseloads and number of IDVAs. This has an impact on the cases allocated and length of time that an IDVA remains involved after the initial advice and interventions.

157. None of the services provided follow up support in regard to the domestic abuse towards either Susan or Lena as victims. There is no reference to the availability of perpetrator programmes and there was a high reliance on Scott complying with the DVPO and the Non-Molestation Order which were largely ineffective.

158. None of the services who know about the revocation of the Non-Molestation Order followed this up. This included the specialist IDVA service who are dealing with domestic abuse. Some of that can be attributable to insufficient refection and oversight that by implication has resource implications, as well as the mindset and training that is applied to information about court orders being revoked.

159. The absence of referral to a perpetrator service also reflects a potentially disguised capacity issue. Unless opportunities are provided to tackle perpetrator attitudes and behaviour the cycle of domestic abuse will not be disrupted.

Conclusions and recommendations

160. This review is unusual in that although Stockport commissioned the review the majority of contact with services are located in Manchester. This review will, therefore, have implications and learning for the community safety partnerships in both areas.

161. 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.

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

Recognition and understanding of domestic abuse

163. Failure to identify domestic abuse and coercion or control, in particular, perpetuates false premises that create the latent conditions for wrong conclusions or judgements; examples include the victim and perpetrator being in separate locations or that disclosure or incident have never been reported previously or a previous history involves a different partner. Behaviour in a close relationship that causes physical, mental, or emotional damage and control may not be recognised by the victim as being abusive.

164. Professionals need to be able to look for and to distinguish between the controlling and coercive behaviour that constitutes domestic abuse and other behaviours that for example reflects marital or relationship difficulties and tensions which requires a very different mindset and strategy to deal with. Separation or divorce is difficult and distressing experiences especially for children that can be ameliorated by strategies such as mediation and support; domestic abuse represents a distinct and different attitude, behaviour and threat that requires clarity in its recognition, definition and response by professionals to ensure that further victimisation does not occur by using the wrong approach. 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 to anybody; to their friends, family or services.

165. The Greater Manchester Domestic Abuse Procedures emphasise that workers in all agencies need to be in a position to identify and receive disclosures about domestic abuse and to be prepared to ask direct questions. This review suggests that this was not yet happening on a sufficiently consistent basis and across all relevant organisations. GPs and other primary health professionals along with others located in schools and housing services will be recipients of information and often before any formal report has been made to the police or to social care services if children are involved. GP practices are in receipt of significant information about patients and are managing thousands of detailed records.

166. The police and CPS have the prime responsibility for ensuring that the criminal law is used to respond to and manage perpetrator risk and to provide protection to victims. This review has highlighted that those processes rely on all services having information that is given appropriate attention and consideration. For victims who are reliant on civil law remedies to prevent contact from a perpetrator, it is important that courts have a similar level of understanding about issues such as coercion and control. An applicant who seeks revocation of a Non-Molestation Order should need to satisfy the court that the application is being made freely, and if it is, to have evidence about what had changed in regard to risk and especially when children are involved. Courts have an important role in managing risk and responses to domestic abuse whether under criminal or civil law proceedings. A recommendation is made in regard to considering the guidance and training provided to courts on dealing with such orders to explore whether for example applications to revoke Non-Molestation Orders are because of undue influence or coercion of the applicant.

167. Emotional abuse and isolation from support and coping with the needs of children with complex additional needs can affect the behaviour of a victim. It could have been a factor for example in regard to the application to revoke the Non-Molestation Order. Limited cooperation of victims in DASH processes is also often misunderstood.

168. The quality of professional response influences the likelihood of victims engaging with strategies and action. Victims will be concerned and fearful of an escalation in abuse and violence against them or any dependent children. Victims who return to relationships that they have left can be blamed and can lead to professionals deescalating their level of concern.

169. A victim's circumstances that do not trigger the highest level of risk in assessments and become subject to MARAC provide limited opportunity for those victims to be engaged in ongoing support and encouraging further disclosure. Arguably this puts victims at even greater risk from domestic abuse. There is limited capacity in any service to provide ongoing support after the initial response to incidents.

170. The absence of challenge in regard to the CPS decision to refuse charge in regard to incidents concerning Susan and the decision to not process a DVPN in regard to Lena highlight how victims who report domestic abuse can be left feeling even more isolated and vulnerable. To be clear, this is not a statement saying particular decisions are right or wrong, but to query the capacity and rigour of the various processes for sufficiently informed and reflective decision making and challenge. In the absence of a report from CPS, there has not been any analysis or reflection about the quality and clarity of information that was given in the DASH and other police information for the CPS lawyer to make their decision.

171. Making a disclosure of abuse elevates risk as does an attempt to leave an abusive relationship. Scott demonstrated that he continued to contact both women; it was complicated in regard to Susan who felt abandoned and was struggling to meet the needs of two children with health and other additional needs and the children wanted contact with their father. An assessment should have explored this much more.

172. Lena's description of feeling ashamed of being a victim of domestic abuse resonates with the experience of many victims of domestic abuse and of being isolated. Lena never disclosed domestic abuse to people who were working with her for example in mental health services. This is not unusual given the barriers that face victims generally and described in earlier sections of the report.

Risk assessment

173. All professionals need to have the capacity to risk assess at a level that is proportionate to their role.

174. The overall strategy and mindset to risk assessment needs to appreciate that disclosure of domestic abuse and/or an attempt to leave an abusive relationship represents an increased rather than a decreased level of risk to the victim and potentially for their children. It also requires a realistic assessment of the motivation and capacity of the perpetrator and of the victim in developing a plan of safety. The far larger proportion of domestic abuse reported to the police is risk assessed at low to medium level. There is very little opportunity for multi-agency discussion or co-ordination unless there are concerns about children that will involve for example CIN or safeguarding frameworks. Those frameworks need to have the capacity to recognise the significance of domestic abuse as a factor in children's lives. This review has highlighted weaknesses in how that was being undertaken in this particular case, albeit some years ago.

175. Reliance on perpetrators abiding by court orders or any other agreement is intrinsically vulnerable to being breached. Using children to convey messages or to exert emotional pressure, combined with a victim feeling isolated and with damaged self-esteem and confidence will have difficulties in enforcing boundaries or making further reports to the police. Realistically, none of the services has the resources to take on significant additional follow up work outside of any statutory work such as CIN or a child protection plan.

176. With the exception of the police in 2011, there is no record of any agency considering a referral to a perpetrator programme. This absence of follow up work on either supporting the victim or working with a perpetrator creates the latent conditions for a cycle of further abusive relationships.

177. The DASH does not encourage any enquiry with a victim as to whether they may have additional needs or vulnerabilities associated for example with their mental health or whether they are receiving support from any services. Although many victims will be wary of disclosing much if any information to a professional of authority such as a police officer, giving a prompt to at least inquire about contact with other services and to seek consent to share information for example about an incident can help promote information sharing for example with a specialist mental health service.

178. The assessment of risk in relation to Lena resulted in no referrals being made to other services on the basis that there were no children involved or 'adult social care issues'. Given the extensive history of mental health support and the fact that the assessment did not identify this at the time of the DASH being completed is significant.

179. Local adult safeguarding boards have distinctly different and arguably more limited roles and responsibilities to the safeguarding of adults compared for example to those of the local children safeguarding board. A considerable proportion of the adult safeguarding board's remit relates to identifying and preventing the abuse or neglect of people with care and support needs who are living in their own homes or for example are in a care or nursing home setting. Scott and Lena came within the category of being adults with care and support needs; Lena particularly in regard to significant mental illness and also in regard to substance misuse although had not been referred to or accessed substance misuse services. It is within that context that this review panel believes there is potential learning for both the adult and child safeguarding boards.

180. The panel draws attention to the guidance published by the Local Government Association and Association of Directors of Adult Social Services in 2015[14]. Some key areas of interest relate to the need for services working with perpetrators and victims of domestic abuse who have additional needs being sufficiently aware of how to identify and recognise abuse, control and coercion; they need to be aware of the need to use specialist intervention programmes which challenge behaviour and offer appropriate support; they must never refer to interventions such as anger management, mediation or generic counselling between a perpetrator and victim; they have a role to speak directly with perpetrators and victims about domestic abuse; they need to ensure that they can operate effectively as part of wider virtual teams who are in contact with victims such as children for example; they need to be aware of the dangers of placing undue optimism on the capacity of families to deal with abuse, coercion or control. These are important messages that go wider than any single setting.

[14] LGA, (2015) *Adult safeguarding and domestic abuse a guide to support practitioners and managers*. Available from https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf

181. It is within that context that the two safeguarding boards in regard to adults and children have areas of mutual interest in developing the capacity of local services to consider what further opportunities can be identified for improving coordination of risk management of an adult perpetrator and victims with support needs such as mental illness and substance misuse whose behaviour represents risk.

182. Attention, in particular, should be given to ensuring that the safety of adult and child victims remain the priority when services are working with an adult who has support needs such as mental health and substance misuse and that local multi-agency safeguarding and MARAC procedures are complied with. It has been noted that the MMHSCT has implemented MARAC marshals. There is merit in asking the safeguarding boards to consider whether any additional opportunities are provided for joint training on risk assessment between practitioners working with children and those working in adult mental health and substance misuse services.

Domestic abuse as a safeguarding issue for children

183. 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 for example from social care or criminal justice service 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.

184. All children who live with or are exposed to domestic violence are affected by it. It is the child itself who should be providing information for example through what they say, but importantly, also their behaviour, presentation and demeanour. The views, wishes and feelings of the children were not part of the record of any assessment over and above for example third party reports of the children missing their father for example. Along with recording information directly from children, there should be sufficient exploration of any significant information that indicates particular or additional vulnerability and their significance along with any factors that indicate particular resilience. For example, research indicates that older children with good attachment, good self-esteem and a good relationship with a sibling combined with a higher IQ will indicate higher levels of resilience compared to another child in similar circumstances.

185. The local domestic abuse procedures across Greater Manchester highlight that research makes clear the links between domestic violence and the abuse and neglect of children and also found more than half of serious case reviews. For

example, 30 per cent of children screened through the local multi-agency safeguarding hub (MASH) in Stockport show domestic abuse as the predominant issue.

186. The physical, psychological and emotional effects of domestic abuse 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 to blame themselves for the abuse. All children living with abuse are under stress.

187. GP practices often hold significant information about children from a range of sources that are generally archived after the initial receipt. If GP practices are not routinely approached as part of a statutory assessment there is clearly a missed opportunity to collate evidence that goes beyond asking whether there are direct concerns.

188. The point of assessments is to move beyond the generalized concerns that for example two of the children were the subject of in this DHR and establishing a clearer focus on specifics. In this case, the information and reports about domestic abuse were generally kept separate from each other. Although information about domestic abuse had been reported for example to children's social care services there is little evidence that this was sufficiently considered along with other information collated for the assessments.

189. It is noted later in this chapter that the multi-agency child protection procedures updated in November 2016 in regard to domestic abuse include guidance regarding children's behaviour for example. However, professionals such as social workers have to have the training and the capacity to develop their understanding and knowledge and to apply it to the task of assessing children. Similarly, staff in education, health and specialist paediatric settings need to factor such information into their assessments and diagnosis.

Policy and training arrangements

190. Developing clear policies supported by effective training and continual professional workforce development to reinforce learning is the foundation upon which good domestic abuse detection and prevention is based. Although it is the responsibility of statutory services such as the police and of social care services to protect adult and child victims and assess and manage the risk from perpetrators, it is far more likely that other services will be presented with information and indicators before formal complaints of abuse are raised with the police for example.

191. Domestic abuse can often be exacerbated by other factors such as mental ill-health or substance misuse.

192. The Royal College of General Practitioners publishes guidance to help staff working in general practices to respond effectively to patients experiencing domestic abuse[15]. 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 of a strategic lead from within the clinical commissioning group. The Royal College of General Practitioners also endorses the IRIS (identification and referral to improve safety) commissioning guidance published by The University of Bristol. This is discussed further in this chapter under the policy.

193. The Royal College of General Practitioners also provides through their 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.

194. 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 lead professional for safeguarding. 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.

195. In Manchester, three clinical commissioning groups cover a total of 96 GP practices across Manchester of which fifty GP practices have been designated for receiving an IRIS domestic abuse service since 2013[16]. The same GP practice in the south of the city provided primary health care to Scott, Lena and Susan and the children is one of the practices that was included in the IRIS service since December 2013.

196. The expectation of the IRIS designation is that all of the GP practice staff attend training provided by a GP trainer and a domestic abuse worker referred to as the advocate educator. The training consists of four hours of training delivered through an initial two-hour session that is followed up four to six weeks later. The expectation is that GP and nursing staff attend the four hours of training which introduces the HARKS template[17]. The template records disclosures and referrals and the HARKS can be added as a specific code to the patient record.

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

[16] North Manchester-14 IRIS Practices, Central Manchester-24 IRIS Practices and South Manchester-12 IRIS Practices.

[17] HARKS is a mnemonic Humiliation, Afraid, Rape, Kick and Safety.

The splitting of training allows the template to be introduced and to be installed on the practice systems and following the initial training for it to be activated. The follow-up session can check on implementation and provide advice and assistance. The template is specifically for women only although in Manchester the IRIS supports men as well as women over 16 experiencing domestic abuse or violence and irrespective of sexuality or ethnicity.

197. IRIS is also expected to involve reception, administrative and support staff as well as the practice manager in a separate one-hour session training. An update is provided every three years. The purpose of the training is to improve the recognition and identification of domestic abuse whether it is current or historical, and for the GP or other practise staff to make a referral to IRIS for a specialist advocate educator to speak with the patient. None of the three adults was referred to the specialist service.

198. As a result of the domestic homicide review, further inquiries were made regarding the IRIS. This identified that the initial training provided in December 2013 was attended by seven of the nine GPs although the safeguarding lead was one of the GPs missing from the initial training. There was a delay in delivering the follow-up training which was postponed from January 2014 until July 2014. The same two GPs did not attend the follow-up; this meant that the safeguarding lead had not participated in either of the sessions. None of the nursing staff was in attendance. The IRIS offers an opportunity for clinical staff to participate in another training session at an alternative practice although this was not taken up. It was also established that the HARKS template was not operational at the practice. Six patients were referred from the practice between December 2013 and September 2016.

199. The review provided by the service has prompted a range of actions to be taken. These include rerunning the training, ensuring that clinical staff understand that male consultations do not trigger the HARKS but access to IRIS is available. It is understood that nationally the template is being updated to include male as well as female disclosures. The review also identified that the GP pathway for perpetrators required updating to ensure that although staff have verbal advice that anger management is not an appropriate response in regard to DVA it is not made explicit in the written pathway. This was done by October 2016. A checklist for practices in relation to IRIS is being developed and shared nationally. The protocol will be completed by March 2017. The Stockport Clinical Commissioning Group has not introduced the IRIS and is at a preliminary stage of considering whether IRIS or another similar model is the preferred framework.

200. The reason for including the level of detail about the implementation of the IRIS is to highlight the learning opportunity that arose from the review. On paper, the IRIS had been implemented although it has been shown that unless vital

programmes such as IRIS have the support and leadership at a local practice level and there is a scrutiny of how robust the arrangements are, the integrity and value of the programme risk being undermined by less than adequate implementation.

201. The leadership of safeguarding across diverse settings such as schools, primary and specialist health settings requires people in those roles having the knowledge and being accessible. For example, one of the agency reports describes a safeguarding lead as having an awareness of arrangements such as MARAC but not a detailed knowledge and understanding about the process and making referrals. Similarly, risk identification is often delegated to individual 'professional judgment' that does not ensure a proper balance is given to information that is known as well as the information that is missing or unknown.

202. The Greater Manchester Child Protection Procedures were updated in November 2016 to 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. A previous domestic homicide review in Stockport (DHR3) made recommendations for updates and includes specific advice and guidance; identifying potential signs and symptoms through children's behaviour for example. There is however little explicit reference to coercion and control or to the reasons that adult and child victims are often reluctant to disclose information or disguise the abuse.

203. Unless professionals have the training and capacity to understand the nature of domestic abuse they are less likely to be sufficiently proactive in how they process and enquire into the information and circumstances. Equally, an understanding of why victims find it so difficult to uproot themselves or to break from a relationship is essential to prevent a cultural mindset that blames adults who return to or resume a relationship. This level of understanding has to apply to professionals and to those who have the responsibility for hearing evidence and making decisions in court. Courts need to have the assurance that an application is made freely and without control or coercion. This cannot rely on the applicant who is the victim or just their legal representative although solicitors taking instructions in such cases should have sufficient training and understanding about control and coercion and domestic abuse more generally.

204. Multi-agency training on complex areas of work such as domestic abuse needs 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.

205. The decision by police officers not to use a DVPN in regard to the reports from Lena in September 2015 raised issues in regard to how far policy or custom and practice guide some aspects of decision making. According to the account

of one police officer, the fact that Lena and Scott were not co-habiting would mean that a superintendent would not authorise the use of a DVPN. This is not in written policy and suggests that at least in some police officer's minds there is a custom and practice that is based on a false premise. The policy does not contain any checklist in regard to the use of DVPN or in regard to referring CPS refusal to charge decisions. Clarification in this regard would be prudent.

206. This particular case has raised questions about how private applications for revoking protective orders under civil legislation such as Non-Molestation Orders are processed by the court as well as ensuring that the police are notified when such orders that carry powers of arrest if breached are both granted and revoked. The police are routinely informed of orders made under criminal law such as restraining orders; no such arrangements are in place for civil proceedings which are the only course of action if, for example, the CPS had refused a charge.

207. Policies by agencies working with adult and child victims of domestic abuse need to have clear protocols in place that ensure that when they receive information about a civil order of protection such as Non-Molestation Orders being revoked that the circumstances are inquired into to establish whether this is evidence of control or coercion of the victim.

208. Access to perpetrator programmes was not evident in this case. The review has focussed on identifying and assessing risk and ensuring appropriate support is given to victims.

209. An essential element to preventing and reducing domestic abuse is ensuring appropriate and effective perpetrator programmes are available and routinely signposted as part of incident investigation and assessments. The Freedom Programme is available in Greater Manchester and works with perpetrators is the subject of evaluation across Greater Manchester with involvement from the Office of the Police and Crime Commissioner.

210. This domestic homicide review has been unusual in that almost all of the contact with various services were from outside of Stockport. This has presented a logistical challenge for the conduct of the review. With hindsight, and upon receipt of the draft overview report, it was acknowledged that the agencies providing reports to the review should have been participants in the review panel from the outset rather than relying on the specialist policy officer liaising between the panel and local agencies. It has been agreed that there is learning to be shared across Greater Manchester in regard to the commissioning and coordination of reviews when more than one area is likely to be involved.

211. Following evaluation of the report by the Home Office, an additional recommendation to the Greater Manchester Police has been included to address the missed opportunity to correctly assess the level of risk as being high in September 2015.

Recommendations

1. The Greater Manchester Police should consider the value of developing a checklist or threshold guidance to assist the process of professional judgement in regard to deciding whether a Domestic Violence Protection Notice is appropriate. This should make explicit the risk of a false premise; the importance of taking account of previous relevant perpetrator history in regard to other relationships and should not rely on whether the perpetrator and victim have separated or not.

2. The Safer Stockport Partnership should clarify and report upon arrangements for the local courts to inform the police service about the granting and revocation of civil orders such as Non-Molestation Orders.

3. The Safer Stockport Partnership should refer this overview report to the Greater Manchester Domestic Abuse Partnership Board for further consideration regarding opportunities for training and development with the local courts in regard to domestic abuse and the commissioning and management of statutory reviews that involve services from more than one local authority area.

4. The learning from the review should be shared with the Community Safety Partnership, the Safeguarding Adults and Safeguarding Children's Boards in both Manchester and Stockport so that they can determine what further action needs to be taken locally.

5. NHS England and the Manchester Clinical Commissioning Groups should ensure that all GP practices in Manchester 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*.

6. The Safeguarding Advisor for Schools in Manchester should ensure that learning from the review is shared with schools to raise awareness and encourage compliance with the relevant statutory guidance including 'Keeping Children Safe in Education' advising schools to 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.

7. Greater Manchester Police should provide an account to the Safer Stockport Partnership about any further learning or action required to address the correct grading of DASH assessments and for overview by specialist officers.

National policy

212. The importance of ensuring all aspects of the judicial system provides robust protection from domestic abuse has to ensure that people in key decision-making roles have sufficient training and understanding about the nature and impact of domestic abuse. This encompasses judges, magistrates', solicitors and barristers along with CAFCASS officers. An application to discharge a Non-Molestation Order should, for example, invite appropriately rigorous and sceptical enquiry and challenge on issues such as whether the applicant is making the application freely. The Home Office will be better placed to determine what, if any, further representations in regard to policy and training should be addressed with the Ministry of Justice and related judicial organisations.

213. The Home Office should consider whether this review's findings in regard to how decision making on charging decisions merits further discussion with the Crown Prosecution Service. The Home Office should also consider whether the CPS are sufficiently engaged with the work of other domestic homicide reviews.

214. The conduct of serious case reviews commissioned by Local Safeguarding Children Boards is supported by primary legislation and statutory guidance which includes important aspects such as the cooperation and supply of information from organisations and individuals for the purpose of completing a review. Section 14b of the Children Act 2004 makes clear that requests for information must be complied with. No similar provision is provided in regard to the conduct of domestic homicide reviews commissioned by a community safety partnership. The Home Office should consider if similar legal requirements to cooperate with a domestic homicide review should be developed.

Appendix 1: Single agency action as a result of the domestic homicide review

Education Casework Children and Families Manchester

1. Quality assures safeguarding files ensuring records are clear and concise. Share the learning with all designated safeguarding leads. Check schools have a process to ensure records are quality assured.
2. Where domestic violence has been an issue previously consider safety as an outcome of all multi-agency meetings. DVA to be added to all meetings as an agenda item. If an Early Help Assessment is in place, always to have an outcome/discussion regarding current DVA.

Greater Manchester Police

1. Consideration to be given to reminding all officers who have contact with victims of domestic abuse of the importance of providing relevant helpline and support agency information. Also making sure that when this is done, a record is made within the PPI document write up or FWIN what information has been provided to the victim should he/she wish to make use of any external agency support.
2. Consideration to be given to reminding all officers dealing with domestic abuse incidents of researching background history fully and ensuring that the relevant information is shared with all other persons concerned in the investigation to ensure that fully informed decisions can be made.
3. Consideration to be given to providing training for all custody staff with regards to the DVPN/DVPO process and its' effectiveness as a safeguarding tool.

Manchester Mental Health and Social Care Trust

1. Domestic abuse training to continue to be delivered across al MMHSCT accident and emergency liaison teams.