THE EXECUTIVE SUMMARY OF A DOMESTIC HOMICIDE REVIEW

‘Scott’

October 2015

PETER MADDOCKS
INDEPENDENT AUTHOR

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The review process

1. This summary outlines the process undertaken by the Safer Stockport Partnership domestic homicide review panel in reviewing the homicide of Scott who was a resident in their area.

2. The following pseudonyms have been in used in this review; Scott for the 45-year-old victim and Lena for the 48-year-old perpetrator and Susan for Scott's 47-year-old previous partner to protect their identities and those of their family members. Scott was, and Lena and Susan are, white British and English their language of communication. Extended family members are referred to by their relationship to Scott (or to Lena). Scott had children with Susan the eldest of who was in their twenties and the youngest not yet in their teens when Scott died. Professionals are referred to by their roles such as consultant psychiatrist, community psychiatric nurse, GP, police officer, probation officer or social worker for example.

3. Lena was convicted of murder in November 2016 and was sentenced to life imprisonment.

4. The decision to commission a review was made on the 7th of December 2015. The first meeting of the DHR panel was in March 2016. The review was postponed at the request of the Crown Prosecution Service in June 2016 pending the completion of the criminal proceedings. These were the subject of delay and the trial took place in late October 2016 and completed in November 2016. There was an appeal against the sentence that was not completed until August 2017.

5. Eleven of the more than 40 agencies contacted as part of the initial scoping for the review confirmed that they had contact with Scott and/or Lena and were asked to secure their files.

1.1 Contributors to the review

6. A scoping meeting in January 2016 reviewed responses from the services who had contact or knowledge about the victim and/or perpetrator. All were asked to provide chronological information. Most of the organisations were required to complete an individual management review (full report) that required analysis of their contact whilst other organisations who had less significant involvement provided a short report.

    i. 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;

ii. Greater Manchester Police (notification of homicide and a full report about the previous contact regarding disclosures of domestic abuse by Susan and Lena and management of firearms certification for Scott);

iii. 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);

iv. 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);

v. Manchester Education Service (full report in regard to Scott and Susan's younger children);

vi. Manchester IDVA (independent domestic violence advocacy) service; (full report in regard to Susan's disclosures of domestic abuse);

vii. 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);

viii. NHS England and local Clinical Commissioning Group (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];

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

x. Victim Support (full report in relation to domestic abuse of Susan by Scott in 2011);

xi. 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).

[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.

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

8. All of the authors providing reports to the review were independent of any direct involvement or supervision of decision making regarding Lena, Scott or Susan.

1.2 The review panel members

9. 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.

10. The author of this report chaired the panel. All of the panel members were independent of any involvement or decision making in regard to the events and people concerned with the circumstances examined by the review. The membership of the panel is listed below.

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, Senior Policy Officer, Crime and Disorder 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

[2] The APR 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.

	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

1.3 Author of the overview report

11. Peter Maddocks is the independent chair and overview report author for this domestic homicide. 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 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 in the borough or in Manchester and has no personal or other relationship with any individual who has a professional or elected position in Manchester.

1.4 Terms of reference

12. The time period under review is from August 2011 when the first record of domestic abuse was recorded by the police in connection with Scott and Susan up until the date of Scott's death in October 2015. 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

1.5 Summary chronology

13. Scott and Lena had been in a relationship since 2011. According to Scott's family, they had never cohabited. They began the relationship while Scott was still living with Susan and their younger children. Scott and Susan had lived together for 24 years until their separation in 2011 and after Susan found out about Scott's relationship with Lena.

14. 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.

15. 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'.

16. 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 persuaded that an offence had occurred.

17. Prior to his relationship with Lena, Scott had 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 have been used.

18. There were five other recorded incidents of domestic abuse made by 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.

19. 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 removed temporarily. He was found to have more ammunition than his firearms certificate permitted; he was charged and admitted the offence. Susan declined to participate with the DASH assessment and withdrew her statement about threats to kill. The DASH was closed at the standard (lowest) level of risk threat assessment and Scott's firearms were subsequently returned.

20. Two weeks later in mid-September 2011, Susan reported to the police that she had been struck in the 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. The officer also recorded 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.

21. 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 assault her 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.

22. 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 service.

23. 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.

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

25. 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.

26. 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.

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

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

29. 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.

30. 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.

31. 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.

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

33. 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.

34. 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 to children's services in May 2015.

35. 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 was killed before any further action was developed.

Key issues arising from the review

36. This domestic homicide review is unusual in that the victim of the homicide was the perpetrator of abuse and violence upon 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 collapse in his long 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 to them about any abuse (and neither did Scott in regard to Lena). This is at variance with the evidence of contact with and recording from services described in greater detail in the overview report and summarised in the previous section of this report.

37. Some of the circumstances described and analysed by this domestic homicide review challenge the usual categorisation of there being one 'perpetrator' and one 'victim' of domestic abuse. Responses and the provision of services often categorise on this basis and focus on separating the intervention accordingly.

38. 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 does not spring from a common cause or objectives. Many fatal domestic homicides have occurred at the point at which the homicide victim has been leaving an abusive controlling relationship. This tragic homicide appears to be more the product of what is often referred to as situational abuse or violence.

39. 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 rather than one partner seeking control and coercion of the other. The violence can escalate as it did in this case between Scott and Lena with severe and catastrophic consequences.

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

41. Scott was never identified or reported to be a victim of domestic abuse except to the GP and to the mental health team who became involved after he presented with depression. His account of abuse from Susan 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 did not take 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.

42. Until this domestic homicide review, none of the services had a complete record of information relating to all incidents, although all of the services had some 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 inquired into.

43. Susan secured a Non-Molestation Order in 2011 with the support of local services Susan although went back to court weeks later to have it revoked. That decision was made without any service being asked to provide information to the court. The police were not aware of the revocation. Susan did not wish to provide information for this review and therefore the circumstances have not been clarified with her.

44. 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.

45. The review also highlights the absence of perpetrator engagement and support is sufficiently embedded in the overall response to domestic abuse.

46. Key areas of learning include;

a) The victims of domestic abuse face multiple barriers and inhibitors that impede clear disclosure and participation in processes such as DASH;

b) The nature of domestic abuse means that rarely are there independent witnesses; the emotional and psychological impact of domestic abuse is far more difficult to identify than more tangible evidence such as physical injury;

c) Making judgments and decisions about risk need to take account of historical information and previous incidents; statutory processes such as social work child care assessments and child protection conferences should be opportunities to draw information together from disparate sources; GPs and education providers are more likely to receive information or disclosures about domestic abuse before reports are made to the police or to social care services.

d) Keeping personal information confidential remains an important principle of law and professional ethics; it should not be regarded as an impenetrable obstacle to sharing information or consulting relevant specialist advisors or professionals to clarify the significance of information or finding out about other people and services who may already be giving advice and support;

e) Domestic abuse can often coexist with other sources of risk and vulnerability such as mental illness and substance misuse; they are not the cause of domestic abuse but they can exacerbate and elevate the level of abuse; using assessments and enquiries to signpost or to seek the cooperation of the victim in sharing information opens lines of communication and joint planning;

f) Courts being asked to make an early revocation of orders to control and prevent harassment and molestation should require appropriate consultation and information from relevant organisations;

g) Children will feel confused and conflicted and are susceptible to being manipulated to exert pressure for example on a victim to consider reconciliation; children's behaviour is often the first indicator of domestic abuse before any disclosure is forthcoming; professionals such as teachers, health professionals and social workers need to have the capacity to recognise and explore potential domestic abuse and recognise its significance in professional assessments and decision making;

h) Implementation of new working arrangements requires well informed and committed leadership in the workplace setting; examples in this review included IRIS (identification and referral to

improve safety) domestic abuse service provided since December 2013[3] not being supported in the GP Practice and resource pressures leading to less rigorous oversight on issues such as challenging charging decisions by police officers.

Conclusions and recommendations

47. 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.

1.6 Recognition and understanding of domestic abuse

48. 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.

49. 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

[3] IRIS is an exemplar project that aims to improve identification and action by primary health practitioners in regard to domestic abuse. 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 were in attendance. The IRIS offers 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. Only six patients were referred from the practice between December 2013 and September 2016.

signs and symptoms of domestic abuse given the barriers that face victims in disclosing it to anybody; to their friends, family or services.

50. 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.

51. 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.

52. 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.

53. 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.

54. 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.

55. 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 informed and reflective decision making and challenge. In the absence of an IMR 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.

56. 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.

57. 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.

1.7 Risk assessment

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

59. 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.

60. Reliance on perpetrators abiding by court orders or any other agreement is intrinsically vulnerable to breach. Using children to convey messages or applying emotional pressure combined with the victim's 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.

61. 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.

62. 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.

63. 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.

64. 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.

65. The panel draws attention to the guidance published by the Local Government Association and Association of Directors of Adult Social Services in 2015[4]. 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.

66. 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.

67. 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.

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[4] 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

1.8 Domestic abuse as a safeguarding issue for children

68. 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.

69. 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.

70. 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.

71. 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.

72. 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.

73. 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.

74. 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.

1.9 Policy and training arrangements

75. 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.

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

77. The Royal College of General Practitioners publishes guidance to help staff working in general practices to respond effectively to patients experiencing domestic abuse[5]. 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)

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

commissioning guidance published by The University of Bristol. This is discussed further in this chapter under the policy issues.

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

79. 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.

80. 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[6]. 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.

81. 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[7]. The template records disclosures and referrals and the HARKS can be added as a specific code to the patient record. 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.

82. 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

[6] North Manchester-14 IRIS Practices, Central Manchester-24 IRIS Practices and South Manchester-12 IRIS Practices.
[7] HARKS is a mnemonic Humiliation, Afraid, Rape, Kick and Safety.

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.

83. 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.

84. 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.

85. 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.

86. 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.

87. 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 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.

88. 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.

89. 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.

90. 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.

91. This particular case has raised questions about how private applications for revoking protective orders under civil legislation such as non-molestation 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 has refused a charge.

92. 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 being revoked that the circumstances are inquired into to establish whether this is evidence of control or coercion of the victim.

93. 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; 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.

94. 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.

95. 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.

1.10 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.

1.11 National policy

297. 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.

298. 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.

299. 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.