WIGAN

BUILDING STRONGER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

INTO THE DEATH OF

"STAR"

OVERVIEW REPORT

Chair and Author: David Hunter

January 2016

CONTENTS

1. INTRODUCTION

1.1 The main people referred to in this report are:

STAR	Victim	20 years	White British
BOB	Offender	23 years	White British
Child 1	Child of STAR and BOB	Less than 2 years	White British

1.2 This case is about the homicide of STAR who was murdered in early 2015 by her partner BOB who was also the father of their very young child. STAR and BOB had been in a relationship since early 2011. After the death of STAR it emerged that the level and frequency of domestic abuse experienced by STAR was far greater than that known to local agencies. However, despite her family and friends encouragement for STAR to report the abuse to the police she felt unable to do so because she feared significant retaliation by BOB, and believed his threats that their child would be removed by the authorities.

1.3 A post mortem revealed STAR died of a single "stab" wound[1] to her neck which was inflicted in the home she shared with BOB. She also had 36 separate injuries dating back months which, according to the Home Office pathologist, may have been associated with domestic abuse.

1.4 BOB was arrested and charged with her murder and manslaughter. Later that year he was found guilty of murder and sentenced to life imprisonment with a minimum tariff of 16 years. Child 1 is safe and well in the care of STAR's family.

[1] Caused by scissors

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Wigan Building Stronger Communities Partnership [WBSCP] decided on 24.02.2015 that the death of STAR met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set at 24.08.2015. This was extended twice by the Chair of WBSCP to cater for seeing the families. STAR and BOB moved from Lancashire to Wigan in the summer of 2013. Therefore material relevant to the DHR needed to be obtained from non-Wigan agencies. Several agencies had resource difficulties in providing information which contributed to the delay in completing the DHR. The last agency report was received on 13.10.2015.

2.1.3 An additional delay happened when STAR's mother felt it was too soon to talk to the independent chair about her daughter. The DHR Panel felt it was right to wait until she had the strength to contribute. That meeting took place in late October 2015. In very late November 2015 the report was ready to be shared with STAR's Mother. However and understandably she advised the DHR chair through the family social worker that she preferred to wait until after Christmas 2015 before learning of its contents. Mother's priority was to provide a happy environment for Child 1 at a time when STAR would traditionally celebrate with her family. STAR's Mother felt knowledge of the report in the pre-Christmas period would jeopardise that priority. The Chair of WBSCP agreed and the completion date was reset at 15.02.2016. STAR's family were seen by the DHR Chair on 07.01.2016 who shared the findings of the report with them.

2.1.4 This timetable did not stop the agencies or Wigan Building Stronger Communities Partnership from beginning work on implementing the actions.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 24.02.2015. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. He was supported in the task by Paul Cheeseman also an independent practitioner. Additional independence and domestic abuse expertise was

provided by Drop in and Share [DIAS], a registered charity in Wigan that supports any person harmed by domestic violence and abuse.

2.2.2 The first of six panel meetings was held on 20.04.2015. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

2.2.3 The Panel Membership:

Jeanette Bailey[2]	Chief Officer	Drop in and Share [DIAS] Domestic abuse support service Wigan
Helen Case	Interim Named Nurse Safeguarding Children	Bridgewater Community Healthcare NHS Foundation Trust
Paul Cheeseman	Support for Chair	Independent
Clare Devlin	Detective Chief Inspector	Greater Manchester Police [GMP]
Amanda Crane	WBSCP Project & Implementation Officer	Wigan Council
Jill Cunliffe	Wigan Safeguarding Board Business Support Officer	Wigan Council
Garry Fishwick	Review Officer	Lancashire Constabulary
Reuben Furlong	Assistant Director Safeguarding Adults	Wigan Borough Clinical Commissioning Group [CCG]
Louise Green	Service Manger	The Brick Project
Sharon Heap	Named Midwife & Safeguarding Vulnerable Families	Wrightington, Wigan and Leigh NHS Foundation Trust
Andrew Hill	Manager	West Lancashire Community Safety Partnership

[2] Jeanette provided additional independence and domestic abuse expertise to the Panel

Sue Hogan	Well-Being Prevention and Early Help	Lancashire County Council
David Hunter	Chair/Author DHR	Independent
Elaine Lamprell	Adult Safeguarding Manager	Wigan Council
Barbara Mooney	Manager	Birchwood Centre Supported accommodation
Deborah Morris	Safeguarding Manager	Wigan & Leigh Homes
Kathy Owen	Team Manager Council Children's	Lancashire County Council
Sarah Owen	Strategy Business Manager Well & ISAPP	Wigan Council
Cliff Owens	Community Safety Officer	West Lancashire
Jenny Scott	Senior Social Worker	Wigan Council
Duncan Shaw	Homelessness Advice and Prevention Officer	West Lancashire Borough Council
Kerry Walton	Assistant Head	Burscough Priory Science College
Paul Whitemoss	BCSP Business Manager	Wigan Council

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

Wigan

- Greater Manchester Police (GMP)
- Bridgewater Community Health Care NHS Foundation Trust
- Wigan Clinical Commissioning Group [CCG]
- The Brick Homeless Project

- Wigan and Leigh Homes
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Children's Services Wigan Council
- Welfare Desk Wigan Council

West Lancashire

- West Lancashire College
- Lancashire Constabulary
- Homelessness Advice and Prevention Team
  West Lancashire Borough Council
- West Lancashire CCG
- Southport and Ormskirk NHS Hospital Trust
- Children and Young Peoples Service
- Health Visiting, School Nursing, Mental Health

2.4 Agencies submitting non-IMR Information

- National Society for the Prevention of Cruelty to Children [NSPCC]
- Merseyside Police
- Birchwood Centre [Assisted Housing]
- Citizen's Advice Bureau Wigan

2.5 Notifications and Involvement of Families

2.5.1 The independent chair wrote to the parents of STAR in May 2015 informing them of the DHR and expressing condolences for their loss. He also wrote to the parents of BOB in May 2015. Both families were invited to contribute to the DHR after the criminal trial.

2.5.2 STAR's mother and another family member were seen in late October 2015 and their views appear in the report as appropriate. The family is devastated by the death of STAR and have not been able to come to terms with what happened.

2.5.3 BOB's mother and step-father were seen in September 2015 and where appropriate their views are in the report.

2.5.4 Both families were seen by the Independent Chair in early January 2016 and told of the review's findings.

2.5.5 Paul Cheeseman saw BOB in prison in early October 2015. He provided unverified information some of which appears in this report. However, what he says must be treated with caution and has not been corroborated. It is known from other facts that his account during this interview minimised his role and responsibility. [3]

2.5.6 The member of the public who reported concerns to the NSPCC was seen by the chair and the information obtained from that meeting has proved useful to the report.

2.6 Terms of Reference

2.6.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.6.2 Timeframe under Review

The DHR covers the period 01.01.1999, when there is a significant entry in BOB's GP record to 15.02.2015 which encompasses a post homicide period so that the care arrangements for Child 1 and support for the families can be examined.

2.6.3 Case Specific Terms

1. Were there any significant factors in the childhoods of STAR and BOB that could have impacted on domestic abuse once they reached 18 years of age?

[3] Also see 3.3.6

2. Were any child protection issues in respect of STAR and BOB as children, recognised and dealt with in accordance with the contemporary procedures?

3. Once STAR and BOB reached adulthood, what if any indicators of domestic abuse did you agency have in respect of STAR and BOB and what was the response in terms of risk assessment, risk management and services provided?

4. How did your agency ascertain the wishes and feelings of STAR and BOB in respect of domestic abuse and were their views taken into account when providing services or support?

5. What knowledge did the family, friends and employers have of any domestic abuse between STAR and BOB that could help the DHR Panel understand what was happening in their lives and if they received disclosures did they know what to do?

6. How effective was inter-agency information sharing and cooperation in response to the subjects' needs [pre and post homicide] and was information shared with those agencies who needed it?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to STAR and BOB.

8. How were the child safeguarding issues dealt with post the homicide? Did the action comply with local single agency and multi-agencies policies and procedures?

9. What consideration was given by agencies to support the families of STAR and BOB in the four weeks after STAR's death?

10. Agencies preparing IMRs should explore the actual day of the incident and if possible say what made that day different and why events led to the homicide

3. BACKGROUND

3.1 The information in this section is drawn from the IMRs, statements provided by GMP and contributions from the families.

3.1 STAR [Victim]

3.1.1 STAR was born and spent the majority of her life living in West Lancashire within a loving family. She was a good student at school and is described as a very happy go lucky child. She had lots of friends and this continued when she moved to high school. STAR's mother told their GP that STAR was being bullied at school [STAR was about twelve]. She started going out with boys and one of those relationships lasted throughout secondary school.

3.1.2 During her final year at high school, STAR's outlook changed somewhat and she became what her mother describes as "a bit stroppy". This resulted in a number of disagreements between them. The family, with STAR's agreement, thought they would all benefit if STAR spent a period living with her maternal grandparents. That happened and what the family described as 'generational differences' [between STAR and her grandparents] led STAR to seek alternative accommodation at the Birchwood Centre, an assisted housing project which provides support to young people who are in danger of becoming homeless.

3.1.3 STAR's mother said STAR loved being at Birchwood and benefitted from her stay. In September 2011 STAR began a level 2 Children's Care Learning & Development course at West Lancashire College. The following September she enrolled onto, "level 3 Children's Care Learning & Development" at the same college and withdrew in February 2013 for family/personal reasons. STAR won the student of the year award which made her and the family very proud. STAR did not have any criminal convictions.

3.1.4 Her parents wish her to be remembered as a good person. STAR's mother said "STAR was a perfect mum and gave her baby everything she could and kept him safe from harm, she had dreams and hopes for her and her baby's future. STAR was very well liked, always smiling and kind hearted. She will be missed so much by all her family including her child".

3.2 BOB [Offender]

3.2.1 BOB was the middle of seven children who grew up in Liverpool and West Lancashire. His mother re-married when he was at primary school. During this period of schooling his mother sought help from Child and Adolescent Mental Health Services [CAMHS] for his abusive and compulsive behaviour. His mother said he was bullied at school. At one time BOB wanted to be a vet. He had a particular affinity with animals, sometimes bringing home injured specimens.

3.2.2 In 2009 he enrolled in engineering and youth work courses at a local college but did not complete them. He spent about six months living in supported accommodation. His real passion was music and dance which he supported by working in a national fast food outlet. He lost his job and lived with his biological father for a while. On return to his mother and step-father's home

he was noted to have started taking drugs and was still self-harming. His mother and step-father recognised the harm drugs had on him and strongly advised him to give them up when Child 1 was born.

3.2.3 BOB told Paul Cheeseman that he was diagnosed with depression at nineteen and was given medication. He went to a few counselling sessions. The depression just happened. He noticed he was becoming different because when he was younger he would get angry and stand up and fight back when he was bullied. Later he started to just take things on the chin and let people walk all over him. When he met STAR he changed and had a reason to live.

3.2.4 BOB had the following convictions prior to the homicide.

- Resist/Obstruct Police Officer x 1 (2013)
- Train Fare evasion x 3 (2012 and 2 in 2011)
- Breach of Community Order x 2 (2011)
- Handling Stolen Goods x 1 (2011)

Plus

- Given fixed penalty notice on 15.10.2011 for possession of a weapon [razor blade] and threatening behaviour
- Given two street warnings for possession of cannabis.
- Arrested several times for breaching bail conditions. [4]

3.2.5 It is clear from emerged during the review that BOB did not respect STAR and from the above convictions neither did he respect authority.

3.3 Relationship between STAR and BOB

3.3.1 BOB met STAR when he visited the Birchwood Centre [5] in 2011. They met again at college and soon formed a relationship which STAR told her GP about in February 2011. STAR left her supported accommodation and moved in with BOB in February 2011. It emerged during the homicide investigation that their relationship was volatile and on several occasions STAR disclosed to her mother and other people that BOB had assaulted her. On one occasion STAR sent pictures of her facial injuries to her mother. STAR's mother also recalls receiving telephone calls from STAR saying that she had been locked in the house; that she had been arguing with BOB and he had pushed her. The telephone calls continued and her mother suggest telephoning the police but STAR stated she was alright and it was just arguments. Her mother encouraged her daughter to return home but STAR always said she was alright. STAR did return home on a few occasions with the support of her family, but BOB always persuaded her to return, claiming he would change.

[4] See paragraph 3.3.2

[5] An organisation that works with Young People [13-25 years old] to prevent homelessness and improve well-being. It also provides supported accommodation, delivers mediation, training, plus development and move on support.

3.3.2 In April 2013 BOB was arrested by Lancashire Constabulary for assaulting STAR. He was charged with Common Assault [Section 39 Offences Against the Person Act 1861] and initially remanded in police custody. He was given conditional bail in the Magistrates' Court which he breached. STAR later withdrew her allegations against him and therefore BOB was not convicted of assaulting her. BOB later apologised to STAR saying he loved her and would not assault her again. This "apologetic and promising" behaviour is very common in domestic abuse and is in itself a form of coercive and controlling behaviour. Their relationship continued and appeared settled for a short time. STAR's mother describes an occasion when STAR telephoned her saying that she and BOB had had been arguing and BOB had hit her and smashed her head into the floor. Her mother states she had always taught her children to hit back and asked STAR if she had retaliated, STAR said she had hit back at BOB. As a result of this incident STAR was seen with a black eye and bruising around her ear, she was pregnant at this time. Her mother encouraged STAR to telephone the police. STAR replied it was not possible to telephone the police when your telephone has been taken away [by BOB]. This is another example of controlling and coercive behaviour.

3.3.3 The couple moved to private rented accommodation in the Wigan area in mid-2013 and STAR was pregnant with Child 1. BOB's brother lived with them and things appeared settled between STAR and BOB for a short time. There is evidence that they were under financial pressure. Their income was derived from benefits and they received monthly food parcels from The Brick Project. It appears, and was confirmed by BOB, that their drug use [cannabis/cocaine] consumed much of their income. BOB's brother moved out and they accrued rent arrears, ending in an eviction notice. Housing intervened, discovered that STAR was well advanced in pregnancy, and provided accommodation treating them as a priority case.

3.3.4 Child 1 was born and there is evidence that the relationship between the couple was still unsettled. However, before the NSPCC referral to GMP and Wigan Children' Services in May 2014, agencies in Wigan had no knowledge or suspicions about domestic abuse. His arrest for domestic abuse in Lancashire was not known to GMP but it could have been easily discovered by them interrogating the Police National Computer [PNC][6] or the Police National Database [PND].[7]

[6] Police National Computer a national database base holding information on convictions, arrests and vehicles; accessible to all police forces within England, Wales and Scotland.

[7] Police National Database – an information and intelligence database populated by and accessible to all police forces within England, Wales and Scotland.

3.3.5 BOB described his relationship with STAR as: "…Overall it was good… we just had problems and we weren't very good at dealing with them. Mine was obvious I was suffering from depression. She did as well, she never went for help. It was good until we moved in together. Even the bad times were good… There was a point when we wanted to leave each other…When Child 1 was born I fell in love with her again".

3.3.6 The DHR panel was conscious that BOB's remarks could not be challenged by STAR. On listening to the full account of the interview with BOB, the panel felt from its independent experience and the available evidence that he was a minimiser who did not take responsibility for his actions.

4. THE FACTS

4.1 Introduction

4.1.1 The information in the following paragraphs is taken from agencies' returns and is presented as "factual" save for an occasional commentary from the DHR Panel. The analysis of events is dealt with under Section 5 Terms of Reference.

4.2 Health Agencies including General Practitioners [GP]

4.2.1 STAR and BOB had early traces of testing behaviours. BOB's mother took him to the GP who referred him to CAMHS with reported abusive, aggressive and impulsive behaviour fearing he might be a danger to himself. Attention Deficit Hyperactivity Disorder [ADHD] questionnaires had been completed by his mother and class teacher. He was assessed as not having ADHD; it was more a case of attention seeking. It was reported that generally he was well behaved in school and that his mother had good control of him.

4.2.2 STAR was seen by her GP when aged about twelve. Her mother reported that STAR loses her temper easily, gets in trouble at school and home, gets tearful, takes about two hours to get to sleep and is bullied at school. The GP considered a referral to CAMHS but decided it unnecessary and gave mother appropriate advice.

4.2.3 The DHR Panel felt that STAR and BOB's "testing behaviours" were not so unusual and did not link them to the homicide. When BOB was discharged from CAMHS in late 2010 the following note was made by the clinician, "Does not anticipate too many problems for him in the future". However, the DHR Panel did note the early indicator of BOB's aggression.

4.2.4 In the summer of 2011 STAR had three contacts with her GP [two visits and one telephone discussion]. Firstly she reported being low for last three weeks and was encouraged to talk to her family, particularly her mother on how she felt. The GP noted, "No suicidal thoughts". Secondly STAR said she was having family problems and becoming snappy, aggressive and slamming things which were affecting the household. Lastly she reported excess sleeping, feeling low and had self-image concerns. STAR was unable to find work but had "no active suicidal thoughts. No risk of self-harm. Started to exercise and swim".

4.2.5 In mid-July 2012 STAR took an impulsive overdose of thirty two paracetamol tablets and was taken to a local accident and emergency department and referred to a mental health professional from Lancashire Care NHS Foundation Trust [LCFT]. She reported being very distressed after being asked to move out of her grandparents' home and felt generational issues were the cause. STAR said her parents were planning to move to the Lake District without her. She felt lonely and rejected and felt there was not much point in carrying on and decided to take the paracetamol tablets which were on her bedside table. She began to feel unwell and realised that she did not want to end her life. She contacted her mother via text and her mother requested an ambulance. STAR regretted her actions, but still felt sad about some aspects of her life. She denied any further thoughts of self-harm or suicide and said she was willing to engage with services. She was provided with the LCFT Mental Health Helpline telephone number and contact details for the Crisis Team if required. LCFT established that STAR was in contact with Children's Services who were hoping to do some mediation work with STAR and her grandparents, thereby

tackling the homelessness facet of her unhappiness. STAR was discharged in October 2012.

4.2.6 When seen a few weeks later in the GP surgery STAR presented as well dressed, bubbly and in a bright mood. She declined support and felt she was getting all the help she needed at the Birchwood Centre. STAR reported being under stress recently due to family issues.

4.2.7 STAR's mother explained to the DHR Chair that STAR was frustrated that some of her peers were making independent lives and described STAR as wanting to run before she could walk. However, her mother said, STAR's outlook was positive.

4.2.8 Thereafter STAR's contact with her GP was unremarkable and the records show she took Child 1 for routine checks and immunisations, which illustrates she took her parental responsibilities seriously.

4.2.9 Prior to the summer of 2010 the GP record shows that BOB had several attendances at a hospital with various "sporting" injures plus one following an altercation with his brother. In early summer 2010 BOB's GP received notification from a hospital that he had been diagnosed with a panic attack and was given appropriate advice before leaving.

4.2.10 Some thirteen months later [July 2011] the GP received a letter saying BOB had attended a local hospital with self-inflicted superficial cuts to his wrists. It appears a long term relationship [not STAR] had ended and he was in trouble with the police for handling stolen goods. He was referred to LCFT Community Mental Health Team by his GP for increased stressors following a split from his girlfriend.

4.2.11 He reported he had depression in the past for around five years after a previous girlfriend died of suicide. [When BOB was seen post his conviction for murder he said the person who committed suicide was a friend and not a girlfriend and that her death did not lead to his depression. It made him appreciate people more.] Telephone contact was made with BOB and he was offered support and services. BOB contacted the LCFT Community Mental Health Team a week later wanting access to services as he felt low and had fleeting thoughts of self-harm. He did not respond to a number of appointments and in September 2011 was discharged to the care of his GP.

4.2.12 In August 2011 BOB saw his GP who noted; "Palpitations – was seen in hospital x 3 with overdose of citalopram (someone else's); inadvertent overdose of cocodamol; and superficial stabbing to upper chest. Describes rapid heartbeat pounding sob makes dizzy, may last minutes. Denies drug misuse. Referral for further care to cardiology…"

4.2.13 Later that month he told his GP that 2/3 years ago he used cocaine, ketamine and ecstasy. Two months ago he used cocaine and also uses cannabis now and again. The GP recorded, "…Stress at home – split from partner, criminal offence, tagged, lost job. Low mood, recent attempt at para-suicide with alcohol – bottle of vodka, cocodamol 20 tablets. Called ambulance and seen by crisis team last night. Was on citalopram by Drs in Skelmersdale stopped medication. O/E {on examination} – multiple superficial cuts to chest and abdomen…"

4.2.14 Between August 2011 and February 2013 [BOB's last visit to his GP], his notes show continuing issues with self-harm, oscillating mood and reference to taking drugs. At this last visit he was given a "sick note" for three months which identified he was suffering from anxiety and depression which required further assessment. There is no evidence that BOB took up this offer.

4.2.15 On 24.12.2013 STAR's GP received notification that she had attended A+E, Wigan with a forehead injury and a cut to face which was sutured. The hospital noted 'fainted X 2, with a transient loss of consciousness resulting in a wound to the forehead which was cleaned and sutured'.

4.2.16 The DHR Panel thought that STAR and BOB had general vulnerabilities which from time to time manifested in self-harm; him on several occasions, STAR just once. BOB's propensity for wanting to dominate STAR resulted in him being physical violent as well as displaying coercive behaviour and exercising controlling over STAR.

4.3 West Lancashire College

4.3.1 STAR was a student at West Lancashire College from September 2011 to February 2013, studying Child Care Level 2 and Level 3. In April 2012 STAR's tutor heard that STAR was having unspecified family difficulties. From examining the combined chronology the Panel felt the family difficulties were around STAR's accommodation. She had moved in with her maternal grandparents in November 2011 as a solution to improving the relationship with her mother and step-father. It then appears that by April 2012 tensions between STAR and her grandparents resulted in her looking for other accommodation. The College support staff made two appointments with her in April 2012 to talk through the family issues but STAR kept neither. However, STAR was still attending classes and in contact with teaching staff and was judged to be on course to successfully complete her studies.

4.3.2 On 01.02.13 the College was contacted by the Crisis Centre who suggested they have a meeting to share information and to clarify the rumours surrounding STAR's wellbeing. Several attempts were made to contact STAR but her mobile telephone was always switched off and despite the efforts of staff contact was not achieved. STAR withdrew from the course on 06.02.2013.

4.3.3 In September 2009 BOB began, and two years later completed, an Engineering level 2 course and Certificate in Youth Work. In September 2013 he enrolled onto a Performing Arts level 3 course but withdrew in January 2013 to seek employment. His College record does not contain any concerns about BOB.

4.3.4 Therefore STAR and BOB's attendance at the College overlapped for about sixteen months and they left within three weeks of each other. His withdrawal coincided with STAR's unspecified difficulties identified by the Crisis Centre.

4.4 West Lancashire: Housing Provision and Children's Services pre Birth of Child 1

4.4.1 In November 2011 STAR called into her local Children's Services office saying she was homeless after her mother barred her from the home because they argued the previous day. The duty social worker spoke on the telephone with STAR's mother who acknowledged the argument with her daughter but refuted the claim she was homeless, stating her daughter had stayed at her grandmother's house the previous night.

4.4.2 As identified above STAR resided with her grandparents for several months. In June 2012 she presented herself to West Lancashire Borough Council Homelessness Advice and Prevention Team and advised the worker her grandparents had asked her to leave their accommodation by 20.07.12. At the time of the interview she was a full time student at West Lancashire College, as was BOB. The Homelessness Team established through contact with the family that her mother and step-father and her grandparents were adamant they did not want STAR living with them because of the continuing arguments.

4.4.3 The Homelessness Team completed a Common Assessment Framework [CAF] and sent it to Children's Services requesting a Child In Need Assessment [CIN] under Joint Working Protocol for Homeless 16 and 17 year olds.

4.4.4 Children's Services completed an Initial and Core Assessment in conjunction with STAR who stated that she did not wish to become a looked after child.[8] They judged she was competent to make this decision. Children's Services consultation with STAR is an example of them taking her views into account. Consequently an appointment was made for her with Young People's Service [YPS] and West Lancashire Council Homelessness Advice and Prevention Team who would assist STAR look for accommodation in accordance with the above mentioned protocols. Negotiations began with the Birchwood Centre who agreed to provide accommodation for STAR when it became available.

4.4.5 During the YPS and the Homelessness Advice and Prevention Service's work with STAR and her family, she took the overdose of thirty two paracetamol

[8] A term used to describe children in the formal care of a local authority.

tablets. This resulted in her grandparents rescinding their deadline for STAR to find other accommodation and continuing their care.

4.4.6 This crisis re-focussed the need to find a quicker solution to STAR's accommodation needs and she moved into the Birchwood Centre on 30.07.2012 and stayed there until 17.02.2013 when she went to live with BOB.

4.4.7 In April 2013 the YPS completed a home visit and spoke to STAR who reported being settled at BOB's home and going to college regularly. The YPS worker advised STAR she would be removed from the caseload, adding she could contact the case worker through the library if she felt in need of support.

4.4.8 The DHR Panel felt the cooperation and joint working between Children's Services, including the YPS, the Homelessness Advice and Prevention Service and the Birchwood Centre was an example of excellent interagency working against pre-existing protocols. It prevented a vulnerable person from becoming homeless.

4.5 The Brick Homeless Project [9]

4.5.1 In about July/August 2013 STAR and BOB were living in private rented accommodation in the Wigan area. On 08.08.2013 BOB attended The Brick Homeless Protect with a food parcel referral form issued by the welfare support desk at Wigan Life Centre. It appears BOB had not received benefit payments since 16.07.2013. He was provided with a food parcel for one adult.

4.5.2 The history of food parcel allocations to BOB is set out below.

Date	What Received
08.08.2013	Food parcel for one adult
05.11.2013	Food parcel for one adult
03.12.2013	Food parcel for one adult

[9] The Brick is a crisis intervention centre based in Wigan Town Centre, dealing with issues such as homelessness, debt and welfare and also offers a signposting service to other agencies. The Brick has a large food bank, which accepts referrals from agencies across the Borough for individuals and families in need.

17.12.2013	Food parcel for one adult
10.03.2014	Food parcel for one adult
20.03.2014	Food parcel for one adult
08.05.2014	Food parcel for two adults
18.06.2014	Food parcel for two adults
14.08.2014	Food parcel for two adults and one child
21.08.2014	Food parcel for two adults and one child
09.09.2014	Food Parcel for two adults and one child

4.5.3 The Brick acknowledges that it provided food parcels in isolation of BOB and STAR's wider social circumstances and did not consider sharing information with children's services when the food parcels included an allocation for a child.

4.6 STAR's Pregnancy

4.6.1 On 07.10.2013 STAR was referred by her GP to ante-natal services. On 10.10.2013 STAR, accompanied by BOB, attended Wrightington, Wigan and Leigh NHS Foundation Trust {Maternity Services} [WWL] where a community midwife "booked" the pregnancy.[10]

[10] At the time of this appointment, women were routinely asked about domestic abuse, but in this case, there was no opportunities to ask as STAR was always accompanied by BOB. There is a section in the maternity case notes to ask routinely at booking/first appointment and another section to ask a second time if missed.

This has been reviewed as a result of this DHR, and the Named Midwife from the safeguarding team at WWL has developed a routine enquiry checklist that the community midwives use at the first appointment to enquire about domestic abuse, but only in the absence of a partner or third party. This has been incorporated into the domestic abuse maternity guideline for WWL NHS foundation trust. Midwives are also aware to enquire throughout the pregnancy and postnatal period should signs/triggers for domestic abuse be evident.

The antenatal clinic midwives at Wigan and Leigh Hospitals will follow this up after the dating/first scan appointment if the opportunity was missed due to partner or third party being present and being unable to take the woman out of the room at the first booking appointment. If a partner or other person is present, the midwife will take the woman out of the room to make the enquiry. Compliance with the policy will be audited in March 2016.

The safeguarding team at WWL (adults and children's and maternity) is also devising a domestic abuse awareness trust wide policy, have formed a domestic abuse sub group which meets monthly, and half day training sessions are booked from January 2016 to raise awareness of all aspects of domestic abuse.

4.6.2 On 08.11.2013 Bridgewater Community Care NHS Foundation Trust [Health Visiting Service] received notification of STAR's pregnancy from midwifery at WWL. The notification included the following points.

- No history of cot death
- No history of severe mental health problems
- No current mental health problems
- No history of infertility
- No history of traumatic events
- No financial concerns - worries
- No current or past involvement with Social Services
- No ongoing illness
- Not a single parent family
- No issues with social network
- Expected date of delivery
- BOB suffers from depression

4.6.3 It is known that the source of these "points" was STAR's answers to the community midwifes questions during the booking appointment. It is also known that some of them did not fully reflect what was or had happened in STAR's life. For example STAR had received support from Social Services, additionally there were some financial concerns as evidenced by BOB's access to the food bank at The Brick. While the details are not known it is evident that STAR and BOB's finances were supporting their drug use, a fact acknowledged by BOB when he was seen in prison post-conviction. However, given what is now known as BOB's dominance over STAR the Panel felt it was very doubtful if she had a real choice in how the family income was spent and noted this as an example of BOB's financial control over STAR.

4.6.4 On 05.01.2014 it is documented in the antenatal records that STAR's mood had been discussed. It was stated that she had felt 'up and down' and she had been "referred". There was no documentation of where she had been referred to. The community midwife had no clear recollection of the referral, but did recall the conversation. The standard options for referral are: a GP appointment or if the case appeared more severe the mental health team and the public health midwife team if the lady was under 28 weeks gestation.

4.6.5 Two months later STAR was seen by the same community midwife. STAR said she was feeling better and her mood had lifted. BOB was present at both of these routine ante-natal appointments.

4.6.6 Child 1 was born in spring 2014 and received standard post-natal care from midwifery and Health Visiting.

4.7 Wigan and Leigh Housing [WLH]

4.7.1 About a month before the birth of Child 1, STAR and BOB made an application to WLH for a tenancy. Part of the application form asks whether there is any domestic abuse. STAR answered "no". There was no indication that STAR was in danger of losing her current accommodation or that she was pregnant. STAR and BOB were noted as partners. It was within the professional experience of many Panel members that victims will often disguise their victimisation on housing applications particularly while they are still in the relationship because they fear the abuser will find out they have made a disclosure.

4.7.2 A few weeks later STAR told WLH that their private landlord had served them with a notice to quit. WLH confirmed this with the landlord and after taking her fairly imminent confinement into account, they acted swiftly; made her case a priority, and allocated a property to the couple who signed for it in very early June 2014. In-between time Child 1 was born and WLH negotiated with the private landlord who allowed STAR and BOB to remain in his property until the move. They were living in the WLH property at the time of STAR's death.

4.8 Lancashire Constabulary's Involvement

4.8.1 Between September 2012 and June 2013 Lancashire Constabulary had nine dealings with either STAR and/or BOB, four of which were related to domestic abuse.

4.8.2 In the first incident BOB's step-father reported that BOB was at the house in a drunken state and refusing to leave. BOB had climbed on the porch roof and banged on a window demanding accommodation for the night. During the disturbance BOB broke a window pane. His step-father expressed concerns to the attending officers about BOB's mental health [for which he declined professional help] and said BOB's erratic behaviour saw him changing rapidly from being happy to aggressive. It was also reported that BOB had self-harmed.

4.8.3 The incident was recorded as domestic abuse and the risk assessment showed BOB presented a Standard[11] risk to his step-father. Step-father did not want any action taking about the damage which he judged to have been caused accidentally. A Protecting Vulnerable Persons [PVP] referral was then passed to Lancashire Constabulary's Public Protection Unit [PPU] where it was filed without making any referrals.

4.8.4 The second occurrence came in April 2013 when BOB contacted the police requesting help but terminated the call before giving any details. The police call taker listened to the recording of the call and heard a male say that his girlfriend had assaulted him. A female was heard shouting and swearing in the

[11] Standard risk is the lowest of the three risk levels: Standard, Medium and High and means current evidence does not indicate a likelihood of serious harm.

background. The telephone number used to make the call was traced to STAR.

4.8.5 Police officers attended and spoke with STAR and BOB separately. BOB said he had not been assaulted but had been arguing with STAR and threatened to call the police. This account was consistent with STAR's reply to the officer's questions. There were no visible injuries. The matter was recorded as domestic abuse and a DASH risk assessment recorded that BOB was the victim and concluded he faced a Standard risk from STAR. A PVP referral was submitted to PPU who filed it no further action.

4.8.6 The third report came on 23.04.2013. Lancashire Constabulary received a third person report that STAR had been assaulted. On attending the address STAR told officers that she had been arguing with BOB and he slapped her hard on the forehead causing reddening. He also threatened to burn her belongings. STAR said to the officers that BOB had assaulted her previously but she had never reported him to the police.

4.8.7 BOB was arrested and charged with Common Assault and kept in police custody overnight and appeared at a Magistrates' Court the following day. BOB was granted bail with conditions designed to protect STAR and the third party. The PVP report went to PPU who judged that STAR faced a Standard risk of serious harm from BOB.

4.8.8 The fourth and last domestic related incident came when on 07.06.2013 when Lancashire Constabulary investigated a report that BOB was breaching his bail conditions by staying at STAR's address. When an officer attended the address he was met by BOB who provided a false name before breaking down in tears and revealing his true identity. STAR was not in the property. BOB's behaviour became erratic and the officer noted he had many old scars.

4.8.9 The officer arrested BOB who was placed in handcuffs. However, BOB ran away from the officer but was captured nearby by another officer. On returning to his police van STAR appeared. It was apparent to the officer that some incident had happened between BOB and STAR but she denied it. STAR told the officer that she had agreed to "drop" the charges against him.

4.8.10 The officer could not prove that a domestic incident had taken place, however he did express concern over BOB's mental state due to his behaviour and his self-harm injuries. The officer submitted a Protecting Vulnerable People (PVP) Vulnerable Adult referral graded Standard Risk with the intention that BOB would be referred on to mental health services. The referral was passed through to the Multi Agency Safeguarding Hub (MASH) and the information was shared with Lancashire Mental Health Services.

4.8.11 On 21.06.2013 a bail check on BOB showed he breached his curfew. He was later arrested and re-bailed with tighter conditions.

4.8.12 STAR felt unable to continue supporting the prosecution against BOB and the Common Assault charge was dropped. Later in the report the reasons why victims feel unable to continue with a prosecution are discussed.

4.8.13 On 24.07.2013 the police saw STAR following an incident where a male known to her had demanded repayment of what appears to be a private debt. BOB was not present when the officer called. The DHR panel noted that this was one of several occasions when the couple were chased for money they allegedly owed.

4.9 Greater Manchester Police, NSPCC and Wigan Children's Services Involvement

4.9.1 On 15.05.2014 the NSPCC received a call from a member of the public [MoP] raising concerns for the welfare of Child 1. The family was now living in Wigan.[12] MoP's concerns were recorded as:

- Substance misuse by STAR and BOB
- Domestic violence witnessed between STAR and BOB on 4/5 occasions; [this included BOB chasing STAR into the garden and then grabbing her face or wrists and forcing her back inside the house]
- Strong smell of cannabis from property
- Shouting and banging of doors
- Garden littered with furniture and other rubbish
- Two large dogs in property

4.9.2 MoP provided a name and contact telephone number stating a willingness to speak with Children's Services should any further information or clarity be required. The DHR Panel felt that MoP's actions were commendable. NSPCC passed the referral to Wigan Children's Services and GMP.

4.9.3 Within ninety minutes GMP dispatched an officer to STAR and BOB's address where he saw them and Child 1. The summary of what the officer found at the address states that both parents were present on police arrival and access was allowed to the property by BOB. The baby was present also. The officer noted, "…The house was untidy but not overly dirty. The baby appeared to be clean and normally sized for … age. STAR stated that she was breastfeeding, both parents were young and looked tired. The officer spoke to STAR alone who said she was not subject to domestic abuse.

4.9.4 The address was searched and no evidence was found of drugs or drug paraphernalia. There was no reported smell of cannabis. The officer expressed his opinion that although the house was untidy he had no concern about anything he saw and suggested that the couple may benefit from support from a health visitor or some other outside agency but reiterated that he had

[12] The DHR panel considered whether being in debt was a potential reason for moving to Wigan. However, in the absence of evidence no conclusion could be drawn.

no immediate concerns for the child. The officer recorded that STAR told him they had received visits from a health visitor. It is known from Health Visiting records that only one visit had taken place by this time. There was a boxer dog at the address but this was kept well away from the baby. The officer graded the situation at the address as a Standard risk which was later endorsed by a specialist officer working in GMPs Publication Protection Investigation Unit [PPIU]. The Standard risk grading meant that GMP policy did not require the Police National Database [PND] to be checked and therefore the officer making the risk decision on the NSPCC referral was unaware of the April 2013 arrest of BOB for assaulting STAR. The incident was finalised by passing details to Children's Services and Health Visiting. The DHR Panel notes that Health Visiting did not receive the original information from NSPCC and therefore had nothing to compare the police information to.

4.9.5 It is known that NSPCC send all the referral information to GMP, a fact accepted by them. It has not been possible to establish whether the GMP dispatcher sent the same documentation to the attending officer or a limited version of it. It is known that the attending officer did not speak to MoP. Had MoP been spoken to a different picture of domestic abuse would have emerged. The possible reasons for the attending officer not seeing MoP are explored later in the analysis.

4.9.6 Children's Services received feedback from GMP on their findings and made contact with the family Health Visitor. The HV reported:

- Primary care visit completed [01.05.2014] no concerns for Child 1's welfare.
- BOB informed he suffers with depression and agreed to access his GP when needed
- STAR reported no mental health issues
- Home was untidy but clean
- Health Visitor to visit again in a week and will discuss domestic violence. [13]

4.9.7 Children's Services telephoned STAR and left a voice mail message. The Team Manager decided that no further action was needed because:

- No concerns raised by health
- Police completed a welfare visit, no concerns raised
- Home is untidy but this is due to the family moving property
- Health visitor to complete visits to see child 1 more frequently than the expected protocol.[14]

[13] The Health Visiting records show that the HV would visit on 04.06.2014, and not in a week.

[14] There is nothing recorded in the Health Visiting records to say that more frequent visits would be undertaken.

4.9.8 The referral was closed and Children's Services wrote to STAR with information on available support services. Shortly after the NSPCC referral the family took up tenancy of their new home. During the course of the DHR Panel discussions it became apparent that Children's Services made their judgements without knowing that MoP was willing to speak with them and that MoP's partner had also witnessed the domestic abuse. It also appeared to the Panel that the police conclusion of "no concerns" following their visit was one of the influencing factors in Children's Services decision to take no further action. This was acknowledged by the Children's Services representative on the DHR panel. The decision making by Children's Services is looked at in more detail under the analysis.

4.9.9 Following the move to WLH accommodation there was a short period when Health Visiting was unaware that the family has moved. However, they used their networks and soon discovered the family's new address. There is also good evidence that the Health Visitor discussed with STAR and BOB the NSPCC referral and the visit of the police.

4.9.10 On 31.07.2014 GMP received an abandoned 999 call requesting the police. The number was redialled by police who identified themselves to the male who answered. When asked why the 999 call was made the male - who is now known to be BOB - said, "Someone was being pathetic". When asked to clarify what he meant the line cleared. The call was traced to STAR/BOB's address and an officer dispatched. Research was completed on the address and there was no record of domestic abuse there.

4.9.11 An officer attended [PC2] and spoke with STAR and BOB. He believed both were being evasive and suspected a domestic incident had taken place. PC2 attended by himself and found it difficult to see STAR alone. When asked by PC2 if she had been assaulted STAR said no.

4.9.12 PC2 observed that BOB appeared in control of STAR; she presented as very meek. When PC2 challenged comments made by BOB, STAR would immediately side with BOB. He was asked why his pupils appeared very wide. He denied he had taken any substance and STAR immediately agreed. PC2 recorded that his suspicions were that BOB has a degree of control over STAR. The DHR Panel thought this was insightful and an example of good practice.

4.9.13 PC2 completed a Domestic Abuse and Stalking and Harassment risk assessment [DASH] which showed STAR faced a Standard risk of harm from BOB. It was noted that Child 1 was present in the house at the time of the "incident" but there was no evidence of alcohol.

4.9.14 PC2 recorded that STAR although answering "No" to question 15 on the DASH which relates to whether the abuser tries to control everything the victim does, he is of the opinion that STAR was not providing a true picture of her relationship with BOB.

4.9.15 STAR also confirmed that BOB had self-harmed in the past (Q25 of DASH). She indicated to PC2 that BOB has previously breached bail conditions when he had been on bail for assaulting her in the past, she states this is the only knowledge she has of BOB having a criminal history (Q26 & Q27 of DASH). PC2 explained that STAR was not very forthcoming with her responses and was very protective of BOB, stating that he had assaulted her in the past but had "done his time". It is known that the charges against BOB for assaulting STAR were dropped and therefore he had not served a custodial sentence for the assault. The DHR Panel felt this reference was significant as it indicated previous contact with the police for domestic abuse. STAR was very careful with her replies to PC2's questions and appeared guarded and mistrustful of the officer. PC2 had the impression STAR thought he was trying to "trip her up" in order to implicate BOB and provide an excuse to arrest him.

4.9.16 STAR was informed of the services offered by Victim Support, DIAS and the new service available to victims known as the Independent Domestic Abuse Centre (IDAC). PC2 records that STAR "*merely laughed when these services were mentioned, stating that she did not need them*".

4.9.17 PC2 judged it was unnecessary to take any immediate safeguarding action in respect of Child 1.

4.9.18 The incident log and DASH risk assessment was passed electronically to PPIU for further evaluation but because it was a Standard risk it sat in a queue until 12.08.2014. GMP report that a twelve day wait is not unusual in these circumstances.

4.9.19 The PPIU member of staff who dealt with the case was TO1 [a Triage Officer] who acknowledged that STAR made reference to a previous domestic abuse incident between herself and BOB. TO1 was unable to find any such incident within the GMP.[15] As a result, TO1 checked the Police National Computer [PNC] for BOB and recorded that she found a "match" but did not record the details. It is not expected within the GMP policy that during an enhanced risk assessment [ERA] by a specialist officer for a Standard case, that a PNC check should be completed for either the victim or the perpetrator. More in depth background checks are required for medium or high risk cases.

4.9.20 TO1 finalised the document on the basis that the DASH procedure generated 4 out of 27 positive responses from the victim. A domestic abuse letter -

[15] An internal GMP database holding intelligence data and other police reports.

which noted that a child had been present - was to be sent to the victim. Regrettably, details of the incident were not shared with Children's Services or Health Visiting. The case did not meet the threshold for a referral to a Multi-Agency Risk Assessment Conference [MARAC].[16]

4.9.21 On 07.01.2015 a call was made to GMP reporting a disturbance in the street where STAR and BOB lived. BOB was in dispute with a male over a monetary debt BOB believed he was owed. BOB and STAR reported being assaulted by the alleged debtor who was arrested but following an investigation no further action against him was taken. This incident is included to illustrate another example of STAR and BOB's finances.

4.9.22 About a week after this incident Children's Services received an anonymous referral alleging STAR and BOB were smoking cannabis. They noted their May 2014 involvement when similar information was received from NSPCC. Children's Services contacted Health Visiting who reviewed their records and told Children's Services there were no concerns and the Health Visitor was scheduled to visit the home on 24.02.2015 [in about six weeks]. Children's Services and Health Visiting reached an agreement that the latter would share any concerns after the February appointment. GMP were not contacted by Children's Services and therefore they did not know about the abandoned 999 call which was classified as domestic abuse.

4.9.23 Children's Services sent a letter to STAR informing her of the concerns raised and advising no further action would be taken at this time. BOB contacted Children's Services about this letter. He told them that some of their neighbours assaulted him and also tried to assault STAR who was holding Child 1. He added that the police were involved and the case was going to court. That is now known not to be the case, but it is not known if BOB knew this when he spoke to Children's Services. He attributed the anonymous referral to that altercation saying that while he and STAR used to smoke cannabis they stopped after Child 1 was born. That is now known not to be true.

4.9.24 BOB was advised that no concerns were identified by health and no further action was being taken by Children's Services. He stated he just wanted his views noting.

4.9.25 This was the last contact any agency had with the family before STAR's homicide.

[16] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist, police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. Source: www.safelives.org.uk

4.9.26 Following STAR's death and BOB's arrest, Children's Services worked effectively with other agencies to protect and safeguard Child 1.

4.10 Post Homicide Information from Police Investigation

4.10.1 GMP identified a number of people who knew of the domestic violence perpetrated by BOB on STAR. A summary appears below.

Date	Event
Unspecified	STAR told a friend [Friend 1] that she and BOB argued. STAR spoke of being grabbed, having her neck stood on, being called names, receiving bruising and black eyes, being pushed down stairs and verbally abused by BOB. Apart from the first time Friend 1 met STAR she never saw her without BOB being present. STAR told Friend 1 that she hit BOB which Friend 1 thought was a retaliatory act. STAR gave two examples. She hit BOB in the face when she had a key in her hand and caused a visible minor injury. STAR described another incident when she caught BOB's fingers in a door when he was trying to get at her. Friend 1's partner corroborates her accounts.
Unspecified	Friend 1 said that STAR would avoid Health Visitors if she had a black eye and would not answer the door to avoid her bruises being seen. Friend 1 felt STAR was protecting BOB but also suspected she was scared of him when they were home. Friend 1 also expresses her concern about the cannabis and more latterly the cocaine habits of STAR and BOB.
Unspecified	Friend 1's partner said that he had spoken to BOB about STAR. BOB admitted that he hit STAR and he was smiling when he was saying this.
Unspecified	Other people who knew STAR saw her with bruises and provided evidence of controlling behaviour such as BOB withholding STAR's bankcard.
Unspecified	STAR told another friend that BOB had bitten her on the top of her thigh when she was in the bath. Note from the DHR Panel: This could be an indicator of sexual violence. See Appendix B
Unspecified	Another witness saw STAR with a bleeding nose. STAR

	explained that BOB hit her because he said she was flirting with a man. This is an example of controlling behaviour and an unacceptable way to resolve perceived differences.
Summer 2014	STAR seen with a nose bleed which she said BOB caused. Child 1 was a few months old.
Late December 2014	Friend 1 described an incident when STAR said she had been staying at her mother's house as a result of BOB trying to drown her in the bath and scaring her. STAR would always say that she loved BOB and did not want to break up the family, she was also worried that BOB would self-harm. This may be the incident referred to below.
Late January 2015	STAR told her mother that BOB hit her in the face during an argument. STAR reported waking up in the bath of water, fully clothed but wet and unable to recall how she got there.
Late January 2015	STAR sent her mother two photographs via mobile telephone of her facial injuries probably caused during the above assault.
Late January 2015	The next day STAR sent another photograph of the injuries with a text saying she was getting better. Her mother did not think so.
The day of the homicide	STAR telephoned her mother saying she had cracked the fish tank querying how to repair it and there was water everywhere.
The day of the homicide	STAR's mother returned her daughter's call and heard her saying she had had enough of BOB who was heard laughing in the background. STAR said she had to go and would ring back as BOB had just kicked another hole in a door.
The day of the homicide	STAR telephoned BOB's mother and calmly asked if she would come and pick up BOB as he was getting on her nerves. His mother declined as she was going out. BOB took the telephone from STAR and calmly told his mother that STAR was being silly and they would be fine.

4.10.2 What is apparent from the above summary is that BOB was violent, coercive and controlling towards STAR and while there were accounts from friends that STAR would sometimes hit BOB [very likely in retaliation] there appears no doubt he was the aggressor.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

Note:

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

5.1 Term 1

Were there any significant factors in the childhoods of STAR and BOB that could have impacted on domestic abuse once they reached 18 years of age?

5.1.1 There is nothing in STAR's childhood that the DHR Panel felt could be directly linked to her future victimisation at the hands of BOB. The DHR Panel considered whether her sometimes strained relationships with her parents and grandparents might have been an indicator that she was a vulnerable person in the general sense of the word. Her deliberate overdose of paracetamol was a reaction to what she told professionals was a feeling of rejection by her family thereby adding to her general vulnerabilities. She presented to her GP three times in July 2011 with low mood. No major risk factors were identified. STAR sought treatment for a cross bow injury in September 2011 but there is no explanation of the circumstances. Therefore 2011 seems to have been a difficult time in STAR's life but nothing was known to agencies to suggest she would be a homicide victim several years later.

5.1.2 STAR's mother described her as a bit stroppy during her final year at school. However, that is a fairly common description and there is no empirical data to link such a description to becoming a homicide victim.

5.1.3 The beginning of the review period was set at January 1999 to cater for BOB's referral in April 1999 to CAMHS for what his mother termed his abusive, aggressive and compulsive behaviour. It was also queried whether he might have ADHD. Over the next year BOB was seen in the CAMHS clinic and observed in school. He was assessed as not having ADHD and his behaviour improved. He last visited CAMHS in May 2000 and was discharged from the service in October 2000 for non-attendance.

5.1.4 The DHR Panel felt the above episode could have been an early indicator of his future aggressive and violent behaviour but the gap between it and STAR's death meant that no safe conclusion could be drawn as to cause and effect.

5.1.5 BOB history of self-harm began when he was no longer a child.

5.1.6 In summary the DHR panel did not feel there were any significant factors in STAR or BOB's childhoods that would have identified her as a victim and him as a potential domestic abuser.

5.2 Term 2

Were any child protection issues in respect of STAR and BOB as children, recognised and dealt with in accordance with the contemporary procedures?

5.2.1 West Lancashire Children's Shad some involvement with STAR when she presented as homeless. They worked closely with West Lancashire Homelessness Prevention and Advice Team and had substantial contact with STAR's parents and grandparents while supporting her. When STAR took an overdose of paracetamol in response to her feelings of rejection, children's services successfully negotiated with her family for her to remain with them until the supported accommodation at the Birchwood centre became available.

5.2.2 The DHR Panel noted that West Lancashire's Children's Services and Homelessness Service were working to pre-existing protocols and adherence to these coupled with good information sharing and staff perseverance, prevented STAR from becoming homeless thereby safeguarding her as a child.

5.2.3 There is no record that BOB was involved with Children's Services as a child or young person and the DHR Panel did not identify any missed opportunities in this respect. His self-harm events were dealt with within a health setting which the DHR Panel thought appropriate.

5.3 Term 3

Once STAR and BOB reached adulthood, what if any indicators of domestic abuse did you agency have in respect of STAR and BOB and what was the response in terms of risk assessment, risk management and services provided?

5.3.1 The following agencies or people either knew that STAR was the victim of domestic abuse, or had allegations shared with them; these were:

Who knew?

- Lancashire Constabulary
- STAR's family/friends
- STAR
- BOB

Who had the allegations shared with them?

- NSPCC via a referral from member of the public
- Greater Manchester police via NSPCC and children's services
- Wigan Children's Services via NSPCC
- Health Visiting via Children's Services and GMP

5.3.2 All the agencies mention above have well established policies and processes for identifying and dealing with domestic abuse.

5.3.3 On 03.01.2012 BOB told his GP that his recent self-harm resulted from an argument with his unnamed girlfriend. It is known this was not STAR. However, there was no detail of the argument and it cannot fairly be said that all arguments in relationships amount to domestic abuse. The DHR Panel felt that self-harming can be a deliberate method with which to exert control over another. [17]

5.3.4 The DHR Panel believed the arguments and difficulties between STAR and her family did not constitute domestic abuse; they seem to have been around STAR's disagreement with her parents' guidance. Children's Services did not raise any domestic abuse concerns when it supported STAR with her accommodation crisis.

5.3.5 The first time any agency recorded domestic abuse between the couple was in April 2013 when BOB telephoned Lancashire Constabulary saying his girlfriend [STAR] had assaulted him. The investigation did not reveal any offences but the DASH risk assessment showed BOB faced a Standard risk of harm from STAR. The DHR Panel noted the response was appropriate and complied with the Constabulary's domestic abuse policy.

5.3.6 A closer look at this incident shows that BOB and STAR had been arguing and he threatened to telephone the police. When he did he was recoded as the victim. The incident would have befitted from a more probing enquiry by the police to determine the nature of the relationship and which of them had power and control. It has been observed in other DHRs that the police very often record the victim as the person who first telephoned the police.

5.3.7 Following STAR's death a friend told the police that STAR acknowledged that she and BOB fought and that sometimes during these incidents she would hit him. However the friend believed this was retaliatory. [See paragraph 4.10.1]

5.3.8 The DHR Panel heard that when BOB was seen in prison he remarked that the police did not take his claims to be a victim seriously. The panel discussed this point and found only one incident [referred to above April 2013] where he claimed to be the victim. As seen he was recorded as such even though he denied being assaulted. A DASH was completed and in all respects he was treated as a victim.

5.3.9 The panel further discussed that it was very likely that STAR was engaged in "violent resistance" which is defined as, "where a victim of domestic abuse responds violently to the abuse they are experiencing - typically in self-

[17] In 2012 the Government definition of domestic abuse applied to people aged 18 and over. The age was lowered to 16 years or over on 27.03.2013.

defence or to stop a violently abusive act from occurring, or in response to extreme coercive control, possibly out of frustration. This is where we are likely to see a perpetrator (generally male) of domestic abuse claim they are a victim of domestic violence to avoid scrutiny of their abuse of the victim.[18]

5.3.10 The Panel felt BOB's view was part of his continuing non-acceptance, denial and minimisation of his responsibility for domestic violence and the homicide. There is ample independent evidence to say that it was STAR who was the victim and not BOB.

5.3.11 In late April 2013 a friend of STAR'S reported to the police that STAR had been assaulted by BOB. He was arrested, interviewed and charged with assaulting STAR. He was on conditional bail which he breached twice. Eventually STAR withdrew her support for the prosecution and the case was dropped.

5.3.12 The DHR Panel made a number of observations on this incident. Members remarked that sometimes victims do not want to make a direct complaint to the police fearing additional retribution from the perpetrator, but are nevertheless content for a complaint to be made by a third party thereby seemingly absolving themselves from blame for reporting it or protecting themselves from retribution. It was also apparent that BOB had wheedled and coerced STAR into withdrawing her complaint with false promises of changing his abusive ways. The evidence for this view is supported by disclosures STAR made to her mother about BOB's apparent contrition. Research[19] shows just how difficult it is for victims to report matters to the police.

5.3.13 On 24.12.2013 it was noted in STAR's GP records that she had attended at the Accident and Emergency Department, Royal Albert Edward Infirmary Wigan with a forehead injury and a cut to the face that required sutures. STAR reported she had sustained the injuries in a fall following a dizzy feinting episode. The DHR panel thought, given what is now known, the injuries could be domestic abuse related. STAR was pregnant at this time.[20]

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[18] A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and situational couples violence - Michael P Johnson, 2010

[19] On average victims experience 50 incidents of domestic abuse before getting effective help. See notes 4 and 5

Note 4 SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.
Note 5 Walby, S. (2004), The Cost of Domestic Violence. London: Women and Equality Unit.
Source: www.safelives.org.uk

[20] Pregnancy can also be a risk factor for domestic violence.

Over a third of domestic violence starts or gets worse when a woman is pregnant
One midwife in five knows that at least one of her expectant mothers is a victim of domestic violence
A further one in five midwives sees at least one woman a week who she suspects is a victim of domestic violence
www.refuge.org.uk

5.3.14 Two weeks later [January 2014] STAR attended a routine ante-natal appointment where it was noted she had an up and down mood. Again there is no reason recorded as to what was impacting on her mood. The DHR Panel felt it could be linked to domestic abuse because it is now known what was really happening in her life.

5.3.15 After Child 1 was born a student health visitor [SHV] completed the primary visit and saw STAR, BOB and Child 1. The SHV was unable to see STAR alone and therefore did not ask the routine question of whether she had or was experiencing domestic abuse. However, the SHV did not observe anything to suggest domestic abuse was present in the relationship.

5.3.16 The next opportunity to detect indicators of domestic abuse came from the NPSCC when on 15.05.2014 a member of the public [MoP] called them to express concerns about the welfare of Child 1. NSPCC recorded this information on a form titled, "Request for Service". The "Request for Service" form was e-mailed to GMP and Children's Services thereby ensuring those agencies had exactly the same information that NSPCC obtained from MoP.

5.3.17 The information on the "Request for Service" form made a direct reference to MoP having witnessed domestic abuse and was recorded as a separate bullet point thus:

"The referrer {MoP and another person}… have witnessed 4-5 incidents of domestic violence since the family moved in 6 months ago. Mum has been seen running outside into the garden to be followed by Dad who has grabbed her face or wrists and forcefully told her to get inside".

5.3.18 As stated earlier the police attended and found no evidence of domestic abuse, drug use or child neglect. The officer felt STAR and BOB were young parents who needed support in looking after a new baby and made the necessary notifications to Children's Services and Health Visiting.

5.3.19 The incident was dealt with by GMP primarily as a "Concern for Child", albeit the attending officer explored the drug and domestic abuse aspects of the NSPCC information. Officers dealing with vulnerable persons, which this case was classified as, are expected to complete a risk assessment based upon the information given within the guidelines set out in Chief Constable's Orders 2013/28. The risk assessment grades are, low medium and high. The officer graded this incident as Standard[21] which is a grade associated with the domestic abuse DASH risk assessment. It was a simple error which had no subsequent impact. However, the officer was unaware that BOB had been arrested in 2013 for assaulting STAR.

[21] Standard is the lowest of the three DASH risk levels; the others are medium and high.

5.3.20 The DHR Panel discussed whether the officer attending the concern for child call should have contacted MoP after receiving denials from STAR that she had been assaulted by BOB. The information from MoP was very specific and spoke of witnessing domestic abuse on 4/5 occasions. Additionally MoP said there was another witness to the assaults. [See paragraphs 5.3.22 for an explanation of why this contact with MOP was not made.] However, even with this knowledge STAR may have continued denying she was a victim, albeit she may have made a disclosure. Research shows why victims find it difficult to make disclosures and/or leave abusive relationships. It is now known that STAR was frightened of BOB, while still having feelings for him.

5.3.21 **Emotional reasons for staying**

- belief that the abusive partner will change because of his remorse and promises to stop battering
- fear of the abuser who threatens to kill the victim if abuse is reported to anyone
- lack of emotional support
- guilt over the failure of the relationship
- attachment to the partner
- fear of making major life changes
- feeling responsible for the abuse
- feeling helpless, hopeless and trapped
- belief that she is the only one who can help the abuser with his problems

Situational reasons for staying

- economic dependence on the abuser
- fear of physical harm to self or children
- fear of emotional damage to the children over the loss of a parent, even if that parent is abusive
- fear of losing custody of the children because the abuser threatens to take the children if victim tries to leave
- lack of job skills
- social isolation and lack of support because abuser is often the victim's only support system
- lack of information regarding
- belief that law enforcement will not take her seriously
- lack of alternative housing
- cultural or religious constraints

Source: www.domesticviolenceroundtable.org

5.3.22 The original information that NSPCC sent to GMP cannot be found by the Force. If the referral followed the normal pattern the NSPCC information would have arrived at GMP in two parts. The first part is a very generic e-mail

and the second part is an attachment with the referral details. It is safe to say that GMP received both parts because they actioned the referral which they could not have done from the generic e-mail alone. This point is accepted by GMP.

5.3.23 Having received the referral GMP then moved it through an internal process resulting in an officer being dispatched. It is not known for certain if the officer received the important piece of information that the MoP [and another person] had witnessed the domestic abuse. It is known that the officer received the information about the concern for the child, domestic abuse and the drug use because he refers to them the clearance log. He also specifically asked STAR about domestic abuse thereby reinforcing the view of what he knew. The DHR panel concluded that GMP should review the routing of referrals from NSPCC to ensure those officers acting on such referrals had all the information available to them.

5.3.24 The DHR Panel felt that had the officer known about the availability and willingness of a witness [es] he should have made contact with MoP. He would then have been in a position to balance MoP's account against STAR and BOB's denial and use the knowledge to inform the risk assessment.

5.3.25 The incident was passed from the attending officer to PPIU for further assessment. The GMP IMR author helpfully describes what that involves. The PPIU has a triage desk which assesses and processes electronic cases sent to it. This case was marked as "concern for child" and was dealt with by an officer who was not a domestic abuse specialist.

5.3.26 The usual procedure is for the triaging officer to read through the incident log to assess the circumstances and decide whether further action needs taking. Checks are also carried out on OPUS. For a low or medium risk no further checks would usually be done. If there was some indication that the persons involved were known to a different police force then a PND check would usually be completed to ascertain whether any other information or intelligence was known about them so as to inform the risk assessment.

5.3.27 It was explained by a PPIU member of staff that each case was different and decisions made regarding further action are based upon the circumstances of each case. It is the role of the triage officer to make a judgement based on the information available and that officer's experience of child protection matters.

5.3.28 It is not known whether the triage officer saw both parts of the referral e-mail from NSPCC and took the domestic abuse element of the "concern for child" referral from the NSPCC into account when making decisions. It appears the focus was on the child and not domestic abuse. The NSPCC referral contained strong evidence from MoP that STAR was subject to domestic abuse, but as mentioned above this line of enquiry was not pursued by the officer who

attended the incident. The GMP representative on the DHR panel felt that PPIU did not know about the availability of a witness [es] because it was highly unlikely that such an obvious point would be overlooked, particularly as STAR and BOB had denied there was any domestic violence.

5.3.29 The DHR Panel was conscious not to be too judgemental using hindsight but felt there might be a gap in PPIU procedures in that the Police National Database and the Police National Computer held information about STAR's 2013 victimisation at the hands of BOB in Lancashire. Such knowledge might have altered the actions of the PPIU triage officer. However, there is no requirement for PPIU staff to check PND or PNC in the circumstances described. The policy of not checking PND and/or PNC for standard/low risk cases is based on the volume of domestic abuse cases but does present a real conundrum of not identifying information which could increase the level of risk.

5.3.30 Had the information about BOB's arrest in Lancashire been known to the triaging officer it may have refocussed attention on the domestic abuse facet of the NSPCC referral and perhaps have prompted contact with STAR to complete a DASH risk assessment. The DHR Panel felt that GMP and Children's Services should have scrutinised the NSPCC referral more thoroughly and pursued the opportunities it presented them to explore domestic abuse within the family.

5.3.31 Following triaging, PPIU notified Children's Services and Health Visiting of GMP's involvement and findings. The notification decision was based on the comments made by the attending officer that the couple were young parents, with a very young baby and would benefit from the support of other agencies and there were no immediate concerns for Child 1.

5.3.32 While informing Health Visiting was appropriate and dealt with the support needs of the family as identified by the police, it only told part of the story. Health Visiting did not have the original information from NSPCC and had no way of judging whether the reported outcome of the police visit dealt with all the information provided by the NSPCC. The DHR Panel felt that in future any agency who was involved in responding to a case, or informed of the outcome, should also be shown the original referral information thereby allowing them to identify whether the reported actions and decisions were appropriate. In this case either GMP or Children's Services should have shared the original NSPCC information with Health Visiting.

5.3.33 There is also a significant difference in the records of Children's Services and Health Visiting on what action the Health Visitor was going to take. Children's Services recorded that the Health Visitor would visit next week [and more frequently than the expected protocol] and would discuss domestic violence; Health Visiting records do not contain this detail. Instead Health Visiting recorded that the Health Visitor would visit on the 04.06.2014 some twenty

days away and not a week as noted by Children's Services. Also the Health Visiting record makes no mention that the Health Visitor would discuss domestic violence or visit more frequently.

5.3.34 Children's Services decision to take no further action was in part informed by the fairly imminent and additional support they thought the Health Visitor would provide. The DHR Panel has not been able to reconcile the differences. However, if the information sharing proposal in the preceding paragraph had been in place, Health Visiting would have been aware of the context of the NSPCC referral and been in a far better position to respond to the family's needs.

5.3.35 Children's Services received the same information as GMP, but mistakenly believed the NSPCC source was anonymous. The DHR panel was told by Children's Services this was an oversight. Children's Services had no direct contact with STAR, BOB or Child 1. The rationale for no further action appears in paragraph 4.8.7.

5.3.36 The DHR panel heard from the Children's Services representative that even if they had known there was a witness to the alleged domestic abuse the no further action outcome would have remained. It was explained that prior to the NSPCC referral the family was not known to Children's Services and the positive feedback received from the police and the health visitor meant that the case fell below the threshold for additional assessment. The DHR panel challenged that position but Children's Services believed it was a reasonable stance.

5.3.37 Children's Services might have made a different decision had they known about the 2013 assault in Lancashire. They could not have been expected to know of this without being told by the police. Wigan Children's Services has reflected on this case and if the circumstances were to be repeated they would want to know what MoP had to say before making a final decision.

5.3.38 The next opportunity came on 31.07.2014 when GMP received an abandoned 999 call from STAR's address. The officer attending observed their evasiveness and STAR's subservience to BOB and suspected domestic abuse. The officer completed a DASH risk assessment which showed STAR faced a Standard risk of harm from BOB. The officer signposted STAR to domestic abuse services.

5.3.39 The incident log was placed in the appropriate OPUS queue for Standard grade domestic incidents. This queue tends to have the most logs waiting for assessment by specialist officers. There is no priority system within this queue that allows triage staff to select logs that may have a report of crime or recordable offence[22] attached to them. Such logs may require follow up action

[22] National Crime Recording Standards: Home Office Counting Rules For Recorded Crime. www.gov.uk

before others that do not have a report of crime attached. However staff are unable to identify readily these type of Standard risk logs in the queue. The DHR Panel noted that GMP made a recommendation to remedy this.

5.3.40 The log was examined some twelve days later on 12.08.2015 by a specialist domestic abuse officer [TO1] who noted from the log that BOB had been arrested previously for assaulting STAR and had also breached bail conditions but could not find the details on OPUS. TO1 checked PNC and found the details but did not record them. Following TO1's intervention the risk assessment remained at Standard.

5.3.41 The DHR Panel felt this was a missed opportunity to link three important events that would have informed the risk assessment. These events were:

- BOB's arrest in 2013 for assaulting STAR together with his other dealings with Lancashire Constabulary
- The NSPCC referral of May 2014
- The abandoned 999 call in July 2014

5.3.42 TO1 has reflected on the missed opportunities and would make different decisions in future cases.

5.3.43 Had these matters been considered together the Panel thought in hindsight the risk faced by STAR from BOB would have been medium which would have meant a referral to a Multi-Agency Risk Assessment Conference. The fact that the previous history was not considered was an oversight.

5.3.44 The position could have been recovered had GMP notified Children's Services and Health Visiting of the 999 call. Again the Panel judged this to be an oversight. Had Children's Services been told it was highly likely they would have checked with Health Visiting [as they did for the NSPCC information] and discovered that the opportunity to ask STAR about domestic abuse had not arisen because BOB was always present. This information, when put together with GMPs note that BOB was controlling STAR is likely to have led to additional scrutiny by Children's Services. Equally, if Health Visiting had been informed of the 999 call they may have found a mechanism to see STAR on her own.

5.3.45 On 14.01.2015 Wigan Children's Services received an anonymous letter raising concerns that STAR and BOB smoked cannabis in front of Child 1 and were outside drinking in Child 1's presence at midnight. Children's Services noted the 2014 NSPCC referral identified similar concerns. The Health Visitor was contacted but had no concerns [she did not know about the 999 call]. Children's Services closed the 2015 case no further action without STAR having been spoken to. The reason was recorded as, "No further action to be taken by social care at this time - the department have no information that would substantiate the allegations made".

5.3.46 GMP was not contacted by Children's Services and therefore the 999 incident was unknown to their decision maker. Children's Services decided not to contact GMP because the anonymous letter contained very similar information to the NSPCC referral. STAR was sent a letter informing her of the concerns raised and advising no further action.

5.3.47 While this incident did not mention domestic abuse it did provide an opportunity to explore just what was happening in the family. Children's Services noted that the 2015 anonymous letter raised similar concerns to the 2014 NSPCC referral. That is only partly true; the NSPCC information was much more extensive and included direct and witnessed allegations of domestic abuse. The Panel felt the anonymous letter should have prompted Children's Services to extend its search for additional information before making a decision. Had that work been done the GMP 999 call would have been discovered.

5.3.48 In summary there were four opportunities to identify domestic abuse between STAR and BOB. Three DASH risk assessments was completed none of which reached the threshold for a referral to MARAC. No agency held information about all the four events and had they been shared within a multi-agency setting the risk faced by STAR from BOB may well have been higher than Standard, thereby allowing additional tactics [via MARAC] to support and protect STAR. In the absence of a multi-agency setting there were opportunities for Children's Services and in particular GMP to gather all the relevant risk factors.

5.4 Term 4

How did your agency ascertain the wishes and feelings of STAR and BOB in respect of domestic abuse and were their views taken into account when providing services or support?

5.4.1 All the five agencies who knew or had allegations shared with them that there was or might have been domestic abuse in the family [Lancashire Constabulary; NSPCC; Greater Manchester Police, Health Visiting and Wigan Children's Services, had responsibilities to seek the views of STAR and/or BOB.

5.4.2 Despite BOB's comments that the police did not take his alleged victimisation seriously, Lancashire Constabulary followed its domestic abuse procedures and recorded him as the victim of a domestic abuse, judging he faced a Standard risk of harm. Therefore the DHR Panel concluded that his comments were unfounded and were probably made as part of his "justification" for committing domestic abuse.

5.4.3 When STAR's friend reported that STAR was a victim of domestic abuse, Lancashire Constabulary acted swiftly and in accordance with their procedures. Arresting, charging and keeping BOB in police custody overnight

was a good example of supporting STAR and taking her views into account. The Magistrates' Court was also supportive in setting bail conditions when he appeared before them the following morning. The DHR Panel felt the liaison between Lancashire Constabulary, the Crown Prosecution Service and the Magistrates' Court in support of STAR was good practice.

5.4.4 GMP saw the couple twice and each time spoke alone with STAR. During the NSPCC enquiry the police officer felt the couple needed support with the new baby and made the necessary referrals. That was thoughtful but it set the tone for Children's Services response, which influenced not only the no further action on the May 2014 NSPCC referral, but also the January 2015 anonymous letter. As mentioned previously, if the officer had spoken to MoP [the NSPCC information provider] a contrasting picture would have emerged. Health Visiting provided routine services for the family and were aware that the NSPCC referral contained information that STAR was reported to be a victim of domestic abuse. Health Visiting never found the opportunity to speak with STAR alone as BOB was always present. Therefore anything she said would have been tempered by his presence and asking the question may have aggravated what is now known to have been a difficult position for STAR.

5.4.5 GMP's second contact with STAR and BOB produced a much different picture. While STAR continued to say she was not a victim of domestic abuse, the attending officer insightfully believed she was and encouraged her to disclosure. He signposted her to domestic abuse services which she declined. The DHR Panel felt STAR's responses were dictated by her fear of BOB. Therefore, in his presence she was displaying a "false loyalty" as a way of managing her real situation. The DHR Panel thought this was another example of his controlling and coercive behaviour.

5.4.6 Children's Services unsuccessfully tried on several occasions to speak with STAR on the telephone. They made their decisions without seeking her views directly; they relied on GMP and Health Visiting. They could and should have spotted that the NSPCC informant [MoP] was willing to be contacted. Had Children's Services done that, it is likely they would have persevered and spoken to STAR given the strong links between child protection and domestic violence.

5.4.7 The GP also had relevant information about STAR and BOB. However, it is not usual for Children's Services to approach a GP for information but advances have been made in Wigan so that the Integrated Safeguarding and Public Protection Team [ISAPP] [23] has access to the Medical Interoperability Gateway [MIG] so that they can view part of the GP record

5.5 Term 5

[23] A multi-agency team of police officers, social workers, housing, probation and drug and alcohol workers in Wigan to tackle domestic abuse.

What knowledge did the family, friends and employers have of any domestic abuse between adult STAR and BOB that could help the DHR Panel understand what was happening in their lives and if they received disclosures did they know what to do?

5.5.1 STAR was not in paid employment and BOB had short terms of employment in the fast food take away industry. There is nothing of relevance known from his employment.

5.5.2 As in common with many other DHRs the family and friends in this case had a greater knowledge of domestic abuse than agencies, including material that could have been used as evidence in a criminal prosecution, e.g. injuries seen, photographs of injuries, disclosures from STAR and admissions from BOB. See paragraph 4.9. With one exception, family and friends did not have the permission of STAR to report her victimisation to the police; in fact she prohibited such reporting. The exception was the third party reporting by STAR's friend to Lancashire Constabulary. STAR's mother encouraged STAR to report BOB but like many victims of domestic abuse she felt unable to do so.

5.5.3 STAR's mother told the independent chair that she was in a real dilemma over what to do with STAR's disclosures of domestic abuse; she did not know what to do for the best. On reflection she believes she should have talked with someone [e.g. Citizen's Advice] about what was happening to her daughter. STAR's mother said she allowed herself to be over influenced by STAR's insistence that she could manage the relationship with BOB. STAR was concerned that if Children's Services became involved they would take Child 1. This thought was put into her mind by BOB who reinforced it many times. He told STAR she was a bad mother and that Child 1 would be taken away if she disclosed domestic abuse to professionals. The DHR Panel noted that BOB's behaviour in this respect was controlling and coercive not only to STAR but it also impacted on her mother. STAR's mother provided a safe haven for STAR and did everything she felt she could to support her daughter. [24]

[24] Prompted by a Panel member, the Independent Chair checked with Wigan Citizens Advice Bureau [CAB] about how they would respond to such a query from a family member or a friend. CAB's first priority would be to do nothing that would put the victim at additional risk of harm. Their approach to the third party [or a victim for that matter] would be to provide them with the tools to help the victim in terms of her/his rights in areas such as housing and to encourage the third party to get the victim to report the matter to the police. CAB was very conscious that involving the police before an appropriate safety plan was in place might increase the danger to the victim. If the family member or friend disclosed the presence of a child in the house, CAB would only seek to potentially breach confidentiality where the person who has discussed the matter with them was not willing to contact the Police or Children's Services themselves. If the person indicates that they want to report the matter then CAB would offer assistance to do this. If the local CAB judges that the family member or friend refused or is not likely to make contact with Children's Services, the local CAB would contact the National CAB organisation and discuss the child protection issues with them. The National CAB then seek advice from NSPCC following which a decision would be made on whether to break the confidentiality of the family member or friend.

If it is agreed to break confidentiality permission is remitted to the local CAB so that they can refer the case to Children's Services. The National organisation will usually make a decision about breaching confidentiality within

5.5.4 MoP telephoned the NSPCC. The Chair of the DHR saw MoP and asked why they chose NSPCC. MoP's prime concern was for the welfare of Child 1 and an internet search using words similar to, "what to do if you suspect child neglect", produced the link to NSPCC. The independent chair has tested this and was able to replicate the result.

5.5.5 MoP told the independent chair that NSPCC said they do not provide feedback to callers. NSPCC confirm this. MoP assumed that because the issues were referred to NSPCC action would be taken. As time went by MoP felt nothing had yet been done because the matters that concerned them were still happening. This was reinforced by the fact that no agency had responded to MoP's "contact me" invitation. MoP said had they known the police and Children's Services had been involved and the family had been seen by the police it would have alerted MoP to the fact that the agencies interventions had not been effective and MoP would have made additional calls to agencies.

5.5.6 The NSPCC has a system for providing feedback to callers. They are given a referral number to quote for future contact, should they have further concerns they wish to share

5.5.7 The NSPCC point out:

"Obviously we need to be clear who is contacting us and asking for feedback. If the referrer did call again asking for feedback, we would ask them if they had a referral number – if they did, they would be asked to clarify their name/date they contacted us and the names/address of the referred family. The only information given would be that all concerns we received will have been shared with external agencies – we would not inform them of any feedback we may have received from C/S or the Police, we would not answer any other questions, the caller would be advised to contact C/S for further information.

5.5.8 If the caller did not have a referral number and it was felt they were trying to find out if a referral had been made or, the identity of a referrer, they would be told that all concerns we receive regarding the safety and wellbeing of a child/children are passed on to the relevant local authority Children's Services and they would be advised to contact CS should they require further information".

5.5.9 An internet search asking the question, "I know someone who is the victim of domestic violence, what should I do?" was conducted by the independent chair. The response readily identified www.womensaid.org.uk and a visit to

one hour. However, if there is a concern of an imminent risk then the local CAB can contact the Police and/or Children's Services immediately without going to the national organisation first. All such incidences must be recorded and reported to a designated senior person within the National organisation.

that site reveals a heading on the home page titled, "How can I help a Friend?" This is a practical guide of what to do and what not to do, plus direct internal links to a document called, "Survivor Support Q&A for Family and Friends".

5.5.10 Therefore the DHR Panel concluded there was support available via the internet to help family and friends who had knowledge of or received disclosures from domestic abuse victims. However, they did not underestimate the difficulty faced by family and friends especially when sworn to secrecy by the victim or who may not have access to the internet. [25]

5.5.11 The Wigan Community Safety Partnership and the representative from West Lancashire Community Safety Partnership recognise that there is not a proactive campaign aimed at family and friends and that their current responses are ad hoc. A recommendation is made by the Panel for this gap to be filled.

5.6 Term 6

How effective was inter-agency information sharing and cooperation in response to the subjects' needs [pre and post homicide] and was information shared with those agencies who needed it?

Pre-Homicide

5.6.1 When STAR presented as homeless, significant information sharing took place between Lancashire Children's Services, West Lancashire Homelessness Advice and Prevention Service and more latterly The Birchwood Centre. This ensured that STAR had accommodation in a period of crisis in her life.

5.6.2 There was good information sharing between NSPCC, GMP, Wigan Children's Services and Health Visiting following the May 2014 report of MoP to NSPCC. Non-confidential information was also shared effectively between Wigan and Leigh Homes and the private landlord when STAR, BOB and Child 1 faced eviction. Additionally the family was lost to Health Visiting for a short period after they moved but good interagency communication quickly located them.

5.6.3 STAR's single episode of self-harm and BOB's multiple episodes resulted in good information sharing within health and externally to Children's Services.

5.6.4 GMP should have shared information with Children's Services and Health Visiting following the abandoned 999 call, but an oversight by an individual meant it remained within GMP. GMP could and should have done more to seek information on BOB's background when dealing with suggestions of domestic

[25] STAR's mother is now an advocate for the White Ribbon Campaign [www.whiteribboncampaign.co.uk] whose aim it is to end violence against women and has spoken at several events about her dilemma.

abuse. There was relevant information to be had that would probably have impacted on risk assessment.

5.6.5 The Brick Project now recognises that families, particularly those with children, who receive support from food banks might also have other needs and in such cases contact with Social Care agencies may be beneficial. Since February 2015, a new food policy was introduced which now makes it mandatory for all referrals, regardless of the agency making the referral, to require that every client is seen in The Brick's crisis intervention area to ascertain if any further support can be provided. This interaction between volunteers and clients can prompt referrals to statutory services if deemed appropriate.

Post Homicide

5.6.6 The response to information sharing post homicide is dealt with under term 8.

5.7 Term 7

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to STAR and BOB.

5.7.1 STAR, BOB and Child 1 were white British and the adults' first language was English. There is no evidence that they followed a particular faith or held other such beliefs. They were literate and numerate and had minor mental health needs as evidenced by their self-harm. STAR's self-harm was limited to one episode of a spontaneous paracetamol overdose. BOB's self-harmed on several occasions. They received appropriate help and support for these matters which seemed to have lessened by the autumn of 2013.

5.7.2 The DHR Panel did not find anything of relevance under this term that could explain, or help explain, what happened to STAR, or form a lesson.

5.8 Term 8

How were the child safeguarding issues dealt with post the homicide? Did the action comply with local single agency and multi-agencies policies and procedures?

5.8.1 GMP and Wigan Children's Services moved swiftly to safeguard Child 1 following the death STAR and imprisonment of BOB. Child 1 was placed with

foster parents and within a few days an Interim Care Order was granted to Wigan Children's Services.

5.8.2 The allocated social worker worked with the families and courts to determine the long term future of Child 1.

5.8.3 The DHR Panel concluded that the safeguarding of Child 1 post the homicide was exemplary and complied with all local policies and procedures.

5.9 Term 9

What consideration was given by agencies to support the family of families of STAR and BOB in the four week period after STAR's death?

5.9.1 The DHR Panel is indebted to the GMP IMR author for the following detail.

5.9.2 "In all cases of homicide early deployment of a Family Liaison officer [FLO] is crucial in order to provide support for the victim's family, build trust in the investigation process and obtain important information and/or evidence. The task of identifying a suitable FLO for each case, is the responsibility of the "on call" Family Liaison Co-ordinator [FLC] who will attempt to obtain the services of a suitably trained FLO to assist with family liaison matters".

5.9.3 The Association of Chief Police Officers [ACPO] Family Liaison Strategy 2008 details the purpose of deploying FLOs and their roles within the investigation team. The vast majority of that strategy concentrates on deploying FLOs to families of the victim in a homicide case. There is however a section of the strategy that considers the use of a contact officer with the defendant's family.

5.9.4 The strategy states:

- In appropriate cases the Senior Investigating Officer [{SIO}/Senior Identification Manager {SIM}] may consider deploying a contact officer to a defendant's family…..to act as a conduit of communication between the family and the investigation team -

5.9.5 The strategy suggests that such a case would be when the victim and suspect come from the same family. A domestic homicide could be considered as such, the defendant's family may well be close to the victim having known them and been close to them for a long time. The offender's mother said she knew STAR fairly well and that she visited the house often.

5.9.6 The IMR author spoke to the FLC who was "on call" on the day of the homicide and deployed the FLOs to the victim's family. He explained the procedure with regards to identifying FLOs and matching them to cases.

5.9.7 The FLC also discussed the use of a contact officer for the defendant's family in certain circumstances described above. A contact officer is not always a trained FLO but would be part of the investigation team and whose main role was to signpost the family to support services available to them.

5.9.8 The IMR author has spoken with the initial SIO who explained that consideration was not given in the early stages of the investigation to appointing a contact officer for the defendant's family. This was not something the officer had any previous experience of but accepts that it should be one of the considerations made during the initial stages of a homicide investigation and one which could be made in conjunction with a trained FLC.

5.9.9 The final SIO, who took over responsibility for the investigation three days after the incident, has also been spoken to about contact officers. He states that he was not aware of the need to consider appointing a contact officer for the defendant's family. This practice was not widely used and he agreed that to remain in line with the ACPO Strategy this issue should be raised with the Head of GMP's Major Incident Team and discussed at the next SIO meeting.

5.9.10 STAR's family is very complimentary about their FLO.

5.9.11 BOB's mother and step-father told the independent chair that they felt excluded from events post STAR's death and perceived that others thought they had some responsibility for what happened. They would have welcomed closer contact from the police. This is what the ACPO contact officer policy aims to achieve.

5.10 Term 10

Agencies preparing IMRs should explore the actual day of the incident and if possible say what made that day different and why events led to the homicide

5.10.1 The GMP IMR author provided some details of the events in the few days immediately preceding the homicide and the day itself. The following points are thought to be relevant:

- STAR's mother says that in the days before her daughter's death STAR told her that she was sick of her situation and of being belittled. She was exhausted and wanted to end the relationship.

- STAR told her mother that BOB hit her in the face a few days before her death and the next thing she remembered was:

- Waking up in a bath of water with her clothing on with no recollection of how she got there

- STAR sent her mother photographs of facial injuries
- STAR's mother remembers STAR calling her on the day she died to say she had broken the fish tank; that it was leaking and how could she repair it.
- STAR's mother then re-called STAR on instinct and overheard STAR swearing saying she had had enough. BOB was heard laughing in the background.
- STAR then said she had to go and would ring back as BOB had just kicked another hole in a door in the house. This was the last time that her mother spoke to STAR.
- BOB's mother was also called by STAR on the day she died asking if she would come and pick up BOB as he was getting on her nerves and annoying her. BOB took the telephone from STAR and said to his mother that STAR was being silly.
- There is no evidence that BOB was suffering from depression or any other mental illness at this time and his last self-harm episode was almost two years ago.

5.10.2 It appeared to the DHR Panel that in the few days before STAR's death the domestic abuse intensified. The assault on STAR that led to facial injuries probably resulted in a loss of consciousness. This is evidenced by the fact that STAR said she woke up fully clothed in a bath of water and did not know how she got there. That incident was a serious criminal offence matter and represented a very high tariff risk factor.

5.10.3 It is clear that STAR was signaling her unhappiness with the relationship and wanted it to end. In recounting BOB's behaviour towards her as "belittling", STAR was describing the coercive and controlling element of domestic abuse. The physical violence was also evidence by her black eyes and MoP observations.

5.10.4 After BOB was found guilty of STAR's murder a national newspaper reported, that an undated note written by STAR in crayon was found addressed to BOB in which she wrote 'I have come to the conclusion that me and you just aren't meant to be.' The police Senior Investigating Officer confirmed the presence of the note and without knowing for certain, believed that BOB has seen it.

5.10.5 Whether or not the broken fish tank was the catalyst remains unknown. BOB pleaded not guilty claiming the fatal scissor wound was caused accidently when STAR fell. However, and unanimously, the jury did not believe that account.

5.10.6 It is well establish through research that risk of serious harm, including death, increases at the time of separation or soon after. In this case STAR and her Mother exchanged messages indicating that the relation with BOB was ending. However, neither STAR nor her mother could be expected to know that this represented an increase in risk.

6. LESSONS IDENTIFIED AND GOOD PRACTICE

6.1 Lessons Identified

Lesson 1
It is necessary for agencies to scrutinise referral documents to ensure that pertinent detail is not overlooked.

Narrative:
The NSPCC form completed when MoP reported her concerns for Child 1 contained detailed information on domestic abuse including eye witness testimony. The detail was overlooked by Wigan Children's Services and not acted on by GMP.

Recommendation 1 applies

Lesson 2
Not looking for additional, and ideally, independent sources of information when faced with conflicting evidence can lead to inferior decisions.

Narrative:
This lesson relates to the investigation by GMP and Children's Services into the NSPCC information. MoP should have been seen by one or both of the agencies.

MoP and another person had witnessed domestic abuse and their knowledge and testament would have influenced and probably altered the risk assessment.

Recommendation 1 applies

Lesson 3
Agencies who respond to requests for information without knowing the detail of the original referral cannot fully judge the value of their contribution.

Narrative:
Health Visiting did not receive the original referral from NSPCC and when they received feedback from Children's Services and a notification from GMP, were not in a position to evaluate their response.

Recommendation 1 applies

Lesson 4

Family and friends need ready access to information on how to support victims of domestic abuse.

Narrative:
Family and friends had significant knowledge that STAR was suffering domestic abuse and having been sworn to secrecy were left in an unenviable position of not knowing what to do for the best.

Recommendation 2 applies

Lesson 5
Bite marks can be an indication of sexual violence.

Narrative:
BOB bit STAR on her thigh. While this was not known to professionals it is important that professionals involved with victims, or suspected victims, of domestic, know the connection between bite marks and sexual violence.

Recommendation 1 applies

Lesson 6
Failing to gather a comprehensive history of domestic abuse is likely to weaken risk assessments and leave victims vulnerable to further abuse.

Narrative:
In this case there was a growing amount of evidence that BOB was perpetrating domestic abuse on STAR. There would have been benefit to STAR if someone had stopped and thought, "What is happening in this relationship" and then gathered all the available information with which to complete a risk assessment.

Recommendation 1 applies

Lesson 7
Some agencies offering services [in this case The Brick Project] may have tangential information which could help identify financial and other family pressures.

Narrative:
The family received eleven food parcels from The Brick Project, including three when additional provisions were added for a child. Such circumstances provide an oblique opportunity to refer the beneficiaries to other services.

Recommendation 1 applies

Lesson 8
"Healthy Relationship" education may help to reduce domestic abuse.

Narrative:
The DHR Panel debated the need to have bespoke "Healthy Relationship" programmes available to strengthen the work that is done on the subject through more generic programmes.

Note:
An internet search question: "Healthy relationships for young people" produces many links to useful information one of which is www.womensaid.org.uk. This site has the following links.
Bursting the Bubble - Website for teenagers living with family violence.
National Youth Advocacy Service - Information and advocacy service for children and young people up to 24 years.
Fast Forward - Information on drugs and alcohol education for youth.
Respect Not Fear - Website for young people about healthy relationships, with games and activities.
The Site - Support and guidance for young people throughout life.
Young Minds - mental health charity for young people.

Recommendation 3 applies

Lesson 9

Defendants' families can be left isolated follow a homicide.

Narrative
The ACPO policy on "Contact Officers" for defendants' families in domestic homicide cases was not known to either of the Senior Investigating Officers in this case.

GMP recommendation 4 applies

6.2 Good Practice

a. The liaison between Lancashire Children's Services, West Lancashire Homelessness Prevention and Advice Service and The Birchwood Centre prevented STAR from becoming homeless and adding to her vulnerabilities.

b. Wigan and Leigh Homes acted swiftly and allocated the family a property when they realised STAR was pregnant and about to be evicted.

c. Health Visiting used networking to identify the family's new address after temporarily losing contact.

d. The police officer who attended the abandoned 999 call recognised that BOB was exercising control over STAR.

e. While it did not apply in this case an innovative scheme is now in place in Wigan which sees mental nurses deployed alongside police officers to those calls for service which are judged to have a mental health element.

f. The liaison between the police, the Crown Prosecution Service and the Magistrates' Court to impose bail conditions on BOB in support of STAR was judged to be good practice by the Panel.

7. CONCLUSIONS

7.1 STAR and BOB were young people who came together having shared similar experiences of living in supported accommodation, albeit at different times. BOB was a few years older than STAR.

7.2 STAR came from a loving family who decided that a period living with her grandparents would help her transition to adulthood. This arrangement is not uncommon within families.

7.3 The breakdown in the relationship with her grandparents was caused by generational differences. A date was set for STAR to find alternative accommodation and as it neared she reacted impulsively by taking an

overdose of paracetamol. This crisis saw STAR move into supported accommodation where she enjoyed the experience and developed as a person. She left there and moved in with BOB.

7.4 BOB had a period living away from his mother and step-father before moving to the same supported accommodation as STAR. However, they were not resident at the same time. He had a greater involvement with mental health services through several episodes of self-harm. He was never assessed as posing a risk to others. His mother and step-father saw a significant deterioration in him once he started taking illegal drugs.

7.5 STAR and BOB attended the same college but on different courses. They formed their relationship and moved into together. They were given notice to quit by a private landlord because of rent arrears and moved into social housing once it was established STAR was near to giving birth. Neither had sustained employment and relied on benefits. It is known that they frequently used cannabis and sometimes cocaine. This will have consumed some of their income hence the support they received from a foodbank. There were also other indicators of financial pressure such as people demanding repayment of debts they alleged owed.

7.6 BOB's arrest for assaulting STAR in Lancashire in 2013 resulted in a charge of Common Assault. However, STAR withdrew the allegation following what was likely to have been sustained badgering by BOB accompanied with false promises of reform.

7.7 Child 1 was born in spring 2014 and between then and STAR's death there is evidence of an escalation of domestic abuse by BOB on STAR. This trend was not recognised by any agency.

7.8 There were several opportunities to discover that STAR was the victim of coercive and controlling behaviour and physical violence. These were only partly uncovered and a golden opportunity was missed in May 2014 by GMP and Children's Services to speak with two independent witnesses [MoP and partner] who having reported concerns to NSPCC were willing to speak with the authorities.

7.9 That missed opportunity was compounded when police attended a second incident at their home, two months later. The police did not carry out, or follow up on the domestic abuse history of BOB nor did they notify Children's Services and Health Visiting of their involvement and belief that STAR was a victim of domestic abuse.

7.10 The risk assessments done by GMP did not take into account all the information that was available. This case needed a professional to take the initiative and put together a holistic picture of what was happening in the family or call for a multi-agency meeting where information could be shared.

Had either of these approaches been adopted, it is possible that STAR would have been identified as a medium or high risk victim.

7.11 STAR's disclosed to her family and friends that BOB was abusing her and swore them to secrecy because she feared BOB and was persuaded by his promises to change. STAR's mother did not know what to do for the best and acceded to STAR's insistence that BOB would mend his ways. STAR was in genuine fear of losing Child 1 should it be known to agencies that she was a victim of domestic abuse, a view continually reinforced BOB.

7.12 Over 65,000 domestic abuse incidents are reported to GMP every year; this represents around 170 incidents a day and about 6% of GMP's total workload. Therefore, the demand on staff in the Public Protection Investigation Unit is substantial and judgements have to be made on which cases require additional thought and checks. The DHR Panel felt that STAR was one of those cases that needed additional scrutiny.

7.13 There is evidence that in the weeks leading to her death STAR was subjected to escalating violence and confided in her mother that she had had enough of the relationship. The DHR Panel does not know if STAR conveyed this directly or indirectly to BOB. What is known is that at the point of separation or soon afterwards the risk of serious harm to victims increases.

7.14 Post STAR's death Children's Services worked closely with GMP, the families and courts to ensure that Child 1 was safeguarded and his immediate future secured.

8. PREDICTABILITY/PREVENTABILITY

8.1 Lancashire Constabulary completed two DASH risk assessments; one on BOB and one on STAR. Both DASH's showed they each faced a Standard risk of harm from the other. GMP had two opportunities to complete a DASH risk assessment; these were May 2014 [the NSPCC referral] and July 2014 [the abandoned 999 call].

8.2 The NSPSS referral attracted a Vulnerable Persons risk assessment which was recorded as Standard, albeit the terminology should have been Low. As previously noted Standard is a DASH risk assessment outcome. Regardless of the misuse of Standard instead of Low, a DASH risk assessment was not completed because the NSPCC referral was dealt with primarily as a "concern

for child" and coded accordingly. The domestic abuse element was not in plain sight. Had MoP been seen then a probable outcome would have been the completion of a DASH risk assessment for STAR.

8.3 The only DASH risk assessment undertaken by GMP was in response to the 999 call in July 2014. The DASH risk assessment completed on STAR judged BOB posed a Standard risk of causing serious harm to her. The definitions of risk used by GMP are:

- Standard — Current evidence does not indicate likelihood of causing serious harm
- Medium — There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances
- High — There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious

8.4 Therefore, using the Standard definition of risk it was not possible to predict that BOB would cause serious harm to, or kill STAR. However, the DHR Panel felt that the risk faced by STAR was under-assessed because not all the risk factors were identified and taken into account.

8.5 Had MoP been seen following the referral from NSPCC to GMP and Wigan Children's Services then the domestic abuse element of the information would have received greater prominence and almost certainly have resulted in a DASH risk assessment. In the professional judgement of the DHR Panel, using hindsight, the risk faced by STAR from BOB at the time of the NSPCC referral would have been medium thereby making predictability more likely.

8.6 The second opportunity to complete a DASH risk assessment came about eleven weeks later with the abandoned 999 call. On this occasion GMP completed the DASH and judged STAR faced a Standard risk of serious harm from BOB. Again in the professional opinion of the DHR Panel, using hindsight, this was understated and should have been medium. The Standard outcome did not take account of all the risk factors including the historic abuse in Lancashire.

8.7 The DHR Panel very carefully considered its position on predictability and decided that even if the risk assessment had been medium at the time of the NSPCC referral or the abandoned 999 call [May 2014 and July 2014 respectively] there was too much time between then [July 2014] and the homicide to say STAR's death was predictable. The DHR Panel also felt STAR's death was not preventable.

8.8 However, the DHR Panel judged the understating of risk prevented an opportunity for STAR's case to be examined in more detail at MARAC with the probability of producing a plan aimed at lessening her victimisation.

9. RECOMMENDATIONS

9.1 Set out below are the three recommendations from the DHR Panel. They also appear in the Action Plan at Appendix C.

9.2 The Single Agency actions appear in the Action Plan and are not repeated here.

DHR Panel Recommendations

1. That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership use the findings from this DHR in their domestic abuse multi-agency training programmes and specifically highlight the importance of:

   Lesson 1 Scrutinising original referral documents

   Lesson 2 Seeking additional sources of information

   Lesson 3 Sharing full information from referral documents

   Lesson 5 That bite marks on victims can be a sign of sexual violence

   Lesson 6 Poor information gather leads to poor decisions and does not support victims

   Lesson 7 That agencies may hold tangential information of value to other agencies engaged in domestic abuse identification and assessment

2. That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership review their current advice to family and friends on what to do if they receive disclosures of domestic abuse to determine whether the advice:

   - Is still appropriate
   - And has it penetrated the community

3. That Wigan Building Stronger Communities Partnership consider whether healthy relationships programmes have a place in reducing domestic violence and if so to determine how such programmes are best delivered in Wigan.

End

Appendix A

Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

3. *Controlling behaviour is:* a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

4. *Coercive behaviour is:* an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Appendix B

Sexual Bite Marks

"Alternatively, it is well known that assailants in sexual attacks, including sexual homicide, rape and child sexual abuse, often bite their victims as an expression of dominance, rage and animalistic behaviour."

British Dental Journal 190, 415 - 418 (2001)
published online: 28 April 2001 | doi:10.1038/sj.bdj.4800990A look at forensic dentistry – Part 2: Teeth as weapons of violence – identification of bite mark perpetrators

Webb D A, Pretty I A, Sweet D. Bite marks: a psychological approach. Proceedings of the American Academy of Forensic Sciences Reno, NV, February 2000; 6: 147

Appendix 'C'

Action Plan

DHR Panel Recommendations						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership use the findings from this DHR in their domestic abuse multi-agency training programmes and specifically highlight the importance of: Lesson 1 Scrutinising original referral documents	Wigan BSCP: Domestic Abuse Steering Group / Wigan Safeguarding Adults and Children's Joint Training Group to ensure lessons / key training issues are included within review of Domestic Abuse Training package Review to ensure that domestic abuse is incorporated within overall	Domestic Abuse Steering discussion and mandate, Training Sub Group incorporate domestic abuse training package refresh and inclusion within overarching competency framework within work plan	Refreshed Domestic Abuse Training package that incorporates key lessons. Children's and Adult's Competency frameworks	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group) Elaine Lamprell / Nicola Osborne (Joint Chairs Adults and Children's Boards Training Delivery Group)	Refreshed Training Package by April 2016 Incorporation of training package within over-arching children's and adults training competency frameworks by June 2016 First reporting of domestic abuse competency framework to Domestic Abuse

	Lesson 2 Seeking additional sources of information Lesson 3 Sharing full information from referral documents Lesson 4 That bite marks on victims can be a sign of sexual violence Lesson 5 Poor information gather leads to poor decisions and does not support victims Lesson 6 That agencies may hold tangential information of value to other agencies engaged in domestic abuse identification and assessment	competency framework (children's and adults)		incorporates refreshed domestic abuse training package and becomes part of both boards performance and quality assurance framework		Steering Group / Safeguarding Boards September 2016.

2	That Wigan Building Stronger Communities Partnership and West Lancashire Community Safety Partnership review their current advice to family and friends on what to do if they receive disclosures of domestic abuse to determine whether the advice: 1. Is still appropriate 2. And has penetrated the community	Wigan BSCP: Wigan Domestic Abuse Steering Group to commission specific needs analysis regarding advice / information for friends and family regarding disclosures. Analysis to incorporate and provide recommendations regarding • victims / friends / families views on current / future content / access / methods. • Assessment of potential needs and demands on partnership services	Needs Analysis completed Recommendations to BSCP Executive Action Plan (incorporated within overarching Domestic Abuse community capacity programme) agreed and in place with suitable links made to partner agencies corporate Information / Advice policies and strategies	Domestic Abuse Community capacity programme to develop and implement a Domestic Abuse Information and Advice Plan and Framework Quality Assurance / output / performance monitoring / cost benefit analysis for plan regarding increased and earlier reporting of domestic abuse	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group) Joyce Swift (Domestic Abuse Community Capacity Programme lead)	Analysis complete by May 2016 Plan in place by July 2016

		• Quality assured framework for responding to family / friends advice • Links to wider corporate Deal for Wigan Programme, / Domestic Abuse Community Capacity Programme / Operations Strive Early Help Programme				

3	That Wigan Building Stronger Communities Partnership consider whether healthy relationships programmes have a place in reducing domestic violence and if so to determine how such programmes are best delivered in Wigan.	Domestic Abuse Steering Group to identify what works / need /opportunities for healthy relationship programmes within refreshed Domestic Abuse Strategy and Action Plan (scoping to form part of strategic needs analysis process)	Strategic needs analysis identifies and recommends suggested approach within broader domestic abuse strategy and action plan	Issue is identified with achievable action plan within Early Intervention Objective in refreshed strategy / action plan	Sarah Owen / CI Gareth Hughes (Chairs DA Steering Group)	Domestic Abuse Strategy and Early Intervention objective and action plan in place by June 2016

Single Agency Recommendations

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Clarity to be provided for PPIU specialist staff in relation to what level of checks are required to be completed during an Enhanced Risk Assessment.	Review current policy document/newly revised policy document with regards to what standards of research are expected from staff completing an Enhanced Risk Assessment.	Correspondence update to be provided to the Panel when the policy has been revised and result of the consideration given to what checks are expected and on which GMP databases for each of the risk assessment grading.	Provide clarity to specialist staff when completing Enhanced Risk Assessments and produce a standardised method across the Force to risk assessing domestic abuse incidents.	Detective Chief Superintendent Jardine	30.04.2016

2	Consideration to be given to reviewing the electronic Enhanced Risk Assessment within the PPI document to make it fit for purpose.	Review the electronic document used for Enhanced Risk Assessments. Are the questions specific enough? How can the requirement in the policy for an assessment to be completed on both the victim and perpetrator be met if the form allows for research results only on the perpetrator?	Correspondence update to be provided to the Panel when the use of the electronic Enhanced Risk Assessment document has been reviewed.	A revised Enhanced Risk Assessment document or method of recording Enhanced Risk Assessment research results will allow for a more standardised assessment which will include both victim and perpetrator information recorded appropriately.	Detective Chief Superintendent Jardine	30.04.2016.
3	Enquiries to be made to developing and introducing a flagging system within the PPI OPUS system to enable PPIU triage staff to identify those standard risk PPIs awaiting assessment which have	Liaise with OPUS IT services to ascertain the feasibility of introducing a flagging system as described.	Correspondence update to be provided to the Panel once the enquiries have been completed and the possibility of such a flagging	PPIU triage staff will be better placed to process PPI records that have a recordable crime attached to them. These types of PPIs are	Detective Chief Superintendent Jardine	30.04.2016

	recordable reports of crime attached in order that the can be processed prior to those that do not.		system being introduced is known.	more likely to require further action by a specialist officer and the earlier that action can be highlighted and taken the better the service provided to victims.		
4	All SIOs involved in leading a homicide investigation to be reminded to consider the appropriate use of a contact officer to signpost the defendant's family to support agencies available to them.	This matter has already been brought to the attention of the Head of GMP's Major Incident Team (MIT) for discussion at the next MIT managers meeting.	The Panel will be updated from information from the minutes taken at the MIT managers meeting when the subject of contact officers for defendants' families is discussed.	SIOs will be reminded that as per ACPO guidelines relating to family liaison consideration should be given to providing a contact officer for defendants' families to signpost them to support agencies.	Detective Superintendent Jackson	29.02.2016

Wigan CCG						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Draft communication to GP Practices across Wigan Borough to share the following learning: a. Relevance of previous history b. Enquiring about domestic situation c. Recording identity of partner/father at new patient registration	Draft letter to GPs Letter to be tabled for discussion at GP safeguarding Leads Forum	Letter Minutes & Slides	Increased awareness of learning identified from Overview Report	Reuben Furlong	28.02.2016

Wigan and Leigh Homes						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To ensure that all relevant staff have refresher training within three years of attending initial training on domestic abuse	Identify relevant staff and ensure refresher training on domestic abuse included on their individual training plans.	Attendance of relevant staff recorded.	All relevant staff are confident and competent in identifying domestic abuse and the appropriate referral mechanisms	Deborah Morris	To be incorporated within staff training plan 2016/2017.

Bridgewater Community Healthcare NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	An audit of the routine enquiry for domestic abuse by the Health Visiting Service in the Wigan Borough should be undertaken.	An audit of routine enquiry will be undertake across the Wigan Borough	Audit results will be available.	Routine enquiry will be evident on a consistent basis. If routine enquiry	Helen Case	Completed

				not undertaken the reason will be clearly documented e.g. not safe to undertake as partner present.		
2	Staff will be reminded of the risks to adults and children associated with 'toxic trio'	Staff to be reminded of the risks to adults and children associated with toxic trio via i) the Safeguarding Children Newsletter *What's Hot in Safeguarding Children*	Safeguarding Children Newsletter *What's Hot in Safeguarding Children*.	Staff will have an increased awareness of the risks associated with 'toxic trio'	Helen Case	Completed

West Lancashire CCG						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Training session to be offered to the practices involved in this DHR re domestic abuse and violence to ensure adherence to NICE guidance ph50.	1) Discuss with practices 2) Develop training materials 3) Deliver session	Feedback forms Training materials	Increased awareness of issues. Increased detection and referral on for support of those affected.	Dr Linda Whitworth	28.02.16
2	Audit of training needs around domestic abuse and adherence to NICE guidance ph50 in GP practices across the area.	1) Develop audit tool (with help of CCG staff) 2) Disseminate audit 3) collate the results	Audit results	To get a clearer picture of current training needs to help the LSCB/CCGs plan training strategy.	Dr Linda Whitworth	Completed
3	Ensure the practices involved in this DHR	1) Include this in discussions with	Feedback forms	Additional safety net for children	Dr Linda Whitworth	Completed

	have, and adhere to, a DNA policy for children and vulnerable adults, as well as up to date safeguarding children and adults policies.	practices as in number 1 above		and vulnerable adults.		

West Lancashire Health Centre						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	Although staff receive regular updates to their mandatory training at appropriate levels to their roles, it wold appear that domestic violence training / awareness may need to be covered separately	To provide training specifically in domestic violence to all staff at West Lancs Health Centre To contact West Lancs Women's	E-mail trail of evidence to arrange training meetings. Minutes of	Improved awareness of presentations of domestic violence and questions to ask during consultations and raise awareness of where to refer	Dr Sally-Ann Hawkins	31.12.16

		Refuge for help with training Review and update domestic violence policy To identify a domestic violence lead for the department	meetings Policy document Minutes of meetings	women to if they are victims of domestic violence		
2	Access to the Medical interoperability gateway (MIG) will improve patient safety as we would be able to access patient's GP records relating to safeguarding concerns rather than relying on GPs to send us alerts when they remember, it would also mean we could access data on patients	To finalise discussions with CCG and IG lead and have IT install access to MIG on Adastra system.	e-mail trail Access to computer system to view if required.	Improved awareness of any safeguarding issues known to the patient's registered GP. Also safer prescribing will result from access to patient's PMH and prescribed medication.	Donna Wright	01.03.16

	presenting from out of area.					
3	Regain access to the Alchemy server	To enable access to patient records stored on the server between 2009-2011	e-mail trail Access to computer system to view if required	To enable reports to be provided in a timely manner to assist multi agency reviews.	Donna Wright	31.12.16

Wigan Children's Services						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	All appropriate correspondence to be saved appropriately on the IT System Liquid Logic. This relates to any information received by the department and any correspondence sent	Continued clear management oversite, through regular supervision Regular audits to be completed. To identify any areas	Following a review of the duty service in 2014. Quality of decision making, planning and recording have improved this is evidenced in audits and daily management oversight.	To continue to ensure clear and concise record keeping. To ensure continued quality assurance of recording on cases.	Jayne Ivory, Lynn Fields	Completed

	by the department in respect to a family.	which require improvement and to ensure quality assurance of cases.				
2.	All information to be recorded appropriately within contact records. This to include outcomes and specify clear actions requested of other agencies along with dates for these to be completed. Agencies requested to complete an action to be informed both verbally and in writing. This to be recorded and evidenced within the contact record outcomes.	Clear and concise management oversite on all contacts received by the department. A drive in quality assurance of all contacts. A more robust process of information gathering at the initial contact stage. Regular auditing of cases	Audit of contacts and following actions on 16-17.09.2015 by the Contact and Referral Team. Policy documents	To ensure clear and concise record keeping. To ensure continued quality assurance of recording on cases.	Sharon Oxenham, Lynn Fields	Completed

3	Families to be provided with appropriate information in respect to available support services, when the department are taking no further action. This information to be clearly recorded on the IT System Liquid Logic.	Outcome category to be changed on the child's record on the recording of a contact referral. This to have a clear option of advice and professional support or signposting rather than the current option of no further action.	IT system will display new action within the contact outcomes tab on the child's record. To ensure families are provided with the relevant information/advice/signposting.	To allow for clear recording of information/advice provided to the family. To clearly evidence actions, decision making and planning completed by the local authority,	Lynn Fields, Sharon Oxenham	Completed

Wrightington, Wigan and Leigh NHS Foundation Trust [Maternity Services]						
No	**Recommendations**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To ensure opportunities are made to routinely ask pregnant women about domestic abuse.	Routine enquiry checklist devised and a routine enquiry pathway devised.	Maternity guideline updated. Community midwives and antenatal clinic staff trained and confident in using the routine enquiry checklist/using the pathway.	To assist midwives to make enquires regarding domestic abuse and referring on to the relevant support agencies/utilising the pathway.	Sharon Heap Named Midwife child protection and safeguarding vulnerable families	Completed
2	To raise awareness of domestic abuse, recognition and response	A targeted approach to domestic abuse awareness training will be commenced across WWL to include midwives.	Half day training sessions booked for the all WWL staff from January 2016 and staff training figures will be collated and saved on	To ensure that all midwives are trained to recognise the indicators of domestic abuse and can ask the relevant questions to help women disclose their past or	Safeguarding team WWL	Complete and ongoing

			database as evidence.	current experiences of domestic abuse.		
3	Audit of routine enquiry by WWL Maternity Services	An audit of routine enquiry will be undertaken by March 2016 Audit results will be available.	Audit results will be available and presented.	Routine enquiry will be evident on a consistent basis.	Sharon Heap Named Midwife child protection and safeguarding vulnerable families	31.05.16