# OVERVIEW REPORT

# DOMESTIC HOMICIDE REVIEW 7

## Deceased May 2015

**Chris Few**
**October 2018**

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## INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was revised in December 2016 and that revision provided the framework within which this Review was conducted.

1.3 A Domestic Homicide Review (DHR) is defined as:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:-

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 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; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;

- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- Contribute to a better understanding of the nature of domestic violence and abuse; and,

- Highlight good practice.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing

policies and procedural frameworks Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

Summary of Circumstances Leading to the Review

1.6 The deceased (N) was in an intimate relationship with Z and they resided together in Stoke-on-Trent.

1.7 At 0345 hours on 30 May 2015 a telephone call was received by the West Midlands Ambulance Service from N to the effect that he was going to die. The call was then terminated. Over succeeding hours attempts were made by both the ambulance service and Police to contact N and gain access to his address without success.

1.8 Around 1400 hours that date Z shouted from the first floor window of the address that she had killed N. The Police were contacted and secured access to the address where they found N deceased. Z was arrested.

1.9 A post mortem examination identified the cause of N's death as a stab wound to his heart.

1.10 Z maintained on interview that she acted in self-defence. She was subsequently charged with Murder of N.

1.11 On 24 June 2015 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group.

1.12 In February 2016 Z pleaded guilty to Manslaughter on grounds of diminished responsibility and was sentenced 6 years and 3 months imprisonment.

Terms of Reference

1.13 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

1.14 The Review considered in detail the period from 16 June 2012 (when an incident occurred involving N and a previous partner, leading to MARAC consideration of the circumstances) until 30 May 2015, when N was found deceased.

1.15 Summary information regarding significant events outside of this period was also considered.

1.16 The focus of the Review was on the following individuals:

| **Name** | N | Z |
|---|---|---|
| **Relationship** | Deceased | Partner of Deceased |
| **Age (in May 2015)** | 33 | 20 |

| Gender | Male | Female |
|---|---|---|
| Ethnicity | Asian | White British |

Other individuals referred to in this report by initials are:

| | |
|---|---|
| R | Previous female partner of N |
| S | Previous female partner of N |
| V | Previous male partner of Z |
| W | Male acquaintance of Z in early 2013 |

1.17 In the context of general areas for consideration by a Domestic Homicide Review outlined in the statutory guidance this Review specifically focussed on[1]:

- Previous incidents of violence involving N
- Recognition and responses to abuse and associated risk by agencies in contact with Z and/or N, including
    - operational responses,
    - interagency cooperation,
    - safeguarding victims who do not seek or support professional intervention,
    - effectiveness of MARAC arrangements
- Recognition of Z as a vulnerable young person and responses to this.

Review Process

1.17 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

1.18 Management Review and Summary Information Reports were submitted by:

- Arch (North Staffordshire) Ltd
- National Probation Service
- NHS England North Midlands (in respect of primary care services)
- Staffordshire Housing Association
- Staffordshire Police
- Stoke-on-Trent City Council Early Intervention and Children's Social Care[2]

[1] The Terms of Reference were revised by the Review Panel as the Review progressed to take into account new information. These areas are the final version agreed by the Panel.

- University Hospitals of North Midlands NHS Trust
- West Midlands Ambulance Service NHS Trust.

1.19 Throughout the period examined by this Review, Arch (North Staffordshire) Ltd was commissioned to provide domestic abuse support services in Stoke-on-Trent. From October 2018 a new Pan Staffordshire range of domestic abuse services has been jointly commissioned by Stoke-on-Trent City Council, Staffordshire County Council and Staffordshire Commissioner for Fire & Rescue and Crime. Within this, domestic abuse victim services are provided by Victim Support whilst those targeted at perpetrators of abuse are provided by Staffordshire and West Midlands Community Rehabilitation Company.

1.20 Other sources of information accessed to inform the Review included:

- Independent Police Complaints Commission report on an Investigation into the circumstances surrounding the death of N
- Correspondence between the Independent Police Complaints Commission lead investigator and the Independent Review Panel Chair
- Psychiatric Report on Z dated September 2015
- OAsys Report on Z dated April 2016
- OAsys Report on Z dated January 2018
- University Hospitals of North Midlands discharge letter dated 9 November 2014 in respect of Z
- Ofsted Inspection of Stoke-on-Trent services for children in need of help and protection, children looked after and care leavers, 10 August 2015
- Ofsted report on a focussed visit to Stoke-on-Trent Children's Services, 9 May 2018
- Multi-Agency Risk Assessment Conference Review; Staffordshire and Stoke-on-Trent MASH, 23 November 2016.

1.21 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

1.22 The Review Panel comprised the following post holders:

- Paula Brogan
  IDVA and MARAC Team Leader
  Arch (North Staffordshire) Ltd

- John Mason
  Deputy Head of Operations (Stoke-on-Trent and Staffordshire)
  National Probation Service

- David Giles
  Senior Investigating Officer
  Staffordshire Police

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[2] Until April 2017 this Directorate was known as Vulnerable Children and Corporate Parenting (VCCP).
[3] Under the Children Act (2004) and its associated statutory guidance.

- Mark Harrison
  Investigative Services Policy, Review and Development Unit
  Staffordshire Police

- Nathan Dawkins
  Commissioning Officer – Community Safety
  Stoke-on-Trent City Council

- Janice Johnson
  Lead Nurse Adult Safeguarding
  University Hospitals of North Midlands NHS Trust

- Wendy Henson
  Primary Care Quality and Safety Manager
  NHS England (North Midlands)
  (in respect of primary care services)

- David Allcock
  Housing Manager
  Staffordshire Housing Association

- Amanda Owen
  Early Intervention and Children's Social Care
  Stoke-on-Trent City Council

- John Griffith
  Interim Strategic Manager - Vulnerable Children
  Stoke-on-Trent City Council

- Carly Manning
  Safeguarding Manager
  West Midlands Ambulance Service.

1.23 The Review Panel was provided with specialist advice by:

- Leanne Barnett
  National Probation Service
  (advising on behalf of MAPPA)

- John Maddox
  Staffordshire Police
  (advising on the MARAC arrangements)

- Iftikhar Ahmed
  Stoke-on-Trent City Council
  (advising on community cohesion issues)

1.24 In addition to the Scoping meeting on 24 June 2015, the Review Panel met on 15 January 2018[4], 23 May 2018 and 24 August 2018 to consider contributions to and emerging findings of the Review.

1.25 Completion of the Review was delayed as a consequence of an Independent Police Complaints Commission investigation. The report of that Investigation was provided to the Review at the end of August 2017. Further delay then resulted from engagement with Z, attempts to engage family members of N and Z and addressing community cohesion concerns related to this Review.

1.26 This Overview Report was endorsed by the Review Panel on 8 October 2018, following electronic circulation of a final draft, and then forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. It was presented to and endorsed by the Responsible Authorities Group on 9 November 2018.

Parallel Processes

1.27 The criminal investigation into the homicide of N was conducted in parallel with this Review. In February 2016 Z pleaded guilty to Manslaughter on grounds of diminished responsibility and was sentenced to 6 years and 3 months imprisonment.

1.28 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal prosecution. Consequent to N's conviction the inquest was not resumed.

1.29 Following the death of N the Independent Police Complaints Commission[5] (IPCC) commenced an investigation of Police Involvement in the case. The Terms of Reference of that investigation were extended, as a result of information provided to this Review, to include responses to domestic abuse in N's previous relationships. Relevant Police staff were unable to be interviewed for the purposes of this Review whilst the IPCC investigation was ongoing. The IPCC lead investigator provided regular updates on that investigation to the Review Panel Chair. The conclusions of IPCC investigation have informed this Review. No Police Officers or staff were the subject of disciplinary action as a result of the investigation.

Family Engagement

1.30 Members of N's family were advised of the Review at its outset and invited at key stages of the Review to meet with the Independent Review Panel Chair. They declined to contribute to the Review or engage with the Review Panel.

[4] Rescheduled from 11 December 2017 owing to adverse weather conditions.

[5] Now the Independent Office for Police Conduct (IOPC).

1.31 Z and her mother were also informed of the Review at its outset. Z agreed to meet with the Review Panel Chair and that meeting took place at the prison where Z was held on 22 February 2018. The Review Panel Chair was accompanied at the meeting by the Stoke-on-Trent City Council Commissioning Officer for Community Safety. Z's mother declined to contribute to the Review.

1.32 The contribution of Z to the Review together with information drawn from a Psychiatric report on Z and subsequent Probation Service risk assessments of Z is incorporated into the report in *italic font*.

1.33 Members of N's family and Z were offered sight of this report on its completion and prior to its submission to the Home Office.

## SUMMARY AND COMMENTARY ON EVENTS

Background of N

1.34 N was brought up in Stoke-on-Trent, one of nine siblings. His mother resides in Stoke-on-Trent. His father is deceased.

1.35 N had a history of criminality, dating from 1999, which included perverting the course of justice, violence, possession of an offensive weapon, possession and supply of controlled drugs. He had 8 previous Court appearances resulting in convictions. In 2005 N was convicted of domestic violence against a previous partner. This involved punching the partner to the face and head, apparently motivated by jealousy or possessiveness.

1.36 From 2010 N held a joint tenancy of a first floor flat with a previous partner (R) The property is owned and managed by Staffordshire Housing Association (SHA) which received complaints about noise from the property. In May 2011 (R) advised an SHA Housing Officer that she intended to vacate the property due to violence by N towards her. She asked for assistance with rehousing but did not want any other action taken against N. She was provided information about services available and moved out of the property and the local area in November 2011.

Background of Z

1.37 Z is the second of three siblings and was brought up in Stoke-on-Trent. Her parents split up during the period considered by this review, described by Z as being connected with the long hours worked by them both. Z informed the Review Panel Chair that there was no violence within her family and that she had a good childhood. Z and documents accessed by the Review did however identify adverse childhood experiences which would be likely to increase her vulnerability as an adult.

1.38 Z informed the Review Panel Chair that she enjoyed school and while shy when younger she became more confident as her school career progressed. She was part of a gifted and talented pupil programme and did well in her examinations, obtaining all A and B grades in her GCSEs. In 2011 she commenced A level courses at sixth form college in Stoke-on-Trent and passed her first year examinations.

1.39 Z informed the Review Panel Chair that her first intimate relationship was with a man referred to in this report as V, who was around 22 years old when the relationship started in her first term at college. V told Z that he was British / mixed race but she later found out that he was from Pakistan and had a wife and child in that country. He also told Z that he worked in a 'studio' but was actually a takeaway worker. Z only found out the truth about V when he returned to his family in Pakistan at Christmas 2012. She took this badly as he was her first boyfriend.

1.40 In December 2012 Z sought assistance from her GP for low mood[6]. She was diagnosed as having moderate depression and prescribed fluoxetine hydrochloride (20mg/day for one month).

1.41 Z has stated that she felt better and did not seek a repeat prescription. Z has however reported starting to routinely consume significant quantities of alcohol around that time.

1.42 There is reference in the primary care records to Healthy Minds[7] but a referral to that service was not made and in any event would not have been accepted as the service is for adults from 18 years old. The Review Panel was advised that current practice is for patients to be followed up after one month and advised to self-refer to IAPT[8] services if the problem remains unresolved (there is nothing to prevent patients self referring earlier than this). Self-referral is considered preferable to GP referral as the non-attendance rate is significantly lower.

1.43 Z did not complete her A levels but left college to undertake a Business Administration Apprenticeship. She reports that she also obtained her first employment as a care worker around that time and when she did so she stopped consuming alcohol, reportedly without difficulty.

1.44 Z had no criminal convictions and was never arrested prior to the death of N.

Summary of Events

1.45 **June 2012**

1.46 At 0128 on 16 June 2012 S, then aged 24 and at that time a partner of N, reported to the Police that she had been assaulted by N, that she was covered in blood and that although he had done this before it had never been as bad. Police Officers attended and as there was no ambulance resource available conveyed S to the Royal Stoke Hospital.

1.47 S was noted to have a cut to her forehead. She reported that she had refused to let N check her phone for evidence of her being unfaithful to him and that he had sat astride her on the kitchen floor, then repeatedly punched her on the face and choked her. She told Police Officers that she had been in a relationship with N for three months.

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[6] PHQ-9 (a diagnostic instrument validated for use in primary care settings) score of 11/27 indicating moderate depression.

[7] Healthy Minds Stoke-on-Trent is a consortium made up of specialist mental healthcare providers - North Staffordshire Combined Healthcare NHS Trust, Changes and North Staffs Mind. The service provides talking therapies and self-help courses for adults with common mental health difficulties such as mild to moderate anxiety and depression.

[8] IAPT (Improving Access to Psychological Therapy) services are for people with mild and moderate symptoms of anxiety or depression.

1.48 Police records detailed three previous domestic abuse related contacts with S during the relationship[9]. None of these involved physical violence but it is noteworthy that one of the incidents involved an argument arising from accusations by N that S had been “sleeping around”.

1.49 A crime of assault was recorded by the Police and attempts were made to locate N.

1.50 A location marker was added to Police systems in relation to S’s home address to alert members of Staffordshire Police around the potential for domestic violence and to treat all calls as needing an immediate response. However, there was not a commensurate marker placed against N’s address.

1.51 In the afternoon of 16 June 2012 Police were advised by a neighbour of N that he had returned home. Police Officers attended and getting no reply, forced entry. N was not however at home. The damage caused was reported to SHA.

1.52 On the evening of 17 June 2012 N visited a Staffordshire Police custody suite where he was arrested. He was later charged with assault and bailed to attend court on 28 June 2012.

1.53 N’s bail conditions were:

- Not to contact or communicate with S by any means or otherwise approach her
- Not to visit or go within 100 metres of the street where S lived
- To attend one alcohol arrest referral intervention with Adsis[10] on 21 June 2012.

1.54 The rationale for the Adsis referral intervention was that N was alleged to have committed the offence whilst under the influence of alcohol and that he had a history of offending in such circumstances. It was therefore considered necessary to reduce the risk of further offending.

1.55 A DIAL[11] form was completed and the incident was discussed within the Multi-Agency Safeguarding Hub (MASH) where it was decided that the case should be considered at a Multi-Agency Risk Assessment Conference (MARAC).

1.56 This incident was dealt with appropriately in accordance with the policies and procedures in place at that time. However, to be effective, location markers need to be applied to the home and any other addresses frequented by both of the parties. The policy of Staffordshire Police now reflects this requirement and work is ongoing to promote and monitor compliance through transformation of the model for responding to vulnerable victims, which includes local senior level ownership. Notwithstanding this development the Police report for this Review includes a recommendation to highlight the significance of this practice area.

[9] Each of these incidents was responded to appropriately within the Police policies and operating procedures in place at the time.

[10] The provider of alcohol misuse services in Stoke-on-Trent at that time.

[11] DIAL - Domestic Incident Assessment Log. The DIAL form is the means by which Staffordshire Police assess the level of risk to a victim of domestic abuse, they are also used to record additional information and professional judgement. The risk score on the DIAL form is used to determine the level of response to the incident.

1.57 **July 2012**

1.58 The MARAC was held on 3 July 2012. Actions agreed at the MARAC were

- "for all agencies to update service and systems and where appropriate flag and tag case files to ensure that victims are monitored and repeat incidents investigated".
- Provision of IDVA support to (S), it being noted that she was willing to be referred to the Freedom Programme[12]
- Staffordshire Police would continue their provision of the 7 Steps[13] intervention

1.59 Notwithstanding the agreed action for all agencies "to update service and systems…" a marker was not placed on Police systems against N's address following the MARAC.

1.60 There is no indication that the MARAC considered prompting N to undertake a non-statutory Domestic Abuse Perpetrator Programme, which was available in Stoke-on-Trent. It seems unlikely, given his later minimal engagement with the Probation Service S.I.A.D.A. programme (see 9.24), that he would have taken this up voluntarily but that was not known at the time of the MARAC and such an offer would have been appropriate.

1.61 On 10 July 2012 Police Officers visited S. They explained the actions agreed at the MARAC and linked a "Skyguard"[14] alarm that had been provided to her with her mobile telephone. N's bail conditions were explained to S. She responded that she and N were not together properly, "they were taking things slow". This was interpreted by the Officers to mean that N and S were in contact and that S was accordingly at risk of further assault. The Officers explained to S that they would be checking for any breaches of N's bail conditions at her address.

1.62 S was regularly visited by local officers and she retained the use of the Skyguard system despite her on/off contact with N. After Officers established that S was definitely no longer having any contact with N the Skyguard alarm was collected back from her in the week commencing 10 December 2012.

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[12] The Freedom Programme is a 12 week support group for women. It aims to:

- help women to understand the beliefs held by abusive men and in so doing recognise which of these beliefs they have shared
- help women to gain self-esteem and the confidence to improve the quality of their lives
- look at the effects of domestic abuse on children
- help women to recognise potential future abusers
- introduce women to community resources such as the Police Domestic Abuse Unit and Rape Crisis.

[13] A Staffordshire Police response standard for domestic abuse incidents outlining 7 Steps from initial recognition and response through to the victim being visited 28 days after the incident. The plan is no longer part of Staffordshire Police procedures.

[14] "Skyguard" is a telephone based system offering direct connection to lines monitored by staff who can then alert the necessary emergency services. In Stoke-on-Trent it has been superseded by "TecSOS", with provision of enhanced facilities and greater capacity.

1.63 On 18 July 2012 a referral was received by Arch from the IDVA[15] requesting that S attend the Freedom Programme. The next Freedom Programme was planned for September 2012 and the IDVA was advised of this. On 27 July 2012 the Arch Senior Access and Prioritisation Officer (SPO) attempted to contact S by telephone and got no reply. Further unsuccessful attempts were made to contact her on 10 and 15 August 2012. The IDVA had indicated that it was safe to leave messages on S's phone and two messages were left, neither of which led to S contacting Arch.

1.64 In accordance with Arch policy[16] of closing cases after three unsuccessful attempts to establish contact the case was then closed. The IDVA was advised of this by email.

1.65 On 26 July 2012 N pleaded guilty to assaulting S. He was sentenced to 10 weeks imprisonment, suspended for 12 months and 12 months supervision with 10 days community activity. A Restraining Order for the protection of S from harassment was also imposed for 12 months. This sentence included N's first period of supervision in the community as an adult.

1.66 N was thereafter supervised by the Probation Service until 26 July 2013. N explained his assault on S as being due to the influence of a number of substances and the possibility that he may have been 'spiked'. Enquiries made at the time identified the previous incidents where Police had been called to S's address in relation to verbal arguments and damage being caused.

1.67 N's supervising Probation Officer noted that the account on record of his assault on S had close similarities with that toward his previous partner in 2005, with the motivation being jealousy and possessiveness, and observed that there was a clearly identifiable pattern of behaviour.

1.68 N's Probation Officer oversaw both the supervision element and delivery of 10 sessions of the domestic violence workbook (S.I.A.D.A. - Structured Intervention Addressing Domestic Abuse). Records indicate that N complied to a sufficient level to avoid breaching the Order, although a number of warnings were issued.

1.69 Full Offender assessments (OASys) were completed on five occasions over the 12 months with the spousal assault risk assessment (SARA) updated on each occasion. Delivery of the SIADA modules was clearly evidenced.

1.70 N's Probation Officer was aware of N initially wishing to resume his relationship with S (which was apparently reciprocated) and N was advised on the legal action required to have the Restraining Order which was in force rescinded. He did not follow that advice.

1.71 **August 2012**

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[15] The IDVA service in place at that time was provided directly by Stoke-on-Trent City Council, and supported only victims going through the court process. This model is non-standard and did not follow the Safelives model of IDVA provision, which provides support to all high-risk victims of domestic abuse.

[16] The Arch Domestic Abuse Services Waiting List & Prioritisation Procedure states that if a service user does not engage on 3 consecutive contacts, the case will be closed. The case can be re-opened if the service user is re-referred and chooses to engage with the service. Arch provided the Review Panel with a comprehensive outline of their procedures for managing referrals and waiting lists for their programmes. These were considered appropriate.

1.72 At 0428 on the morning of 26 August 2012 S reported to the Police that N was in her garden and had damaged the door handle of her home. Police Officers attended and arrested N, who was also found to be in possession of a small amount of cannabis.

1.73 S was recorded as not supporting the Restraining Order, stating "we are still kind of seeing each other but he isn't supposed to be anywhere near my address". N was charged with breach of the Restraining Order and possession of cannabis then released on bail.

1.74 N appeared at Court for this on 27 September 2012, when he pleaded guilty to breach of the Restraining Order. He was sentenced to 40 hours unpaid work[17] under the concurrent Community Order, and ordered to pay costs. At the request of S the Restraining Order was discharged.

1.75 **September 2012**

1.76 At 0010 29 September 2012 a neighbour twice reported hearing a man and woman arguing, screaming and shouting at each other in N's address.

1.77 The Police attended but found the address to be quiet and in darkness. They were unable to raise any occupants. It was recorded that there were no previous "domestics" at this address and all previous calls related to anti-social noise nuisance[18]. The Police spoke to the neighbour who stated they would call if there were any further problems.

1.78 Four hours later the same neighbour rang the Police and reported that a female in N's address had started to shout again but had gone quiet whilst the neighbour was dialling for the Police. The neighbour stated that there was "no need for police" but would ring again if need be.

1.79 This call was initially categorised as "Domestic" related. Research led to N's name being identified. A previous partner (R) was also identified from earlier incidents and erroneously recorded as the victim. Information was available on Police systems about N's current relationship with S and violence in that relationship. Minimal research would have revealed this. After failing to raise any occupants and finding the disturbance had subsided the incident was re-categorised as anti-social behaviour.

1.80 Failure to properly research the databases and the decision to re-categorise the incident led to it not being robustly investigated to ensure the safeguarding of individuals involved in the reported argument. No DIAL form was submitted and therefore no risk assessment was undertaken by the MASH.

1.81 This was an ineffective response which left potential victim at risk. This was however 6 years ago and there is evidence of the deficiencies being addressed by changes implemented in the interim.

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[17] The unpaid work hours were completed by 30 December 2012.

[18] There had been 4 recent calls to the Police complaining about loud music from N's address which had been signposted to the Staffordshire Housing Association. In two cases Police Officers attended and advised N to turn down the volume.

1.82 **October 2012**

1.83 Around 0100 on 6 October 2012 the Police were called to N's address by a neighbour who reported that they could again hear arguing, with a female shouting and screaming, and it sounded like one of them had fallen over. The attending Police Officer spoke with N and S, who were both described as "heavily in drink" and S left the address to go home in a taxi. This incident was recorded as a non-crime domestic incident. No DIAL form was submitted.

1.84 There was no further Police investigation of this incident despite an action from the MARAC on 3 July 2012 to ensure there was "monitoring and investigation of repeat incidents". A DIAL form should have been submitted in accordance with policy and procedures in place at that time.

1.85 As above there is evidence of deficiencies in practice being addressed by changes implemented since 2012.

1.86 Later that day N attended the Royal Stoke Hospital Emergency Department with injuries to his left leg and hand. He was discharged with no follow up.

1.87 Other than the fact of his attendance, University Hospitals of North Midlands have been unable to find any record of this. The cause of the injuries reported and whether any consideration was given to them being the result of violence is therefore unknown.

1.88 At 0647 on 7 October 2012 the Police were called to N's address by S who said she needed Police assistance, had been assaulted and had hit N because he had hit her. S stated that she had also been assaulted the previous day when the Police had attended. The incident was categorised as a domestic abuse incident by control room staff. The Police call-taker recorded that they could be heard arguing. The call was terminated and then very shortly afterwards a second call was received from the same number that was also abandoned.

1.89 Police officers attended and found that both N and S were heavily intoxicated and arguing. The Officers took S home. The incident was recorded as a non-crime domestic with the rationale from the Officers recorded as "the pair have only disclosed to us that they have had a verbal argument and that she wanted to go home, which we have done". No DIAL form was submitted.

1.90 In view of the previous history of involvement with N and S, as well as the information passed to the Police call taker, this represented a missed opportunity to investigate the assaults and take positive action to safeguard S. The absence of an alert an alert flag linked to N's home address led to background information, unless already known to local Officers not being readily identified to inform the response. Wider research would have identified this but there is no indication of this being pursued.

1.91 At 0141 on 11 October 2012 S contacted the Police to report that she was at N's address and that "he has battered me". She was recorded to be very distressed and stating that she was bleeding. Shortly afterwards N also called the Police alleging that S had attacked and hit him stating that they had both been drinking and that he needed an ambulance.

1.92 Officers attended and recorded that during a drunken argument which had commenced following N's insistence on checking the messages on S's phone, N was alleged to have attacked S by stamping on her body whilst she was on the floor then throwing a games

console at her head. S was noted to have swelling to the left side of her face and a cut to the lip. An ambulance was requested.

1.93 N was recorded as claiming that S had assaulted him as a jealous reaction upon him receiving a text from a person he described as an ex-partner. N was noted to have minor scratches to his face.

1.94 N was arrested and charged with assault occasioning actual bodily harm. He was bailed with conditions not to enter the street where S lived and not to contact or communicate in any way with her or via any third party.

1.95 This incident, the decision to charge N and his subsequent prosecution was dealt with in accordance with the Staffordshire Police policy on cases involving counter-allegations. Within this the evidence indicated that N was the primary aggressor.

1.96 At 0042 on 18 October 2012 S called the Police to complain that N was contacting her by telephone and it was distressing her and stating that he was on bail with conditions not to contact her. Police Officers spoke with S and discovered that she had been initiating contact with N and visiting his home address. Before any alleged breach was enforced S re-contacted the Police to request that nothing further be done. Advice was given to both parties about their contact with each other.

1.97 At 0357 on 21 October 2012 S again called the Police to complain that N was contacting her in breach of his bail conditions. She claimed he had damaged her mobile phone and if the Police did not do something to support her she would commit suicide.

1.98 Officers visited S and ascertained that she had been staying with N at his home address for the past couple of days prior to this call from her. She had initiated contact with him and had gone to meet him. He had been dropping her off at her home address when he had seen a Police patrol and fearful of being dealt with for a breach of his bail conditions he had rushed her out of his car. She said he had thrown her mobile phone to her, which she had failed to catch resulting in it being damaged. S said that N had later phoned to apologise to her but had, in her eyes, shunned her and this had motivated her to call the Police. Advice was given to both parties about their contact with each other.

1.99 Although S and N had a relationship in which domestic abuse was a feature they both continued contact with each other in breach of bail conditions that had been set in an effort to safeguard S. The circumstances of these breaches were recognised by the Police to have the potential to frustrate justice if they were enforced and so were dealt with by way of advice to both parties.

1.100 **November 2012**

1.101 At 0330 on 17 November 2012 S called the Police and reported that N had approached her in Hanley town centre in breach of his bail conditions. N was arrested at the time on the basis of this information but S could not be located to provide evidence of the alleged breach of bail conditions. The encounter between N and S occurred in a busy public area and in the absence of evidence that N had deliberately sought out S, N was released with no further action.

1.102 This was the last occasion when any agency in Stoke-on-Trent received contact regarding a relationship between S and N.

1.103 On 26 November 2012 the Crown Prosecution Service (CPS) wrote to the Police highlighting shortcomings in the evidence regarding the alleged assault on S and a lack of information in relation to the earlier Restraining Order. The CPS advised that they were proposing to discontinue the case against N. Records identify that additional evidence was submitted by the Police but the detail of that has not been traced. The case was nevertheless discontinued by the CPS on 10 December 2012 on the basis that there was no realistic prospect of a conviction.

1.104 The rationale for the decision was forwarded to the Police investigating Officer but was not recorded on electronic systems and accordingly was not available to Officers dealing with subsequent incidents involving N.

1.105 **First mention of Z – January & February 2013**

1.106 Between January and June 2013 Z had contact with the Police on a number of occasions in connection with her associating with a group of older men. She confirmed to the Review Panel Chair that none of these men had any connection with N and the Police have no indication of such an association.

1.107 *Z informed the Review Panel Chair that one of these men was W, who was in his late 20s, and who she had met through a classmate at college.*

1.108 *Z stated that she was never in an intimate relationship with W but he was very controlling, followed her everywhere and had stalked her at her home and at college. W was reported to have looked younger than he was and to have been a bit "weird". Z stated that she was not afraid of him.*

1.109 *Z informed the Review Panel Chair that she had heard gossip about exploitation of young girls in the area, but she does not believe this happened to her; for her it was 'just for fun, not malicious or dark'. She was happy to take the blame for possession of cannabis belonging to the men with whom she associated.*

1.110 At 0123 on 8 January 2013 Z used the 999 system to contact the Police from her parents' address. The call taker heard a young female shouting "leave me alone" and the sounds of a disturbance before the call was ended without Z identifying herself. Attending Officers established that she had made the call to force a man (not named) to leave before her parents returned home.

1.111 At 0122 on 28 January and at 2350 on 2 February 2013 Z was found by Police Officers within cars occupied by a group of 3 men, aged 23-31 years, including W. In both cases the males were in possession of cannabis and were arrested. On the second occasion the drugs were packaged for supply to others and Z tried to hide some of the packages, resulting her being given a 'Cannabis warning'[19].

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[19] A locally recorded warning which could be issued for possession of cannabis after proper investigation. It would be recorded as a detected crime but would not constitute a criminal record. In November 2014 this was discontinued by

1.112 On 22 February 2013 Z was also referred by the Police to Stoke-on-Trent City Council Safeguarding Referral Team (SRT)[20] in relation to the incident on 28 January 2013. The referral noted that Z did not appear concerned about the events, claimed that she had known the 28 year old driver of the car (W) for over a year as a friend and regularly spent time with him driving around in his car. The SRT were advised that the vehicle and W had links to child sexual exploitation.

1.113 The reason for the delay in referring Z to the SRT has not been established.

1.114 The receiving Social Worker recorded that due to Z's age (17 years 9 months) there were no lateral checks that could be carried out to gain more information and that no school or college had been identified as attended by Z. A recommendation was made to send a letter of concern, to discuss concerns and ensure that safeguarding support was in place for Z although there is no record of any letter being sent from the SRT. Z was also not referred to the Multi-Agency Child Sexual Exploitation Panel. The case was closed to SRT, authorised by a Practice Manager, on 25 February 2013.

1.115 Given the nature of the referral, regarding Child Sexual Exploitation (CSE), the Stoke-on-Trent SRT should have conducted all relevant lateral checks, including with the College attended by Z, commenced a social work assessment and referred Z to the multi-agency Stoke-on-Trent CSE Panel[21].

1.116 The rationale that Z's age constrained what action could be carried out is without foundation. Z was still a child and all indications were that she was a victim of Child Sexual Exploitation. The man concerned was 11 years her senior and was known to the Police Child Sexual Exploitation Team. Further, the Review Panel were informed that there are young women aged 18 years or more whose cases are overseen by the multi-agency CSE Panel, and that the support services available to that Panel engage with both children and young adults.

1.117 That no school or college had been identified as attended by Z is irrelevant to a decision on what action should be taken but in any event the information could have been readily obtained. All of the local colleges were standing members of the Stoke-on-Trent CSE Panel.

1.118 The real reason that this opportunity to intervene was missed has not been established.

1.119 The Review Panel considered whether the ethnicity of the men in whose company Z was found may have affected the responses of the Police or Children's Social Care. Assurances were provided by both organisations that this was not the case.

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Staffordshire Police in favour of a 'Community Resolution' which includes provision for a range of associated options such as drug treatment / awareness sessions.

[20] Formerly known as the Advice & Referral Team (ART).

[21] The Stoke-on-Trent Child Sexual Exploitation Panel was introduced in 2012 and is a well-attended, well-established multi-agency forum with key safeguarding partners around the table. It meets monthly to consider and coordinate responses to all cases assessed as High or Medium Risk.

1.120 **April 2013**

1.121 On 13 April 2013 Police Officers stopped a car occupied by Z and a 23 year old man[22]. Cannabis was found in the vehicle and the man was given a 'Cannabis warning'. No action was taken in relation to Z, who was still 17 years old at this time, other than recording her presence in the car.

1.122 The man should not have been issued with a 'Cannabis warning' as this was not his first offence for possession of Cannabis. Further, all three of the aggravating factors outlined in the relevant ACPO guidance as precluding such action were present; the offence was committed in public view, it was in a local policing problem area, and there was a need to protect a young person.

1.123 There is no indication that sexual exploitation of Z by the driver, or the potential to use prosecution for other offences as a means of disrupting such exploitation, was considered.

1.124 On 24 April 2013 a member of staff at the College attended by Z reported to the Police that she had disclosed being harassed by W. He was reported to be following Z in his car and to have turned up at the College.

1.125 Z was visited by a Police Officer and she related that W was a friend who had become jealous since she had started a relationship with another male (not named in the records). He had sent her abusive texts and had turned up at the College which she attended. The Officer recorded that the texts were abusive and that Z had also sent W abusive texts. The Officer warned both about their behaviour.

1.126 The Police control room assessed the report as constituting a course of conduct amounting to stalking and recorded a crime report for it. The attending Officer and their supervisor decided that as Z had expressed satisfaction with the action taken by the Officer W about his behaviour no further investigation or process was to be pursued. A request was made for the incident to be re-classified as anti-social behaviour.

1.127 This was not an appropriate and sufficiently robust response to the stalking of a 17 year old girl by a 28 year old man. It appears that the professionals over-relied upon Z's perception of the relationship and that both failed to recognise that W's actions constituted child abuse.

1.128 **May 2013**

1.129 At 2304 on 10 May 2013 Z and a 16 year old girl were found by Police within a car occupied by two older men, one of whom was W. One of the men was in possession of cannabis and was given a street warning. No action was taken by the Police Officers in respect of Z or the other girl in the vehicle.

1.130 As with the incident on 13 April 2013 there is no indication that sexual exploitation of Z and the 16 year old girl by the older men, or the potential to use prosecution for other offences as a means of disrupting such exploitation, was considered.

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[22] This man is not otherwise referenced in this report as an associate of Z.

1.131 **June 2013**

1.132 At 1537 on 3 June 2013 Z (then aged 18) called the Police and reported that she was being abused by a man (W) in his car. Officers attended and advised W about his behaviour. He claimed his girlfriend had been "winding him up". The officers recorded they had not managed to speak directly to Z.

1.133 Police systems held information linking this vehicle to controlled drugs and vulnerable females. The intelligence system was not however updated with information from the incident. An opportunity was therefore lost to increase the detail of the intelligence picture held regarding CSE in Stoke-on-Trent.

1.134 On 4 June 2013 a 17 year old girl complained to the Police about harassment by W. She informed the Police that this man was the controller of a girl with Z's forename. This was assumed by the Police to be Z although it was never confirmed that the girl was referring to Z.

1.135 **July 2013**

1.136 In July 2013 N's Supervision Order expired. N's assessed risk of serious harm increased during the period of supervision and was raised from Medium to High at the termination of the Order. This was, substantially due to disclosure by N of involvement in substance misuse and gang related activity. This was reported to Staffordshire Police.

1.137 N's OASYS objectives were still marked as unmet in his termination assessment. His Probation Officer felt that his compliance was superficial and that he had failed to increase his insight, in particular tending to revert to blaming the injured party or his own intoxication for his actions. The assessment stated that, "[N] lacks the necessary problem solving and decision making skills to deal effectively with potentially confrontational situation, in general and within relationships."

1.138 There was no subsequent contact between N and the Probation Service.

1.139 **Relationship between N and Z.**

1.140 *Z informed the Review Panel Chair that her relationship with N commenced on 4 August 2013 when she was 18 years of age and he was 31 years old after they were introduced by a mutual acquaintance. N had apparently tried to engage with Z earlier via Facebook although she reports that this was one of a number of unsolicited contacts to which she did not respond.*

1.141 *Z is recorded as stating that during her relationship with N she again started drinking alcohol frequently with him, although this later evolved into binge drinking about every two weeks. Along with the renewed consumption of alcohol Z was given cannabis by N early in their relationship and thereafter smoked it regularly, although not every day. She was also given cocaine by N on a couple of occasions when she had taken it to "… please him and share an experience with him."*

1.142 *Z informed the Review Panel Chair that a friend of S (N's former girlfriend) warned her that N had hit S but that she dismissed this as resulting from S being jealous of her new relationship with N. Z continued that she was not aware of the detail or extent of N's violence in previous relationships until informed by the Police after the death of N.*

1.143 *Z is recorded as stating that the first assault on her by N was when he punched her on her nose about three weeks after their relationship started. In respect of this she has stated that she remained happy to be in the relationship and that "When he hit me I felt it was something I should try to fix."*

1.144 *Z also stated that because everybody was afraid of N she felt safe being with him.*

1.145 *Z informed the Review Panel Chair that on average N beat Z once or twice each week, but the controlling and coercive behaviour 'was 24/7'. Z believes that N had mental health problems but would not seek help with this due to his religious beliefs and cultural background.*

1.146 *Z further informed the Review Panel Chair that when anyone asked Z about injuries which she had sustained she always denied that N caused them, usually claiming it was ex-boyfriends or random people who had attacked her in the street. Z believes that her parents knew something was wrong, and that her father blames himself for what happened.*

1.147 *In relation to N's controlling behaviour Z informed the Review Panel Chair that she lost a number of jobs owing to her unreliability, connected with N making it difficult for her to attend work but also her not wanting to be seen when she had visible injuries. She said that N normally insisted on taking her to and from work but had been persuaded to pick her up a few streets away from her work in one care home because her boss noticed injuries and told her to break up with N or leave the job.*

1.148 The Review Panel noted that the Staffordshire Police and Crime Commissioner developed a "Supporting Domestic Abuse Victims at Work" initiative as part of the Police and Crime Plan for 2017-20. This includes provision of training to private and public sector employers to promote identification of victims and signposting to professional support. It is reported to be having a positive impact.

1.149 *Z continued that when she was at her mother's house N would ask her to take photos of certain actions, e.g. standing in a certain spot in the hallway in front of a painting, in order to prove she was at her mother's house at that very moment and not with another man. After a while Z consented to having a tracking 'app' put on her phone so that N would always know her whereabouts. Her views on this at the time were that she "didn't mind as I had nothing to hide."*

1.150 *Z also stated that N frequently smashed Z's phone in anger, "roughly every four weeks", as a result of which she bought new ones. In the end, from early April 2015 (2 months before the fatal incident), when her last phone got smashed, she gave up and decided not to bother buying another one as it was would be easier not to have one.*

1.151 **24 September 2013**

1.152 In the early hours of 24 September 2013 a Police Officer witnessed Z being punched in the face and knocked to the ground by a man as she left late night licenced premises in Stoke-on-Trent. The man responsible was arrested nearby. Z declined medical treatment.

1.153 During the subsequent Police investigation Z disclosed that her attacker had been known to her for around two years[23] and that she had visited the premises with another man. The assailant was prosecuted and subsequently convicted of assaulting Z.

1.154 Z's lifestyle at this time was centred round her friendships with older men and attending late night licenced premises in her local area. There were tensions and jealousy created by this which were exposing her to risk.

1.155 There is no positive evidence of N being aware of the assault on Z and the surrounding circumstances. The Police view is however that it is highly unlikely that N would not have learned about this through his social connections.

1.156 **29 September 2013**

1.157 *Z informed the Review Panel Chair that through the early hours of 29 September 2013 she was subjected to a protracted period of beating by N. He was stated to have beaten her on-and-off for hours, occasionally stopping to smoke cannabis, drink vodka and take cocaine. There were endless questions and accusations about Z having an affair with another man.*

1.158 *Z explained that the beating started when she returned home having borrowed a jacket from a female friend. It was a 'boyish' jacket which led N to believe that Z had been with a man who had given it to her. Despite a phone call to the friend who lent the jacket, N still did not believe Z.*

1.159 *Z stated that the beating ended around 0600 on 29 September at which time N said that he would end his own life if he was not in a relationship with Z. Z said that she had agreed to do likewise and had let N cut her wrist, but when she went to cut his wrist he changed his mind. She then fell asleep or passed out.*

1.160 *When Z woke up there was a lot of blood and Z's arm had gone purple. She also had a badly swollen eye. She asked N to take her to hospital but he did not want to as it would raise questions about how she was injured.*

1.161 *Z said that N gave her £100 to get a taxi to hospital and that before going there she tried to cover her injured face by wearing sunglasses and wrapped her injured wrist in a scarf. Z described it taking some time to get to hospital as she went to collect her (female) friend to go with her.*

1.162 Hospital records describe Z arriving at the Royal Stoke Hospital Emergency Department on the afternoon of 29 September 2013 with facial swelling. Z reported that she had been involved in a fight that morning with a male friend who had punched her face, after which she had punched a mirror causing a cut to her wrist. Z did not name the friend and there is no record of her being asked about this. There is also no indication of any consideration that the injuries might be the result of domestic abuse.

[23] Neither of these men is otherwise referenced in this report as an associate of Z.

1.163 Further exploration by the Doctor as to the identity of the perpetrator could have identified that Z's injuries resulted from domestic abuse. There is however no indication that the professionals dealing with Z demonstrated any degree of professional curiosity or even basic domestic abuse awareness.

1.164 The Review Panel noted that the Staffordshire and Stoke-on-Trent Domestic Abuse Strategy 2017-20 "Breaking the Cycle", contains a specific initiative on raising awareness of domestic abuse amongst professionals, to;. "Ensure the relevant agencies (including health / GPs and social care professionals) and their frontline workforce has the skills and confidence to encourage people to disclose / discuss domestic abuse".

1.165 The Review Panel was advised by University Hospitals of North Midlands that since 2013 training on identification and responding to indications of domestic abuse has been provided by Arch to Emergency Department and midwifery professionals[24].

1.166 The new pan-Staffordshire domestic abuse support service, which commenced on 1 October 2018, includes hospital-based support and liaison in the Emergency Department and Maternity units at the Royal Stoke University Hospital and at the Stafford County Hospital.

1.167 Z was admitted to hospital and had surgery to repair tendon injury to her wrist. The nursing care plan documented that Z had good support from her family although there is no record of them visiting Z at the hospital. Z's next of kin was recorded as being her partner, N.

1.168 After her surgery Z refused intravenous antibiotics and discharged herself from the hospital at 2300 on 1 October 2013.

1.169 *Z informed the Review Panel Chair that her friend remained with her whilst she was in hospital. She said that her friend suspected that the facial injuries had been caused by N and said she would never speak to Z again if she went back to him. However, when Z left the hospital N was waiting outside in his car and she went straight to him.*

1.170 *Z is recorded as stating that N would not let her attend the follow up appointments arranged by the hospital and that she had to remove the stitches from her wrist wound herself.*

1.171 *Z has also reported that following this assault she suffered from nightmares and daytime flashbacks about being assaulted, which increased as time went on.*

1.172 *Z further stated that after this incident N went through the contacts on her phone and Facebook and blocked most of them. He thereafter regularly monitored the number of blocked contacts and if the number went down, for example because someone changed their account profile, N would accuse her of unblocking someone and beat her.*

1.173 In relation to the events on 29 September 2013 two neighbours of N's address recorded and subsequently reported to SHA that they had witnessed N arguing with a girl in the car park outside his address early on that morning. One reported hearing N accuse the girl of "going

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[24] All hospital staff receive mandatory safeguarding awareness training which includes Domestic Abuse. In addition, all qualified staff are required to undertake an enhanced level of safeguarding training which is specific to the area in which they work i.e. adults, children and maternity. This training covers Domestic Abuse in more detail and highlights how to obtain support for their patients and other at risk.

with someone else" and the other witnessed N kick her. N and the girl were reported to have then gone into N's address where they continued shouting at each other. Both neighbours were advised to report this incident and any similar ones to the Police. There is no record of them doing so and the Housing Officer did not confirm with the Police whether they had received any report.

1.174 On 14 October 2013 a SHA Housing Officer interviewed N about the reports. N admitted having an argument with his girlfriend but denied assaulting her. He was warned that action would be taken to end his tenancy if such behaviour was repeated.

1.175 The response to the neighbours' reports represented a missed opportunity to address violence in the relationship of Z and N in the early stage of it coming to agency attention. The Police remained unaware of this and therefore it did not inform the nature of responses to later incidents.

1.176 SHA informed the Review Panel that the majority of reports received regarding N's address were reported and investigated as incidents of Anti-Social Behaviour (ASB); including those that may have involved domestic abuse. This was due to a focus on how the disturbance and disruption associated with such incidents affected the other residents.

1.177 SHA has a clause within its tenancy agreement which enables it to take action to end a tenancy where a tenant is a perpetrator of domestic violence and it would have been more effective to deal with these as domestic abuse cases. The SHA also identified that with hindsight there should have been liaison with the Police before N was interviewed by the Housing Officer.

1.178 SHA has made a number of recommendations for improving their ability to recognise and respond to domestic violence, particularly in connection with incidents that do not initially present as domestic abuse but as ASB.

1.179 **February 2014**

1.180 At 1125 on 20 February 2014 a neighbour of N reported to the Police that about 0200 that day a domestic argument had been heard inside N's address, involving the man and woman living there. The woman had then knocked on the neighbour's door saying "help me, help me". The caller said that disturbances from N's flat were quite a common occurrence and asked for advice on what to do. The caller was advised to call when the disturbances were actually occurring but was reluctant to do this as they were fearful of repercussions.

1.181 Police Officers visited N's address and spoke with him and Z, who was noted to have an injury to her right eye. Z stated that N had not caused the injury and she did not want to talk about it. The Officer recorded that it could not be confirmed that any offences had been committed and that Z was content to remain at the flat. Z was given an Arch domestic abuse information leaflet and advised to keep it safe in case she needed it.

1.182 The Police Officers attending were instructed not to disclose where the call had come from and not to visit the caller.

1.183 This incident was categorised by the Police as a "concern for safety-adult" throughout, even though sufficient information had been passed by the caller to indicate that the incident was a domestic related one. The control room manager added a prompt to the incident record for

the attending Officers to consider whether it should be reclassified at domestic related but did not amend it within the control room.

1.184 The College of Policing has provided national guidance on appropriate incident classification as Authorised Professional Practice (APP). Staffordshire police seeks to follow APP within its own policies and procedures, directing Officers and staff to the online information resource for APP provided by the College of Policing.

1.185 The APP states "staff working in contact and dispatch centres should be trained to identify and grade domestic abuse incidents appropriately. The inappropriate logging of domestic-related incidents as, e.g., a concern for safety, criminal damage or antisocial behaviour, can cause delay and place victims at risk. The training should emphasise that abuse is not only physical and should ensure staff are familiar with more subtle forms of abuse such as controlling or coercive behaviour"

1.186 The Review Panel were informed that the appropriateness of incident classifications is now much more rigorously inspected by supervisors and managers, with staff trained and encouraged to apply the right ones particularly in the area of domestic abuse and violence.

1.187 At the time of this incident Staffordshire Police procedure was for a DIAL form to be submitted if there were criminal offences (for which in this incident the officers believed there was no evidence) or if there were "concerns", which included MARAC cases, incidents at locations with high risk flags[25] and other concerns.

1.188 N had previously been discussed at two MARACs, involving two previous partners and this information was held on Police IT systems. The provision of the "ARCH leaflet" to Z can only have been because the Officer had concerns that domestic abuse had been a feature of the incident.

1.189 A DIAL form was not however completed and therefore no opportunity was provided for risk assessment by the MASH and consideration of whether referral to a MARAC was appropriate.

1.190 Present Staffordshire Police policy is for a DIAL to be submitted for every domestic incident, which underlines the importance of ensuring that domestic related incidents are correctly classified.

1.191 Also on 20 February 2014 the SHA Housing Officer spoke with neighbours of N. One stated that at 0236 N and a woman had been heard arguing and it sounded as if N was bashing the female against the front door. The female was then heard screaming for help and saying "I beg you, I beg you stop it, don't". The female was then heard banging on another tenant's door[26]. The whole incident was described as lasting 10-15 minutes.

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[25] As noted earlier in this report domestic violence by N had not led to location markers being placed against his address.

[26] The tenant on whose door Z had knocked was not seen on this date but informed the Housing Officer of what had happened on 20 May 2012.

1.192 The neighbour also referred to a further incident a few weeks previously when around 0600 N was heard arguing with a woman who was heard to fall down the stairs and scream. She was then heard to go into N's address where an argument continued for around 20 minutes.

1.193 SHA informed the Review Panel that this neighbour, in common with the one who had called the Police on 20 February 2014 and others in the vicinity were reluctant to report incidents because they feared retribution from N.

1.194 SHA further advised the Review Panel that this should have been reported to the Police but the Housing Officer did not do so as the identity of the victim was not known and, as noted above, the domestic abuse was not recognised behind neighbours' complaints which centred on antisocial behaviour.

1.195 On 25 February 2014 the Housing Officer wrote to N requesting that he visit the Housing Association offices to be interviewed about incidents at his address. N was interviewed on 6 March 2014. He stated that he could not remember the earlier incident but stated that the one on 20 February involved his ex-girlfriend, S, who kept coming round asking for them to get back together. He said he would keep her away from the address and apply for an injunction to enforce this. N was sent a letter warning about his conduct and advising that any further incident may lead to action to end his tenancy.

1.196 On the basis of Police Officers' contact with Z on 20 February 2014 it is clear that it was not S who had been at N's address on 20 February 2014. It is speculated that the mis-information provided by N was intended to deflect SHA attention away from his relationship with Z.

1.197 The review panel was informed that an information sharing agreement is in place between agencies across Staffordshire which allows for information to be shared for the purposes of preventing and detecting crime and in relation to ASB. Staffordshire Police and Housing providers also participate in regular multi-agency meetings to discuss crime, ASB and vulnerable residents with a view to agreeing plans to tackle issues raised.

1.198 In relation to this SHA commented that communication between the agencies is good but decisions on what to share rely upon the good judgement of individuals.

1.199 The Review Panel was informed that two Districts in Staffordshire are currently piloting local Partnership Hubs (see 14.7 for the application of this initiative to MARACs) which involve all local agencies and meet daily to share information, with a weekly meeting to explore complex cases in more depth. Stoke-on-Trent is likely to be towards the end of the roll out period (early 2019) for this initiative owing to the scale and complexity of the issues to be addressed.

1.200 **April 2014**

1.201 At 0418 on 13 April 2014 N called the Police; the call taker recorded hearing a female shouting in the background but the call was cut off. N then called the Police again and complained that a woman would not leave his address. The call taker recorded that the female was very vocal and upset in the background.

1.202 Officers attended and were informed by N that he had called the Police because his partner, Z, would not leave the address. Both Z and N were noted under the influence of some

substance. Neither would disclose what, if anything had taken place. Z was taken to her mother's address by the Police.

1.203 The attending Officer requested the incident log be closed and categorised as a "no crime domestic". It was recorded on the incident log that a DIAL had been submitted to the MASH but this was not received there.

1.204 As the incident was finalised as indicating there were no criminal offences a DIAL form would not have been required unless the Officer dealing with it had additional "concerns".

1.205 The record that one had been submitted was in response to an automated question from Staffordshire Police's electronic systems and although marked "yes" it had become common practice for control room operators to respond to automated question sets in this way so that the system would allow them to move on to resource incidents; with intention of returning to the question set later to answer it accurately. This recap process could however become overlooked. The automated question sets was abandoned as a process within Staffordshire Police in May 2016 and this is no longer an issue.

1.206 It would have been preferable for a DIAL form to be submitted and as previously noted current policy of Staffordshire Police is for a DIAL form to be submitted in respect of every domestic incident, regardless of whether a crime is suspected or not.

1.207 *Z has stated that from around June 2014 she left home to live with N at his flat. She has described doing this so that she could stay indoors to avoid other people, including her family, seeing the injuries which N inflicted on her. Also, that when her family did notice injuries she would make up an explanation for them.*

1.208 **September 2014**

1.209 At 0250 on 21 September 2014 the Police were called to an address in Stoke-on-Trent where it was reported that a man was trying to force entry. The attending Police Officers learned that Z had been visiting friends at the address when N forced his way in, pulled Z outside by her hair and threw her to the ground. N was arrested but subsequently released. It was recorded that Z was not injured, would not cooperate with an investigation and was unwilling to attend court. None of the other people present would provide evidence and the offence was denied by N.

1.210 Police advised the Review Panel that this was recorded as a non-crime domestic incident and that all hard copy records were destroyed under in accordance with their information management procedures (MOPI[27]).

1.211 *Z informed the Review Panel Chair that one of her friends had called the Police after N had pulled her out of the house by her hair. She did not however want her friend to pursue the matter with the Police and would not support her friend's statement.*

[27] Management of Police Information. College of Policing Authorised Professional Practice.

1.212 *Z stated that she had a long telephone conversation with a Police Sergeant, begging him not to charge N, and that the Sergeant had agreed to pass Z's request on to a senior Officer. She believes that this contributed to N's release later that day.*

1.213 *Z further informed the Review Panel Chair that after she was reconciled with N her father had threatened N in relation to him hitting Z, the only occasion on which her father had intervened in the relationship.*

1.214 Staffordshire Police Policy required completion of a DIAL form in respect of this incident and one of the attending Officers recorded that one would be submitted. A DIAL form was not however received by the MASH and a safeguarding opportunity was missed.

1.215 In the 12 months from September 2013 there five incidents known to agencies in Stoke-on Trent, three of which were clearly domestic abuse related and in relation to two of which Z had sustained injuries. None of these had however resulted in a DIAL form being submitted to the MASH or any other action which might have led to holistic consideration of abuse in the relationship between Z and N.

1.216 **October 2014**[28]

1.217 The following narrative relates to one incident and the response to it over the following 11 days.

1.218 At 2343 on 23 October 2014 a call on the 999 system was received by the Police. A female was heard to say "hello", scream and then the call ended. Research of the number led the police to contact Z's mother who advised that although registered to her the phone was actually used by Z. Z's mother further advised that Z spent most of her time with N at his home address and added that the Police would have been to that address before around "domestics".

1.219 Police patrols were then directed to N's address but got no reply there. At 0338 the incident was deferred for day shift staff to pick up on 24 October 2014.

1.220 Deferring an incident is a procedure where the electronic record for an incident is not closed as it has not been resolved but it sits in the background of the Police control room systems until a selected time and date and then becomes active again, requiring action by the Police.

1.221 By 1418 on 24 October 2014 it was recorded that Police patrols were committed at other incidents and this incident had not been resourced.

1.222 At 1531 on 24 October 2014 it was recorded on the incident log that a member of the Police control room staff had spoken to Z by telephone and that she had stated that she had been having an argument with her boyfriend. The status of the incident was altered from "priority" to "appointment" as in the control room staff's judgement "immediacy was no longer present". A 'Managed Crime Incident' appointment for an Officer to see Z at her mother's address was booked for 1600 on 26 October 2014.

1.223 This was not an appropriate course of action given the nature of the initial call, the information passed on by Z's mother and the information available within Police systems

[28] The IPCC Investigation Report inaccurately puts this incident one year earlier – on 23 October 2013.

about Z and N. Z had not been physically seen so any potential intimidation or coercion during the telephone contact could not be assessed. In fact the call to Z may have increased risk to her as her circumstances were unknown.

1.224 On the afternoon of 26 October 2014 an Officer attended the appointment with Z but she was not present. She was spoken to on the telephone and stated that she was available at 0900 the following day. There were however no 'Managed Crime Incident' appointments available for that date.

1.225 A member of the Police control room staff consequently called Z who stated that (on 23 October 2014) "she did not mean to ring 999, she pressed the buttons to get a signal back on her Blackberry phone". Z added that she was at that time with her boyfriend, N, at the address which she shared with him. Z was advised that due to the scream heard in the original phone call a physical safe and well check would have to be carried out.

1.226 The difference in account to that previously given by Z was not addressed with her and the likelihood that this was connected with N being present during the call was not recognised by Police Officers and staff continued to rely on telephone contact with Z. In this connection there is no indication that records associated with N's previous relationships, and in particular his controlling behaviour, were accessed.

1.227 Police patrols for the area were recorded as heavily committed and the incident log was again deferred until 0600 on 28 October 2014. Following reactivation of the incident log on the morning of 28 October 2014 there continued to be no action taken until 0438 on 29 October, at which time it was again deferred until 0600 that morning.

1.228 At 1321 on 29 October 2014 Police resources were directed to see Z but were then diverted to another incident (a drink driver). The incident thereafter remained un-resourced with it being recorded that Police patrols remained heavily committed on other incidents.

1.229 At 0051 on 30 October 2014 Police Officers visited N's address but could not get any response. These patrols were then diverted to another incident. At 0157 on 30 October 2014 the incident log was again deferred until 0600 that day.

1.230 At 1530 on 30 October 2014, in view of the unsuccessful attempts to contact Z on her mobile telephone number, an unsuccessful attempt was made by Police control room staff to contact the landline telephone number of Z's mother (which was linked to Z on Police IT systems) but again without success.

1.231 At 2237 on 30 October 2014 the Police control room staff recorded that the night shift had 28 open incidents to deal with and this incident remained un-resourced. At 0204 on 31 October 2014 the incident was again deferred until 0600 that date.

1.232 At 0926 on 31 October 2014 the incident log was altered from "appointment" to "resolved" by a member of control room staff with the reason given as "grade given in error". This could have led to closure of the incident if endorsed by a Supervisor.

1.233 The inability to physically see Z over a period of eight days, including the potential for issues of control and coercion to be behind this, should have been raising concerns about the risk to Z rather than suggesting that the incident was resolved.

1.234 The Police informed the Review Panel that there was no understandable reason for status of the incident log being changed. The Review Panel was however advised that the current Staffordshire Police's control room procedures, which are subject of managerial oversight and dip sampling, would not allow for it and that the training of control room staff around domestic violence and abuse has been improved substantially.

1.235 At 1645 on 31 October 2014 a different member of the Police control room staff sent resources to this incident but within 3 minutes they were diverted to another incident and again it went un-resourced.

1.236 On the morning of 1 November 2014 a Police Sergeant referred the incident to the control room Force Duty Officer[29] (FDO) with the request "…we have spoken to the female and she has missed the appointments. Do not believe there are any safeguarding issues. Can we ask if this can be closed?" The FDO requested that the MASH and Real Time Intelligence (RTI)[30] staff research any previous domestic incidents involving Z and provide a risk assessment.

1.237 RTI staff populated the incident log with the results of their database research. This included information around the offending history of N, previous "domestic incidents" and intelligence links to Child Sexual Exploitation.

1.238 A Detective Sergeant from the MASH also updated the incident log, detailing that there had been a total of eight referrals relating to domestic abuse by N of three different partners and that there had been assaults which had resulted in hospital treatment for at least two of these previous partners. Evidence which indicated that N was very controlling of his partners around mobile phone use and going out was also provided.

1.239 The Detective Sergeant observed that "there is no doubt that [N] poses a significant risk to [Z]. This incident is now 8 days old and we have not yet been able to see [Z] which is concerning and would seem to fit in with his controlling nature of women". The Detective Sergeant continued, "…my assessment is that he (N) poses a significant risk and effort should be made to speak to [Z]. Of note this is at least the third reported domestic incident between [N] and [Z] and as of yet no DIAL has been submitted. A DIAL must be submitted on this occasion".

1.240 This assessment provides a succinct but fairly comprehensive overview of risk issues which should be considered by Officers responding to domestic incidents involving N. The information was not new and could have been available to the Officers responding to previous incidents referred to above. Had it been recognised and collated earlier it appears likely that a more robust approach may have been taken to the investigation of those incidents and the current one. It cannot however be established whether it would have resulted in any different outcomes.

1.241 There is no indication that the research undertaken at the behest of the FDO led to any change in the approach taken by the control room staff to the incident, or to any further intervention by the FDO in that regard.

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[29] A supervisory Officer, usually of the rank of Inspector.

[30] Staff who provide operational Officers attending incidents with relevant information from Police systems in a timely manner.

1.242 At 0954 and again at 2245 on 2 November 2014 it was recorded that Police patrols remained committed at other incidents.

1.243 At 0744 on 3 November 2014 Z was again spoken to on the telephone by control room staff. She stated that she was in bed at N's address and was informed that a Police patrol would be dispatched to see her.

1.244 Z was seen by a Police officer at N's address. She would not say what had happened. It was however recorded that, "…she has not been assaulted in any way and has no visible injuries." It was recorded that a DIAL had been submitted to MASH, however, a further record entry stated "she would not complete a DIAL form as requested and did not want us at the address". A DIAL form was not submitted to the MASH. The incident log was closed on the 3 November 2014.

1.245 The absence of visible injuries 11 days after the initial phone call was not a useful comment and appears to be used to justify an end to the incident response.

1.246 The completion of a DIAL form does not require the co-operation of the alleged victim and one should have been completed on this occasion; particularly in view of the specific instruction from the Detective Sergeant who had reviewed the incident.[31]

1.247 Staffordshire Police Policy now mandates that where a victim refuses to assist in the completion of a DIAL a risk score which triggers secondary risk assessment by specialised staff is automatically recorded.

1.248 On 4 November 2014 a member of staff from the MASH added to the incident log "From MASH – have noted the fact IP refused to complete DIAL form, has Officer considered completing one with as much detail as he/she knows in order for a risk assessment to be conducted in MASH?"

1.249 This information was added to the incident log after it had been closed. Without re-activation of the incident log this request would not have come to the attention of anyone and there was no mechanism in place to monitor whether a DIAL form had been completed.

1.250 The Review Panel was advised that it was only during the research for this Domestic Homicide Review that the Detective Sergeant learned that his instructions to complete a DIAL form had not been followed.

1.251 In the absence of a DIAL form or associated risk assessment in the MASH there was no trigger in place to prompt referral of Z's situation for consideration at MARAC, or to Arch; albeit in respect of the latter all indications are the Z would have denied being a victim of domestic abuse and declined any offer of support. This is the position which she maintained when interviewed by the Review Panel Chair.

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[31] The IPCC was unable to fully investigate the outcome of this incident as the Officer concerned declined to provide an account of his actions. He was dismissed from the Police in connection with other matters.

1.252 **November 2014**

1.253 At 0357 on 9 November 2014 N contacted the Police and reported that a woman was creating a disturbance at his address, damaging his property and assaulting him. It was recorded three times on the incident log that he alleged she was damaging his property.

1.254 N stated that he had locked himself in the toilet. A woman could be heard in the background shouting "Don't call them" and "let me in the toilet". N also referred to Z as "some kind of German Nazi, she is saying about putting bacon on me". The call was then terminated.

1.255 There is no record of the cultural/religious significance of N's allegations about Z being considered at the time. During the period under review there were no other reports of this nature or any indication that ethnicity was a factor in the events considered or agency responses to them.

1.256 Attending Police Officers found "distinct signs of large disturbance" at the address. They also noted that Z had cuts to her head and facial bruising. N was alleged by Z to have punched her several times during a "drunken argument".

1.257 *Z informed the Review Panel Chair that after being beaten by N, which included being hit with a vodka bottle, she had told N that she was going to call the Police. He had then phoned them reporting a disturbance and saying that he was hiding in the toilet from Z who was threatening him. She said that the Police Officer who spoke to her had a body-worn camera and she asked him to turn it off, which he pretended to do, before she told the Officer that N had assaulted her. She added that this was the first time that she had admitted to anyone that N was assaulting her.*

1.258 A crime of assault was recorded with Z as the victim and N was arrested.

1.259 *Z informed the Review Panel Chair that the arrest of N followed him being aggressive towards the Police Officers and them having to physically restrain him.*

1.260 The Review Panel was advised that N's aggression towards the Police Officers was recorded on the Officer's body worn cameras. The Police are however clear that N's arrest was in relation to assault on Z and advised that no offences were committed in relation to N's behaviour towards the Officers in his home.

1.261 An ambulance was called and Z was taken from the address to the Royal Stoke Hospital, arriving there at 0559 on 9 November 2014. She then left the hospital prior to being triaged. Attempts were made by the Police to trace Z with a view to obtaining her statement without success.

1.262 At 1555 on 9 November 2014 Z returned to the Emergency Department of the Royal Stoke Hospital. She was accompanied by her mother and sister but would not let them into the room where she was seen by hospital staff.

1.263 Z informed hospital staff that she had been assaulted by her partner that morning both physically, including being hit on the head with a bottle, and sexually. She disclosed that she was assaulted by her partner quite often but refused to name him and did not want her family or the Police to know. There is no record of attempts being to establish further details from Z regarding the domestic abuse to which she was being subjected.

1.264 *Z informed the Review Panel Chair that outside the room where she saw the hospital staff she tried to convince her mother and sister that she and N were 'fine together'. She added that if the information shared by her had been reported to the Police by the hospital she would have denied that the abuse which she described had happened.*

1.265 *Z informed the Review Panel Chair that there were regular sexual assaults by N. A pattern developed of N forcibly raping Z at the end of a session of physically beating her. Z said that she did not want to have sex with him but did not fight back. Z had been told by a friend that she too had been sexually assaulted by a partner and this had helped Z to believe that "the assaults were OK, and worth it to be with N."*

1.266 *Z has also stated that in conjunction with accusations from N that she was seeing other men he subjected her to intimate examination when she returned after being out alone.*

1.267 Z was noted to have a head injury, a bruised arm and cuts to her face, which included an infected 1cm laceration to her lip. Her scalp wound was glued and she was prescribed antibiotics for the lip injury.

1.268 *Z informed the Review Panel Chair that on one occasion N stabbed her on the chin with a knife and the wound took weeks to heal, with failed attempts to close the wound 'boxing-style' with Vaseline.*

1.269 It appears that this assault is likely to be the cause of the infected facial injury noted to be present on 9 November 2014.

1.270 Z was provided with information on Arch but declined to see the Arch Outreach Team. She did however consent to a referral to Arch being made by the Emergency Department staff.

1.271 Following this incident an alert was put against Z's name on the University Hospitals of North Midlands electronic database identifying her as being at high risk of domestic abuse.

1.272 The Review Panel was advised that in 2016 University Hospitals of North Midlands introduced a policy on supporting patients who have disclosed domestic abuse. Within this policy specific information is provided regarding sexual abuse and the Sexual Assault Referral Centre (SARC). Since the introduction of this policy staff are expected to offer the support of SARC to patients who have disclosed sexual abuse.

1.273 No information regarding Z's report of being sexually abused was shared by the hospital with the Police or MASH.

1.274 As Z had asked that the hospital did not share information pertaining to the assault with the Police she was regarded as having withheld consent. Sharing of information by the hospital without consent is addressed at 10.17-20.

1.275 The hospital discharge letter to Z's GP does not explicitly identify domestic violence and advises only that the GP should consider a full audit of Z's alcohol use[32].

[32] The reference in the hospital discharge letter is to the "Alcohol Use Disorders Identification Test" - AUDIT C

1.276 The rationale behind the content of the discharge letter has not been established. NHS England advised the Review Panel that the content of the letter, taking into account Z's history of not attending appointments, gave limited opportunities for GP led intervention.

1.277 The hospital referral of Z to Arch was received by them on 11 November 2014. It did not include a safe contact number and one was requested from the Hospital Emergency Department by email. A number was provided but not one established as a safe contact. Between 17 November and 8 December 2014 four attempts were made by Arch to contact Z on the number provided but none of these were answered. The case was therefore closed in accordance with Arch Policy.

1.278 Arch advised the Review Panel that a review of the hospital Emergency Department Domestic Violence Outreach referral process in April 2015, conducted as part of their commitment to continuous improvement, prompted a number of amendments to their processes for establishing contact with referred individuals, intended to improve safety and security[33].

1.279 In respect of the Arch case closure policy the Review Panel was advised that to overcome potential barriers to establishing contact with victims, including that they may not have access to a phone, as was the at times the case for Z, a range of alternative contact methods are attempted before the policy is applied.

1.280 N was interviewed on the evening of 9 November 2014 and responded to questions by providing a written statement in which he denied assaulting Z.

1.281 A decision was then taken that N should be released without charge. The rationale for this decision was recorded as: "insufficient evidence to reach the threshold test or referral to CPS. No IP [injured party] account or sufficient to consider victimless prosecution. There is consideration of a DVPN which is being progressed however there are no grounds to keep the DP [detained person] in for this purpose, case officer is attending to assist in DP [detained person] release".

1.282 Making N the subject of a Domestic Violence Prevention Notice (DVPN) was subsequently discussed with a Detective Superintendent who advised that the threshold for authorising a DVPN was not met. A formal application for a notice was not made and consequently the information provided to the Detective Superintendent and the rationale for his decision was not recorded.

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[33] The amendments include:

- The referral form is now clearer on who has made the referral and the date that this was made so that a point of contact is available if further information is needed.
- The form now asks if Arch is to contact the patient or vice versa, and if support has been declined at the point of referral.
- When requesting a safe contact number, safe times to call are also requested.
- When the phone is answered Arch staff state that the call is a follow up from the Emergency Department and do not mention domestic violence until they are sure they are speaking with the person referred.
- Patients are informed that Arch will call from a withheld number for their safety and that an alternative number which they can text if they wish will be provided after Arch established contact and it is safe to do so.

1.283 It is clear that the information held by the Police at that time did provide a proper basis for making N subject of a DVPN and making an application to the Court for a DVPO and indicated that such intervention would have been appropriate. It has not been possible to ascertain whether the decision reached by the Detective Superintendent was the result of deficiencies in the information provided to him or some other consideration.

1.284 When contacted (by telephone) by a Police Officer on 18 November 2014 Z became distressed. She stated (in contradiction to her allegation at the time of N's arrest[34] and as reported to the Emergency Department staff) that she had been injured earlier by a female, whom she refused to identify, in Hanley Town Centre (Stoke-on-Trent). Z was asked during this telephone contact if she wanted the Police to put anything in place for her protection. She replied that she did not need any protection or further contact from the Police.

1.285 There was no way for the Police Officer to know if Z's responses during the telephone call were subject to any control by N. There was information available from this and previous incidents that could have prompted the Officer to consider whether another means of contact would have been safer and with less potential for undue influence.

1.286 A DIAL form was received by the MASH on 10 November 2014 indicating a high level of risk to Z from N. It was arranged for the case to be discussed at MARAC on 9 December 2014.

1.287 The MASH requested that in the meantime the local policing team implement interim safeguarding measures. A 'location marker', indicating that Z was at high risk of domestic violence from N and that all calls should be treated as "immediate response" was put in place. This was however linked to the address of Z's mother, which Z gave as her home, rather than that of N where both the current incident and previous ones had taken place.

1.288 The Police have attributed this, which meant that the marker would not be immediately evident staff responding to any future call to N's address, to poor individual judgement. It was however a repeat of similar decisions made in 2012. Action has been taken to address this area of practice and the Police have made a recommendation in their report to the Review to highlight the significance of this.

1.289 **December 2014**

1.290 On 9 December 2014 a MARAC in Stoke-on-Trent discussed Z.

1.291 SHA who were in possession of information which would have usefully contributed to the effectiveness of the MARAC, were not present or otherwise engaged with the MARAC process. They are emphatic that social housing providers should be engaged with MARACs. New partnership hub arrangements being implemented across Staffordshire and Stoke-on-Trent are intended to improve engagement in MARACs of agencies, including housing providers (see 14.7).

1.292 The Police record of the MARAC, on the basis of researching all local and national databases, indicates:

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[34] Her original allegation at the time had been recorded via a body worn camera on one of the attending Officers.

Risk Factors identified:

- Risk of physical and emotional harm to Z.
- Risk of sexual exploitation.
- Risk to any future partner of N.
- Risk to the public.
- Risk to young females from him.

Trigger Factors identified:

- Serial perpetrator.
- Both for alcohol.
- Both for drugs.
- Damages property.
- Minimising.
- Lack of engagement with agencies.
- Weapons.
- Prolific offence history.
- Her extreme attachment to him.

1.293 At the MARAC information was shared from health professionals that Z had "alleged physical and sexual assault by partner" at the Emergency Department on 9 November 2014.

1.294 University Hospitals of North Midlands were asked for an explanation of why information regarding the abuse alleged by Z was shared at the MARAC but had not been shared earlier. The Review Panel was advised that by virtue of being considered at MARAC the case was considered as a high risk one and this gave the attending professional the confidence to share the information.

1.295 No explanation was offered for the risk level not being identified earlier. It appears that there was no mechanism in place for information regarding domestic abuse to be risk assessed in front line services at the hospital and for appropriate decisions on inter-agency information sharing to be made and recorded.

1.296 An Action was agreed at the MARAC for the attending Police Sergeant to update the Officer investigating the incident on 9 November 2014 with the information shared at the meeting. There is nothing within the Police records to show that this, including the disclosure of sexual assault, led to further investigation.

1.297 The IPCC investigation identified that no further action was taken in respect of this because Z was deemed to have declined to make a formal complaint and would not name the alleged perpetrator when disclosing the offences to hospital staff on 9 November 2014. The Review Panel was advised that this decision was in accordance with the National Crime Recording Standards.

1.298 As at the MARAC concerning S and N in 2012 there is no indication that the MARAC considered prompting N to undertake a non-statutory Domestic Abuse Perpetrator Programme, which was available in Stoke-on-Trent. In this regard the Review Panel was advised that the process to recommission Stoke-on-Trent Domestic Abuse services from October 2018 includes an increased focus on providing interventions to address the behaviour of Domestic Abuse perpetrators.

1.299 There is also no indication that disclosure of N's history of violence to Z as a "Right to Know" issue under the Domestic Violence Disclosure Scheme[35] was considered.

1.300 *Z informed the Review Panel Chair that she was not aware of the MARAC process, or that she had been discussed at a MARAC. She was very tearful when told that agency professionals had discussed her situation with a view to putting in place measures to protect her.*

1.301 At the MARAC a new contact number for Z was shared by the Police and Arch agreed to use this to try to establish contact with Z; including informing her that her situation had been discussed at the MARAC and provide feedback from the meeting. After three unsuccessful attempts to call Z the phone was answered by a man on 19 December 2014. Shouting could be heard in the background then Z took the call. She was asked if it was safe to talk and she stated she did not want any support. Arch consequently closed the case and informed the Police that they had done so. Z was not informed that the MARAC had been held.

1.302 It should have been apparent that whatever Z said on the telephone she was not in a position to speak safely with Arch. The presence of a man who could reasonably be assumed to be N was immediately known and the circumstances under which Z was providing a response were not.

1.303 There is no indication that any alternative means of informing Z that she had been discussed at MARAC and providing feedback to her was considered. There was also no mechanism in place to monitor completion of actions agreed at the MARAC. Closure of the Arch case without this taking place was accordingly not challenged within Arch or by the Police.

1.304 *Z informed the Review Panel Chair that when she had been repeatedly contacted by phone, she asked N what to do and he took the phone from her and spoke to the caller saying "Can't you see she doesn't want to be contacted".*

1.305 Following the MARAC on 9 December 2014 the Police also made a referral to Stoke-on-Trent City Council SRT highlighting concerns that domestic abuse of Z by N may impact on Z's brother, then aged 14. It was recorded in the referral that Z "…refused to support any complaint and stated that she will never make a complaint against him as she loves him."

1.306 The SRT decided that Z's brother was not at risk from N and that there was no need for formal social work intervention. The information was however recorded to ensure that it would be available if any further concerns arose. The case was closed to SRT, authorised by a Practice Manager, on 12 December 2014.

1.307 Z was by that time over 18 years so could not herself be subject of a referral to Children's Social Care.

1.308 At 0403 on 26 December 2014 a 999 call was made by a woman at the home of Z's family who asked for the Police and then ended the call. A possible disturbance was heard in the background. The number led to the address of Z's mother being identified, along with the location marker relating to risk of domestic violence.

[35] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

1.309 Officers attended and ascertained that Z and N had been at the address with Z's immediate family. N was stated to have taken offence at opinions voiced by the family about him and Z's relationship with him. N had left and Z was stated to have "over reacted" and rang for the Police. Z had since left the address and was believed to be with N.

1.310 Neither Z nor N were seen by the attending Police Officers who recorded "There is no concern for this female and the relationship they are in, it is purely that he may have been under the influence whilst driving". Observations were requested for the car that N was believed to be driving and the incident log was closed.

1.311 *Z informed the Review Panel Chair that this incident arose when N verbally abused and threatened a member of her extended family.*

1.312 The Police advised the Review Panel that in view of the location marker to flag a high risk of domestic abuse to Z from N, and the information held behind this more positive action should have been to confirm that Z was safe and well. There is no record of any supervisory oversight for this incident. Staffordshire Police now require supervisory oversight of all domestic related incidents.

1.313 **March 2015**

1.314 At 0300 on 7 March 2015 Police Officers attended a night club in Hanley, Stoke-on-Trent following a report that N and Z had been assaulted. They reported that they were together in the foyer of the club and about to leave when they were approached by a group of three men who "set about" N and punched Z to the face. The nature of the assault was seen on the club CCTV as unprovoked and sustained, with at least 10 blows from an assailant described as a heavily built 6' 1" male. Z was recorded by the Police as being intoxicated.

1.315 Both N and Z had minor facial injuries. N attended the Royal Stoke Hospital. He was discharged after investigations revealed no bony injury.

1.316 One of the alleged assailants was arrested for the assaults but released without interview because he suffered a medical condition (sleep apnoea) that put him at risk whilst in Police custody without appropriate medical apparatus. Although the assault was subsequently admitted by the man he was not prosecuted owing to legal technicalities.

1.317 *Z believes that the assault was principally directed at N as a revenge attack. There was history between the assailants and N because of a previous incident involving the assailant's sister, who N had referred to as a "slag". Z stated that she thought the attack took place then because N had been going to the gym less often (being otherwise busy with monitoring what Z was doing) and was therefore less strong and muscular.*

1.318 That Z's intoxication was recorded as worthy of note indicates she was intoxicated to a high degree. She later disclosed having consumed 7 double vodka and "Red Bull" drinks.

1.319 *Z is recorded as stating that during the 2-3 months before the fatal incident she was depressed and miserable, being locked in N's flat by him and only let out when he decided.*

1.320 **Death of N**

1.321 On 29 May 2015 Z visited Chester Zoo with her father and siblings.

1.322 *Z has stated that on her return she mentioned to N that she may go out with a friend later and he was angry about this. Nevertheless she later went to her friend's house and consumed several drinks whilst there. They then went to a bar and had another drink, following which N came into the bar. Z has said the she could see he was angry, but she was hugging him to try and keep him on side. Z then left her friend and went with N to another bar and then a nightclub where she consumed more alcohol. Z has said they went outside for a cigarette and a man she knew spoke to her. N was rude to the man and pulled her by the arm down the stairs to leave. The bouncers stopped her and asked if she was alright and she said she was. N and Z got into a taxi together.*

1.323 *Z has stated that N said to the taxi driver that her behaviour was shameful, asked the driver to stop and then tried to push Z out of the taxi; but she refused to get out. When they reached N's flat she apologised to N and changed into shorts and a t-shirt so he would not throw her out. Z has said that N then started dragging her by her hair and called her a "whore". N then rang Z's Mother and left a message on her answerphone to the effect that Z was a "whore" and should have opened a brothel.*

1.324 *Z has stated that N was hitting her and when he stopped she grabbed a domestic implement from a table and stabbed him in the shoulder area. Z said they were both in shock, froze and looked at each other. Blood started gushing out of his shoulder and she started screaming but he did not say anything. She tried to stem the blood flow and tried to walk him to the sofa. She then tried to ring an ambulance using N's phone, but he would not tell her the pin code. N rang for an ambulance himself and put the telephone on loud speaker.*

1.325 At 0354 on 30 May 2015 WMAS received a 999 call from a mobile phone. The call was made by N although at that time the call handler was not aware of the caller's identity. The WMAS call handler attempted to go through a series of questions to obtain information to be used in prioritising the response to the call.

1.326 The call-handler experienced difficulty in obtaining information from N, who seemed to be in considerable distress and struggling to explain why he required assistance, and she was assisted by a supervisor, who was able with some difficulty to confirm the caller's address (the home address of N) after which the call was cut off.

1.327 *Z has stated that she kept saying to him "you're going to die." N then collapsed and soon after she knew he was dead, although she shook him and shouted at him as she wanted him "to wake up." Z has stated that she wanted to be with N and tried to stab herself approximately 4 times in the stomach, but the implement was too blunt. She took some painkillers, lay down with N and fell asleep.*

1.328 At 0402 that date WMAS contacted Staffordshire Police control room to request information on the address relating to the mobile phone number that had made the 999 call. Any additional information that might be linked to the phone number was also requested. The Police call handler confirmed the address to be that of N and also provided information about previous domestic incidents at the address. Police assistance was not requested by WMAS at that stage.

1.329 The call to WMAS was graded as requiring a 30 minute response time and an ambulance arrived at the address approximately 30 minutes later. Initially the ambulance crew were

unable to gain entry to the block in which N's flat is situated and Police assistance was requested at 0440. The Police control room call handler treated the WMAS request as a concern for safety and graded the incident as requiring a 'Priority' response[36], within 60 minutes.

1.330 The IPCC concluded that it was a reasonable exercise of judgement to grade the call as requiring a 'Priority' response. Although the call handler was aware of some previous domestic incidents ambulance service staff were already at the address and had reported that they were getting no response from N's flat and that there was nothing unusual evident.

1.331 The Police patrol that would have dealt with the incident was diverted to a domestic incident at a different address that was in progress at the time and had been given a higher priority. That call resulted in an arrest, thereby keeping the patrol committed for some time. The IPCC Investigator confirmed that all other Police resources (with the exception of an armed response patrol which had to remain available for deployment to firearms incidents) were committed on other incidents throughout the remainder of the shift ending at 0700.

1.332 Having listened to a recording of the call to N's address WMAS staff identified that a female in the background, who sounded distressed, seemed to have said "You're going to kill yourself if you continue doing that". This was reported to the Police at 0451. It did not prompt a re-grading of the incident by the Police call handler.

1.333 The IPCC advised the Review Panel that having repeatedly listened to the recording the words quoted appear to be a misquotation from a female voice repeatedly crying out in a very distressed tone of voice, "You're going to die" and that the called seemed to have stated that he had been stabbed in the chest. There is no indication that this was heard by either the WMAS call handler or her supervisor.

1.334 The receipt of information suggesting that someone might die along with confirmation that both a male and a female were present should have prompted consideration by the Police that this was potentially a domestic violence incident for which re-grading of the call would be appropriate.

1.335 In this regard the IPCC Investigator observed that the neutral tone in which the message was delivered may have removed the sense of urgency which would have been evident to Police control room staff from listening to the recording of the call. Further, there is a possibility that the additional elements subsequently identified by the IPCC Investigator may have been picked up at that time.

1.336 The Police call handler has observed that a large number of calls of this sort are received by the Police control room and it is difficult to determine the urgency based on the limited information available.

1.337 The IPCC considered making a recommendation on the sharing in real time of West Midlands Ambulance Service call recordings with the Police. Following exploration of this the ambulance service advised that the technology to do this was not available but that it was a facility that could be considered by the National Police Chiefs Council, National Fire Chiefs

[36] Under the system of grading that was then in use a Priority response was the second highest category and required resourcing within 60 minutes. The highest grading would have been an immediate response requiring police attendance within 15 minutes.

Council and the Association of Ambulance Chief Executives as joint working arrangements for control room facilities were developed in the future.

1.338 Police records indicate that further calls to enquire about the availability of Police resources were received from WMAS at 0534, 0550, 0631 and 0651; in the last of which WMAS informed the Police that their ambulance crew had been stood down but would return when the Police were able to send Officers to the incident.

1.339 At 0750 a Police patrol became available and was dispatched to N's address, arriving at 0832. The Officers entered the block of flats using the trade button on the intercom panel, but obtained no response to heavy knocking on the door of N's flat or calls to the mobile number from which the 999 call had been made. WMAS were advised of this at 0840.

1.340 The Officers then left, intending to return to the address later. WMAS called the Police back at 0859 and expressed concern that the Police had left and had not informed them, specifically asking why the Police had not broken into the flat.

1.341 The Police incident log was then reviewed by a control room supervisor who instructed that staff confirm with WMAS what phone number the 999 call had been made from and the address that had been given in the call. At 0918 this information, which was already held by the Police was confirmed by WMAS.

1.342 It was queried whether the caller had confirmed that he was at that address, to which the WMAS call handler replied "I believe so. That's what the notes say".

1.343 At 0936 the two Police officers returned to N's address where they met with an ambulance crew. They again reported to the control room that there had been no response to knocking on the door of N's flat and no answer from the mobile phone that had been used to make the 999 call.

1.344 At the request of the attending Police Officers SHA were contacted by the Police control room to enquire whether they held keys for the property. SHA informed the Police that they did not have keys but, if it was necessary to force entry, they would come out and repair the damage.

1.345 The Police Officers at N's address advised their control room that they did not consider that they had grounds to break into the flat. On being advised that the Police did not intend to force entry the WMAS resources left the scene.

1.346 Police Officers have a power under section 17(1)(e) of the Police and Criminal Evidence Act 1984 to enter premises for the purpose of "saving life or limb or preventing serious damage to property".

1.347 The rationale given by the Police Officers for not forcing entry was that the call had come from a mobile phone and there was no evidence that it had been made from N's address, there was no evidence that anyone was in the flat and that although there was a car registered to N in the car park, another car known to have been recently used by him was not present.

1.348 The Police control room did not inform the Officers that it had been confirmed with WMAS that the call was recorded as having been made from N's address. The member of control room staff concerned has stated that he did not do so on the assumption that they were

already aware of this, being at the address with WMAS and having already enquired about getting access with SHA keys.

1.349 The IPCC advised the Review Panel that an awareness of previous domestic incidents and that that someone may have been self-harming could have tipped the balance in favour of forcing entry to the flat. However the Officers attending did not have confirmation that the call had been made from the address and the information they did have about the nature of the risk was ambiguous at best. It was also highlighted that the Officers took a number of steps short of forcing entry to assess this risk.

1.350 In relation to this last point the Officers involved have advised that some housing associations hold spare keys for their properties and have provision for their housing officers to enter the properties for their own purposes written into tenancy agreements – presenting a potential means of establishing if Police or ambulance assistance was required.

1.351 After the officers had left N's address on the second occasion they went to the address of N's mother but were not able to get any reply there. They were then diverted to another incident and were unable to return to N's address prior to 1401, at which time a neighbour reported that a woman in N's address had shouted out of a window "Help, help, he is dead, I've killed him."

1.352 *Z has stated that after a number of hours asleep she woke up and went downstairs to a neighbour but was not let in. She then returned to N's flat and started stabbing herself with scissors, but "couldn't do it." Z has stated that she then tried to put some belts together to hang herself, but again could not do it. She thereafter shouted for help out of the window.*

1.353 An immediate Police response was provided to that information. Z let Officers into N's address where they found his body. A post mortem examination later identified that N died as a result of a stab wound to his chest.

1.354 Z was arrested and subsequently informed Police that she had remained in N's address following the initial 999 call but had been asleep or unconscious and had not been aware of the Police and WMAS staff visiting the address. She had a stab wound to her lower abdomen which was treated at the Emergency Department of the Royal Stoke Hospital. This wound was subsequently identified as being self-inflicted.

1.355 Z was later charged with Murder of N.

1.356 Expert evidence provided at the trial of Z indicated that the injury that N suffered would not have been survivable even with immediate treatment and he is likely to have died within minutes of the 999 call made at 0354 on 30 May 2015. Consequently he was almost certainly deceased by the time the first ambulance crew arrived.

1.357 *Z informed the Review Panel Chair that N's death was not pre-meditated, that she regretted stabbing him immediately afterwards and remembers the look of complete shock in N's eyes. She stated "It was my choice to be with him, I loved him, no matter how he treated me"*

1.358 In February 2016 Z pleaded guilty to Manslaughter on grounds of diminished responsibility and was sentenced 6 years and 3 months imprisonment.

1.359 The court accepted N had a propensity to be violent towards women and also the evidence of Psychiatrists appointed by both prosecution and defence that Z was suffering from a form of Post-Traumatic Stress Disorder (PTSD); ‘Battered Woman Syndrome’.

1.360 *The Review Panel Chair asked Z about her guilty plea to Manslaughter after her trial had started. She responded that she had no previous dealings with or knowledge of the Court system; she had never been arrested before. Z continued that her QC had advised that she should plead not guilty to Murder on grounds of self-defence. Her QC was intending to call witnesses, including N’s ex-partners, to give evidence of his violence towards women.*

1.361 *Z stated that she was not initially aware what a manslaughter plea was but the prosecution offered to accept a plea of guilty to this on the second day of her trial, apparently because of the psychiatric reports’ conclusions regarding her suffering from ‘battered woman syndrome’.*

1.362 *Z advised the Review Panel Chair that she decided to plead guilty against the advice of her QC, and said “It would not feel right if I was found not guilty and just walked away. I needed to go to prison to move on, it was the right thing to do”. Z added that she was certain she had made the right decision.*

## THEMATIC ANALYSIS

Safeguarding victims who do not seek or support professional intervention

1.363 Throughout her relationship with N, Z consistently denied that she was being abused, to both professionals and her own family. On the two occasions when she did disclose that she had been abused (in September 2014 at hospital and to a Police Officer in November 2014) this was conditional on the information not being used as a basis for intervention. Z was herself explicit that she would have denied what happened if any action was taken.

1.364 The Review Panel considered how it might be possible to safeguard a victim of domestic abuse victim who, of their own volition or as a result of coercion by an abuser, continued a violent relationship, did not engage with services and was willing to subvert professional attempts to protect them. A number of strategies and tools which might contribute to this were identified. Opportunities to utilise these were missed in respect of the relationship between Z and N.

1.365 **Effective and proactive investigation of incidents, risk assessment and engagement of partner agencies.**

1.366 When attending a reported incident there was at times no robust activity to see the couple. If it was quiet when Police Officers arrived and no one would answer the door this was not viewed as a cause for concern. The incident would be handed on to others to attempt contact, sometimes taking days to establish contact, and then not face to face. The 'golden hour' principle of investigation was missed and over time there was a loss of focus and accountability.

1.367 Further, when co-operation was not forthcoming from either party investigation ceased despite there being evidence of domestic violence and damage at the dwelling they shared. This lack of investigative thoroughness was an avoidable obstacle to robust positive action, including prosecution, being taken.

1.368 Police supervisory oversight was not apparent in a number of incidents until the front line Officers asked for it themselves. The Review Panel was informed that Police supervisory oversight is now required for all domestic related incidents and that this was having a positive effect on meeting investigative and crime recording standards.

1.369 The Review Panel was further advised that lack of willingness of a victim to support investigation and prosecution is also now explicitly recognised within training provided by Staffordshire Police as not being a bar to a robust response. It is emphasised that all other available investigative avenues should be pursued. This includes consideration of using multiple charges arising from different aspects of an incident, provided this is consistent with the Police Code of Ethics, which has been shown to improve the proportion of successful prosecutions.

1.370 A lack of engagement by a victim also now automatically generates a risk assessment in the Staffordshire and Stoke-on-Trent Multi-Agency Safeguarding Hub (MASH) where decisions

are taken on what further action may be required, including engagement of support services and referral to a MARAC[37].

1.371 Notwithstanding the default position in respect of victims who do not engage it is important that DIAL forms are completed with information that is available to support effective risk assessment. Despite this risk assessments were not completed in many of the earlier reports of domestic incidents.

1.372 The Review Panel concluded that there should have been greater recognition that N had a history of violence towards previous partners. This was known to the Police and should have prompted engagement of the MARAC process from February 2014 rather than December of that year, and earlier if information regarding the incidents in September and October 2013 had been shared by the health service and SHA staff respectively.

1.373 Staffordshire Police policy is now for this to be done by Officers responding to all domestic incidents and for these to be reviewed by a local supervisor. The Staffordshire Police incident database has also been amended to prompt the completion of the DIAL forms, with DIAL forms re-designed in 2018 and specific versions introduced for family incidents and stalking / harassment cases.

1.374 The Review Panel was advised that as a consequence of these measures the current compliance rate for completion and submission of DIAL forms in the Staffordshire Police area has risen to around 90%.

1.375 In addition to Staffordshire Police, two other agencies had information relating to abuse within the relationship of Z and N

1.376 The Review Panel considered the effectiveness of communication between Staffordshire Housing Association and the Police. The Review Panel was advised that overall the agencies do work closely together but that the effectiveness of this is dependent on the good judgement of individual staff members involved in a case. In this respect the Housing Association observed that in relation to events at N's property the Housing Officer did not share information that should have been shared. A focus on the anti-social impact of incidents on neighbours rather than the underlying domestic abuse was a factor in this. SHA have made a number of recommendations to improve their response to domestic abuse.

1.377 The Review Panel was informed that communication between the two agencies has particularly improved since the introduction, in January 2016, of local Vulnerability Hubs which provide a framework to promote the sharing of information between all local agencies concerned with community safety.

1.378 The Review Panel was informed that two Districts in Staffordshire are currently piloting local Partnership Hubs (see 14.7 for the application of this initiative to MARACs), successors to the previous Vulnerability Hubs, which involve all local agencies and meet daily to share information, with a weekly meeting to explore complex cases in more depth. Stoke-on-Trent is likely to be towards the end of the roll out period (early 2019) for this initiative owing to the scale and complexity of the issues to be addressed.

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[37] It is anticipated that the location of such risk assessment will change as the Partnership Hub model (see 9.155) is rolled out in Stoke-on-Trent.

1.379 University Hospitals of North Midlands referred Z to Arch, with her consent, in November 2014. They did however advise the Review Panel that their policies made it difficult to refer a victim of domestic abuse to support services without their consent, highlighting that information is shared; it is just not done in the context of a formal referral. This is not an appropriate approach to information sharing.

1.380 University Hospitals of North Midlands were asked by the Review Panel for an explanation of why information regarding the abuse alleged by Z was not shared at that time, when it was shared at the MARAC in December 2014. The Review Panel was advised that by virtue of being considered at MARAC the case was considered as a high risk and this gave the attending professional the confidence to share the information.

1.381 No explanation was offered for the risk level not being identified earlier. It appears that there was no mechanism in place at the hospital for information regarding domestic abuse to be risk assessed and for appropriate decisions on inter-agency information sharing to be made and recorded in front line services.

1.382 University Hospitals of North Midlands have agreed a recommendation to review, with external input from the MASH, their information sharing arrangements in cases where an individual is at risk but does not consent to sharing relevant information.

1.383 **Disclosure of an abuser's history of violence as a "Right to Know" issue under the Domestic Violence Disclosure Scheme[38] (known as Clare's Law).**

1.384 Z informed the Review Panel Chair that at the start of her relationship with N she was warned by another woman that he had hit his previous partner, but that she dismissed this as resulting from jealousy about her new relationship. She continued that she was not aware of the detail or extent of N's violence in previous relationships until informed by the Police after the death of N.

1.385 There were a number of opportunities in 2014 to share information on N's previous history of violence with Z as a "Right to Know" issue under the Domestic Violence Disclosure Scheme; not least as an action from the MARAC in December 2014. There is however no indication that this was ever considered.

1.386 The Review Panel was advised that since 2015 the Domestic Violence Disclosure Scheme process has been more embedded within front line policing, with formal arrangements for recording and decision making now used in all cases, and that this is supported by staff training.

1.387 It is unknown whether possession of such information would have materially changed Z's position in regard to her relationship with N. Over time and as Z had spent longer in a relationship where violence was commonplace this seems increasingly unlikely. She should however have been able to make any decision regarding the relationship from a more informed standpoint.

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[38] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

1.388 **Use of Domestic Violence Protection Notices and Domestic Violence Protection Orders, as provided for by the Crime and Security Act, 2010**

1.389 The use of a Domestic Violence Protection Notice, and subsequent application to the Court for a Domestic Violence Protection Order[39] does not require support from, or even the cooperation of the victim. As such they provide a useful and potentially effective means of intervening, albeit only for a limited period, in cases where a victim is unable or unwilling to support prosecution, with the associated potential to use bail conditions, or action in the Family Court.

1.390 The use of these provisions was considered by Police Officers dealing with the assault on Z in November 2014 and grounds to pursue it were present. It has not been established why the senior Police Officer consulted decided that the threshold was not met.

1.391 The Review Panel was advised that in Stoke-on-Trent there has been some success in protecting victims through the use of the Crime and Security Act, 2010, although it was acknowledged that this was time limited and that in the longer term there was very little that could be done unless the victim engaged with services.

1.392 In 2018 the Government consulted on a proposed new Domestic Abuse Bill[40] and posed 65 questions regarding this and associated services intended to:

- promote awareness – to put domestic abuse at the top of everyone's agenda, and raise public and professionals' awareness
- protect and support – to enhance the safety of victims and the support that they receive
- pursue and deter – to provide an effective response to perpetrators from initial agency response through to conviction and management of offenders, including rehabilitation
- improve performance – to drive consistency and better performance in the response to domestic abuse across all local areas, agencies and sectors

1.393 A number of the proposals which are subject to the consultation, for example the introduction of Domestic Abuse Prevention Orders with a wider range of powers than the current DVPOs, touch on issues identified within this Review. The government response to the consultation which ended on 31 May 2018 is awaited.

1.394 The Review Panel recommend that:

***The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should seek assurances that agencies supporting victims of domestic abuse are fully utilising existing tools and powers to support victims of domestic abuse, including Domestic Violence Protection Notices/Orders and the "right to know" under the Domestic Violence Disclosure Scheme (Clare's Law).***

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[39] A Domestic Violence Protection Notice may be issued by an authorised Police Superintendent which sets out prohibitions that, in effect, bar a suspected perpetrator from returning to a victim's home and/or contacting the victim. Following the issue of the Domestic Violence Protection Notice the Police must apply to the Magistrates Court for a Domestic Violence Prevention Order. If the required conditions are met the DVPO will be granted. The Orders last for a maximum for 28 days. Breaches are dealt with as if a breach of bail but the DVPO is not extendable past the maximum 28 day period.

[40] https://consult.justice.gov.uk/homeoffice-moj/domestic-abuse-consultation/

1.395 The Review Panel further recommend that:

***Upon the enactment of the current Domestic Abuse Bill into law, the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should widely promote the provisions of the new Act, and should seek assurances that agencies supporting victims of domestic abuse have in place plans to fully utilise the new tools and powers within the Act.***

Understanding of control by a perpetrator and taking steps to minimise its potential effect

1.396 The potential for Z to be the subject of coercion was not adequately understood or catered for by the Police or Arch.

1.397 Coercive and Controlling Behaviour became an offence in 2015 under Section 76 of the Serious Crime Act, and this features strongly in Police training and Public Protection development days. It is however unlikely, given Z's unwillingness to support action in respect of physical and sexual abuse that she would have supported action in respect of Coercive and Controlling behaviour even if the legislation was in place earlier.

1.398 There were however opportunities to recognise the potential for N to be controlling Z's access to services and these were not taken.

1.399 For example, N and Z were interviewed by responding Police Officers whilst together (within earshot or at the same location) and on other occasions telephone contact was used without considering Z's situation, including her ability to respond without being controlled or influenced or even that the contact itself might increase the risk level.

1.400 There was also a lack of consideration that coercion could extend to controlling Z's access to a telephone and consequently her ability to respond to calls and messages. This was reported by Z to have been the case and this has implications for agencies, such as Arch, which operate a policy of closing cases after a fixed number of attempts to contact an individual.

1.401 The Review Panel recommend that:

***The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should ensure that all domestic abuse support service providers across Stoke-on-Trent and Staffordshire are made aware of this review and its findings, and seek assurances from the providers that their case closure policy is robust and in line with national guidance.***

Use of warning flags on Police systems

1.402 Following the arrest of N for assault on Z in November 2014 a warning flag regarding high risk of domestic violence was placed on police systems. The address chosen for this was however that of Z's mother and no flag was put against N's address, where Z was known to be spending much of her time (and in fact residing): and where nearly all of the domestic related incidents regarding this couple were centred. The Police have attributed this, which meant that the marker would not be immediately evident staff responding to any future call to N's address, to poor individual judgement

1.403 This mirrored earlier issues, in 2012, with the placing of warning flags on the address of only one party involved in domestic abuse incidents.

1.404 To be effective, location markers need to be applied to the home and any other addresses frequented by both of the parties. The policy of Staffordshire Police now reflects this requirement and work is ongoing to promote and monitor compliance through transformation of the model for responding to vulnerable victims, which includes local senior level ownership. Notwithstanding this development the Police report for this Review appropriately includes a recommendation to highlight the need to address this practice area.

Police Incident categorisation

1.405 In February 2014 the Police control room did not categorise a report of a domestic argument as domestic related but asked responders to consider if it needed to be such. This was an inappropriate delegation of a decision that should have been made on the information provided by the caller supported by that accessed from Police databases.

1.406 In October 2014 an incident arising from a dropped call from Z's phone was initially graded as requiring a response within 60 minutes but then had the response deferred, subsequently downgraded to be dealt with by appointment and eventually closed after Z was seen 11 days later. The grading of the response to this call was not appropriate.

1.407 The Review Panel received assurance that following review and simplification of call prioritisation domestic incidents in particular must always be given a priority which will prevent them remaining un-resourced.

1.408 The Review Panel was informed that increased supervisory oversight of Police incident management was mandated and training provided to Contact Services staff from February 2016. The new arrangements require that any downgrading of an incidents priority must be authorised by a Manager, Control Room Supervisor or the Force Incident Manager. A re-grade to a higher response grade does not require any authorisation. In addition Staffordshire Police now operates a performance management tool (BRAIN – Business Reasoning through Analysis and Intelligent Navigation) which can identify incidents which have been inappropriately categorised or graded.

1.409 The Staffordshire Police contact services department have also overhauled their mandatory domestic abuse training, which includes input around coercive control, the voice of the victim, the work of Independent Domestic Violence Advisers (IDVAs) and the work of the National Centre for Domestic Violence. This training includes the use of the THRIVE principles for risk assessment in conjunction with the National Decision Model (NDM)[41].

1.410 As an example of the improvements made in the management of domestic incidents the Review Panel was informed that in the 12 months from February 2014 there were 1,267

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[41] The THRIVE model for risk assessment comprises assessment of Threat / Harm / Risk / Investigation / Vulnerability / Engagement. The National Decision Model (NDM) is available from the College of Policing https://www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/
Training on THRIVE and NDM are statutory training modules for all Staffordshire Police Officers and staff.

domestic incidents which were not classified as domestic, which in the 12 months from February 2017 had been reduced to 114.

MARAC effectiveness

1.411 Domestic Violence by N was the subject of two MARACs (in 2005 and 2012) prior to the start of his relationship with Z.

1.412 In relation to the 2012 MARAC it appears that the actions agreed were implemented, although the effectiveness of these was undermined by continuation of the relationship between N and S and her request to the Court to have a Restraining Order discharged.

1.413 In 2015 a Peer Review by Safelives[42] of MARAC arrangements in Staffordshire and Stoke-on-Trent, identified strengths, but also a number of deficits, in those arrangements.

1.414 The areas for development included a number of issues which were evident in relation to the MARAC held on 9 December 2014 in relation to Z and N:

- MARAC being seen as an end in itself rather than as part of a process, with an absence of agreed actions being monitored and their impact evaluated.
- Cases presented by the Police chair of the MARAC from a pre-prepared list of risk and trigger factors, reducing the likelihood of comprehensive and up to date information being provided by the referring agency and others.
- A lack of focus on actions to address the perpetrator's behaviour. Arch informed the Review Panel that through the MARAC process an offer of a Perpetrator programme could have been made to N if he was willing to engage with them.
- Delay from the index incident to the MARAC, with an absence of information sharing in the interim, and with actions to address risk being delayed on the basis of a MARAC having been planned.

1.415 A further deficit in relation to the December 2014 MARAC process was inadequate consideration of how Z would be engaged in the process, including advising her of the MARAC; or whether information should be shared with Z about N's history of violence under the Domestic Violence Disclosure Scheme[43].

1.416 Overall there is no indication that the MARAC made any contribution to reducing risk of violence in the relationship of N and Z.

1.417 The issues identified by the Peer Review, in conjunction with significant increases in the number of cases referred to MARAC which could not be met within the existing organisational framework and resource capacity, led to a review by an officer of the Staffordshire and Stoke-on-Trent MASH and consideration of alternative provision models. From this, in 2017, a project commenced, using pilot localities and then wider roll out, to implement a devolved MARAC model across Staffordshire and Stoke-on-Trent. It is intended that these arrangements will lead to more timely and effective intervention, with greater

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[42] Previously "Coordinated action against domestic abuse" (CAADA).
[43] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

engagement of relevant partner agencies. The Review Panel were advised that indications from the pilot sites are to date positive in this regard.

1.418 The Review Panel recommend that:

***The Responsible Authorities Group request that the implementation of the recommendations from the review of MARAC effectiveness be taken forward across the force area, and that the local approach for Stoke-on-Trent be developed, agreed and implemented as a matter of urgency, in consultation with the Responsible Authorities Group.***

N as a victim of domestic abuse?

1.419 The Review Panel considered whether N at any point prior to the fatal incident was a victim of domestic abuse and whether he should have been recognised and responded to as such.

1.420 The Review Panel concluded that prior to the fatal incident N was primarily the perpetrator of abuse against Z. This followed a history of violence and abuse towards three previous partners which had resulted in him be convicted and the subject of an Order intended to curtail his abusive behaviour.

1.421 On the one occasion that N alleged that he was the victim of violence and abuse by Z it was established that he was in fact the perpetrator of abuse against Z. The Review Panel concluded that N contacting the Police and alleging that he was the victim of abuse was only a means of deflecting attention from the abuse which he had perpetrated. This mirrored his actions in his former relationship with S.

1.422 The Review Panel did note that in the media attention surrounding the death of N he had very much been presented as a victim and no mention of his history or violence to women had been made.

1.423 Conversely all information available to the Review Panel indicated that that Z had always been a victim of violence prior to the fatal incident, never the perpetrator.

1.424 In relation to the fatal incident the Review Panel noted that Psychiatrists appointed by both prosecution and defence concluded that Z was suffering from a form of Post-Traumatic Stress Disorder (PTSD); 'Battered Woman Syndrome'. Further, that notwithstanding this she pleaded guilty to Manslaughter, informing the Review Panel Chair that "*It would not feel right if I was found not guilty and just walked away. I needed to go to prison to move on, it was the right thing to do*"; adding that she was certain she had made the right decision, *"It was my choice to be with him, I loved him, no matter how he treated me."*

Discrimination affecting agencies' responses to N and Z

1.425 Following a specific request from N's family the Terms of Reference for the IPCC investigation included consideration of whether the Police response following the 999 call on 30 May 2015 was influenced by any form of prejudice, discrimination or pre-conceived judgement against N on the part of the Police.

1.426 The IPCC investigation found no evidence that the response provided was negatively impacted by prejudice or negative perceptions from individual Officers or Staffordshire Police as a whole. The Review Panel reached the same conclusion on this issue.

1.427 The Review Panel also considered whether the ethnicity of the men in whose company Z was found in early 2013 may have affected the responses of the Police or Children's Social Care in respect of Z being at risk of sexual exploitation. Assurances were provided by both organisations that this was not the case.

1.428 With the exception of Z's age, when she was referred to Stoke-on-Trent City Council in 2013, the Panel identified no other protected characteristics which were relevant to the responses of agencies involved in this Review.

Effectiveness of the multi-agency approach to Child Sexual Exploitation

1.429 Between January and June 2013 Z came to the attention of the Police on 7 occasions (and was possibly the subject of one further report) in ways which suggested that she was subject to or at risk of Child Sexual Exploitation.

1.430 Most of these do not appear to have led to any recognition by the Police Officers involved that Z was at risk.

1.431 One occasion, in January 2013, did lead to her appropriately being referred to the Stoke-on-Trent Children's Social Care SRT. No action was however taken in respect of this referral, Z was not referred to the multi-agency CSE Panel and the case was closed, authorised by a Practice Manager, on 25 February 2013. The reason that this opportunity to intervene was missed has not been established, although there are suggestions that Z's age, at that time 17 years and 9 months, may have been a factor.

1.432 It is important that professionals across all agencies recognise that young people do not become any less vulnerable to exploitation as they approach adulthood and that at any age they should not be viewed as consenting to their own exploitation.

1.433 Notwithstanding this, victims of Child Sexual Exploitation often do not see themselves as such. Many children, and professionals, can misinterpret relationships as consensual and fail to recognise the exploitation involved. This can contribute to misplaced feelings of loyalty or shame on the part of victims, many of whom will consequently not engage with services, and also a failure to identify abusive situations on the part of professionals. This misinterpretation of relationships is evident in the perspective which Z related to the Review Panel Chair.

1.434 It is accordingly uncertain whether an appropriate response from Children's Services would have made Z any safer as it would have required her to have engaged in a meaningful way with the assessment. Nevertheless an assessment should have been conducted and Z should have been referred to the multi-agency CSE Panel, maximising the chances for effective intervention.

1.435 Children's Social Care informed the Review Panel that the information that Z was at risk of Child Sexual Exploitation would now trigger an assessment, using the risk factor matrix[44], by any professional working with her; and that these processes are embedded. All medium and high risk assessments are considered at the multi-agency operational CSE panel. This is a well-attended, well-established multi-agency forum with key safeguarding partners around the table.

1.436 The Review Panel was further informed that an experienced safeguarding Social Worker from SRT joined the Police Child Sexual Exploitation Team in November 2013. As a result there has been a very much stronger understanding of Child Sexual Exploitation and better links made between the Police and Children's Social Care safeguarding teams. This has been positively highlighted in both an independent review of Child Sexual Exploitation and Missing Services (Chanon Consultants: May-July 2014) and through an Ofsted inspection in June 2015.

1.437 More recently, in September 2018, Staffordshire Police launched a specialist Child Protection and Exploitation Team (CPET), within the Specialist Investigations Department; with a remit to investigate all serious and complex crime against children, including sexual exploitation and trafficking. The team comprises 49 Detective Officers working alongside dedicated Child Sexual Exploitation Social Workers.

1.438 Ensuring that the services for children exposed exploitation are as good as they can be is inherently desirable. Effective responses are however also important to addressing the longer term impact of exploitation and other adverse childhood experiences on the individual when they are an adult.

1.439 In this respect a response to Z's situation in early 2013 which included recognition of Z as a victim of exploitation and provision to her of services as such, may have reduced Z's vulnerability as a young adult and consequently her susceptibility to abusive treatment by N.

1.440 The Review Panel recommend that:

***The Responsible Authorities Group write to the Stoke-on-Trent Safeguarding Children Board and the (Staffordshire and Stoke-on-Trent) Child Sexual Abuse Forum to bring the findings of this review to their attention and recommend that they:***

- **a.** ***seek reassurance from partners that their processes and training provision enable all staff to effectively identify and respond to children at risk of Child Sexual Exploitation, and***
- ***b. reinforce the message that young people do not become any less vulnerable to exploitation as they approach adulthood and that at any age they should not be viewed as consenting to their own exploitation.***

[44] A Risk Factor Matrix has been in use since 2013 across Stoke-on-Trent. In September 2017 a new CSE risk factor matrix was launched and all practitioners are expected to apply this where there are CSE concerns. Medium and High Risk cases are referred to Children's Social Care. In respect of low risk cases a specialist provider (Catch 22) advises on work that can be undertaken to reduce risk to the child.

**CONCLUSION**

2.1 Expert evidence at the trial of Z indicated that the injury that N suffered would not have been survivable even with immediate treatment and he is likely to have died within minutes of the 999 call which was made at 0354 on 30 May 2015. Accordingly, none of the issues relating to the Police and WMAS responses on that date impacted on whether N would have died as a result of the injury which he sustained.

2.2 Taking into account the violence from N towards his previous partners and the information known to Police, and to lesser extent partner agencies, it was predictable that violence would continue within the relationship of N and Z.

2.3 More effective operational responses to reported incidents, better sharing of information held by University Hospitals of North Midlands and SHA, and a robust MARAC arrangement may have led to a greater appreciation of the level of risk and a more effective approach to intervention. To be effective such intervention would, however, have had to over-ride the clear wish of Z and N to remain in a relationship and the repeated refusal of Z to engage with professionals. There were options available to do this, either through a more rigorous approach to gathering and using evidence to support prosecution or, temporarily at least, using powers under the Crime and Security Act 2010, but the opportunities to do so were missed.

2.4 In any event it is doubtful whether they would have secured a reduction of the risk to Z and N in the longer term. With hindsight it is clear that, set against a background of earlier exploitation and grooming at the hands of older men and the absence of recognition of and support to Z as a victim of this, N's treatment of Z undermined her integrity as an individual to the point where, despite the violence and abuse which she was subjected to, Z saw (and still sees) an abusive relationship with N as a positive experience and preferable to being without him. In this context it seems inevitable that the relationship would have continued until the unrelenting abuse led to the death or at least serious injury of one or other party.

**RECOMMENDATIONS**

3.1 The Review Panel made five recommendations from this Review, that:

1. ***The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should seek assurances that agencies supporting victims of domestic abuse are fully utilising existing tools and powers to support victims of domestic abuse, including Domestic Violence Protection Notices/Orders and the "right to know" under the Domestic Violence Disclosure Scheme (Clare's Law).***

2. ***Upon the enactment of the current Domestic Abuse Bill into law, the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should widely promote the provisions of the new Act, and should seek assurances that agencies supporting victims of domestic abuse have in place plans to fully utilise the new tools and powers within the Act.***

3. ***The Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should ensure that all domestic abuse support service providers across Stoke-on-Trent and Staffordshire are made aware of this review and its findings, and seek assurances from the providers that their case closure policy is robust and in line with national guidance.***

4. ***The Responsible Authorities Group request that the implementation of the recommendations from the review of MARAC effectiveness be taken forward across the force area, and that the local approach for Stoke-on-Trent be developed, agreed and implemented as a matter of urgency, in consultation with the Responsible Authorities Group.***

5. ***The Responsible Authorities Group write to the Stoke-on-Trent Safeguarding Children Board and the (Staffordshire and Stoke-on-Trent) Child Sexual Abuse Forum to bring the findings of this review to their attention and recommend that they:***

   a. ***seek reassurance from partners that their processes and training provision enable all staff to effectively identify and respond to children at risk of Child Sexual Exploitation, and***

   b. ***reinforce the message that young people do not become any less vulnerable to exploitation as they approach adulthood and that at any age they should not be viewed as consenting to their own exploitation.***

3.2 Recommendations for action to improve their services were also made by the agencies which contributed to this Review. These recommendations are provided at Appendix B.

3.3 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group.

3.4 A further recommendation to Staffordshire Police was made by the Independent Police Complaints Commission, which will retain ownership of its completion:

***That in conjunction with upgrades to their IT system, Staffordshire Police considers operating a process in the Control Room to proactively audit un-resourced incidents and to demonstrate that, where a response has been***

***delayed beyond the target time limit, the incident has been regularly reviewed by a supervisor.***

## Appendix B

## Management Review Recommendations

**UHNM**

**5** Where a patient discloses Domestic Abuse the discharge letter to the GP will reflect the level of abuse and any actions taken.

**6** UHNM to review, with the Principal Officer for MASH, the process for the sharing of patient details with external agencies when the patient does not consent.

**Staffordshire Police**

**7** Staffordshire Police to utilise location markers for all the known residential addresses for each person in relationships giving cause for concern of Domestic Violence / Abuse.

**Stoke-on-Trent City Council Early Intervention and Children's Social Care**

**8** Briefing to SRT to ensure that all referrals relating to CSE are considered in relation to risk and vulnerability and are not to be determined by age. This is to ensure that all children are offered the opportunity to engage in services to make them safer.

**9** Disseminate message through CSE training that a child is a child until they are 18 years and should be offered an assessment as this may provide a smooth transition into accessing services for adults

**Staffordshire Housing Association**

**10** Domestic abuse awareness training and practical guidance on how to deal with such issues is delivered for all customer facing staff within Staffordshire Housing Association.

**11** Staffordshire Housing Association to review its ASB and Domestic Abuse policies and consider if clearer guidance can be provided if it is believed that domestic violence or abuse is a cause of the ASB issue reported. Consider should also be given whether an information exchange request should be submitted for all reports of violence or domestic abuse. SHA will consider if reports of violence or domestic abuse, and whether domestic abuse should be reported to Arch's domestic abuse services.

**12** Ensure that Staffordshire Housing Association`s ASB recording systems are able to easily recognise infrequent, but repeat incidents of ASB to ensure that appropriate action is taken.

**13** Staffordshire Housing Association to consider agreeing a process when domestic abuse is reported via a third party who wishes to remain anonymous, and in cases where the victim and perpetrator do not report the issue, engage with services or consent for action to be taken.

**14** Staffordshire Housing Association to improve information sharing across the group, specifically with Arch domestic abuse services, in situations where services are dealing with the same customers who may be at risk.

**National Probation Service**

**15** Where there are known issues of domestic violence and agency involvement there should always be an explicit victim protection plan in order to ensure all possible preventatives steps have been taken to avoid future harm.

**West Midlands Ambulance Service**

**16** West Midlands Ambulance Service Safeguarding Manager to request review of case by Emergency Operations Centre Clinical Manager to review and audit original call and also a review of information sharing with other emergency services where West Midlands Ambulance Service have been the sole agency to receive the call - findings from this to be fed back to safeguarding manager.