PENNINE LANCASHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Marianne

Chair: David Hunter

Author: Paul Cheeseman and Carol Ellwood

Date: October 2019

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1. THE REVIEW PROCESS

1.1 This executive summary outlines the process taken by Pennine Lancashire Community Safety Partnership [the CSP] following the homicide of Marianne. It includes Marianne's story, the views of her family, friends and work colleagues and ends with learning and recommendations.

1.2 Marianne's Mother provided the following tribute about her-

'Marianne was my eldest daughter and the day she was taken, so was part of me. I write this on behalf of all her family, including her two young children.

Since losing Marianne the whole family has been affected in so many ways. Grief follows us around like a shadow. Complete happiness and contentment in our lives is no longer within our reach because of what has happened to Marianne. Our whole lives have changed beyond recognition not only losing Marianne but becoming 'parents' to our grandchild when our own children are all flying the nest. Our well-planned future is no longer our own. There is a huge Marianne sized hole in all our hearts, a void that will never heal, memories and photographs are all we have left. Even happy memories are painful to think about now because we know she should still be here making many more memories and nurturing her children, all she ever wanted to be was a mummy.

Marianne was such a wonderful, loving mum. Family, especially her children were her absolute world and everything Marianne did she did for them or other members of her family. Her children have the very difficult task of not only growing up without a mummy, but inevitably, growing up knowing what happened to her. Her little children will grow up having no real memories of her as they are so young, and they have a lifetime of issues to face without their mummy. To hear them still crying out in the night "Mummy, Mummy", a call that she cannot answer just adds to our already broken hearts.

Marianne loved life, she was mischievous and funny. She worked full-time and was a single mum of two little children. She filled her spare time with trips for the children or messy play at home which she loved as much as they did. She loved family time when we were all together and we would often holiday all together.

As a family we cannot possibly put into words how the loss of Marianne has made us feel. It affects every moment of our everyday lives. The horrific

circumstances in which she died are still beyond our comprehension. "Our lives will never be the same" these words seem such a cliché but are so true. NOTHING is ever going to be the same. Nothing is 'normal', we try to create a new normal for the sake of Marianne's children, but we struggle every day.

Every day we face new challenges without Marianne and struggle to function at a level that was taken for granted before the events of that awful night. The sickening events of that night often plague our waking and sleeping moments, the horrific, shocking and brutal last moments of her life. She is missed more than words can say'.

1.3 In September 2019 Marianne received the Queen's Commendation for Bravery [posthumous]. The official citation contained the following information. '…neighbours heard someone screaming for help and on further investigation, found that they were coming from her home where she lived with her small child. Inside the premises, Marianne was subject to a sustained, brutal attack by her former partner who earlier came to her home for that purpose, armed with a kitchen knife. The attacker then doused Marianne with petrol and subsequently set the house on fire. The neighbours attempted to open the door but found that it was locked. As a result, the landlady and the police were called to the scene.

The attacker then started a fire which quickly spread throughout the house. Her child was found by a police officer sat upright on the kitchen counter in wet clothing. The tap was running and the window was open, suggesting that Leanne had doused her daughter in water and attempted to get her out of the window, away from the fire.

Once the police arrived, an officer was able to pull Marianne's daughter to safety quickly through a window. Marianne was also rescued but later sadly died in hospital from her injuries.

Her family said they were "immensely proud and honoured that Leanne's final actions as a devoted mum have been acknowledged in such a way"

1.4 The following pseudonyms agreed with Marianne's family are used within the report.

Name	Relationship	Age	Ethnicity
Marianne[1]	Victim	25	White British female
Ajaam	Perpetrator	39	British Asian/Non-practicing Muslim
Child 1	Marianne's eldest child	n/a	White British
Child 2	Child of Marianne and Ajaam	n/a	Mixed race.

1.5 When he killed her, Marianne had been in a relationship with Ajaam for two and a half years. Child 1, Marianne's elder child from a previous relationship, lived with them together with Child 2. At the time of her death Marianne was no longer in a relationship with Ajaam and she lived with her children.

[1] Marianne's family chose her pseudonym and the DHR Panel chose the offenders.

2. CONTRIBUTORS TO THE REVIEW

2.1 The following agencies provided information to the review.

Lancashire Constabulary	Lancashire County Council Children's Services
Lancashire Care NHS Foundation Trust (Health Visiting)	Lancashire Care NHS Foundation Trust (Mental Health)
East Lancashire Clinical commissioning Group (CCG)	East Lancashire Hospitals NHS Trust (ante-natal care)
Bolton NHS Foundation Trust (Midwifery)	Bright Futures Day Nursery (Private)
North West Ambulance Service (NWAS)	

2.2 Some of Marianne's family, friends and work colleagues some knew some aspects of her relationship with Ajaam. Their contribution is incorporated within section 6 of this report. Ajaam and his family declined to take part in the review.

3. THE REVIEW PANEL MEMBERS

Name	Job Title	Organisation
Paul Cheeseman	Support to Panel chair and author	Independent
Dee Conlon[2]	Operations Manager	Lancashire Victim Services
Jill Cooper	Specialist Safeguarding Practitioner	East Lancashire Hospitals NHS Trust
Carol Ellwood	Support to Panel chair and author	Independent
Andrea Hull	Senior Manager Children's Social Care	Lancashire County Council
David Hunter	Panel Chair	Independent
Damian McAlister	Review Officer	Lancashire Police
Sam McConnell (first meeting only)	DA Lead	Pennine Lancashire Community Safety Partnership/Burnley Borough Council
Yvonne Jackson	Specialist Safeguarding Practitioner	East Lancashire Clinical Commissioning Group
Robert Ruston (first meeting only)	Victims and Vulnerable People Lead	Office of Police and Crime Commissioner Lancashire
Sandra Thompson		Lancashire Care NHS Foundation Trust
Alison Wilkins	Community Projects and Partnership Manager	Rossendale Borough Council
Sarah Wright	Safeguarding Practitioner	North West Ambulance Service

3.1 The Chair of Pennine Lancashire Community Safety Partnership was satisfied that the Panel Chair was independent. The Panel Chair believed

[2] Dee brought expertise to the panel from her training and position as an Independent Domestic Violence Advocate (IDVA). An IDVA is a person that is trained to provide support and safety planning to victims of domestic abuse.

there was sufficient independence and expertise on the Panel to prepare an unbiased report.

3.2 The panel met four times and the review chair was satisfied that the members were objective and did not have any operational or management involvement with the events under scrutiny. There were no reported conflicts of interest.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 On 5 October 2017 Pennine Lancashire Community Safety Partnership determined the criteria for a domestic homicide review had been met, and thereafter appointed David Hunter as the Independent Chair. Paul Cheeseman wrote the overview report and executive summary. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. They were supported by Carol Ellwood who was gaining experience in the role of domestic homicide reviews. All three are former UK police officers. None of them has been employed by any of the agencies involved with this review and were judged by the Chair of Pennine Lancashire Community Safety Partnership to have the necessary experience, skills and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The purpose of a Domestic Homicide Review is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to policies and procedures as appropriate;

Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7] The Guidance was update in December 2016.

5.2 Timeframe under Review

The review covers the period 1 November 2014 to 10 August 2017.

5.3 Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Marianne as a victim of domestic abuse and what was the response?
2. What is your agency's policy on 'routine enquiry'[3] and was it followed in this case?
3. What knowledge did your agency have that indicated Ajaam might be a perpetrator of domestic abuse and what was the response?

[3] Routine Enquiry is where a professional asks the person they are providing services to a direct question of whether they are (or have) experienced domestic violence and abuse.

4. What services did your agency offer to Marianne and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Marianne from seeking help for the domestic abuse?

5. What knowledge or concerns did the victim's family, friends and employers have about Marianne's victimisation and did they know what to do with it?

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

7. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Marianne and Ajaam, or on your agency's ability to work effectively with other agencies?

8. What learning has emerged for your agency?

9. Are there any examples of outstanding or innovative practice arising from this case?

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Rossendale?

6. SUMMARY CHRONOLOGY

6.1 Marianne

6.1.1 Marianne was one of three daughters. Her parents separated and her Mother re-married. Marianne was brought up with her siblings and stepsiblings. She attended Carlisle University and took a degree course to qualify as a teacher. She met her previous partner there and gave birth to Child 1 during her final year of study. After leaving University, and first living with Marianne's family, the couple bought a house together. They separated in September 2014. The following month Marianne met Ajaam who worked at the same place as she did.

6.2 Ajaam

6.2.1 As he did not wish to engage, the panel learned little about Ajaam's background. He was born in the UK, has no convictions recorded against him and was not known to UK Police Forces prior to the incident with Marianne. Ajaam worked as a Carer. Before meeting Marianne he had been in a relationship with a partner for 17 years. They never married and did not have any children.

6.3 The Relationship

6.3.1 In December 2014 Ajaam moved into Marianne's house. The following February the couple and Child 1 moved into his parent's house in Manchester. Ajaam's parents do not speak English and Marianne found this move difficult. After four weeks the couple and Child 1 moved to a property in Lancashire. Shortly after Marianne became pregnant.

6.3.2 Marianne's mother said her daughter received pressure from Ajaam's family to marry him. Despite her reluctance, Marianne agreed to take part in a 'Nikah'[4] ceremony at his parent's house. During her pregnancy Marianne

[4] In a Muslim wedding ceremony, the marriage contract is signed in a *Nikahh*, in which the groom or his representative proposes to the bride in front of at least two witnesses. The bride and groom demonstrate their free will by repeating the word *qabul* ["I accept," in Arabic] three times. Source: https://www.theknot.com/content/muslim-wedding-ceremony-rituals

was seen by a Health Visitor and was asked about domestic abuse as part of routine enquiry. She did not make any disclosures.

6.3.3 After Child 2 was born, Marianne, Ajaam and the children went to live in her mother's house. The couple remained there until they separated in April 2017. Marianne then moved to another address where she lived with both children. At the time of her death, Marianne worked at a local nursery where her children also attended.

6.3.4 Work colleagues, family and friends provided information to the homicide enquiry and to the DHR about Ajaam's behaviour towards Marianne. The examples below indicate that Ajaam perpetrated domestic abuse[5] upon Marianne. His behaviour included coercive and controlling acts and there is evidence Ajaam was also responsible for assaults upon both Marianne and an assault upon Child 1;

- Ajaam would sit outside the nursery in his car waiting for Marianne to take her lunch break. He would then join her while she ate;
- Marianne disclosed to a staff member that Ajaam would not let her come to work unless he came with her;
- Her family said Ajaam would sit outside the nursery all day waiting for her;
- Ajaam would tell Marianne to 'cover her shoulders' as well as isolating her, by not babysitting for her when she wanted to go out;
- Marianne's mother said Ajaam was very moody. He would storm around the house when arguing with Marianne;
- Marianne was seen crying at work. She told a colleague Ajaam had pulled Child 1 around the kitchen by her hair. When Marianne asked

[5] The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

him to stop he then pulled her around the kitchen in a similar manner;

- When he went to collect Child 1, Marianne's former partner saw she had a black eye. Child 1 told him her mother and Ajaam were constantly arguing. The child heard Ajaam tell her Marianne he would take Child 2 from her and to Pakistan;
- Ajaam was seen on one occasion by a family member 'squaring up' to Marianne;
- Marianne telephoned work to say she was going to be late. This was because Ajaam had been violent and grabbed her in front of the children;
- On two occasions Marianne was seen at work with bruising. On one of these occasions she said Ajaam had been violent towards her. On the other occasion she said the injury had been caused by Child 1;
- Marianne locked Ajaam out of the house and he climbed a drainpipe to get in. She telephoned a friend who thought Marianne was scared;
- Ajaam was concerned Marianne was seeing someone else. He was extremely jealous;
- He bombarded Marianne with telephone calls and text messages;
- After Marianne separated from Ajaam she was frightened he may come after her. She therefore programmed an emergency number into her telephone and showed Child 1 how to use it.

6.4 Information known to Statutory Agencies

6.4.1 The DHR found that no statutory agency held any information concerning the matters described in paragraph 6.3.4.

6.4.2 On 2 March 2015 Marianne attended at her GP practice complaining of stress at work. It was recorded that she was ten weeks pregnant and worked as a carer. During an appointment with a Health Visitor on 17 May 2015 Marianne was asked about domestic abuse and made no disclosures. During her maternity care there are no records that 'routine enquiry' was made with Marianne. However, the DHR panel heard that the timing and appropriateness of asking a 'routine enquiry' needs to be considered within the presenting medial circumstances and the enquiry made in the sole presence of the person receiving the service.

6.4.3 The DHR heard that Ajaam had contact with his GP in July 2015 when he had suicidal thoughts and low mood following the cessation of his previous relationship. The GP referred him to the Lancashire NHS Foundation Trust Mental health team who referred him for 'talk therapy'. He did not voice

any thoughts, plan or intent to harm others. There is no reference in the GP records that questions were asked of Ajaam in relation to domestic abuse, family details and his current living arrangements. Ajaam did not attend the appointment for 'talk therapy' and there is no record to indicate the failure to attend was followed up by any agency.

6.4.4 After the birth of Child 2, Ajaam, Marianne and the children were visited by the Universal Health Visiting Service. No safeguarding concerns or relationships problems were identified between Marianne and Ajaam. Child 2 was admitted to hospital with sepsis and, after she was discharged, the agency undertook a further home visit on 1 December 2015. Again, no safeguarding or relationship problems were identified.

6.4.5 The DHR found that no statutory agency knew of the couple's separation around Easter 2017. On 5 July 2017 Ajaam visited his GP with low mood. Ajaam told his GP he was going through a bad-period and said his partner had left him. He said he lived alone and that he could not face work and slept poorly. There was no record of self-harm, drug or alcohol use and Ajaam was prescribed medication.

6.4.6 A follow up appointment took place on 18 July 2017. Ajaam told his GP the medication had not helped. He said he was not suicidal or thinking of self-harm. He was prescribed further medication. No referral or contact with Mental Health Services was made following either of these visits by Ajaam to his GP. The DHR panel heard that it may have been the GP thought these unnecessary. However, the DHR panel felt the GP should have asked Ajaam about domestic abuse.

6.4.7 At 22.44 hours on a date in the summer of 2017, Lancashire Police received a call from a neighbour of Marianne stating they could hear screaming, the sound of a fire alarm and that her house was on fire. Emergency services attended address one and Marianne, Ajaam and Child 2 were rescued from the house and taken to hospital with significant injuries.

6.4.8 Sadly, three days after the incident Marianne died in hospital. A post mortem examination found she died from burns and multiple stab wounds. Child 2 was later discharged from hospital into the care of the maternal family. A homicide enquiry established Ajaam had been planning to attack Marianne for several weeks. On the night he carried out the attack he went to address one with Child 2 claiming the child wanted to see its mother. Once inside, he attacked Marianne and started a fire in the kitchen with petrol he brought with him in a fuel canister.

6.4.9 In Spring 2018, Ajaam appeared at a Crown Court and pleaded guilty to the murder of Marianne and arson with attempt to endanger life. Ajaam was sentenced to life imprisonment for murder with a minimum tariff of 30 years and 10 years to run concurrently for the offence of arson. The charge of attempt murder of Child 2 was left to lie on file. He will not be released from prison until he has served at least 30 years.

7. FINDINGS

17.1 The DHR panel found that Ajaam subjected Marianne to domestic abuse. There was evidence that Ajaam used force against Marianne such as 'squaring up' to her and pulling her and Child 1 by the hair. The panel is in no doubt that the physical injuries Marianne was seen with at her place of work were caused by Ajaam when he abused her.

17.2 While Marianne told work colleagues about Ajaam's physical abuse of her (she was seen with a black eye on at least two occasions and told work colleagues about her and Child 1 being been pulled by their hair) these were not recorded by the nursery nor shared with statutory agencies. While the nursery had procedures in place for dealing with disclosures made by children and sharing that information they had never had to deal with a disclosure from a member of staff. They did not recognise what Marianne told them was domestic abuse. When Marianne left Ajaam, her employer at Nursery 2 mistakenly believed she was out of danger.

17.3 In fact, as has been identified in many other reviews[6] and is embedded in practice, the risk to a victim increases at the point of separation. That was exactly the case with Marianne and in a previous DHR [Chan] in Rossendale when a victim was killed by her partner. Families often feel confused, conflicted and concerned about how to support their loved ones without pushing them away. Victims feel that they cannot open up to their families without actions being taken. As in the case of Chan, the DHR panel believe there is some important learning here about raising the awareness of friends, family and work colleagues about how domestic abuse can manifest itself and what to do with that information if it is disclosed.

17.4 The DHR panel found no evidence statutory agencies had knowledge of what Marianne had to endure at Ajaam's hands. While there were some missed opportunities to ask Marianne routine questions, there was no connection between those and her homicide. The panel felt it was important to highlight that victims often suffer in silence through many

[6] This was a learning point already identified in the case of 'Chan', a previous domestic homicide review in the Rossendale, Pennine Lancashire Community Safety Partnership area.

episodes of abuse before they make a disclosure[7]. That is why it is important that, at every opportunity, routine questions are asked.

17.5 When Ajaam visited his GP with thoughts to harm himself, the panel felt the GP should have asked him routine questions about his relationship and whether there was domestic abuse. Mental Health is an issue that can increase the risk of domestic abuse[8]. Similarly, Marianne's GP should have asked these routine questions when she attended with work related stress and at the time she became pregnant. Pregnancy is a factor that can significantly increase the risk of domestic abuse.

17.6 The panel felt there were too many variables to conclude there was a connection between the failure to make routine enquiry and Marianne's death. However, the panel felt the learning here is that opportunities need to be taken to ask questions.

17.7 Finally, the DHR panel concluded Ajaam was a moody, controlling and abusive man who inflicted physical harm upon Marianne and Child 1 and tried to control her life. However, there was simply no information available to statutory agencies that would have allowed them to put measures in place to protect Marianne from Ajaam.

[7] The Crown Prosecution Service reported that women suffer on average 35 incidents of domestic violence before reporting their experiences.

[8] For example, Mental health issues were present in 25 of the 33 intimate partner homicides reviewed by the Home Office: Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

8. LEARNING

Note: The DHR did not identify any examples of outstanding or innovative practice.

8.1 Agencies

Bolton NHS Foundation Trust

- Receipt of transfer information needs to be clearly documented;
- Transfer to Health Visiting Service to be documented;
- Update Post-Natal Care Planning standards (Trust Standard Operating Procedure SOP);
- Investigate the possibilities of 'routine questioning' when women are 'unknown' in the postnatal period.

East Lancashire Clinical Commissioning Group

Learning for both GP practices

- Mental health consultations with the GP did not include DA enquiry;
- There was no enquiry about existing children when Marianne and Ajaam presented with stress and low mood respectively;
- It is not known if clinicians were aware of Marianne and Ajaam's inter-racial relationship and whether cultural differences were taken into consideration.

Learning for Marianne's medical practice

- Post-natal consultation did not include DA inquiry;
- Not all consultations included details of who had brought the child.

Learning for Ajaam's medical practice

- There does not appear to have been any follow up after Ajaam did not attend his Minds Matter appointment;
- There did not appear to be recognition of increased risk of DA following separation.

East Lancashire Hospitals NHS Health Trust

- At maternity booking appointment women (and their partners/family are told that it is Trust policy that the woman is seen at least once on her own (for all, or part of an antenatal appointment). There is space for this to be documented on page 4 of Antenatal Book 1;

- At the 28-week appointment there is a reminder to check if routine enquiry has been asked (Page 23 of Antenatal Book 1);
- ELHT is considering how the guidance included in NICE Guidance PH50 Domestic Violence and Abuse, can be implemented, specifically recommendation 6 which states: "Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.";
- Marianne was seen within a clinic and could have been asked Routine Enquiry at this time;

N.B. Some of the learning identified in this IMR has already been acted on and implemented between Marianne's contact with maternity service and her final attendance, namely:

- Clear documentation of who accompanies a woman when she attends each antenatal appointment;
- All women and their families/partners are told that Trust policy is that ALL women are seen on their own for all or part of at least one antenatal appointment.

8.2 The Domestic Homicide Review Panel's Lessons

8.2.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at paragraph 8.1. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Lesson 1 [Panel recommendation 1 and 2]
Narrative
Marianne was at risk from Ajaam because he perpetrated domestic abuse upon her and Child 1. He exercised coercive and controlling behaviour as well as physically abusing Marianne and Child 1. Family and friends knew about some, although not all, of his behaviour. Marianne's family and friends did not appear to recognise at the time that Ajaam's behaviour amounted to domestic abuse.
Lesson
It is not unusual for family and friends not to recognise when the actions of a perpetrator may amount to domestic abuse. This is particularly so

when the perpetrator engages in coercive and controlling acts. Agencies need to recognise this, and the need to change the public perception about domestic abuse particularly to increase knowledge about the dangers of coercive and controlling behaviour and what to do with that information.

Lesson 2 [Panel recommendation 3]
Narrative
Marianne told colleagues at the nursery where she worked about some of the domestic abuse she suffered at the hands of Ajaam. She also told them that Ajaam had pulled Child 1 by the hair. The nursery and its staff failed to separate the personal relationship they had with Marianne from the professional relationship they should have had with her as a colleague and employee and as a Mother of Child 1 who was a pupil there. The nursery and its staff failed to follow safeguarding practices.
Lesson
Nurseries as places of early learning need to have robust policies, procedures and training in place. These need to recognise the duty of care to safeguard the wellbeing of their staff and all their pupils.

Lesson 3 [Panel recommendation 1]
Narrative
When Marianne separated from Ajaam she was frightened he may come after her. She programmed an emergency number into her telephone and showed Child 1 how to use it. Ajaam used subterfuge to gain entry to address one after he had separated from Marianne. While in the house he attacked Marianne and set fire to the property killing her and injuring Child 2.
Lesson
The risk to Marianne increased significantly after she separated from Ajaam. This is a lesson that has been learned in many other domestic homicide reviews.

Lesson 4 [Panel recommendation 4]
Narrative
Ajaam was employed as a carer. He was therefore in a position of trust and responsible for the welfare of vulnerable people. The controlling and coercive behaviour he displayed towards Marianne and other examples of his abusive behaviour towards her and Child 1 meant that he was also potentially a risk to those he cared for. That was not recognised by those who knew about his behaviour, including Marianne's family, friends

and colleagues at the nursery.
Lesson
Perpetrators of domestic abuse who are in a position of trust and who are caring for vulnerable people such as the elderly or children may present a risk to them as well. When agencies, such as the nursery, become aware of such information they need to ensure it is referred through safeguarding processes.

Lesson 5 [Panel recommendation 5]
Narrative
During the enquiry into the homicide of Marianne, part of the focus of the investigation was upon the nursery where Marianne worked. Criminal justice agencies identified that Marianne made disclosures about domestic abuse to the nursery and staff there. Criminal justice agencies did not recognise that the disclosure Marianne made concerning domestic abuse, and safeguarding of her children, was not dealt with appropriately by the nursery.
Lesson
As well as concentrating upon the core task [investigation of the homicide] criminal justice agencies should have recognised the wider safeguarding issues for children exposed to domestic abuse and acted in relation to the nursery's none-compliance with safeguarding practice.

Lesson 6 [Panel recommendation 6]
Narrative
Victims who are pregnant may be at increased risk of domestic abuse. Marianne consulted her GP about stress at work at which time she was ten weeks pregnant. While she was asked about her home life there was no specific record that she was asked direct questions about domestic abuse.
Lesson
Pregnancy within the previous 12 months was found to double the risk of physical violence. Pregnancy and mental health presentations are two of the situations in which NICE guideline 50 recommends routine inquiry about domestic abuse, even where there are no indicators of abuse. Even if there is no disclosure made, or abuse is not happening at that time, it gives a message of support to the patient.

9. RECOMMENDATIONS

9.1 The panel and single agency recommendations appear in tables within Appendix A.

Appendix A

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Pennine Lancashire Community Safety Partnership review the ways in which they use social and other forms of media to increase the understanding and knowledge of family, friends and colleagues about the type of behaviour that comprises domestic abuse, including	Local	Undertake a publicity campaign to raise awareness and increase understanding and knowledge about the types of behaviour that are domestic abuse	Pennine Lancashire Community Safety Partnership	Identify lead from Media team. Agree the messages to be publicised and media to be used. Deliver the campaign.	31.01.19 31.03.19 30.06.19	31.12.18 DA signposting posters distributed to GP's across Rossendale. 04.13.19 Contact made with Rossendale BC media lead and Lancashire OPCC Campaign planned in conjunction with Lancashire OPCC.

	coercive and controlling behaviour.						
2	Pennine Lancashire Community Safety Partnership explore ways in which it can increase the understanding and knowledge of family, friends and colleagues about the importance of sharing information and concerns about domestic abuse with agencies. This should include ensuring information is provided to them on what steps they can take to safely support victims of domestic abuse.	Local	Undertake a publicity campaign to raise awareness and increase understanding and knowledge about the importance of sharing information and concerns about domestic abuse with agencies.	Pennine Lancashire Community Safety Partnership	Identify lead from Media team. Agree the messages to be publicised and media to be used. Deliver the campaign.	31.01.19 31.03.19 30.06.19	04.13.19 Contact made with Rossendale BC media lead and Lancashire OPCC Campaign planned in conjunction with Lancashire OPCC.
3	Pennine Lancashire	Local	Write to Lancashire	Pennine	Letter written and	30.06.19	Letter sent 11.01.19

	Community Safety Partnership work with the Lancashire Safeguarding Children Board to assist this and other nurseries in their area to review their policies, systems and training so the risk pupils, employees and their children face from domestic abuse is recorded and, when appropriate, referred through safeguarding processes.		Safeguarding Children Board setting out the recommendation's background. To support Lancashire Safeguarding Children's Board in how it decides to deal with the recommendation.	Lancashire Community Safety Partnership	sent. Initial written feedback from Lancashire Safeguarding Children Board on the request. Identification of what support might be needed for the review and how it can be delivered. Provide support to the Board with the delivery of any training.	30.06.19	20.01.19 Chair, Lancashire Safeguarding Children Board has confirmed that she is happy with the recommendations and will support them, perhaps with a Joint Seven Minute Briefing.
4	Pennine Lancashire Community Safety Partnership work with the Lancashire Safeguarding Children Board to	Local	Write to Lancashire Safeguarding Children's Board setting out the recommendation's background.	Pennine Lancashire Community Safety Partnership	Letter written and sent. Initial written feedback from Lancashire	30.06.19	Letter sent 11.01.19

	assist this and other nurseries in raising awareness and increasing their understanding of domestic abuse as well as in training them about the need to recognise and report the risks presented by perpetrators of domestic abuse who are in a position of trust and therefore might present a risk to vulnerable people in their care.		To support Lancashire Safeguarding Children's Board in how it decides to deal with the recommendation.		Safeguarding Children Board on the request. Identification of what training might be needed and how it can be delivered. Provide support to the Board with the delivery of any training.	30.06.19	20.01.19 Chair, Lancashire Safeguarding Children Board has confirmed that she is happy with the recommendations and will support them, perhaps with a Joint Seven Minute Briefing.
5	Pennine Lancashire Community Safety Partnership work with the Lancashire Criminal Justice Board who should use this case as an example to their	Local	Write to Lancashire Criminal Justice Board setting out the recommendation's background and asking them to consider putting the	Pennine Lancashire Community Safety Partnership	Letter written and sent. Feedback from Lancashire Criminal Justice Board on the request.	30.04.19	

	partners about the importance of identifying non-compliance with safeguarding practice when undertaking investigations or considering the results of investigations.		issue on the Board's agenda so that its constituent agencies can benefit from the learning.		Confirmation that the Board shared the learning.		
6	East Lancashire Clinical Commissioning Group consider ways in which they can raise GP's understanding of the heightened risk factors of pregnancy and improve the use of direct questions and signposting or follow up in appropriate cases. For example by	Local	Any templates used by the practice for antenatal or postnatal consultations should be amended to include domestic abuse screening questions.	ELCCG	Templates produced	31.3.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18 08/02/19 Audit visit to W practice – GP does not routinely see ante natal women RE completed by midwifery service. If ante natal and see's GP for another reason any family stress would initiate RE of DA and GP would use RE if other

	highlighting good practice or making use of the Identification and Referral to Improve Safety [IRIS] programme.						indicators present – there are no ante natal templates. RE is included on post-natal assessment template. 21/02/19 Audit visit to F practice – Ante natal checks do not take place – these are completed by Midwife. GP uses RE in postnatal checks and info about Domestic Abuse included in information given to new parents.
7	Home Office to consider a national campaign aimed at families and friends who have knowledge of domestic abuse on how they can report those concerns to safeguarding	National	Write to the Home Office Domestic Violence Unit setting out the background to the recommendation. Feedback from the Home Office.	Pennine Lancashire Community Safety Partnership	Letter written and sent. Home Office Feedback received.	31.01.19	

	professionals.						

Bolton NHS Foundation Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1.	Update Post Natal Care planning standards [SOP] to include transfer of care information and requirement to document family/household members and social support and who is present at visits.	local	Revised SOP	Maternity	Updated SOP to be implemented and disseminated to all staff Audit of compliance to be completed after 6 months	May 2018 November 2018	Updated in April 2018 however is again under review as part of planning for EPR. Completion date May 2019 Audit of written notes and electronic information system completed in November 2018 for cases discussed at Learning and

							Improvement Panel. To be reviewed annually and is included on Trust Safeguarding Audit Plan for 2019
2.	Consider the value of routine enquiry in post- natal contacts	Local/ region	Review evidence base for post-natal routine enquiry and consider implications for midwifery practice	Maternity	Identify practice regionally in respect of routine enquiry to inform midwifery practice	July 2018	Completed November 2018. Named Midwife link to colleagues in other Maternity Units to share good practice Additional domestic abuse training provided to all maternity staff by Named Midwife/Safeguarding Team

East Lancashire Clinical Commissioning Group

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
NB – any recommendation on routine enquiry should not be implemented until staff have had the relevant training. The practice to which a recommendation refers is denoted by a letter, F for the medical practice attended by Marianne and W for the Medical Practice attended by Ajaam							
3.	Enquiry about family/relationships /social circumstances should be made in mental health consultations as there may be a "child behind the adult". [Keep Me Safe RCGP 2005]. This would enable any risk to children or vulnerable adults to be identified.	FW	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG. After allowing a suitable period for this practice	ELCCG	Audit undertaken, any necessary changes implemented, and audit cycle completed	31.03.19	ELCCG discussed recommendations with both GP surgeries. Both surgeries have specific DA policies and guidelines in place which are up to date. 09.11.18 Training delivered to staff at W practice regarding DA and implementation of the recommendations. W practice has developed the use of Routine Enquiry and

			to become embedded, there should be an audit of random mental health consultations to ensure this is taking place.				are linking DA concerns with children's records and following up mental health referrals. 08/02/19 Audit visit to W practice: random check of records shows exploration of social circumstances and involved children. GP has monthly HV meeting and information sharing processes. Safeguarding concerns would be addressed via safeguarding policy 21/02/19 Audit visit to F Practice. Met with Safeguarding Lead GP. Assurance given that GP explores family/relationships and social situations in

							mental health consultation and evidence visualised in records.
4.	There should be an awareness of possible increased risk of DA in inter-racial relationships.	FW	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG	ELCCG	All staff received domestic abuse training	31.12.18	09.11.18 Training delivered to W Practice regarding DA and implementation of the recommendations. DA in inter racial relationships included in training package. 13.12.18 Domestic Abuse training delivered to F Practice and learning from the DHR shared.
5.	tice staff should receive domestic abuse training.	FW	This should be for all staff, both clinical and administrative, facilitated by East Lancashire	ELCCG	All staff received domestic abuse training	31.12.18	Training on DA given to staff at W and F Practices on 09.11.18 and 13.12.18

			CCG				
6.	NICE guideline PH50 recommends that enquiry about Domestic Abuse should be made in mental health consultations, including when a patient presents with stress, even where there is no indication that such abuse is taking place. Clinicians should incorporate this into their practice. This recommendation is also in accordance with findings from the 2016 Domestic Homicide Review Case Analysis.	W	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG. After allowing a suitable period for this to become embedded, there should be an audit of random mental health consultations to ensure this is	ELCCG	Audit undertaken, any necessary changes implemented, and audit cycle completed	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18. 08/02/19 Audit visit to W practice – random sample seen of implementation. When issues related to mental ill health and stress are discussed a prompt for asking about domestic abuse appears on electronic record and specific template for domestic abuse is completed if DA present. 21/-2/19 Audit visit to F practice. Evidence seen in GP records that RE takes place in Mental Health Consultations. New

			taking place.				GP's will shortly be joining the practice and this will be included in their mandatory training package
7.	NICE guideline PH50 recommends screening for DA both ante and postnatally as several studies have shown there is increased risk of domestic abuse at those times. The practice should incorporate DA screening questions into any ante or postnatal protocols.	W	Any templates used by the practice for antenatal or postnatal consultations should be amended to include domestic abuse screening questions.	ELCCG	Templates produced	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18. 08/02/19 Audit visit to W practice – GP does not routinely see ante natal women RE completed by midwifery service. If ante natal and see's GP for another reason any family stress would initiate RE of DA and GP would use RE if other indicators present – there are no ante natal templates. RE is included on post-

							natal assessment template. 21/02/19 Audit visit to F practice – Ante natal checks do not take place – these are completed by Midwife. GP uses RE in postnatal checks and info about Domestic Abuse included in information given to new parents.
8.	All records of consultations involving a child should include details of any accompanying adult. Where this is another family member, the clinician should confirm that this	W	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire	ELCCG	Audit undertaken, any necessary changes implemented, and audit cycle completed	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18. 08/02/19 Audit visit to W practice – record search of 1 month sample shows 327 children attended – none were

	person has consent for examination and treatment of the child from someone with parental responsibility.		CCG. After allowing a suitable period for this to become embedded, there should be an audit of random children's consultations to ensure this is taking place.				unaccompanied by a parent. All stated on record who was accompanying child. Practice have a protocol for ensuring consent for examination/treatment in place 21/02/19 Audit visit to F practice - protocols in place. Evidence seen on records and GP gave verbal examples of practice

9.	The practice should incorporate routine screening questions for domestic abuse into its new patient checks.	W	The practice's new patient template should be amended to include domestic abuse screening questions	ELCCG	Template produced	31.03.19	Training on DA and the recommendations from the DHR given to staff at W and F Practices on 09.11.18 and 13.12.18. 08/02/19 Audit visit to W practice – RE included in New patient check template as standard practice. 21/-2/19 Audit visit to F practice – Information about DA is discussed and given at New Patient checks – written evidence seen
10.	The practice should implement a policy for following up mental health DNAs	F	The practice should produce and implement a written policy for following up mental health DNAs	ELCCG	Policy produced	31.03.19	08/02/19 Audit visit to W practice up to date DA policy in place and staff aware. Policy accessible on GP team net. 21/02/19 Audit visit to F practice – There is a

							policy in place for follow up of Mental Health patients and vulnerable people who DNA appointments. These patients are also given priority access to a GP
11.	Clinicians should be aware of the increased risk of DA following separation particularly in the initial post-separation period	F	This recommendation should be communicated to the practice as part of a bespoke domestic abuse training session facilitated by East Lancashire CCG.	ELCCG	All staff received domestic abuse training	31.12.18	Training on DA and the recommendations from the DHR given to staff at W practice by CCG on 09.11.18. GP has also delivered to staff who could not attend. F Practice 13.12.18 received training from CCG
12.	Clinicians' practice of routine enquiry needs to be evidenced and incorporated into	F	The surgery should provide its new patient and any antenatal/postn	ELCCG	Templates produced	31.03.19	Audit visit to W Practice 08/02/19 – RE now incorporated into standard EMIS templates and

	the standard EMIS templates		atal templates to evidence that these include domestic abuse screening questions				evidence shown. 21/02/19 Audit visit to F practice – have not been able to incorporate into standard templates on instruction of IT Governance but have shown evidence of RE in records. Also have developed new patient and new parent information regarding DA. `All clinical computers have an alert on reminding staff to ask about domestic abuse. GP team net includes up to date information regarding DA in line with NICE and also advises on Clare's Law Posters signposting for DA support and tear

							off contacts given to both surgeries

ELHT East Lancashire NHS Hospital Trust							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
13.	All women receiving maternity care from ELHT are asked routine enquiry at least once during their maternity care episode	Local	Audit of current routine enquiry practice to be completed for maternity services.	ELHT	To provide assurance that changes made to routine enquiry from August 2017 have been embedded into practice.	August 2018	Audit completed August 2018. Results showed a decline in compliance from 83% in November 2015 to 72%. Action plan put in place and completed. To be presented at Audit meeting 5.2.19. Due for re-audit Jan-May

			Policy to be updated to ensure Routine Enquiry is carried out on at least one occasion during maternity care. Policy and Practice Guidelines for Domestic Abuse C112		Policy ratified by Policy Council Re-audit carried out within 6 months of ratification shows all women are being asked routine enquiry	August 2019	2019. Re-audit to be completed Jan-May 2019
14.	Implementation of NICE recommendation 5	Local	Policy updated Policy and Practice Guidelines for Domestic Abuse	ELHT	Routine enquiry is asked in areas identified by NICE recommendation 5, specifically gynaecology	August 2019	

			C112		department.		

Nursery Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
15	Have chronology sheets on hand to record any concerns that maybe disclosed by anyone.		Keep well documented evidence.	Nursery Two	Being able to refer when necessary with all relevant information.	ASAP	30.04.18 Staff Safeguarding Policy now in place and file for documenting any concerns regarding staff or children, including chronology sheets.

End Rossendale Exec Summary