A Domestic Homicide Review

Calderdale Community Safety Partnership

Executive Summary

Maria

2017

Table of Contents

The Review Process 3
Membership of the review panel and access to expert advice 3
Independent author of the overview report and the chair of the review panel 4
The terms of reference and key lines of enquiry 4
Family contribution to the Domestic Homicide Review 4
Chronology of Contact with Agencies 4
Key Issues and Lessons Learned 18
Conclusion 19
Recommendations 19

The Review Process
Introduction and agencies participating in the review

1. This summary outlines the process undertaken by Calderdale Community Safety Partnership (the Community Safety Partnership for Calderdale), Domestic Homicide Review Panel in reviewing the homicide of Maria, who was a resident in their area. A review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an appropriately senior and experienced person. An experienced and independent person has provided this overview report.

2. This Domestic Homicide Review (DHR) concerns the murder of Maria by Mark. Maria and Mark were married and they had 3 children together. Maria and Mark were Polish and English was their second language.

3. On 17th November 2017 the police were called by a neighbour to a domestic incident at Mark and Maria's address. Mark was arrested and released on 18th November without charge.

4. On 26th November 2017 Mark stabbed Maria at the family home and she died from her injuries.

5. On the 29th of November 2017 Mark was charged with the murder of Maria. On the 25th of May 2018 Mark was convicted of murder at Leeds Crown Court. He was sentenced to life imprisonment with a minimum term of twenty four years.

6. This DHR considered agencies contact and involvement with Maria, Mark and their children between January 2014 and 26th November 2017. No agencies identified significant background histories on family members pre-dating the scope of the review.

7. Two agencies; West Yorkshire Police (WYP) and Together Housing Association (THA) had involvement with the family and were required to provide an individual management review (IMR) which were completed by senior members of staff who had no direct involvement or responsibility for the services provided.

Membership of the review panel and access to expert advice

8. The case review panel that oversaw this review comprised the following people and organisations.

Clare Hyde MBE, Independent Chair and Author

Ben Leaman, Public Health Lead, Calderdale Metropolitan Borough Council

Clare Robinson Head of Nursing & Safeguarding, Designated Nurse Safeguarding Adults NHS Calderdale, Greater Huddersfield & North Kirklees CCGs

Vicky Thersby, Head of Safeguarding, Calderdale and Huddersfield NHS Foundation Trust

Wayne Logan, Team Manager, Calderdale Social Care

Mark Patterson Calderdale, Neighbourhood Manager, Together Housing

Gary Stephenson, Detective Inspector, West Yorkshire Police

Christopher Gibson, Detective Superintendent, West Yorkshire Police

Iain Baines, Director of Adult Services & Wellbeing, Calderdale Metropolitan Borough Council

Maggie Smallridge, Head of Calderdale & Bradford Probation Service

Sarah J Barker, Senior Community Safety & Resilience Officer, Community Safety Partnership

Stuart Bainbridge, Detective Chief Inspector, West Yorkshire Police

Sue Lewis, Head of Supported Housing, Together Housing

Granville Ward, Serious Case Review Officer, West Yorkshire Police

Adrian Waugh, Chief Inspector, West Yorkshire Police

Independent author of the overview report and the chair of the review panel

9. The independent chair and author was Clare Hyde MBE. Ms Hyde is founder and Director of The Foundation for Families, a not for profit community interest company established in 2010. Ms Hyde was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009). Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

10. Ms Hyde also designed and facilitated a multi -agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair of several Serious Case Reviews and has designed and led DHRs and Learning Reviews on behalf of local safeguarding children and adults boards.

The terms of reference and key lines of enquiry

11. In this case Maria, Mark and the children had very limited contact with agencies other than with WYP and THA. Both of these agencies were, therefore, asked to complete Individual Management Reports (IMRs) responding to agency specific key lines of enquiry. The key lines of enquiry were accompanied by additional prompts for the agencies and their authors to consider when undertaking their agency review. For example, authors were asked to consider whether any information known to their services should have led to a different response and to consider the significant contributory factors that influenced how people made their decisions at the time.

Family contribution to the Domestic Homicide Review

12. The victim's family were advised of the review through the police family liaison officer following the first meeting of the panel and were then asked by their individual support workers if they wished to meet with the Lead Reviewer or contribute in some other way. They did not feel able to do so and the Lead Reviewer and the DHR Panel members wish to express their sincere condolences to them.

Chronology of contact with agencies

13. This section of the report summarises the information known to agencies and professionals in contact with Maria, Mark, the children and Maria's sister and her partner.

2014

14. Mark's tenancy commenced on 4th August 2014. The tenancy was signed in the sole name of Mark although the application for housing had been in joint names (this is covered in more detail elsewhere in this report). THA were advised that Maria would be living at the property along with the 3 children.

2015

15. On 12th March a Notice of Seeking possession was hand delivered to Mark due to level of arrears. An agreement was reached to pay a weekly amount to reduce the arrears.

16. On 5th April the police responded to a domestic assault/ breach of the peace incident between Maria's sister and her male partner. Maria and the children were present but not involved in the incident. On 24th April there was a further domestic incident involving Maria's sister and her partner. Maria was also present and she provided a statement on 25th April. In the statement she details numerous incidents of violence she has witnessed committed against her sister. In her statement she states that she is currently staying with her mother. Maria's sister's partner was subsequently found guilty of physical assaults.

2016

17. On 6th April a Notice of Seeking Possession was served on Mark due to the level of arrears and missed payments.

18. In May 2016 Maria registered with a GP practice and attended an appointment with one of her daughters who acted as a translator. There were no further visits to the GP.

2017

19. Maria visited the THA offices on 11th July. One of her daughters accompanied her. She explained that Mark was not working and negotiated how much rent they could afford to pay for the next 2 weeks.

20. On 21st July Maria made a separate housing application stating that she had been living with friends/family since 19th June 2017. The application process is an online process. Comments made by Maria on the application were as follows "My situation now is so poor, I'm getting divorce with my husband and I have 3 kids, now I live at my friend's house and it is possible that I will have to leave in few week. My kids are with my husband now but I want to take them to me as we getting divorce but I don't have a chance now because I don't have a house yet. Also I'm working. I have a contract".

21. On 24th July an email was sent to Maria by THA in response to her application. This said "Further to your recent application I am writing to advise you that your application has been declined. The decision to decline your application was made on the following grounds: Current Rent Arrears of: £*** (which is a joint tenancy with applicant and ex-partner)". In fact Maria was not a joint tenant.

22. On 17th November 2017 the police were called by Mark and Maria's neighbours who reported screaming and banging. The neighbour stated that '*they do this a lot but tonight it is really loud and the screaming hasn't stopped'*. The neighbour confirmed that there were children present in the house. The police attended and established that Mark had followed Maria upstairs during a 'row' and she had locked herself in a bedroom fearing that he would assault her. Mark had then forcibly opened the door. Maria stated that she had been fearful of an assault and that she wanted Mark to leave the house. She explained that she wanted a divorce

and that Mark had previously assaulted her. She also explained that she had left the family home in July. The children were spoken to by the officers who attended. The officers noted the language barriers with both adults being Polish speakers. Maria stated that she did not want to support a prosecution. A DASH risk assessment was completed on 18th November with the aid of an interpreter and resulted in a 'standard' assessment of risk. Mark was arrested and taken into custody and interviewed with the assistance of an interpreter on 18th November 2017. Mark was released without charge.

23. On 26th November Mark murdered Maria at the family home.

Analysis of information against the key lines of enquiry

24. Did the police response to the domestic abuse incident in April 2015 between Maria's sister and her partner present any opportunity to identify Maria as a victim of domestic abuse?

25. When police attended at Address 3 on the 5th of April 2015 it was in response to a report of a disturbance in the street involving Maria's sister and her partner. The police attendance at this incident did not present an opportunity to identify Maria as a victim of domestic abuse. Even had Maria been spoken with at length by the officers it would have been in regard to what had taken place between Maria's sister, her partner and neighbour and they would only have made such an inquiry had Maria or some other person indicated that she may have been subject to abuse.

26. Was the response to the domestic abuse incident on 17th November 2017 appropriate? Please specifically explore the fact that Maria disclosed that she had been pushed and beaten by Mark previously and that the current incident was due to the fact that she had reiterated her wish for a divorce.

27. The initial call was correctly graded as an emergency by the Customer Contact Centre operator who properly applied the required risk assessment tool and Force policy in respect of incident grading.

28. At the house Maria described what had taken place and the officers identified the potential offences of damage and common assault. Despite Maria telling the officers that she did not wish to make a criminal complaint and did not want Mark prosecuting the officers complied with Force policy and took positive action by arresting Mark. Evidence was secured by photographs being taken of the damage to the bedroom door. One of the officers recorded their attendance on his Body Worn Video (BWV) device.

29. The officers subsequently returned to Maria's address later that evening and using a telephone translation service contracted to the police completed a DASH risk assessment with her. This was completed using one of the officer's mobile data device. This is recognised best practice. An officer also completed an electronic pocket note book entry which detailed the recent history of the couple, the events of that evening and Maria's wishes. Maria signed this. Although not a witness statement this document effectively served the same purpose and it was good practice on the part of the officer to complete it.

30. The DASH risk assessment identified the following risk indicators: Previous domestic incidents; feeling depressed; separation; abuse happening more often; perpetrator under the influence of alcohol, perpetrator has problems with alcohol.

31. Additional information given by Maria was that numerous arguments had taken place over the past six months. In July Mark pushed her though she did not want to report this. Mark's

behaviour was making her 'feel down'. In July the Maria left Mark but returned in September after discussions. Arguments were happening more frequently due to the threat of divorce. This has been exacerbated by Mark's increased alcohol consumption.

32. The overall risk assessment level recorded on the DASH was determined following discussion with the officers' supervisor and there were 'No significant current indicators of risk of serious harm'. There was no recorded history of domestic abuse by Mark albeit Maria had disclosed that in July Mark had assaulted her causing minor injury and this had caused her to move out of the family home. Since she had returned home in August, approximately three months before, he had not assaulted her again although on this occasion she had been in fear of being assaulted.

33. The attending officer submitted a Niche domestic assault crime occurrence. Three recording errors occurred in this process. The officer did not tick the 'domestic' tab on the drop down menu on the occurrence's Stats Class Miscellaneous tab. This tab is used by units and HQ data analysts to search for domestic crime occurrences and if ticked the occurrence is automatically tasked to the Safeguarding Unit's niche mailbox. When asked by the author the completing officer did not know of the menu's existence or the requirement to 'tick' the domestic abuse box on the menu. However, the occurrence was correctly identified by him as a domestic crime in the occurrence type field and he tasked the report himself to the domestic abuse team mailbox. All crime occurrences are reviewed by the Force Crime Management Unit (FCMU) and at 4.48pm on the 18th of November the FCMU reviewed this report, identified that the menu had not been endorsed and did so.

34. The officers initially submitted an 'assault by beating' common assault crime occurrence. The FCMU officer amended this to a common assault crime at the same time as she added the domestic abuse flag. "*Victim and suspect are wife and husband respectively. An argument ensues as the victim wants a divorce. The suspect becomes aggressive and the victim removes herself to the upstairs bedroom. The suspect follows and the victim attempts to push against the door to prevent the suspect entering. The suspect applies bodily force thereby ripping the pair of door handles from the door. The suspect enters shouting "bitch" and other such insults. The victim perceives that she is going to be attacked though is not".*

35. However, Maria had made reference to a previous assault in July where she had suffered bruising. No separate report was recorded in respect of this and this is only referred to in the PNB entry attached to the occurrence and the DASH report. The FCMU officer did not identify this as it was not referenced in the occurrence MO. The Deputy Force Crime Registrar has advised that in these circumstances the correct recording procedure should have been:

36. Given the close proximity of the initial report, and the later fuller disclosure, it can legitimately be considered one disclosure, and only one crime is required. The type of crime required is the most serious one, in this case an ABH. The crime recorded should have been one ABH, with the MO and dates to match, not the Common Assault. All the other crimes should be noted on the OEL.

37. This would have served to highlight the previous incident but may not in effect have made much difference to the outcome of the investigation. Maria had declined to make a statement and the officers had only the most general details of the earlier incident. MARIA had indicated that she did not want the likely witnesses, her children, to provide statements. The report should have been recorded in accordance with the Registrar's guidance but it is not likely that this would have altered the evidential content of the report or final outcome. However the occurrence type was correctly shown as a 'Domestic crime'.

38. The officer correctly 'tasked' the occurrence to the Calderdale Safeguarding Domestic Unit mailbox (i.e. sent an electronic notification that the occurrence had been created) so that that unit was aware of it.

39. Since the beginning of 2017 and as part of the Whole Systems Approach initiative an Independent Domestic Abuse Advisor (IDVA) employed by the Pennine Domestic Violence Group (PDVG) has been contracted to work with police on a Friday and Saturday night between the hours of 6pm and 2am. This is so that immediate independent support can be provided to victims of domestic abuse following the initial attendance of response officers. She is present in the police station and an officer is designated to be available to attend incidents with her if required. The IDVA was working on the evening of Friday the 17th of November but had no contact with Maria.

40. Mark was detained overnight and was interviewed by two officers on the 18th of November using an interpreter. Mark answered all questions in Polish. In the course of the interview he denied that he had assaulted Maria or caused damage to the door handle which he stated was broken before this incident. He denied that he had intended to cause her to fear that she would be assaulted. He said that they were both shouting at each other. He was asked if he had ever assaulted Maria before and he replied: *"Once in the past we had a scuffle with each other. You know when you argue one would push away the other but there was no beating up".* Mark was told that Maria wanted him to leave and live elsewhere and he replied: "*We work on it. It's not simple. She's got nowhere to go, I've got nowhere to go. For now we live together"*.

41. At the conclusion of the interview the officer in the case spoke with her supervisor. He made two decisions:

- That there was insufficient evidence to sustain a prosecution; and
- That there were insufficient grounds to apply to a Superintendent for the issue of a Domestic Violence Protection Notice (DVPN).

42. The first of these decisions was made on the basis that Maria had declined to provide a witness statement or support a prosecution and Mark had denied both offences. There was also no corroborating evidence to support Maria's account.

43. It is not indicated in the supervisor's entry whether the children had been spoken with other than by the initial attending officers and an account sought from them but the log had been endorsed by the attending officers' supervisor that the children can only state a verbal argument, nothing else. In the WYP IMR author's view this decision that there was insufficient evidence to sustain a charge was appropriate.

44. Section 24 of the Crime and Security Act 2010 creates a power for a senior police officer to issue a Domestic Violence Protection Notice (DVPN) to secure the immediate protection of a victim of domestic violence.

45. In this case the reviewing supervisor endorsed the occurrence: *"I have explored the option of a DVPO in this case, however I do not deem that this is an appropriate safeguarding measure as no violence has been made to the victim, by the suspect, in this case".* When spoken with as part of the review the officer said that he based his view on the fact that on this occasion there had been no assault, that there was no previous reported domestic abuse history and also that Maria had disengaged from the police as he understood that she had terminated a

call to her from police. Asked about the content of the PNB entry signed by Maria and the entry on the DASH risk assessment which reference a previous assault he stated that whilst he must have read those documents at the time he was unable now to explain why he had not referred to them or more apparently factored them into his decision making. The wording of the offence and its reference to 'threats of violence' was discussed but he expressed the view that given the absence of an assault resulting in injury on this occasion he did not believe that a magistrate would grant an order on the evidence available and maintained that this was still his view. It appears that neither the attending nor interviewing officers who had contact with Maria discussed the possibility of a DVPO with her.

46. The circumstances of this case have been referred to the manager of the unit who has been asked to consider if the case would meet the criteria for an application. In his view it would. It is true that he lays some stress on the damage caused to the door which actually may not have been as severe as initially thought but additionally points out that Maria was frightened and felt threatened that Mark would physically harm/assault her, saying in the PNB entry she made: '*I was scared and fearful that Mark might hit me because he was angry and drunk'.*

47. This was obviously supported by the previous assault upon her and he believes that because she felt in immediate fear of violence the case could successfully be made that she was in need of protection.

48. Furthermore, this Unit also has an (IDVA) as a staff member. When Orders are granted she contacts the victim, explains the stipulations of the 28-day Order in full and starts a safety plan with the victim discussing her needs and concerns to try to establish any immediate risk factors. Referrals are sent by the unit to the appropriate local support service to enable them to follow up with a home visit to discuss further support and safe guarding measures. If the perpetrator does not attend court the unit contacts him and explains the order and all the prohibitions attached to it, explaining that breaching them would result in arrest, fine or imprisonment. The unit tasks District patrol teams to carry out compliance checks at the protected address and requests patrol officers to attend the address at unscheduled times to ensure that the perpetrator is not at the victim's address or in contact with them. This service was however not available in November 2017.

49. After the interview an officer contacted Maria by telephone. At this time Maria was at work and no interpreter was used for this conversation (it would not have been possible by telephone alone). The officer described Maria's English as broken but said that they managed to have a conversation. She informed Maria that Mark had been released without charge. She said that Maria agreed that Mark could return home but had to move out. The officer said that she made it clear to Mark that this was what Maria wanted before he left the station.

50. The officer's OEL entry is ambiguous: "The victim was then spoken to and she said that she was happy for the suspect to return home but that he would need to sort alternative accommodation at some point. She was currently at work so it would give time for the suspect to come home and sort his things out before she got back. The victim did not want to pursue matters and said that the suspect just needed to accept the relationship was over. This was all explained to the suspect upon his release and he agreed stating he would sort things out when he got home".

51. It is unclear whether this means that Mark was returning home and would move out at some future time or was returning home to collect his things and go before Maria returned from work. It is likely that a fuller discussion would have taken place had the officer spoken with Maria via an interpreter. In particular there is no evidence that discussion took place about a

safety plan for Maria. Whilst a referral was to be made to the support service Staying Safe and the officer had no concern that Maria was at risk of serious harm there should have been a discussion with Maria about her safety when Mark was released. This was hindered by Maria's limited ability to speak English and this is the subject of a single agency recommendation.

52. At 12.16pm on Monday the 20th of November 2017 the occurrence was reviewed by a supervisor in the SGU who electronically tasked an SGU clerk to send a standard letter to Maria about sources of assistance, make a referral to the Calderdale domestic abuse support service 'Staying Safe' and also complete referrals for the children to health and CSC. These are routine actions undertaken in every domestic abuse case although referral to support agencies is only made with consent apart from High Risk cases. In this case these actions were not completed. There was no further police contact with Maria.

53. Maria disclosed that there had been several arguments over a 6 month period since she had told Mark that she wanted a divorce. Did the response, including risk assessment, take into account the escalation in incidents and the increased risks associated with separation?

54. The DASH assessment correctly identified separation and escalation as risk indicators. The risk of serious harm was assessed as Standard. On the circumstances of this incident this was a reasonable assessment.

55. Was Maria's additional vulnerability in terms of the language barrier taken into account?

56. The attending officers on the 17th of November 2017 initially spoke with Maria with her daughter's assistance as interpreter. Force policy is that children and other family members should not be used to communicate with adults in these circumstances. In this case the assistance of Maria's daughter was appropriate as the officers needed to quickly obtain an initial account and understanding of what had taken place in order to immediately deal with the incident. When the officers returned later that night they communicated via a telephone interpreter service and were able to communicate effectively with Maria by that means.

57. Force policy also states that that the officer in the case is responsible for ensuring that the victim has been fully updated or making reasonable attempts to contact the victim and left messages about the proposed course of action before the suspect leaves custody.

58. The interviewing officer did this. However, Force policy also states that officers are responsible for taking into account any safety issues raised by the victim or identified by the police/other agency (including a review of the DASH risk assessment) and any risk(s) removed or reduced whenever possible. All risk assessments are dynamic and must be reviewed when circumstances change, i.e. when a suspect is to be released from custody. The Supervisor is responsible for this review.

59. When officers spoke with Maria the following morning to notify her of the outcome of Mark's interview no interpreter was used. The officer who spoke to her described Maria as speaking in broken English but she was satisfied that Maria had understood the information she passed to her, did not want further assistance from the police and believed that it had not been necessary to visit her and speak with her directly. To this extent policy was complied with.

60. It would have been more effective to have spoken directly with Maria through an interpreter to discuss her on going safety. In order to do so; the officer would have had to be physically with her. The language barrier prevented a full discussion of her circumstances and in particular discussion about a safety plan. It cannot be known how much of what she was told

Maria understood or what she would have said to the officer had an interpreter been used to allow her to express herself. This is the subject of a single agency recommendation

61. Were the living arrangements of the child/ren confirmed during the response to the domestic incident of 5th April 2015? I.e. did they live with the victim and perpetrator? What was their relationship to Maria's sister and her partner?

62. As previously noted the officers attending the incident could not what discussion took place about the living arrangements of the children. On officer's witness statement states that two children were present but does not provide their details.

63. It is noted that a referral to children's social care was made on 8th April 2015. Which child/ren did this referral relate to?

64. Enquiries have been made with the Calderdale SGU who state that referrals were made in respect of Child 1 and Child 2. There is no record of the referral as such but it was practice to refer those children linked to the occurrence on the occurrence 'involved' tab.

65. Was a referral to children's social care made following the incident on 17th November 2017?

66. At 12.16pm on the 20th of November 2017 the SGU sergeant sent an electronic task on niche to the unit's clerk asking her to complete: victim letter, referral to Staying Safe and child referrals. At 1.54pm the clerk opened and closed this message. She did not however complete any of these actions. She did not endorse the OEL that she had done so which would be normal practice. The clerk was spoken with by her supervisor about this matter shortly after the homicide. She accepted that the failure to complete these tasks was an administrative error on her part and purely the result of human error. She believed she may have opened and closed the task intending to undertake the actions but then taken a telephone call or been otherwise distracted and failed to do so. She now prints the letter out first, makes the referrals and endorses the OEL before closing the task as she did on this occasion.

67. Was Maria's 17 year old daughter who was present at the incident asked about any previous incidents of domestic abuse (she provided interpretation for Maria after the incident)?

68. There is no indication that Maria's daughter was spoken with by police about any previous incidents of domestic abuse. The attending officer could not recall if she was asked but does recall that the children were spoken with when the officers returned to the address at about 9pm that evening and they did not wish to act as witnesses. He thought this was either because they did not want to or because their mother did not want them to. He said they were vague about what had happened that night, only being able to confirm that an argument had taken place.

69. Clarification about considerations of a referral to other agencies. How well did your agency share information which contributed directly to assessments and decision making?

70. In 2015 WYP referred details of two children to CSC and health who were recorded as either present or a child in the family. It did not refer Maria's other children who were not present at the incident. This was contrary to Force policy.

71. In 2017 WYP clearly failed to pass information to CSC, health and a domestic abuse support agency in line with normal practice. This was because of human error by the SGU clerk. A daily multi-agency triage meeting did take place in the Domestic Abuse Hub but that did not review

Standard risk cases. Those cases were reviewed by a supervisor and this happened in this case but the supervisor's instructions re further action were not complied with by the clerk.

72. **Did your agency adhere to their own domestic abuse and safeguarding policies and procedures and if not what the barriers that prevented this from happening were (organisational and individual e.g. training deficit, threat of redundancy, lack of management oversight);**

73. **Identify any aspects of the case that exhibit good practice**.

74. The actions taken by the attending officers on the evening of the 17th of November 2017 were, apart from recording issues on the Niche occurrence, commensurate with policy and an example of best practice in the management of initial attendance at a domestic abuse incident. The actions they took would have supported an evidence led prosecution had there been sufficient additional evidence to sustain that, for example an independent witness, evidence of injury or substantive damage, and in the author's view was of the standard the Force seeks to achieve.

75. **THA Responses to Agency Specific Lines of Enquiry**

76. **Does your agency's current online application processes for accommodation adequately provide for people attempting to leave domestic abuse?**

77. Within the reasons for moving section, applicants may make disclosures if the reason for seeking rehousing is due to domestic abuse or other types of abuse. If during the application process, a person does disclose domestic abuse, then staff should follow procedures accordingly. This includes referring the application to their line manager (Lettings Coordinator) who would take over the management of the application and making arrangements to contact the applicant to understand the situation in more detail and to offer advice. This advice would include how the application will be dealt with which will vary depending on each situation and to explain that the applicant should arrange to see the Council's Housing Options team and or seek their consent for THA to make a referral on their behalf to the Council's Housing Options team to enable the Council (who have a statutory duty to fully assess those who are faced with homelessness, including due to domestic abuse).

78. The Lettings Coordinator would normally be the member of staff who made contact with the applicant. However, in the situation that the applicant is an existing customer of THA (as was the case for Maria as a member of a household who had been living in one of our properties with her children), the Lettings Coordinator may instead liaise with the Neighbourhood Officer to request that they make contact with the applicant (and this could be via a phone call or for the Neighbourhood Officer arranging to visit the applicant in the place they are temporarily residing). Noting that any contact would be carefully managed to ensure that the safety of the applicant is not put at risk where a disclosure has been made. This would allow THA to gather more information as there would be tenancy management issues arising from such a situation as well as understanding in more detail the circumstances regarding the application for rehousing.

79. However, if an applicant doesn't make a specific disclosure but only indicates that the relationship has broken down, staff are trained to be aware that there could be underlying issues such as an abusive relationship, recognising that not all applicants want to make such a disclosure for many reasons, including at the point of making an online application. So at the point of receiving an application which states that a relationship has broken down, then staff

should still make contact, where it is safe to do so, to check and verify the initial information provided and gain a fuller understanding of the situation.

80. Likewise, even if there isn't a disclosure of abuse but the application states relationship breakdown and provides details such as living away from the family home and separated from their children, a referral should still be made to the Council's Housing Options service (with the applicant's consent), given there could be possible homelessness implications.

81. Again, even if a disclosure of abuse hasn't been made, in instances where the applicant is an existing customer of THA e.g. a tenant or member of a household in one of THA's properties, then contact should still be made with the applicant (as mentioned this could be via the local Neighbourhood Officer in the Sustainable Neighbourhoods team) as there will be tenancy management issues that will need to be considered e.g. verifying someone's status, welfare benefit considerations if there is a change in circumstances etc.

82. Once the Lettings Coordinator has a fuller understanding of the situation, then they would determine the next steps regarding the application including liaison with the applicant and the Council's Housing Options team. It would also mean ensuring that the applicant is informed about local support services regarding domestic abuse where a disclosure is made.

83. The Neighbourhood Officer would also liaise with THA's Income team to notify about the change in circumstances regarding the existing tenancy as that could affect rent payments and benefit entitlements. However, the timing and actions taken would be done in such a way that ensures confidentiality about the applicant's circumstances and without comprising the safety of the applicant and other members of the household.

84. However, in this case, the above procedures weren't followed and the applicant was not contacted to gain further information about her circumstances. Nor to explain about contacting the Council's Housing Options team, directly or via THA staff, to obtain advice about the fact she had had to leave the martial home and was in unstable accommodation and also separated from her children.

85. The email notification that was sent to Maria on the 24th July 2017 to notify her that her application had been declined (on the grounds that there were current rent arrears and it being a joint tenancy with ex-partner) did include information about what to do if the applicant wanted to appeal against this decision, including stating the reasons why the application should not be declined along with supporting evidence that is felt to be appropriate. An appeal was not received. Although notified of right to appeal, management oversight of rejected applications being appropriate would mean that there isn't sole reliance on applicants appealing to highlight errors being made in policy and procedures**.**

86. Maria's application stated that her preferred language was Polish. It is not possible to surmise how much Maria would have understood the email response including right to appeal or if she was receiving assistance with her applicant and subsequent response from THA. The THA lettings application system does enable applicants to use Google Translate and likewise for THA staff to use the same to translate responses from THA into their preferred language. THA staff also have access to Language Line. However, the email response from staff was sent in English albeit it should have been translated into Polish given that this was Maria's stated preferred language.

87. Does the current online application process for accommodation adequately meet the needs of non-English speaking applicants?

88. Applicants are able to select preferred language on line to complete their housing application using Google Translate. This includes our staff then using the same when sending any responses/correspondence.

89. Please consider what steps your agency could take to ensure that people who are attempting to leave domestic abuse are aware that they can make an application in person and that they will be supported to do so e.g. translation, materials in other languages.

90. As described above, THA online application system allows applicants and THA staff to use translations via Google Translate. Whilst we do offer face to face assistance, this is not fully publicised. However, work is currently underway to refresh service standards which will be re-launched and this includes making sure customers are clear that assistance can be given to customers applying for a home with THA, if unable to make an online application.

91. Access to translators would currently be arranged via staff who speak other languages or by accessing local agencies but this can be patchy. As part of the review of practices and from an E&D perspective, THA will also review arrangements for customers who require translators and materials in other languages, including those applying for housing.

92. Staff in the Lettings team have received safeguarding training relating to both adults and children (and the adults training includes domestic abuse) and this has also been tailored and delivered specifically to the Lettings team to make it particularly relevant to their role. However, refresher training which takes place three yearly is due and plans in place to roll out the refresher training programme.

93. Please consider what steps your agency could put into place to ensure that the confusion over Maria's joint tenancy status in this case could not occur again.

94. Staff receive training on the THA housing management system (QL) and this includes being able to view tenancy details correctly as well as ensuring every contact with customers is recorded. Training is also provided on GDPR requirements. However, clearly there was human error in this case, given that checks done when the application was received about Maria's status as a joint tenant were incorrect.

95. Therefore, Managers in relevant services, including the Lettings service will arrange to discuss with teams their level of competency in using the QL system to do tenancy checks, to reinforce the importance of checks being accurate and arrange for further training to be done where gaps are identified. Given the learning from this SHR, refresher training on correct use of QL to check tenancy details will be done as a matter of course for all members of staff in the Lettings team.

96. Also, Lettings procedures currently require that applications that are not straight forward i.e. include information that could have implications re; homelessness should be referred to the Lettings Coordinator (irrespective of whether someone is a sole or joint tenant). This will be reinforced with the Lettings team, including for applicants who state "relationship breakdown" on their application.

97. The safeguarding refresher training will also reinforce that staff need to be aware of indicators and situations of potential or actual abuse. Likewise, within the domestic abuse refresher training that is also due to be rolled out later this year. This will include reinforcing that in terms of the lettings service, that relationship breakdown could be an indicator of domestic abuse, even if no specific disclosure has been made initially on the application. And even if

abuse is not an issue there is still the possibility that the person could be facing homelessness as a result of the breakdown and that they should be advised to seek further advice from the Council's Housing Options service (and that staff would make a referral with their consent

98. The THA IMR author reflects that there needs to be improved communication and joint working between the Lettings team and other teams (Sustainable Neighbourhoods and Income teams) in situations where the applicant is a customer of THA. Whilst Maria wasn't a tenant (albeit the Lettings advisor incorrectly thought she was), Maria and her children were members of the household who had been residing in one of THA's properties. Therefore, when the application was received which highlighted the change of Maria's circumstances, then it would have been appropriate for the Lettings team to contact the Neighbourhood officer to inform them of this and arrangements made for the Neighbourhood Officer to make safe contact with Maria to find out more about her circumstances.

99. Likewise, to strengthen arrangements going forward so that the Income team is also notified regarding the change of circumstances to the household of Mark's tenancy. This will include ensuring that any follow up actions are carefully handled and timed so as not to inadvertently divulge confidential information about a partner who has left a property.

100. Please consider your agency's current response to applicants who are joint tenants, where there are arrears and who are attempting to leave domestic abuse situations. Does your current policy and process make exceptions in such cases and does your agency make this clear to members of the public?

101. THA's current policies and procedures (Allocations/lettings, Income and Domestic abuse) all include that arrears will not mean rejection of applications for rehousing where the person is experiencing or is threatened by domestic abuse. Each case would be considered individually and polices do reflect that there will always be exceptions to general rules. THA would therefore support an application for rehousing, even if there are arrears (current or former) if they have been accrued due to domestic abuse or as part of a safeguarding plan to help protect the person from harm. This would be considered by respective Managers (Lettings, Income and Sustainable neighbourhoods) and arrangements would be made for rehousing via a management transfer.

102. THA would not publicise this as such to members of the public but would expect through training and compliance with procedures that each case would be carefully and correctly managed with the applicant (tenant) and that the applicant would be made fully aware, on an individual basis as part of advice and guidance that we should give, both directly and via the Council's Housing Options service.

103. As there wasn't a disclosure of abuse by Maria in her application, it's not possible to surmise if procedures would then have been correctly applied. However, there is a need to address how THA deal with applications where relationship breakdown is given for the reason. If contact with Maria had been made to gain more information, it could have revealed that there was abuse occurring or she felt under threat. Staff should then have referred the application to their line manager as explained above.

104. Please consider how your services are promoted to all members of the community who are experiencing domestic abuse and what learning there may be from this DHR.

105. THA currently have some information about helping to keep people safe (safeguarding from abuse) on their website. This includes reference to domestic abuse as well as other types of

abuse. THA also participate in Calderdale's Safeguarding Week. Whilst this is only one week in a year, it does provide an opportunity to help raise awareness and promote availability of local services as a multiagency partnership to the public. As part of this year's safeguarding week's programme, this included THA hosting an event with to bring together third sector partners.

106. Clarification about considerations of a referral to other agencies. How well did your agency share information which contributed directly to assessments and decision making?

107. Given the information that was provided and the member of staff did not undertake or arrange for any verification checks/ follow ups with the applicant to find out more about her circumstances, THA then missed the opportunity to share information with other agencies, most notably, the Council's Housing Options. Also to provide advice to Maria on local services such as the Women's Centre for advice and support (if disclosure of domestic abuse had been made at any point).

108. The way the application was dealt with also meant that the line manager of the Lettings Advisor wasn't able to consider the application and ensure that procedures were followed, most notably contacting the applicant (directly or via the Neighbourhood officer) to find out more and signpost or refer to the Councils Housing options team.

109. Establish if all agencies adhered to their own domestic abuse and safeguarding policies and procedures and if not what the barriers that prevented this from happening were (organisational and individual e.g. training deficit, threat of redundancy, lack of management oversight).

110. From a THA position, procedures weren't followed:

- Allocations/lettings - the application should have been discussed with the line manager or service manager, contact then made with the applicant (given there was information provided that Maria was in a homeless situation, separated from her children and was a member of a household of a THA property);

- THA allocations/lettings policy and procedures also make it clear that consideration will be given to waiving rent arrears where abuse is a factor These weren't followed as the member of staff didn't attempt to find out more information about the applicant's circumstances and also as the checks re: tenancy incorrectly deemed Maria to be a joint tenant (thus liable for the current rent arrears) which she wasn't;

- Whilst disclosure of abuse wasn't made on the application, our safeguarding procedures do explain that staff need to be aware of possible indicators and hidden or less obvious signs of abuse (if verification checks had been done then disclosure of abuse may have been made)

111. The first concerns the original granting of the tenancy – whilst the likelihood is that this wouldn't have had any implications in terms of what happened to Maria, the IMR author's review of this case has brought this to light. That being that the original application for rehousing made in 2014 was made jointly by Maria and Mark in 2014.

112. However, when the tenancy sign up took place, Mark informed the neighbourhood officer that his wife wasn't available to sign the agreement as she and the children were on a long holiday in Poland. The Neighbourhood officer went ahead and signed Mark up as a sole tenant. In doing so, this inadvertently deprived Maria of becoming a joint tenant and having

tenancy rights which is poor practice, given it was a joint application. It could also give rise to possible tenancy fraud issues.

113. Instead, consideration should have been given by the Neighbourhood Officer to either to add Maria on to the tenancy on her return or explain that the offer would have to be withdrawn until such time as Maria was back in the country and in a position to sign for a property as a joint applicant.

114. Secondly, relating to the follow-up settling in visit that was undertaken a couple of months later by the Neighbourhood Officer. According to the records, the Neighbourhood Officer didn't appear to see or speak to Maria but was told by Mark that everything was okay and his wife and children had returned in early August and the family had settled in. This also highlights the need to review our practices around settling in visits as again this links to tenancy fraud, income and safeguarding controls.

115. Thirdly relating to discussions with customers regarding rent arrears Maria came into THA offices in July 2017 to explain what she was going to pay to help address the current arrears, the member of staff should have checked the tenancy management system. This would have shown that Maria wasn't actually a joint tenant. This in turn should have led to the advisor explaining that she would note the content of what Maria said but explained that discussions about rent arrears can only take place with the tenant themselves (so as not to inadvertently breach GDPR) and advise the person that the tenant must get in touch directly.

116. Were practitioner's sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

117. Based upon the information provided on the application, there was a missed opportunity to find out more about Maria's situation by THA's failure to contact her. There was mention of a marital breakdown, and Maria had explained that she had also moved out of the family home, was temporarily staying with friends which was unstable and was separated from her children as a result and was causing her distress. Efforts should have been made to contact Maria, in line with procedures to gather more information and offer advice and signposting to the Council's Housing options team. Even if there hadn't been any subsequent disclosure of abuse, she was still in a potentially homeless situation, separated from her children and in these instances, THA should advise the applicant to seek advice from the Council's Housing service.

118. Moreover, as well as in terms of an application for rehousing, from a tenancy management point of view (as Maria and her children were known to be members of a THA household) further enquiries should have been made. This was compounded by the Lettings Advisor incorrectly deeming that Maria was a current tenant with liabilities for rent arrears and declining her application for rehousing on this basis.

119. Whilst THA safeguarding procedures explain that staff need to be professionally curious, to look beneath the surface for possible signs of abuse (and in a lettings context, this includes that abuse could be a factor in a relationship breakdown, even if not initially disclosed), the Lettings team had been set up some 9 months earlier. So the depth of knowledge and experience of all would have been mixed.

120. In terms of the use of the tenancy management system, it is not possible to say exactly how much training each individual member of staff had had by late 2017 or how competent they were in using the system (which is a complicated system for newer members). The competency of all staff due to training and experience in using the tenancy management system (QL) may also therefore been a mitigating factor.

121. There was lack of communication and joined up working between the Lettings team and Sustainable Neighbourhoods team. This is an expectation on staff to work jointly with colleagues and in this instance contact with the Neighbourhood Officer should have been made. It could then have been possible to build a better picture of the situation and ensure that Maria was provided with the appropriate advice and assistance. It would also have been another safeguard regarding her status within the household (i.e. not a joint tenant and not liable for rent arrears). The THA IMR author surmised that the Neighbourhood officer, who would have been more conversant with the tenancy management system would have realised the error and Maria application for rehousing would then have been corrected and assistance given with rehousing.

Key issues and learning identified by the review

122. Maria, Mark and the children had very limited contact with any agency that may have been in a position to offer support around domestic abuse.

123. The single significant missed opportunity to provide help, support in respect of Maria's application for re-housing is described in detail elsewhere in this report and single agency actions have been recommended to share and embed the learning from what happened in this case.

124. The human error which led to the police not sharing information with other agencies is also described elsewhere in this report. It is worth noting that even if information *had* been shared; the time between the first reported incident and Maria's murder was such that agencies with whom information should have been shared would have had limited opportunity to offer support.

125. The use of a DVPO in this case may have been appropriate.

126. It is clear from the information made available to this DHR that Maria's family, neighbours and friends knew about the abuse and it is also clear that the 3 children experienced at least two significant incidents one of which resulted in Maria leaving the family home and living temporarily with friends/ family.

127. Maria faced barriers to accessing support and services because she did not speak English with confidence. This may have contributed to her reluctance or inability to disclose the abuse. The language barrier undoubtedly compounded difficulties for Maria when she was attempting to secure housing for herself and the children.

128. This case shares similar themes and learning with another recent Calderdale DHR (and others nationally) specifically in relation to the prevalence of domestic abuse and the reluctance of victims and their families, friends and communities to report it or ask for help

129. Research suggests that women (legitimately) fear losing their children if social care become aware that there is domestic abuse occurring within the household and this too may have prevented Maria from disclosing what was happening.

Conclusion

130. This DHR reflects learning from other reviews which have focused on homicides which appear to have been a ‘one off’ event. Domestic homicides are usually underpinned by a longstanding sense of ownership, coercive control, and possessive behaviours: they are not a random event.
131. The DHR also reflects learning concerning the reluctance of or barriers to victims, families and communities in reporting that abuse is taking place.

Recommendations

- The learning from this and the other recent Calderdale DHR reflects the learning from other DHR’s across England and the Independent Reviewer and the DHR Panel request that the Home Office consider how a national domestic abuse public awareness campaign could be developed as a matter of urgency.

- Public awareness campaigns should focus not only on the victim’s and perpetrator’s silence but also of the silence, tolerance, and inhibition of the social circles surrounding the victims.

- The patterns of abuse and the risks associated with these should be explicitly described in public awareness campaigns. E.G. coercion, stalking and attempted strangulation and separation as high risk indicators for homicide.

- Campaigns should also describe the criminal act of coercion and raise awareness of what coercion ‘looks and feels’ like to victims and their family and friends.

- Public education campaigns also need to transmit the idea of social responsibility in issues of domestic violence. Greater social response (in particular of those who know but choose not to tell) would help break the climate of social tolerance, thus increasing the costs for perpetrators, and acting as a deterrent.

- Domestic abuse policies should target the reduction of the gap between prevalence estimates and reported cases. These policies would benefit from a greater research focus on societal attitudes towards intimate partner violence issues (reporting, victim blaming, tolerance, inhibition, silence).

- Prevention policies would also benefit from data monitoring indicators of social silence, inhibition, and tolerance. This could be done, for example, by monitoring changes in the number of cases reported by those who know about the violence (neighbours, relatives, friends, health or law enforcement personnel), as well as changes in social attitudes (such as victim blaming, balance of power between men and women in relationships, or zero tolerance attitudes).

- The CSP and partner agencies who provide help and support to victims of domestic abuse and their children should review their own roles in promoting the message that victims (and perpetrators) can trust agencies responses and proactively address the concerns that many female victims express about ‘losing their children’ if they disclose abuse.

- The promotion of voluntary perpetrators programmes (and other agencies which offer support to perpetrators) may also be an important part of the public health approach.

- The promotion of healthy and safe relationships within education and other settings for children and young people should be considered.

- The CSP should ensure that all partner agencies have processes in place to support victims and their families for whom language and other issues may be a barrier to disclosure and support. (For example hearing or visually impaired, learning or cognitive difficulties, physical disabilities)

- The CSP should consider how the learning from Monckton Smith's Temporal Sequencing in Intimate Partner Femicides study can broaden understanding and responses to risk.

Individual Agency Recommendations and Action Plans. The two Individual Management Report authors identified learning for their agencies and these are available as an appendix to the DHR Overview Report.