

# **St. Helens Community Safety Partnership**

## **Domestic Homicide Review**

### **Overview Report**

#### **Report into the death of Mark (pseudonym) December 2016**

Author and Domestic Homicide Review Chair - Stephen McGilvray 2018

**This report is the property of the St. Helens Community Safety Partnership. It must not be distributed or published without the express permission of the Chair. Prior to its publication it is marked Official Sensitive under the Government Security Classifications April 2014.**

<b>Contents</b>	<b>Page</b>
Glossary	3
Introduction	5
Scope	5 - 6
Key issues	6 - 7
Methodology	7
Family and Friends	8 - 11
Contributors to the Review	11
Equality	14
The Facts	15 – 20
<ul style="list-style-type: none"><li>• Background Mark and Zoe</li><li>• Key Issues</li></ul>	
Analysis	20
Conclusions and Recommendations	27
Action Plan	Appendix A
Chronology	Appendix B

## Glossary

CAADA	Coordinated Action Against Domestic Abuse
CAHMS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CGL	Change Grow Live (provider of substance misuse services)
DHR	Domestic Homicide Review
G.P.	General Practitioner
IDVA	Independent Domestic Violence Advocate
IMR	Independent Management Review
LSCB	Local Safeguarding Children's Board
MARAC	Multi Agency Risk Assessment Conference

## DOMESTIC HOMICIDE REVIEW

### OVERVIEW REPORT

Independent Author: Stephen McGilvray - March 2018

#### **1. Introduction**

1.1 This report has been undertaken following the death in December 2016 of Mark during a domestic incident involving his partner Zoe at their home address in St Helens Merseyside.

1.2 In December 2016, Merseyside Police were informed by the Ambulance Service about a reported stabbing at the couple's home address where it was discovered that Mark had received a single stab wound to the chest Paramedics and an emergency Doctor attended and treated Mark at the scene but were unable to save his life.

1.3 Zoe was arrested at the scene and later charged with the murder of Mark.

1.4 Zoe pleaded not guilty to the murder of Mark and following a trial at Liverpool Crown Court on 22nd June 2017 Zoe was found not guilty.

#### **2. Scope of the Review**

2.1 In accordance with the statutory guidance for the conduct of DHRs, the Panel agreed that the purpose of this DHR was to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked 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 upon, and what is expected to change as a result.

- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working.

## Key lines of enquiry

2.2 The DHR Panel at its first meeting agreed the focus of the Review should be upon the following Key Lines of Enquiry;

- A. What policies and what level of capacity exists within each agency for non-U.K. born residents to;
  1. Overcome barriers to reporting domestic abuse
  2. Encourage victims/survivors of domestic abuse to disclose and report the abuse.
  3. Respond to needs identified following their report.
  4. What training of staff is undertaken to equip staff to deal with these issues.
- B. What more can housing providers do to encourage neighbours who are aware of domestic disputes taking place to report it and help prevent an escalation.
- C. From their interactions with children and adults within this family where there opportunities for agencies to identify and assess domestic abuse risk.
- D. How can agencies engage with employers to ensure employees are made aware of access routes to support in areas of domestic abuse and key public health matters such as drug and alcohol misuse.

2.3 On the basis that;

1. There are no known incidents of domestic abuse involving either of the two main parties' subject of this Review prior to 2014
2. In 2014 Zoe's son first came to the attention of Statutory Services

It was agreed that the time period of this Review would be 2014 – 2016.

## **Timescales**

2.4 This review began on 1<sup>st</sup> September 2017 and was concluded on 6<sup>th</sup> March 2018. The Review was not completed within the six-month period stipulated within the statutory guidance. This delay was due to commissioning the Overview Reports translation into Polish prior to posting copies of the full Report to Mark's family in Poland. Time was allowed for the family to read and digest the contents of the report before they were contacted and their observations invited on the contents of the Overview Report.

2.5 Following the first meeting of the DHR Panel held on 15<sup>th</sup> September 2017 all evidence was secured, and chronologies of agency engagement with Mark and Zoe and their families were commenced.

## **3. Confidentiality**

3.1 The findings of this review are confidential. Information is available only to the Panel's participating professionals and their line managers.

3.2 The following pseudonyms were agreed by the Panel and are used throughout this report to protect the identity of the individual(s) involved.

Mark	male partner in the relationship. Deceased.	Aged 29 years
Zoe	female partner in relationship.	Aged 34 years
Kevin	son of Zoe.	Aged 17 years

3.3 All are white and their place of birth was Poland.

## **4. Methodology**

4.1 In May 2017 Merseyside Police notified St Helens Community Safety Partnership of the fatal incident. Members of the Community Safety Partnership met one month later on 15<sup>th</sup> June 2017 to agree the requirement for and then to commission a Domestic Homicide Review (DHR) in line with expectations contained within Multi-Agency Statutory Guidance for the Conduct of DHRs 2011 as amended in 2016.

4.2 As a result of the Community Safety Partnership decision the Chair of the DHR Panel was commissioned in September 2017.

## **5. Involvement of Family, Friends, work colleagues, neighbours, and the wider community.**

5.1 The Coroner opened the inquest into Mark's death on 13<sup>th</sup> January 2017, and that day released Mark's body for burial in Poland where he now rests.

5.2 Prior to the fatal incident Mark's brother was a resident of St Helens and on the 23<sup>rd</sup> December 2016 Mark's parents arrived in the U.K. in order to attend a family and friend's party. However following Mark's death all his family and friends returned to Poland.

5.3 Zoe also returned to Poland very shortly after her acquittal at Court and she now lives in Poland together with her son at her parent's home.

5.4 Kevin had returned to Poland, before the fatal incident, for the Christmas holiday, staying with extended family members, and he now remains living in Poland.

5.5 During enquiries with the College of Further Education that Kevin attended it was established that a tutor from Kevin's course continued to maintain contact, via email, with him. At the request of the Chair of the Panel the Tutor kindly agreed to forward to Kevin an email from the Chair asking if he would take part in the DHR. This email was accompanied by a Home Office leaflet for Family and Friends which had been translated into Polish.

5.6 Kevin did not however, reply to his Tutor's email and has not been in contact with the Tutor via email since.

5.7 Ewa Wilcock (Manager of the National Polish Domestic Violence Help Line) alerted other Panel members to the support available to the DHR from the Polish Consulate.

5.8 Contact was made by the Chair with the Vice Consul at the Polish Consulate in Manchester who undertook to trace the whereabouts of Mark and Zoë's family in Poland and to also establish, via contacts made by the local Police, their willingness to take part in the Review.

5.9 Home Office leaflets for Family and Friends, which had been translated into Polish, were made available to the Polish Consulate. These were also given to Mark and Zoe's family when they received the invitations to take part in the Review.

5.10 Marks mother, father and brother all agreed for their contact details to be shared with the Panel and also indicated their desire to take part in the Review.

5.11 Merseyside Police investigations revealed that prior to his death Mark had been in regular contact with his family in Poland. Mark's mother said that she always

probed him about his relationship with Zoe after her other son had told her of domestic incidents between the couple. Despite her probing Mark was never forthcoming about this with his mother.

5.12 Contacts were made with Marks family but it was soon established that none of the family were able to speak English. In these circumstances Panel Member Ewa Wilcock agreed to complete interviews with family members by telephone.

5.13 Ewa interviewed Mark's mother, father and brother. There was, the Panel felt, no requirement to amend the key lines of enquiry as a result of these interviews with family members and no change was requested by them.

5.14 Mark's mother knew of problems within the relationship between Mark and Zoe explaining that she knew that they argued a lot and after such incidents Mark would go and briefly stay at his brother's home, also in St. Helens.

5.15 Marks mother advised that the incidence of such arguments increased once Mark found out about the affair Zoe was having with another colleague from work. This affair led to a temporary separation of the couple during which they lived apart.

5.16 Marks father witnessed Zoe assault Mark at the friend's party on 26th December 2016 and his mother describes how the following day all the family then tried to persuade Mark to return home to Poland with them. Mark declined the offer and responded by telling his family that he wanted to speak to Zoe.

5.17 Marks mother describes how "*deeply in love*" Mark was with Zoe and they were aware that following disputes during which Mark went to stay at his brothers Mark would receive contacts from Zoe's sister. She would ask Mark to go back to Zoe because "*Zoe was not eating and did not go to work*". The love the couple had for each other was also later described by Kevin who said that despite a volatile relationship his mother "*loved Mark and always forgave him.*"

5.18 Zoe and her family including Kevin were also traced and contacted via the Polish Consulate. They too were asked to indicate their willingness to contribute to the Review.

5.19 The Consulate later received notification from Zoe's family that they did not wish to take part in this Review and requested that their contact details not be shared with the Review.

5.20 One of Zoë's sisters, Janet, continues to reside in St Helens. An address for Janet was obtained and the Chair wrote to Janet seeking her involvement with the DHR. A Home Office Leaflet for Family and Friends translated into Polish was also included with the letter.

5.21 No response was received to this letter and therefore Janet was contacted by telephone and messages left for her to indicate her desire to take part in this Review.

This also failed to obtain any form of response from Janet. Calls to Janet's home address made by the Chair also went unanswered

5.22 Once completed the draft Overview Report was translated into Polish and copies posted to all members of Mark's family who had contributed to this Review using the address obtained via the Polish Consulate. A letter also translated into Polish accompanied the Overview Report in which the family were advised of their ability to alter or amend the Report contents.

Having allowed sufficient time for Mark's family to read and digest the contents of the Overview Report on behalf of the Panel Ewa Wilcock then contacted the family by telephone in order to obtain any feedback from them. Having read the report both Mark's parents disagree with some of the reports contents because they do not believe that there was any domestic violence within Mark and Zoe's relationship. They acknowledge, as they indicated when first interviewed, that there were arguments between the couple but this they attribute to Zoe's excessive consumption of alcohol. Mark's parents feel a great sense of injustice following the verdict at the trial of Zoe in Liverpool and have begun legal proceedings against Zoe in Poland.

5.23 Mark's brother was also spoken to by Ewa and he stated that he had no comment to make but having read the report he could say that the report describes things as they actually happened.

5.24 Friends and associates of Mark and Zoe were also interviewed as part of this Review. An interview was completed by the Chair of the Review with the Manager of the local glass inspection and packaging factory which employed both Mark and Zoe. The manager reported that there had been no conflict between Mark and Zoe whilst at work and he had not seen any injuries or others signs of abuse on either of them. He described them as "*two very nice people who he would employ again*". Since the date of the fatal incident Zoe has not returned or made contact with her former employers.

5.25 During his enquiries to trace family and friends of Mark and Zoe the Chair was able to identify a community worker who on a voluntary basis provided help and support to Polish nationals who had come to live and work in the U.K. When interviewed by the Chair this person said that he had been in contact with Mark and Zoe and had provided them support in resolving tenancy matters during the period when they first began their relationship.

5.27 This contact was not maintained throughout their relationship as the community worker felt they were happy together in the relationship and no they longer required any further support from him.

5.28 At the request of the Panel the Local Area Housing Manager completed interviews with immediate neighbours to Mark and Zoe's former home. It was established that one of the neighbours had heard disputes taking place and on one occasion had witnessed domestic violence taking place between the couple. The neighbour said that these matters were reported to Merseyside Police at the time and the following day to the local area housing manager. Record searches by Merseyside Police and Torus have unfortunately been unable to locate these incident reports.

5.29 The Panel were advised that a friend of Zoe's had received a number of social media contacts from Zoe disclosing the domestic abuse she was suffering within her relationship. It was reported that the person still lived and worked in St Helens. Enquires with her former place of work revealed this information regarding her current whereabouts to be incorrect. The Panel has been unable to locate her.

## **6. Contributors to the Review.**

6.1 A DHR Panel was established by St Helens Community Safety Partnership comprised of the following agency representatives:

- Stephen McGilvray, Independent Chair of DHR Panel
- Martin Earl, Merseyside Police
- Neil Fairhurst, Torus Group (Housing)
- Gill Healy, Torus Group (Housing)
- Wendy Wright St Helens MBC Domestic Violence Co-ordinator
- Andrea Derbyshire Northwest Boroughs Healthcare NHS – Children's Safeguarding
- Nina Ellament, Principal Solicitor Peoples Services St Helens Council,
- Julie Dunning St Helens MBC Public Health
- Samantha Atkinson, Clinical Commissioning Group Safeguarding Service
- Jason Pickett, St Helens Council, Assistant Director Community Services
- Natalie Hendry St Helens and Knowsley Teaching Hospitals Adult Safeguarding
- Catherine Ballans St Helens MBC People's Services Manager
- Ewa Wilcock, Manager Polish Domestic Violence Helpline.
- Simon Cousins St Helens MBC Equalities Officer

6.2 Expert guidance on issues of domestic abuse was provided to the Panel by Wendy Wright St Helens Council Domestic Violence Coordinator and co-ordinator of the MARAC (Multi Agency Risk Assessment Conference).

6.3 Expert guidance was also provided to the Panel by another Panel Member, Ewa Wilcock the Manager of a National Polish Domestic Violence Helpline which is based in another North-West Authority area.

6.4 The Polish Domestic Violence Helpline is a registered charity the main purpose of which is to provide Polish people who are experiencing domestic violence with a confidential contact, which will allow them to talk about their situation in their native language and to obtain information about available help and support. It co-operates with English and Polish organisations and support groups with the aim of referring victims to them and uses the Safe Lives DASH risk checklist.

6.5 The Panel met a total of 4 times during the course of this Review with meetings held on the following dates;

15 <sup>th</sup> September 2017	Chaired by Stephen McGilvray
9 <sup>th</sup> October 2017	Chaired by Stephen McGilvray
27 <sup>th</sup> November 2017	Chaired by Stephen McGilvray
6 <sup>th</sup> March, 2018	Chaired by Stephen McGilvray

## Individual Management Reviews

6.6 The following agencies submitted Individual Management Reviews:

- Merseyside Police
- North West Boroughs Healthcare (CAHMS)
- St Helens and Knowsley Teaching Hospitals NHS Trust
- St Helens Clinical Commissioning Group
- St Helens Council Peoples Services
- St Helens Youth Offending Service
- Torus Housing

6.7 None of the DHR Panel Members or the authors of agencies Independent Management Reviews had any previous contact with anyone from Mark or Zoe's family nor any involvement with the investigation of the fatal incident.

## **7. Chair of the Domestic Homicide Review Panel**

7.1 St Helens Community Safety Partnership commissioned Stephen McGilvray to Chair the Review Panel and he was appointed in September 2017. Stephen McGilvray is also the author of this overview report.

7.2 Stephen McGilvray is a former Head of Community Safety in a different Local Authority where he worked for nine years. Included within his area of management responsibility within that Authority was a multi-agency co-located team of professionals focussed on providing support to victims of domestic abuse and their families. This role included responsibility for the coordination and commissioning of services to meet the needs of domestic abuse victims and their children. During the period this unit was under Stephen's management the team achieved CAADA Leading Lights accreditation for the quality of its systems and risk management processes.

7.3 Whilst Head of Community Safety Stephen also had management responsibility for the Integrated Offender Management Unit a multi-agency collocated team of Police, Probation, and Substance Misuse workers whose role was to reduce the level of threat and risk posed by offenders, including perpetrators of domestic abuse.

7.4 Stephen has successfully completed the Home Office training course for Chairs of DHR's. He was responsible for the development of a reciprocal agreement with a neighbouring Authority in relation to the Chair and writing of reports following the work of DHR Panels and has completed several Overview Reports as well as taking part in a number of Serious Case Reviews. Prior to this Stephen had completed 30 years Police service.

7.5 Before undertaking this Review Stephen McGilvray has not had any involvement with the individual people subject to this Review, nor is he employed by any of the participating agencies.

## **8. Parallel Reviews**

8.1 This Review did not run parallel with any other Review or any criminal investigation. The criminal trial was concluded one week after the DHR was commissioned by St Helens Community Safety Partnership.

8.2 No other reviews or inquiries have been used to inform the work of this Panel or this Overview Report

8.3 Issues of children's safeguarding did however emerge during the course of this Review in regard to Kevin. On identification of these issues liaison took place between the Chair of this Review and the Chair of the Local Safeguarding Children's Board (LSCB) whereupon it was agreed that a parallel Review would not be undertaken by LSCB at this time but the findings of the DHR Panel on matters of a children's safeguarding nature would be shared with the LSCB at the conclusion of this Review.

## **9. Equality**

9.1 Mark, Zoe and Kevin are all Polish born nationals and English was not their first language however Kevin could speak English fluently.

9.2 The Review found evidence that on all occasions that language became a barrier during face to face meetings between Mark, Zoe and agency professionals the appropriate measures were put into place to support Mark and Zoe.

9.3 The Chair of this Review sought out groups that existed to support non-U.K. born victims of domestic abuse who were Polish and invited Ewa Wilcock, Manager of one such service (National Polish Domestic Violence Helpline) to form part of the Review Panel.

9.4 The Review is indebted to the support provided by Panel Member Ewa Wilcock and the Polish Consulate in Manchester which has facilitated the participation in the Review of Mark's family who might otherwise have been excluded from doing so.

9.5 The Panel at its first meeting agreed that one of the key lines of enquiry for this Review should be examination of any barriers for non-U.K. born residents to access domestic abuse support services. The outcome of that key line of enquiry is included later within this report.

9.6 At no time during the Review did the Chair have to challenge any Panel member on the grounds of equality or diversity.

## 10. The Facts

### Background of Zoe and Mark.

#### Zoe

10.1 Zoe is one of five sisters born and raised Poland. In 2006 Zoë's mother and two of Zoe's sisters were living in St Helens. At that time Zoe's mother worked at the same factory that Zoe was employed at prior to the fatal incident.

10.2 Zoe was not fluent in English and did require the support of an interpreter in face to face contact with agencies.

10.3 Whilst living in Poland Zoe had been married and had given birth to a male son Kevin in 1999. Zoe divorced and her former husband and son did not accompany Zoe in her move to the U.K. Initially retaining her married name Zoe reverted to using her maiden name in May 2012.

10.4 Zoe had migrated to the U.K. for employment and, Housing records show that Zoe was living in the U.K. as long ago as 19<sup>th</sup> July .2010, in private rented accommodation, a house she shared with a male colleague from work.

10.5 In 2011 Zoe applied for a tenancy of her own to a Registered Social Landlord, Torus.

10.6 In 2013 Zoe again moved house and began living with her maternal Aunt and Uncle at another address in St Helens but within 8 months, in December 2013, she had again signed her own tenancy with Torus, remaining in St Helens. At this time Zoe had now begun work at a glass bottle inspection and packaging company in St Helens

10.7 In January 2014 within 2 months of moving into this new tenancy Zoe's son, Kevin, then 15 years of age had travelled over from Poland and he moved into the home with her.

10.8 English was not Kevin's first language however, he was a fluent English speaker and did not require the support of interpreters in any interactions with agencies.

10.9 Kevin attended a secondary school in St Helens before moving to the local College of Further Education to complete his studies. Enquiries were made with Pastoral Teams at the School and College attended by Kevin but it was established that he did not disclose to either School or College about the domestic abuse he was witnessing in his home nor was there any indication to the School or College that Kevin was witnessing domestic abuse.

10.10 During the completion of a Youth Offending Service (YOS) assessment of Kevin in 2014, prior to Zoe and Mark being in a relationship, the report shows that there were no reports from either Kevin or his mother of any domestic violence or harm. As part of the assessment, made by the YOS member of staff, questions regarding domestic abuse at home were asked of Kevin and he stated that he *“has never seen people within his family having fights and arguments”*.

10.11 A little over 12 months after taking up her new tenancy Zoe began cohabiting at that address with Mark and they remained living together continually until the date of the fatal incident. Apart from a two-month period in 2016 when Zoe separated from Mark and began a relationship with another male worker from the factory who she cohabited with for the duration of that relationship.

10.12 During the early stages of their relationship a volunteer community worker, of Polish origin, who provided support, access to G.P. registration, schools, and benefits etc. for recently settled Polish people did provide support to Zoe and Mark however, in those early years *“they appeared to be happy together and having no need for further help”* from him. As a consequence, he lost contact with them.

## **Mark**

10.13 In December 2013 Mark moved to UK from Poland on the promise of employment and he initially lived with friends of his family who had first alerted him to the work in St Helens. That offer of work did not immediately materialise and he was unemployed until gaining employment at the same glass bottle inspection and repackaging company in St Helens that Zoe was employed at.

10.14 Mark was not fluent in English and did require the support of an interpreter on occasions.

10.15 In April 2015 Mark registered with the social landlord, for the property in which Zoe lived, that he was cohabiting with Zoe.

10.16 In October 2015 Mark, Zoe and Kevin moved to another property in St Helens, owned by the same housing provider, located very close to their place of work, where they remained until the fatal incident.

10.17 At the factory Mark worked 12 hour shifts which varied between 6am – 6pm day shifts and 6pm – 6am night shifts. This shift pattern was different to Zoe who worked on a permanent 6am – 2pm shift.

10.18 When speaking to the Manager of the factory he advised Stephen McGilvray that both Mark and Zoe were in his opinion *“very nice people and he would employ either of them again.”* He advised that he had not witnessed any incidents of

domestic abuse taking place in the workplace and that he had not seen any obvious signs of physical injury on either of them.

10.19 Both Mark and Zoe when not in work consumed strong Polish lager alcohol and in 2015 when receiving treatment for a self-inflicted injury Kevin declared that both his mother Zoe and Mark were alcoholics. Zoe when interviewed by officers investigating the fatal incident confirmed that she and Mark both consumed alcohol after work and that she “*would shake*” if she didn’t consume alcohol.

10.20 Kevin also disclosed following his treatment for the self-inflicted injury that Mark was physically abusive towards him.

## **11. Summary of key events.**

11.1 The catalyst for the dispute which led to Mark’s death the next day was a party at the home of family friends held on Boxing Day 26<sup>th</sup> December 2016. Mark and Zoe together with Mark’s parents, who had travelled over from Poland to see their son, all attended the party.

11.2 During the course of this party Zoe believed that Mark had been too attentive towards another female at the party and she struck Mark and continued to kick him to the body as he lay on the floor. Zoe left the party immediately after this incident.

11.3 During the early evening of Tuesday 27<sup>th</sup> December 2016, following a dispute between herself and Mark, Zoe went to the home of a neighbour and asked her to telephone for an ambulance.

11.4 An ambulance and a trauma incident Doctor attended the home address of Mark and Zoe but despite their efforts to save his life, Mark was pronounced dead at the scene.

11.5 Zoe described to Police the circumstances leading up to Marks death.

11.6 Zoe explained that she had been in bed when her partner Mark returned home with some beers. She formed the opinion that he was drunk, so she went downstairs to make herself a sandwich. Zoe alleges that Mark then began calling her names, shouting at her, saying she “*was a whore and had been shagging around*”.

11.7 She stated that Mark then took hold of her by the arm and began to throw her around the kitchen area and against the cupboards, while continuing to insult her. Zoe explained that she picked up a knife from the kitchen to scare him and stop him from hurting her. She stated that Mark came towards her whilst she was holding the knife and the knife entered his chest. She did not realise this had happened until

Mark fell to the floor. It is Zoe's assertion that Mark must have impaled himself on the knife she was holding and that she did not intend to murder or hurt him.

11.8 A neighbour confirms hearing Mark shouting to Zoe that she was coming home and complaining about his behaviour but that Zoe "*was sleeping with someone else.*" The argument continued until the neighbour banged on the adjoining wall and the shouting stopped. Later however the shouting between Mark and Zoe was heard to begin again and the neighbour heard three loud bangs and then all went quiet.

11.9 A post mortem examination was carried out and it was established that Mark died, as the result of a single stab wound to the chest. The knife used had passed through the very lower tip of the heart and entered the top of his liver.

11.10 An inquest into Mark's death was opened and adjourned on 13<sup>th</sup> January 2017.

11.11 Both Mark and Zoe were employed by the same company, which was where they first met. They began a relationship together and in April 2015 began living together. The couple shared their home together with Kevin, then aged 16 years, who is Zoe's son from a previous relationship.

11.12 In 2015 treatments and consultations were held with Kevin and Zoe following Kevin's admission to hospital after self-harming himself. During these meetings Kevin disclosed to professionals working with him that he felt that his mother Zoe was an alcoholic.

11.13 At the conclusion of these meetings the Social Worker present spoke with Zoe independently about her alcohol abuse and offered to make a referral for her to alcohol support services but Zoe declined this.

11.14 When registering with a G.P. for the first time during their health checks Zoe disclosed that she drank 0 units of alcohol per week and Mark disclosed he drank only 4 units of alcohol per week.

11.15 The professionals, report that at no time during these consultations with Hospital staff, Social Workers, and staff from CAMHS was there any evidence to suggest indicators of domestic violence as features in Kevin's life at that time.

11.16 Following the initial CAMHS and Social Care assessments and prior to Kevin's discharge from hospital arrangements were made for a planned follow up post discharge appointment with CAMHS for Kevin and Zoe. Neither attended the appointment. Further attempts to liaise with Kevin and Zoe were made by CAMHS via their G.P. and Children's Social Care all of which were unsuccessful.

11.17 However, during the investigation of the fatal incident Police interviewed Kevin who said that he observed violence and verbal arguments between Mark and Zoe on a regular basis and on one occasion he saw Mark strangle his mother in the street

outside their home. His happy relationship with Zoe deteriorated and he spent more time away from home to avoid seeing his mother's distress and increased alcohol consumption.

11.18 Police report that Kevin had told them that he planned to return to Poland realising his mother loved Mark and always forgave him for the abuse.

11.19 In June/July 2016 a neighbour witnessed a domestic violence incident involving Mark and Zoe in the rear garden of their home. Mark was heard to shout "*I am going to f.....g kill you*" and was then seen to punch and kick Zoe about the face. The neighbour intervened by shouting at them to stop. The violence stopped and no further shouting was heard from Mark and Zoë's home that night. The neighbour states that they reported the matter to Merseyside Police who later attended but were unable to gain access into the house. A couple of days later the neighbour saw Zoe and on speaking to her noted that her eye was bruised.

11.20 Marks mother states that in October 2016 following Mark's discovery that Zoe was having an affair with another work colleague and the increase in the number of arguments the couple were having Zoe "*attacked Mark with a knife*" injuring his hand. This matter was not reported to Police, Mark did not require hospital treatment for his injuries but the means by which the injury had occurred were shared with a manager at Mark's place of work.

11.21 During Police interviews following her arrest Zoe described the relationship with Mark as being good, until late 2016, when they started arguing. She added that they would argue, but there was never any violence. She blamed Mark's jealousy for the arguments, stating that he believed that she was having an affair with someone else.

11.22 Zoe admitted that they both consumed alcohol on a daily basis and if she didn't drink, she "*would break out in cold sweats*". She admitted to having a problem with alcohol, stating that she generally drank five or six cans of beer each day, although her preference was wine. She also states that Mark would drink Vodka, although he occasionally smoked cannabis.

11.23 Zoe blamed alcohol for triggering Mark's anger.

11.24 The arguments which the couple had and one incident when Mark banged Zoe's head against the bath were never reported to the Police by Zoe because she states "*she didn't want to get him into trouble, as she loved him*".

11.25 In September 2016 Zoe began a relationship with a work colleague and moved out of the home, she shared with Mark, for a period of two months. Following this brief separation Mark and Zoe resumed their relationship together and by the end of November 2016 were reported by another family member and a friend of Zoe to be "*very happy together*"

11.26 A statement made to Merseyside Police from the male with whom Zoe had an affair states that Zoe had been strangled and attacked by Mark. He provided Police with social messenger details of threats to kill Zoe from Mark, and he paints a picture of a relationship that was volatile.

## **12. Overview.**

12.1 Mark, Zoe and Kevin all had contact, though limited, with agencies and professionals during the period when they were in a relationship.

12.2 However, there are no records held by agencies forming part of this Review of any disclosures or incidents of domestic abuse taking place involving Mark and Zoe.

12.3 During the time Kevin lived with Zoe and Mark he also came into contact with a number of professionals but never disclosed the level of abuse that was taking place within the relationship until post incident interviews with the Police.

12.4 CAMHS include within their IMR following their contact with Kevin that "*there was no evidence to suggest indicators of domestic violence as features in Kevin's life at that time*".

12.5 The Manager of Mark and Zoe's workplace did not witness any disputes between the couple nor did he recall seeing signs of injury carried by either Mark or Zoe.

12.6 It is however clear that statements obtained from family and friends of Mark and Zoe as part of the Police investigation following the fatal incident that domestic abuse was present within their relationship. One describes the relationship between the two as "*volatile*".

## **13. Analysis**

13.1 The DHR Panel agreed the following key lines of enquiry be undertaken as part of the review of this case and the Panel now report as follows.

### **13.2 Key line of enquiry**

**What policies and what level of capacity exists within each agency for non-U.K. born residents to;**

- 1. Overcome barriers to reporting domestic abuse**
- 2. Encourage victims/survivors of domestic abuse to disclose and report the abuse.**
- 3. Respond to needs identified following their report.**
- 4. What training of staff is undertaken to equip staff to deal with these issues.**

13.3 All agencies, taking part in this Review have arrangements in place for access to interpretation, services at short notice should the need arise. Additionally, all agencies taking part in this Review will upon request make available copies of their information and advice leaflets in any language required.

13.4 There are however clear gaps within agencies' response to overcome language barriers between professionals and clients. In some cases, following the initial engagement, subsequent follow up provision of letters and notices etc. were provided only in English, and therefore excluded the client.

13.5 However, there is also an inequality of access to services present in all agencies taking part in this Review within their web-based support to victims of domestic abuse. A client could not locate the relevant advice and guidance regarding domestic violence they seek by searching the websites using their native language. They must first use English to take them to the relevant pages on the website before they can obtain an immediate translation.

13.6 "In 2016, the number of UK residents born in Poland was estimated at 911,000, making them the largest foreign-born group in the country, and there is a wider population of British Poles, including the descendants of over 200,000 immigrants who settled in the UK after World War II. The Polish language is the second most spoken language in England and the third most spoken language in the UK after English and Welsh. About 1% of Britain's population speaks Polish."

Office for National Statistics

13.7 Yet the Review was unable to find any examples of training staff within the agencies represented at this Review which had been undertaken with the aim of raising their awareness of cultural issues for this group of non-U.K. born residents.

13.8 Nor could any agency illustrate a partnership or joint working with any group existing specifically to support Polish people in the U.K.

13.9 A possible consequence of this lack of training is that the Police Officers investigating this fatal incident did not immediately alert the Polish Consulate of the death thus preventing the Consulate from providing much needed support to the families of Mark and Zoe.

13.10 The Panel were unable to find any research relating specifically to the experience of Polish victims of domestic abuse within the U.K. however, research has reported on experiences of Black and Minority Ethnic (BME) victims of abuse.

13.11 Women who accessed support services stated that they preferred to receive BME specific support as the service provided was accessible and relevant to them. (Call to End Violence Against Women and Girls, 2011; Hester, et al., 2012).

13.12 The support of a BME specialist service was a key factor for them (BME victims of abuse) in accessing the criminal justice system, including contact with police and courts. (Thiara & Roy, 2010)

13.13 Generic services are four times as likely to be unable to meet a woman's support needs in community based services than specialist services (Taylor, 2013).

13.14 Agencies taking part in this Review make no exemption, based upon any of the nine characteristics contained within The Equality Act 2010, when responding to identified need and an established and robust MARAC process exists within the Borough to support this.

13.15 The Review did find an example of good practice within the St Helens area in relation to the identification of non-reported domestic abuse.

13.16 Torus have a concern raising/alert system in place for their in-house contractors called ABC Respond. To accompany this there is ongoing training for contractors who enter people's homes during the course of their duties which enables them to recognise and report concerns on safeguarding and matters of abuse. All Torus properties are inspected annually during the gas safety inspection and contractors are required to report "*concern or no concern*" at job sign off.

### **13.17 Key line of enquiry**

#### **What more can housing providers do to encourage neighbours who are aware of domestic disputes taking place to report it and help prevent an escalation.**

13.18 The Review felt the need for this to be included as a key line of enquiry on the grounds that Zoe when interviewed stated that she chose not to report the abuse and the domestic abuse was hidden to agencies. However, during Police investigation of the incident it emerged that one of the neighbours could provide evidence of domestic abuse taking place within Mark and Zoe's home.

13.19 Transmitted through the adjoining walls of the properties, shouting and threats could be heard, and on one occasion the neighbour witnessed an assault taking place in the rear garden of the house which took place in June/July 2016. Six months before the fatal incident.

13.20 There is no record held by Merseyside Police or by Torus, the housing provider, of any reports to them by neighbours of this domestic abuse.

13.21 Torus have a concern raising/alert system in place for their in-house contractors called ABC Respond referred to earlier within this report, and have an extensive range of Neighbourhood Offices and Managers to which issues affecting the quality of life in their tenancy can be reported.

13.22 Torus also have a referral route into their Complex Needs Team for tenants having difficulty in maintaining their tenancy for a variety of reasons and included within this is domestic abuse. A Complex Needs Officer or Independent Domestic Violence Advocate (IDVA) will contact the tenant and complete an assessment of need and then will work with that tenant to overcome or reduce these needs and that support will remain in place with the tenant for up to one year.

13.23 Torus did not prior to this Review, have in place a reporting process which specifically promotes tenants reporting domestic abuse taking place in adjoining properties. However, available from January 2018 will be an interactive section on the Torus website with information and advice for victims of domestic abuse and others such as neighbours to report and access services for domestic abuse.

#### **13.24 Key line of enquiry**

**From their interactions with children and adults within this family where there opportunities for agencies to identify and assess domestic abuse risk.**

13.25 Due to their limited involvement with agencies and professionals the Panel felt that there is only one occasion when agencies had an opportunity to identify and assess the domestic abuse risk present within this relationship.

13.26 This followed an incidence of self-harm and subsequent hospitalisation of Kevin, who was a student at St Helens College at this time, during which he made statements as to why he had self-harmed. From the point of view of this key line of enquiry, the significance of the statement made at the time of his hospitalisation becomes greater when combined with;

- A failure of agencies to follow up the non-attendance of Kevin at the arranged CAHMS meeting. (This denied professionals the opportunity for further investigation of the context within which Kevin self-harmed which may in turn have led to a disclosure regarding the domestic violence he was witnessing in the home.)
- Disclosures Kevin made during Police interviews post the fatal incident.

13.27 Combined they may provide an indication that domestic abuse was taking place within Kevin's home at the time of his self-harm and that domestic abuse may have been one of the driving factors behind his self-harm.

13.28 The Panel makes no comment upon the treatment and support Kevin was afforded whilst in hospital which was all in accordance with the agreed policies. However, had agencies persisted in trying to contact Kevin and his mother when they failed to attend the follow up appointment and then continued to support Kevin post the self-harm, then he may have disclosed the incidence and scale of domestic abuse much earlier.

13.29 During Kevin's period of hospitalisation all safeguarding policies were followed and appropriate referrals and assessments made but at no time did Kevin or his mother disclose domestic abuse. Nor did any of the professionals, who came into contact with them during this time, raise any concerns about the presence of domestic abuse with this family.

13.30 The key elements for this Review relate to the following;

- When being treated in hospital for his serious self-inflicted injury Kevin told Doctors that the reason for his actions was that he felt "*he was a burden to his mother and wanted to die*". At this time Zoe and Mark were cohabiting.
- When interviewed by Police after the fatal incident Kevin disclosed that "*his happy relationship with his mother had deteriorated*"

13.31 Reflecting upon these two statements both describing his relationship with his mother, made at different times within Mark and Zoe's relationship, they provide an indication that the primary reason behind the feelings that Kevin describes may have been the domestic abuse he was witnessing taking place in his home and the impact this was having upon his mother whom he was clearly very close to.

13.32 This belief is further supported by other disclosures made by Kevin during his interview with Police post the fatal incident.

13.33 The outcome of witnessing domestic abuse in his home was that in addition Kevin self-harming he was seeking to distance himself from Mark and Zoe.

13.34 Post incident Kevin told Police Officers that "*He observed a dramatic change in his mother after she met Mark. He witnessed violence and verbal arguments on a regular basis, on one occasion he saw Mark strangle his mother in the street outside their home. His happy relationship with her deteriorated and he spent more time away from home to avoid seeing her distress (following the domestic abuse and*

*violence) and her increased consumption of alcohol. Prior to the fatal incident he planned to return to Poland, realising his mother loved Mark and always forgave him (for his domestic abuse and violence towards her)”*

The incident of Zoe being “*strangled*” in the street was not reported to any agency.

13.35 Whilst receiving treatment in hospital all Trust policies in relation to Kevin’s well-being, safeguarding, and mental health were followed. Referrals were made to CAMHS Assessment and Response Team who saw Kevin that same day and, due to the inability to contact Kevin’s mother who only attended hospital two days after his admission, a referral was made to St Helens Children’s Social Care.

13.36 Having completed a Children and Families Assessment Children’s Services closed the case immediately on the grounds that no action was required by Children’s Social Care.

13.37 The Panel questioned this decision on the grounds of safeguarding for two reasons. Firstly, despite efforts made by the hospital and Police it was two days after the incident of self-harm that Zoe first attended the hospital and secondly the statement made by Kevin to those treating him that Zoe was an alcoholic and they had no money for food.

13.38 The decision to close the case immediately was made by Social Care because they felt that the most appropriate avenue for care of Kevin was via CAHMS.

13.39 CAHMS interviewed Kevin prior to his discharge. A full mental health assessment was completed and CAMHS assessed Kevin as appropriate for psychiatric discharge.

13.40 Further on-going support was put into place prior to Kevin’s discharge with arrangements made for a follow up meeting by CAMHS with Kevin and his mother three days after his discharge.

13.41 The follow up appointment with CAHMS was not kept by Kevin or his mother and CAHMS made further attempts to re-engage with Kevin via his G.P. and by letters to his home address but without success.

13.42 Kevin’s G.P. did, following the notification from CAHMS regarding the self-harm and subsequent non-engagement, make attempts to contact Kevin and his mother. This was unsuccessful but the G.P. did not alert any other agency regarding the ongoing inability of services to engage with Kevin or his mother.

13.43 A review by CAHMS of the clinical record of this engagement with Kevin for the purposes of this Review highlighted the need and recognised the improvement required in the non-engagement policy and procedures for CAHMS services.

13.44 Their review of policies following this case has resulted in CAHMS redevelopment of their non-engagement procedures. Improved pathways for communication and information sharing amongst multi agencies, and CAHMS have created more robust processes in response to children and families who disengage from referrals to CAHMS.

13.45 At no time during his hospitalisation did Kevin or his mother make any direct disclosures regarding domestic abuse. Nor did any of the staff who came into contact with them during this time raise any concerns about the presence of domestic abuse with this family.

13.46 There is no indication of domestic abuse recorded within the G.P. or hospital records of Zoe, Mark or Kevin and the strong Pastoral and Safeguarding Team present within Kevin's school and college had no indication of the domestic abuse that Kevin was witnessing.

13.47 Zoe also disclosed to Police Officers during interview following her arrest that she "*chose not to report domestic abuse.*"

### **13.48 Key line of enquiry**

**How can agencies engage with employers to ensure employees are made aware of access routes to support in areas of domestic abuse and key public health matters such as drug and alcohol misuse.**

13.49 During the interview with Mark's mother she advised that just prior to attending the wedding of his brother in Poland in October 2016 "*Zoe attacked Mark with a knife*". This caused a hand injury which was seen by a manager at Mark's work. His mother advises that Mark was asked how this had happened and Mark told the manager how he had sustained the injury. This injury was not however reported to any other agency.

13.50 Kevin described both his mother and Mark as alcoholics and other family members describe the large part that alcohol played in their lives and how domestic disputes usually followed the consumption of alcohol.

13.51 Both Mark and Zoe were employed full time at the same factory. The Panel felt that in all instances in which domestic abuse and/or substance misuse is harming relationships between people, and in particular the circumstances surrounding this case where language barriers existed and there has been little contact with agencies, the absence of supportive literature being available in the workplace was an opportunity lost.

13.52 Following this Review support has been given to the factory at which both Mark and Zoe were employed by Public Health services and leaflets and posters in Polish are now available within the refreshment/rest room area of the factory.

13.53 The Chamber of Commerce were contacted by the Chair of this Review and agreed with the support of Public Health colleagues to use the network with industry that the Chamber of Commerce has to raise awareness and provide support in the workplace to managers and staff on issues of domestic abuse and substance misuse.

## 14. Conclusions

14.1 In spite of the recorded size of the Polish community within the U.K. amongst the agencies taking part in this Review there is only limited evidence to illustrate encouragement and support of Polish people now resident in the U.K. to report domestic abuse. There is an inequality of access to domestic abuse services for Polish people. There is a total absence of an end to end process within any of the agencies in which the language barriers faced by this group to reporting domestic abuse are resolved. Neither are there any specialist support services, within this Partnership area, in place to meet the specific needs of Polish victims of abuse.

14.2 At the time of the Review none of the agencies taking part employ Polish speaking members of staff within domestic abuse reporting or support services and there is no partnership with any other organisation or charity in place to overcome this. Nor are there any training programmes provided for agency staff to assist them in overcoming any cultural barriers to dealing effectively with domestic abuse within the Polish "*community*".

14.3 The weaknesses in re engaging clients and the consequences that failure can bring have been recognised by CAHMS and processes put into place as a result of that learning.

14.4 The Review recognised the individual and cultural difficulties surrounding the reporting of domestic abuse to agencies which exist within neighbourhood communities.

14.5 "*Grassing*" on neighbours who will continue to live next door to you generates a continuum of emotions ranging from never being an informer to those in authority

to a personal dilemma of choosing to becoming involved in a neighbour's relationship balanced with an individual's right to privacy in their own home.

14.6 As evidenced by this Review neighbour's failure to alert others can have serious consequences which may have been avoided. In particular in cases such as Mark and Zoe where agencies able to support victims of domestic abuse are unaware, prior to the fatal incident, of the abuse taking place within that relationship.

14.7 The responsibility for achieving this difficult cultural change rests with all agencies and neighbour reporting of domestic abuse should be promoted alongside the work to encourage victims of domestic abuse to report it.

## **15. Recommendations**

15.1 The majority of the recommendations emerging from this Review focus upon local issues present within the communities of St Helens however there is a recommendation contained within the action plan regarding the national support available for charities and groups representing BME communities.

15.2 The Panel recognised weaknesses present in all the participating agencies systems for accessing domestic abuse support and recommend actions are taken that would provide an equality of access for groups such as the Polish community in St Helens.

15.3 The Panel also recognised that opportunities exist to extend the reach of domestic abuse and substance misuse services into new areas by making information and support available within the workplace to victims of abuse and those needing support in dealing with issues of substance misuse.

15.4 A final recommendation and area for action concerns the need for agencies to pursue with greater vigour the re engagement of patients and their families, following an initial assessment, with key services such as CAHMS.

15.5 A full list of actions is included at Appendix A of this report.

# **Appendix A**

## **Action Plan**

<b>Recommendation</b>	<b>Scope</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones</b>	<b>Target date</b>	<b>Completion date and outcome</b>
Overcome barriers to accessing services	Local	CSP members to amend their websites to enable non English-speaking residents to search for and access information re domestic abuse services in their own language.	Community Safety Partnership (CSP)	CSP Partner agencies amended web pages are operational.	June 2018	Outcome. Non English-speaking residents able to search web pages using own language. St Helens Council Equality and Hate Crime web pages already amended to include details of National Polish Domestic Violence Helpline.
Overcome barriers to accessing services	Local	CSP members to ensure they have translation and interpretation arrangements in place and that staff understand how to access interpreter and translation services when needed.	Community Safety Partnership (CSP)	Ensuring agency has access to the service. Education program for all front line staff to make them aware of service existence and how to access it.	March 2018	Outcome. Service in place and all front line staff are aware of its existence.
Overcome barriers to accessing services	Local/Regional	Employment of Polish speaking Independent Domestic Violence	Community Safety Partnership	Polish speaking IDVA being in place.	June 2018	Outcome. Polish speaking IDVA in place within

		Advocates (IDVAs)				Community Safety Partnership.
Overcome barriers to accessing services	National	Increased support for existing charities and organisations which work with victims of domestic violence from BME communities	Home Office	Increase or redirection of Home Office funding for such services.	2018	Increase in number of charities supporting BME victims of domestic abuse.
Torus Housing to amend web site to encourage tenants greater reporting of domestic abuse.	Local	Amend web site to encourage and signpost ways in which victims and neighbours of victims can report domestic abuse to their Housing Managers and others.	Torus Housing Group	Web site up dated with required information.	January 2018	Victims and neighbours on accessing web site will be aware of gateways to reporting domestic abuse and the support which is available to them.
Review of system to follow up missed appointments following CAHMS referrals to G.P.	Local	Policy and procedures to follow up missed appointments put into in place	CCG	Policy and procedure written and agreed between CCG and CAHMS service.	June 2018	All missed appointments are identified and procedure followed to re-engage with patient/
Increase the number of companies and businesses making literature available detailing the support	Local	Working with the Chamber of Commerce make literature available for display in employee meeting areas to	Public Health	Establish link with businesses through the Chamber of Commerce. Make literature	June 2018	Advice on where to go to seek help and support in cases of domestic abuse and

<p>available to victims of domestic abuse and substance misuse.</p>		<p>businesses in St Helens</p>		<p>available to businesses for display in meeting rooms and refreshment areas. Once a pre discussion has taken place between the Chair and Advocate and key contacts have been established within workplaces a discussion between CGL and businesses can take place to offer something bespoke. The following can definitely be offered to businesses; Leaflets and general information in the Polish language. Stall in the workplace to raise awareness and engage with employee's on many</p>		<p>substance misuse available to more managers and employees in the workplaces of St Helens businesses.</p>
---	--	--------------------------------	--	--	--	---

				public health issues. \bespoke intervention dependent upon the needs and wants of the employer/employee. CGL (Change Grown Live) are ready to prioritise this and can begin liaison with the employer to develop a suitable approach.		
--	--	--	--	--	--	--

## **Appendix B**

### **Chronology**

## Comprehensive Agency Chronology

Date	Time	Source of evidence	Initials of Professional making entry	Family/ friend referred to	Event description, action taken, decision made
19.12.2011		I.T. Systems	SAW	Zoe	UoR application received in the name Zoe. On the application she also declared that she was house sharing with deleted who was a colleague from work. That her sister deleted was her family connection to St Helens who currently resides at deleted and had been in the UK for 5 years.
20.12.2011		I.T. Systems	SAW	Zoe	Letter sent from UoR requested employer's / employment details.
09.01.2012		I.T. Systems	SAW	Zoe	UoR receive letter from deleted confirming employment details.
11.01.2012		I.T. Systems	SAW	Zoe	UoR request a reference via letter from Zoe's current landlord.
09.03.2012		I.T. Systems	SAW	Zoe	Phone call to UoR from Zoe checking to see if her landlord had returned a completed reference.
03.05.2012		I.T. Systems	SAW	Zoe	UoR receive an L/Lord reference for Zoe confirming that she has been residing at deleted since deleted and there have been no issues. Landlord is deleted.
28.05.2012		I.T. Systems	SAW	Zoe	UoR received a letter from Zoe notifying them of a name change from deleted (Married name) to deleted proof provided .

18.06.2012	I.T. Systems	SAW	Zoe	UoR amendment received, notifying of a change of address to deleted, proof provided.
18.06.2012	I.T. Systems	SAW	Zoe	UoR amendment received, notifying of a change of address to 18 (Deleted), proof provided.
24.04.2013	I.T. Systems	SAW	Zoe	UoR amendment received, notifying of a change of address to deleted, proof provided also declared that she had moved in with her auntie & uncle deleted.
04.09.2013	I.T. Systems	SAW	Zoe	UoR amendment received, notifying now at C/o address 38A (Deleted), proof provided.
13.11.2013	I.T. Systems	SAW	Zoe	UoR send a letter offering accommodation / tenancy at 54 (Deleted).
29.11.2013	I.T. Systems CRM (Customer relationship management)	SAW	Zoe's Sister	Phone call to UoR from Janet arranging a viewing at 54 (Deleted).  Signup for 54 deleted - Zoe has an income of £ wage pw. Full rent payer, 2 weeks paid at sign up, DD form completed.
02.12.2013	CRM	Lettings/SL		SIGNED UP 2.12.13 - Tenant speaks very little English. Did have interpreter with her. Gas Stage 2 booked for Thursday PM. My Communal Key given to tenant (got Helena red key ring on it and I need it back when LO issue communal key) Wilko £130.
05.12.2013	I.T. Systems	SAW	Zoe	Helena Homes Neighbourhood Officer completes a home visit and provides Zoe with information on a coffee morning that takes place in the area that many Polish / Turkish residents attend.
16.01.2014	I.T. Systems	SAW	Zoe	Zoe called into Helena Central (HC) to add her son Kevin to her tenancy as an occupant.

				Letter sent from Helena Homes advising of a home visit on 1st April to complete post tenancy visit.
03.03.2014	I.T. Systems	SAW	Zoe	
11.03.2014	School health records	JF Nurse	Kevin and Zoe	School health service informed by school that child Kevin had transferred into the school from Poland. Kevin had no NHS number and not yet registered with a GP. Not known how long Kevin had been in England. Letter sent from school health service with health questionnaire for completion and return to school health service before any health assessments take place. This was not returned and not followed up by school health service.
17.03.2014	I.T. Systems	SAW	Zoe	Zoe called into HC to report a repair to bedroom light fitting.
01.04.2014	I.T. Systems	SAW	Zoe	Home visit by Helena Homes to complete post tenancy visit, Zoe was not at home, card left.
04.04.2014	I.T. Systems	SAW	Zoe	Repair to bedroom light fitting completed.
25.04.2014	I.T. Systems	SAW	Zoe	Zoe called into HC to request the gas connection to cooker to be raised to accommodate her cooker.
29.04.2014	I.T. Systems	SAW	Zoe	Repair to gas cooker connection completed.
21.05.2014	I.T. Systems	SAW	Zoe	Zoe called into HC to ask if any further works were required to the gas cooker connection. She was informed all works had been completed.
18.11.2014	I.T. Systems	SAW	Zoe	Letter sent to Zoe informing her of an overpayment and that she had been refunded £439.10, this was paid direct to her bank account.

26.11.2014	School health records	CH Nurse	Kevin	School health received a referral from St Helens Youth Offending Service requesting a health assessment for child Kevin and support to register with a GP and Dentist. Appointment made for Child KP to have the assessment 04/12/2014.
27.11.2014	CRM	NN		Approved for Home Swappers - Completed 12 months on 03.12.14. There were no issues with tenancy/rent to date at this property – just usual repairs etc.
03.12.2014	School health records	CH Nurse	Kevin and friend	School health service was contacted by a friend of Kevin to request a different appointment. Friend contacted school nurse as Kevin does not speak much English. Another appointment made for 12/12/2014. School Nurse met with Kevin to carry out a health assessment as planned. Kevin's English was enough to carry out the physical and emotional health assessment as planned. Kevin presented as generally healthy, did not know his immunisations status, was having additional support in school with his English language and learning, he informed the nurse that he had used cannabis but wasn't using at the time of the assessment, reported sleep disturbance, wasn't overly worried about anything and was attending a gym and using protein drinks to gain muscle. Kevin also reported that he had self-harmed and had split with his girlfriend which had affected him greatly. He wouldn't raise his sleeves to show the nurse. Kevin reported that he would be fine and declined a referral for support. Further appointment to see Kevin with his Mother in school 20/01/2015 to revisit the health plan.
12.12.2014	School health records	CH Nurse	Kevin	
20.01.2015	School health records	CH Nurse	Zoe	School Nurse met with Kevin and his Mother as planned. Kevin and Mother now registered with a GP and a Dentist. No outstanding health issues. School health contact details reinforced to Kevin and his Mother.
17.05.2015	I.T. Systems	SAW	Zoe	Zoe called into HC with proofs for her UoR application. She also completed an application to add Mark to her tenancy at 54 (deleted) as an occupant
28.05.2015	Medical		Zoe	attended the x-ray department following a GP referral for an ultra-sound pelvis.

notes

19.06.2015	I.T. Systems	SAW	Zoe	Letter sent by UoR requesting confirmation of Mark's addresses for the last 6 years and also to provide wage slips for the last 6 months
24.6.2015	I.T. Systems	SAW	Zoe	Home visit by neighbourhood officer to complete transfer inspection for UoR application. During the visit Zoe reported the window lock and the outer pane of her son's bedroom window broken.
29.06.2015	I.T. Systems	SAW	Zoe	window repairs cancelled due to no access. Zoe called into HC to provide supporting evidence for her UoR application. Letter from Mark providing previous addresses for the last 6 years until December 2013 he lived at deleted Poland. On arrival in the UK he lived at 2 - 6 deleted, in May 2015 Zoe
14.07.2015	I.T. Systems	SAW	Zoe and Mark	declared that Mark had moved into 54 deleted, although Mark provided wage slips as proof of address the earliest dating back to 12.4.15.
19.09.2015	Medical notes		Mark	Attended A&E with a fractured Right ankle after jumping from a bridge. He was put in a cast and was admitted due to being unable to weight-bear.
22.09.2015	Medical notes		Mark	Discharged home.
24.09.2015	I.T. Systems	SAW	Zoe	Letter send by UoR offering alternative accommodation / tenancy at 28 deleted.
25.09.2015	I.T. Systems	SAW	Mark	Mark contacted UoR by phone confirming that he and Zoe were interested in the offer of accommodation at 28 deleted.
28.09.2015	I.T. Systems	SAW	Zoe	Zoe called into HC to provide bank statement and proof of child tax credits as requested by Helena Homes.

06.10.2015	I.T. Systems	SAW	Zoe	Phone call to Zoe arranging an appointment to view 28 deleted.
09.10.2015	I.T. Systems	SAW	Zoe and Mark	Completed viewing at 28deleted and accepted the property.
14.10.2015	I.T. Systems	SAW	Zoe and Mark	Mark and Zoe sign for the tenancy at 28 deleted, Zoe also signed a notice to end her tenancy at 54 deleted on the 25.10.15.
26.10.2015	I.T. Systems	SAW	Mark	Mark called into HC to return the keys to 54 deleted on Zoe's behalf MJ contacted Emergency Duty Team. Kevin had been brought to Whiston Hospital by ambulance in the early hours of Sunday morning. He had staggered into a petrol station after cutting his left wrist and staff there had called an ambulance. The cut was described as severe and required surgery to repair the tendons. Kevin described that he felt like a burden to his mother, he said she is an alcoholic and they have no money for food. He said they had lived in the UK for 2 years. Hospital could not contact his mother and advised police had been to his home address but had also failed to make contact so had left a note requesting she contact the Ward. Checks were completed by the police on 22/11/15 (DC Jade Wright) who advised mum was not known to the police. Kevin reported to be known due to possession of amphetamines, 2 years ago. At the time of referral to EDT, Kevin was still in hospital awaiting a CAMHS assessment and mum had not been contacted.
22.11.2015	Staff Nurse, 3F Whiston Hosp	CB	Kevin	
23.11.2015	Staff Nurse, 3F Whiston Hosp	CB	Kevin	Case sent to CYPS Duty Team and allocated to social worker, to complete a C&F Assessment. C&F Assessment was completed and agreed no further action for children's social care.
15.01.2016	Medical notes		Mark	Attended fracture clinic, ankle is healing well.

18.03.2016	Medical notes		Mark	Failed to attend fracture clinic, discharged.
18.05.2016	IBS			IBS states that Mark was added as an occupant of 54 deleted on 18/6/15.
06.09.2016	I.T. Systems	SAW	Zoe	Zoe called into HC to re-arrange her appointment for her annual gas service.
27.09.2016	I.T. Systems	SAW	Zoe	Zoe reported online that the central heating boiler had broken down and that they had no heating or hot water .
28.09.2016	I.T. Systems	SAW	Zoe	Zoe called into HC to check when the central heating boiler would be repaired, she was informed 29.9.16.
29.09.2016	I.T. Systems	SAW	Zoe and Mark	Central heating boiler repaired and a new flue was fitted at the property.
20.11.2016	Medical notes		Kevin	Chest infection.
29/12/2016	Merseyside Police	CB	Zoe and Mark	Referral received from Merseyside Police to the Emergency Duty Team wanting a check to see if either Mark or Zoe were known to social care. Advised neither were known to services but EDT made police aware that Zoe had a son, Kevin aged 17 years. Screening by the Front Door Team advised that Kevin is currently in Poland and was due to return on 6/1/17. C&F Assessment completed. Kevin seen on 12/1/17. He was with mum's sister, Janet. He had come to St Helens to collect his belongings and was returning to Poland on 14/1/17. No further action - case closed.

30/12/2016	CRM	Onecall/JH	Janet	Called in by Neil Fairhurst (he is on call duty manager) he has received a call from Merseyside Police and requires a lock change - He has advised to bypass the charges and he has notified the on call joiner but can we ring him with a job number.
03.01.2017	I.T. Systems	SAW		<p>Email received from Janet stating her sister had been arrested and won't be needing the property at 28 deleted, she would be flying over from Poland on 5.1.17 to clean the property and remove any belongings from the address.</p> <p>Email sent by S Williams to Zoe sister in Poland – “return email sent to Zoe sister, she is currently in Poland but looking to come to the UK to organise her sister's affairs. She wants access to her sister’s tenancy to remove her belongings and also wants to terminate the tenancy on her sister's behalf. Return email sent to sister Dear deleted, Thank you for contacting Helena Partnerships with regards to your sister’s tenancy at 28 deleted. I appreciate that you will be travelling over from Poland to organise your sister’s affairs however, the tenancy Zoe has at 28 deleted is still currently a crime scene and is being held by police, therefore no one other than crime scene investigators are allowed to enter the property. I believe that the keys to the property are with officer Tracy Aubrey and her contact number is 0151 XXXX or 0151 XXXX. I have attached a form for your sister to complete, she will need to provide 4 weeks’ notice to terminate the tenancy at that address and the form will need to be signed by her. However, I understand that you will be wanting to clear her home of her belongings during your visit, in order to do this you will need to make arrangements with the police as they may not provide access at this time. I have provided you with the police officers contact details above. Please do not hesitate to contact me if I can assist you further. Regards Sharon”</p>
04/01/2017	CRM	SW		

04.01.2017	I.T. Systems & Self	SAW	Janet	Email sent to Janet - 28 deleted is still a crime scene and Helena would be unable to provide access to the address. Provided names and contact numbers for the police dealing with the incident and advised her to contact them prior to flying to the UK. Also provided a termination notice and advised her that her sister Zoe would need to complete this to terminate the tenancy.
11.01.2017	I.T. Systems & Self	SAW	Janet and Kevin	Janet and Kevin called into Helena East to speak with me, they provided a termination notice signed by Zoe which ended the tenancy on 15.1.2017. A letter was also provided from Zoe granting her sister Janet permission to enter 28 (deleted) to remove her belongings on her behalf. They were advised that the keys to the property were still with the police and that they would need to contact them to arrange access.
16.01.2017	I.T. Systems	SAW	Janet	Janet called into HC to return the keys to 28 deleted.
17/01/2017	School health records	GL Nurse	Kevin and Zoe	Health information provided to St Helens Multi Agency Safeguarding Hub following a request for information in light of an alleged murder at the family home.
11/04/2017	School health records	AD NNSC	Kevin	Referral made to St Helens LSCB Case Review Panel to determine any learning.