Domestic Homicide Review

Sarah

Died April 2016

Overview Report

Author Ged McManus
Date: 23 April 2017

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1 Introduction

1.1 This Domestic Homicide Review overview report is about Sarah who was murdered by her husband, Adam at their home in Stockport. Adam was arrested soon afterwards and was subsequently convicted of murder. He was given a life sentence with a minimum tariff of twenty years before parole can be considered. The Senior Investigating Officer considered whether this was a so called honour crime and decided that on the balance of the evidence it was not.

1.2 The couple met in 1999 when they were introduced to each other by their families in Pakistan. Adam had travelled to Pakistan for a family wedding and whilst there, the couples respective families agreed and arranged the marriage.

1.3 The marriage in Pakistan went ahead during the same trip and Adam returned home. Sarah moved to Stockport eighteen months later, where the couple lived with his extended family. Primarily this was Adam's parents but at different times over the years it also included Adam's sisters and their families. The couple had three children during the course of their marriage who all lived with them in the family home. At the time of her death both Sarah and Adam were thirty eight years old.

1.4 Sarah is a pseudonym chosen by the DHR panel and known to her family in Pakistan. The position with Sarah's family in Pakistan is explained later in the report. The Panel recognised the significant trauma that the family, especially Sarah's children have gone through and wish to express their sincere condolences.

1.5 The offender agreed to the pseudonym Adam when he was seen in prison.

2 Establishing this Domestic Homicide Review

2.1 Following Sarah's death, a Scoping Meeting by the Safer Stockport Partnership took place on 22nd June 2016, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 11th July 2016. A trial date was set for Adam in October 2016 and following liaison with the Senior Investigating Officer, the Safer Stockport Partnership made a decision to extend the timeframe for this DHR to 28th February 2017, in order to protect against the potential for witnesses in the trial to be compromised by the DHR process. That was later adjusted to 30 April 2017 to allow additional time for contact with Sarah's relatives in Pakistan.

2.1.2 DHR Panel

2.1.3 David Hunter was appointed as the Independent Chair in July 2016.

2.1.4 He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. He has never been employed by any of the agencies involved with this DHR. He was assisted by another independent practitioner, Ged McManus who wrote the report. Both have spent their professional lives in the public sector and were judged by the Chair of the Safer Stockport partnership to have the experience and skills for the task.

2.1.5 **The panel consisted of**:

Member	**Organisation**
David Hunter	Independent Chair
Ged McManus	Independent Author
Steve Skelton	Stockport MBC. Policy, Performance and Review
Anna Buchanan	Greater Manchester Police
Julie Parker	Stockport NHS Foundation Trust
Bilkis Hirani	Stockport MBC, Workforce Development [Children]
Karen McLaughlan	Stockport MBC, Workforce Development [Adults
Sue Gaskell	Stockport NHS CCG [representing GP practice]
Stephanie Longson	Stockport MBC, Ethnic Diversity Service
Leanne Baines	Stockport MBC, Domestic Abuse and Child Sexual Exploitation Team
Rebecca Key	Stockport MBC, Children's Social Care
Jo Lancaster	Stockport MBC, Adult Social Care
Nuala O'Rourke	Stockport MBC, Safeguarding and Learning

Lisa Spencer	Alliance for Positive Relationships
Yasmon Bukhairy	Great Manchester Fire and Rescue Service
Elaine Alkin	Stockport MBC, Administrator, Public Protection and Safety

2.2 **Agencies Submitting Individual Management Reviews (IMRs)**

2.2.1 The following agencies submitted IMRs.

Greater Manchester Police (GMP)

Stockport NHS Foundation Trust

Stockport Clinical Commissioning Group

School 1

School 2

Care Agency 1

2.2.1 As well as the IMRs, each agency provided a chronology of interaction with Sarah including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate.

2.3 **Notifications and Involvement of Families**

2.3.1 The families of Sarah and Adam come from the same area of Pakistan and are linked through marriage at many levels, Sarah has no blood relatives in the United Kingdom; they are all in Pakistan. Their first verbal language is Pashto. Stockport Children's Services used an interpreter to speak with Sarah's brother - the male head of the family - to ascertain their wishes about the future of Sarah and Adam's children and to inform them of the domestic homicide review. The DHR chair, with the help of Stockport Children's Service, attempted to replicate that arrangement but was unsuccessful. A court granted a Special Guardianship Order to Adam's parents and by mutual consent with Sarah's family in Pakistan the children will remain in England. One of Sarah's cousins in Pakistan, who lives in the same area as Sarah's brother is fluent in English but initial attempts to contact him by e-mail and telephone were unsuccessful. However, the panel persevered and telephone

contact was made with the cousin by the Panel chair on 3 April 2017 and e-mail communication was established. The cousin confirmed the family knew about the domestic homicide. The Panel chair offered to share the report with the cousin. The cousin suggested the following in an e-mail dated 5 April 2017.

'Further to the detailed letter attached to your email dated December 2015, I would be happy to help, give you some feedback and possible recommendations to help and avoid future incidents. I will speak to Sarah's brother too and also ask him if would like to give a mini statement so that we could have something collective from the whole family'.

At the time of submitting this report [23 April 2017] nothing further had been heard. The Panel felt further communication from them could be seen as intrusive. However, before the report is published, the Panel chair will send an e-mail to the cousin and offer the family an opportunity to see the report before it is published.

2.3.2 Adam's parents live in the family home in Stockport where he was brought up. His first language is English and his parents' first language is Pashto. They speak fluent English. The DHR Panel was keen to engage with Sarah's in laws given that she had lived in the home for many years and they would be able to provide insight into her life and also how they saw the relationship between Sarah and Adam.

2.3.3 The DHR chair wrote to Sarah's in laws. The letter and DHR leaflets from Home Office and AAFDA[1] [Advocacy After Fatal Domestic Abuse] were delivered by the family Social Worker from Stockport Children's Services. Despite substantial efforts by the social worker to encourage Adam's parents to contribute to the DHR they felt unable to do so. It seems the trauma of the homicide, the trial and family court proceedings have left them exhausted. They reported via the social worker that they now need to concentrate on rebuilding the family and not to be involved in another process that would hamper the beginning of that task. The DHR Panel understood that position and respected their wishes.

2.3.4 One of Sarah and Adam's children was old enough to make a meaningful contribution to the DHR. However, the Guardian ad Litem and the paternal grandparents felt it was not appropriate. Again that is a decision accepted by the DHR panel.

2.4 Terms of Reference

[1] A registered charity [number 1125973] which supports the families of domestic homicide victims.

2.4.1 The purpose of a DHR is to:

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

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

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

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

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

Highlight good practice.

[Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

The DHR began using Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2013. The 2016 guidance was published when the DHR was already substantially progressed but account has been taken of the new guidance.

2.4.2 **Timeframe under Review**

The DHR covers the period 1st April 2015 to the date of Sarah's murder in April 2016.

2.4.3 **Case Specific Terms**

1. What contact did your agency have with the subjects?

2. Were there effective and appropriate policies and procedures in place in your agency for assessing risk in cases of domestic abuse?

3. Did your agency have knowledge of domestic abuse in this family? If so, were any formal domestic abuse risk assessments undertaken and what was the response to that risk?

4. What services did your agency offer to the subjects of the review? Were these services accessible, appropriate, effective and sympathetic to the presenting needs?

5. What safety planning was offered to the subjects including referral to specialist domestic abuse services?

6. What, if any, services were offered to Adam as a perpetrator of domestic abuse?

7. What knowledge did the victim's family and friends have about domestic abuse within the family composition and what did they do with it?

8. In addition, this Review will seek to understand the role that was and potentially could have been played by family, friends and members of the wider community to either mitigate or exacerbate instances of domestic abuse.

9. What advice does your agency provide for people who receive disclosures of domestic abuse?

10. How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?

11. Were there any specific cultural and/or diversity issues relating to the subjects?

12. Was child and adult safeguarding adequately assessed and acted upon?

13. Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the subjects and to work effectively with other agencies?

14. Did managers in your agency have effective oversight of the case?

15. Was information sharing within and between agencies appropriate, timely and effective?

16. Do any of your agency's policies / procedures / training require amending or new ones establishing as a result of this case?

17. Was it possible for your agency to predict and prevent the harm that came to the victim?

18. If your agency has information relevant to the terms of reference that relates to events before the 01.04.2015 please include it in the Individual Management Review as a short narrative.

2.4.4 The intention of the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

2.4.5 **Note:**
It is not the purpose of this DHR to enquire into how Sarah died. That is a matter that has already been examined during Adam's trial.

2.4.6 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. (There has been nothing to suggest that a disciplinary inquiry or process is merited in respect of any agency involved in this review).

2.5 Methodology

2.5.1 This overview report has been compiled from analysis of the multi-agency chronology, the information supplied in the IMRs and supplementary reports from some agencies. Information from police statements has also been used. The findings of previous reviews and research into various aspects of domestic abuse has been considered.

2.5.2 In preparing the overview report the following documents were referred to:

- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2013
- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews 2016
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.

- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Key findings from analysis of Domestic Homicide Reviews. Home Office December 2016
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.
- Evan Stark (2007) Coercive Control. How Men Entrap Women in Personal Life. Oxford University Press.
- Re-presenting Battered Women: Coercive Control and the Defense of Liberty**.** Prepared for Violence Against Women : Complex Realities and New Issues in a Changing World, Les Presses de l'Université du Québec (2012) Evan Stark.
- Agency IMRs and Chronologies.
- Asian women domestic violence and mental health toolkit. Government office for London/EACH counselling February 2009
- The Casey Review. 'A review into opportunity and integration'
- Recommendations from previous DHRs in Stockport

3 Definitions

3.1 Some of the situations experienced by Sarah fell within the Government definition of domestic violence which can be found at Appendix A. (Hereinafter referred to as domestic abuse). The structure and governance of domestic abuse services within The Safer Stockport Partnership is described at Appendix B.

4 BACKGROUND – Sarah and Adam

4.1.1 Note: The information in this section is drawn from chronologies, IMRs, the police investigation, family members and interviews with agency staff. Adam agreed to contribute to the review and was interviewed in prison by the Independent Chair of the review and the author. The interview is dealt with at paragraph 4.2.

4.1.2 Sarah was born in Pakistan and was introduced to Adam in Pakistan by their respective families. Adam had travelled to Pakistan for a family wedding and the couples' marriage was agreed and arranged by their families. The marriage took place during the same visit and the couple eventually moved to Stockport to live with Adam's extended family. Sarah was twenty one years old when she came to live in England.

4.1.3 Sarah did not speak English and it would seem that for some years she lived a relatively isolated life. She did however learn English and was able to communicate verbally and in writing in English. She also learned to drive and passed her test. The couple had three children and for many years Sarah's priority was looking after her children and ensuring that they were well cared for.

4.1.4 Adam was born in England and is of Pakistani heritage. He worked in a number of jobs including call centres but rarely, if ever, directly contributed financially to Sarah and the children, instead relying on his parents to provide money for food and clothing for his wife and children. However, he says he contributed half of his wages to his parents. He was a regular cannabis user and was dealt with by the police for minor possession of cannabis on three occasions. Whatever money he earned, he kept for himself apart from the contribution to his parents.

4.1.5 Sarah is described as a modest woman whose faith was important to her. Adam said he was not religious and did not regularly attend the local Mosque. Since his life sentence he has become a devout Muslim.

4.1.6 The couple's relationship was sometimes stormy and they split up on a number of occasions. On one occasion Adam slept in his car for several weeks. At other times he would simply sleep in a different room in the family house. Adam complained that on occasions Sarah would pretend to be asleep to avoid having contact with him.

4.1.7 When she first came to England Sarah found Adam's family to be quite controlling and she felt isolated and unhappy. However, she determined that this was her life and she would make the best of it. In more recent years she had found Adam's family to be more supportive of her. She remained in the extended family home with her children during her breakups with Adam and was supported by his family. Increasingly over the years his family appeared to lose respect for Adam and increase support for Sarah.

4.1.8 In December 2015, Sarah applied for and obtained a job as a care assistant, supporting elderly people in their own homes. Adam helped her to apply for the job. Her motivation was to gain independence and earn money in order to provide for her growing children. Her father in law bought a car for her so that she could do the job effectively.

4.1.9 Following a period of training and shadowing with other staff Sarah began to conduct care visits independently. She showed great promise and was highly thought of by her employers. They could see her quickly developing as a person and growing in confidence in her work but also in her approach to

everyday life.

4.1.10 Adam said that he did not like Sarah visiting men to provide care even though she made it clear to him that these visits were simply to provide food and medication and did not involve personal care. On the day of her death Sarah and Adam argued by text about this before she returned home from work. The argument continued in the family home and Adam stabbed Sarah repeatedly, killing her without mercy.

4.1.11 At Adam's trial, the judge commented on passing sentence

"Behind the traditional line taken in your texts, appeared to lurk an element of jealousy of your wife's independence of mind and a resentment of her defiance of your orders.

She was a devoted mother. She worked hard to support her family and she was good at that job.

Unless anyone should think there was a cultural clash, let it be said the evidence shows your parents and sister were entirely supportive of [Sarah's] choice."

4.2 **Interview with Adam**

The DHR panel was mindful that the 2016 Home Office DHR Guidance says there should not be a hierarchy of testament. Nevertheless the account provided by Adam has not been challenged; there are several obvious discrepancies in what he has said and information obtained from his family's account in police statements.

4.2.1 Adam's first memory of Sarah is when he went to a family wedding in Pakistan as a child of around seven years old. Adam cut his finger whilst in the men's section of the wedding party and Sarah was asked to take him to his Mum in the women's party. He did not see her again for many years.

4.2.2 In 1999, Adam travelled to Pakistan with his family for his sister's impending wedding. Whilst in Pakistan discussions took place between his and Sarah's family leading to an agreement between the two families that they should marry. Adam did not want to get married at that time. He was nineteen and working in a bar at Manchester airport having left college with no savings to support a family. He states that he was contributing £600 a month to the family from his wages.

4.2.3 Despite his reservations Adam agreed to the marriage following assurances from his father that he and Sarah would be looked after. Adam's Father

promised that he would set Adam up in a business and that Sarah would be able to fly home to visit her family every year. As a result of the assurances Adam agreed to get married and the marriage went ahead within a short time as a ‘double wedding’ with his sister and her new husband.

4.2.4 Adam returned home to England and resumed his normal life. Sarah did not follow for eighteen months. When Sarah arrived in England a civil wedding was arranged and took place at Stockport Town Hall. The couple spoke privately for the first time in the wedding car on the way to their reception.

4.2.5 Adam and Sarah moved into his parents’ home as was expected of the oldest [or in Adam’s case the only] son. He continued to work and contributed half his wages to the family. Communication between the couple was difficult as Sarah spoke no English and Adam only spoke rudimentary Pashto, Sarah’s first language.

4.2.6 For a number of years Sarah would cry every day. Adam describes this as silent crying and no matter what he did nothing would change. For example he recalled a time when the couple had gone out for the day and been very happy but when they returned home Sarah began crying for reasons that Adam did not understand.

4.2.7 Adam’s parents encouraged the couple to have a child and he thought that the birth of their first child might mark a turning point in their relationship, however from his point of view it did not. Sarah continued to be unhappy and cried every day.

4.2.8 After around five to six years of trying to make the relationship work, Adam started to become frustrated and disenchanted with the relationship. He felt trapped and questioned what he had done but could not see a resolution. He began spending money on credit cards and staying out. He found it difficult to concentrate at work and left several jobs as he was unable to cope. As a result, he got into debt and bailiffs came to the family home on a number of occasions. The money owed was paid by his Father and Adam repaid his Father later.

4.2.9 Adam continued to contribute financially to the family finances when he was working and helped his Father with significant building work and renovations to the house. Despite this he did not feel appreciated and felt that his sisters and their families were treated better than him. Even though he did building work and gardening and Sarah was cooking and cleaning, Adam felt his status within the family had lessened over the years. As the only son Adam felt that he should be showed respect and he felt that slipping away in favour of his sisters and wife.

4.2.10 Although Adam became disillusioned with the marriage over time, he encouraged Sarah to learn English and pass her driving test. He provided money to the family, but he did not give Sarah money directly as he was aware that when she came from Pakistan she had around £1500 of her own. Ultimately the couple were separated and got back together on a number of occasions. Usually this meant that whilst they stayed in the family home they slept in different rooms and Adam would spend a lot of time out of the house. He developed a drug habit and at its height he would spend up to £60 a week on cannabis.

4.2.11 Around six months before Sarah's murder, the couple decided to give their marriage another chance and moved back into the same room together. Adam encouraged Sarah to get a job because he thought it would be good for her to get out of the house and helped her to fill in application forms and complete on line training. The decision was also partly based on a reduction in income because of the way that tax credits were calculated.

4.2.12 Around three months before Sarah's death one of Adam's sisters and her children moved back into the family home. This in his mind marked a change in his relationship with Sarah, as she and his sister became very close. Adam became marginalised and he felt that the rest of the family wanted him out of the house.

4.2.13 Adam was aware of the nature of Sarah's work caring for elderly people and often looked at the work rota on her phone to help her plan her working week. When he saw that she had male clients he was not happy because he considered Sarah may be physically vulnerable and had concerns regarding potential racism from male clients. In his view his concerns were misinterpreted by Sarah and his sister as being about his mistrust of Sarah.

4.2.14 Sarah continued to provide care to male clients, although this was limited to providing food and medication and did not include intimate care. Adam was challenged by this and wanted to win the argument. In an attempt to do so he looked up a number of religious quotes on the internet and began to text them to Sarah, using her devout beliefs to try and control her.

4.2.15 On the night of her murder, Adam returned home from work ready to continue the argument. He felt that the whole family was against him and when it became clear that not only his wife, but others wanted him to leave he felt overwhelmed and snapped. Whilst he accepts that he killed Sarah he cannot remember the act of doing so.

4.2.16 When asked what would have made a difference to the relationship Adam thought that on reflection, relationship counselling outside of the family may

have helped. He would not have known how to arrange it.

4.2.1 Adam would like Sarah to be remembered as a kind, caring person. A good Mum who took care of those around her.

5 Comment on the Individual Management Reviews (IMRs)

5.1.1 The aim of the individual management review is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided.

5.1.2 It should include a comprehensive chronology that charts the involvement of the agency with the victim, Adam and their family over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to the victim, Adam and their family and any other action taken.

5.1.3 It should also provide an analysis of events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

5.1.4 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

5.1.5 The IMRs in this case were relatively brief and illustrated little contact with agencies by Sarah and Adam. They were quality assured by the respective agency and by the Panel Chair. Where challenges were made they were responded to promptly and in a spirit of openness and co-operation. The IMR submitted by Sarah's employer was supplemented with an interview with the Chair and author and the proprietors of the business. This was done to introduce an independent view of Sarah in the absence of contact with Sarah's blood relatives.

6 THE FACTS BY AGENCY

The agencies who submitted IMRs are dealt with in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 7.

6.1 Stockport Clinical Commissioning Group and Stockport NHS Foundation Trust

6.1.1 Stockport CCG completed the IMR on behalf of the General Practice which provided primary medical care to the whole extended family. None of the family members attended at a frequency disproportionate to their health. Stockport NHS Foundation Trust provides the health visiting and school nursing service for the area. (services accessed by Sarah)

6.1.2 On 29th December 2009, Sarah visited a baby clinic at the GP's surgery, over 6 years before her death. Sarah was crying and distressed reporting that the relationship with her husband was finished. She told the Health Visitor that her husband was verbally abusive to her and that he had hit her on one occasion eight years previously. She said that she had never told anyone about what was happening and that she was controlled by family.

6.1.3 The Health Visitor contacted the national Domestic Violence Helpline and they stated that they could help Sarah with refuge and funding if she contacted them; although no further detail around this was recorded.

6.1.4 The following day this contact was followed up with a home visit by the Health Visitor. Sarah disclosed that her children were witnessing emotional and verbal abuse by their father and she stated that she was preparing to leave the family home. The Health Visitor provided support and advice; encouraging Sarah to seek legal advice. Appropriate contact was made with the school nursing service, Children's Social Care and the Asian Link Worker[2].

6.1.5 On 18th January 2010, the health visitor and Asian link worker visited Sarah together. She said she felt lonely and would like to meet other women from her culture. She said her husband was only using the house to sleep in and they had little else to do with each other.

6.1.6 Support was put in place and Sarah signposted to Women's Aid[3]. Women's Aid do not have a record of any contact from Sarah and staff do not recall her. It is possible that she contacted a confidential helpline, in which case there would be no record of her details. She was also signposted to her local Mosque to assist with integration into the community.

6.1.7 The health visitor remained involved offering support until 15th February 2011 when Sarah reported that her relationship with her husband was good and there were no concerns regarding domestic abuse; she declined further support and said that she would contact the health visitor again if she required support.

6.1.8 On 12th February 2016, Sarah visited the GP surgery seeking preventative services, which were provided. However, the situation in her relationship was not explored further.

6.2 School 1 and school 2

[2] The core role of the Asian link worker was to support Asian women with children to access health care, especially those for whom English was not their first language.

[3] Women's Aid, now known as Stockport Without Abuse, the organisation now also works with men.

6.2.1 Both schools reported that the children of the family achieved a high attendance rate and were well engaged in and learning. The children appeared to be well supported and were well clothed and fed. There were no negative indicators or signs which would have given the schools concerns around domestic abuse in the family or indeed any other negative issues.

6.3 **Care Agency 1**

6.3.1 Care Agency 1 is a private business with approximately twelve employees. It is contracted by Stockport Council to provide 390 hours a week homecare to various elderly clients in their own homes. This care can take the form of assistance with food and medication as well as personal care.

6.3.2 The Agency has been established for approximately six years and was rated as good in all areas by the Care Quality Commission at its last inspection. It has safeguarding policies in place which mirror those of Stockport MBC and takes advantage of training offered by Stockport MBC and Stockport Safeguarding Boards.

6.3.3 Sarah applied to the Care Agency for a position as a home carer in December 2015. She was not known to the proprietors before her application. She was accepted and began a period of training and shadowing with other staff.

6.3.4 In a very short time Sarah grew in confidence and the owners of the business comment that she started flourish. It was apparent that Sarah enjoyed her new found independence and she discussed with the proprietors that she was working because her husband didn't give her any money. She also told them that despite her working to provide for herself and the children, that Adam took part of her wages from her.

6.3.5 Sarah told the proprietors that her husband didn't like her visiting men. As a result, they made sure that Sarah's visits to male clients were simply to assist with food and medication and there was no personal care involved.

6.3.6 One day in April 2016, whilst conducting a home visit to a client with one of the proprietors Sarah disclosed a series of text messages that she was receiving from her husband telling her to stop attending to male clients. He said she was 'forbidden' from attending to men. The proprietor offered to speak to Adam and explain to him that Sarah was not providing personal care. Sarah declined the offer and said she would sort things out herself.

6.3.7 The proprietors of the business have experienced similar reactions from the husbands of staff before, as well as in their own careers. Sarah did not appear

to them to be frightened in any way and they were not concerned for her safety. This was particularly the case as Sarah had told them that Adam's extended family were supportive of her desire to work.

7 Analysis against the terms of reference

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

7.2 What contact did your agency have with the subjects?

7.2.1 The agencies requested to complete IMRs have fully outlined their contact with the subjects of the DHR. In addition, Greater Manchester Police have been helpful in providing details of their limited contact with the subjects, although they were not asked to complete an IMR due to the small amount of contact, none of which had reference to domestic abuse.

7.3 Were there effective and appropriate policies and procedures in place in your agency for assessing risk in cases of domestic abuse?

7.3.1 The only clear identification of domestic abuse in this case was Sarah's disclosure of abuse in late 2009/early 2010. The disclosure was quickly followed up and support was provided by a Health Visitor and Asian link worker for over twelve months. The policies and procedures in place at the time were followed. Those policies have now changed significantly and include more formal risk assessments using the DASH model.

7.3.2 Agencies who knew Sarah do have appropriate policies and procedures in place for assessing domestic abuse or making referrals to others who can do so. However, after she had declined further support in February 2011 Sarah was not in touch with any agency that provided Domestic Abuse services or was in a position to recognise Domestic Abuse from the information available.

7.4 Did your agency have knowledge of domestic abuse in this family? If so, were any formal domestic abuse risk assessments undertaken and what was the response to that risk?

7.4.1 The only agency knowledge of domestic abuse in the family was in 2009/10. Formal risk assessments were not undertaken as they had not been adopted at that time. However, there is evidence from comprehensive notes made by professionals at that time that there was a thorough approach to safety planning and appropriate services were offered.

7.4.2 A health visitor and Asian link worker continued to offer support for over twelve months. Some contact was arranged through a third party and visits were conducted at a neutral location in order to ensure Sarah's privacy and safety.

7.5 **What services did your agency offer to the subjects of the review? Were these services accessible, appropriate, effective and sympathetic to the presenting needs?**

7.5.1 Sarah raised a concern about Domestic Abuse when attending a baby clinic at her GP's surgery in December 2009. This was followed up without delay. She was introduced to an Asian link worker with appropriate cultural awareness and information about more specialist domestic abuse services was given. Sarah was offered accommodation and financial support had she wanted to leave the family home.

7.5.2 Following her disclosure of abuse Sarah quickly received support and advice appropriate to her needs at the time. Timing and location of contact and visits was tailored to Sarah's needs.

7.6 **What safety planning was offered to the subjects including referral to specialist domestic abuse services?**

7.6.1 The Health Visitor provided Sarah with information about domestic abuse helplines and Women's Aid. Advice around Sarah's personal safety and that of the children was reiterated at every visit and the Health Visitor ensured that Sarah was aware of emergency numbers. That was in line with contemporary practice.

7.7 **What, if any, services were offered to Adam of domestic abuse?**

7.7.1 There were no services offered to Adam by any agency. In 2009/10 when Sarah disclosed abuse there were no perpetrator services available. No agency had formal contact with the family in relation to domestic abuse or had cause to think that there was domestic abuse between 2011 and Sarah's death. It was therefore not possible within the arrangements that existed at the relevant time to offer any service to Adam.

7.7.2 The 'Bridging to Change' service run by Relate, offers domestic abuse perpetrators in Greater Manchester the opportunity to self-refer to an education programme. There is a charge on a sliding scale according to income. It would have been possible for Adam to access this programme. The Stockport Alliance for Positive Relationships www.stockportapr.org also runs a perpetrator programme which is free to access. However, from the interview with Adam in prison post his conviction it was apparent to the DHR chair and

author that he did not see himself as a perpetrator of domestic abuse. He was a minimiser who did not accept his behaviour and attitudes contributed to his diminishing status within the family home. Adam did not see himself as a perpetrator of Domestic Abuse and so whilst the opportunity for help was there, he did not look for help.

7.8 **What knowledge did the victim's family and friends have about domestic abuse within the family composition and what did they do with it?**

7.8.1 Adam's family knew that the relationship between him and Sarah was sometimes difficult. They witnessed arguing between the couple on many occasions and Adam left the family home on a number of occasions over the years because of difficulties in the relationship.

7.8.2 There is evidence from medical notes and other conversations that Sarah found her extended family to be controlling in her early years in England. For example, she would be asked where she was going if she went out of the house. She did not consider that she had a good relationship with some family members.

7.8.3 In later years and certainly leading up to her death, Sarah's relationship with her extended family had improved. The previous Summer the family had paid for her and the children to go on an extended holiday to Pakistan. A car had been purchased in order to allow her to work and gain a degree of independence.

7.8.4 Adam continued to come and go as he wished and made little contribution to the family, even when asked he would simply not contribute to simple tasks. This seemingly contributed to his perception [as described by him in interview] of a diminishing respect for him within the family and growing support for Sarah.

7.8.5 To the extent that they recognised that Sarah and Adam had a troubled relationship the family sought to provide support within the family for both parties. They did not seek external help and in any event they did not recognise what was happening as domestic abuse.

7.8.6 In hindsight and with discussion with professionals the family recognise that at times what was happening was at least emotional abuse and perhaps more. They wish now that they had been equipped to recognise what was happening and do something about it. There is no information to suggest that Sarah ever disclosed her victimisation to her family in Pakistan.

7.9 **In addition, this Review will seek to understand the role that was and potentially could have been played by family, friends and members of**

the wider community to either mitigate or exacerbate instances of domestic abuse.

7.9.1 Family members attempted to support Sarah in the family home. She stayed in the home at all times in her marriage and was supported financially and materially by the family despite Adam moving out several times.

7.9.2 It is possible that this support could also be seen as controlling. Sarah mentioned this to medical professionals and others on a number of occasions. She also told others that when she had intended to leave the family home she had been persuaded from doing so by family members who said they would get Adam to change his ways.

7.9.3 It is possible that this well intentioned conciliation simply enabled Adam to continue behaving as he had always done with his controlling behaviour unchecked.

7.9.4 Adam, although not a particularly religious man at the time of the murder, sought to relate his controlling behaviour to Islam. He told Sarah that her actions were 'Haram'[4] and that as her husband, Islam said she must obey him. Dominant culture in British South Asian communities sees the man as the head of the family and 'in charge' of family affairs. In Adam's world his wife was becoming more independent and he was losing respect from his family. It is possible to see in hindsight how this combination of circumstances came to exacerbate the difficulties in the relationship. During the interview in prison Adam conceded that in the final analysis he wanted Sarah to obey him because he felt that was what a wife should do. The fact that Sarah was resisting subservience is an important element in understanding what was happening in the relationship.

7.10 **What advice does your agency provide for people who receive disclosures of domestic abuse?**

7.10.1 The agencies involved in this review all have clear polices for staff who receive disclosures of domestic abuse. The only disclosure of domestic abuse in this case was in 2009. Stronger multi-agency policies and responses to Domestic Abuse have been developed since then.

7.10.2 Stockport has developed a Domestic Abuse and Child Sexual Exploitation team [DACSE] and much work has gone into ensuring that that the Multi-Agency Safeguarding and Support Hub [MASSH] provides a clear pathway for referrals of domestic abuse.

[4] Arabic – meaning forbidden or proscribed by Islamic law

7.11 **How did agencies, family members and friends deal with any confidentiality issues the victim might have requested of them?**

7.11.1 When the Health Visitor and Asian link worker were supporting Sarah in 2010 they maintained her confidentiality and safety by meeting at a neutral location. This was at Sarah's request as she did not want her extended family to know that she was seeking outside support.

7.11.2 There have been no other specific confidentiality issues raised in the review.

7.12 **Were there any specific cultural and/or diversity issues relating to the subjects?**

7.12.1 Sarah was born, brought up and educated in Pakistan. She was one of nine children. Her father is deceased and the eldest son is now the head of the family. Sarah's first language was Pashto. She has a maternal cousin who was fluent in English having studied and worked in England before returning to Pakistan. Sarah and her family are Muslims and it is reported that she cared deeply about her faith.

7.12.2 Adam's parent were born and educated in Pakistan. Their first language is Pashto. Their long term residency in England resulted in them being fluent in the language. Adam was the eldest of four siblings. He was born, brought up and educated in England and his first spoken and written language is English. Adam's family are also Muslims. Adam acknowledged during his interview in prison with the DHR author and chair that he had let his observance to Islam wane during the years leading up to Sarah's death. Since then he has rekindled his compliance.

7.12.3 Adam visited Pakistan with his family and his father arranged for him to marry Sarah. While Adam and Sarah's families were known to each other, he did not know Sarah before the introduction. Adam said he was not ready for marriage, he had no career or money and felt he was too young. He reported he agreed to the marriage out of respect for his family. The marriage took place in Pakistan and within a few weeks Adam returned to England leaving Sarah with her family. Sarah stayed in Pakistan for eighteen months, then came to England and married in accordance with English law. They lived together with Adam's parents in the family home. One or more of Adam's siblings also lived there.

7.12.4 Sarah and Adam did not share a common first language. When Sarah arrived in England she was unable to speak English and according to Adam struggled with learning it. Sarah's in-laws paid for her to go to English classes which helped. Adam claimed there was a language barrier between them and that while he could speak some Pashto he was not fluent and could not always

express himself in the way he wished. Adam said this did not help with his understanding of Sarah's feelings and needs.

7.12.5 When Sarah first started as a carer her employer said she was able to communicate with clients in English. Her employer saw significant improvements in Sarah's spoken English during the five months she worked as a carer and described her spoken English as good to very good.

7.12.6 Earlier in the report it was learned that in 2009 Sarah disclosed to her health visitor that she had suffered physical abuse and was experiencing emotional and verbal abuse from Adam and the children were witnessing it. There is no evidence that Sarah needed an interpreter when she first disclosed. However, she was introduced to an Asian link worker thereby demonstrating that consideration had been taken of her needs. She was signposted to a local mosque in order to assist with integration into the community but there is no record of referral to other services which may have been appropriate, for example the Saheli Manchester Asian Women's project.[5] What is unknown is the impact on Sarah's ability to access services at this point in her life because English was not her first language.

7.12.7 Adam confirmed that he did not provide Sarah with an allowance for household expenses. It seems she relied on his family for financial support which was occasionally supplemented by one off payments from Adam. It was this lack of financial independence and the increasing cost pressures of growing children that eventually led Sarah to find work. Once she was in work it appears her horizon widened and she grew more confident and independent.

7.12.8 Adam said that within the last year before Sarah's death, his influence and standing in the household diminished and Sarah's increased. He was not comfortable with that albeit he claimed he encouraged Sarah to seek work. What is known for a fact, as evidenced by Adam's text messages to Sarah, is that he wanted to stop her caring for male clients. He said they may be more likely to racially abuse her. However, he conceded in his interview with the DHR representatives that ultimately he wanted to control Sarah and only allow her to do what he dictated. He saw her opposition to his will as against Islam and used selected passages from the Holy Book [Koran] which he had looked up on the internet to support his arguments.

[5] Saheli Asian Women's Project provides advice, information and support services to Asian women and their children fleeing domestic abuse and/or forced marriages and is based in Manchester, UK. www.saheli.org

7.12.9 The DHR Panel carefully considered whether the death of Sarah was in any way connected to so called, 'honour based violence'. The Crown Prosecution Service's web site[6] had the following entry.

'There is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

The CPS, ACPO and support groups have a common definition of HBV: 'Honour based violence' is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community'.

7.12.10 As reported earlier [paragraph 1.1] the Police Senior Investigating Officer did not classify the homicide as so called 'honour based'. The DHR Panel found no evidence to contradict that decision. The panel noted that Adam upheld the family honour in conceding to his father's wishes that he marry, when given a free choice he would not have. However, Adam also said it was not a forced marriage. It appeared to be a compromise on his part.

7.12.11 Sarah told the health visitor that she felt Adam's family was quite controlling [see paragraph 4.1.7]. When that was discussed with the family by children's services after Sarah's death they were surprised. When the concept of controlling behaviour was explained to the family they could see, on reflection, how their support for Sarah could be seen as controlling. They viewed the dynamics between them and Sarah as normal and would have addressed it had they known how she felt.

7.12.12 It is worthy of note that some of Sarah's experiences may be reflected in the findings of 'The Casey Review. A review into opportunity and integration'

Extracts of the review state

[6] http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/#a04

Research[7] on domestic violence documents the particular vulnerability of some immigrant or ethnic minority women that might exacerbate their experience of domestic abuse, including [paragraph 7.15]

- lack of English language skills hampering understanding of rights and services available and the ability of service providers to respond; and
- social isolation and notions of honour and shame in some communities, including fear of censure from wider family and community which leads victims to report later and can involve greater safety risks.

We have heard concerns from service providers and experts that a lack of English language skills can create further complicating problems for victims of abuse in coming forward and getting help that might include: [paragraph 7.16]

- the need for a translator (often a family member) when interacting with services, meaning a victim is less likely to reveal abuse;
- having a reliance on a husband's English skills economically and socially, making a victim more fearful of seeking help;
- a reliance on a husband for their immigration status which victims fear would be at risk from coming forward;
- a lack of awareness - that abuse is unacceptable in the UK, of services that may be available to help or of how to access them, or sometimes even that they are being abused at all.

7.13 **Was child and adult safeguarding adequately assessed and acted upon?**

7.13.1 Appropriate referrals were made to the school nursing service. The children's demeanour and appearance did not give rise for concern and it was appropriate that no further action, other than watchful monitoring was taken. There were no concerns which would have reached the threshold for adult safeguarding procedures.

7.14 **Were there issues in relation to capacity or resources in your agency that impacted the ability to provide services to the subjects and to work effectively with other agencies?**

7.14.1 There were no issues in relation to the capacity of services. When Sarah asked for help it was quickly given and sustained for a lengthy period.

[7] Home Office and Department for Communities and Local Government (2015) review of Domestic Abuse Services (data not published)

7.15 **Did managers in your agency have effective oversight of the case?**

7.15.1 Managers within the health agencies involved had appropriate oversight whilst support was being provided to Sarah. After 2011, management oversight was unnecessary because Sarah was only receiving universal services[8] from health agencies.

7.15.2 Sarah's employers were aware of the issues she was facing but did not consider at that time that the issues amounted to domestic abuse. They are aware of how to report domestic abuse and make adult safeguarding referrals.

7.16 **Was information sharing within and between agencies appropriate, timely and effective?**

7.16.1 Information was shared effectively between the Health Visitor, Asian link worker, and school nursing service. In addition the Health Visitor judged that it was appropriate to speak directly to the primary school head teacher about the issues that had been raised. There was no opportunity to share information after 2011 as Sarah did not access services and nothing of any concern came to the attention of services.

7.17 **Do any of your agency's policies / procedures / training require amending or new ones establishing as a result of this case?**

7.17.1 Whilst there has been nothing identified by agencies in terms of new or amended policies, a review of the Stockport Domestic Abuse strategy is taking place and it will be informed by this and previous DHRs. An action plan will be developed which will be used to take forward lessons learned. There is a desire to revisit training in how to recognise domestic abuse which will be captured in the action plan.

7.18 **Was it possible for your agency to predict and prevent the harm that came to the victim?**

7.18.1 No agency believes it could have predicted or prevented Sarah's sad death. Her employer who spoke to her only hours before her death about the issues she was experiencing with Adam remains shocked that the issue could have escalated to murder in such a short time.

8 Key lessons learned

[8] Universal health visiting services. Health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation. This service stops after the five key visits. These are: Antenatal; New baby; 6 – 8 weeks; 9 – 12 months; 2 – 2 ½ years.

8.1.1 **Narrative**

Sarah came to England as a twenty one year old who could not communicate effectively in English. She spent a number of years living a relatively isolated life in the family home. When problems in her relationship with Adam arose the extended family sought to intervene to keep them together.

Lesson 1

A person who is socially isolated may be unable to easily access universal services. This highlights the need for culturally specific services and awareness raising so that the opportunities to refer to them are maximised.

8.1.2 **Narrative**

Adam's parents were aware of his poor behaviour towards Sarah but did not recognise that some of it was controlling and abusive and therefore domestic abuse.

Lesson 2

There is a continuing need to raise awareness of domestic abuse and healthy relationships within the wider community. This may particularly be the case in relation to newer elements within the definition of domestic abuse such as coercion and controlling behaviour.

8.1.3 **Narrative**

The critical point in the relationship occurred when Sarah sought independence by working outside the family home. By all accounts Sarah was flourishing and growing personally and professionally. At the same time Adam was working in a job he did not like and he perceived that he was losing the respect of his family.

Lesson 3

It seems likely that it was this significant change in the balance of power in the relationship that led to Adam's inexcusable actions as he sought to retain control. Losing control can create risk and may increase the severity of perpetrator behaviour.

8.1.4 **Narrative**

Adam did not see his actions to retain control and assert his authority over Sarah as domestic abuse. He viewed his actions as normal in the expectation that his wife should obey him.

Lesson 4

Perpetrators of domestic abuse do not always recognise or accept that their behaviour is abusive. There is a need to:

1. Inform people in the community what constitutes domestic abuse.
2. To develop programmes so that perpetrators can begin to address their behaviour.

8.1.5 **Narrative**

Sarah's employers were aware of Adam's attitude to her work and his attempts to control what she did, but did not recognise the behaviour as domestic abuse.

Lesson 5

Employers can play a key role in helping to protect potentially vulnerable people if they have a good understanding of domestic abuse risk factors and know how to respond appropriately.

9 Conclusions

9.1.1 Sarah came to England following an arranged marriage and accepted that her role was to look after her children and the family home. She confided in others that her early life in England was unhappy but that she had determined to make the best of things.

9.1.2 When Sarah's relationship with Adam became intolerable in 2009 she sought help and this was quickly provided and sustained for over a year until she declined further help. Professionals did not get another opportunity to intervene.

9.1.3 The couple's extended family sought to keep them together. Despite this there were a number of breakups over the years and the family's attempts at reconciliation were ultimately ineffective. Adam took little notice of his family, refusing at times to contribute financially or practically to the household.

9.1.4 Sarah's decision to seek employment and a little independence outside the family home was supported by the extended family and initially by Adam. The change in power in their relationship however, led to Adam trying to reassert control by 'forbidding' her from doing certain work. Sarah refused to accept this, argued back and asked Adam to leave, as did another family member.

9.1.5 Adam was unable to cope with the changing balance of power which threatened his presumed superiority in the relationship. He sought to reassert his authority and when that failed he murdered Sarah.

10 Predictability and Preventability

10.1.1 The most widely used definitions of predictability and preventability in the context of safeguarding can be found in the reports of various Independent enquiries conducted by NHS England.

10.1.2 **Predictability is defined as:**

'The homicide would have been predictable if there had been evidence from [Adam's] *words, actions or behaviour at the time that could have alerted professionals that he/she might become violent imminently, even if this evidence had been un-noticed or misunderstood at the time it occurred.'*

10.1.3 **Preventability is defined as:**

'The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy'.

10.1.3 It is the view of the review panel that Sarah's death was neither predictable nor preventable. Sarah was known to services for a year, five years prior to her murder. Any more recent contact through schools and the school nursing service did not give rise to any concern.

10.1.4 Sarah's employers were aware of some difficulties in her relationship and of Adam's attitude to her work. They sought to mitigate this by amending the work she did but they could not have foreseen the tragic outcome that occurred.

11 Recommendations

11.1 DHR PANEL

11.1.2 **Recommendation one**

The Safer Stockport Partnership should consider an awareness raising campaign, targeting employers with particular reference to the care industry. This will help to ensure that employers have the ability to recognise domestic abuse and have appropriate policies in place in order to respond and support victims.

11.1.3 **Recommendation two**

The Safer Stockport Partnership should ensure that every opportunity to raise awareness of Domestic Abuse is taken, when its partner organisations interact with people for whom English is not their first language.

11.1.4 **Recommendation three**

The Safer Stockport Partnership should ensure that an appropriate response is in place to address attitudes and behaviours in the community with specific reference to healthy relationships and domestic abuse.

11.1.5 **Recommendation four**

The Safer Stockport Partnership should:

1. Raise practitioners' awareness of domestic abuse within different cultures.

2. Ensure that appropriate resources, such as interpreters and culturally aware independent domestic violence advocates, are available to practitioners when they discuss domestic abuse with clients whose first language is not English, or receive a disclosure from them.

12 Agency Specific recommendations and action plans

12.1.1 No Single agency recommendations have been made.

Appendix A

Terms

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) was: "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14 February 2013 is: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional, Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

3. Therefore, experiences in Sarah and Adam's relationship fell within the various descriptions of domestic violence and abuse.

DASH risk assessment model

4. Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently by the Safer Stockport Partnership.

5. DASH is an essential element to tackling domestic abuse. It provides the information that would influence whether or not to refer the victim

to a Multi- Agency Risk Assessment Conference [MARAC].

6. There are three parts to the DASH risk assessment model:

i. Risk identification by first response police staff

ii. The full risk assessment review by specialist domestic abuse staff

iii. Risk management and intervention plan by specialist domestic abuse staff

7. The definitions of risk used by the safer Stockport Partnership are:

Standard: Current evidence does NOT indicate likelihood of causing serious harm.

Medium: Identifiable indicators of risk of serious harm. Offender has potential to cause serious harm but unlikely unless change in circumstances.

High: Identifiable indicators of risk of imminent serious harm. Could happen at any time and impact would be serious All High risk cases go to MARAC.

Demographics and strategic overview Of Domestic Abuse services in Stockport

Stockport has a population of approximately 283000 people. Over 90% of people living in Stockport were born in England. 0.8% were born in Pakistan.

According to the 2011 census The religious make up of Stockport is 63.2% Christian, 24.7% No religion, 3.3% Muslim, 0.6% Hindu, 0.5% Jewish, 0.3% Buddhist, 0.1% Sikh, 0.1% Atheist. 18,510 people did not state a religion.

THE ALLIANCE FOR POSITIVE RELATIONSHIPS

The Alliance for positive relationships [APR] is a collaboration between four organisations in Stockport which was commissioned by Stockport Council and began delivering services on 1st August 2015. The organisations are

- Stockport without abuse
- Stockport Women's centre
- Relate [Greater Manchester South]
- Stockport Homes

Up to date information on the services provided by The Alliance for Positive Relationships can be accessed at www.stockportapr.org

APPENDIX C

Domestic Homicide Review 7 – Action Plan

Recommendation 1 The Safer Stockport Partnership should consider an awareness raising campaign, targeting employers with particular reference to the care industry. This will help to ensure that employers have the ability to recognise domestic abuse and have appropriate policies in place in order to respond and support victims.			
Action 1	**Evidence**	**Outcome**	**RAG**
The Domestic Abuse Steering Group should oversee the development of a communications plan to support employers' awareness of domestic abuse and to put appropriate policies in place.	A draft policy for employers will be in place. An awareness campaign will have been developed and implemented.	Employees living in a domestic abuse household will be more supported by their employers. Employers will be more aware of the impact of domestic abuse on their employees.	
Recommendation 2 The Safer Stockport Partnership should ensure that every opportunity to raise awareness of Domestic Abuse is taken, when its partner organisations interact with people for whom English is not their first language.			
Action 1	**Evidence**	**Outcome**	**RAG**
The Domestic Abuse Steering Group will support agency DA leads to review communication plans and literature for residents whose first language is not English.	Appropriate communications and literature for engaging people whose first language is not English.	Stockport residents whose first language is not English will have access to appropriate advice and guidance around accessing support for domestic abuse.	
Recommendation 3 The Safer Stockport Partnership should ensure that an appropriate response is in place to address attitudes and behaviours in the community with specific reference to healthy relationships and domestic abuse.			
Action 1	**Evidence**	**Outcome**	**RAG**

The DA Steering group should support to development of a coordinated community response model to domestic abuse that ensures appropriate support is in place around attitudes and behaviours.	Evidence of uptake of behaviour change programmes offered through partners.	Communities, families and individuals will be more aware of domestic abuse and its impact. They will also be aware of what support is available and how to access it.	
Recommendation 4.1 The Safer Stockport Partnership should: 1. Raise practitioners' awareness of domestic abuse within different cultures.			
Action 1	**Evidence**	**Outcome**	**RAG**
This recommendation is covered by Recommendation 2.			
Recommendation 4.2 The Safer Stockport Partnership should: 2. Ensure that appropriate resources, such as interpreters and culturally aware independent domestic violence advocates, are available to practitioners when they discuss domestic abuse with clients whose first language is not English, or receive a disclosure from them.			
Action 1	**Evidence**	**Outcome**	**RAG**
Partners should review the accessibility of appropriate resources to support victims and perpetrators whose first language is not English.	A mapping exercise detailing the resources available.	People living in domestic abuse households whose first language is not English will have access to appropriate resources.	