EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

Of a

Domestic Homicide Review
Overview Report
DHR 02

Into the circumstances of the death of

'Marie'

Aged 54 years in 15th November 2016

Independent Author

Malcolm Ross M.Sc.

September 2017

The sister and brother-in-law of Marie wish for the following testimony to Marie to be included in this report

Marie

When I woke up today, after just having 20 minutes sleep, I heard somebody on the radio said, "To err is human, to forgive divine."

To be honest, I don't know what I'm feeling at the moment as our Big sister, Belen Basañes Maneja has been taken away from us.

I know that we have been like opposites, Ade and you are like Nanay Saring, a bit loud and say what you think. On the other hand, Celia and me are like Tatay Betud, the calm behind the storm. But even though we are different, we love you as what you are. You are unique in your own way. You make people laugh with your odd and blunt jokes and sometimes straight to the point comments.

You will be missed by your nieces, Jade Sollano Sanopao, Christina Racaza, Maria Feby Racaza, and Holly Beetlestone, nephews, Adam Sollano and James Beetlestone, your great nieces, Sian Sanopao and Cher. And I better not forget, your ever loving brother-in-law, Peter Vincent Beetlestone for his full support to both of us, picking us up or dropping us off, and sometimes, bearing gifts in the form of food from my house or from yours.

You will leave footprints in mine and Celia M. Racaza's heart.
Also, I know the Filipino Community in Telford will never ever forget you. They cherished the times and the good camaraderie you've given to them.

Goodbye our Big Sis. Rest in Peace now. We love you.

List of Abbreviations

AAFDA - Advocacy After Fatal Domestic Abuse

CCG - Clinical Commissioning Group

DHR - Domestic Homicide Review

GP - General Practitioner

HGV - Heavy Goods Vehicle

HMRC - Her Majesty's Revenue and Customs

IMR - Individual Management Review

MARAC - Multi-Agency Risk Assessment Conference

NHSE - National Health Service England

SIO - Senior Investigating Officer (Police)

TWCSP - Telford and Wrekin Community Safety Partnership

Domestic Homicide Review

Into the circumstances of the death of

'Marie'

Aged 54 years in 15th November 2016

1. Introduction

It is the express wish of the family members that the name of the deceased, Marie, be used throughout this report.

This Domestic Homicide Review (DHR) examines the circumstances of the death of Marie, aged 54 years, in her home on 15th November 2016. Her husband, the Perpetrator was charged with her murder. He appeared before the Crown Court in February 2017 and pleaded guilty to her murder. He was sentenced to life imprisonment with a recommendation that he serves 13 years. He was 70 years of age at the time of being sentenced.

Marie was born in the Philippines. She was one of 4 daughters in her family. One sister lives in the UK and the other lives in the USA. The oldest sister died at the age of 39 years. Marie was 54 years of age at the time of her death.

The Perpetrator was employed by the Ministry of Defence in the UK and met Marie whilst he was on holiday in the Philippines. He travelled back to the Philippines to be with Marie and she eventually came to the UK where they married. Marie found employment as a Carer in an elderly person's home.

The Perpetrator had been married before and had divorces his wife. It is recorded that there was domestic violence within this relationship.

The review has established that once they were married the Perpetrator was a controlling man and going to extreme lengths to ensure that he was aware of everything that Marie was doing.

On 15th November 2016, after a full day's work, Marie left her place of work. She stopped off on the way home to do some household shopping and arrived home just after 11.00pm. Within 20 minutes she was screaming down the telephone to the police for assistance. The Operator could hear her saying, 'Do you want to kill me?' and a man (the Perpetrator saying, 'Yes'.

Police officers were soon on the scene but found the front door to the house locked. A short conversation took place through the letter box between the officers and the Perpetrator before the officers forced the door. They found the Perpetrator covered in blood and the body of Marie upstairs. She had been stabbed. The officers also found the gas hob in the kitchen had also been turned on releasing gas into the house. The officers had to ventilate the house. Paramedics arrived and pronounced Marie dead at the scene.

The Perpetrator was arrested and charged with Marie's murder. He remained in custody until his trial at the Crown Court on 27th February 2017 where he pleaded guilty to the offence of murder and was sentenced to life imprisonment with a recommendation from the Judge that he serves 13years. He was 70 years old.

The details of the Terms of Reference and the composition of the DHR Panel members are contained in an appendix at the rear of this Executive Summary.

2. Summary of Events.

According to Marie's sister and her husband, as soon as Marie and the Perpetrator were married and settled in the UK, they noticed that the Perpetrator began to control Marie's life. There had been an incident of controlling behaviour demonstrated whilst Marie and the Perpetrator were in the Philippines. Marie's father was very poorly and naturally, Marie was spending time with him. The Perpetrator complained that he had gone all the way to the Philippines to see her and she was spending time with her father.

Marie's sister and brother-in-law told the Overview Author that Marie would come to them with brand new electrical items that did not work. On examination the brother-in-law found that the fuse had been removed so that Marie could not use the appliance whilst the Perpetrator was at work. It transpired that the Perpetrator would remove fuses in the household lighting, the washing machine and the heating so that Marie could not use these things whilst he was at work or out with his hobby (train spotting).

Marie never complained about abuse to her sister, albeit her sister did on occasions tackle her about what she saw as signs of abuse. Marie would often say that she was not frightened of him and that she could 'give as good as she got'. It may be, now that the circumstances of Marie's life are known, Marie's refusal to acknowledge or admit she was being abuse was due to the control the Perpetrator had over her.

Marie did not drive and relied on the Perpetrator to take and collect her from her place of work. Staff at the Care Home would often be aware that the Perpetrator was waiting outside the Care Home and if Marie was a few minutes later leaving, he would sound the car horn and when she got into the car staff could hear him shout at her for being late. They also witnessed Marie having to travel in the rear seats of the car whilst the family dog occupied the front passenger seat.

In the event of the Perpetrator not being able to collect Marie from work, she would rely on fellow work colleagues or get a taxi home. The Perpetrator accused Marie of having an affair with the taxi driver.

Marie went away for a weekend with a close female work colleague on one occasion. While away she would have to ring him on a regular basis to tell him what she was doing and where she was. On her return the Perpetrator accused her of having an affair with her female work colleague.

Police were called to the family home of Marie and the Perpetrator on two occasions regarding domestic abuse issues. In December 2012, officers attended after Marie and the Perpetrator had been arguing. He had turned the gas hob on and threatened to light matches to burn the house down. Marie reported that he has assaulted her a few days before with the end of a pair of scissors after he had been cutting her clothes. Police removed the Perpetrator to one of his family member's home.

The Perpetrator was arrested for criminal damage to her clothes. He denied assaulting her and threatening her. He received an adult caution for his actions. These circumstances did not reach the threshold for Marie to be subject of a MARAC[1]. Marie

[1] MARAC – A Multi-Agency Risk Assessment Conference

was spoken to by officers of the Domestic Violence Unit but by that time Marie reported that the relationship had improved.

Marie called the police again in September 2013 but not for a domestic related incident. She reported that she had been 'scammed' over the internet with the parting of £12.530 by a bogus Reverend Pascal purporting to be from Nigeria. She was advised that this was a fraudulent activity. She was not refunded any money. She decided not to tell the Perpetrator anything about this and explained to her work colleagues and her sister that it was her money in any event. Her decision not to tell the Perpetrator was clearly a sign of her not wanting him to know which may have provoked more aggression towards her.

The second domestically related incident Marie called for police assistance was in September 2016, when, following an argument, the Perpetrator had told her to pack her bags and leave the house. She was adamant that she did not want to leave the house. The Perpetrator stated that he had had to rescue Marie from a domestic violent family existence in the Philippines where she had to look after all of her family, clearly making reference to the incident when Marie was looking after her dying father.

The DASH[2] Risk assessment was 'standard' and no further action was taken by the police who attended.

On 15th November 2016, Marie went to work at the Care Home as usual. She worked a long shift, finishing at 10.00pm. En route home she stopped to do some household shopping and arrived home at about 11.00pm. At 11.20pm she called 999 for police assistance. The police operator could hear screaming and Marie asking someone, clearly the Perpetrator, 'Do you want to kill me?' to which the operator heard a reply 'Yes'.

Officers arrived within a short period of time and found the front door locked. After a short conversation with the Perpetrator through the letter box, officers forced the door to find the Perpetrator covered in blood. They found the body of Marie on the landing upstairs, she had been stabbed. Officers also found that the Perpetrator had turned the gas hob on filling the kitchen with gas. They had to ventilate the kitchen. Paramedics arrived and tried, unsuccessfully, to resuscitate Marie. Life extinct was declared at 0019 on 16th November 2016.

The Perpetrator was arrested and charged with Marie's murder. He appeared before the Crown Court on 27th February 2017 and pleaded guilty to the offence of murder. He was sentence to life imprisonment with a recommended tariff of 13 years before being considered for parole.

3. Analysis and recommendations

Evidence in this review has been provided by friends and family members of Marie. There are accounts from Marie's sister and brother-in-law to the effect that the Perpetrator controlled everything that Marie did and they suspected for some time that there was domestic violence from him towards Marie. Marie, however, was a strong person and would not complain about any violence towards her from her husband. Marie spoke to her work colleague in particular about how much she disliked the Perpetrator and her work colleague and her sister told Marie to seek a divorce and leave him. Marie's reply was often that 'she would give as good as she got' but it is

[2] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

suspected that the topic of divorce had been raised with the Perpetrator shortly before the death.

Marie was a Roman Catholic Filipino, whose cultural beliefs were strong, meaning that she observed a sense of duty as a married woman and took her marriage vows seriously. The Police IMR author also explains the Filipino culture of 'Pakikisama', the tendency to conforming in such a way as to avoid confrontation and avoiding inconvenience to others.

Whilst some of her work colleagues were aware of Marie's domestic situation, they were dissuaded from doing anything about it by Marie. In reality, no one was aware of the extent of the constant aggression, intimidation and coercive control that the Perpetrator had over her.

There is nothing recorded in Marie's medical records to suggest that domestic abuse was suspected by any the professionals she saw at her medical appointments. She did however have several hospital appointments, some of which, records indicate, she attended with her husband. The presumption is that others she attended unaccompanied as there is nothing to indicate otherwise. There may have been opportunities to enquire about domestic about eat those appointments but without due course to ask, it is doubtful of this would have happened.

In hindsight, there were a number of high risk indicators that the police missed when they attended on the few occasions to calls from Marie. The use or threats to use gas to cause damage or injury is especially alarming and is quite frequently used by perpetrators of domestic abuse. Threats to kill and incidents involving a weapon of some kind are also indicators that should cause concern. In addition in this case there was extreme coercive and controlling behaviour by the Perpetrator and abuse of his former wife. Marie was also socially isolated due to her Filipino background. It is appreciated however, that the officers that attended to Marie's calls would not have been aware of these facts as they were not disclosed by Marie.

It is also appreciated by the Police that the incident where Marie was defrauded out of a large amount of money and explained that she did not want to complain may have been a missed opportunity to identify her vulnerability.

The Police IMR Author also points out that the officers responding to this incident did little in the way of preserving and securing evidence, in that none of the damage property nor the scissors and meat cleaver were taken as evidence. The injuries to Marie's hand and knee were not recorded. The Author has determined that the officer did not have specialist domestic abuse training and was not equipped with any camera equipment. The Author does state however that the force is currently upgrading IT to frontline staff that will ensure opportunities to secure and preserve evidence through digital evidence are made available. It is important to acknowledge that officers did comply with force policies at the time, but the police do accept that the officers may have signposted Marie to other support agencies and that may have helped her. Whether she would have taken that advice further is unknown.

The responding officer tended to deal with the incident as a domestic abuse incident rather than specific offences of criminal damage, assault. Since the Serious Crime Act 2015, the offence of controlling and coercive behaviour in intimate or familial relationships can now be considered.

Just over 3 years ago West Mercia Police created Harm Assessment Units (HAU's) that are co-located within the Multi Agency Safeguarding Hubs (MASH'S) within all of West Mercia's Local Authorities. They are currently focussed on Safeguarding

children, though plans are in place to include Adult Safeguarding teams within MASH's. Here information is shared quickly without the need for bureaucratic written information requests between agencies whilst still maintaining an audit of what information was shared, when and with whom.

In addition to the creation of MASH and HAUs, all police forces across the UK have improved their training for response officers with regards to domestic abuse and enforced a greater awareness for all officers of the consequences of domestic abuse by training, conferences and joining with other agencies to promote a general awareness of the subject.

Recommendation No1 from the Review Panel, concerns employers who engage with migrant women workers, who, research shows are more likely to become isolated from their community ties and thereby more vulnerable, should make formal links with traditional services dealing with domestic abuse so information, support and expert advice is readily available.

Recommendation No 1

Telford and Wrekin Community Safety Partnership communicate with employers to raise the awareness of their duty of care to their employees with respect to recognising signs of domestic abuse, offering immediate support, dealing with employees who have concerns about domestic abuse and signposting them to relevant support opportunities.

The panel were also aware for the need to raise awareness of domestic abuse throughout industry and commerce throughout the Telford and Wrekin area by including the issues identified in this review within existing training.

Recommendation No 2

Telford and Wrekin Community Safety Partnership to ensure that all training includes the raising of awareness of the issues faced by communities that potentially become isolated and vulnerable by virtue of their culture and migrant status.

West Mercia Police indicate in their IMR that there is a significant piece of work being implemented across the force area with regard to training in domestic abuse, which at present is too young to meaningfully access the impact. The Panel agreed that there should be a recommendation asking West Mercia Police to report back to the CSP in due course regarding the success of the training initiative taking into account the impact of partner agencies.

Recommendation No 3

West Mercia Police to

a) audit the impact and outcomes of their training programme as outlined in the Police IMR in this case, and report back to the Community Safety Partnership in 9 months from the date of this report, with evidence of multi-agency triangulation, for example from Victim Support, Women's Aid and Social Care.

b) Remind officers where possible, to provide information to victims at the scene of domestic incidents, with details of specialist services that provide support

The panel also raised the issue of specialist support agencies across the authority and considered that the profile should be raised for the benefit of those in need of their services.

Recommendation No 4

Specialist Support Agencies such as Women's Aid, should seek to increase their profile across Telford and Wrekin to raise awareness for both professionals and individuals from all communities of the availability of services and how to access them.

The Author made attempts to contact a Filipino Association to gain expert advice and knowledge regarding Filipino cultural issues, but regrettably without success. There appears to be a requirement for the Filipino communities to be made aware of the issues surrounding domestic abuse and especially how to seek help and assistance. There are numerous avenues for assistance signposted aimed at supporting all nationalities both locally and nationally but it is uncertain if the Filipino communities are receiving the same degree of advice, support and assistance.

Recommendation No 5

Telford and Wrekin Community Safety Partnership ensures that the Filipino communities within Telford and Wrekin are informed of domestic abuse support, advice and strategies especially within the community's churches and any Filipino Associations that exists.

In the process of completing this report and also to comply with Home Office Guidance[3] of 2016, the author wrote to both family and friends of Marie and received very positive responses as indicated above.

The author also wrote to the Perpetrator and his legal advisor but has had no response from either. Home Office Guidance 2016 suggests that medical information of the Perpetrator may be disclosed to the review process even without the Perpetrator's consent. Many Local Authorities and Health Authorities are uncertain about disclosing information in these circumstances and Telford and Wrekin CCG are one of those authorities. As such, this report is submitted without any medical evidence pertinent to the Perpetrator. His reluctance to speak to the Author means that his versions of events have not been included in this report.

There is communication with the Home Office from various Local Authorities requesting clarity on this issue.

4. Conclusions

The Perpetrator in this case was a controlling, coercive person who bullied his wife almost from the start of their relationship, which is evident from information supplied by Marie's sister and the incident when he demonstrated frustration and extreme jealousy at the time of her father's serious illness. This behaviour continued largely unnoticed by anyone outside the immediate family.

Marie made several comments to her sister and brother-in-law that indicated an unhappy relationship between her and the Perpetrator but Marie was self-assured and confident that she could deal with the issues as they arose. Towards the end of her

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office – December 2016

life, Marie spoke to her sister about divorcing the Perpetrator but she did not take that issue any further.

There is almost no agency involvement with the family. Police attended on two occasions and dealt with the situations in accordance with the policies in existence at the time. However, in hindsight there is an appreciation that Marie could have been signposted towards voluntary agency support at an early stage.

The Police IMR Author is also conscious that the police could have made a better attempt of recovering evidence supporting the reported abuse. This has been dealt with by modern training issues across the force and by the national police training regarding all aspects of dealing with domestic abuse and the creation of the HAUs by West Mercia Police.

The risk assessments made during the police attendances were recorded as standard, in accordance to policy at the time, and would not have warranted a referral to the MARAC process. Indeed if incidents occurred today of a similar nature they would still not meet the MARAC criteria.

In hindsight, this report paints a picture of a Perpetrator spiralling out of control and a victim who may have not only been entrapped physically and emotionally by her Perpetrator but also by her cultural beliefs and marital expectations.

There is also a past history of domestic violence, trying to gas the house, extreme coercive control and abuse, direct threats to kill, threatening with a weapon, Marie stating that she is frightened of him, sleep deprivation all on top of her cultural restrictions that could have contributed to her feeling of helplessness and entrapment.

5. Recommendations

Recommendation No 1

Telford and Wrekin Community Safety Partnership communicate with employers to raise the awareness of their duty of care to their employees with respect to recognising signs of domestic abuse, offering immediate support, dealing with employees who have concerns about domestic abuse and signposting them to relevant support opportunities.

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Specialist Support Agencies such as Women's Aid, should seek to increase their profile across Telford and Wrekin to raise awareness for both professionals and individuals from all communities of the availability of services and how to access them.

Recommendation No 5

Telford and Wrekin Community Safety Partnership ensures that the Filipino communities within Telford and Wrekin are informed of domestic abuse support, advice and strategies especially within the communities churches and any Filipino Associations that exists

6. Individual IMR Recommendations

Telford and Wrekin CCG

Recommendation No 1.

Clarity could be provided whereby all consultations and care events identify who precisely has attended a consultation, i.e. a patient being seen alone, or if accompanied, who is accompanying and their involvement in the consultation, if any. This may then highlight issues/patterns which might potentially identify instances of controlling and coercive behaviours from partners or care givers.

Recommendation No 2

In order to fully ensure that services are fully sensitive to protected characteristics within the Equality Act 2010 that all forms i.e. referral forms identify preferred language alongside need for interpreter services.

Recommendation No 3

The CCG to address the recommendations identified to promote accuracy in record keeping and full consideration to protected characteristics within the Equality Act 2010.

Malcolm Ross M.Sc.

December 2017.

Appendix No 1

Terms of Reference

Purpose of a Domestic Homicide Review

The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[4] on 13th April 2011 and reviewed in December 2016[5]. Under this section, a domestic homicide review means a review "*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
> *(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death"*

Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken.

It should be noted that an intimate personal relationship includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse[6], which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse 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*

[4] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*
[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016
[6] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office now revised again by 2016 guidance.

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and Criminal Courts. Neither are they part of any disciplinary process. The purpose of a DHR is to:

- Establish what lessons are to be learned from the 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 the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse : and
- Highlight good practice

Process of the Review

In compliance with Home Office Guidance[7], on 21st November 2016, West Mercia Police notified the circumstances of the death in writing to Telford and Wrekin Community Safety Partnership (TWCSP).

On 24th January 2017, the Chair of the TWCSP advised the Home Office that the circumstances did meet the criteria for a Domestic Homicide Review and as such a review should be conducted under Home Officer Guidance as well as guidance from the TWCSP Safety Partnership.

Home Office Guidance[8] requires that DHRs should be completed within 6 months of the date of the decision to proceed with the review.

Independent Chair and Author

Home Office Guidance[9] requires that;

> *"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and "…The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."*

[7] Home Office Guidance 2016 Page 9
[8] Home Office Guidance 2016 pages 16 and 35
[9] Home Office Guidance 2016 page 12

TWCSP decided that in this case to appoint an independent chair and author.

The Independent Author, Mr Malcolm Ross, was appointed at an early stage, to carry out this function. He is a former Senior Detective Officer with West Midlands Police and since retiring over 17 years ago he has gained experience in writing over 27 Domestic Homicide Reviews in the last 6 years and chairing those reviews on many occasions. He has previously performed both functions in relation to over 80 Serious Case Reviews. Prior to this review process he had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it. Mr. Ross has attended the Home Office DHR Training course as well as numerous child Serious Case Review courses.

DHR Panel
In accordance with the statutory guidance, a DHR Panel was established to oversee the process of the review. Mr Ross chaired the Panel and also attended as the author of the Overview Report. Other members of the panel and their professional responsibilities were:

- Chris Morris, Executive Nurse, NHS Telford and Wrekin Clinical Commissioning Group
- DCI Paul Moxley, West Mercia Police
- George Branch, Community Rehabilitation Company
- Sue Coleman, Women's Aid
- Sarah Constable – Partnership Manager, CSP
- Malcolm Ross, Independent Chair and Author

The Panel members confirm they had no direct involvement in the case, nor had line management responsibility for any of those involved. The Panel was supported by the DHR Administration Officer. The business of the Panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of this review having been undertaken.

The Panel met on 5 occasions; on 16th February 2017, 28th March 2017, 18th April 2017, 23rd May 2017, and on 26th June 2017 when the Marie's sister and brother in law were invited and attended the Panel meeting.

Parallel proceedings
The Panel were aware that the following parallel proceedings were being undertaken:

- TWCSP advised HM Coroner in December 2016, that a DHR was being undertaken. HM Coroner opened the inquest and adjourned to a date to be fixed on 30th December 2016.
- Criminal proceedings had been commenced and this review was aware of the rules of disclosure.

Time Period

The time period for the review has been determined to start from 2002, the year that Marie and the Perpetrator met, until the date of Marie's death on 16th November 2016.

Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting. The scoping exercise was completed by the TWCSP to identify agencies that had involvement with Marie and Perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies were requested to inform the Review by a report.

Individual Management Reports

An Individual Management Reports (IMR) and comprehensive chronology was received from the following organisations:

- West Mercia Police
- Telford and Wrekin CCG

In addition reports were received from:

- West Midlands Ambulance Service
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Fire and Rescue Service

Guidance[10] was provided to IMR Authors by the Chair/Author of the report through local and statutory guidance. Statutory guidance determines that the aim of an IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standard
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.

Agencies were encouraged to make recommendations within their IMRs and these were accepted and adopted by the agencies that commissioned the reports. The recommendations are supported by the Overview Author and the Panel.

The IMR Reports were of a high standard providing a full and comprehensive review of the agencies' involvement and the lessons to be learnt.

Individual Needs

Home Office Guidance[11] requires consideration of individual needs and specifically:

> 'Address the nine protected characteristics under the Equality Act 2010 if relevant to the review. Include examining barriers to accessing services in addition to wider consideration as to whether service delivery was impacted'

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

[10] Home Office Guidance 2016 Page 20
[11] Home Office Guidance 2016 page 36

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the Protected Characteristics under the Act.

The Protected Characteristics are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation

There was nothing to indicate that there was any discrimination in this case that was contrary to the Act.

Marie was a Roman Catholic Filipino lady and this report contains information regarding the Filipino culture, with helpful research by the Police IMR Author and information gleaned from Marie's sister. Attempts were made by the Overview Author to obtain additional and independent information from the Filipino community's experts and contact was made with the Filipino Society of Oxford via its Secretary. Arrangements were made for the Author to visit her but a few days before the date of the appointment the Secretary called to say that she didn't think she could help.

Further attempts were made to contact the Filipino Society of Bristol and an email sent to the Secretary of that organisation requesting help. The email was not answered and no communication was made. This situation has been explained to the AAFDA representative who is supporting Marie's sister and the AAFDA representative is content that efforts to obtain independent advice and views have been made and understands the problems experienced.