

# Tameside Community Safety Partnership

## Domestic Homicide Review

### Overview Report

'MARK'

Died May 2019

Chair: David Hunter  
Author: Ged McManus

Date finalised: June 2020  
Resubmission 14 September 2023

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## 1 Introduction

- 1.1 This report of a Domestic Homicide Review examines agency responses and support given to Mark<sup>1</sup>, a resident of Tameside prior to his death in May 2019. The DHR panel would like to offer their condolences to Mark's family on their tragic loss.
- 1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
- 1.3 Mark and Paula<sup>2</sup>, lived together in a social housing flat in Tameside. The couple had known each other at school, but had not seen each other for many years before starting a relationship around 2014, after they had met by chance.
- 1.4 Mark and Paula did not have children and had sought medical help in 2017, when they said that they had been trying for a baby for three years. After initial appointments Mark did not attend for necessary tests and although Paula asked for a referral for IVF - In vitro fertilisation - this was not followed up. It is thought that the couple had lived together for approximately two years prior to the fatal incident.
- 1.5 At just after midnight on a night in May 2019, the police were called to a disturbance at the couple's home. Mark was found dead on the balcony and had suffered multiple stab wounds.
- 1.6 Paula was arrested and provided a prepared statement when interviewed in which she briefly stated, "she stabbed Mark as she was in fear of her own life, she could only recall stabbing him once."
- 1.7 At her trial, Paula admitted manslaughter but denied murder. Following a two week trial, the jury, after a two hour deliberation, was unanimous in finding her guilty of murder.
- 1.8 Prior to sentencing her, the judge is reporting as saying:

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<sup>1</sup> A pseudonym chosen by the victim's family

<sup>2</sup> A pseudonym for Paula chosen by the DHR panel

'You launched an entirely unprovoked and sustained attack with the larger of the two knives, a sharp bladed chef's knife and inflicted the horrific wound to his neck most probably as he lay prone on that bed. The knife snapped during the attack and the defendant injured herself during her initial onslaught which left Mark fighting for his life.

[Mark] tried to escape but would have been unable to raise the alarm because of the wound to his throat.

You went to the kitchen and selected a second further carving knife from the block and went back into the living room where you commenced a second attack on him. He put up a fight for his life, sustaining multiple wounds to his hands and arms in self-defence and using his body weight to push you against the railings.

You were strong enough to push him back and stabbed him three times to the back with that sharp knife'.

- 1.9 Paula was sentenced to life imprisonment with a minimum prison tariff of eighteen years before she can be considered for release.
- 1.10 The review will consider agencies contact and involvement with Mark and Paula from 11 January 2016, until Mark's death in May 2019. This time period was chosen because the couple's relationship did not come to the attention of any agency until 11 February 2016 and the panel felt it appropriate to start a detailed analysis of events a month prior to that. Background information, including any knowledge of domestic abuse held by family, friends and employers, prior to the terms of reference period was also available to the panel and is used in the report for context.
- 1.11 The intention of the review process is to ensure 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.
- 1.12 **Note:**  
It is not the purpose of this DHR to enquire into how Mark died. That is a matter that has already been examined during the Paula's trial.

## 2 **Timescales**

- 2.1 This review began on 24 September 2019 and was concluded on 5 June 2020 following consultation with Mark's family. The panel met on three occasions before the work was interrupted by the effects of the Covid-19 pandemic. Further work was then completed by telephone calls, the exchange of documents and video conferencing.
- 2.2 The overview report was presented to the Community Safety Partnership on 15 September 2020, submitted to the Home Office in 2022 and resubmitted on 14 September 2023.

## 3 **Confidentiality**

- 3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.
- 3.2 The report uses pseudonyms in order to protect the identity of the victim and perpetrator. The pseudonyms have been agreed with Mark's family.

## 4 **Terms of Reference**

### 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]

#### 4.2 **Timeframe under Review**

The DHR covers the period 11 January 2016 to the homicide in May 2019.

#### 4.3 **Case Specific Terms**

##### **Subjects of the DHR**

Victim: Mark aged 37 years

Perpetrator: Paula aged 35 years

##### **Specific Terms**

1. What indicators of domestic abuse did your agency have that could have identified Mark as a victim of domestic abuse by Paula and what was the response?
2. What knowledge did your agency have that indicated Paula might be a perpetrator of domestic abuse against Mark and what was the response?
3. What knowledge did your agency have that indicated Paula might be a victim of domestic abuse by Mark and what was the response?
4. What thought was given by your agency as to whether Mark or Paula was the primary perpetrator?
5. What services or signposting [including substance misuse services] did your agency provide for, or offer to, Mark or Paula, and were they accessible, appropriate and sympathetic to their needs and were there any barriers in your agency that might have stopped Mark or Paula from seeking help for the domestic abuse?
6. What knowledge or concerns did Mark and Paula's families, friends or employers have about their involvement in domestic abuse and did they know what to do with it?
7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Mark and/or Paula?

8. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Mark and/or Paula, or on your agency's ability to work effectively with other agencies?
9. What learning has emerged for your agency?
10. Are there any examples of outstanding or innovative practice arising from this case?
11. Does the learning in this review appear in other domestic homicide reviews commissioned by Tameside Community Safety Partnership?

## 5

### **Methodology**

- 5.1 Following Mark's death, formal notification of the homicide was sent to Tameside Community Safety Partnership by Great Manchester Police on 29 May 2019. A Scoping Meeting took place on 15 July 2019 where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed of the decision.
- 5.2 Once the decision to conduct a DHR had been taken David Hunter was appointed as the independent chair on 19 July 2019. The Community Safety Partnership carried out a scoping exercise which identified those agencies that had contact with Mark and Paula. Thereafter a DHR panel was assembled from agencies judged to have an involvement with the family or contribution to make to the review. Care was taken to ensure people with additional independence and domestic abuse expertise were invited to be panel members. Agencies shown at section 7 of the report provided Individual Management Reviews and chronologies of their involvement. These documents were scrutinised by the panel and informed the development of the overview report. The panel scrutinised drafts of the overview report and panel discussion contributed to the development of the report.
- 5.3 The Domestic Homicide Review was presented to Tameside Community Safety Partnership 15 September 2020 and was sent to the Home Office on 20 September 2022. There was a delay in Tameside Community Safety Partnership submitting the report to the Home Office. This delay was due to a misunderstanding within Tameside Community Safety Partnership around the submission of the report, which was not identified until the summer of 2022, at which point the report was submitted.

## 6 **Involvement of family, friends, work colleagues and wider community**

### 6.1 **Mark**

6.1.1 The DHR Chair wrote to Mark's family inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet.

6.1.2 Mark's sister agreed to contribute to the review and met with the independent chair and author of the review. She was assisted by a worker from the Victim Support Homicide Service. The chair and author of the review offered their personal condolences and those of the DHR panel. The draft terms of reference were shared with Mark's sister who agreed to them.

6.1.3 Mark's sister was happy to provide Mark's personal history to the review. She had also known Paula and was happy to speak openly about both Mark and Paula. The information provided is largely contained within section 13 of the report.

6.1.4 The chair of the review kept Mark's sister updated on the progress by email and telephone calls. The panel stopped meeting in person as a result of the Covid-19 pandemic. The stoppage was before the planned appearance of Mark's sister. This was in the early stages of the pandemic before Teams/zoom were well established. On completion of the work Mark's sister was informed.

### 6.2 **Paula**

6.2.1 The DHR chair wrote to Paula in prison. This was followed by an email sent through the services of [www.emailaprisoner.com](http://www.emailaprisoner.com). No reply has been received and attempts to follow this up have been hindered by restrictions as a result of the coronavirus. The Community Safety Partnership is aware that less than fifty percent of perpetrators take up the offer of involvement in a review and therefore made a decision to continue the process without Paula's involvement. In doing so the CSP took account of the risk of a long delay to the review which may still not result in Paula's involvement.

### 6.3 **Others**

6.3.1 Greater Manchester Police shared a number of statements with the review that had been taken for the purposes of the criminal investigation into Mark's murder. Information from these statements is used in the review and

referenced where appropriate. These people were not seen separately by the Chair or author of the review.

7 **Contributors to the review/ Agencies submitting IMRs<sup>3</sup>**

7.1	<b>Agency</b>	<b>Contribution</b>
	Greater Manchester Police	IMR
	Tameside and Glossop Clinical Commissioning Group	IMR
	North West Ambulance Service	IMR
	Tameside and Glossop Integrated Care NHS Foundation Trust	IMR
	Change Grow Live	IMR
	Jigsaw Homes	IMR

7.2 As well as the IMRs, each agency provided a chronology of interaction with Mark and Paula 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. Each IMR author had no previous knowledge of Mark or Paula or any involvement in the provision of services to them.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator 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 Mark and Paula and any other action taken.

7.4 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.

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<sup>3</sup> Independent Management Reviews [IMRs] are detailed written reports from agencies on their involvement with Mark and/or Paula.

7.5 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.

7.6 The IMRs in this case were of good quality and focussed on the issues facing Mark. They were quality assured by the original author, 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.

## 8 **The review panel members**

8.1	David Hunter	Independent Chair
	Ged McManus	Independent Author
	Carol Elwood-Clarke QPM	Independent support to chair and author
	Zylla Graham	Detective Inspector Investigation and Safeguarding Review Team Greater Manchester Police
	Lindsey Curry	Detective Sergeant Major Crime Review Unit Greater Manchester Police
	Richard Cartwright	Manager qualified independent domestic abuse advocate [IDVA]. Bridges Domestic abuse service. [provider Jigsaw Homes]
	Cheryl Hallwood	Independent Domestic Violence Advocate. Bridges Domestic Abuse service [provider Jigsaw homes] <sup>4</sup>
	Angela Jones	Designated nurse for looked after children, Tameside and Glossop CCG <sup>5</sup> [observer]

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<sup>4</sup> Bridges is Tameside's local authority commissioned domestic abuse service. The contract is delivered as Bridges, by Jigsaw Homes (formerly New Charter Housing Trust) and has been since 1 October 2013. From 10 July 2019 the directorate that the Bridges service sits within became Jigsaw Support. Bridges recently retained the tender and were issued with a new five-year contract which began on 1 April 2019. This includes support for male victims of domestic abuse.

<sup>5</sup> The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

Vicki Gee	Service Unit Manager — Operations, Adults, Tameside MBC
Mags Deakin	Trust lead for Domestic Abuse, Tameside & Glossop Integrated Care NHS Foundation Trust
Tracey Hurst	Designated Nurse Adult Safeguarding Tameside & Glossop Clinical Commissioning Group
Suzanne Antrobus	Head of Legal Services, Tameside Metropolitan Borough Council

8.2 The chair of Tameside Community Safety Partnership was satisfied that the Panel Chair was independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

## 9 **Author and Chair of the overview report**

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author were separate people.

9.2 The chair, David Hunter completed forty-one years in public service [the military and a British police service] retiring, from full time work in 2007. He has undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews.

9.3 The author of the report, Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He is currently Independent Chair of a Safeguarding Adult Board in the north of England [not Greater Manchester] and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England.

9.4 The chair and author were supported by a third independent practitioner, Carol Elwood-Clarke. She retired from thirty years public service [British policing – not Greater Manchester] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medical

(QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives<sup>6</sup>. The additional support for the Chair/Author was part of a mentoring process.

- 9.5 All three independent practitioners have undertaken all the available Home Office Training on DHRs as well as attending regional and national conferences for chairs, authors and other professionals involved with DHRs. None of them has worked for any agency contributing to this review. David Hunter chaired a DHR in Tameside in 2012.

## 10 **Parallel Reviews**

- 10.1 An inquest was opened and adjourned immediately following Mark's death. The review was told that HM Coroner is not going to resume the inquest.
- 10.2 Greater Manchester Police conducted a criminal investigation which resulted in Paula being convicted of Mark's murder. Some material from the investigation was disclosed to the DHR and is referenced appropriately.
- 10.3 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 no indication during the review that any agency is considering such a process.

## 11 **EQUALITY AND DIVERSITY**

- 11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:
- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
  - **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy

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<sup>6</sup> <http://www.safelives.org.uk/> The UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].

- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is

a lesbian. So a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines 'disability' as:

- (1) A person (P) has a disability if:
  - (a) P has a physical or mental impairment, and
  - (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

11.2 All subjects of the review are of white British heritage and were living in an area of predominantly the same culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.3 Domestic homicide and domestic abuse in particular, is predominantly a gendered crime with women by far making up the majority of victims, and by far the vast majority of perpetrators are male. A detailed breakdown of homicides reveals substantial gendered differences. Female victims tend to be killed by partners/ex-partners. For example, in 2017, according to the Office of National Statistics homicide report<sup>7</sup> "There were large differences in the victim-suspect relationship between men and women. Half of female adult victims aged 16 and over were killed by their partner or ex-partner<sup>1</sup> (82 homicides) in the year ending March 2017. In contrast, only 3% of male victims aged 16 and over were killed by their partner or ex-partner (13 offences).

11.4 The Equality Act 2010 [Disability] Regulations 2010 [SI 2010/2128] specifically provide that addiction to alcohol, nicotine or any other substance [except where the addiction originally resulted from the administration of medically prescribed drugs] is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol or drug addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 [care and support] assessment is completed. Neither Mark nor Paula ever came to the attention of Adult Social Care and therefore there was no opportunity to consider whether a care and support assessment was appropriate. The panel discussed in the light of the

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<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2017>

information now available, whether either Mark or Paula would have had a level of need requiring a care and support assessment and concluded that they would not.

## 12 **DISSEMINATION**

Mark's family  
Home Office  
Tameside CSP  
Tameside and Glossop Clinical Commissioning Group  
Northern Care Alliance  
Greater Manchester Police  
Greater Manchester Police Crime Commissioner  
Pennine Care NHS Foundation Trust  
Her Majesty's Prison and Probation Service  
Tameside & Glossop Integrated Care NHS Foundation Trust  
Bridges Domestic Abuse Service

## 13 **BACKGROUND, OVERVIEW AND CHRONOLOGY**

### 13.1 **INTRODUCTION**

13.1.1 This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is from documents and information provided by agencies and the family and material gathered by the police during the homicide investigation. Analysis of events appears at section 14.

13.1.2 Mark was nine years younger than his sister and there are no other full siblings. In their earlier years both Mark and his sister lived together with their parents until around 1984 when their parents split up. Mark lived with their Dad whilst his sister stayed with their Mum. Mark visited and stayed with his Mum most weekends and the two houses were close enough that he could move between them quite freely. In the first two years following the breakup relations between their parents were strained but they became better with time and eventually they got on quite well although they were never reconciled.

- 13.1.3 After some time, Mark moved to live full time with his Mum but still visited and saw his Dad regularly. His Mum passed away in 1996 when he was 14. After that he lived with his Dad again for a short period but mainly lived with his sister who by then had her own house.
- 13.1.4 Mark went to local schools and left aged 16 to work in a bakery. He moved into his first flat in 2002. This was near to his sister's house and he visited her regularly. Mark's sister said that he always had girlfriends and when a relationship was not going well, he would move back in with his sister and her family. This was a repeated pattern over the years.
- 13.1.5 Mark moved to Scotland for a year where lived with his half-brother [same Mum different Dad] This was about a year before he met Paula. He worked in a toffee factory, laboured on building sites and for six months looked after two children whilst their mother went to work.
- 13.1.6 Mark returned to Tameside about a year before he met Paula. He initially stayed with his Dad but after a problem about his Dad's benefits he moved and obtained his own flat from the local social housing provider. This was the flat where he and Paula would later live together. Mark was the sole tenant of the flat and he was almost unknown to the social housing landlord other than for routine matters.
- 13.1.7 Mark was a working man, who over the years had a number of manual and factory jobs, for example working as a meat packer or on production lines. He was known to the police who had been called to domestic incidents involving Mark and his father on a number of occasions. These usually occurred when Mark had been drinking and his behaviour could at times be volatile. Mark's father passed away a few weeks before the murder.
- 13.1.8 Paula is from a large family. Prior to the time period of the review she had a history as a victim and perpetrator of domestic incidents with family members and as a victim of an ex-partner.
- 13.1.9 In 2007, Paula was involved in an incident when after she had been out drinking with another female, they engaged in an argument which led to one of them setting fire to the lounge curtains. They both escaped along with children who were present and then both blamed the other for starting the fire.
- 13.1.10 Between 2007 and 2012 there were five further reports of domestic incidents between Paula and various family members, she received a fixed penalty

notice in 2007 following an incident with her father. In 2009 following a reported suicide attempt Paula had to be removed from her mother's address following an incident at which time she said she was pregnant. Further incidents involved Paula her mother and Paula's siblings. On each occasion alcohol was a factor.

- 13.1.11 During 2007 and 2008 there were a number of domestic incidents reported between Paula and her then partner [not Mark], this culminated in a serious allegation being made by Paula against the male.
- 13.1.12 Paula worked as a builder's labourer but had also during the time period of the review spent some time working in a factory making window blinds before returning to work as a labourer.
- 13.1.13 It is thought that Mark and Paula started a relationship in 2014. They had known each other in their earlier life but had lost touch and began seeing each other after a chance meeting. When they met the couple both lived independently but it is known that they soon living together in Mark's flat.

### 13.3 **Information during the DHR timeframe**

- 13.2.1 Mark often spoke to friends and colleagues about his relationship with Paula. He told them that he was unhappy in the relationship and that he paid for everything whilst Paula never contributed. He also told male friends that Paula had assaulted him by banging his head on a wall. On one occasion Mark showed a friend deep cuts to his neck and chest which appeared to have been caused by 'someone really digging their nails in'. Mark told two people that Paula had threatened him with a knife.
- 13.2.2 For her part Paula confided in friends that Mark was abusive and threatening to her and did not contribute to the household, leaving her to pay for everything. Witnesses told the police that they had seen Mark assault Paula on a number of occasions.
- 13.2.3 Mark was also said to have acted in a controlling way towards Paula on occasions, for example following her [stalking] when she was out with friends and family. On other occasions he would ring her when she was visiting friends and family and insist on speaking to them in an apparent attempt to check on Paula's true whereabouts.
- 13.2.4 Neighbours often heard the couple arguing loudly and their domestic disputes and arguments appear to have become normalised and accepted by others

over time. It is not thought that any of the incidents described by third parties were reported to any agency.

- 13.2.5 On 11 February 2016, the couple's relationship first came to the attention of agencies when the police and ambulance service were called to the couple's home after Paula had self-harmed. Paula was taken to hospital and treated for minor injuries whilst Mark was arrested for possession of a controlled drug. Whilst Paula did not report anything to the police, she told medical professionals that she had self-harmed as a result of a domestic incident. Paula was referred to the on-site mental health team but left the hospital without being seen. This resulted in a police visit to the couple's address to check on Paula who was found to be safe and well.
- 13.2.6 On 2 October 2016, Greater Manchester Police attended at the couple's address following a report of domestic incident between Paula and her brother. Paula's brother was arrested nearby and later released with No Further Action on the advice of the Crown Prosecution Service. Officers were unable to make contact with Paula after the incident to complete the DASH<sup>8</sup> report.
- 13.2.7 In April 2017, the couple attended their respective GP's. They said that they had been trying for a baby for three years and asked for help. In May 2017, Paula told a gynaecologist that she had suffered a number of miscarriages.
- 13.2.8 On 23 May 2017, Paula attended a GP appointment for a physical condition and disclosed that she was feeling anxious. She was given appropriate treatment for the physical condition and reassured.
- 13.2.9 On 20 July 2017, Mark attended an outpatient's appointment for a physical condition. He disclosed a history of binge drinking.
- 13.2.10 On 31 July 2017, Paula attended a gynaecology outpatient's appointment. She requested a referral for In-Vitro Fertilisation. Mark was sent a letter asking him to attend his GP for tests.
- 13.2.11 On 9 August 2017, Paula attended a GP appointment as she was experiencing anxiety and depression. She discussed a recent miscarriage and family

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<sup>8</sup> 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.

bereavement. Paula said that she had a supportive family and did not feel suicidal. The GP discussed safety mechanisms with her.

Paula completed the Tameside & Glossop Primary Care Mental Health Service Access Questionnaire:

(Self-Assessment Document 0-3 scores, 3 being indication that the person is experiencing emotional upset)

She scored 3 for anxiety and nervousness

1 for becoming annoyed

2 for feeling afraid

0 for feeling better off dead.

Paula was prescribed Fluoxetine<sup>9</sup> and advised to self-refer to Healthy Minds

- 13.2.12 On 26 August 2017 A third party reported to the police that Mark was "beating the shit out of his missus". On Police arrival Paula appeared upset and stated that they had been arguing but made no complaint of assault. Paula was taken to her mother's address at her request. A DASH risk assessment was completed which indicated a number of concerns and was initially recorded as Medium Risk. This was then reclassified as a standard risk by the Triage Team and a STRIVE<sup>10</sup> contact was requested. The incident was later closed with no contact being made.
- 13.2.13 On 14 September 2017, during an interview with her employer to discuss repeated incidents of sickness absence Paula indicated that she had been a victim of domestic abuse by Mark and that the police had moved her to a refuge. The assertion that police had moved her to a refuge was untrue. Her assertion to her employer about domestic abuse was rejected by the judge at her trial after she had given evidence. The judge thought that Paula had used the assertion of domestic abuse to deflect her employer from taking action against her.
- 13.2.14 On 17 January 2018, Mark attended a GP appointment. He reported experiencing low mood, taking drugs and binge drinking. He was not sleeping. He said that he felt angry and lost his temper but was not violent. The GP discussed Mark's lifestyle with him and prescribed Fluoxetine,

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<sup>9</sup> Fluoxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor). It is often used to treat depression, and also sometimes obsessive compulsive disorder and bulimia.

<sup>10</sup> A police operation intended to provide early intervention and signposting to reduce risk in standard risk domestic abuse incidents.

Thiamine<sup>11</sup> and vitamin B. Mark was signposted to Be Well Tameside and Healthy Minds and given a Fit note for anxiety and depression from 17 January 2018 to 14 February 2018. Be Well Tameside and healthy Minds have no record of Mark contacting them.

- 13.2.15 On 11 February 2018, Mark telephoned the police reporting that Paula had left the address and told him that she had slit her wrists. Paula was located nearby by police officers and was transported to hospital with minor scratches to her arms. Paula did not wait to be seen and left without treatment. Following a multi-agency discussion on 12 February 2018, the police made contact with Paula's GP in order to ensure that she received medical support. Paula's GP tried but was unable to contact her following the police notification. The ambulance service information received by the GP practice indicated that domestic abuse was a factor in the incident and this was flagged on Paula's GP record.
- 13.2.16 On 19 February 2018, Paula's GP tried but was unable to contact her following the police notification of 11 February 2018. The ambulance service information received by the GP practice indicated that domestic abuse was a factor in the incident and this was flagged on Paula's GP record.
- 13.2.17 On 22 February 2018, Paula attended a GP appointment. She reported low mood, but no thoughts of self-harm or suicide. The GP recorded no psychosis, no hallucinations and no anger. Paula said that her self-harm incidents were stress relieving and that she had no intention of suicide. A safety plan was discussed and agreed with her. She was prescribed Loratadine<sup>12</sup> and Sertraline<sup>13</sup>. Paula was also signposted to Healthy Minds. Healthy Minds have no record of Paula contacting them.
- 13.2.18 Paula attended a GP appointment to follow up on the appointment of 22 February 2018. She reported feeling better and had no self-harm or suicidal thoughts. She disclosed emotional abuse by her partner [Mark] and the death of her father two weeks previously. She was signposted to appropriate support agencies and given a Fit note excusing her from work for two weeks. Checks have been made and Paula is not known to the agencies to which she was signposted.

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<sup>11</sup> Thiamine is a vitamin, also called vitamin B1. Vitamin B1 is found in many foods including yeast, cereal grains, beans, nuts, and meat. It is often used in combination with other B vitamins and found in many vitamin B complex products.

<sup>12</sup> Loratadine is an antihistamine.

<sup>13</sup> Sertraline is an antidepressant.

- 13.2.19 On 7 July 2018, Mark's father contacted the police following a minor incident between them which had resulted in Mark leaving his father's house with the keys. This was resolved without police intervention.
- 13.2.20 The incident of 7 July 2018, was the last time that any agency had contact with Mark or Paula.
- 13.2.21 In the following months Mark fell out with his father and stopped seeing him. Paula continued to visit Mark's father, doing shopping and other routine tasks for him. Mark's father gave Paula his bank card and PIN number for this purpose, which members of Mark's family believe she abused by taking money for herself. Following the death of Mark's father in April 2019, his family say that Paula continually asked Mark for money and they assumed that these demands resulted from Paula's access to Mark's father's money being cut off upon his death.
- 13.2.22 In the months before his death Mark had become good friends with a work colleague and they often shared transport to and from work. Mark was not complimentary about Paula to his colleague and in the weeks before his death his complaints about her got worse. He told his friend that a big source of dispute between them was that Mark's father had left Mark some money and Paula thought that she deserved some of the money for looking after Mark's father whilst he was ill. On Monday and Tuesday of the week that Mark died he said that he was going to end the relationship with Paula. On Wednesday Mark was in good spirits when his colleague dropped him off near home after work. He was murdered that night.
- 13.2.23 Evidence gathered by the police for the purposes of the murder investigation shows that Mark was known by friends and acquaintances to be a heavy drinker and an occasional cannabis user.
- 13.2.24 Paula spent a lot of time at Mark's father's home and helped around the house and with shopping. She had access to his bank card and Mark's sister thought that Paula had used this to take money for herself. Paula often borrowed money from Mark's father and the family were not sure how much of it was ever paid back.
- 13.2.25 Mark's sister was aware that Mark liked a drink, but this was generally confined to weekends when he was not working. She also knew that he sometimes smoked cannabis but did not think that he used other substances. She was

aware that Paula told others Mark did not contribute to the household but thought this was untrue as Mark had told her the opposite. She thought that Paula spent her own money, and money borrowed or taken from Mark's father, on drugs and gambling. In the months before his father's death, Mark had urged him to stop drinking and when he did not Mark stopped seeing him. Paula continued to visit and Mark's sister was sure that Paula had taken money from their Dad the day before he died.

- 13.2.26 Evidence gathered by the police during the course of the murder enquiry shows that Paula was a regular cocaine user and spent money on gambling. She often borrowed money from friends and acquaintances. Evidence gathered by the police for the purposes of the murder investigation shows that Mark was known by friends and acquaintances to be a heavy drinker and occasional cannabis user.

## 14 ANALYSIS

### 14.1 **What indicators of domestic abuse did your agency have that could have identified Mark as a victim of domestic abuse by Paula and what was the response?**

- 14.1.1 No agency has reported that it held information to indicate that Mark could have been a victim of domestic abuse. Indeed, the opposite was the case. Mark had a history of domestic abuse towards his father and Paula's medical records noted that her relationship with Mark was abusive.
- 14.1.2 The panel considered whether there was evidence that Paula had subjected Mark to coercion and control and in doing so referred to the Crown Prosecution Service policy guidance.
- 14.1.3 The Crown Prosecution Service policy guidance on coercive control states<sup>14</sup>;  
Building on examples within the Statutory Guidance, relevant behaviour of Paula can include:
- Isolating a person from their friends and family
  - Depriving them of their basic needs
  - Monitoring their time

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<sup>14</sup> [www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship](http://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)

## Official Sensitive

- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or University
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next.

14.1.4 No agency was aware of information which pointed to Paula using controlling and coercive behaviour towards Mark. Mark told friends and family that Paula assaulted, threatened him and did not contribute to the household budget, but that information was never known to agencies. The panel thought that on the information available it could not come to a conclusion whether Mark had been subject to coercion and control. This was complicated by information that Mark may have used controlling and coercive behaviours towards Paula by continually checking up on her, following her and monitoring her communications.

14.2 **What knowledge did your agency have that indicated Paula might be a perpetrator of domestic abuse against Mark and what was the response?**

14.2.1 Paula had a history of domestic abuse towards family members which resulted in contact with the police. She was also a victim of domestic abuse in a previous relationship.

14.2.2 Mark did not report domestic abuse to any agency and no agency suspected that he was a victim of domestic abuse. Mark did tell friends and family on a number of occasions that Paula had assaulted him. He had injuries on some occasions, for example a black eye and deep scratches that he said Paula was responsible for. None of these injuries or incidents was ever reported to any agency. On some occasions, in particular with male friends, Mark related the story of his arguments with Paula and his injuries in such a way that friends thought he might have been joking and therefore did not take what he said seriously. It is a fact that Paula committed the ultimate act of domestic abuse when she killed Mark.

14.2.3 Economic Abuse<sup>15</sup> is defined by the UK Government as:

‘Economic abuse involves behaviours that interfere with an individual’s ability to acquire, use and maintain economic resources such as money, transportation and utilities. It can be controlling or coercive.

It can make the individual economically dependent on the abuser, thereby limiting their ability to escape and access safety. It is designed to intimidate and isolate the victim.

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<sup>15</sup> Economic abuse is included as a category of abuse in the Domestic Abuse Act 2021.

Economic abuse is included as a category of abuse in the Domestic Abuse Act 2021. [Although it should be noted that the events covered by this review predate the Act]. It goes beyond interfering with money and finances to include economic resources more broadly, such as things that money can buy. Examples include housing, possessions and clothing. Financial Abuse is also included as a form of abuse in Section 42 (3) of the Care Act (2014).'

There are indicators that Mark enduring economic abuse by Paula. For example:

Paula had moved in within 2 weeks.

Mark's family thought Paula was using her access to his Dad's bank card to take money for herself, and not paying money back.

Paula felt she deserved money from Mark's inheritance for looking after his father.

That she had smashed a glass table.

That Mark and Paula had told friends the other never contributed financially.

That Mark's family said Paula continually asked Mark for money.

The indicators described above predated the economic abuse definition, but is something the Tameside Community Safety Partnership will review outside of this historical DHR.

14.3 **What knowledge did your agency have that indicated Paula might be a victim of domestic abuse by Mark and what was the response?**

14.3.1 When Paula attended the Accident & Emergency department on 11 February 2016, following an episode of self-harm she disclosed historic trauma [not associated with Mark] and multiple miscarriages. She also disclosed that a domestic incident had triggered her to self-harm. Both of these symptoms could be indicators of potential domestic abuse as detailed in the National Institute for Clinical Excellence, Domestic Violence and Abuse guidance (2016). Paula left before she could be seen by the on-site mental health team and no action was taken in relation to the disclosure of domestic abuse. Patients presenting in A&E with symptoms or conditions which are indicators of potential domestic abuse should be routinely screened in regard to domestic abuse and referred or signposted to support services or offered a referral to Tameside MARAC as appropriate in accordance with NICE guidance (2016) and the Tameside & Glossop Integrated Care NHS Foundation Trust Domestic Abuse policy. This is a learning point and leads to Tameside &

Glossop Integrated Care NHS Foundation Trust single agency recommendation one.

- 14.3.2 Whilst the police attended the incident which resulted in Paula being taken to the hospital it seems that she did not disclose domestic abuse to the police. Mark was arrested for another matter.
- 14.3.3 During 2017, Paula attended a number of gynaecology appointments and disclosed that she had suffered multiple miscarriages. It is known that spousal abuse increases the risk of miscarriage by 50% [World Health Organisation 2005]. History of multiple miscarriages should be considered an indicator in regard to potential domestic abuse in the relationship [NICE QS116, 2016.] The panel thought that it would be a reasonable expectation that routine enquiry would form part of the health assessment for a patient with a history of multiple miscarriages. This does not appear to have been considered during gynaecology out-patients appointments. Following an enquiry, the attending doctor has said that they were unaware that multiple miscarriages could be an indicator of domestic abuse. This is a learning point and leads to Tameside & Glossop Integrated Care NHS Foundation Trust single agency recommendation four.
- 14.3.4 On 26 August 2017, a third party reported to the police that Mark was "beating the shit out of his missus". The caller said that this had happened before but had not been reported. On Police arrival Paula appeared upset and stated that they had been arguing but made no complaint of assault. Paula was taken to her mother's address at her request. A DASH risk assessment was completed which indicated a number of concerns and was initially recorded as Medium Risk.
- 14.3.5 Both Mark and Paula had been drinking but were calm. Paula said that she didn't know why the police had been called but was upset because the couple had been arguing. Neither Mark nor Paula made any criminal allegations against each other.
- 14.3.6 The DASH risk assessment recorded that Paula was scared of Mark's behaviour and of further violence as he had been violent in the past. She stated that he stopped her seeing her friends and constantly rings and texts if she did go out. She stated that she had tried to split with him four months ago and had suffered three miscarriages, the last being two weeks prior to this incident. She stated that the abuse happened daily and he made cruel comments. For example, after the last miscarriage he said that it was for the best as it was probably not his child. Paula described Mark as jealous and

paranoid, that he tried to hit her with a hammer a year ago and had previously strangled her in front of her step-dad. Paula described him paying all the rent as she was only receiving sick pay and had TV licence arrears. Paula stated that Mark used cannabis.

14.3.7 Paula said that she wanted to think about the relationship and requested contact from the police Domestic Violence Unit (DVU). The DASH risk assessment records clear indicators of controlling and coercive behaviour and allegations of historic assault. No crime was recorded in relation to this incident. Whilst Paula did not make a direct allegation of assault in relation to the events of that day, the disclosures she made in order to record the DASH risk assessment should have led to a crime being recorded for controlling and coercive behaviour and/or historic allegations of assault.

14.3.8 The incident was recorded as a Medium Risk DASH and triggered an action for the incident and the officer's assessment be reviewed by a Triage Team. The attending officer indicated that Paula was happy for contact by the DVU and further support and safeguarding advice. The review was conducted the following day and at this point the risk assessment was amended to a Standard Risk with the following rationale

"no offences, no threats violence or injury".

This reclassification did not take into account the details of the DASH report where there were several risk indicators, a criminal offence and potentially further offences disclosed.

14.3.9 The officer tasked with this review had been placed temporarily in the Triage Team at that time and had received no specialist training. At the time the officer was on restricted duties and due to the back log of incidents for triage it was decided that this was a suitable placement. The officer was working from another police station on his own with telephone contact only to the Triage Team for support. This officer was working from a "crib sheet" in what to look for when identifying risk and what referrals could be considered. The chair and author have seen from other reviews that the Triage Team can play a useful specialist role in assessing DASH risk assessments and taking the whole circumstances of a case into account. In this case the system failed as the officer tasked with doing the work had no training and little support. This is a learning point and leads to Greater Manchester Police single agency recommendations one and two.

- 14.3.10 Having been reduced to standard risk, the incident was tasked for a visit by Operation STRIVE. This operation is intended to provide early intervention and signposting to reduce risk in standard risk domestic abuse incidents. At the time this was achieved by visits to victims from Police Community Support Officers. The panel was told that this system has now changed and is managed by volunteers.
- 14.3.11 A task was sent to a Police Community Support Officer (PCSO) the following day to visit Paula. This was reallocated to another PCSO who by 4 December 2017 had closed the incident having been unable to contact Paula on a number of occasions. As no contact was made no referrals or signposting took place.
- 14.3.12 On the 3 April 2018, Paula attended a GP appointment for a review of her mental health and wellbeing and effectiveness of prescribed medications. During this consultation Paula disclosed that Mark emotionally abused her. Paula was signposted to local and national services who can offer support and counselling with regards to Mental Health and Wellbeing but there is no evidence that she was signposted to local Domestic Abuse services. This is a learning point and leads to Tameside and Glossop Clinical Commissioning Group single agency recommendations one, two and three.
- 14.3.13 Paula was asked to return to the GP practice for a review after two weeks but did not return to the practice again prior to Mark's murder.
- 14.4 **What thought was given by your agency as to whether Mark or Paula was the primary perpetrator?**
- 14.4.1 Paula's self-harm and subsequent attendance at hospital on 11 February 2016, resulted in her disclosing that a domestic incident had triggered self-harm.
- 14.4.2 The third party report of Mark assaulting Paula on 26 August 2017, resulted in her disclosing historic assaults and potential controlling and coercive behaviour.
- 14.4.3 At a GP appointment of 3 April 2018, Paula disclosed emotional abuse by her partner.
- 14.4.4 There were therefore three indicators which overtly pointed to Paula being the victim of domestic abuse at the hands of Mark. There were no incidents known to agencies which indicated that Mark was a victim of abuse from Paula.

- 14.4.5 The relatively low frequency of reports to agencies about domestic abuse in Mark and Paula's relationship meant that there was no multi-agency review of the case. The one DASH risk assessment that was conducted initially graded as medium risk but later reduced to standard risk meant that there was no opportunity to refer the case to MARAC which is reserved for high risk cases.
- 14.4.6 The panel however had access to information from a number of witnesses who said that Mark had told them of significant domestic abuse from Paula including assaults and threats with a knife.
- 14.4.7 The panel also had access to information from witnesses who had seen Paula being assaulted by Mark. There was also information about potential controlling and coercive behaviour including Mark following Paula around [stalking] and checking on her whereabouts.
- 14.4.8 The panel discussed the couple's relationship in the context of Johnson's<sup>16</sup> typology of intimate partner violence. This divides domestic abuse [intimate partner violence] into four categories.

**Intimate terrorism**, or coercive controlling violence, occurs when one partner in a relationship, typically a man, uses coercive control and power over the other partner, using threats, intimidation, and isolation. Coercive Controlling Violence relies on severe psychological abuse for controlling purposes; when physical abuse occurs it too is severe. In such cases, one partner, usually a man, controls virtually every aspect of the victim's, usually a woman's, life. Johnson reported in 2001 that 97% of the perpetrators of intimate terrorism were men.

**Violent resistance**, a form of self-defence is violence perpetrated by victims against their partners who have exerted intimate terrorism against them. Within relationships of intimate terrorism and violent resistance, 96% of the violent resisters are women.

**Situational couple violence**, also called common couple violence, is not connected to general control behaviour, but arises in a single argument where one or both partners physically lash out at the other. This is the most common form of intimate partner violence, particularly in the western world and among young couples, and involves members of both sexes nearly

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<sup>16</sup> Michael Paul Johnson is emeritus professor of sociology, women's studies and African and African American studies at Penn State University, USA, having taught there for over thirty years.

equally. Among college students, Markson found it to be perpetrated about 44% of the time by women and 56% of the time by men.

**Mutual violent control**, is a rare type of intimate partner violence occurring when both partners act in a violent manner, battling for control.

- 14.4.9 The panel thought that whilst it was possible that there had been intimate terrorism/violent resistance it was also equally possible that in hindsight the relationship was characterised by the rarer form of mutual violent control. The panel did not think that situational couple violence was a likely explanation.
- 14.5 **What services or signposting [including substance misuse services] did your agency provide for, or offer to, Mark or Paula, and were they accessible, appropriate and sympathetic to their needs and were there any barriers in your agency that might have stopped Mark or Paula from seeking help for the domestic abuse?**
- 14.5.1 Both Mark and Paula were signposted appropriately to local mental health support services when they presented to their respective GP's with low mood anxiety and depression.
- 14.5.2 Mark was appropriately signposted to substance misuse services by his GP when he disclosed that he was drinking alcohol excessively and taking drugs. Mark did not disclose Domestic Abuse and therefore was not referred to Domestic Abuse services.
- 14.5.3 Signposting rather than direct referral to services was normal practice in relation to Mark and Paula's clinical presentation at the time. Neither Mark nor Paula appears to have followed up on this as the relevant services have no record of them.
- 14.5.4 Following the domestic abuse incident of 26 August 2017, an opportunity existed for the police to signpost or refer Mark and Paula to appropriate services. The Police Community Support Officer tasked with making contact with Paula did not manage to do so and the action was closed after several attempts at contact were unsuccessful. Paula had consented for further contact and safeguarding advice, however rather than a referral being made to a domestic abuse agency at this point an action was set to contact Paula to confirm that she still consented. This was a missed opportunity to refer Paula to receive specialist domestic abuse support.

14.5.5 Whilst not directly connected to domestic abuse, learning has arisen from Paula's gynaecology appointments which led to a referral to an assisted conception service. The referral included information that there was no concern with regard to the welfare of any future child. Paula did not disclose her history of self-harm or depression and the records of Paula's A&E attendances were not available to the gynaecologist. Had the information been available, it would have prompted further discussion with regard to Paula's social circumstances and would have given an opportunity to discuss domestic abuse. This is a learning point and leads to Tameside & Glossop Integrated Care NHS Foundation Trust single agency recommendation four.

14.5.6 The British Association of Social Workers [BASW] in a document titled, 'Substance Use and Domestic Abuse Essential Information for Social Workers<sup>17</sup>' note that:

"Not every domestic abuse victim or perpetrator will experience problematic substance use, and not all problematic substance users will experience domestic abuse victimisation or perpetration. Yet, evidence shows there is a strong association between the two. The relationship is not a simple one. Problematic substance use can exist before, alongside, and after experiences of domestic abuse.

A case analysis of domestic homicide reviews found that substance use was a common feature of both intimate partner and adult family murders (Sharps-Jeff & Kelly, 2016). Recent findings by Gilchrist et al (2017) have also shown that domestic abuse perpetration is common among men attending treatment for substance use in England."

14.5.7 The Home Office Research and Analysis published the below document in September 2021 [updated in April 2023].<sup>18</sup>

Key Findings from analysis of domestic homicide reviews: October 2019 to September 2020.

Section 4 looked at The Characteristics of Victims and listed the following under a sub-heading of:

Vulnerability

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<sup>17</sup> <https://www.basw.co.uk/system/files/resources/substance-use-and-domestic-abuse-pocket-guide.pdf>

<sup>18</sup> [www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews](http://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews)

The DHRs were asked to consider the vulnerabilities that victims may have had, in terms of:

illicit drug use  
learning disability  
mental ill-health  
physical disability  
problem alcohol use'

The analysis showed:

'Sixty-one percent of the victims were recorded with at least one vulnerability. Thirty-four percent of victims have been recorded with one vulnerability, 16% with two and 11% with three vulnerabilities.'

Whilst Mark's homicide predates this research he had three of the vulnerabilities: illicit drug use; mental ill-health and problem alcohol use. His case reinforces the importance of taking these vulnerabilities into account when assessing risk.

Updated 12 April.

14.6 **What knowledge or concerns did Mark and Paula's families, friends or employers have about their involvement in domestic abuse and did they know what to do with it?**

14.6.1 It is now known that Mark told friends and family on a number of occasions that Paula had assaulted him, thrown things, threatened him with a knife and abused him.

14.6.2 Paula's family were aware that Mark followed her and checked up on her by ringing and insisting on talking to them when she visited her family. On one occasion Paula told a family member that Mark had said that he would stab her whilst she was asleep.

14.6.3 Neighbours often heard loud arguments coming from the couple's flat and were aware that the couple often argued. The couple spoke about each other in derogatory terms to friends, family and colleagues. There was one occasion on 26 August 2017, when a friend of Paula's contacted the police to report that Mark had assaulted her.

14.6.4 During an interview with her employer to discuss repeated incidents of sickness absence Paula indicated that she had been a victim of domestic abuse by Mark and that the police had moved her to a refuge. The information that she had been moved to a refuge by the police is known to be untrue. Paula's disclosure of domestic abuse halted the employer's action

in relation to repeated absences but there was no other action. This is a learning point which leads to panel recommendation one.

14.7 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Mark and or Paula?**

14.7.1 Information provided by agencies in relation to this term of reference had been used to populate section 11 of the report and is therefore not repeated here.

14.8 **Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Mark and or Paula, or on your agency's ability to work effectively with other agencies?**

14.8.1 Greater Manchester Police set up The Triage function in order to have specialist officers review an incident with the benefit of access to the history of the relationship and information from partners enabling an enhanced risk assessment. At the time the incident of August 2017, was looked at by the Triage Team it seems that there was a backlog of incidents. An officer on restricted duties, without specialist training, was placed in the Triage role. Whilst this may have contributed to reducing a backlog of risk assessments to be reviewed, it is clear that those risk assessments may not have been effective as the officer did not have appropriate training or support. This is a learning point and leads to a Greater Manchester Police single agency recommendations 1 and 2.

14.8.2 No other agency involved has indicated any issues in relation to capacity.

14.9 **What learning has emerged for your agency?**

14.9.1 **Greater Manchester Police**

The Triage function should not be perceived as a suitable posting for an officer on restricted duties with no specialist training. The officer in this case was working in isolation at a remote station therefore limiting access to support from experienced colleagues. [see analysis at paragraphs 14.3.8 and 14.3.9 and single agency recommendation at paragraphs 18.1.1 and 18.1.2]

14.9.2 **GP Practice**

There is a requirement for increased awareness and knowledge regarding local Domestic Abuse Services. [see analysis at 14.3.12 and single agency recommendations at paragraphs 18.2.1 – 18.2.4]

### 14.9.3 **Tameside and Glossop Integrated Care NHS Foundation Trust**

- Information regarding A&E attendances is not routinely recorded in patient case notes but is recorded electronically. This means that there is an expectation that staff in other departments would need to search for this information for it to be available. This is not consistently practiced at Tameside and Glossop Integrated Care NHS FT therefore there is a potential for key information regarding a patient's medical history to be overlooked.
- Safe routine enquiry is not fully embedded into practice where patients present with symptoms which could indicate domestic abuse as a factor.
- Current "essential training" around domestic abuse is generic throughout Tameside and Glossop Integrated Care NHS FT. Additional, bespoke training is currently provided for staff employed on the maternity unit, this may need to be extended to a package for staff in other high risk areas such as A&E to ensure the unique, high pressure environment is taken into account.
- Amendments need to be made to the assisted conception referral form to ensure information regarding potential safeguarding risk is captured effectively.

[See analysis at 14.3.1, 14.3.2 and 14.5.5. Single agency recommendations at 18.3.1 – 18.3.4]

### 14.10 **Are there any examples of outstanding or innovative practice arising from this case?**

14.10.1 No examples of outstanding or innovative practice have been highlighted during the review.

### 14.11 **Does the learning in this review appear in other domestic homicide reviews commissioned by Tameside Community Safety Partnership?**

14.11.1 Tameside Community Safety Partnership has completed one previous review. There are no recommendations from that review which are relevant to the current review.

15 **CONCLUSIONS**

15.1 Mark and Paula formed a relationship in 2014 and Paula quickly moved into Mark's flat where they lived until his death in 2019. In 2017 the couple sought medical help as they wanted to start a family, but Mark did not follow up on appointments and although Paula was referred to a specialist service this was not followed up.

15.2 There were three incidents during the couple's relationship in which domestic abuse was reported to agencies;

- Paula's self-harm and subsequent attendance at hospital on 11 February 2016, resulted in her disclosing that a domestic incident had triggered her self harm.
- A third party report of Mark assaulting Paula on 26 August 2017, resulted in her disclosing historic assaults and potential controlling and coercive behaviour.
- At a GP appointment of 3 April 2018, Paula disclosed emotional abuse by her partner.

All of three incidents pointed to Paula being the victim. There were no reported incidents which pointed to Mark being the victim.

15.3 Mark and Paula blamed each other for problems in their relationship. Mark told friends and family that Paula assaulted, threatened him and did not contribute to the household budget. That information was never known to agencies. Conversely the panel had access to information from witnesses who had seen Paula being assaulted by Mark. There was also information about potential controlling and coercive behaviour including Mark stalking Paula and checking on her whereabouts and it is known that Paula claimed that she spent all her money on household bills whilst Mark did not contribute.

15.4 It is not possible now to know the exact truth of the couple's allegations against each other. What is known is that Paula lied to her employer about being moved into a refuge by the police. This was not true and the judge at her trial dismissed this as an attempt [successful] to deflect her employer from taking action against her for poor attendance at work.

- 15.5 The couple's arguments were well known to neighbours who were often disturbed by loud arguing between them to the extent that it seems their behaviour became normalised.
- 15.6 Evidence from the police investigation shows that Paula had a significant cocaine habit and that she borrowed money from a number of people. Mark's family say that she borrowed or took money from their father. There is also independent evidence from the police investigation that she spent money on gambling.
- 15.7 There is no evidence that Paula sought help or was referred to any agency for her illegal drug use or gambling. The economic abuse perpetrated by Paula was very likely to be linked to these two money dependent activities.

Gamble Aware<sup>19</sup> identifies that arguments 'with family or friends about money and gambling' and 'They borrow money, sell possessions or avoid paying bills in order to pay for gambling' are signs that someone may be having problems with gambling.

Paul said she spent all her money on household bills as Mark did not contribute.

- 15.8 Following the death of Mark's father in April 2019, the couple's problems appear to have become worse. Mark confided in a work colleague that a source of dispute between them was that Mark's father had left Mark some money and Paula thought that she deserved some of the money for looking after Mark's father whilst he was ill. On Monday and Tuesday of the week that Mark died he said that he was going to end the relationship with Paula. On Wednesday Mark was in good spirits when his colleague dropped him off near home after work. He was murdered that night
- 15.9 It is important to understand that there are many barriers to safety in an abusive relationship. Leaving is often dangerous and there are many factors a survivor must consider in the analysis of how to respond to an abusive partner. The better question is "Why does the abuser do this and how can I help the survivor gain access to safety?" The reality is that the most dangerous time for a survivor is when they leave the abusive partner; 75% of domestic violence related homicides occur upon separation and there is a

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<sup>19</sup> <https://www.begambleaware.org/understanding-someone-who-gambles>

75% increase of violence upon separation for at least two years. These concerns are very real and must be addressed with safety planning<sup>20</sup>.

## 16 **LEARNING**

### 16.1 **Narrative**

Paula's allegation that she had been a victim of domestic abuse by Mark and that the police had moved her to a refuge halted her employer's action in relation to repeated absences but there was no other action.

#### **Learning**

The panel thought that Paula's manager had dealt with a difficult situation with compassion but reflected that the position of any manager in dealing with such an allegation would be assisted if their organisation had policy guidance for helping staff who are affected by domestic abuse.

### 16.2 **Narrative**

Friends, family and neighbours of the couple were aware of problems in the couple's relationship including allegations of assault and financial abuse. This finding is consistent with many other DHRs. The panel felt that additional publicity is required so that family, friends, neighbours and communities who suspects someone is a victim of domestic abuse, know what they can do safely.

#### **Learning**

The absence of clear guidance on what family, friends, neighbours and communities can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring.

## 17 **RECOMMENDATIONS**

### **DHR Panel**

17.1 Tameside CSP should use the learning from this case to encourage employers in Tameside to develop domestic abuse policies. Information and

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<sup>20</sup> <https://stoprelationshipabuse.org/educated/barriers-to-leaving-an-abusive-relationship/>

encouragement to develop such policies should be provided to private sector businesses.<sup>21</sup>

- 17.2 Tameside CSP should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and communities about recognising the signs of domestic abuse in male and female victims and where they can go, if necessary anonymously, with such information.

## 18 **Single agency recommendations**

### 18.1 **Greater Manchester Police**

- 18.1.1 The Force Lead for Safeguarding reviews current guidance and training for all Multi Agency Safeguarding Hubs and Early Help Safeguarding Hubs (MASH/EHASH) teams in order to ensure that only specialist trained officers are deployed on Triage Desks.

- 18.1.2 Chief Supt covering Ashton to review current deployment of triage officers.

### 18.2 **Tameside and Glossop Clinical Commissioning Group**

- 18.2.1 All staff at the practice to receive Domestic Abuse training.

- 18.2.2 Safeguarding Lead at the Practice to access information about local Domestic Abuse Services and share with all staff.

- 18.2.3 Safeguarding Lead/Practice Manager to organise appropriate display of information in the surgery to support people experiencing domestic abuse.

- 18.2.4 CCG [see footnote 5 page 10] to support raising awareness of Domestic Abuse Across the System

### 18.3 **Tameside & Glossop Integrated Care NHS Foundation Trust**

- 18.3.1 Bespoke Domestic Abuse training to be provided for staff in high risk areas such as A&E and Gynaecology.

- 18.3.2 Routine enquiry to be embedded into practice during health assessments where factors indicating domestic abuse have been identified.

- 18.3.3 Single source of information regarding health appointments and unscheduled care episodes to be available in full to staff providing care for patients.

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<sup>21</sup> This recommendation has been made in other DHRs undertaken by the DHR chair.

18.3.4 Proforma for IVF referral to be reviewed to allow for more detail in regard to social circumstances.

**18.4 Action Plan**

18.4.1 The Action Plan supporting the single agency and DHR Panel's recommendations is in an accompanying document and should be read in conjunction with this overview report.

# Tameside Community Safety Partnership

## Domestic Homicide Review

### Executive Summary

'MARK'

Died May 2019

Chair: David Hunter  
Author: Ged McManus

Date finalised: June 2020  
Resubmission September 2023

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1 **The Review Process**

- 1.1 This summary outlines the process undertaken by the Tameside Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Mark<sup>22</sup>, who was a resident in their area.
- 1.2 The following pseudonyms have been used in this review for the victim and perpetrator in order to protect their identities.

Name	Who	Age	Ethnicity
Mark	Victim	37	White British
Paula	Perpetrator	35	White British

- 1.3 Mark and Paula<sup>23</sup>, lived together in a social housing flat in Tameside. The couple had known each other at school, but had not seen each other for many years before starting a relationship around 2014, after they had met by chance.
- 1.4 Mark and Paula did not have children and had sought medical help in 2017, when they said that they had been trying for a baby for three years. After initial appointments Mark did not attend for necessary tests and although Paula asked for a referral for IVF this was not followed up. It is thought that the couple had lived together for approximately two years prior to the fatal incident.
- 1.5 At just after midnight on a night in May 2019, the police were called to a disturbance at the couple’s home. Mark was found dead on the balcony and had suffered multiple stab wounds.
- 1.6 Paula was arrested and provided a prepared statement when interviewed in which she briefly stated, “she stabbed Mark as she was in fear of her own life, she could only recall stabbing him once.”

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<sup>22</sup> A pseudonym agreed with the victim’s family  
<sup>23</sup> A pseudonym for Paula chosen by the DHR panel

1.7 At her trial, Paula admitted manslaughter but denied murder. Following a two week trial the jury, after a two hour deliberation was unanimous in finding her guilty of murder.

1.8 Prior to sentencing her, the judge is reporting as saying:

'You launched an entirely unprovoked and sustained attack with the larger of the two knives, a sharp bladed chef's knife and inflicted the horrific wound to his neck most probably as he lay prone on that bed. The knife snapped during the attack and the defendant injured herself during her initial onslaught which left Mark fighting for his life.

[Mark] tried to escape but would have been unable to raise the alarm because of the wound to his throat.

You went to the kitchen and selected a second further carving knife from the block and went back into the living room where you commenced a second attack on him. He put up a fight for his life, sustaining multiple wounds to his hands and arms in self-defence and using his body weight to push you against the railings.

You were strong enough to push him back and stabbed him three times to the back with that sharp knife'.

1.9 Paula was sentenced to life imprisonment with a minimum tariff of 18 years before she can be considered for release.

1.10 Following Mark's death, formal notification of the homicide was sent to Tameside Community Safety Partnership by Great Manchester Police on 29 May 2019. A Scoping Meeting took place on 15 July 2019 where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed of the decision.

1.11 The review began on 24 September 2019 and was concluded on 5 June 2020 following consultation with Mark's family. The panel met on three occasions before its work was interrupted by the effects of the coronavirus. Further work was then completed by telephone calls, the exchange of documents and video conferencing.

2 **Contributors to the review**

<b>Agency</b>	<b>Contribution</b>
Greater Manchester Police	Individual Management Review [IMR]
Tameside and Glossop Clinical Commissioning Group	IMR
North West Ambulance Service	IMR
Tameside and Glossop Integrated Care NHS Foundation Trust	IMR
Change Grow Live	IMR
Jigsaw Homes	IMR

3 **Members of the Domestic Homicide Review Panel**

3.1 David Hunter	Independent Chair
Ged McManus	Support to Chair and author
Carol Elwood-Clarke QPM	Independent support to chair and author
Zylla Graham	Detective Inspector Investigation and Safeguarding Review Team Greater Manchester Police
Lindsey Curry	Detective Sergeant Major Crime Review Unit Greater Manchester Police
Richard Cartwright	Manager [qualified Independent Domestic Violence Advocate (INVA)]. Bridges Domestic abuse service. [provider Jigsaw Homes]
Cheryl Hallwood	Independent Domestic Violence Advocate. Bridges Domestic Abuse service [provider Jigsaw homes]

Angela Jones	Designated nurse for looked after children, Tameside and Glossop CCG <sup>24</sup> [observer]
Vicki Gee	Service Unit Manager — Operations, Adults, Tameside MBC
Mags Deakin	Trust lead for Domestic Abuse, Tameside & Glossop Integrated Care NHS Foundation Trust
Tracey Hurst	Designated Nurse Adult Safeguarding Tameside & Glossop Clinical Commissioning Group
Suzanne Antrobus	Head of Legal Services, Tameside Metropolitan Borough Council

3.2 The review Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

#### 4 **Chair and author of the overview report**

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author were separate people.

4.2 The chair, David Hunter completed forty-one years in public service [the military and a British police service] retiring, from full time work in 2007. He has undertaken the following types of reviews: Child Serious Case Reviews, Safeguarding Adult Reviews, Multi-Agency Public Protection Arrangements [MAPPA] Serious Case Reviews and Domestic Homicide Reviews.

4.3 The author of the report, Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He is currently Independent Chair of a Safeguarding Adult Board in the north of England and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England.

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<sup>24</sup> The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

- 4.4 The chair and author were supported by a third independent practitioner, Carol Elwood-Clarke. She retired from thirty years public service [British policing] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives<sup>25</sup>.
- 4.5 All three independent practitioners have undertaken all the available Home Office Training on DHRs as well as attending regional and national conferences for chairs, authors and other professionals involved with DHRs. None of them has worked for any agency contributing to this review. David Hunter chaired a DHR in Tameside in 2012.

## 5 Terms of Reference

### 5.1 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; [SEP]

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; [SEP]

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

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<sup>25</sup> <http://www.safelives.org.uk/> The UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

abuse; and

Highlight good practice.

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

## 5.2 **Timeframe under Review**

The DHR covers the period 11 January 2016 to the homicide in May 2019.

## 5.3 **Subjects of the DHR**

Victim: Mark , [aged 37 years]

Perpetrator: Paula , [aged 35 years]

### **Specific Terms**

12. What indicators of domestic abuse did your agency have that could have identified Mark as a victim of domestic abuse by Paula and what was the response?
13. What knowledge did your agency have that indicated Paula might be a perpetrator of domestic abuse against Mark and what was the response?
14. What knowledge did your agency have that indicated Paula might be a victim of domestic abuse by Mark and what was the response?
15. What thought was given by your agency as to whether Mark or Paula was the primary perpetrator?
16. What services or signposting [including substance misuse services] did your agency provide for, or offer to, Mark or Paula, and were they accessible, appropriate and sympathetic to their needs and were there any barriers in your agency that might have stopped Mark or Paula from seeking help for the domestic abuse?
17. What knowledge or concerns did Mark and Paula's families, friends or employers have about their involvement in domestic abuse and did they know what to do with it?
18. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Mark and/or Paula?

19. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Mark and/or Paula, or on your agency's ability to work effectively with other agencies?
20. What learning has emerged for your agency?
21. Are there any examples of outstanding or innovative practice arising from this case?
22. Does the learning in this review appear in other domestic homicide reviews commissioned by Tameside Community Safety Partnership?

## 6 **Summary chronology**

### 6.1 **Mark**

6.1.1 Mark was a working man, who over the years had a number of manual and factory jobs, for example working as a meat packer or on production lines. He was known to the police who had been called to domestic incidents involving Mark and his father on a number of occasions. These usually occurred when Mark had been drinking and his behaviour could at times be volatile. Mark's father passed away a few weeks before the murder.

6.1.2 Evidence gathered by the police for the purposes of the murder investigation shows that Mark was known by friends and acquaintances to be a heavy drinker on occasions and that he sometimes used cannabis.

6.1.3 Mark lived independently before meeting Paula and was the sole tenant of the flat that he later shared with Paula. He was almost unknown to the social housing landlord other than for routine matters.

### 6.2 **The Perpetrator - Paula**

6.2.1 Paula is from a large family. Prior to the time period of the review she had a history as a victim and perpetrator of domestic incidents with family members and as a victim of an ex-partner.

6.2.2 In 2007, Paula was involved in an incident when after she had been out drinking with another female, they engaged in an argument which led to one of them setting fire to the lounge curtains. They both escaped along with children who were present and then both blamed the other for starting the fire.

- 6.2.3 Between 2007 and 2012 there were five further reports of domestic incidents between Paula and various family members, she received a fixed penalty notice in 2007 following an incident with her father. In 2009 following a reported suicide attempt Paula had to be removed from her mother's address following an incident at which time she said she was pregnant. Further incidents involved Paula her mother and Paula's siblings. On each occasion alcohol was a factor.
- 6.2.4 During 2007 and 2008 there were a number of domestic incidents reported between Paula and her then partner [not Mark], this culminated in a serious allegation being made by Paula against the male.
- 6.2.5 Paula worked as a builder's labourer but had also during the time period of the review spent some time working in a factory making window blinds before returning to work as a labourer.
- 6.2.6 Evidence gathered by the police during the course of the murder enquiry shows that Paula was a regular cocaine user and spent money on gambling. She often borrowed money from friends and acquaintances.

### 6.3 **The couple's relationship**

- 6.3.1 It is thought that Mark and Paula started a relationship in 2014. They had known each other in their earlier life but had lost touch and began seeing each other after a chance meeting. When they met the couple both lived independently but it is known that they soon moved into together to Mark's flat.
- 6.3.2 Mark often spoke to friends and colleagues about his relationship with Paula. He told them that he was unhappy in the relationship and that he paid for everything whilst Paula never contributed. He also told male friends that Paula had assaulted him by banging his head on a wall. On one occasion Mark showed a friend deep cuts to his neck and chest which appeared to have been caused by 'someone really digging their nails in'. Mark told two people that Paula had threatened him with a knife.
- 6.3.3 For her part Paula confided in friends that Mark was abusive and threatening to her and did not contribute to the household, leaving her to pay for everything. Witnesses told the police that they had seen Mark assault Paula on a number of occasions.

- 6.3.4 Mark was also said to have acted in a controlling way towards Paula on occasions, for example following her [stalking] when she was out with friends and family. On other occasions he would ring her when she was visiting friends and family and insist on speaking to them in an apparent attempt to check on Paula's true whereabouts.
- 6.3.5 Neighbours often heard the couple arguing loudly and their domestic disputes and arguments appear to have become normalised and accepted by others over time. It is not thought that any of the incidents described by third parties were reported to any agency.
- 6.3.6 On 11 February 2016, the couple's relationship first came to the attention of agencies when the police and ambulance service were called to the couple's home after Paula had self-harmed. Paula was taken to hospital and treated for minor injuries whilst Mark was arrested for possession of a controlled drug. Whilst Paula did not report anything to the police, she told medical professionals that she had self-harmed as a result of a domestic incident. Paula was referred to the on-site mental health team but left the hospital without being seen. This resulted in a police visit to the couple's address to check on Paula who was found to be safe and well.
- 6.3.7 In April 2017, the couple both attended their respective GP's. They said that they had been trying for a baby for three years and asked for help. Paula later told a gynaecologist that she had suffered a number of miscarriages.
- 6.3.8 On 9 August 2017, Paula attended a GP appointment as she was experiencing anxiety and depression. She discussed recent a miscarriage and family bereavement. Paula said that she had a supportive family and did not feel suicidal. The GP discussed safety mechanisms with her. Paula completed the Tameside & Glossop Primary Care Mental Health Service Access Questionnaire (Self-Assessment Document 0-3 scores, 3 being indication that the person is experiencing emotional upset) She scored 3 for anxiety and nervousness  
1 for becoming annoyed  
2 for feeling afraid  
0 for feeling better off dead.  
Paula was prescribed Fluoxetine<sup>26</sup> and advised to self-refer to Healthy Minds.

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<sup>26</sup> Fluoxetine is an antidepressant

- 6.3.9 On 26 August 2017 A third party reported to the police that Mark was “beating the shit out of his missus”. On Police arrival Paula appeared upset and stated that they had been arguing but made no complaint of assault. Paula was taken to her mother’s address at her request. A DASH risk assessment was completed which indicated a number of concerns and was initially recorded as Medium Risk. This was then reclassified as a standard risk by the Triage Team and a STRIVE<sup>27</sup> contact was requested. The incident was later closed with no contact being made.
- 6.3.10 On 14 September 2017, during an interview with her employer to discuss repeated incidents of sickness absence Paula indicated that she had been a victim of domestic abuse by Mark and that the police had moved her to a refuge. The assertion that police had moved her to a refuge was untrue. Her assertion to her employer about domestic abuse was rejected by the judge at her trial after she had given evidence. The judge thought that Paula had used the assertion of domestic abuse to deflect her employer from taking action against her.
- 6.3.11 On 17 January 2018, Mark attended a GP appointment. He reported experiencing low mood, taking drugs and binge drinking. He was not sleeping. He said that he felt angry and lost his temper but was not violent. The GP discussed Mark’s lifestyle with him and prescribed Fluoxetine, Thiamine<sup>28</sup> and vitamin B. Mark was signposted to Be Well Tameside and Healthy Minds and given a Fit note for anxiety and depression from 17 January 2018 to 14 February 2018. Be Well Tameside and healthy Minds have no record of Mark contacting them.
- 6.3.12 On 11 February 2018, Mark telephoned the police reporting that Paula had left the address and told him that she had slit her wrists. Paula was located nearby by police officers and was transported to hospital with minor scratches to her arms. Paula did not wait to be seen and left without treatment. Following a multi-agency discussion on 12 February 2018, the police made contact with Paula’s GP in order to ensure that she received medical support. Paula’s GP tried but was unable to contact her following the police

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<sup>27</sup> A police operation intended to provide early intervention and signposting to reduce risk in standard risk domestic abuse incidents.

<sup>28</sup> Thiamine is a vitamin, also called vitamin B1. Vitamin B1 is found in many foods including yeast, cereal grains, beans, nuts, and meat. It is often used in combination with other B vitamins and found in many vitamin B complex products.

notification. The ambulance service information received by the GP practice indicated that domestic abuse was a factor in the incident and this was flagged on Paula's GP record.

- 6.3.13 On 22 February 2018, Paula attended a GP appointment. She reported low mood, but no thoughts of self-harm or suicide. The GP recorded no psychosis, no hallucinations and no anger. Paula said that her self-harm incidents were stress relieving and that she had no intention of suicide. A safety plan was discussed and agreed with her. She was prescribed Loratadine<sup>29</sup> and Sertraline<sup>30</sup>. Paula was also signposted to Healthy Minds. Healthy Minds have no record of Paula contacting them.
- 6.3.14 Paula attended a GP appointment to follow up on the appointment of 22 February 2018. She reported feeling better and had no self-harm or suicidal thoughts. She disclosed emotional abuse by her partner [Mark] and the death of her father two weeks previously. She was signposted to appropriate support agencies and given a fit note excusing her from work for two weeks. Checks have been made and Paula is not known to the agencies to which she was signposted.
- 6.3.15 On 13 July 2018, Mark's father contacted the police following a minor incident between them which had resulted in Mark leaving his father's house with the keys. This was resolved without police intervention. This was the last contact that any agency had with Mark or Paula.
- 6.3.16 In the following months Mark fell out with his father and stopped seeing him. Paula continued to visit Mark's father, doing shopping and other routine tasks for him. Mark's father gave Paula his bank card and PIN number for this purpose, which members of Mark's family believe that she abused by taking money for herself. Following the death of Mark's father in April 2019, his family say that Paula continually asked Mark for money and they assume that these demands resulted from Paula's access to Mark's father's money being cut off upon his death.
- 6.3.17 In the months before his death Mark had become good friends with a work colleague and often shared transport to and from work. Mark was not complimentary about Paula to his colleague and in the weeks before his death his complaints about her had got worse. He told his friend that a big source of dispute between them was that Mark's father had left Mark some money and Paula thought that she deserved some of the money for looking after Mark's

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<sup>29</sup> Loratadine is an antihistamine.

<sup>30</sup> Sertraline is an antidepressant.

father whilst he was ill. On Monday and Tuesday of the week that Mark died he said that he was going to end the relationship with Paula. On Wednesday Mark was in good spirits when his colleague dropped him off near home after work. He was murdered that night.

## 7 **Conclusions**

7.1 Mark and Paula formed a relationship in 2014 and Paula quickly moved into Mark's flat where they lived until his death in 2019. In 2017 the couple sought medical help as they wanted to start a family, but Mark did not follow up on appointments and although Paula was referred to a specialist service this was not followed up.

7.2 There were three incidents during the couple's relationship in which domestic abuse was reported to agencies;

- Paula's self-harm and subsequent attendance at hospital on 11 February 2016, resulted in her disclosing that a domestic incident had triggered her self-harm.
- A third party report of Mark assaulting Paula on 26 August 2017, resulted in her disclosing historic assaults and potential controlling and coercive behaviour.
- At a GP appointment of 3 April 2018, Paula disclosed emotional abuse by her partner.

All of three incidents pointed to Paula being the victim. There were no reported incidents which pointed to Mark being the victim.

7.3 Mark and Paula blamed each other for problems in their relationship. Mark told friends and family that Paula assaulted, threatened him and did not contribute to the household budget. That information was never known to agencies. Conversely the panel had access to information from witnesses who had seen Paula being assaulted by Mark. There was also information about potential controlling and coercive behaviour including Mark stalking Paula and checking on her whereabouts and it is known that Paula claimed that she spent all her money on household bills whilst Mark did not contribute.

7.4 It is not possible now to know the exact truth of the couple's allegations against each other. What is known is that Paula lied to her employer about being moved into a refuge by the police. This was not true and the judge at

her trial dismissed this as an attempt [successful] to deflect her employer from taking action against her for poor attendance at work.

- 7.5 The couple's arguments were well known to neighbours who were often disturbed by loud arguing between them to the extent that it seems their behaviour became normalised.
- 7.6 Evidence from the police investigation shows that Paula had a significant cocaine habit and that she borrowed money from a number of people. Mark's family say that she borrowed or took money from their father. There is also independent evidence from the police investigation that she spent money on gambling.
- 7.7 Following the death of Mark's father in April 2019, the couple's problems appear to have become worse. Mark confided in a work colleague that a source of dispute between them was that Mark's father had left Mark some money and Paula thought that she deserved some of the money for looking after Mark's father whilst he was ill. On Monday and Tuesday of the week that Mark died he said that he was going to end the relationship with Paula<sup>31</sup>. On Wednesday Mark was in good spirits when his colleague dropped him off near home after work. He was murdered that night.

## 8 **Learning identified**

### 8.1 **Narrative**

Paula's allegation that she had been a victim of domestic abuse by Mark and that the police had moved her to a refuge halted her employer's action in relation to repeated absences but there was no other action.

#### **Learning**

The panel thought that Paula's manager had dealt with a difficult situation with compassion but reflected that the position of any manager in dealing with such an allegation would be assisted if their organisation had policy guidance for helping staff who are affected by domestic abuse.

### 8.2 **Narrative**

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<sup>31</sup> There is an abundance of research that shows an increase in risk of fatal domestic abuse at the point of, and for several weeks after, a victim leaves an abusive relationship.

Friends, family and neighbours of the couple were aware of problems in the couple's relationship including allegations of assault and financial abuse. This finding is consistent with many other DHRs. The panel felt that additional publicity is required so that family, friends, neighbours and communities who suspects someone is a victim of domestic abuse, know what they can do safely.

### **Learning**

The absence of clear guidance on what family, friends, neighbours and communities can do when they know or suspect that someone is a victim of domestic abuse, could contribute to the abuse enduring.

## **9 RECOMMENDATIONS**

### **9.1 DHR Panel**

- 9.2.1 Tameside CSP should use the learning from this case to encourage employers in Tameside to develop domestic abuse policies. Information and encouragement to develop such policies should be provided to private sector businesses.<sup>32</sup>
- 9.2.2 Tameside CSP should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and communities about recognising the signs of domestic abuse in male and female victims and where they can go, if necessary anonymously, with such information.

### **9.2 Single agency recommendations**

#### **Greater Manchester Police**

- 9.2.1 The Force Lead for Safeguarding reviews current guidance and training for all Multi Agency Safeguarding Hubs and Early Help Safeguarding Hubs (MASH/EHASH) teams in order to ensure that only specialist trained officers are deployed on Triage Desks.
  - 9.2.2 Chief Supt covering Ashton to review current deployment of triage officers.
- #### **Tameside and Glossop Clinical Commissioning Group**
- 9.2.3 All staff at the practice to receive Domestic Abuse training.
  - 9.2.4 Safeguarding Lead at the Practice to access information about local Domestic Abuse Services and share with all staff.

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<sup>32</sup> This recommendation has been made in other DHRs undertaken by the DHR chair.

- 9.2.5 Safeguarding Lead/Practice Manager to organise appropriate display of information in the surgery to support people experiencing domestic abuse.
- 9.2.6 CCG [See footnote 3] to support raising awareness of Domestic Abuse Across the System
- 9.2.7 **Tameside & Glossop Integrated Care NHS Foundation Trust**  
Bespoke Domestic Abuse training to be provided for staff in high risk areas such as A&E and Gynaecology.
- 9.2.8 Routine enquiry to be embedded into practice during health assessments where factors indicating domestic abuse have been identified.
- 9.2.9 Single source of information regarding health appointments and unscheduled care episodes to be available in full to staff providing care for patients.

### **9.3 Action Plan**

- 9.3.1 The Action Plan supporting the single agency and DHR Panel's recommendations is in an accompanying document and should be read in conjunction with this overview report.

## Tameside Community Safety Partnership

### Action Plan

#### 'Mark' Domestic Homicide Review

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
<b>Tameside Community Safety Partnership</b>							
1	Tameside CSP should use the learning from this case to encourage employers in Tameside to develop domestic abuse policies. Information and encouragement to develop such policies should be provided to private sector businesses.	Local	Deliver presentation to Tameside employer's/business network to promote the Business in the Community (BITC) and Public Health England (PHE) toolkit for employers	Tameside LA	July 2023: 1. Contact made with Local Authority employment and skills team to identify lead for the network 2. Information and DA toolkit sent to employment and skills lead to share across networks	March 24	Expected outcome to be increased knowledge and awareness from private sector employers. Increase in the number of private employers developing policies for domestic abuse.

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					<p>with all Tameside employers.</p> <p>3. DA toolkit shared with network in July newsletter and feedback that the item received the largest number of hits on that edition.</p> <p>4. Follow up work with Network planned for 3 months' time to review whether any organisations have implemented the toolkit.</p> <p>5. Agencies represented on Community Safety Partnership and Domestic Abuse Steering Group asked to confirm</p>		

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					that their organisations have DA policies in place.		
2	Tameside CSP should review the effectiveness and if necessary, strengthen the information provided to family, friends, neighbours and communities about recognising the signs of domestic abuse in male and female victims and where they can go, if necessary anonymously, with such information.	Local	Targeted communications campaigns towards family, friends and neighbours to be developed	Tameside LA	July 2023 1. A new draft domestic abuse communications strategy has been developed which outlines the areas of focus for awareness raising. This includes greater work on supporting communities to recognise domestic abuse, particularly coercive and controlling behaviours. 2. Award winning male victim	December 2023	<b>Complete.</b> 1. This is part of an annual strategy and plan overseen by the local DA steering group. 2. Tameside’s “Open Up” campaign was delivered again in August/September 2023, engaging local cricket clubs in sharing the message, and saw a 23% increase in visits to the domestic abuse webpage during the campaign. The campaign was

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					<p>campaign has been delivered again across Tameside engaging cricket clubs in the promotion of the key messages.</p> <p>3. Tameside is currently establishing a domestic abuse champions' network which will identify professional and community champions to support engagement and awareness raising activities across agencies and out in the local communities</p>		<p>originally developed in 2017/18 and has received national recognition from Mankind and won an award at the National Public Sector communication awards in 2018.</p> <p>3. Tameside domestic abuse network has been initiated with 37 professionals from across statutory, VCSE and private sector signing up to be champions.</p>

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<b>Greater Manchester Police</b>							
1	The Force Lead for Safeguarding reviews current guidance and training for all MASH/EHASH teams in order to ensure that only specialist trained officers are deployed on Triage Desks.	Local	Review of training provision and guidance for triage staff.	GMP	<p><b>Update August 2023:</b> DA Matters training has been delivered to 3814 First Responders 111 Champions across GMP with ongoing training built into student officer training.</p> <p>A Public Protection Governance Team was set up at the end of 2019. GMP is in the process of a review of the key principles of ISR2. In addition the following will also form part of this work :</p>	January 2021	<p>Complete January 2021</p> <p>Triage staff have adequate training/experience for the role.</p>

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					<ul style="list-style-type: none"> <li>• Review of District MASH teams</li> <li>• Response to incidents and investigations relating to Domestic Abuse</li> </ul> <p>The review team is led by D/Ch. Supt</p> <p>A TRIAGE FOCUS GROUP led by Det. Superintendent took place on 24/02/20 and Triage Training is currently under review.</p>		

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
2	Chief Supt covering Ashton to review current deployment of triage officers.	Local	Review current deployment of triage officers whether they have adequate training /experience for the role	GMP	<p><b>Update August 2023:</b> DA Matters training has been delivered to 3814 First Responders 111 Champions across GMP with ongoing training built into student officer training.</p> <p>The PPD Governance Team is a Force wide Review. A review of the staffing within Tameside MASH has been completed.</p> <p>Update 29/05/20 Detective Inspector has recently taken</p>	August 2020	<b>Completed May 2020-</b> Review confirms that triage staff have adequate training/experience for the role.

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					<p>over the MASH at Tameside.</p> <p>Cluster vulnerability DCI has management</p> <p>The MASH currently has 3 very experienced officers on triage.</p> <p>In addition a further officer has been recruited and 2 experienced OSOS's</p> <p>OSO's dealing with risk assessments have appropriate support in that Triage officers are mentored by colleagues who have attended relevant safeguarding Courses.</p>		

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
<b>Tameside and Glossop Clinical Commissioning Group<sup>33</sup></b>							
1	All staff at the practice to receive Domestic Abuse training.	Local	Staff training/ Awareness  IRIS Training	Named GP  IRIS Clinical Lead/Task and Finish Group	GP Leads received awareness training by Named GP 2021. GPs have access to Train the Trainer Domestic Abuse Awareness Training 2022/23.  Target session held April 23.  IRIS training being rolled out 2023/24	March 2024	<b>Complete 2021</b> – All staff received training and have an improved understanding of domestic abuse.  Further training is underway via IRIS project which will deliver DA training to all GP practices in the Borough
2	Safeguarding Lead at the Practice to access information about local Domestic Abuse Services and share with all staff.	Local	Training/ awareness raising	All Primary Care GP Practices	All GP practices supported with ongoing DA awareness via Primary Care Safeguarding Newsletter	March 2023	<b>Complete March 2023</b> Patients have access to information at GP practices about DA  Patients who disclose DA are supported

<sup>33</sup> The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					<p>Safeguarding Snippet Sessions</p> <p>Safeguarding Facebook Involved in Raising Awareness of DA amongst older people 2022 WEAAD Named GP worked with Bridges to improve GP understanding and access to Website.</p> <p>IRIS training is being rolled out.</p>		timely by referral into local services
3	Safeguarding Lead/Practice Manager to organise appropriate display of information in the surgery to support people experiencing domestic abuse.	Local	Information about Domestic abuse is visible in GP Practice	All Primary Care GP Practices	Display boards present in GP practices all practices encouraged to display national and local contact numbers in surgery. Including	March 2023	<b>Complete March 2023</b> Patients have access to DA advice when visiting GP practices

No	Recommendation	Scope i.e. Local/national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					national and local campaigns/posters  IRIS being rolled out across Tameside		
4	CCG [see footnote 1] to support raising awareness of Domestic Abuse Across the System	Local	Strategic Leadership/attendance at Board.	All partners	ICB support the Domestic Abuse Steering Group and Domestic abuse operational group which are the strategic groups delivering the DA strategy in Tameside.	March 2023	<b>Complete March 2023</b> Partners across the system are aware of DA and know how to respond and refer to support services.
<b>Tameside &amp; Glossop Integrated Care NHS Foundation Trust</b>							
1	Bespoke Domestic Abuse training to be provided for staff in high risk areas such as A&E and Gynaecology.	Local	Develop training plan Liaise with domestic abuse support agencies in regard	TGICNFT	<ul style="list-style-type: none"> <li>Bespoke package developed.</li> <li>Training to be incorporated in</li> </ul>	March 23	<b>Complete March 23</b> – training developed and embedded in to practice

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No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
			to content of training. Factors indicating potential domestic abuse to be included in package.		orientation package for new starters. <ul style="list-style-type: none"> <li>• Training compliance to be monitored and reported to clinical leads.</li> <li>• Training embedded into practice in high risk areas.</li> </ul>		
2	Routine enquiry to be embedded into practice during health assessments where factors indicating domestic abuse have been identified.	Local	Routine enquiry to be included in e-cas card. Patients to be provided with opportunity for routine enquiry to be performed.	TGICNFT	<ul style="list-style-type: none"> <li>• Patients to be seen alone for initial part of health assessment to provide opportunity for disclosure.</li> <li>• Routine enquiry to be</li> </ul>	March 23	<b>Complete March 23</b> – Process embedded into practice

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					<p>included on e-cas card with no opportunity to bypass.</p> <ul style="list-style-type: none"> <li>Process to be audited 6 months after introduction to monitor compliance and effectiveness.</li> </ul>		
3	Single source of information regarding health appointments and unscheduled care episodes to be available in full to staff providing care for patients.	Local	All health information to be available on a single digital record thus negating the need for paper records.	TGICNFT	<ul style="list-style-type: none"> <li>Paper records phased out and replaced with digital record.</li> <li>Review of social circumstances recorded on digital record to be</li> </ul>	March 23	Ongoing. Expected outcome to be holistic overview of patients' needs in order to fully inform risk assessment and planning

No	Recommendation	Scope i.e. Local/ national	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
					embedded into practice.		
4	Proforma for IVF referral to be reviewed to allow for more detail in regard to social circumstances	Local	Discuss with obs/gynae leads in regard to amending form. Task and finish group to develop amended form.	TGICNFT	<ul style="list-style-type: none"> <li>• Task and finish group members identified.</li> <li>• Amendments to form completed.</li> <li>• Form circulated for comments and tabled at obs/gynae clinical governance for ratification.</li> </ul>	March 23	<b>Complete March 2023</b> – new form circulated

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25<sup>th</sup> April 2024

Dear Sarah,

Thank you for resubmitting the report (Mark) for Tameside Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2024.

The QA Panel was grateful for sight of a detailed and well-drafted report, determined to draw lessons on what was clearly a challenging case. The decision to conduct a DHR even though the CPS felt there was not enough evidence for a prosecution was welcomed. The Panel noted the honesty and lack of defensiveness in setting out where each agency might have acted differently.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

There are areas of development that the QA Panel would like the CSP to note.

- There remain numerous issues with formatting, typos and spacing in the resubmission. Coronavirus is still incorrectly spelt in 1.11.
- The phrase 'difficult relationship' is still evident in 6.2.4. this should be amended.
- No amendments have been made to 14.4.8...It still reads 'Markson' under the para on intermate terrorism.
- There is an author's comment under 'mutual violent control' on pg. 30.
- There are still some overall outcomes missing from the action plan.



Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to [DHREnquiries@homeoffice.gov.uk](mailto:DHREnquiries@homeoffice.gov.uk). This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at [DHR@domesticabusecommissioner.independent.gov.uk](mailto:DHR@domesticabusecommissioner.independent.gov.uk)

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel