

TAMESIDE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Richard'

Date of death – December 2018

OVERVIEW REPORT

Following Home Office QA Processes

July 2023

Resubmitted 14 September 2023

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CONTENTS

Section	Page
1. Introduction	3
2. Timescales	6
3. Confidentiality	7
4. Terms of reference	8
5. Method	10
6. Contributors to the review	12
7. The review panel members	13
8. Chair and Author of the overview report	15
9. Parallel reviews	16
10. Equality and diversity	17
11. Dissemination	21
12. Background information (The facts)	22
13. Chronology	23
14. Overview	25
15. Analysis using the terms of reference	30
16. Conclusions	50
17. Learning Identified	52
18. Recommendations	55
Appendix A - Government definition of domestic abuse	57
Appendix B - Coercive and controlling behaviour	58
Appendix C - Events Table	60

1. INTRODUCTION

- 1.1 This report of a domestic homicide review examines how agencies responded to, and supported, Richard, a resident of Ashton-under-Lyne, prior to his death in December 2018.
- 1.2 Initially the death was treated as non-suspicious but following an intervention by a family member, Great Manchester Police alerted HM Coroner who authorised a Home Office post mortem which established the cause of death as:
- 1a Multiple drug toxicity (fentanyl)¹
 - 2. Chronic obstructive pulmonary disease (COPD)²
- 1.3 As will be seen later there was no criminal prosecution.
- 1.4 Tameside Community Safety Partnership and the domestic homicide review panel offer their sincere condolences to Richard's family and friends.
- 1.5 The family did not wish to provide a tribute for the report.
- 1.6 In May 2019, Susan was arrested on suspicion of attempting to murder Richard by placing excessive fentanyl patches on Richard's back. She was released without charge while further investigations took place. In December 2019, Greater Manchester Police, having consulted the Crown Prosecution Service, decided there was insufficient evidence for a realistic prospect of conviction for gross negligence manslaughter. Susan was informed.
- 1.7 Gross negligence manslaughter is an offence at common law. The requirements of the law were comprehensively reviewed and re-stated by the Lord Chancellor, Lord Mackay of Clashfern in the case of *R v Adomako* [1994] 99 Cr. App. R 362. Case-law on the offence of gross negligence manslaughter has evolved over time but the offence now clearly constitutes 5 elements as noted in *R v Honey Rose* [2017] EWCA Crim 1168:
- (a) The defendant owed an existing duty of care to the victim;
 - (b) The defendant negligently breached that duty of care;
 - (c) It was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death;

¹ A strong opioid painkiller

² Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing.

- (d) The breach of that duty caused the death of the victim;
 - (e) The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.
- 1.8 There is sufficient evidence to say that Susan owed a duty of care to Richard which she breached. There is insufficient evidence to demonstrate that she reasonably foresaw that the breach of that duty gave rise to the serious and obvious risk of death. Susan stated that she left a patch in situ on Richard's back after administering another. This was to provide Richard with the placebo effect as he was struggling with pain relief.
- 1.9 There is no likelihood of further information coming to light which would provide sufficient evidence to allow the police to pursue a prosecution for gross negligence manslaughter. The panel considered this information at its meeting on 10 December 2019 to see whether it affected the decision to hold a domestic homicide review.
- 1.10 The Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 Section 2 states:

This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act). The Act states:

 - (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —
 - (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
 - (b) a member of the same household as himself,

held with a view to identifying the Learnings to be learnt from the death
- 1.11 In arriving at the decision that the domestic homicide review criteria were still met the panel considered: the couple's history and the reported attempted murder in Turkey in 2015 and the two subsequent reports of domestic abuse to Greater Manchester Police. It has established that Richard's death did not result from violence or abuse nor from the criminal standard for gross negligence. Nevertheless, it appeared to the panel that there had been some level of neglect within the relationship and learning was very likely to be identified from the death.

1.12 In February 2020 HM Coroner held an inquest and determined the cause of death was due to –

1a – Multiple Drug toxicity (Principally fentanyl)

2 - Chronic Obstructive Pulmonary Disease (COPD)

The Coroner recorded - 'Richard' died at his home on (redacted) as a consequence of multiple drug toxicity (mainly fentanyl). His death is likely to have resulted principally from the administration of fentanyl patches in excess of the prescribed dose'. The conclusion of the Coroner was that Richard's death was drug related.

2. TIMESCALES

- 2.1 On 18 July 2019 Tameside Community Safety Partnership determined the death of Richard met the criteria for a Domestic Homicide Review [DHR]. This was before the Crown Prosecution Service advised there was insufficient evidence to proceed with any criminal charges.
- 2.2 The first meeting of the review panel took place on 24 September 2019. Thereafter the panel met four times. Between March and May 2020, due to the Covid-19 situation, contact was maintained with panel members via email and telephone. This contact focused on reviewing draft overview reports, analysing the information, and identifying relevant learning. In June 2020, a virtual panel meeting was held to agree the learning and recommendations of the review.
- 2.3 The DHR covers the period 8 May 2015 to 5 December 2018.
- 2.4 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.
- 2.5 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.

3. CONFIDENTIALITY

- 3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.
- 3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim and perpetrator. The pseudonyms were chosen by the panel with the agreement of Richard's family.
- 3.4 This table shows the age and ethnicity of Richard and his wife at the time of his death.

Name	Relationship	Age	Ethnicity
Richard	Husband of Susan	59	White British male
Susan	Wife of Richard	50	Black Caribbean female

4. TERMS OF REFERENCE

- 4.1 The Panel settled on the following terms of reference at its first meeting on 24 September 2019. These were shared with the family who were invited to make any comments or amendments.
- 4.2 The review covers the period 8 May 2015, [which was the date of the incident in Turkey], until the date of Richard's death in December 2018.

The purpose of a DHR is to:³

- a] 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;
- b] 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;
- c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d] 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;
- e] Contribute to a better understanding of the nature of domestic violence and abuse; and
- f] Highlight good practice.

Specific Terms

1. What indicators of domestic abuse did your agency have that could have identified Richard as a victim of domestic abuse and what was the response?
2. What knowledge did your agency have that indicated Susan might be a perpetrator of domestic abuse against Richard and what was the

³ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

response? Did that knowledge identify and controlling or coercive behaviour by Susan?

3. What consideration did your agency give to child safeguarding during any domestic abuse interaction it had with Richard and/or Susan?
4. What consideration did your agency give as to whether Richard was an adult in need of care and support and if so, who did you refer his needs to?
5. What services or signposting or assessments did your agency provide for, or offer to, Richard and were they accessible, appropriate and sympathetic to his needs and were there any barriers in your agency that might have stopped Richard from seeking help for the domestic abuse?
6. What knowledge or concerns did Richard's family and or friends have about his victimisation 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 Richard and/or Susan? This includes Richard's complex medical needs.
8. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Richard and/or Susan, 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. METHOD

- 5.1 Greater Manchester Police notified Tameside Community Safety Partnership on 15 May 2019 of the death of Richard, and that the case potentially met the criteria for a Domestic Homicide Review. A meeting held on 18 July 2019 determined the criteria had been met for a Domestic Homicide Review to be undertaken.
- 5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The DHR Author and Chair provided IMR training for agencies.
- 5.3 The written material was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.
- 5.4 On 10 December 2019 the DHR panel reviewed the initial decision to hold a DHR following an update on the charging decision of the Crown Prosecution Service. The DHR panel concluded that the criteria had been reached and learning from the case could be identified.
- 5.5. The review gathered information in relation to Richard's medical illnesses and diagnoses. This included detail of prescribed medication, presentation to health professionals and recorded attendance with medical practitioners.
- 5.6 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. The review panel experienced difficulty in identifying contact details for family members; however, in April 2020, contact was made with Richard's granddaughter following an extensive search of social media. The Chair spoke with Richard's granddaughter who provided useful information to the review process which has been included within the report. The Chair informed Richard's granddaughter of the availability of advocacy support and offered to make a referral if required. Towards the end of the DHR process, due to personal reasons, the family declined any further involvement within the review. The DHR panel respected the family's wishes.

- 5.7 The DHR Chair wrote to Susan to inform her that a DHR was being undertaken and inviting her to contribute to the process. To date there has been no contact from Susan.
- 5.8 The Chair and Author were also provided access to statements provided to the Police from Richard and Susan. This provided background information on Richard and Susan and their relationship. Relevant details have been included within the report.
- 5.9 The panel were conscious of the limited information from family and sought to identify other family and friends who could be approached to provide information to the review. The panel was unable to establish the identity of any relevant individuals.
- 5.10 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was discussed with Richard's granddaughter during contact by the Chair. The final report has not been seen by the family in accordance with their wishes. Prior to publication the family will be afforded the opportunity to see the report.

6. CONTRIBUTORS TO THE REVIEW.

6.1 This table show the agencies who provided information to the review.

Agency	IMR ⁴	Chronology	Report
Department for Work and Pensions			✓
East Lancashire Hospital Trust			✓
GP Services	✓	✓	
Greater Manchester Police	✓	✓	
Jigsaw Support (Bridges) ⁵	✓	✓	
North West Ambulance Service (NWAS)	✓	✓	
Pennine Care NHS Foundation Trust	✓	✓	
Tameside Adult Social Care	✓	✓	
Tameside Children's Social Care	✓	✓	
Tameside and Glossop Integrated Care NHS Foundation Trust	✓	✓	
Victim Support	✓	✓	

6.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

⁴ Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

⁵ 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.

7. THE REVIEW PANEL MEMBERS

7.1 This table shows the Review Panel Members.

Review Panel Members		
Name	Job Title	Organisation
Suzanne Antrobus	Solicitor	Tameside Metropolitan Borough Council
Richard Cartwright	Operational Manager	Jigsaw Support
Hazel Chamberlain	Deputy Designated Nurse Safeguarding	Health – GP Services
Mags Deakin	Trust Lead for Domestic Abuse	Tameside and Glossop Integrated Care NHS Foundation Trust
Carol Ellwood	Panel Author	Independent
Zylla Graham	Detective Inspector	Greater Manchester Police
John Gregory	Head of Community Safety & Homelessness	Tameside Metropolitan Borough Council
Laura Heywood	Team Leader	Victim Support
Susan Holden	Named Nurse for Safeguarding Children,	Tameside and Glossop Integrated Care Foundation Trust
Charlie Hoszowskyj	Service Support Business Partner	Tameside Metropolitan Borough Council
David Hunter	Panel Chair	Independent
Tracy Hurst	Designated Nurse Adult Safeguarding	Tameside & Glossop CCG
Ged McManus	Support to Panel Chair and Author	Independent
Lynette Morgan	Complex safeguarding Service Unit Manager	Tameside Children’s Social Care
Mark Whitehead	Head of Services, Operation Services	Tameside Adult Social Care
Jane Whittaker	Safeguarding Practitioner	North West Ambulance Service
Haley Wilkinson	Keyworker	Jigsaw Homes
Wendy Yuille	Safeguarding Specialist Nurse (Children & Adults)	Pennine Care NHS Foundation Trust

- 7.2 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.
- 7.3 The panel met four times and matters were freely and robustly considered. Outside of the meetings the Chair's queries were answered promptly and in full.

8. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

- 8.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors.
- 8.2 David Hunter was appointed as the Panel Chair. David is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service (not Greater Manchester).
- 8.3 Carol Ellwood was appointed as the Author. 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 SafeLives⁶.
- 8.4 The Chair and Author were supported throughout the DHR process by Ged McManus. Ged McManus has experience of chairing and authoring Domestic Homicide Reviews and is an independent Chair of a Safeguarding Adult Board.
- 8.5 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPAs] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking Domestic Homicide Reviews.
- 8.6 Neither the Chair nor author have worked for any agency providing information to the review.

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

9. PARALLEL REVIEWS

9.1 Her Majesty's Coroner for Manchester South held an inquest into Richard's death on 19 February 2020. The cause of death was recorded as

1a – Multiple Drug toxicity (Principally fentanyl) (Immediate condition)

2 - Chronic Obstructive Pulmonary Disease (COPD) (Contributing condition)

9.2 Greater Manchester Police undertook a criminal investigation into the circumstances surrounding the death of Richard. The investigation concluded in December 2019 and following consultation with the Crown Prosecution Service no criminal charges were instigated in relation to Richard's death.

9.3 The Chair is not aware that any other agency has conducted a review or investigation into Richard's death nor intends to do so.

10. EQUALITY AND DIVERSITY

10.1 Section 4 of the Equality Act 2010 defines protective 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 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].

10.2 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 activities⁷

10.3 Richard retired at the age of 35 years due to ill health. He had multiple and complex medical conditions and a history of misusing alcohol and drugs.

10.4 Richard was on a large amount of medication. Susan was often referred to within agency records as Richard’s carer. There is no record that a Care Act 2014 assessment was done to determine whether Richard was a person in need of care and support or that Susan was offered a carer’s assessment by Adult Social Care. There is no evidence that identified Richard or Susan lacked capacity.

10.5 Richard had a history of not maintaining appointments with health professionals. Richard had been referred to a psychiatrist and for periods of the review was working with a Care Co-ordinator in response to his mental health needs. There is no evidence that Richard’s mental health had any impact on his decision making regarding his personal relationships and lifestyle.

10.6 Richard’s complex medical needs meant he met the ‘disability’ criteria under Section 6 [1] [a] of the Section 4 of the Equality Act 2010. Agencies involved in the review were aware of Richard’s complex medical needs, and impaired physical health. Richard was involved with occupational therapists, who provided adaptations within the home. Agencies did not identify any concerns that required Richard being referred to Adult Social Care for assessments of his care needs.

⁷ Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

- 10.7 The panel considered whether Richard’s complex medical needs could have made it more difficult for him to attend appointments. Whilst there was information provided to the review that Richard did not maintain appointments there was no evidence that this was due to his health needs. The panel considered whether Richard’s non-engagement may have been due to coercion and control. The panel saw no direct evidence that this was the case for attending appointments. However, on some matters Richard was subjected to Susan’s coercive and controlling behaviour. Therefore the missed appointments may well have resulted from coercive and controlling behaviour by Susan. For example it is known from GPs that Susan controlled and obstructed their access to Richard.
- 10.8 Richard was white British with English being his first language. Susan was a black Caribbean who spoke English as her first language. It is known that Susan also spoke in Patois, a Jamaican dialect, but the majority of interactions with Professionals were in English and there is no record that there was a barrier to communication.
- 10.9 The panel recognised that Domestic Abuse is a gendered crime with women being more likely to be victims than men. According to the Office for National Statistics homicide report 2021/22⁸ there were 134 domestic homicides in the year ending March 2022. Of the 134 domestic homicides, 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son or daughter and 16 were killed by another family member. Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect.
- Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.
- 10.10 In addition to National Statistics, in April 2021, Mankind Initiative published a document – ‘Male victims of domestic abuse and partner abuse: 55 key facts’⁹. This included the following statistical data:
- One in six/seven men and one in four women will be a victim of domestic abuse in their lifetime. In 2019/2020, 757,000 men and 1.56 million women said they were victims that year.

⁸<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects>

⁹ <https://www.mankind.org.uk/wp-content/uploads/2021/04/55-Key-Facts-about-Male-Victims-of-Domestic-Abuse-and-Partner-Abuse-Final-Published-April-2021.pdf>

- Over the past five years (April 2015 to March 2020), on average 12 men per year had been killed by a partner or ex-partner (74 women per year).
- In 2019/20, 1.9% of men who were 60-74 stated they had suffered domestic abuse (4.4% women) and 1.1% had suffered from partner abuse (3.4% women). The peak for men and women is 16-24.
- In 2019/20, 7.5% of men who were disabled stated they had suffered domestic abuse (14.7% women) and 5.1% had suffered from partner abuse (11.5% women). The rate of domestic/partner abuse is double that of those who are not disabled.

10.11 The panel considered Richard's age and that Susan had been undertaking a 'caring' role for Richard. The panel were aware of research undertaken by Safelives¹⁰ which identified that victims of domestic abuse aged over 61 are much more likely to experience abuse from an adult family member or current intimate partner than those 60 and under. Whilst Richard was slightly younger than these findings the panel thought that they were of relevance for this review. The report¹¹, which has the support of Age UK, identifies that an additional key barrier arises where there is a level of dependency due to health problems, reduced mobility, or other disabilities – including mental health, and in particular when the perpetrator is also the victim's carer.

¹⁰ <http://www.safelives.org.uk/>

¹¹ <http://www.safelives.org.uk/spotlight-1-older-people-and-domestic-abuse>

11. DISSEMINATION

11.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The family
- Tameside Community Safety Partnership
- All agencies that contributed to the review
- Tameside Children's Services
- Police and Crime Commissioner for Greater Manchester
- STRIVE Coordinators Greater Manchester
- Domestic Abuse Commissioner for England and Wales

12. BACKGROUND INFORMATION [THE FACTS]

- 12.1 Richard was 59 years old at the time of his death. He had not worked for since the age of 35 years due to his health conditions. It is understood Richard met Susan, in late October 2014 and they married in 2015. Richard had children and grandchildren from a previous relationship; the majority of whom he did not have contact with, apart from a granddaughter who had lived with Richard for a period prior to his marriage to Susan. Richard's granddaughter informed the Author that she had lived with Richard for a significant time during her childhood.
- 12.2 In May 2015, Richard and Susan went on honeymoon to Turkey. While there, Richard reported to the Turkish police that Susan had tried to kill him. The local police took no action. The matter was reported to Greater Manchester Police upon their return to England and Susan was arrested. The case was referred to MARAC. Following an investigation, no criminal charges were instigated. Richard and Susan remained in a relationship. This is covered later within Section 15.
- 12.3 Between November 2015 and July 2017 Richard and Susan lived in Blackpool, Lancashire. In 2017 and 2018, there were two reported domestic abuse incidents reported to the Police. In each case Susan was identified as the perpetrator. Neither case was referred to MARAC. These incidents are reviewed further within Section 14.
- 12.4 In December 2018 Richard was found deceased at home. This was initially treated by the police as a normal sudden death with no suspicious circumstances noted by the attending officers. A few days later, Richard's granddaughter contacted the Police and reported concerns about the death citing the previous incident in Turkey and describing Susan as being controlling and abusive towards Richard.
- 12.5 A Home Office post mortem was undertaken and a criminal investigation commenced. Susan was arrested in May 2019 and following consultation with the Crown Prosecution Service in December 2019, no criminal charges were taken in relation to the Richard's death.

13. CHRONOLOGY

13.1 Background

Richard

Richard was one of three children and the Father to three children, from a previous marriage. The youngest of Richard's children died in 2003, and following that death, Richard's granddaughter spent a considerable amount of time living with Richard.

Richard retired from work in his 30's due to ill health. Prior to then Richard had owned a café, where he worked alongside his Mother. Richard later worked as a taxi driver in the local area.

Richard's family described him as being a good hearted and wise person, who was younger in his outgoing than his actual age.

Susan

Not a lot is known about Susan. The Chair and Author have not visited any of Susan's family or previous partners as part of this review. Susan did not respond to an invitation to contribute to the review.

The Author has had access to the statement provided to the Police following Richard's death, which is the only account that Susan has provided in respect of her relationship with Richard.

Susan is believed to have been born in the UK. Her ethnicity is black Caribbean, and English is recorded as her first language. Susan has six previous convictions, several which are for violence. Susan was also known to Children's Social Care following an allegation of assault on a child. (See section 14.2.4). Susan has been involved in domestic abuse incidents with previous partners and in some of these she was identified as the perpetrator. (See section 14).

Susan was described by Richard's family as a volatile and erratic woman, who was unpredictable in her behaviour, often shouting and swearing at family members. The family described one incident, shortly after Susan had moved in, where Susan had poured bleach on a bed and changed the house locks to prevent family staying at the home.

Relationship between Richard and Susan

The first record of Richard and Susan being in a relationship was in October 2014. Richard and Susan lived near each other and had met when Richard became ill. Susan had informed Richard that she was a

nurse and had worked in various hospital departments. Richard stated that Susan did a good job caring for him.

Three months after they met, Richard and Susan got engaged. They married in April 2015, and then went on honeymoon to Turkey. The honeymoon was originally planned for two weeks, but whilst out there, they decided to stay for a further week. Richard informed the Police that he had obtained a loan to pay for the wedding and then spent £14,500 whilst in Turkey, on his credit card, as he showered Susan in presents during their stay.

During the honeymoon Susan assaulted Richard, to the extent that he feared that she was going to kill him. This is covered later within the report and along with further incidents of domestic abuse.

During their relationship, some members of Richard's family reported concerns to the Police of Susan isolating Richard from his family and his dependency on Susan for his medical care. They also expressed fears for his safety.

The Author was informed by family that Richard had wanted to end his relationship with Susan but he feared for his safety and had thought it was better to stay with Susan, as she cared for him with his long term medical conditions.

14. OVERVIEW

14.1 Introduction

14.1.1 This section of the report summarises what information was known to the agencies and professionals involved with Richard and Susan. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to the events table contained within Appendix C. Detailed analysis of the contacts appears at section 15.

14.2 Events predating the timescale of the DHR

- 14.2.1 Susan has 6 convictions recorded on the Police National Computer (PNC)¹², which include an unprovoked assault on a female in 1995 and in 1998. An assault against a male whom she grabbed around the neck causing deep scratches, and an assault against a female whom she dragged to the ground, breaking and dislocating her fingers. In 2005 Susan was arrested for an assault on a child. Children's Social Care were involved in the latter incident.
- 14.2.2 In 2005, the Police attended a domestic incident between Susan, and her then husband. The initial call, from Susan's husband, indicated that he was being assaulted by Susan. Following the attendance of the Police, Susan's husband was arrested and later released with no criminal action being taken against either party. This is the first recorded domestic incident involving Susan.
- 14.2.3 A week after this incident Susan's husband contacted Children's Social Care and reported that Susan was physically abusive towards him. No further action was taken.
- 14.2.4 Between June 2010 and May 2013 the Police attended 16 concern for safety and domestic abuse incidents between Susan and her husband. A significant number of these coincided with the breakdown of the marriage, with both living in the marital home. In some of these incidents Susan was named by her husband as the perpetrator. Children's Social Care were involved, and an assessment undertaken that concluded neither Susan nor her husband, recognised the impact of the domestic abuse on their child.

¹² The Police National Computer (PNC) is a computer system used extensively by law enforcement organisations across the United Kingdom. Set up in 1974, it now consists of several databases available 24 hours a day, giving access to information of national and local matters.

- 14.2.5 Between 2012 and 2014 Police attended two domestic incidents between Susan and her partner. (This was a new partner).
- 14.2.6 In October 2014, Police attended a domestic incident involving Richard, his adult son and Susan. It is recorded that Susan was Richard's neighbour and carer at this time. This is the first record of Richard and Susan's relationship. Richard confirmed the status of their relationship to a Care Co-ordinator the following month.
- 14.2.7 In January 2015, Richard informed his Care Co-ordinator that he was engaged to Susan. Two months later a member of Richard's family contacted the Police to report that they had been assaulted by Susan, but when spoken to 10 days later, they stated that they did not wish to pursue a complaint and no further action was taken.
- 14.2.8 On 18 April 2015, Richard and Susan were married. The following day they left England to go on honeymoon to Turkey.

14.3 Events within the timescale of the DHR

Attempted murder incident - Turkey

- 14.3.1 On 8 May 2015, Susan assaulted Richard by wrapping a telephone cord around his neck, pulling him to the floor, covering his mouth and nose with one hand and grabbing his throat, at this point Richard started to pass out. Richard managed to break free, but Susan lunged at him, before Richard ran from the room to the reception. Police attended the hotel and Susan was moved to a different hotel.
- 14.3.2 On 11 May 2015, Richard and Susan flew back to England. Susan was arrested at the airport. Richard was collected by family and taken to a relative's home which was outside of the Local Authority area. A DASH risk assessment was completed and graded as high. A MARAC referral was completed. Susan was interviewed by Police and released on conditional bail.

- 14.3.3 On 12 May 2015, Victim Support received an automated data referral¹³ from the Police. Three attempts were made to contact Richard, all of which were unsuccessful, and the case was closed on 18 May 2015.
- 14.3.4 On 13 May 2015, Richard attended at hospital via ambulance with symptoms he claimed were as a result of the assault in Turkey. After examination Richard was discharged back into the care of his GP.
- 14.3.5 On 19 May 2015, Richard and Susan's case was referred to MARAC. The following day the case was allocated to an IDVA¹⁴, who attempted to contact Richard and left a voicemail on his telephone. The Deputy Manager at Bridges spoke with Richard on 21 May 2015 and on the same day Richard's case was referred for telephone triage with the housing department.
- 14.3.6 On 5 June 2015, Police attended at Richard's address. Susan was present, and in breach of her bail conditions. Susan left the property. Four days later, on 9 June 2015 Richard and Susan's case was discussed at MARAC.
- 14.3.7 Following a telephone triage with the housing department, Richard was accepted on the Tameside Housing Register. Details of the housing allocation process were provided to Richard during a telephone conversation and in a follow up letter. Richard's case was shortlisted but attempts to contact Richard during July were unsuccessful. A letter was sent to Richard at the end of July and following no contact the case was closed on 21 August 2015.
- 14.3.8 On 29 June 2015, Police were contacted by a family member who expressed concerns for Richard's welfare since his return home from Turkey. Police attended at Richard's home address, Susan was present, and she was arrested for breach of her bail conditions. Susan was later released from custody.
- 14.3.9 At the beginning of July Richard's case was closed by the IDVA as there had not been contact. Susan answered her Police bail and was informed that no further action was being taken by the British Police. Richard accompanied Susan to the Police station. At the end of July, the Police transferred the investigation back to the Turkish authorities via Interpol and closed the investigation. Turkish Police did not pursue the investigation.

¹³ Victim Support receive automated data transfers from the Police as a method of compliance with the Victims Code of Practice.

¹⁴ Independent Domestic Abuse Advocate

Events during Richard and Susan's residency in Blackpool

- 14.3.10 In November 2015, Richard and Susan moved to Blackpool. Not all agencies were aware of the move. On 22 January 2016, Blackpool Clinical Commissioning Group (CCG) received a letter from Richard's previous mental health provider which contained details of the MARAC referral from June 2015. This was the first notification that Blackpool CCG had of the MARAC.
- 14.3.11 In February 2016, Richard attended an appointment with his GP. Susan accompanied Richard to the appointment. The GP recorded that it was a difficult consultation and that information could only be obtained when Susan left the room. The GP challenged Susan.
- 14.3.12 On 10 June 2016, a GP spoke to Susan about Richard's hospital appointment earlier in the month. Susan did not let the GP to speak with Richard about the appointment. Richard could be heard in the background by the GP.
- 14.3.13 In October 2016, Susan contacted her GP requesting medication as her prescription had been stolen whilst they were in Turkey (April/May 2015). During the same month, on separate occasions, Richard and Susan were found collapsed and unresponsive. Richard was taken to hospital, medicated and then self-discharged before diagnosis.
- 14.3.14 In February 2017, Lancashire Police dealt with an allegation of assault involving Richard and his landlord. No further action was taken over this matter. Richard and Susan are believed to have moved from Blackpool at the end of February.

Events during 2017 and 2018

- 14.3.15 At the beginning of May 2017, the Police attended a domestic incident between Richard and Susan in Ashton-under-Lyne. During the incident Susan grabbed Richard by the shoulders and pulled him to the floor, sat on his chest, punched and slapped him, placed her knee and tabletop against his neck. Richard sustained injuries. Susan was arrested and charged with an offence of battery. The case was later discontinued. The risk level for the incident was set to medium.
- 14.3.16 On 16 January 2018, Police were contacted by a family member who expressed concerns for Richard as they had had no contact for five days. Police attended and spoke with Richard. An ambulance was requested to

discuss Richard's mental state. Police left the house. There is no record if the ambulance attended to see Richard. No referrals were made.

- 14.3.17 On 21 May 2018, Police attended a domestic incident between Richard and Susan, which they recorded as a verbal argument. Richard informed the Police the relationship was over, and he was fearful that once they left Susan may harm him. Richard left the property with the Police. The risk level for the incident was set to standard.
- 14.3.18 The incident was referred to STRIVE¹⁵ for contact to be made with Richard. Three attempts were made to contact Richard, all of which were unsuccessful. On the last attempt Susan is seen, she refused to provide contact details for Richard and a letter is left with Susan for Richard's attention should he wish to engage. The case was closed in accordance with policy. Richard was not seen following this incident.
- 14.3.19 On 4 December 2018 a Respiratory Nurse undertook an unannounced home visit to see Richard due to his lack of engagement and attendance at the clinic. This was the last contact Richard had with a professional before his death.

¹⁵ The STRIVE initiative involves police, local authorities and other partner agencies working with the voluntary sector to signpost people to relevant support services, share best practice and prevent repeat victims of domestic abuse.

15. ANALYSIS USING THE TERMS OF REFERENCE

15.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Richard as a victim of domestic abuse and what was the response?

- 15.1.1 It was not until the incident on 8 May 2015 that Richard was identified as a victim of domestic abuse. On this occasion, it was Richard himself who reported the attempted murder to the Police both in Turkey and then on his return home to England. Susan was arrested at the airport, which removed the immediate risk at that time of further offences being committed.
- 15.1.2 The risk level for the incident was set as high and Richard was referred to MARAC and Victim Support. Within the DASH it was recorded that Richard was afraid of further violence and that there had been arguments which had increased in number and had now escalated to the current incident of attempted murder. The DASH detailed that Susan had wrapped a telephone cord around his neck, pulled him to the floor, covered his mouth and nose with one hand and grabbed his throat, to the point Richard started to pass out. The panel acknowledged that these acts, which amounted to strangulation were a high risk factor. Richard stated that during their 10-month relationship, Susan had tried to isolate him from his friends and family. Women's Aid say¹⁶: 'Domestic abuse isn't always physical. Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.'
- 15.1.3 Susan was released on bail with conditions to reside at a relative's address, not to contact Richard directly or indirectly and not to go to their home address. Richard was living out of the area at this time; however, during a telephone conversation with Bridges on 21 May 2015, Richard informed them that he was not aware of Susan's bail conditions. The Police record stated that Richard was left a voicemail and a text message was sent which detailed the outcome of the arrest and bail conditions. In addition, the Police also sent a request to Lancashire Police to conduct a safe and well check with Richard.
- 15.1.4 Richard attended at a hospital in East Lancashire on 13 May 2015 complaining of symptoms linked to the assault in Turkey. Richard was very

¹⁶ <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/>

clear that these injuries were as a result of domestic abuse. This did not result in a referral from the hospital to support services for Richard or clarification that the matter had been reported to the Police. The IMR Author for East Lancashire Hospital Trust has identified this as an area of learning.

- 15.1.5 Susan breached these bail conditions on two separate occasions but was only arrested once. The Police have a power of arrest where an Officer has reasonable grounds for believing that conditions imposed on pre-charge bail have been breached (s. 46A(1A) PACE)¹⁷. In determining whether to arrest, the Police must also establish that the arrest is lawful and necessary. Code G of the Police and Criminal Evidence Act 1984 provides details of what in law is classed as 'necessary', this includes to protect a vulnerable person. In this case, Susan was on bail for the attempted murder of Richard, and had breached her bail conditions, therefore the arrest of Susan in these circumstances was both lawful and necessary in order to protect Richard for further harm. The DHR panel concluded that Susan should have been arrested on both occasions.
- 15.1.6 The first breach of bail incident occurred four days before the MARAC meeting. Susan was removed from the address and Richard arranged to stay outside of the area with family. During this incident Richard told the Police that he was very scared of Susan and that she used emotional blackmail to get close to him. The attending Officer was aware that this was a high-risk case and that the MARAC was to be heard. The Officer sought advice from a CID¹⁸ Officer who advised no arrest could be made. This advice was incorrect. The Officer submitted an intelligence report for the attention of the Public Protection Investigation Unit. However, despite it being submitted in relation to domestic abuse, no PPI¹⁹ was generated by the evaluator and therefore a DASH was not completed for the incident. The DHR panel agreed that an arrest should have been made, and a DASH completed for this incident.
- 15.1.7 The DHR panel concluded that a more robust approach should have been taken and Susan should have been arrested. The panel acknowledged that the Officer identified safeguarding in relation to Richard but took no steps to implement this, resulting in Richard having to leave his home and seek safety with relatives. This was clearly a domestic incident and should have been recorded as such.
- 15.1.8 The second breach of bail resulted in the arrest of Susan. Positive action was taken on this occasion, but no DASH was completed, and the incident was not recognised as a domestic incident. Had a DASH been completed,

¹⁷ <https://www.cps.gov.uk/legal-guidance/bail>

¹⁸ Criminal Investigation Department

¹⁹ PPI – Public Protection Investigation

this would have been triaged by a Specialist Officer and a repeat referral for MARAC would have been made. Both of the breach of bail incidents were reported to the Police by family members who expressed concerns for Richard from Susan.

- 15.1.9 At the beginning of July 2015, the Police closed the investigation into the attempted murder of Richard in Turkey. The case had been referred to Interpol²⁰ and forwarded to the Police in Turkey, and as a result a decision was made that the British Police would take no further action against Susan as the offence occurred outside of their jurisdiction. The crime report recorded that Richard and Susan were back in a relationship, and that on-going safeguarding was being managed through MARAC.
- 15.1.10 This latter statement was inaccurate as the safeguarding was not being managed through MARAC, the case had been heard on 9 June 2015 (a month earlier) and was not listed to be heard again unless a further incident of domestic abuse had been identified. The incident at the end of June, which the Police attended, was not recognised as a domestic incident and therefore not referred into MARAC.
- 15.1.11 The rationale for the Police not pursuing a criminal investigation was recorded as – ‘Murder and manslaughter are among the exceptional cases where the English courts have jurisdiction over offences committed abroad. By section 9 of the Offences against the Persons Act 1861 and section 3 of the British Nationality Act 1948 a murder or manslaughter committed by a British citizen on land anywhere out of the United Kingdom may be tried in England as if it had been committed here. Section 9 allows criminal courts to claim parallel jurisdiction, though it is now more normal for the trial to take place abroad, and extradition procedures have been made much simpler to allow for this procedure’. In reaching this decision, the Police were cognisant that there was little independent evidence about the incident, the case was unlikely to reach the Code for Crown Prosecutors²¹ in considering a criminal charge, and Richard had indicated that he did not wish to proceed with the matter and had actively tried to have Susan’s bail conditions removed.
- 15.1.12 The Police had contact with Richard on a further five occasions. On each occasion the Police attended incidents that were reported by either family members or neighbours who had concerns that Richard was in a violent and controlling relationship and was vulnerable due to his failing health. None of these resulted in Richard being referred into MARAC.
- 15.1.13 The first of these incidents was responded to the Police as a concern for safety, despite the informant stating that Richard was in a volatile

²⁰ <https://www.interpol.int/en>

²¹ <https://www.cps.gov.uk/publication/code-crown-prosecutors>

relationship and that contact with his family had to be arranged secretly otherwise Susan would punish Richard. Police attended and described Richard as in 'low mood', Richard was left in the care of Susan, awaiting the attendance of an ambulance who had been called to assess Richard's mental health. There is no record that an ambulance attended.

- 15.1.14 The incident log was closed as a 'Concern for Safety' with no further need for Integrated Neighbourhood Service (INS)²² as Richard had regular contact with his GP and Community Nurse and Susan, who was his recorded as being his full time carer. The IMR Author from the Police has identified that the case did meet the criteria for the INS as they had daily meetings with partner organisations where persons with perceived vulnerabilities are discussed to consider what services may already be working with them or what services could be considered following the incident. The IMR Author stated that consideration should have also been given for a multi-agency meeting within the INS where Richard's needs could have been addressed.
- 15.1.15 The panel considered whether Richard's case should have been referred into the INS. Located within the INS is a keyworker from Bridges, whose role is to provide support and guidance and lead on any domestic abuse related matters. If Richard's case had been brought to INS, then the keyworker would have been able to provide an overview of service/MARAC history and either advise that the case fitted the criteria for referring back to MARAC, or the potential for a referral into Bridges, which would have resulted in Richard being allocated to a keyworker for support. The panel agreed that Richard should have been referred back to MARAC in the first instance but recognised that had the matter been referred to INS, this would have also identified the need for referring back to MARAC.
- 15.1.16 The incident on 21 May 2018 was closed as a domestic incident with the risk level set as standard and referred to Operation Strive in accordance with policies in place at that time. Three attempts were made to see Richard by a Police Community Support Officer (PCSO) and a member of Bridges (commissioned service in Tameside for domestic abuse). Richard was not seen. On the last visit, which took place at Richard and Susan's home address, Susan stated Richard was not living at the address, she refused to provide contact details. A note was left with Susan for Richard to contact the Police if he wished to pursue the incident. The case was closed in accordance with the service level agreement. At the time of this incident STRIVE was being delivered by Police Community Support Officers.

²² INS was a multi-agency partnership set up in Tameside, running from two locations. The purpose and remit of the INS was to problem solve lower level incidents – not specifically/exclusively domestic abuse, whereby one or more service were aware of issues and had attempted interventions that had not been successful.

That has now changed and there is a volunteer coordinator in post. The DHR panel agreed that it was not appropriate for a note to have been left with Susan and have made a recommendation that the learning from this case is shared with STRIVE.

- 15.1.17 The DASH for this incident recorded clear indicators of coercive and controlling behaviour. There was no crime report created for this incident or criminal investigation undertaken. The DHR panel agreed that the Police should have explored further action in relation to this incident.
- 15.1.18 There is no evidence that the GP had been made aware that Richard had been referred to MARAC, until being notified during correspondence with mental health service providers after the MARAC. At the time of the MARAC, it was not practice within Tameside for the GP to be informed that a person was being considered for MARAC. Information sharing protocols have since been devised to address this matter. The DHR panel have made a recommendation to the Community Safety Partnership to obtain assurances and evidence that this process is taking place.
- 15.1.19 Although there may not have been a need for a response from the GP at the time of receiving the information, there is no evidence that in later consultations between Richard and Susan the GP considered the past history when Susan was demonstrating controlling factors such as speaking on Richard's behalf during consultation with the GP.
- 15.1.20 During a consultation with a GP, Susan reported to her GP that she was a victim of abuse, and named Richard as the perpetrator, who was reported to be living out of the area. This was seen by the GP as a protective factor. There is no evidence that either couple was advised to seek help. In addition, there is little evidence that the GP considered domestic abuse between the couple separately to the other complex medical issues for which both attended or that domestic abuse was an integral part of the complex relationship between the couple and the medical conditions which they presented.
- 15.1.21 A report published by Safelives - Spotlight Report #HiddenVictims, Disabled Survivors Too: Disabled people and domestic abuse²³, identified that disabled people experience higher rates of domestic abuse than nondisabled people. In the year to March 2015 the Crime Survey for England and Wales reported that women and men with a long standing illness or disability were more than twice as likely to experience some form

23

<https://safelives.org.uk/sites/default/files/resources/Disabled%20Survivors%20Too%20CORRECTED.pdf>

of domestic abuse than women and men with no long standing illness or disability²⁴.

- 15.1.22 In addition the report by Safelives stated – ‘For a disabled person, the abuse they experience is often directly linked to their impairments and perpetrated by the individuals they are most dependent on for care, such as intimate partners and family members. Our national data shows that disabled victims are much more likely to be suffering abuse from a current partner (31%) than non-disabled victims (18%). Intimate partners or family members often act as carers and this position of power can be exploited leading to widespread and pervasive means of coercive control and social isolation’.
- 15.1.23 Following the MARAC an alert was entered onto computer records held by Tameside and Glossop Integrated Care NHS Foundation Trust. It is standard practice for such an alert to be recorded on the electronic health record for all victims of domestic abuse heard at Tameside MARAC to prompt staff to consider domestic abuse as a factor when the patient presents during a care episode, this would include unscheduled care episodes such as attendance in A&E. Staff are expected to review any alerts which may be present when accessing computer systems and take action if required. This alert remains in place for 12 months and is automatically inactive if no further incidents are referred to the MARAC. As no further incidents were referred the alert became inactive on 16 June 2016.
- 15.1.24 The panel found no evidence that agencies considered disclosing Susan’s history of domestic abuse to Richard as part of the processes contained within the Domestic Violence Disclosure Scheme (DVDS)²⁵. The panel has made a relevant recommendation in relation to this learning point.
- 15.1.25 Richard’s family told the Chair that Richard had wanted to end the relationship with Susan but that he feared for his safety and had thought it was better to stay with Susan, as she cared for him with his long term medical conditions. This information was not known to agencies. The panel acknowledged at the point of separation or the end of a relationship, then the risk of domestic abuse is high. In 2019 Dr Elizabeth Bates published a paper - "I am still afraid of her": men’s experiences of post separation abuse²⁶. The aim of the study was to qualitatively explore

²⁴ Crime Survey for England and Wales 2015. In the year to March 2015 the Crime Survey reported women (16%) and men (8.8%) with a long standing illness or disability were more likely to experience some form of domestic abuse than women (6.8%) and men (3.2%) with no long standing illness or disability.

²⁵ <https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance>

²⁶ <http://insight.cumbria.ac.uk/id/eprint/4370/>

men's experiences of abuse post-separation and the barriers they experience to help-seeking. Results revealed that their experience of Intimate Partner Violence continued post-separation through harassment, false allegations and manipulation of the parental relationship. This abuse often continued, and in some cases escalated, for some time after the relationship broke down.

15.1.26 The panel considered whether there were indicators of economic and financial abuse in this case as during contact with the Police, Richard stated that he had obtained a loan to pay for the wedding and then spent £14,500 whilst in Turkey, on his credit card. Richard explained that he spent the money on buying presents for Susan. The charity Surviving Economic Abuse²⁷ describes economic abuse as – 'A legally recognised form of domestic abuse. It often takes place in the context of intimate partner violence. It involves the control of a partner or ex-partner's money, finances and things that money can buy, such as clothing, transport, food and a place to live'. Financial abuse is described as a sub category of economic abuse and includes controlling finances, stealing money and coercing someone into debt.

15.1.27 The panel acknowledged that Richard had told the Police about the financial expenditure whilst on honeymoon. The panel acknowledged that this could have been an indicator of domestic abuse; however, the panel had no direct evidence that this was fact.

15.1.26

Term 2

15.2 What knowledge did your agency have that indicated Susan might be a perpetrator of domestic abuse against Richard and what was the response? Did that knowledge identify and controlling or coercive behaviour by Susan?

15.2.1 Susan had been known to the Police for incidents of violence, in which she was identified as the perpetrator. This included five convictions for assault. In addition, Susan had been named as a perpetrator in domestic abuse incidents between 2010 and 2013. None of these domestic incidents resulted in Susan being arrested and convicted. This term has also been addressed within Term 1.

15.2.2 The Police received information from family members that Richard was being subjected to coercive and controlling behaviour from Susan. Some

²⁷ <https://survivingeconomicabuse.org/about-us/>

of these reports were made prior to the enactment of legislation within the Serious Crime Act 2015 (December 2015). None of the incidents reported to the Police after this time, from family members and from Richard himself were recognised as being evidence as coercive and controlling behaviour and responded to as a criminal matter.

- 15.2.3 The DHR panel has identified that incidents were dealt with in isolation and there was a lack of a holistic review, taking into account past incidents and convictions when determining the risk level in the relationship between Richard and Susan.
- 15.2.4 There were episodes with the GP when Susan was insisting that she was to be the main informant in discussions held about Richard's health, and on one occasion Susan refused to let the GP speak to Richard on the telephone. In retrospect these incidents could be an indicator of domestic abuse and in reaching this decision practitioners need to balance this against the view that Susan was undertaking this role so that Richard was able to access health care which was in his best interest. This can be evidenced when Richard did not attend a hospital appointment, and Susan later telephoned the GP and requested a further appointment and she believed he needed medical intervention in his health care.
- 15.2.5 Richard had provided consent for information to have been discussed with Susan. The GP was aware that Richard was non-compliant with some aspects of his care, including being unreliable in attending appointments. It would have been good practice for the GP surgery to reaffirm with Richard his consent for Susan to be informed of his health needs, taking into consideration that the GP had had to challenge Susan during consultations with Richard and that information could only be obtained from Richard after Susan had left the consultation room.

Term 3

15.3 What consideration did your agency give to child safeguarding during any domestic abuse interaction it had with Richard and/or Susan?

- 15.3.1 In March 2015, Police attended a domestic incident between Susan and a family member. During the incident Susan had pulled the family member's hair and threatened them with a mop. The family member disclosed that they had suffered emotional abuse from Susan, but this was the first occasion it had become violent. The actions of Susan amounted to a recordable crime. The family member left the address to stay with another family member. The risk level for the incident was set as standard.

15.3.2 A follow up visit was made to see the victim 10 days later. There was no complaint made about the incident and assault and no further action was taken in relation to the incident. It was recorded that a referral to other agencies was declined. The matter was not shared with Children's Social Care. The victim was a child²⁸. The DHR panel acknowledged that the victim was old enough and had capacity to decline a referral to agencies, however; they agreed that as they were legally a child, the incident should have been notified to Children's Social Care.

15.3.3 Richard's granddaughter informed the Author that she had lived with Richard for a significant period since being a young child, and prior to his relationship and marriage with Susan. Whilst this was not her permanent residence, she lived with Richard to help with his daily living. This information was known to agencies, and yet the review found no evidence that she had been considered as a young carer²⁹. Section 17 Children Act 1989 places a duty on Local Authorities to assess whether a young carer in their area needs support and what those needs are if:

- it appears to the Local Authority that a young carer may have need for support;
- the Local Authority receive a request from a young carer or a parent of a young carer to assess the young carer's need for support; or
- an assessment has been carried out, but the circumstances of the young person or person being cared for have changed.

The review identified this as an area of learning and made a relevant recommendation.

15.3.4 During the phone contact between Richard and Bridges in May 2015, he informed them that his granddaughter was living with him. Richard provided her details, which included her age, this identified her as being 17 years old. Bridges stated that a referral was not made to Children's Social Care as Susan was not living in the home and Richard and his granddaughter were living out of the area. The DHR panel concluded that a referral should have been made to the Children's Social Care where Richard and his granddaughter were living. In reaching this decision the DHR panel acknowledged that agencies had established that a level of safety was in place, but a referral could have offered support via early help services in terms of emotional support, housing and finances if needed.

²⁸ <https://learning.nspcc.org.uk/child-protection-system/children-the-law/#:~:text=In%20England%20a%20child%20is,living%20independently>

²⁹ A young carer is a person under 18 who regularly provides emotional and/or practical support and assistance for a family member who is disabled, physically or mentally unwell or who misuses substances.

- 15.3.5 Following the MARAC meeting in June 2015 the Care Co-ordinator contacted the Public Protection Investigation Unit within the Police and was informed about the incident on 5 June 2015 when Susan was arrested for breach of bail. It was reported that Richard's granddaughter was present at the address at this time. On receiving the information, the Care Co-ordinator telephoned the local Child Safeguarding Team and informed them of the recent domestic abuse and Police involvement. The Care Co-ordinator was advised that contact would be made with the legal guardian whom Richard's granddaughter should be living with.
- 15.3.6 This was the first time that the information had been shared with the safeguarding team, and prior to this, the information had been known to several agencies and processes. The DHR panel considered these facts collectively and acknowledged the balance that professionals have to contend with when dealing with incidents that involve young people, who are able to provide consent and make their own informed decisions, yet within the definition of the law are classified as a child, but as already identified within this term of reference, the information should have been shared at the time of agency involvement to allow any relevant action and intervention to have taken place at that time.

Term 4

15.4 What consideration did your agency give as to whether Richard was an adult in need of care and support and if so who did you refer his needs to?

- 15.4.1 The DHR panel found no evidence that Richard was an adult in need of care and support as defined by Care Act 2014³⁰. Richard presented as a person who was able to make decisions about his health care independently of others. Richard accessed care as and when he perceived that he needed to. Whilst there is evidence that he did not attend health appointments, this did not appear to be because he lacked mental capacity to make such decisions, but rather because he chose to make the "unwise decision" about his health care.
- 15.4.2 There are entries in agency records that Susan was referred to as Richard's carer. This role was a mutual agreement between Richard and Susan, clearly linked to their relationship, and was not a role for which Susan was being paid or undertaking following an assessment of Richard's care and support needs by Adult Social Care. The panel considered whether Richard's complex medical needs identified him as being an adult in need of care and support as defined by Care Act 2014. The panel concluded

³⁰ <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp>

there was no evidence seen within the review that required a referral to Adult Social Care for assessments of his care needs.

Term 5

15.5 What services or signposting or assessments did your agency provide for, or offer to, Richard and were they accessible, appropriate and sympathetic to his needs and were there any barriers in your agency that might have stopped Richard from seeking help for the domestic abuse?

- 15.5.1 The Police completed a DASH and Enhanced Risk Assessment following the incident in Turkey in May 2015. The risk level was set to high and referred to MARAC. The DHR panel agreed with this assessment. The MARAC referral indicated Richard as a high-risk victim of domestic abuse, therefore requiring the offer of support from Bridges as a domestic abuse support service and specifically an IDVA, allocated to deal with cases identified as high risk.
- 15.5.2 The MARAC referral contained information relating to Richard's health. In addition, there was information around a potential housing need, as Richard was staying outside of the Tameside area. The referral indicated that Richard was frightened as to what Susan might do to him if he returned to his address.
- 15.5.3 The MARAC referral did not contain the DASH and therefore any additional specific risk factors that might have been included/evidenced were not available. The DHR panel were informed that this was an anomaly that occurred infrequently with the system that was in place at the time, which resulted in some referrals not containing the DASH. In the rare occasions when this occurred it was expected that the IDVA would contact the Police for the missing information. Since this time there has been a change in electronic processes which now automatically transfers DASH information between agencies.
- 15.5.4 Bridges contacted Richard to identify what support needs could be available for Richard. The IMR Author for Bridges stated that the complexity of Richard living out of area, coupled with the perceived safety element that this brought, meant that Bridges contact at this time was only by phone. This is covered further under Term 8. Richard was provided with details of Susan's bail conditions and contact details for Housing Advice.
- 15.5.5 Richard was referred to Victim Support following the incident in Turkey. This was an automated referral direct from the Police. Details of perpetrators are not included in this referral. Victim Support made three attempts to contact Richard to offer their service. Contact was made at

- different times of day across a three-day period; however, as they were unable to make successful contact with Richard and the case was closed.
- 15.5.6 The Police set the risk level as medium for the incident in May 2017. The risk level was triaged by an Officer who was not a specialist Public Protection Investigation Officer and was in fact on restricted duties working in isolation at a secondary location. The officer attempted to contact Richard but there was no reply, so a letter was sent. Richard was not referred to any support services. It is the DHR panel's opinion that given the circumstances of this incident the risk level should have been set as high and the case referred to MARAC. Susan was charged with an offence of assault for this incident, but the case was later discontinued.
- 15.5.7 The Police attended a further domestic incident in May 2018, a year after Susan was arrested and charged with assaulting Richard. The risk level for this incident was set as standard by the attending Officer, who would not have been aware of the history of the case, and at that time there were no domestic abuse markers on the police system. This meant that it was not triaged by a Specialist Public Protection Investigation Officer but was passed to a Police Community Support Officer (PCSO) as part of Operation Strive. It is the opinion of the DHR panel that given the previous domestic incident and the comments that Richard made to the attending Officer that this was not an accurate risk assessment.
- 15.5.8 Richard received several assessments, medical reviews and referrals to medical services in response to his health needs. Richard was seen on his own at his mental health appointments to allow Richard to speak freely about his relationship with Susan, and he was provided with contact numbers for agencies that could assist if he felt threatened by Susan.

Term 6

15.6 What knowledge or concerns did Richard's family and or friends have about his victimisation and did they know what to do with it?

- 15.6.1 In May 2015, following the incident in Turkey, Richard contacted his family who attended at Manchester airport and took him back to their address. The DHR panel have seen no evidence of any further contact from agencies by those family members regarding further concerns about Richard and Susan's relationship.
- 15.6.2 On three separate occasions, a member of Richard's family, contacted the Police directly to report their concerns regarding Richard's relationship with Susan. (June 2015 x 2 & January 2018). They provided the Police with details of Susan isolating Richard from his family and his dependency on

- Susan for his medical care. They also expressed fears for his safety. As result of these calls Police attended the home and spoke to Richard.
- 15.6.3 The evidence provided by the family to the Police identified a pattern of coercive and controlling behaviour as defined by the Section 76 of Serious Crime Act 2015. This legislation became law in on 29 December 2015 but did not allow for evidence prior to this date being used for criminal charges. The information in January 2018, which was after the legislation was enacted, did not result in an investigation into coercive control, no DASH was completed, and the incident was graded as a concern for safety rather than domestic abuse.
- 15.6.4 The reports from the family clearly identified the concerns they had for Richard's relationship with Susan. The family informed the Author that other than contacting the Police they did not know where to go to for help and did not have access to the internet to search for other agencies or support. The DHR panel have seen no evidence that the family were provided with information on how they could support Richard in his relationship, including what options were available to him and them in dealing with the domestic abuse in the relationship.
- 15.6.5 The internet, social media and other forms of on-line communication are a useful tool for agencies to raise awareness of, and accessibility to domestic abuse support services. This form of communication allows agencies to ensure that their information is up to date, relevant and accessible 24/7. However, it is known that not everyone has access to the internet, or for some, the use of the internet can increase the risk within their relationship, particularly where perpetrators of abuse monitor an individual's internet access and search history.
- 15.6.6 The panel discussed the challenges to agencies in promoting awareness by using what can often be regarded as 'traditional' methods of communication such as leaflets, newspaper articles, posters etc. The panel recognised that this form of communication relies on the information being available in a range of locations, often at places of 'high foot fall', such as GP surgeries, high streets etc. Unlike the internet, it is not as easy for these forms of communication to be updated, monitored in terms of people accessing the information and replenished when stocks of communications run low. The panel recognised these challenges and considered the views of the family in regarding their experience of being provided with and being able to access information. The panel have identified this as an area of learning and made a relevant recommendation.
- 15.6.7 Tameside Metropolitan Council published a revised Domestic Abuse Communications Strategy in January 2023. Information is disseminated in a variety a ways including local newspapers, radio, posters, banners, bus adverts and leaflets. The strategy outlines the authority's approach,

including our focus on community engagement activities alongside communication campaigns.

Term 7

15.7 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Richard and/or Susan? This includes Richard's complex medical needs.

- 15.7.1 Susan was recorded in agency records as being a black Caribbean. In the 2011 census black Caribbean people accounted for 1.1% of the United Kingdom population. In June 2015, whilst the Police were dealing with the domestic abuse incident between Richard and Susan it is recorded that Susan spoke to Richard in 'Patois' (a Jamaican dialect)³¹ telling Richard to come and meet her once the Police had left. This is the only record of Susan speaking in this language and is an example of using language as a form of controlling behaviour.
- 15.7.2 Bridges is a service that is accessible to male and female victims of domestic abuse. Bridges had brief interaction with Richard, through one phone call and two text messages. Further analysis on the availability and accessibility of services for Richard are covered within Term 8.
- 15.7.3 Richard's health had deteriorated over the years, this had an impact on Richard's ability to work, and he had not been in employment for the last 30 years. There were a significant number of medical appointments that Richard did not attend with Specialists responding to his health needs. The review found no evidence that these 'missed' appointments were linked to domestic abuse. Richard had a full psychosocial assessment and joint medical assessments and there is evidence that Richard's Care Co-ordinator and Consultant Psychiatrist liaised with Richard's GP about his health and prescribed medication when working to address his complex needs.
- 15.7.4 There is no record of Richard and Susan's faith within agency contacts. Nor is there of any record on their racial and cultural issues being taken into consideration or impacting on services that were provided.

Term 8

³¹ Jamaican Patois, known locally as Patois (Patwa or Patwah) and called Jamaican Creole by linguists, is an English-based creole language with West African influences (a majority of loan words of Akan origin)[4] spoken primarily in Jamaica and among the Jamaican diaspora; it is spoken by the majority of Jamaicans as a native language.

15.8 Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Richard and/or Susan, or on your agency's ability to work effectively with other agencies?

- 15.8.1 Bridges has a target of making initial contact with victims of domestic abuse within 48 hours of a referral being received by the service. Richard was referred to Bridges in May 2015, 8 days after Susan was arrested for the attempted murder of Richard. Bridges contacted Richard within the 48-hour timeframe. The panel considered the timeliness of the referral being received by Bridges (8 days following arrest) and were informed that this was not an exceptional delay at that time due to case volume, electronic systems, and staff availability. The panel were informed that electronic systems have since changed which has seen a reduction in the timeframe or referrals being made and improved information sharing.
- 15.8.2 The Author has had access to the Greater Manchester MARAC protocol (2012) which states that referrals into MARAC can be made up to 8 days prior to the MARAC meeting. There are no timescales into relation to when a referral should be made to MARAC following an incident or completion of a risk assessment. The document details processes for holding an emergency MARAC. An emergency MARAC was not held on this case.
- 15.8.3 Richard was living with relatives outside of the Tameside Metropolitan Borough Council area. The contractual specification for Bridges service is that 'The Provider will operate several elements relating directly to domestic abuse provision whilst sourcing and utilising other existing appropriate local services to support victims domestic abuse living in Tameside with the aim of reducing repeat victimisation and helping prevent the damage inflicted by abuse'³².
- 15.8.4 This restricted Bridges to working with victims living in the borough of Tameside. Bridges informed the review that this is a 'grey' area and from their experience they always try to provide continued support where it is deemed that a client has the intention of, or there is a likelihood of them returning to live in Tameside. Where not, they would try to provide details for, or refer into services in the area that a person has gone to. This could include the completion of, or request for a MARAC transfer to be done. This did not happen in Richard's case.
- 15.8.5 Richard's case remained open to Tameside even though it would not have been considered appropriate or necessary for an IDVA to travel outside of the area to initiate face to face contact with Richard. The panel were informed that there had been occasions where staff had visited clients out of

³² Tameside Metropolitan Borough Council tender document dated 1 December 2017.

the area, but this had been when they were living in boroughs bordering the locality of Tameside. This was not the situation with Richard's address.

- 15.8.6 Safelives provides guidance³³ and transfer forms for use by MARACs on transferring of cases. The guidance details this as being at the point of a victim moving out of the original MARAC's area, regardless of whether the move is temporary or permanent. In addition, the Greater Manchester MARAC protocol provides guidance on the completion of MARAC to MARAC transfer. The DHR panel felt that Richard's case should have been transferred, which would have provided an opportunity for Richard to have been allocated an IDVA and access to support agencies within his local area, who could have attempted to engage with Richard. This was a crucial time for Richard, as Susan was on Police bail with conditions not to have contact with Richard. The panel have identified this as an area of learning in relation to transferring of cases and referring to support services out of areas and have made a relevant recommendation.
- 15.8.7 Bridges is the council commissioned domestic abuse service and is accessible to male and female victims of domestic abuse. In 2015 Bridges employed a male IDVA (Independent Domestic Violence Advisor) and a male Deputy Manager (also qualified IDVA). Neither of these members of staff were employed specifically to deal with male clients, nor was this part of their remit, but they would have been available if a client specifically wanted a male worker. In 2015 Bridges were operating a client support group called LAVA (Life After Violence and Abuse). This group was effectively a staff led support network for victims and was open to males and females alike. The review panel were informed that there were occasions when males attended this group, however, these numbers were limited, which was due to the gender make up of participants – i.e., predominantly female. Richard did not attend this group.
- 15.8.8 Since 2015, Bridges have delivered a Freedom programme³⁴. The panel were informed that Bridges were willing to accept male victims on the course; however, to date they have had no male victims attend this programme. The panel recognised that there may be barriers around a male victim seeking and accessing this course, most notably the gender bias in the course material, whereby the victim is perceived as a female

³³

<http://www.safelives.org.uk/sites/default/files/resources/MARAC%20to%20MARAC%20referral%20process%20FINAL.pdf>

³⁴ <https://www.freedomprogramme.co.uk/>

The Programme was primarily designed for women as victims of domestic violence, since research shows that in the vast majority of cases of serious abuse are male on female. However, the programme, when provided as an intensive two day course, is also suitable for men, whether abusive and wishing to change their attitudes and behaviour or whether victims of same sex domestic abuse themselves.

and the perpetrator as a male. The panel also recognised that nationally the emphasis on victim programmes tends to be predominantly aimed towards female victims which is supported by research around the gendered nature of abuse as detailed in Section 10.

- 15.8.9 Bridges also has a refuge provision; however, this is a refuge for women and children. In 2015 a process was in place for seeking dispersed accommodation within the borough of Tameside, which was available to male victims, or any other client who may have required the service. Whilst it is clear that it was the intention of Bridges that any client should receive the same level of support, regardless of their gender, the ability to be able to achieve this is a challenge for services commissioned to support victims of domestic abuse. The panel recognised that this is both a local and national issue.
- 15.8.10 In terms of responding to perpetrators of abuse, the panel were informed that in May 2015 Bridges were in receipt of funding for the provision of a voluntary perpetrators programme – ‘New Paths’ and were working towards the delivery of a female attendee’s course. The programme could have been available for Susan, but due to the nature of the programme and with Bridges being a victim focussed service, Susan’s accessibility for the programme would have been dependant on Richard engaging with the service and the course being discussed with him as a potential offer to Susan. Richard had no contact with the service and therefore this opportunity was not progressed.
- 15.8.11 In June 2019 the British Medical Journal published a research article³⁵ which identified that men who experience domestic abuse faced significant barriers in accessing help and specialist support services. The study was undertaken by researchers at the University of Bristol’s Centre for Academic Primary Care and Centre for Gender and Violence Research. ‘Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis’ by Alyson Huntley et al³⁶ found that men were often not aware of specialist support services or that they felt the services that were available were not appropriate for male victims of abuse. The report recognised the need for services to be more inclusive and tailored to more effectively address the needs of all genders, ethnic

³⁵ <https://policybristol.blogs.bris.ac.uk/2019/06/18/male-victims-of-domestic-abuse-face-barriers-to-accessing-support-services-new-study/>

³⁶ <https://bmjopen.bmj.com/content/9/6/e021960>
Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis
<http://orcid.org/0000-0001-9409-7891>Alyson L Huntley¹, Lucy Potter¹, Emma Williamson², Alice Malpass¹, Eszter Szilassy¹, Gene Feder¹

and socioeconomic backgrounds and specialised training is needed to address the specific needs of men and to foster greater levels of trust.

- 15.8.12 Moving forwards to 2020, Bridges now employs one male member of staff, whose role is that of Operational Manager. This member of staff is available should a male client specifically wish to receive support from a male. For the year April 2019 to end of March 2020, Bridges received 779 referrals for females and 37 for males. There were no specific requests seeking support from a male member of staff. Bridges has played an integral role in the successful #open up/he's keeping a secret campaign^{37,38}, which was launched in 2018 and re-launched in January 2020, to encourage male victims of abuse to come forward. This campaign won UK public sector best low budget campaign and has also been acknowledged by the national service Mankind initiative, who reference this within their training delivery.
- 15.8.13 The Police IMR Author researched a number of Public Protection Investigation (PPI) logs around the timescales of this case, to look at risk identification on cases of domestic abuse. The Author identified concerns around the triaging function of domestic incidents, in that incidents were being inaccurately risk assessed. The Author identified that this was linked to a backlog of domestic incidents being triaged by staff who had not had the requisite training or experience to undertake the task. The IMR Author has made an appropriate recommendation in response to this matter which has featured within a previous domestic homicide review in the Force area.
- 15.8.14 The panel have been informed that a Senior Officer within the Police is currently undertaking a review of the resourcing of the MASH's and specialist officers, along with identified training needs. The review is also taking account of learning from previous local child safeguarding practice reviews and domestic homicide reviews.

Term 9

15.9 What learning has emerged for your agency?

- 15.9.1 Agency learning is identified within Section 17.1 of the report.

³⁷ <https://www.tameside.gov.uk/domesticabuse>

³⁸ <https://twitter.com/abouttameside/status/951093636229451776?lang=en>

Term 10

15.10 Are there any examples of outstanding or innovative practice arising from this case?

- 15.10.1 The IMR author for Tameside and Glossop Integrated NHS Foundation Trust identified that the home visit undertaken by the Specialist Respiratory Nurse as an example of outstanding practice, as that action is not standard practice and was initiated due to her concern for Richard's welfare and commitment to ensuring he received the best possible outcome in regard to his long term health condition.

16. CONCLUSIONS

- 16.1 Richard was 59 years old at the time of his death and had not worked since the age of 35 due to his ill health. Richard had multiple and complex medical conditions and a history of misusing alcohol and drugs. Following a criminal investigation, which included the arrest of Susan, a decision was made that no criminal charges would be instigated in relation to Richard's death.
- 16.2 In February 2020, an inquest was held which concluded that Richard's death was likely to have resulted from the administration of fentanyl patches in excess of the prescribed dose. The death was recorded as drug related.
- 16.3 Susan had a history of violence, this included two occasions where she had been arrested by the Police for assaulting Richard. None of these incidents resulted in a conviction. Despite the violence, Richard and Susan remained in a relationship. The review found no evidence that Richard was aware of Susan's violence in her previous relationships, or that agencies had considered the disclosure of this information to Richard.
- 16.4 Agencies had several opportunities where they could have intervened in the relationship when responding to incidents of domestic abuse, including taking proactive action against Susan. When Richard moved out of the area, the MARAC case was not transferred, and Richard was not referred into a specialist domestic abuse service in the area that he was living. Soon after this move, Richard and Susan recommenced their relationship and moved out of the area for a period of time.
- 16.5 It was established that some agencies were not aware that the case had been heard at MARAC, including that Richard was a victim of domestic abuse. Processes have since been implemented to rectify this matter, but the panel agreed that the Community Safety Partnership should be provided with evidence that this is now taking place.
- 16.6 The review considered whether Richard's gender was a barrier to him being able to access services and concluded that at the time of Richard's involvement with domestic abuse services the programmes available were predominantly aimed towards females, with the content being that of female victims and male perpetrators. The panel acknowledged the proactive work that Tameside have taken towards male victims of domestic abuse, over the last two years, which has received national recognition and that the Community Safety Partnership should seek assurances that accessibility by male victims is embedded into agency practice.

- 16.7 The review identified that further incidents of domestic abuse between Susan and Richard were dealt with in isolation and there was no evidence that the history of their relationship, and Susan's previous involvement in domestic abuse, was considered as part of an overall risk assessment towards Richard. Richard's disability and reliance on Susan as a carer meant that he would have been at a higher risk of being a victim of domestic abuse. This was not considered by agencies as part of their risk assessment.
- 16.8 Richard's family have informed the review that, except for the Police, they were not aware as to who they could report their concerns to regarding Richard and Susan's relationship. The family had limited access to the internet in which to research for help and guidance. The panel recognised that awareness raising and communication for family and friends can be a common area of learning on reviews, and in this case, the learning is aimed particularly for those areas of society who do not actively use social media and internet services.
- 16.9 The panel recognised the death of Richard met the criteria for conducting a Domestic Homicide Review. The panel acknowledged the result of the criminal investigation and the outcome of the inquest during the review. The panel has identified learning and made local recommendations to address the learning in this report.

17. LEARNING IDENTIFIED

17.1 Agencies Learning (taken directly from their IMRs)

East Lancashire Hospital Trust

- Circulation of policy on risk assessment completion when domestic abuse disclosed

Greater Manchester Police

- Identification, understanding and classification of risk
- Training of staff within triage function

Health – GP Services

- Training for GP's on domestic abuse
- Ability to challenge patients
- Information sharing and health role in MARAC

Jigsaw Support (Bridges)

- Reflective learning
- Record keeping

Pennine Care NHS Foundation Trust

- Record keeping

Tameside and Glossop Integrated NHS Foundation Trust

- Review of patients alerts
- 'Safe Routine Enquiry' training
- Disclosures of sexual violence to be embedded in domestic abuse training

17.2 The Domestic Homicide Review Panel's Learning (Arising from DHR panel discussions)

17.2.1 The DHR panel identified the following learning. The panel did not repeat the learning already identified by agencies at paragraph 17.1. Each learning point is preceded by a narrative which seeks to set the context within which the learning sits. When a learning point leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative

It is important that professionals have a wide understanding of the circumstances and situations that can be defined as a disability. In recognising this, then professionals must ensure through engagement they understand the impact that this disability has on the individual and work with them to ensure that their needs are being met. Professionals must also take cognizance of those who are caring for a person with a disability and understand the options available to them as a professional to be able to refer the person into services for an assessment that their needs in this role are being achieved.

Learning

Gathering information on a person’s individual circumstances, home environment, care needs and how these are being met will ensure that, where appropriate, referrals are made, and assessments are undertaken to identify support and access to support services.

Learning 2 [Panel recommendation 2 and 3]

Narrative

MARAC provides agencies with a platform in which to share information, refer cases of concern, and work collectively to ensure the needs of a victim are being addressed. The partnership working of a MARAC provides a platform for agencies to work together to ensure a victim is aware of the support and options that are available to them in managing the risk. Information sharing within the MARAC provides agencies with the level of knowledge and information to be vigilant and proactive during contact with clients.

Learning

Agencies working in the field of safeguarding should have an understanding of MARAC including the process of sharing information and transferring of cases due to the geographical location of the victim.

Learning 3 [Panel recommendation 4]

Narrative

Risk assessment is a dynamic process and in order to fully understand a current risk to a victim of domestic abuse, professionals must take account of current and previous risk factors to ensure that the risk assessment is an accurate reflection based on evidence from current and previous incidents. In considering historical information it allows professionals to consider undertaking other safeguarding measures that will provide the victim with information [For example: Domestic Violence Disclosure Scheme] to help them understand risks by remaining in the

relationship.
Learning
By undertaking a holistic view of a case, it allows professionals to consider emerging and historical factors to reach an informed decision on the current risk factors to an individual and consider safeguarding measures that can be undertaken on the case including the disclosure of information to victims on the risks that have been identified.

Learning 4 [Panel recommendation 5]
Narrative
Victims, families and friends utilise a range of methods to obtain information on domestic abuse services. The challenge for agencies is to ensure that their information is up to date, relevant and available through a range communication methods, including accessibility for those in 'hard to reach' communities or where social media and web based methods are not their preferred mode of seeking help and support.
Learning
Information on domestic abuse including how to report concerns and access to support services must be available for all members of the community, in a format that is easy for them to access and understand.

Learning 5 [Panel recommendation 6]
Narrative
It is known that male victims are less likely to report domestic abuse and seek support than female victims. When male victims do report abuse, it tends to be at a crisis point in their relationship. Ensuring services are available for all genders is a vital part in victims being able to access help and support at an earlier stage and allows professionals to engage with victims to help them understand and manage any known risks in their relationship.
Learning
Agencies must ensure their services are accessible to victims of domestic abuse whatever their gender.

Learning 6 [Panel recommendation 7]
Narrative
Professionals can experience difficulties when attempting to contact victims to provide support and services in relation to domestic abuse.

Where contact has not been achieved, professionals must record what attempts have been made at contact, including what methods of contact have been made.

Learning

Professionals must be aware that seeking to arrange contact with a victim via a perpetrator can lead to an increase in the risk to that victim, and is not an appropriate method of communication.

18. RECOMMENDATIONS

18.1 Panel Recommendations

Number	Recommendation
1	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that practitioners are identifying during contact with individuals, those who are eligible for additional support and needs and completing assessments and referrals to ensure those needs are met.
2	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that professionals understand and comply with the MARAC processes.
3	That Tameside Community Safety Partnership seeks assurances from the Clinical Commissioning Group ³⁹ that the information sharing protocol and link to MARAC is embedded within the GP service.
4	That Tameside Community Safety Partnership seek assurances from its constituent agencies that they take account of historical and emerging factors when undertaking risk assessments with victims of domestic abuse and that these assessments are used to implement safeguarding processes, including the disclosure of information to the victim in accordance with legislation.
5	That Tameside Community Safety Partnership ensures that information on domestic abuse is available for all members of the community and in a format that is easy for them to access and understand.
6	That Tameside Community Partnership seeks assurances from its constituent agencies that their service is accessible to all victims of domestic abuse whatever their gender.
7	That the learning from this review is shared with STRIVE co-ordinators for dissemination within the project. ⁴⁰

18.2 Agencies Recommendations

Greater Manchester Police

³⁹ The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

⁴⁰ STRIVE is no longer in existence. Instead, Tameside will share the learning with GMP.

- 18.2.1 The Force Lead for Safeguarding reviews current guidance and training for MASH/EHASH teams in order to ensure that only specialist officers are deployed on Triage Desks.
- 18.2.2 Chief Supt. Covering Ashton to review current deployment of triage officers.
- 18.2.3 The Force Lead for Safeguarding reviews current training of front line services into the identification and classification of risk at domestic incidents.

Health – GP Services

- 18.2.4 There is a need for GPs in Tameside to receive domestic abuse training which incorporates possible indicators of domestic abuse and resources available so that the GP is able refer and support patients affected by domestic abuse.
- 18.2.5 Processes need to be implemented to facilitate the GP to enable challenge when working with patients with complex needs.
- 18.2.6 A review of the information sharing protocol for health and MARAC needs to be implemented.

Jigsaw Support (Bridges)

- 18.2.7 Best practice case management framework guidance to be produced for consistency across workings of Bridges staff.

Tameside and Glossop NHS Foundation Trust

- 18.2.8 Review of patient alerts on Lorenzo and possibility of incorporating automatic prompt on screen which cannot be bypassed.
- 18.2.9 Targeted "Safe Routine Enquiry" training in A&E and Out Patients department to increase compliance levels and staff awareness and confidence.
- 18.2.10 Management of disclosures of sexual violence to be embedded in ICFT (Integrated Care Foundation Trust) domestic abuse training.

- 18.3** 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.

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework⁴¹

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- 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 of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;

⁴¹ Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- 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;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

EVENTS TABLE

The following table contains important events which help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review. The table contains a summary of medical appointments that are relevant for the review and not a chronology of all medical appointments.

Events Table	
Date	Event – Pre TOR
02.04.95	Susan assaulted a female and later attended court, received a 12-month probation order and ordered to pay £300 compensation.
12.12.98	Susan assaulted a female and later attended at court and received a 12-month probation order.
21.07.05	Susan arrested for an assault on her daughter. Susan's children taken into Police Protection. No further action taken in relation to the assault.
16.09.05	Police attended a domestic incident between Susan and her husband.
21.09.05	Children's Social Care receive referral from Susan's partner that she is physically abusive to him. No further action taken.
19.08.10	Susan contacted Children's Social Care asking for advice due to domestic abuse. Case progressed to initial assessment. Outcome concluded that Susan and her husband did not recognise impact of domestic abuse on their child.
2010 – 2013	Between June 2010 and May 2013 there were 16 domestic and concern for safety incidents involving Susan and her then husband. A large number of these incidents coincided with the breakdown of the marriage and the fact they both remained living in the marital home.
04.07.11	Case conference held in relation to Susan's' child due to ongoing domestic abuse in home. Child made subject of child protection plan.
04.05.12	Police attended a domestic incident between Susan and her partner. (New Partner).
29.10.13	Susan reported a domestic incident with her ex-husband which had occurred in Wales two months earlier.
26.02.14	Police attended a domestic incident with Susan and her partner.
14.05.14	Police attended a domestic incident with Richard and his son.

23.10.14	Police attended a domestic incident with Richard, Susan and Richard's son.
25.11.14	Richard had a review with his Care Co-ordinator and discussed relationship with Susan.
20.01.15	Richard informed his Care Co-ordinator that he was engaged to Susan.
10.03.15	A family member of Richard's contacted Police and reported they had been assaulted by Susan.
20.03.15	The family member were spoken to by Police and stated they did not wish to pursue a complaint of the incident on 10.03.15.
18.04.15	Richard and Susan married.
19.04.15	Richard and Susan left England to go on honeymoon.
Date	Within TOR
08.05.15- 09.05.15	Susan assaulted Richard whilst on honeymoon in Turkey. Incident reported to Police in Turkey.
11.05.15	Richard and Susan travel home from Turkey. Susan was arrested, interviewed and released on Police bail until 8 July 2015.
12.05.15	Susan attended at hospital.
12.05.15	Victim support received referral for Richard. Initial call made to offer support.
13.05.15	Richard attended at hospital.
13.05.15 – 14.05.15	Susan attended follow up appointment at hospital following attendance on 12 May 2015.
15.05.15	Victim support telephoned Richard. Call went to voicemail.
16.05.15	Victim support telephoned Richard. Call went to voicemail.
18.05.15	Victim support telephoned Richard. Call went to voicemail. Case closed.
19.05.15	Richard and Susan's case referred to MARAC.
20.05.15	Richard's case allocated to an IDVA. IDVA telephoned Richard. Call went to voicemail. Message left.
21.05.15	Deputy Manager at Bridges contacted Richard by telephone.
21.05.15	Housing Advice contacted Bridges and informed that Richard had been in contact. Case referred for telephone triage. IDVA details provided.
05.06.15	Police attended Richard's address as Susan was present and in breach of bail conditions. Susan left the property.
09.06.15	Richard and Susan's case discussed at MARAC.
10.06.15	Housing Advice conducted telephone triage with Richard.
11.06.15	Care Co-ordinator telephoned Richard to follow up on MARAC actions.
11.06.15 – 4.12.18	During this 30-month period Richard attended 5 out of 15 appointments in Respiratory Clinic.

15.06.15	Community Mental Health Social Worker referred Richard's Granddaughter to Children's Social Care due to domestic incident between Richard and Susan.
17.06.15	Housing Advice sent letter to Richard in relation to options available. Housing register application completed.
18.06.15	Richard accepted on Tameside Housing Register.
24.06.15 – 12.09.18	During this 39-month period Susan attended 8 out of 10 clinic appointments for pain management.
25.06.15	Care Co-ordinator telephoned Richard. Message left.
29.06.15	Police contacted by family member regarding concern for Richard's welfare.
01.07.15	MARAC action update that there had been no contact. Case closed.
02.07.15	Housing sent letter to Richard to advise he had been shortlisted for property.
08.07.15	Susan answered Police bail and informed no further action being taken. Richard accompanied Susan to the Police station.
24.07.15	Housing telephoned Richard. Recorded number no longer in use.
28.07.15	Housing telephoned Richard. Voicemail message left.
28.07.15	Police closed case in relation to incident that occurred in Turkey.
30.07.15	Housing sent Richard a letter regarding reduction in rehousing priority.
14.08.15	Housing application suspended as no response to letter.
21.08.15	Housing case closed. No contact received.
28.10.15	Richard attended appointment with Care Co-ordinator. Susan accompanied Richard to appointment.
Nov 2015	Richard and Susan moved to GP practice in Blackpool. Information shared from previous GP practice.
10.11.15	Richard attended registration appointment with GP in Blackpool. Richard gave consent for contact with Susan regarding his treatment. GP contacted Richard next day to discuss results.
15.12.15	Care Co-ordinator telephoned Richard. Voicemail message left.
21.12.15	Care Co-ordinator discharged Richard from service. Letter sent to GP with care plan.
07.01.16	Richard attended hospital via ambulance due to shortness of breath. Discharged the following day. GP undertook home visit.
22.01.16	Blackpool CCG received letter from Community Mental Health Ashton under Lyne which contained detail of MARAC referral. This was the first time Blackpool CCG were aware of MARAC.

16.02.16	Richard and Susan attended GP for appointment with Richard. Recorded as difficult consultation as both wishing to talk at the same time. GP challenged Susan.
18.03.16	Richard attended GP appointment and discussed that he had increased use of patches. Advice given against increase usage.
03.05.16	Susan requested referral for Richard to Respiratory clinic. Records noted previous did not attend appointments.
01.06.16	Richard seen in Respiratory Clinic. He did not attend the pulmonary rehabilitation programme.
10.06.16	GP spoke to Susan about hospital appointment on 1 June 2016. Susan declined for GP to speak to Richard.
10.10.16 & 13.10.16	Susan contacted GP requesting medication as prescription stolen in Turkey.
15.10.16 – 19.10.16	Richard attended hospital – collapsed and unresponsive. Self-discharged before diagnosis
21.10.16	Richard contacted GP to report that Susan was collapsed and unresponsive but that her breathing was ok. Richard advised to call the ambulance.
11.01.17	Richard discharged from Primary Intermediate Mental Health Team and referred to complex case team.
18.02.17	Lancashire Police deal with allegation of common assault with Richard as named perpetrator against landlord. No further action taken.
20.02.17	Richard admitted to hospital. Minor surgery undertaken. Discharged on 22.02.17. Richard and Susan believed to have moved from Blackpool.
28.02.17	Richard attended hospital for medical review following surgery on 20.02.17.
01.03.17 & 03.03.17	GP practice attempted contact with Richard. No response to telephone calls. Letter sent. No further contact received.
06.03.17	Richard attended hospital regarding surgery on 20.02.17.
30.03.17	Richard's case transferred to Pennine Care NHS Foundation Trust from Blackpool.
07.04.17 & 11.04.17	Pennine Care NHS Foundation Trust telephone Richard. No answer. Unable to leave a message. Letter sent to Richard requesting contact.
04.05.17	Police attended a domestic incident between Richard and Susan. Susan arrested and charged with an offence of assault. The case was later discontinued.
10.10.17	Susan attended at hospital for back pain as pharmacist had refused to dispense medication. Advice given.
16.01.18	Police contacted by family member expressing concerns for Richard as has they had had no contact with Richard for five days. Police attended and spoke to Richard. Ambulance were requested to discuss Richard's mental state.

21.05.18	Police attended domestic incident between Susan and Richard.
23.05.18 – 01.06.18	Joint visit to Richard at a hotel by Police and staff member from Bridges. Richard had checked out of hotel. Further attempts to see Richard were made on 24.05.18 and 01.06.18 at Richard and Susan’s home address. Susan would not provide contact details for Richard. Note left with Susan for Richard. Case closed.
29.07.18	Susan admitted to hospital. Discharged home on 06.08.18.
30.10.18	Richard attended at hospital due to injury at home.
26.11.18	Richard contacted 111 for an emergency dentist. Advice given.
04.12.18	Respiratory Nurse undertook unannounced home visit to see Richard.
Dec 18	Richard found unresponsive at home. Ambulance attended. Richard pronounced dead. Police attended and responded to death as a sudden death.

TAMESIDE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Following Home Office QA Process

Into the death of

'Richard'

Chair: David Hunter

Author: Carol Ellwood

Date: Re-submission 14 September 2023

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CONTENTS

SECTION	PAGE
1. The Review Process	3
2. Contributors to the Review	5
3. The Review Panel Members	6
4. Chair and Author of the Overview Report	8
5. Terms of Reference for the Review	9
6. Summary Chronology	11
7. Key issues arising from the review	14
8. Learning Identified	15
9. Recommendations	18

1. THE REVIEW PROCESS

1.1 This executive summary outlines the process taken by Tameside Community Safety Partnership following the death of Richard. It includes Richard's story, the views of his family and ends with learning and recommendations.

1.2 The following pseudonyms have been used within the report.

Name	Relationship	Age	Ethnicity
Richard	Husband of Susan	59	White British male
Susan	Wife of Richard	50	Black Caribbean female

1.3 Richard was the husband of Susan. Richard died at his home address in December 2018. Initially the death was treated as non-suspicious but following an intervention by a family member, Great Manchester Police alerted HM Coroner who authorised a Home Office post mortem.

1.4 Greater Manchester Police undertook a criminal investigation into the circumstances of Richard's death. In May 2019, Susan was arrested and released without charge while further investigations took place. In December 2019, Greater Manchester Police, having consulted the Crown Prosecution Service, decided there was insufficient evidence for a realistic prospect of conviction for gross negligence manslaughter. Susan was informed.

1.5 The panel considered the outcome of the criminal investigation and determined that the Domestic Homicide Review criteria had still been met. Richard's death did not result from violence or abuse nor from the criminal standard for gross negligence. Nevertheless, it appeared to the panel that there had been some level of neglect within the relationship and learning was very likely to be identified from the death.

1.6 Tameside Community Safety Partnership and the Domestic Homicide Review panel offer their sincere condolences to Richard's family and friends.

1.7 The family did not wish to provide a tribute for the report.

1.8 In February 2020 HM Coroner held an inquest and determined the cause of death was due to –

1a – Multiple Drug toxicity (Principally fentanyl)

2 - Chronic Obstructive Pulmonary Disease (COPD)

The Coroner recorded - 'Richard' died at his home on (redacted) as a consequence of multiple drug toxicity (mainly fentanyl). His death is likely to have resulted principally from the administration of fentanyl patches in excess of the prescribed dose'. The conclusion of the Coroner was that Richard's death was drug related.

2. CONTRIBUTORS TO THE REVIEW

2.1 The following agencies provided information to the review.

Department for Work and Pensions	East Lancashire Hospital Trust
GP Services	Greater Manchester Police
Jigsaw Support (Bridges) ⁴²	North West Ambulance Service (NWAS)
Pennine Care NHS Foundation Trust	Tameside Adult Social Care
Tameside Children's Social Care	Tameside and Glossop Integrated NHS Foundation Trust
Victim Support	

2.2 The author had contact with Richard's family as part of the review and their contribution is incorporated within the report. Susan was invited to contribute to the review. To date there has been no contact from Susan.

⁴² 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.

3. THE REVIEW PANEL MEMBERS

Name	Job Title	Organisation
Suzanne Antrobus	Solicitor	Tameside Metropolitan Brough Council
Richard Cartwright	Operational Manager	Jigsaw Support
Hazel Chamberlain	Deputy Designated Nurse Safeguarding	Health – GP Services
Mags Deakin	Trust Lead for Domestic Abuse	Tameside and Glossop Integrated Care NHS Foundation Trust
Carol Ellwood	Panel Author	Independent
Zylla Graham	Detective Inspector	Greater Manchester Police
John Gregory	Head of Community Safety & Homelessness	Tameside Metropolitan Borough Council
Laura Heywood	Team Leader	Victim Support
Susan Holden	Named Nurse for Safeguarding Children,	Tameside and Glossop Integrated Care Foundation Trust
Charlie Hoszowskyj	Service Support Business Partner	Tameside Metropolitan Borough Council
David Hunter	Panel Chair	Independent
Tracy Hurst	Designated Nurse Adult Safeguarding	Tameside & Glossop CCG
Ged McManus	Support to Panel Chair and Author	Independent
Lynette Morgan	Complex safeguarding Service Unit Manager	Tameside Children’s Social Care
Mark Whitehead	Head of Services, Operation Services	Tameside Adult Social Care
Jane Whittaker	Safeguarding Practitioner	North West Ambulance Service
Haley Wilkinson	Keyworker	Jigsaw Homes
Wendy Yuille	Safeguarding Specialist Nurse (Children & Adults)	Pennine Care NHS Foundation Trust

- 3.1 The Chair of Tameside Community Safety Partnership was satisfied that the Panel Chair was independent. The Panel Chair believed there was sufficient independence and expertise on the Panel to prepare an unbiased report.
- 3.2 The panel met four times and the Panel Chair was satisfied that the members were objective and did not have any operational or management involvement with the events under scrutiny. There were no reported conflicts of interest.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

- 4.1 On 18 July 2019 Tameside Community Safety Partnership determined the criteria for a Domestic Homicide Review had been met, and thereafter appointed David Hunter as the Independent Chair and Carol Ellwood as the Independent Author, both of whom are independent practitioners.
- 4.2 David is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service. He did not serve in Greater Manchester Police.
- 4.3 Carol retired from thirty years public service British policing (but not Greater Manchester Police) 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 Carol Ellwood was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. Carol is also an Associate Trainer for Safelives⁴³.

⁴³ <http://www.safelives.org.uk/> The UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

5. TERMS OF REFERENCE FOR THE REVIEW

The review covers the period 8 May 2015, [which was the date of the incident in Turkey], until the date of Richard's death in December 2018.

5.1 The purpose of a DHR is to:⁴⁴

- a] 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;
- b] 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;
- c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d] 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;
- e] Contribute to a better understanding of the nature of domestic violence and abuse; and
- f] Highlight good practice.

SPECIFIC TERMS

1. What indicators of domestic abuse did your agency have that could have identified Richard as a victim of domestic abuse and what was the response?
2. What knowledge did your agency have that indicated Susan might be a perpetrator of domestic abuse against Richard and what was the response? Did that knowledge identify and controlling or coercive behaviour by Susan?

⁴⁴ Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

3. What consideration did your agency give to child safeguarding during any domestic abuse interaction it had with Richard and/or Susan?
4. What consideration did your agency give as to whether Richard was an adult in need of care and support and if so, who did you refer his needs to?
5. What services or signposting or assessments did your agency provide for, or offer to, Richard and were they accessible, appropriate and sympathetic to his needs and were there any barriers in your agency that might have stopped Richard from seeking help for the domestic abuse?
6. What knowledge or concerns did Richard's family and or friends have about his victimisation 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 Richard and/or Susan? This includes Richard's complex medical needs.
8. Were there issues in relation to capacity or resources in your agency that effected its ability to provide services to Richard and/or Susan, 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?

6. SUMMARY CHRONOLOGY

6.1 Richard

6.1.1 Richard was one of three children and the Father to three children, from a previous marriage. The youngest of Richard's children died in 2003, and following that death, Richard's granddaughter spent a considerable amount of time living with Richard.

6.1.2 Richard retired from work in his 30's due to ill health. Prior to then Richard had owned a café, where he worked alongside his Mother. Richard later worked as a taxi driver in the local area. Richard's family described him as being a good hearted and wise person, who was younger in his outgoing than his actual age.

6.2 Susan

6.2.1 Not a lot is known about Susan. Susan did not respond to an invitation to contribute to the review. Information in relation to Susan was obtained from agencies contact and information provided to the Police following Richard's death.

6.2.2 Susan is believed to have been born in the UK. Her ethnicity is black Caribbean, and English is recorded as her first language. Richard's family described Susan as a volatile and erratic woman, who was unpredictable in her behaviour, often shouting and swearing at family members. Susan has several convictions and previous incidents of domestic abuse that are relevant for this review.

6.3 Richard and Susan's Relationship

6.3.1 Richard and Susan started their relationship in October 2014. Susan had informed Richard that she was a nurse and had worked in various hospital departments. Richard stated that Susan did a good job caring for him.

6.3.2 Three months after they met, Richard and Susan got engaged. They married in April 2015, and then went on honeymoon to Turkey. During the honeymoon Susan assaulted Richard, upon return to England, Susan was arrested on suspicion of the attempted murder of Richard. Susan was released on bail; the case was referred to MARAC and Richard initially moved out of the area.

- 6.3.3 After a few months, Richard and Susan resumed their relationship and then moved out of the area for 15 months. Three months after the couple returned to Tameside, the Police attended a domestic incident between Richard and Susan. Susan was arrested and charged with an assault on Richard. The case was later discontinued.
- 6.3.4 In May 2018, Police attended a domestic incident between Richard and Susan. Richard informed the Police the relationship was over, and he was fearful that once they left Susan may harm him. Richard left the property with the Police and the case was referred for professionals to contact Richard. Attempts at contact were unsuccessful and the case was closed. There were no further incidents reported to professionals prior to Richard's death.
- 6.3.5 Family members reported concerns to the Police of Susan isolating Richard from his family and his dependency on Susan for his medical care. They also expressed fears for his safety. The review were informed that Richard had wanted to end his relationship with Susan but he feared for his safety and had thought it was better to stay with Susan, as she cared for him with his long term medical conditions.

6.4 Information known to Statutory Agencies

- 6.4.1 Susan had been involved in domestic abuse in previous relationships. Susan has 6 convictions recorded on the Police National Computer (PNC), which include an unprovoked assault on a female in 1995 and in 1998. An assault against a male whom she grabbed around the neck causing deep scratches, and an assault against a female whom she dragged to the ground, breaking, and dislocating her fingers.
- 6.4.2 The first incident of domestic abuse between Richard and Susan known to agencies occurred whilst the couple were on honeymoon in Turkey. Susan was arrested and released with bail conditions. The case was referred to MARAC, by which time Richard had moved out of the area. A MARAC transfer was not completed. Susan breached her bail conditions on two occasions, these incidents were not referred back into MARAC. There had been no contact with Richard and the IDVA closed the case.
- 6.4.3 At the end of July, the Police transferred the investigation back to the Turkish authorities via Interpol and closed the investigation. Turkish Police did not pursue the investigation. The Police took no action in relation to the breach of bail offences.

- 6.4.4 Between November 2015 and February 2017, Richard and Susan lived outside of the Tameside area. This move was not known to some agencies within Tameside. In January 2016, Blackpool Clinical Commissioning Group (CCG) received a letter from Richard's previous mental health provider which contained details of the MARAC referral from June 2015. This was the first notification that Blackpool CCG had of the MARAC.
- 6.4.5 In May 2017, Susan assaulted Richard and was arrested and charged with an offence of assault. The case was later discontinued. A year later the Police attended another incident of domestic abuse. Susan was the perpetrator. Richard left their home and moved into a hotel. Attempts were made to see Richard by Police and an IDVA, these were unsuccessful, a message was left with Susan for Richard to make contact and the case was closed. Richard did not contact any agency.
- 6.4.6 In December 2018, Richard was found deceased at home.

7. KEY ISSUES ARISING FROM THE REVIEW

- 7.1 Susan had a history of violence, including as a perpetrator of domestic abuse, prior to her relationship with Richard. The review found no evidence that Richard was aware of Susan's violence in her previous relationships. There were opportunities during the timescales of the review for agencies to consider additional safeguarding measures such as utilising DVDS⁴⁵ and DVPN⁴⁶ procedures.
- 7.2 Incidents of domestic abuse between Richard and Susan were treated in isolation and research of historical information was not undertaken to inform risk assessments. Richard's disability and reliance on Susan as a carer meant that he would have been at a higher risk of being a victim of domestic abuse. This was not considered by agencies as part of their risk assessment.
- 7.3 Some agencies were not aware that the case had been heard at MARAC, and that Richard was a victim of domestic abuse. When Richard moved out of the area, the MARAC was not transferred and there was no information sharing of the case with support agencies in the area that Richard had moved to.
- 7.4 Richard's case was not referred back to MARAC when Susan breached her bail conditions, nor was she arrested for the breach of bail offence. When Susan and Richard moved out of the Tameside area the history of the domestic abuse in their relationship did not routinely move with them, and there was a delay in agencies receiving this information.
- 7.5 Domestic abuse programmes for victims were predominantly aimed towards females, with the content being that of female victims and male perpetrators.

⁴⁵ Domestic Violence Disclosure Scheme:

<https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet#:~:text=1.->

,What%20are%20we%20going%20to%20do%3F,previous%20abusive%20or%20violent%20offending.

⁴⁶ Domestic Violence Prevention Notice:

<https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010>

- 7.6 Awareness of how to report concerns and access to help and guidance for family members was identified as an area of learning within the review, including accessibility for all members of society.
- 7.7 The panel recognised the death of Richard met the criteria for conducting a Domestic Homicide Review. The panel acknowledged the result of the criminal investigation and the outcome of the inquest during the review. The panel has identified learning and made local recommendations to address the learning in this report.

8. LEARNING IDENTIFIED

- 8.1 The DHR panel identified the following learning. Each point is preceded by a narrative which seeks to set the context within which the learning sits. Where learning leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
It is important that professionals have a wide understanding of the circumstances and situations that can be defined as a disability. In recognising this, then professionals must ensure through engagement they understand the impact that this disability has on the individual and work with them to ensure that their needs are being met. Professionals must also take cognizance of those who are caring for a person with a disability and understand the options available to them as a professional to be able to refer the person into services for an assessment that their needs in this role are being achieved.
Learning
Gathering information on a person’s individual circumstances, home environment, care needs and how these are being met will ensure that, where appropriate, referrals are made, and assessments are undertaken to identify support and access to support services.

Learning 2 [Panel recommendation 2 and 3]
Narrative
MARAC provides agencies with a platform in which to share information, refer cases of concern, and work collectively to ensure the needs of a victim are being addressed. The partnership working of a MARAC provides a platform for agencies to work together to ensure a victim is aware of the support and options that are available to them in managing

the risk. Information sharing within the MARAC provides agencies with the level of knowledge and information to be vigilant and proactive during contact with clients.

Learning

Agencies working in the field of safeguarding should have an understanding of the MARAC including the process of sharing information and transferring of cases due to geographical location victim.

Learning 3 [Panel recommendation 4]

Narrative

Risk assessment is a dynamic process and in order to fully understand a current risk to a victim of domestic abuse, professionals must take account of current and previous risk factors to ensure that the risk assessment is an accurate reflection based on evidence from current and previous incidents. In considering historical information it allows professionals to consider undertaking other safeguarding measures that will provide the victim with information [For example: Domestic Violence Disclosure Scheme] to help them understand risks by remaining in the relationship.

Learning

By undertaking a holistic view of a case it allows professionals to consider emerging and historical factors to reach an informed decision on the current risk factors to an individual and consider safeguarding measures that can be undertaken on the case, including the disclosure of information to victims on the risks that have been identified.

Learning 4 [Panel recommendation 5]

Narrative

Victims, families and friends utilise a range of methods to obtain information on domestic abuse services. The challenge for agencies is to ensure that their information is up to date, relevant and available through a range of methods of communication, including accessibility for those in 'hard to reach' communities or where social media and web based methods are not their preferred mode of seeking help and support.

Learning

Information on domestic abuse including how to report concerns and access to support services must be available for all members of the community, in a format that is easy for them to access and understand.

Learning 5 [Panel recommendation 6]
Narrative
It is known that male victims are less likely to report domestic abuse and seek support than female victims. When male victims do report abuse, it tends to be at a crisis point in their relationship. Ensuring services are available for all genders is a vital part in victims being able to access help and support at an earlier stage and allows professionals to engage with victims to help them understand and manage any known risks in their relationship.
Learning
Agencies working with victims of domestic abuse must ensure that their services are accessible by all genders of abuse.

Learning 6 [Panel recommendation 7]
Narrative
Professionals can experience difficulties when attempting to contact victims to provide support and services in relation to domestic abuse. Where contact has not been achieved, professionals must record what attempts have been made at contact, including what methods of contact have been made.
Learning
Professionals must be aware that seeking to arrange contact with a victim via a perpetrator can lead to an increase in the risk to that victim, and is not an appropriate method of communication.

8.2 Agencies Learning

8.2.1 East Lancashire Hospital Trust

- Circulation of policy on risk assessment completion when domestic abuse disclosed

Greater Manchester Police

- Identification, understanding and classification of risk
- Training of staff within triage function

Health – GP Services

- Training for GP's on domestic abuse

- Ability to challenge patients
- Information sharing and health role in MARAC

Jigsaw Support (Bridges)

- Reflective learning
- Record keeping

Pennine Care NHS Foundation Trust

- Record keeping

Tameside and Glossop Integrated NHS Foundation Trust

- Review of patients alerts
- 'Safe Routine Enquiry' training
- Disclosures of sexual violence to be embedded in domestic abuse training

9. RECOMMENDATIONS

9.1 Panel Recommendations

Number	Recommendation
1	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that practitioners are identifying during contact with individuals, those who are eligible for additional support and needs and completing assessments and referrals to ensure those needs are met.
2	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that professionals understand and comply with the MARAC processes.
3	That Tameside Community Safety Partnership seeks assurances from the Clinical Commissioning Group ⁴⁷ that the information sharing protocol and link to MARAC is embedded within the GP service.
4	That Tameside Community Safety Partnership seek assurances from its constituent agencies that they take account of historical and emerging factors when undertaking risk assessments with victims of domestic abuse and that these assessments are used to implement safeguarding processes, including the disclosure of information to the victim in accordance with legislation.
5	That Tameside Community Safety Partnership ensures that information on domestic abuse is available for all members of the community and in a format that is easy for them to access and understand.
6	That Tameside Community Partnership seeks assurances from its constituent agencies that their service is accessible to all victims of domestic abuse whatever their gender.
7	That the learning from this review is shared with STRIVE co-ordinators for dissemination within the project. ⁴⁸

9.2 Agencies Recommendations

Greater Manchester Police

⁴⁷ The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

⁴⁸ STRIVE is no longer in existence. Instead, Tameside will share the learning with GMP.

- 9.2.1 The Force Lead for Safeguarding reviews current guidance and training for MASH/EHASH teams in order to ensure that only specialist officers are deployed on Triage Desks.
- 9.2.2 Chief Supt. Covering Ashton to review current deployment of triage officers.
- 9.2.3 The Force Lead for Safeguarding reviews current training of front line services into the identification and classification of risk at domestic incidents.

Health – GP Services

- 9.2.4 There is a need for GPs in Tameside to receive domestic abuse training which incorporates possible indicators of domestic abuse and resources available so that the GP is able refer and support patients affected by domestic abuse.
- 9.2.5 Processes need to be implemented to facilitate the GP to enable challenge when working with patients with complex needs.
- 9.2.6 A review of the information sharing protocol for health and MARAC needs to be implemented.

Jigsaw Support (Bridges)

- 9.2.7 Best practice case management framework guidance to be produced for consistency across workings of Bridges staff.

Tameside and Glossop NHS Foundation Trust

- 9.2.8 Review of patient alerts on Lorenzo and possibility of incorporating automatic prompt on screen which cannot be bypassed.
- 19.2.9 Targeted "Safe Routine Enquiry" training in A&E and Out Patients department to increase compliance levels and staff awareness and confidence.
- 9.2.10 Management of disclosures of sexual violence to be embedded in ICFT (Integrated Care Foundation Trust) domestic abuse training.

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.

Annex A
Tameside Community Safety Partnership
Action Plan
'Richard' Domestic Homicide Review

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
1	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that practitioners are identifying during contact with individuals, those who are eligible for additional support and needs and completing assessments and referrals to ensure those needs are met.	Local	<ol style="list-style-type: none"> 1. Multi-agency briefing sessions to be delivered on care and support needs 2. Agencies to re-view their internal assessment processes to ensure that care and support needs are being considered 3. Agencies to provide written assurance to the CSP that actions 	CSP	<ol style="list-style-type: none"> 1. Agencies reviewing internal assessment processes and assurances to be provided to CSP once complete. 2. Multi Agency Safeguarding Adult Training available via Tameside Safeguarding Adults Partnership Board 	March 2024	

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			have been completed as agreed.				
2	That Tameside Community Safety Partnership seeks assurances from its constituent agencies that professionals understand and comply with the MARAC processes.	Local	<ol style="list-style-type: none"> 1. Undertake a review of MARAC in Tameside 2. Deliver training to multi-agency professionals on MARAC 	CSP	<ol style="list-style-type: none"> 1. A review of MARAC locally and across GM is underway and regular updates are provided to Tameside DA Steering Group 2. A local MARAC audit has been completed and the findings presented to the Domestic Abuse Steering Group. A MARAC task and finish group is in place to oversee a local MARAC action plan. 3. Safe Lives' MARAC refresher training has taken place for current MARAC attendees. 	March 2024	

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					4. A local MARAC training session is being developed with the aim to deliver the session 3 times per year to multi-agency partners		
3	That Tameside Community Safety Partnership seeks assurances from the Clinical Commissioning Group ⁴⁹ that the information sharing protocol and link to MARAC is embedded within the GP service.	Local	Work with the new ICB to obtain assurances that the information sharing agreement and MARAC are embedded locally.	CSP	<ol style="list-style-type: none"> 1. IRIS project has been commissioned locally which is a specialist project supporting GPs in relation to domestic abuse. 2. Meeting held with Associate Director of Nursing and Safeguarding for GM ICB to raise the issue of 	March 2024	

⁴⁹ The Clinical Commissioning Group has been superseded by Greater Manchester Integrated Care Partnership [Tameside Locality Board].

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					MARAC and information sharing with GPs. Dedicated workgroup being established to progress across a GM footprint.		
4	That Tameside Community Safety Partnership seek assurances from its constituent agencies that they take account of historical and emerging factors when undertaking risk assessments with victims of domestic abuse and how this information [For example the Domestic Violence Disclosure Scheme] can be used to	Local	Agencies provide written assurance to the CSP along with evidence of risk assessment templates that historical and emerging factors are being captured when undertaking risk assessments. GMP provide data to CSP on the number of Clare’s Law disclosures given	CSP	<ol style="list-style-type: none"> 1. Assurances received from Bridges and CGL. 2. GMP has delivered a social media campaign focusing on Clare’s Law which was supported and shared across Tameside. 3. A 7 minute briefing is being drafted on Clare’s Law to be shared with professionals. 	March 2024	

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	inform safeguarding processes for the victim, including the disclosure of information to the victim in accordance with legislation.		either by right to ask or right to know. Information about Clare's Law to be promoted across professionals and communities.		4. Data on Clare's Law is readily available from GMP within the GM domestic abuse dashboard and will form part of the new Tameside Domestic Abuse dashboard which will be reviewed quarterly by the DA steering group. 5. Briefing on Clare's Law delivered to DA champions network		
5	That Tameside Community Safety Partnership ensures that information on domestic abuse is available for all members of the community and in a	Local	Work with Communications lead to ensure a variety of media is utilised when undertaking campaigns and	CSP	1. A new draft domestic abuse communications strategy has been developed which highlights the variety of channels that will be utilised to support awareness raising	December 2023	Complete. This is an annual strategy and plan that is overseen by the local

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	format that is easy for them to access and understand.		awareness raising activities		<p>campaigns. This includes newspapers, radio etc.</p> <p>2. Targeted campaigns are delivered throughout the year focusing on coercive control, male victims, LGBTQ+ victims and ethnic minoritised communities.</p> <p>3. Tameside has established a domestic abuse champions' network which brings together professional and community champions to support engagement and awareness raising activities across agencies and out in the local communities.</p>		domestic abuse steering group.

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
6	That Tameside Community Partnership seeks assurances from its constituent agencies that their service is accessible to all victims of domestic abuse whatever their gender.	Local	All agencies are asked to confirm that the service is accessible to female, male and non-binary victim/survivors.	CSP	<ol style="list-style-type: none"> 1. Assurances received from Bridges and CGL 2. A new male refuge has been established in Trafford to which Tameside are supporting and are able to refer. 3. Male victims are being identified for the lived experience group to ensure services are developed in line with the needs of victim/survivors 	December 2023	
7	That the learning from this review is shared with STRIVE ⁵⁰ co-ordinators for	Local	<ol style="list-style-type: none"> 1. Learning to be shared with the new Domestic Abuse Inspector 	CSP	<p>Strive has been de-commissioned by GMP.</p> <p>Police to advise when learning from the review</p>	March 2024	

⁵⁰ STRIVE is no longer in existence. Instead, Tameside will share the learning with GMP.

The DHR Panel Recommendations							
No	Recommendation	Scope local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	dissemination within the project.		for Tameside for dissemination to DA officers 2. Learning to be incorporated into the local training for officers that has been developed for new officers		as a whole has been shared with officers.		

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	The Force Lead for Safeguarding reviews current guidance and training for MASH/EHASH teams in order to ensure that only specialist officers are deployed on Triage Desks	Review of training provision and guidance for triage staff.	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 :	Update August 2023: DA Matters training has been delivered to 3814 First Responders 111 Champions across GMP with ongoing training built into student officer training.	GMP Det Ch Supt	January 2021

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
			<ul style="list-style-type: none"> Review of District MASH teams Response to incidents and investigations relating to Domestic Abuse <p>The MASH triage process is to be agreed across GMP. A training / CPD product for MASH staff is being developed by the PPGU with the aim to deliver online training from October 2020.</p>			
2	Chief Supt. Covering Ashton to review current deployment of triage officers	Review current deployment of triage officers whether they have adequate	<p>A review of the staffing within Tameside MASH has been completed.</p> <p>Update 29/05/20</p>	<p>Review completed - Triage staff have adequate training/experience for the role.</p> <p>Update August 2023: DA Matters training has</p>	Det Supt	Completed May 2020

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
		training /experience for the role	<p>DI has recently taken over the MASH at Tameside. DCI – the cluster vulnerability DCI has management</p> <p>The MASH currently has 3 very experienced officers on triage. 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</p>	<p>been delivered to 3814 First Responders 111 Champions across GMP with ongoing training built into student officer training.</p>		

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
			<p>safeguarding Courses.</p> <p>The PPD Governance Team is conducting a Forcewide Review of MASH resourcing and training.</p>			
3	The Force Lead for Safeguarding reviews current training of front line services into the identification and classification of risk at domestic incidents.	Review of training provision of identification and classification of risk of domestic incidents.	PPGU is conducting a full review of all training around DA delivered by the Training School	Update August 2023: DA Matters training has been delivered to 3814 First Responders 111 Champions across GMP with ongoing training built into student officer training.	PPGU	TBC

Health – GP Services						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1.	There is a need for GPs in Tameside to receive domestic abuse training which incorporates	Review of current training being	IRIS commissioned.	GPs receive further training on recognition and response to domestic	All primary Care/Named GP	March 23

Health – GP Services						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
	possible indicators of domestic abuse and resources available so that the GP is able refer and support patients affected by domestic abuse	offered locally to GPs		abuse which is specific to GP practice GP s are confident that they know where and what support is available to patients who are affected by domestic abuse		
2.	Processes need to be implemented to facilitate the GP to enable challenge when working with patients with complex needs.	Share information with GPs re Single point of referral for Adult Safeguarding Concerns. Raise awareness of the Multi-Agency Adult at Risk Model which will be developed into the Tiered Risk	GPs refer Adult Safeguarding via Single point of referral to ASC. GPs take part in Multi Agency Discussions/ meetings. GPs refer people experiencing DA to local services via IRIS processes.	People presenting to GP with complex issues are supported via a Team around the Adult approach and referred timely to specialist support services.	All primary Care/Named GP All Primary Care Designated Nurse Adult Safeguarding /Named GP	March 24

Health – GP Services						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
		Assessment Model				
3.	A review of the information sharing protocol for health and MARAC needs to be implemented	Contact key persons to identify use of protocol Make any amendments required Redistribute to key agencies including TOM and early help and MARAC	Current Review of MARAC Processes in progress. Key person within ICB to support re information sharing protocol.	Confidence that protocol remains a current resource Completion of audit to identify improvements to be made Ensure that key agencies are aware of their role in implementing information sharing protocol.	Named GP/Designated Safeguarding Team ICB	March 24

Jigsaw Support (Bridges)						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1.	Best practice case management framework guidance to be produced	Produce case framework guidance and brief to staff	Reflective learning from the IMR completed by Operational	Case framework and guidance completed and all staff briefed	Operational Manager	Completed November 2022

Jigsaw Support (Bridges)						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
	for consistency across workings of Bridges staff.		Manager at Jigsaw Support identified a need to create a file recording and processes template, to ensure all staff worked to a consistent approach			

Tameside and Glossop NHS Foundation Trust						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	Review of patient alerts on Lorenzo and possibility of incorporating automatic prompt on screen which cannot be bypassed.	Discuss at Integrated Safeguarding Committee – IT leads to be involved.	MARAC alert insitu on Lorenzo for cases heard. Alert automatically closes after 12 months if no repeat.	Implementation of alert prompt. Automatic review of alerts upon admission and any administration episodes.	Named Safeguarding Professionals	Completed June 2020
2	Targeted "Safe Routine Enquiry" training in A&E and Out Patients dept to increase compliance levels and staff	Liaise with local IDVA service for support with delivery.	E-learning available to all ICFT staff with L3 safeguarding requirement.	Minimum 95% compliance with training in high risk areas.	Named Safeguarding Professionals	December 2020

Tameside and Glossop NHS Foundation Trust						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
	awareness and confidence.		Training programme being rolled out for Urgent Care staff in partnership with Bridges Service.	Increased identification of patients/staff and visitors as victims of domestic abuse. Increase in referrals to support services.		
3	Management of disclosures of sexual violence to be embedded in ICFT domestic abuse training.	Review current safeguarding training provided and liaise with sexual violence trained IDVA regarding content.	Domestic abuse training package covering management of disclosures.	Increased staff awareness of current local and national guidance around management of disclosures of sexual violence.	Named Safeguarding Professionals	Completed June 2020

Annex B – letter from Home Office DHR QA Panel



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25th April 2024

Dear Sarah,

Thank you for resubmitting the report (Richard) 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.

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. 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

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