Tameside Community Safety Partnership

Domestic Homicide Review

Victim – Ben, who was unlawfully killed in August 2021

Independent Author – David Mellor BA QPM

Report completed on 12th June 2023

Final amendments following DHR QA Panel feedback on 26 July 2024

1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Ben, a resident of Tameside in Greater Manchester prior his homicide which took place in August 2021 ('Ben' is a pseudonym chosen by the victim's daughter).

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The victim Ben was stabbed to death by his partner's son, who will be referred to as 'Callum', in the home the victim shared with his partner -who will be referred to as 'Jennifer', and her 4 children from previous relationships, including Callum. Callum was 21 at the time of the incident and his 3 younger siblings were aged 13 and under. The incident took place during the early hours of the morning after Ben and Jennifer began arguing after consuming alcohol and Callum, who was in his bedroom, heard the victim and his mother arguing downstairs and, fearing for his mother's safety, armed himself with a combat knife he had purchased earlier and confronted Ben. In the struggle which followed, Callum inflicted the wounds from which Ben died shortly afterwards. Ben was known to the police as a perpetrator of domestic abuse against Jennifer and a previous partner. Callum was arrested and charged. His subsequent plea of 'guilty' to manslaughter on the grounds of self-defence was accepted and he was sentenced to two years and seven months imprisonment.

1.4 On 13th September 2021 representatives of Tameside Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) in respect of the then alleged murder of Ben following a referral from Greater Manchester Police.

1.5 The DHR has considered agency contact/involvement with Ben, Jennifer and her children, including Callum from 1st January 2019 – when an incident in which Ben appeared to assault Jennifer was reported to the police by a third party – and August 2021, when Ben was unlawfully killed. Any significant events which took place prior to this period have also been included.

1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is murdered as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide,

and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

DHR Timescales

1.7 Greater Manchester Police referred the case to Tameside Community Safety Partnership on 6th August 2021 and the partnership decided that the criteria for conducting a DHR had been met on 13th September 2021 and commissioned an independent chair and author. The DHR commenced on 20th October 2021 and was completed on 12th June 2023. Completion of the report was delayed by the need to obtain further information from two agencies. This delay was brought to the attention of the Community. Safety Partnership and dealt with under local governance arrangements.

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. As stated, a pseudonym has been agreed with Bens family and used in the report to protect the identity of the individuals involved. At the time of the unlawful killing, the victim Ben was 47 years old, and the perpetrator Callum was 21. Both the victim and the perpetrator were/are White British.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case the victim leaves his partner, two adult children from a previous relationships and grandchildren. Tameside Community Safety Partnership therefore wishes to express sincere condolences to the family and friends of Ben.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

1. 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;

2. 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;

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

4. 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;

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

6. Highlight good practice.

2.2 The case specific terms of reference are as follows:

a. How effectively were any disclosures by, or indications of domestic abuse to, the victim addressed by the agencies in contact with him?

b. How effectively were the risks to the victim presented by the perpetrator assessed and managed? The perpetrator's acquisition and storage of the weapon with which he unlawfully killed the victim should also be considered.

c. The victim domestically abused the perpetrator's mother on a number of occasions. Did professionals consider the dynamics of the relationship between the victim and the perpetrator's mother and consider whether there was any risk of the perpetrator becoming involved by intervening to protect his mother?

d. Initial information provided to this DHR indicates that no incident of domestic abuse involving the victim and the perpetrator was reported to any agency

prior to the death of the victim. Therefore, any barriers to the victim or the perpetrator accessing support will be explored.

e. How effective was the support offered or provided to the perpetrator in respect of his mental health needs including anxiety and low mood?

f. What support was offered or provided to the perpetrator in respect of education, employment or training?

g. The victim and the perpetrator's mother drank alcohol to excess on occasions which appeared to contribute to verbal arguments between them and also appeared to be a trigger to the victim becoming violent and abusive towards the perpetrator's mother. Were either the victim or the perpetrator's mother referred or signposted to, or offered or provided with support in respect of their use of alcohol?

h. Consider the lived experience of the three children living in the household with the victim, the perpetrator's mother and the perpetrator.

i. How effective was multi-agency working in this case?

j. Did the agencies in contact with the victim, the perpetrator's mother, the perpetrator or the children in the household communicate and share information effectively with each other?

k. Were there any specific considerations around equality and diversity issues in respect of the victim or perpetrator such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

l. Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect the victim, the perpetrator's mother or the perpetrator or impact upon the support provided or offered to them by agencies?

3.0 Methodology

3.1 As stated Tameside Community Safety Partnership decided to commission a DHR on 13th September 2021 following a referral from Greater Manchester Police on 6th August 2021.

3.2 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with the victim, the perpetrator and their children. Several agencies also provided summary IMRs. The authors of the IMRs had the discretion to interview members of staff if this was required.

3.3 The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

Contributors to the DHR

3.4 The following agencies provided Individual Management Reviews to inform the review:

- Greater Manchester Police
- NHS Tameside and Glossop Clinical Commissioning Group (Greater Manchester Integrated Care Board (Tameside) since 1.7.2022) on behalf of the family's GP practice.
- Pennine Care NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust

The following agencies provided summary Individual Management Reviews to inform the review:

- Tameside, Oldham and Glossop MIND.

Additionally, the National probation Service shared relevant extracts from the pre-sentence report they completed in respect of the perpetrator.

3.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

3.6 The victim Ben's partner Jennifer and his daughter were advised that the DHR had been commissioned and invited to contribute to the DHR once criminal proceedings had been completed. Ben's daughter received support from a Victim Support Homicide Service worker. Jennifer was not referred to the Victim Support Homicide Service for which the consent of the person is required. Jennifer decided not to contribute to the DHR. Ben's daughter contributed to the DHR. She was offered the opportunity to meet the DHR Panel but said that she did not wish to do this. She decided not to read and comment on the DHR report although she has asked to be provided with a copy of the report once published. A close friend of Ben has also contributed to the DHR. The perpetrator Callum was invited to contribute to the DHR – which he did.

The DHR Panel Members

3.7 The DHR Panel consisted of:

Name	**Organisation**
Suzanne Antrobus	Head of Legal services, Tameside MBC
Emma Booth	Business Support Officer, Tameside MBC
Suzanne Fawcett	Detective Constable GMP Serious Case Review Unit
Luke Godfrey	Operations Manager, Victim Support
John Gregory	Head of Community Safety and Homelessness, Tameside MBC
Danielle Henniker	Deputy Services Manager, My Recovery drug and alcohol service provided by Change Grow Live
Karen Holden	Head of Nursing for Integrated Safeguarding, Tameside and Glossop Integrated Care NHS Foundation Trust.
Caroline Home	Independent Domestic Violence Advocate
Tracey Hurst	Designated Nurse Adult Safeguarding, Greater Manchester Integrated Care (Tameside).
Anna Jenkins	Principal Social Worker (Adults), Safeguarding, Quality and Practice Team
Darren Lawton-Edge	Named Professional Safeguarding Adults, Pennine Care NHS Foundation Trust
David Mellor	Independent Chair and Author
Vanessa Rothwell	Partnership Manager, Tameside MBC
Faith Scott	Senior Probation Officer, National Probation Service
Dave Smith	Partnership Manager, Tameside MBC
Anna Svarc	Designated Nurse, Greater Manchester Integrated Care Board

3.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions: on 20th October 2021, 17th May 2022, 14th September 2022 and 17th November 2022.

Author of the overview report

3.8 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has ten years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

3.9 The independent chair and author was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

3.10 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

3.11 Whilst a member of Greater Manchester Police he served in Tameside from 1990 until 1992 but has no current connection to services in Tameside.

Parallel reviews

3.12 No inquest is to be held in respect of Ben's death.

Equality and diversity

3.13 The protected characteristic of sex may have been a factor relevant to the victim Ben. Domestic abuse research has found the difference between men and women to be stark, with men significantly more likely to be repeat perpetrators and men significantly more likely than women to use physical violence, threats and harassment (1). As a male who was known to have abused female partners - including Jennifer - previously, the possibility that Ben may be at risk of domestic abuse could be overlooked by professionals. Ben's daughter has advised the DHR that Ben was the victim of controlling behaviour from Jennifer and that her position

as the tenant of the property they shared was a factor in her controlling behaviour. Ben did not share any concerns about his relationship with Jennifer with any professional.

3.14 Ben's dyslexia is a disability which is covered by the Equality Act 2010. During the period under review dyslexia may have been a factor which limited Ben's ability to find work although employers have a legal responsibility to make reasonable adjustments. There is no specific indication that Ben's dyslexia led to him being discriminated against. However, if it was a barrier to employment, dyslexia may have limited Ben's opportunities to gain greater financial independence and obtain a tenancy which could have reduced his dependence on Jennifer.

3.15 The protected characteristic of sex may have applied to Callum as he perceived himself to be his mother's protector and so this perception may have been a factor in his purchase of the combat knife and in the commission of the homicide which took place when he intervened in order to protect her from harm from Ben. It is possible to perceive Callum and Ben as two males who were, to a degree, in competition for the attention/approval of Jennifer.

3.16 The protected characteristic of age may have been a factor relevant to the perpetrator Callum. He has advised the DHR that because of abuse from Jennifer's previous partner and conflict between himself and Ben during Callum's teenage years he had largely secluded himself by spending the majority of time in his bedroom. Whilst there may have been other factors which affected his decision to seclude himself including the effects of a relationship breakdown and generally feeling 'stuck' in his life, as a child and later as a young person who tended to internalise his concerns, he was in a relatively powerless position to obtain sufficient financial independence to leave the family home.

Dissemination

In additional to the DHR Panel members, the report will also be sent to:

Name	**Organisation**
Kate Green	Police & Crime Commissioner - Greater Manchester Combined Authority
Nicole Jacobs	Domestic Abuse Commissioner for England & Wales
All members	Tameside Community Safety Partnership
All members	Tameside Domestic Abuse Steering Group
All members	Tameside Safeguarding Children Partnership
All members	Tameside Adult Safeguarding Board

4.0 Involvement of the family of the victim Ben

4.1 The victim Ben's partner Jennifer and Ben's daughter were advised that the DHR had been commissioned and invited to contribute to the DHR once criminal proceedings had been completed. When the DHR report was considered by the Home Office Quality Assurance Panel, they advised that the involvement of friends or colleagues of Ben would be helpful to provide a 'better sense of him'. Ben's daughter was re-contacted, and she provided the contact details of a close friend of her father who agreed to contribute to the DHR.

4.2 When Jennifer was contacted by the independent author, she said that she was suffering with anxiety and depression and felt that contributing to the DHR in any way 'would bring it all back up' and so she therefore did not wish to contribute to the DHR or read and comment on the DHR report. Her wishes have been respected.

4.3 Ben's daughter decided to contribute to the DHR, which she said she would prefer to do via a telephone conversation with the independent author. She was offered the opportunity to meet the DHR Panel but said that she did not wish to do this. She decided not to read and comment on the DHR report although she has asked to be provided with a copy of the report once published. She described her father as a lovely man who was very affectionate and loved his families. She went on to say that he cared for her 'so much' and had been very proud of her for being in work in a good job. She said that Ben was a 'chatterbox' who enjoyed going out to the pub and being with people, although she said he had become more reserved with age. She said that he 'wasn't perfect' as a younger man but he had grown up, matured and become a better person. She added that Ben's mother had died the year before his death and although they had not had a particularly close relationship, his daughter felt that the death of his mother had had quite a profound effect on Ben and helped him to realise that 'life is short'. Ben's daughter said that she really missed her father.

4.4 Ben's daughter said that she maintained regular contact with her father, and that she would always ring him when she was on the way home from visiting a close friend. She added that she rang her father on the evening he died and could hear Jennifer in the background. She said that they were 'bickering' about the impending birthday of one of Jennifer's children which clashed with a date on which Ben wanted to visit a friend.

4.5 Ben's daughter said that her father was not in employment at the time of his death. She said that she recalled him working in a mill performing manual work loading and unloading. She said that his employment was recorded on her birth certificate as 'painter and decorator'. She added that he was dyslexic.

4.6 Ben's daughter said that her father and Jennifer were in a relationship for just under six years and that she felt that whilst they had loved each other initially, this had 'faded' over time. She said that her father loved Jennifer's three younger children and would pick them up from school after Jennifer found employment. She added that they would 'bicker' over the children because her father felt that Jennifer would give the children 'whatever they wanted' and Ben disagreed with this. Ben's daughter said that she was aware that her father and Callum were not 'fans' of each other, adding that Callum spent all his time in his room playing video games. In this context she added that her father was not a confrontational person, implying that despite their uneasy relationship, they tolerated each other.

4.7 Ben's daughter went on to say that Jennifer's relationship with Ben became quite controlling in that when Ben was not with her, she would message him 'every ten minutes' to ask him when he would be getting home. She gave an example of an evening when Ben met his daughter and her friend just prior to the first Covid-19 lockdown when she recalled Jennifer messaging her father 'all the time'. Ben's daughter felt that Jennifer also 'goaded' Ben and bullied him. She said that Ben had got nowhere else to go, and as the tenant of the address she shared with four of her children, this gave Jennifer the 'upper hand' in her relationship with Ben. His daughter added that Ben had not had a permanent address for some time prior to his relationship with Jennifer beginning and had been 'sofa surfing' prior to moving in with her. If he left Jennifer, his options would be limited to returning to 'sofa surfing' or rough sleeping. She added that her father had spent a night on the streets in the past. She went on to say that Ben's family had been encouraging him to leave Jennifer's home and go and stay with his best friend as they felt that it was not good for him to stay where he was, but she felt that her father was reluctant to 'put people out'. Ben's daughter said that she imagined that Jennifer's house 'became a pressure cooker' during the Covid-19 lockdowns.

4.8 Ben's daughter was aware of one of the incidents involving Ben and Jennifer in which the police became involved. She said that her father had been arrested by the police following the 'New Year's Eve' incident – assumed to be the incident reported to the police on 1st January 2019 (Paragraphs 5.9 and 5.10) – despite his daughter's understanding that it was Jennifer who had assaulted her father on this occasion. Ben's daughter went on to add that Jennifer later rang the police to ask them to release Ben, saying that she had hit him. She felt that the police had arrested her father rather than Jennifer, because of a tendency to assume the woman is the victim in a situation in which there is violence between a man and a woman. It should be noted that Ben also told the police that Jennifer had hit him and that he retaliated and then pushed her which caused her to fall due to her level of intoxication. However, the member of the public who reported the incident to the

police stated that the male was hitting the female who was on the floor. This suggests that the daughter's account of her father's relationship with Jennifer is partly based on what Ben told his daughter, which may, or may not, have been an entirely truthful account.

4.9 Turning to her father's relationship with alcohol, his daughter said that Ben was 'not really a boozer' as he couldn't afford to drink to excess because he didn't have the money. She said that earlier in his life, her father had drunk too much and had not been a nice person when intoxicated. She felt that over time he had matured and had limited his drinking to social drinking at the weekends or drinking cans of beer at home. However, she acknowledged that he could still drink 'quite a lot' on occasions although she didn't feel that her father had been in need of any support or advice in respect of his alcohol consumption.

4.10 Ben's daughter did not feel that justice was done during Callum's trial. She felt that the trial was very one-sided and that her father had been 'painted in a really bad light'. She felt that there was too much emphasis on her father's police record, adding that he was 48 when he was killed and so over the years he had done more 'stupid shit', whereas Callum, as a very young man, had not had anywhere near as much time to accumulate a criminal record. She strongly felt that Callum's actions in bringing the knife downstairs concealed in his shorts demonstrated his intent to attack Ben, adding that she found it 'mind-blowing' that the Court had concluded that Callum had acted in defence of his mother. Ben's daughter was also angry that Jennifer had been seen in a 'good light' by the Court despite the fact that she had washed and hidden the knife Callum used to kill her father. Ben's daughter added that Callum would be out of prison soon and she had 'no idea' where he was going to be living. The National Probation Service (NPS) has advised the DHR that Ben's daughter receives regular updates in respect of key dates in Callum's sentence and there is a condition attached to his licence following his release from prison which prevents him contacting her.

4.11 Reflecting on her father's death, his daughter felt Ben had been in a 'bad relationship' and that he would have been 'better off out of it'. However, she didn't feel that his death could have been prevented, adding that she never felt that her father was in any danger at any time.

4.12 Ben's close friend spoke to the independent author by phone. Ben's friend's partner, who is Jennifer's sister was also present and could on occasion be heard in the background making comments to her partner. Ben's friend's partner and her sister Jennifer appear to be estranged and the animus Ben's friend and his partner felt for Jennifer was apparent.

4.13 Ben's close friend said that he had known him for 30 years and described him as a lovely bloke who could be gullible and as a gentle giant who had 'some domestic stuff put on him'. Ben's friend said that he would never try and portray Ben as a 'saint', that he could be 'a bit of a prat' and was 'not the smartest' in that he would sometimes say things which 'he shouldn't say' and that 'his gob would run away'. Ben's friend added that Ben was never a violent person.

4.14 Ben's friend said that Ben had been assaulted more than once by Jennifer and that Jennifer had admitted assaulting Ben to him (the friend) and his partner. Ben's friend and his partner described Jennifer as a 'nasty drunk' who became 'malicious with her mouth' after consuming alcohol. He said that both Ben and Jennifer drank alcohol and that they had many verbal arguments. He said that Jennifer instigated arguments and then Ben would 'flip'. Ben's friend said that when Jennifer reported incidents involving Ben to the Police, the Police 'took her word' for what had happened. He said that in one of the incidents reported to the Police, Ben had actually stopped the fight but then Jennifer phoned the Police and had him removed from her property. Ben's friend said that the amount of times Jennifer 'threw Ben out' of her home was 'unbelievable'.

4.15 Ben's friend described Ben's relationship with Jennifer as 'toxic' and said that he told Ben that one day he was 'going to end up dead'. He said that he and his partner were worried about Ben and felt that he had become 'quite unhappy' in his relationship with Jennifer. Ben's friend said that he encouraged Ben to leave Jennifer, but he had nowhere else to go as his friend understood Ben to have accumulated rent arrears in the social housing sector and couldn't afford to rent privately. Ben's friend said that he and his partner had offered to let Ben stay with them, but he said that Ben was worried about imposing on them, given that there was not a lot of space in their property. However, he said that Ben did use his (the close friend's) address for all his correspondence, which is how Ben's friend became aware that Ben had accumulated quite a large amount of debt as bailiffs attended the friend's address to enforce debt repayments against Ben on more than one occasion. Ben's friend added that Jennifer wouldn't let Ben register as living in her property as he said that she would lose her benefits. Ben's friend said that he and his partner had been planning to move to Wales and that Ben had agreed to go with them. Ben was killed before this move to Wales took place.

4.16 Ben's friend described Ben's relationship with Jennifer's children as 'not great' although he felt that Ben got on with Jennifer's younger 2 children better than he did with the older two, including Callum, who he said Ben regarded as a 'bum' who was 'sponging' off Jennifer and Ben. The friend added that Callum never left his room. He said that he was aware that Ben and Callum had 'exchanged words' but he said that there had been no violence between them until the night he was killed.

4.17 Ben's friend said that he found the outcome of Callum's trial 'baffling' as Callum had stabbed Ben in the back more than once. He also felt that Jennifer had 'got away with everything' and had faced no consequences for cleaning and hiding the knife with which Callum killed Ben. He said that on the night that Ben was killed, he (Ben's friend) and his partner and Jennifer had been out playing bingo and that she (Jennifer) was 'already drunk' and in a bad mood when they parted company that night and she returned home to Ben who he said was 'babysitting' the children. Both the friend and his partner blamed Jennifer for Ben's death and said that they suspected that it was Jennifer who had stabbed Ben* because they felt that Jennifer was more capable of violence than Callum and that Callum had admitted to killing Ben to cover for Jennifer. However, Ben's friend said that the last time Ben and Jennifer 'had a big fight' prior to the incident, Callum 'broke it up'. The friend added that Michelle had been assaulting Ben during this earlier 'big fight'.

*Callum was charged with murdering Ben and later pleaded guilty to the manslaughter of Ben. Jennifer was not charged with or convicted of any offence relating to the death of Ben.

4.18 Ben's friend said that during the Court proceedings Ben was portrayed as a 'wife beater' which the friend said 'he never was'.

Involvement of the perpetrator

4.19 The independent author wrote to the perpetrator Callum via his prison offender manager to ask him if he wished to contribute to the DHR. The perpetrator replied that he wished to do so, and a preference was expressed for an in-person meeting, which has taken place.

4.20 He said that his mother and Ben were together for 5 years and argued from the start of their relationship. He said that Ben never 'got along' with himself and his younger siblings and in particular, treated his two of his younger siblings 'like crap' and 'hated' Callum. As a result, Callum said that he stayed away from Ben and kept to himself when he was in the house.

4.21 When asked why he thought Ben hated him, Callum said that Ben 'despised' that his mother and father remained on good terms and communicated regularly. Callum felt that Ben didn't like the idea of Jennifer communicating with Callum's father. Callum felt that Ben's annoyance at Jennifer communicating with Callum's father was projected onto him (Callum). Callum added that Ben was 'different behind closed doors', explaining that he came across as 'decent' when interacting

with others but as soon as he got back to Jennifer's house, his behaviour changed for the worse.

4.22 Callum said that his mother and Ben argued all the time, although the arguments never got 'out of hand' and generally didn't go beyond verbal abuse. However, Callum later said that Ben was a violent person and that he knew that one day, if he laid hands on Jennifer, he was going to hurt her.

4.23 Callum recalled an incident between Christmas and New Year in which Ben picked up rocks to throw at the window of Jennifer's house but didn't actually throw them as he 'heard the police sirens and ran'. Callum said that he was 18 or 19 at the time and told his mother to ring the police. He said the police attended but 'just turned round and went away' when they realised that Ben was no longer there. It is assumed that Callum is referring to the incident described in Paragraph 5.11.

4.24 Callum felt that his mother was reluctant to support prosecutions of Ben because she loved him and didn't want him to get in trouble. He added that his mother 'kicked Ben out' a few times but she would always have him back. When asked if it was possible that his mother was in fear of Ben, Callum replied that she could have been in fear, but he wasn't aware of this.

4.25 He said that there were other incidents in which Ben was abusive to Jennifer. He said that he had not witnessed these incidents himself but had only found out about some of them since he had been in prison. Callum felt that his mother had avoided telling him about other incidents because she was aware that they would 'play on his mind'. He added that he saw himself as his mother's 'protector'. He said that he saw himself in this light because he regarded himself as her oldest son as Jennifer's elder two children were not in her care.

4.26 Despite perceiving himself to be his mother's protector, he said that it 'really resonated' with him that he was unable to do anything physically to protect her when he was younger. He then began to talk about his mother's relationship with the father of his youngest two siblings – with whom Jennifer had been in a relationship before she met Ben. Callum said that this partner was 'nice' for six months but after that he 'showed his true colours' and stopped Callum using the TV or the WIFI, saying that these things belonged to him. Callum also said that this partner began being physical to him and his mother and recalled an incident in which the partner grabbed him by the throat and began screaming at him after his mother had called him down from his bedroom for her partner to speak to him.

4.27 Callum said that this was when he began to 'retreat' to his bedroom – which continued when his mother's relationship with Ben began. He said that he would

have been around 13 when he began staying in his bedroom. Callum said that spending a lot of time in his bedroom also made his mother's life easier as she wouldn't see the way her partner was treating him (Callum).

4.28 Callum said that he didn't tell anyone about the effects of his mother's partners hostility towards him 'for a long time'. He said he began confiding in his 'mates' when he was about 20 and this 'eased things a bit' in that it helped him come to realise that this wouldn't affect him for the rest of his life. He added that he had been reluctant to talk to his mates about these issues as he knew that they had also experienced 'bad things'.

4.29 When asked about the support he received from his GP and MIND, Callum said that he saw the MIND counsellor between the first two Covid-19 lockdowns as he had been through a 'really bad' relationship break-up which was 'really killing him' at that time. He said that the MIND counsellor was really helpful because she 'opened his mind' to the possibility of being happy in the future. He went on to say that in the first three sessions they had nearly got to the end of discussing his relationship break-up and he said that he was hoping to move on to discuss the impact of his mother's relationships on his wellbeing in subsequent sessions but he said that MIND had texted him to say that as the country was going back into lockdown, they could no longer offer the sessions. Callum's memory of the circumstances in which the MIND counselling sessions ended is inconsistent with the report which MIND shared with this DHR. Callum said that he hoped to go back to MIND after Covid but that this had not materialised.

4.30 However, he felt that another benefit from his contact with MIND was that he felt able to talk about his difficult relationship with Ben to his friends, adding that it felt positive that he wasn't hiding this from them.

4.31 When asked how he acquired the knife with which he killed Ben, he said that it was an 'accidental purchase' from an app linked to a website in 2019 or 2020. He said that he thought it would be 'cool' to have a knife collection when he got his own home and saw the knife – which he described as similar to a 'Rambo' knife – on the website. He said that he showed the image of the knife to a friend and said he must have accidentally transferred the knife to his 'basket'. He said that if an item was placed in the basket on that particular website, and was not removed, after a set period of time the sale proceeded. He said that this is how the knife came to be purchased by him. He said he 'put it to one side' in his bedroom so that none of his siblings would be aware that it was there.

4.32 Callum went onto say that he never thought of using the knife to protect himself and armed himself with it on the night he killed Ben only after he heard Ben

saying that he was going to 'smash his mother's head in' and heard his mother shout 'what are you doing?'. He said he felt he needed the knife if he was going to confront Ben because of Ben's height and weight advantage.

4.33 When asked if anything might have helped him talk about his relationships with Ben and his mother's previous partner, he said he didn't think he would have been able to talk about it, although he added that it took him 'a while' to realise that relationships with a mother's partners were not supposed to be like that.

4.34 When asked about his contact with agencies, Callum said that he felt that the police 'didn't do enough'. He felt that the police needed to 'get hold of' Ben and find out why he was being abusive to Jennifer. And he felt that the Crown Prosecution Service should have charged Ben in respect of the incident in the churchyard on New Year's Day (Paragraph 5.9).

5.0 Chronology/Overview

Background information

5.1 Ben's relationship with Jennifer began in 2016. He had two daughters from an earlier relationship. One of Ben's daughters has contributed to the DHR, and she described her father as a lovely man who was very affectionate and loved his families. She went on to say that he cared for her 'so much' and had been very proud of her for being in work in a good job. She said that her father was a 'chatterbox' who enjoyed going out to the pub and being with people. She said that he 'wasn't perfect' as a younger man but he had grown up, matured and become a better person. The extent to which Ben assumed co-parenting responsibilities for the four children living with Jennifer, including the perpetrator is unclear. In his contribution to the DHR, Callum described a conflicted relationship between Ben and himself and two of his younger siblings, whilst Ben's daughter said that he loved Jennifer's three younger children and would pick them up from school after Jennifer found employment. However, Ben's daughter said that she was aware that her father and Callum were not 'fans' of each other, adding that Callum spent all his time in his room playing video games. Ben appeared to have been unemployed for some time and when he engaged with largely unsuccessful support to help him find employment, barriers to employment were stated to be dyslexia and literacy. His daughter said that he had earlier been employed as a painter and decorator and in manual work. He appeared to be in good health, attending his GP practice infrequently for asthma and minor health issues. It appears that he drank alcohol to excess on occasions but there is no indication that he was referred or encouraged to self-refer for support from alcohol services.

5.2 The perpetrator Callum lived with his mother Jennifer, his father and a younger sibling until his parents separated. Callum has advised this DHR that he had a difficult relationship with his mother's next partner, with whom she had a further two children. During this period of his life, it appears that he grew accustomed to secluding himself in his bedroom to avoid his mother's partner. Callum was 16 years of age when his mother began her relationship with Ben. Callum also had a difficult relationship with Ben and continued to seclude himself in his bedroom. He attended a local high school and progressed to post 16 college but experienced difficulty in finding employment. He began to experience low mood and insomnia and sought help from primary care and mental health services. He appeared to have been very adversely affected by the break-up of an intimate relationship during his teenage years and when he sought help for his low mood, described himself as 'stuck'. He was asthmatic but this appeared to have been well controlled.

5.3 Jennifer was the mother of six children. Her first two children were born during her teenage years and appear to have been cared for by family members rather than Jennifer herself. It is not known whether this was as a result of formal proceedings or whether it was an informal arrangement. She went on have four more children, including the perpetrator Callum, all of whom were brought up by her. She appeared to struggle to parent the children effectively at times and when agencies became involved she sometimes proved difficult to engage with. Jennifer decided not to contribute to the DHR and so little is known about Jennifer's early life or her employment history. During the period in which she was bringing up the four children who lived with her, she was a lone parent at times, or assumed the bulk of the parenting responsibilities, particularly during her relationship with Ben, although Ben's daughter said that Ben began collecting the younger children from school after Jennifer found employment. Jennifer's youngest child described Ben as her mother's 'friend' to the School Nurse (Paragraph 5.21). Most of Jennifer's contacts with primary care in more recent years related to a condition and on two occasions she presented with acute exacerbation of her symptoms. It is difficult to take a fully informed view of the impact of domestic abuse on her adult life. In his contribution to this DHR, the perpetrator Callum stated that both Ben and her previous partner were abusive towards her. When incidents were reported to the police, she appeared reluctant to support a prosecution. It is unclear why this was the case. There is no evidence of controlling or coercive behaviour from Ben although, when asked, Callum replied that his mother could have been in fear of Ben, but he wasn't aware of this (Paragraph 4.24). It is noted that Ben had a tendency to return to her address intoxicated after she had told him to leave which could be construed as controlling behaviour by Ben, in that he may have been unwilling to countenance her ending the relationship. However, Ben's daughter has drawn attention to her father's long-term lack of a permanent address which she feels created a dependency on Jennifer, and an opportunity for her to exercise control over him, as Ben's daughter said that if his relationship with Jennifer ended, he would have been homeless and reliant on the generosity of friends to allow him to 'sofa surf'.

5.4 It is understood that the relationship between Ben and Jennifer began in 2016, although it is not known when Ben permanently moved into the home Jennifer shared with four of her six children. Jennifer began her tenancy at the address in 2012 when her former partner (father of her youngest two children) was a joint tenant. Ben was never known to Jennifer's housing provider in respect of this address. When their relationship began Ben would have been 42 and Jennifer 38. The four children in her care at the time her relationship with Ben began were the perpetrator Callum (then 16) and his younger siblings. The youngest two siblings had been born to Jennifer and her previous partner. Callum and his eldest sibling were born to Jennifer and an earlier partner.

5.5 Children's social care became involved with the family in November 2016 when Callum's eldest sibling disclosed to a teaching assistant at his primary school that his mother had been punching him in the head and 'tummy' and that it made him feel sick, and as a result he went to bed. The school had not noted any injuries to this child, although there is no indication that the child was examined. The primary school contacted children's social care and informed them that the school felt that the family seemed to be 'borderline' for possible neglect issues in that the children looked somewhat unkempt at times 'as though they have worn the same clothes all week' and there had been issues with head lice. The school spoke to Jennifer who denied 'ever laying a hand' on the children whilst acknowledging that things could be 'hectic' at home.

5.6 Children's social care completed a child and family assessment which recommended that the case was closed to children's social care and that the childrens' needs should be met at the 'universal' level. Jennifer was said to have fully co-operated with children's social care and to have been open and honest. The extent to which Ben took on parenting responsibilities in respect of the four children in her care is unclear. In his contribution to the DHR, the perpetrator Callum stated that Ben 'never got along with him (Callum) and his siblings', adding that Ben treated his two younger male siblings 'like crap' and 'hated' him (Callum) and, as a result, Callum stayed away from him and kept to himself when Ben was in the house (Paragraph 4.20). However, Ben's daughter said that Ben loved the three younger children and began collecting them from school after Jennifer gained employment (Paragraph 4.6).

5.7 During the year before his relationship with Jennifer began – in October 2015 – Ben was arrested by the police after damaging a window at his ex-partner's address by throwing stones at the glass to attract her attention. He and his partner had separated 7 years previously, but Ben visited her home to see the two children they had had together. On this occasion Ben had been drinking and his former partner asked him to leave. He later returned and committed the offence referred to above. The police cautioned Ben for the damage and officers issued him with a harassment warning notice in relation to him attending at his ex-partner's address. These notices were common practice at that time and their purpose was to convey a message to offenders that a pattern of behaviour had been documented and if they continued with that behaviour they would face arrest on suspicion of harassment.

5.8 The police were called to the first reported incident involving Ben and Jennifer in August 2017. Jennifer reported that she and Ben had separated two days earlier, but Ben had visited her address whilst intoxicated, forced his way inside, gone upstairs and fallen asleep. Ben left the address when asked to do so by Jennifer prior to

police attendance. The risk was assessed as 'standard' by the police, who referred Jennifer to Strive[1] but it appears that this service was unable to engage with her.

5.9 The second reported incident took place during the early hours of 1st January 2019 when the police received a call from a member of the public who reported that a male and female were arguing in a church yard in Ashton-under-Lyne and that the male was hitting the female who was on the floor. Officers attended and separated Ben and Jennifer. Jennifer initially stated that she had fallen over and denied any assault had taken place. However, after an officer contacted the caller who had witnessed the assault, Jennifer confirmed that she had been assaulted by Ben but did not wish to provide a statement. Jennifer was described as 'intoxicated' and was taken to her sister's address. Ben was arrested at the scene and it was planned to re-contact Jennifer the following morning when sober.

5.10 When Jennifer was visited the following day, she denied that any assault had taken place and said that she wanted Ben 'back home.' When interviewed Ben stated that he and Jennifer had both been drinking, had had a heated discussion resulting in Jennifer hitting him, he had retaliated and pushed her which caused her to fall due to her level of intoxication. In the absence of an account from Jennifer, it was decided to take no action. The DASH risk assessment generated a 'standard' risk to `Jennifer' which the officer increased to 'medium' risk on professional judgement grounds. There is no indication that any referrals were made in respect of Jennifer or her children.

5.11 On 14th December 2019 the police attended a further domestic incident involving Ben and Jennifer. On this occasion it was documented that they had recently separated and Ben, whilst under the influence of alcohol, had gone to Jennifer's address and attempted to gain entry. When refused, he had picked up a brick and threatened to smash a window. When officers arrived at the location Ben was still in the area and was allowed to leave to stay at a friend's house for the night. After checking the domestic abuse history, officers recorded the incident as 'standard' risk. A DASH risk assessment was completed which did not indicate any areas of concern although Jennifer answered 'no' to most questions. The officer noted that the relationship had recently ended whilst recognising that it could recommence in the future. A crime was recorded in respect of the threat to commit criminal damage which was finalised 'no further action' due to the lack of support from Jennifer. The officer recorded his rationale for not arresting Ben at the scene, in which he referred to the immediate risk to Jennifer and her family against the fact

[1] The STRIVE initiative involved 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.

that Ben did not live at the address and was walking away from the scene at the time of the officers' arrival, the wishes of Jennifer and the previous domestic abuse history.

5.12 The officer noted that there were two children at the address (all 4 of the children who lived with mother were documented including Callum) at the time of the incident and the schools the children attended were subsequently notified under Operation Encompass.[2] Although this should have been actioned prior to the end of the officer's shift, the DHR has been advised that this did not result in a delayed notification as the incident occurred on a Saturday.

5.13 On 27th January 2020 Jennifer saw her GP with acute exacerbation of her condition. A plan was developed, her medication was reviewed and she was commenced on a different medication. Jennifer was again reviewed by her GP on 30th January 2020. Although it has not been possible to seek Jennifer's consent to share her medical records with the DHR, very limited information about her contact with her GP has been included in the DHR report in order to highlight missed opportunities for professionals to make Routine Enquiry about domestic abuse.

5.14 On 18th February 2020 the perpetrator Callum saw his GP and said that he had been struggling with his emotions after breaking up with his girlfriend 4 years previously and was finding it difficult to obtain employment. The GP documented that Callum had no thoughts of suicide or self-harm and diagnosed mixed anxiety and a depressive disorder. The GP prescribed sertraline[3] 50mgs once daily and subsequently referred Callum to Healthy Minds[4] for counselling citing mood changes, anxiety, depression and insomnia.

5.15 On 3rd March 2020 Callum re-contacted his GP to say that he had not been taking the sertraline over concerns about the possible side-effects. After receiving reassurance from the GP, Callum decided to begin taking the medication. The GP planned to review him in two to three weeks.

5.16 On 5th March 2020 Healthy Minds discussed the GP referral in respect of Callum at their multi-disciplinary meeting (MDT) and agreed to invite him for a

[2] Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children experiencing domestic abuse and ensures that there is a telephone call or notification to a school's trained Designated Safeguarding Lead prior to the start of the next school day after an incident of police attended domestic abuse where there are children related to either of the adult parties involved.

[3] Sertraline is a type of antidepressant which is often used to treat depression and also sometimes panic attacks, obsessive compulsive disorder and post-traumatic stress disorder.

[4] Healthy Minds offers a range of talking therapies to support the person's mental health.

telephone assessment triage appointment and wrote to him on 9th March 2020. Callum accepted the invitation and gave permission for Jennifer to speak on his behalf.

5.17 On 13th March 2020 Callum told his GP that he didn't want to continue taking sertraline and preferred cognitive behavioural therapy. He continued to report no thoughts of suicide or self-harm.

5.18 On 18th March 2020 the Healthy Minds telephone triage assessment took place during which Callum explained that he had felt very 'stuck' over the past three and a half years and had found it hard to move forward with his life. He went on to say that throughout high school he had a best friend, with whom he eventually began a romantic relationship. He said that he had 'lost her' in the last year of school and became upset when discussing this. The relationship had ended three and a half years previously. He reported difficulty in speaking to or trusting new people and said he avoided developing new relationships. He also described less enjoyment of his general activities. He said that he had struggled to find a job and had stopped sending out applications as he very seldom got interviews. He reported playing a lot of x-box games to fill his time, adding that he had previously played football but his friends were all busy working in full-time jobs and so he did not go out with them as often. He said he went running every now and again, but he didn't enjoy it. He said he struggled to sleep, sometimes ruminating on the past and stayed awake until he eventually 'crashed'. He said his appetite had diminished. The PHQ 9 [Depression Test Questionnaire] assessment was completed. No significant risk of harm to self or others was identified. A safety plan and crisis numbers were discussed. Callum said he would return to his GP if his mood deteriorated. It was noted that he had stopped taking the prescribed antidepressants as one of the side effects was that he was 'struggling to get out of bed'. He reported not drinking alcohol and smoked cannabis once per month. Psychoeducation[5] was given. The agreed plan was for Callum to be referred to Tameside, Oldham and Glossop MIND for 'adjustment to loss' counselling – which can include support in respect of bereavement, the end of a relationship, losing a job or losing a home. Callum was accepted by MIND and on 26th March 2020 he was discharged by Healthy Minds and his GP informed.

5.19 The concerns about parental neglect referred to children's social care by the primary school in respect of Callum's eldest sibling (Paragraph 5.5 and 5.6) resurfaced in 2020. The child was attending secondary school by this time. In February of that year the secondary school referred the child to children's social care on the grounds of poor home conditions, lack of hygiene and (unspecified) additional

[5] Psychoeducation involves learning about and understanding mental health and wellbeing.

needs. These concerns had been ongoing since September 2019 when the child transferred from primary school. The secondary school had struggled to engage with Jennifer despite sending a letter home and attempting a home visit.

5.20 Children's social care completed a child and family assessment which noted that hygiene and head lice had been long standing issues for the siblings and that if nothing changed for them, this could affect their health, self-esteem, peer relationships and their learning. The assessment recommended that targeted support by Tameside Families Together (TFT)[6] should be provided, informed by an early help assessment (EHA) which had been commenced by the primary school. There was then a delay of three months in the case being sent to Tameside Families Together. Jennifer's engagement with them was described as poor and she cancelled several planned visits, saying she 'worked a lot'.

5.21 The primary school had also referred the youngest sibling to the School Nurse because of head lice infestation, which continued for twelve months (March 2019 to March 2020) despite the School Nurse working with the family, the school and the family's GP over that period. Although family contact for all agencies supporting the children was primarily with Jennifer, the School Nurse came into contact with the victim Ben on two occasions during her work with the family. The youngest sibling referred to him as her mother's 'friend'.

5.22 On 23rd March 2020 the first Covid-19 lockdown commenced. Jennifer had been working part-time at a cashier in a large store from Sept 2019, but she began self-isolating from the first Covid lockdown onwards because she was identified as at high risk of developing complications should she contract Covid-19. Thereafter she does not appear to have worked outside the home.

5.23 On 2nd April 2020 Jennifer again contacted her GP for an acute exacerbation of her condition which resulted in a clinical assessment, medical adjustment and commencement on antibiotics. This was a telephone consultation. The cause of exacerbation was thought to be infection. Covid infection was considered and Jennifer was given advice about self-isolation consistent with government guidelines. The annual review of her condition took place on 14th April 2020 which was again conducted by telephone with her GP practice.

5.24 In October 2020 TFT closed the family's case after Jennifer said that she no longer required their support and she questioned why the schools had any raised concerns in the first place. The primary school were said to have reported that

[6] The Tameside Families Together service provides family intervention work as part of the local multi-agency Early Help offer.

things were 'much better'. The primary school has also advised the DHR that they made weekly telephone calls to the family during the first Covid-19 lockdown and made sure that the family were accessing the food parcel scheme. In their contribution to the DHR, the secondary school questioned the effectiveness of the early help support earlier provided to the older child who transferred to their school describing this child as experiencing what the secondary school described as 'severe neglect' in that they had a strong-smelling odour, general uncleanliness, a visibly filthy uniform and showed signs of hunger whilst at school.

5.25 On 9th September 2020 the MIND counsellor to whom Callum's referral had been allocated telephoned Callum to offer remote counselling either by telephone or online but Callum said that he wasn't comfortable with either of these options and preferred face to face (F2F) counselling. It was therefore agreed that he would be provided with weekly F2F counselling from 16th October 2020. Callum was advised that he would be offered six sessions of 50 minutes duration each.

5.26 In the reports MIND shared with the DHR, they stated that the focus of the sessions was anxiety, low confidence and low self-esteem. MIND have shared his SWEMWBS[7] scores, which indicated a fairly substantial improvement in his mental wellbeing. In his contribution to the DHR, the perpetrator Callum said that the counsellor opened his mind to being happy in the future and he felt that he was in a better place as a result of the counselling.

5.27 Callum attended F2F sessions with his MIND counsellor on 16th, 23rd and 30th October 2020. The counsellor was unable to attend the fourth F2F session scheduled for 6th November 2020 and telephoned Callum to offer to deliver this session by telephone instead. Callum declined this, saying he preferred to wait until the counsellor was available for further F2F sessions. Callum's mother then cancelled his resumed F2F session scheduled for 13th November 2020, and he did not attend the next session scheduled for 20th November 2020. MIND then withdrew their service from Callum as he had either missed or cancelled two sessions. In his contribution to the DHR, Callum stated that the F2F counselling sessions were suspended after his first three sessions because of Covid-19 restrictions. It appears that he is mistaken, although restrictions across Greater Manchester local authority areas had been tightened from October 2020.

5.28 On 12th April 2021 Callum had a telephone consultation with his GP in which he reported low mood. He was documented to have no thoughts of deliberate self-

[7] The SWEMWBS is **a** short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). The WEMWBS was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

harm. The GP prescribed fluoxetine[8] 20mg capsules – one to be taken each day. The GP advised Callum to take them for at least six months. A telephone review would be conducted after three weeks or as needed. The GP documented that Callum would contact MIND, but MIND has advised the DHR that he did not make further contact with them. The GP also issued a fit note[9] on the grounds of Callum's depressive disorder.

5.29 On 4th May 2021 Callum spoke to his GP by telephone and said that he was 'managing on fluoxetine'. Callum again spoke to his GP by telephone on 25th May 2021 when he was documented to be 'happy' with fluoxetine and had had no thoughts of self-harm or suicide.

5.30 On 8th June 2021 Jennifer had a telephone consultation with her GP. She was invited to visit the surgery but declined. The GP conducted a medication review.

5.31 On 30th June 2021 Jennifer presented with worsening symptoms of her condition and her GP referred her for an X-ray.

5.32 On 8th July 2021 one of the perpetrator's younger siblings tested positive for Covid-19. No further details have been shared with the DHR but, at that stage of the pandemic, it is assumed that this may have led to family members isolating themselves.

5.33 On a date in early August 2021 the police received a telephone call from Callum's eldest sibling to say that Callum had stabbed Ben at their home address. Callum then came onto the telephone line to say that Ben had attacked his mother Jennifer and that he (Callum) had run to the kitchen and grabbed a knife with which he stabbed Ben in order to defend his mother. Callum added that he was unable to recall where on his body he had stabbed Ben, but he did not appear to be breathing. Police and paramedics attended the address and found Ben in a collapsed state on the floor of the lounge. Emergency medical intervention was attempted, and Ben was taken to Hospital 1 however life was pronounced extinct within an hour of his arrival at hospital.

[8] Fluoxetine is a type of antidepressant which often used to treat depression, and sometimes obsessive-compulsive disorder and bulimia.

[9] If someone is off work sick for more than 7 days, their employer will usually ask for a fit note (or Statement of Fitness for Work) from a healthcare professional. Fit notes are sometimes referred to as medical statements or a doctor's note.

5.34 Ben was found to have sustained a stab wound from the angle of his right jaw/right ear area through to, and penetrating from the left rear of his neck, with severe force thereby cutting the main vein in the neck. In addition, he had sustained a deep wound to the right upper back, also with severe force, which had cut through the right collar bone and had partially incised the inside of the right third rib. There were two wounds to the right side of his scalp. It is assumed that Ben would have bled to death very quickly.

5.35 The police discovered the knife which Callum used to stab Ben under a sink in the kitchen of the address. The knife was a combat knife which was 18.5cm in length and 3.5cm wide. The sheath for the knife was located in Callum's bedroom and it was established that he had armed himself with the knife before leaving his bedroom and going downstairs to confront Ben. Callum was arrested and later charged with the murder of Ben. Callum maintained that he had purchased the knife some time earlier in order to start a collection of weapons. The murder weapon was the only knife he possessed at the time of the homicide.

6.0 Analysis

6.1 In this section of the report each of the case specific terms of reference questions will be considered in turn.

How effectively were any disclosures by, or indications of domestic abuse to, the victim addressed by the agencies in contact with him?

6.2 The victim Ben is not known to have made any disclosures of domestic abuse to any agency in contact with him. However, Ben's daughter has advised this DHR that, in her view, her father experienced controlling behaviour from Jennifer in the form of frequent text messages when Ben had left the home he shared with her, to socialise with others (Paragraph 4.7). Ben's daughter also felt that Jennifer 'goaded' and 'bullied' Ben. Ben's close friend said that Ben had been assaulted more than once by Jennifer (Paragraph 4.14) and that when Jennifer reported incidents involving Ben to the Police, the Police 'took her word' for what had happened and as a result Ben had had 'some domestic stuff put on him' (Paragraph 4.13) and that Ben had been portrayed as a 'wife beater' during Callum's murder trial which the friend said 'he never was' (Paragraph 4.18). It should be noted that Jennifer decided not to contribute to this DHR and that in all 3 of the domestic abuse incidents reported to the Police involving Jennifer and Ben, Jennifer was regarded as the victim and Ben the perpetrator by the Police.

6.3 Ben's daughter added that as the tenancy of the property in which Jennifer lived with four of her children was in her name, this created a dependency on the part of Ben who his daughter said had 'nowhere to go' – other than 'sofa surfing' with a friend - if their relationship broke down or he was asked to leave (Paragraph 4.7). Ben's daughter felt that this situation prevented Ben from leaving when his relationship with Jennifer deteriorated and was a factor which reinforced Jennifer's controlling behaviour. Ben's close friend reiterated this point, saying that previously accumulated rent arrears prevented Ben from accessing social housing and that he could not afford to rent privately. The friend added that Jennifer would not let Ben register as living in her property as he said that Jennifer was concerned that she may have her benefits reduced as a result (Paragraph 4.15). There is no indication that Ben raised concerns other than with his daughter and other family members and friends. However, Ben's apparent long-term lack of a tenancy of his own sheds fresh light on two of the incidents reported to the police – when he forced his way into Jennifer's house after they had separated, went upstairs and fell asleep (Paragraph 5.8) and when he attempted to gain entry to Jennifer's house after they had recently separated (Paragraph 5.11).

6.4 The intersection of poverty and domestic abuse can exacerbate the impact of domestic abuse (2). If Ben, and also to an extent Jennifer who may have been reluctant to ask Ben to leave if this put him at risk of homelessness, were effectively 'trapped' in a relationship which was no longer working through lack of the financial resources necessary to find alternative accommodation for Ben, this may have created an unhealthy dynamic in which the risk of conflict was heightened.

6.5 Ben was perceived to be a perpetrator of domestic abuse in his relationship with the perpetrator Callum's mother and in his prior relationship with the mother of his two children. As a perpetrator of domestic abuse, his victims were never assessed as being at 'high' risk. Therefore, the prospect of fatal violence being used by a family member to defend a victim of Ben would have appeared unlikely, if considered at all.

6.6 The victim's contact with agencies were quite limited. As indicated above, he came into contact with the police as a perpetrator of domestic abuse. His contact with primary care was minimal. He engaged with support intended to assist him to access employment. Had he contacted his GP in circumstances in which it may have been appropriate to make 'routine enquiry' about domestic abuse, it seems highly unlikely that the victim would have perceived himself as at any risk at all from the perpetrator. There was a considerable physical difference between the victim, who was a tall, well-built man and the perpetrator, who is small in stature and appears to have taken steps to avoid contact and any conflict with Ben by secluding himself in his bedroom when Ben was present.

6.7 Had Ben become aware that Callum had acquired a combat knife which he secreted in his bedroom, he may have felt at risk given the antipathy which appears to have characterised his relationship with the perpetrator, but there is no indication that anyone was aware that Ben possessed the combat knife apart from, possibly, one of his friends. However, this DHR provides an opportunity to reflect on how agencies perceived the victim and whether they were sufficiently open to the possibility that he could conceivably be at risk of domestic abuse from his partner's son. The scenario seen in this case is not unique. Adult children have harmed or killed the abusive partner of their mother in other cases. In this case:

- Callum saw himself as the protector of his mother
- His mother was at risk of domestic abuse from her partner Ben and
- Callum purchased a combat knife.

6.8 Taken together, these three factors indicated that Ben was at risk from Callum. However, some, but not all, agencies in contact with the family over the course of Ben's relationship with Jennifer were aware of just one of the above factors i.e. that Callum's mother was at risk of domestic abuse from Ben.

6.9 There is no indication that Ben sought, or was signposted to, support as a perpetrator of domestic abuse against Jennifer.

How effectively were the risks to the victim presented by the perpetrator assessed and managed? The perpetrator's acquisition and storage of the weapon with which he unlawfully killed the victim should also be considered.

6.10 The victim and the perpetrator appeared together in a single police domestic abuse record which related to the December 2019 incident (Paragraphs 5.11 and 5.12). The officers attending this incident recorded the names of all four of Jennifer's children although Callum by this time was approaching 20 years of age. In his contribution to the DHR, Callum stated that he was instrumental in persuading his mother to contact the police on this occasion, but it is not known whether the attending officers picked up on this dynamic as it was Jennifer who phoned them and she who was appropriately considered to be the victim.

6.11 The National Probation Service (NPS) pre-sentence report observed that Callum presented himself as a quiet and passive individual with no previous offending history which would associate him with aggressive and controlling behaviours. The report added that rather than experiencing issues controlling any kind of temper, Callum appeared instead to internalise angry feelings. The NPS report concluded that his attack on Ben presented as a highly impulsive act which reflected poor problem solving in very specific circumstances.

6.12 There is no indication that professionals who came into contact with Callum prior to the homicide ever assessed his risk to others or probably had reason to do so. When Callum saw his GP in February 2020 and April 2021 (Paragraphs 5.14 and 5.28 respectively) the focus was on the risks he may present to himself. This focus seemed entirely appropriate in respect of the February 2020 consultation as Callum disclosed struggling with his emotions since breaking up with his girlfriend – who he had not been in a relationship with for 4 years. The trigger for Callum's low mood presentation in April 2020 was not explored by his GP, or if explored, not documented. Exploration of the reasons for Callum's low mood on that occasion could conceivably have led to an assessment of his risk to others, depending on what he disclosed.

The victim domestically abused the perpetrator's mother on a number of occasions. Did professionals consider the dynamics of the relationship between the victim and the perpetrator's mother and consider whether there was any risk of the perpetrator becoming involved by intervening to protect his mother?

6.13 There is no indication that professionals who considered the dynamics of the relationship between Ben and Jennifer, also considered the additional dynamic of the antipathy the perpetrator Callum felt towards Ben and the perpetrator's perception of himself as his mother's protector. Indeed, there is no indication that professionals ever became aware of the apparent mutual hostility between Ben and Callum.

6.14 Had there been any reported incidents of conflict between Ben and Callum, this could have flagged the potential risk of violence between them and have indicated the possibility that Callum might intervene to defend his mother if he felt that she was at risk from Ben. However, even in these circumstances professionals could not have foreseen the level of violence Callum used to allegedly defend his mother and himself from Ben.

6.15 There were opportunities for Callum to disclose his feelings towards Ben and his mother when he twice sought help from his GP in respect of his low mood in 2020 and 2021 and during his contact with Healthy Minds and MIND in 2020 but there is no indication whatsoever that he made any relevant disclosures to professionals during these contacts. When Callum sought help in 2020, the issue which appeared to be of most significance was the long-lasting impact of the break-up of an intimate relationship. When Callum sought help in 2021, the presenting issues was simply documented as 'low mood'.

6.16 There may be a case for DASH risk assessments to consider members of the wider household other than the victim and the perpetrator. A 2021 report prepared for the Home Office entitled *Key findings from analysis of domestic homicide reviews* summarised information from DHRs for the 12-month period from October 2019. The report found that for 73% of victims the perpetrator was a partner or ex-partner (3). In 27% of the DHRs the relationship was described as familial. Half of these were where the victim was the parent of the perpetrator (4). There was a wide range of other familial relationships including, for example, grandparent, brother and sister. The analysis does not provide any information on the prevalence of homicides of victims who were partners of the perpetrator's parent. As the percentage of familial domestic homicides is substantial there may therefore be a case for the DASH risk assessment to consider other members of the household who could be drawn into the conflict between the perpetrator and the victim. The DHR has been advised the questions asked in the DASH risk assessment relate almost exclusively to the risks to the victim and the risks presented by the perpetrator. However, the professional completing the DASH is advised to consider the 'context and detail of what is happening' and there is an opportunity to include 'additional information' which may 'alter risk levels'. Issues to be considered under this heading are stated to be the 'victim's vulnerability – disability, mental health, alcohol/substance misuse

and the abuser's interests – does this give unique access to weapons i.e. military, police, pest control) or is there serial offending?' A Domestic Abuse Risk Assessment (DARA) – which has been promoted by the College of Policing – and which incorporates the standard DASH risk assessment, includes a question 'does anyone else present a risk?'. The DARA has not currently been adopted by GMP, but the force may wish to consider adding the 'does anyone else present a risk' question to the DASH as the question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Initial information provided to this DHR indicates that no incident of domestic abuse involving the victim and the perpetrator was reported to any agency prior to the death of the victim. Therefore, any barriers to the victim or the perpetrator accessing support will be explored.

6.17 Callum's contacts with his GP in 2020 and 2021 and Healthy Minds and MIND in 2020 represented opportunities for 'routine enquiry' in respect of domestic abuse to have been made. When people present to health and social care services with indicators of possible domestic abuse, such as low mood, anxiety or depression, such services should ensure that they provide a safe and private environment in which people feel able to disclose that they are experiencing domestic abuse. One of the challenges to 'routine enquiry' is that it has understandably tended to focus primarily on the victims of intimate partner domestic abuse, the majority of whom are female and so health professionals interacting with pregnant mothers and mothers of children for example have been more attuned to the need to make 'routine enquiry'. Less likely to be considered for 'routine enquiry' have been older victims of intimate partner domestic abuse and victims of familial domestic abuse and male victims of domestic abuse generally. This case indicates the importance of 'routine enquiry' focussing not only on intimate partner domestic abuse but also familial domestic abuse.

6.18 On the basis of his contribution to this DHR, the perpetrator Callum was a victim of domestic abuse from an earlier partner of his mother (Paragraph 4.26) and began secluding himself in his bedroom from his early teens to avoid conflict with that partner, behaviour which continued when his mother began her relationship with Ben. Research on the impact of domestic abuse on adolescents indicates that the severity of domestic violence exposure during adolescence positively correlated with engagement in avoidance based coping strategies (5). This finding seems to have been borne out in Callum's case. During the incident he described in Paragraph 4.26, Jennifer's previous partner was said to have grabbed him by the throat and began screaming at him. Following this incident Callum adopted an avoidance based coping strategy by 'retreating' to his bedroom (Paragraph 4.27). There is no

indication that when he presented with low mood to professionals in 2020 and 2021 'routine enquiry' was considered. Indeed, MIND has advised the DHR that they do not use 'routine enquiry' for domestic abuse if 'they are not aware of domestic abuse' and pointed out that there had been no mention of domestic abuse in the referral they received in respect of Callum. This appears to have been a missed opportunity given that exposure to intimate partner violence in adolescence is a well documented risk factor for subsequent mental health outcomes such as depression and anxiety (6). Had 'routine enquiry' been considered, Callum may have been reluctant to talk about his feelings towards Ben and his mother. The issues which he sought help with were the impact of the break-up of an important relationship and a feeling that he had become 'stuck' in his life having been unable to find employment. However, in his contribution to this DHR, Callum said that he planned to seek support in respect of the impact of Ben's behaviour on his mother and himself had the MIND counselling sessions continued beyond the initial three sessions. There is some doubt about Callum's stated openness to discussing these issues with the MIND counsellor as it was Callum himself who stopped attending the sessions rather than cancellation by MIND as Callum stated to the DHR.

6.19 DHR Panel members feel that this review presents an opportunity to fully embed 'routine enquiry' in Tameside as they feel that it is currently a key weakness in the current approach to domestic abuse locally. However, Panel members felt that GPs often had insufficient time to probe what they were being told by their patients and tended to accept explanations from patients which were consistent with the medical model. Jennifer presented with acute exacerbation of a condition to her GP on two occasions during the period under review but there is no indication that potential non-physical causes of this acute exacerbation such as stress were explored with her. Having said that, given the circumstances in which Jennifer presented to her GP, it appeared appropriate to focus largely on physical causes of her condition. The DHR has been advised that Jennifer's GP would not have been aware of the three prior reports of domestic abuse involving Ben and Jennifer as none of the incidents had triggered a MARAC referral or been considered by the Multi-Agency Safeguarding Hub (MASH) – either of which would have generated GP contact. The DHR Panel felt that there was a case for informing GPs of all reported domestic abuse incidents relating to their patients even though this would be quite a significant undertaking. The Panel noted that many domestic homicides arise in cases which had not previously been assessed as 'high' risk.

6.20 Overall, the DHR Panel felt that GPs needed support to play a more substantial role in addressing domestic abuse through 'routine enquiry'. Reference was made to mental health nurses in GP practices who had more time to explore issues with patients and develop a trusting relationship which could encourage disclosures. The DHR has been advised that funding has been secured to procure the IRIS

(Identification and Referral to Improve Safety) for Tameside GP practices. The IRIS programme was first implemented nationally in 2011 and is now an evidence-based specialist domestic abuse training, support and referral programme for general practices that has been positively evaluated. The positive outcomes include helping GP practices to deliver an improved quality of care for patients experiencing domestic abuse.

How effective was the support offered or provided to the perpetrator in respect of his mental health needs including anxiety and low mood?

6.21 The support offered to Callum in respect of his mental health needs did not appear to be fully joined up. There was over five months delay in offering Callum the counselling for which he had been referred to MIND. There is no indication that MIND advised Callum, his GP or Healthy Minds of the delay although it is assumed that Healthy Minds would have been aware of waiting times when they referred Callum to MIND.

6.22 After MIND 'withdrew' the counselling service to Callum, there is no indication that MIND informed his GP or, indeed, Healthy Minds. The DHR has been advised that 'next steps' reports to GP practices are not mandatory and there is no requirement on MIND to inform Healthy Minds if a client is ending therapy unless the client is being stepped up to psychological therapy. MIND has advised the DHR that there was no requirement to inform Callum's GP practice that his involvement with MIND had ended unless there had been a 'disclosure about the client's welfare'. Given that the GP made the initial referral to Healthy Minds which resulted in Callum accessing a service from MIND, it would seem appropriate for the GP practice – as initial referrer and as the repository of patient's health information - to be advised of the eventual outcome of the referral.

6.23 In his contribution to this DHR, Callum described the impact on his daily life of living in a household in which domestic abuse by two successive partners of his mother was present. He described feeling an obligation to protect his mother but also feeling a degree of powerlessness in this regard given his youth and his physical stature compared to the partners. He appears to have experienced a degree of guilt at what he perceived as his failure to protect his mother, which as with other feelings such as his resentment and hostility towards the two partners, he appears to have largely internalised. He also describes secluding himself in his bedroom to avoid conflict with the partners. He may also have distanced himself from friends emotionally and physically during this period of several years.

6.24 Taken at face value, Callum's account illustrates the potential impact on a child, young person or young adult living in a household in which domestic abuse is

present. His account also emphasises the need for children, young people and young adults in such circumstances to be able to access support, although they may find it difficult to talk about what is happening at home for a number of reasons not least the fear of repercussions from the abuser. The DHR has been advised of the following range of support services currently available to children and young people in Tameside:

- 'CHIDVA' (Children's Independent Domestic Violence Advisor)/ Play Worker. Bridges is the specialist domestic abuse service in Tameside which includes a children's team consisting of one senior worker, three CHIDVA's and a refuge play worker. The CHIDVA's work with 6–17-year-olds affected by domestic abuse in either the family home or their own relationships. They also work with teenagers who are displaying perpetrator behaviour. Referrals can be made by any professional working with children who feel that a specialist service is needed. Referral triage considers a variety of risk factors including missing from home episodes, exploitation, exclusion from education, self-harm, suicidal ideation/attempts, abusive relationship (priority) pregnancy or risk of (priority), sexual assaults or reported rapes, substance misuse or experimentation and potential gang related links.

- The Children's team also offer workshops to high schools around healthy relationships.

- Additionally, group work is offered including 'Time 4 You' – an 8-week course designed to support children impacted by domestic abuse. The course helps children & young people explore their feelings in a creative way in a safe environment. It explains what domestic abuse is, how to be safe and provides an opportunity for children to mix with a group of peers who have had similar experiences. 'Managing Emotions' – is a 6-week course designed to support children and young people develop better self-awareness and the skills to manage their emotions in a safer more appropriate way. It addresses self-esteem/self-worth, relationships, coping skills and communication skills. 'Young Freedom' is an adaption of the original Freedom Programme and is a 6-week course primarily aimed at 15–17-year-olds, although Bridges run a version of this in schools for years 8 and up. This course empowers young people to build resilience. It explores abusive behaviours, exploitation and healthy relationships.

- 'Children that harm' – since January 2022 Talk, Listen, Change (TLC) have been running two innovative pilots in Tameside for children aged 12–19 years old. One is the 'Encouraging Healthy Relationships' programme – for children who are displaying harmful behaviours towards their siblings,

girlfriends/boyfriends and people they are dating and the second is the 'Respect Young People's' programme – for children who are displaying harmful behaviours towards their parents or carers. (These interventions are part of a Greater Manchester wide pilot, which is 2/3 funded by the Home Office and 1/3 funded by TMBC. These pilots are currently funded up until 31st March 2023.

6.25 Additionally, Victim Support has a growing number of services providing support to children and young people who have experienced domestic abuse. This can be abuse arising from their own relationship or abuse affecting their household (i.e. parent/carer's relationship). Some services also provide support to young people who have experienced domestic abuse and have started to display their own abusive behaviours. Specialist support within these services is delivered both in person and remotely, offering children and young people 1:1 support, access to group work programmes and peer support opportunities, as well as universal prevention and awareness sessions. These services provide support designed to identify and reduce risks, recognise and build upon protective factors, and help young people increase their levels of resilience. Victim Support has also advised the DHR of 'WeMatter' -a digital support service for children and young people being piloted in four local authority areas nationally.

6.26 The DHR has also been advised of My Recovery Tameside's People Impacted by Parental Substance Use (PIPS) service and the Family and Concerned Others service which offers support to people who are affected by somebody else's drug or alcohol use.

6.27 The range of domestic abuse services developed for children and young people in Tameside is impressive and Callum may have derived benefit from the CHIDVA service and each of the three group work options could also have been of value. Clearly there is no lack of services available – the issue for the DHR is how Callum might have been supported to disclose the impact that domestic abuse between Ben and his mother and between his mother and her former partner had on his life. As we have seen Callum appeared very reluctant to speak to professionals about the impact of domestic abuse on his life as a child, young person and as a young adult. After school/college he did not manage to enter employment and appears to have become somewhat isolated and disempowered until his promising engagement with MIND. For Callum to have engaged with the services described in Paragraph 6.23, he would need to have become aware of them, which emphasises the importance of positive, yet sensitive promotion of those services. For Callum to have been referred to any of the services it would have needed the professionals he was in contact with to have provided the opportunity and encouragement for him to disclose the impact of domestic abuse on his life, which gives even greater emphasis to the importance

of routine enquiry. And for Callum to have disclosed the impact of domestic abuse within his household on his life would have needed a supportive environment in which his concerns could have been sensitively and intelligently explored by professionals with an awareness of the impact of domestic abuse on children, young people and young adults.

6.28 By the time of the homicide, Callum was approaching 22 years of age. Although he was an adult, his daily life did not appear so different from his teenage years in that he continued to live at home, continued to spend much of his time in his room, had not gained employment, was not undergoing training, continued to be affected emotionally by the break-up of a relationship several years earlier and in his own words had become 'stuck'. Therefore, providers of domestic abuse services for children and young people may need to consider the needs of young adults such as Callum as part of continuing service development or adopt a flexible approach to the age ranges of people they engage with.

6.29 Additionally the DHR has been made aware of a 'Perpetrator response pilot' which arose from a perpetrator needs assessment commissioned in Tameside in 2021 and which remains ongoing. Initial findings were that in Tameside, perpetrators' needs are complex and high and that there is a lack of support for 'practical' needs such as financial issues, housing and employment, skills or training. The Commissioning Intentions Paper for 2022/23 received support for a perpetrator response pilot to be commissioned following the completion of the needs assessment, which is expected by the end of 2022.

6.30 Callum was not recognised as a potential perpetrator of domestic abuse until he killed Ben. The conflict in Callum's relationship with Ben appears to have been unknown outside Jennifer and Ben's family. Had professionals become aware of the conflict, it seems unlikely that they could have anticipated the extreme level of violence Callum would use against Ben. However, looking back with the benefit of hindsight and accepting the account Callum has provided to this DHR at face value, one is able to observe several factors which contributed to him becoming a perpetrator of fatal domestic violence – in particular his experience of domestic abuse from his mother's previous partner, the mutual hostility between Callum and Ben, Callum's response to the domestic abuse and the conflict which was to isolate himself in his room to escape/avoid it and to internalise his feelings, the pressure he put on himself to be his mother's protector and his acquisition of a weapon – an action which, with hindsight, appears to have been a concrete step towards a physical confrontation.

6.31 Children's social care and early help services became involved with the family in 2016 and 2019/20 and two child and family assessments were completed. As

previously stated Callum has advised the DHR that he altered his behaviour by secluding himself in his bedroom as a result of the domestic abuse, which begs the question of whether the domestic abuse of Jennifer from Ben and what Callum described as a poor relationship between Ben and two of Callum's younger siblings – although Ben's daughter felt that her father's relationship with the younger children was positive - impacted on the other children in the household. The DHR Panel wondered whether these dynamics could have been picked up the two child and family assessments, although focus of the assessments and the support work generally appeared to be on mother's parenting.

6.32 The Head of Service for Safeguarding and Quality Assurance in Tameside children's social care reviewed the service's two interventions in November 2016 and March 2020. She noted that all the children living with Jennifer – including Callum who would have been 16 at the time – were spoken to and direct work completed with them to ascertain their wishes and feelings. The Head of Service added that children's social care had no information relating to domestic abuse incidents nor was domestic abuse raised during either of the assessments. Tameside children's social care have advised the DHR that they have no records of receiving any notifications of the three domestic abuse incidents reported to the Police in August 2017 (Paragraph 5.8), January 2019 (Paragraph 5.9) and December 2019 (Paragraph 5.11). There is no indication that these 'standard' risk domestic abuse incidents were shared with children's social care by the Police. The officers attending the third incident (Paragraph 5.11) noted the presence of Jennifer's children and the details of the incident were shared with the schools attended by the children via Operation Encompass. Whilst their first children and family assessment in 2016 preceded the three reported incidents, all three incidents had been reported prior to the second child and family assessment in March 2020. An opportunity to consider whether domestic abuse could be a factor in the parental neglect which led to the second child and family assessment appears to have been missed because the incidents had not been shared with children's social care by the Police.

What support was offered or provided to the perpetrator in respect of education, employment or training?

6.33 The perpetrator appears to have limited contact with services which could have provided him with this type of support. Therefore, the question is no longer considered to be relevant to this DHR.

The victim and the perpetrator's mother drank alcohol to excess on occasions which appeared to contribute to verbal arguments between them and also appeared to be a trigger to the victim becoming violent and abusive towards the perpetrator's mother. Were either the victim or the

perpetrator's mother referred or signposted to, or offered or provided with support in respect of their use of alcohol?

6.34 There is no indication that either Ben or Jennifer sought, or were offered, support in respect of problematic consumption of alcohol. As the GMP IMR points out, the most serious incident of domestic abuse took place during the early hours of New Year's Day when alcohol consumption, including excessive alcohol consumption would have been anticipated.

6.35 However, alcohol was a factor in all of the domestic abuse incidents reported to the police. Whilst alcohol is a common disinhibiting factor in perpetrator behaviour, this case suggests that because excessive alcohol is such a common factor in domestic abuse incidents it may be overlooked as an issue in respect of which support should be considered. Government guidance for professionals who are *not* specialists in preventing alcohol misuse, recommends that health and social care, criminal justice and community and voluntary sector professionals should routinely carry out alcohol risk identification and deliver brief advice as an integral part of practice (7). It is also important that professionals who are not specialists in preventing alcohol misuse should recognise the importance of 'supported referral', i.e. positively encouraging the person to make a referral and following up on this.

Consider the lived experience of the three children living in the household with the victim, the perpetrator's mother and the perpetrator.

6.36 The focus of professional attention prior to the homicide was on the evidence of parental neglect on the three younger siblings of the perpetrator. Neglect appeared to be persistent and professional engagement did not appear to be effective in improving the children's lives. The DHR has been advised that domestic abuse was not disclosed or picked up on by the assessments.

6.37 Ben may have been what many years of serious case reviews (now child safeguarding practice reviews) have described as a 'hidden male' (8). These reviews have found that professionals have often relied on information provided by the mother and overlooked significant males in assessments and work supporting families. In this case the four children living with mother, including the perpetrator had two different fathers who Jennifer was no longer living with in addition to her partner Ben. It is unclear to what extent these males, including Ben, were considered in the assessments undertaken by children's social care in 2016 and 2020.

How effective was multi-agency working in this case?
Did the agencies in contact with the victim, the perpetrator's mother, the perpetrator or the children in the household communicate and share information effectively with each other?

6.38 The details of the domestic abuse incident which took place in December 2019 were swiftly shared with the schools attended by Jennifer's school age children (Paragraph 5.12). However, Jennifer's children were overlooked by the officers who attended the earlier incident on 1st January 2019 (Paragraph 5.9 and 5.10), possibly because the incident occurred in a public place some distance from the home Jennifer and Ben shared with their children. It is assumed that the 2017 incident (5.8) took place prior to the implementation of Operation Encompass.

6.39 As previously stated the support offered to Callum in respect of his mental health needs did not appear to be fully joined up. There was over five months delay in offering Callum the counselling for which he had been referred to MIND. There is no indication that MIND advised Callum, his GP or Healthy Minds of the delay although it is assumed that Healthy Minds would have been aware of waiting times when they referred Callum to MIND. And after MIND 'withdrew' the counselling service to Callum, there is no indication that MIND informed his GP or, indeed, Healthy Minds.

Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect the victim, the perpetrator's mother or the perpetrator or impact upon the support provided or offered to them by agencies?

6.44 Covid restrictions meant that some interactions between professionals and Callum and Jennifer were by telephone during the pandemic. It is recognised that in-person contact allows professionals the opportunity to observe body language and any lack of congruence between body language and what is communicated verbally. It is also probably easier to build rapport through in-person communication. However, MIND readily agreed to face to face counselling when this was requested by Callum.

6.45 Covid-19 did not impact upon Callum receiving a timely intervention from Healthy Minds, although it was a factor in the delay in MIND subsequently offering a service to Callum. MIND has advised the DHR that their therapeutic workforce is in part composed of placement counsellors who are studying at local Universities and Colleges and that many of them were neither trained nor insured to offer remote counselling by their place of study. Additionally, many clients – including Callum – wished to wait until the resumption of face-to-face counselling.

6.46 The Covid lockdowns affected the household as Jennifer's employment outside the home stopped and the three younger children appear to have not been in school during the first lockdown from March to July 2020. It is not known how the lockdowns affected Ben. He was not in employment at the start of the pandemic and so his employment status was unchanged. Research (9) has found that drinking patterns in England changed during the COVID-19 pandemic. There has been an increase in the number of higher risk drinkers, and the heaviest drinkers have increased their consumption the most, which brings a risk of more alcohol-related health problems. Changes in alcohol consumption have continued beyond the national lockdowns of 2020 and 2021. It is not known whether these changes in alcohol consumption during the Covid pandemic affected Jennifer and Ben.

6.47 Ben's daughter has advised the DHR of some of the tensions she perceived in the relationships between her father and Jennifer and her father and Callum. She also said that Ben's family had been encouraging him to leave Jennifer's home and go and stay with his best friend as they felt that it was detrimental for him to stay where he was. The daughter said that she imagined that Jennifer's house 'became a pressure cooker' during the Covid-19 lockdowns (Paragraph 4.7).

Availability of combat knives

6.48 'Stabbing knife' was found by the aforementioned review of DHRs prepared for the Home Office to be the most prevalent method of killing (49%) (10). The ease with which Callum was able to purchase a combat knife - the design of which was a fighting knife designed solely for military use and primarily intended for hand-to-hand or close combat fighting – is a concern. Having said that kitchen knives can also be deadly weapons.

6.49 The DHR has not been advised that the sale or purchase of the combat knife used to kill Ben is restricted in any way.

6.50 In Greater Manchester the police approach to tacking knife crime is to prevent and reduce serious violent crime, by disrupting the supply of knives into the UK, by raising awareness of the dangers of knife crime, and providing young people with positive alternatives to crime. Officers regularly undertake a range of activities including targeted operations, weapon sweeps, visits to habitual knife carriers, and education sessions in schools to explain the dangers and consequences that come from carrying a knife. It is understood that there are 13 knife amnesty bins permanently located across the GMP area.

'Think Family'

6.51 'Think Family' means that all staff need to remember that people rarely live in complete isolation and therefore professionals need to assess the needs of the wider family when they are working with a child or adult. Think Family is particularly relevant when responding to the needs of families where substance misuse, learning disability or difficulty, domestic abuse or mental ill-health are evident in the parent's life. As indicated earlier, had children's social care, early help or the school nurse adopted a 'think family' approach, it seems possible that there might have been a stronger focus on the presence of Ben in the household and an exploration of the family dynamics which arose from his presence.

Impact on the family of the perpetrator

6.52 From previous reviews the independent author is aware that the families of people accused or convicted of serious crimes – particularly where there is media attention - can often face abuse from relatives and friends of the victim and also abuse via social media.

6.53 The secondary school attended by Callum's closest sibling in age has advised the DHR that the child has started to carry a knife around the local area as people are angry at his family and the child feels they need protection. The school also advises that the child has been chased in the local community by youths who were carrying knives and has been harmed by them.

6.54 The perpetrator advised the independent author that a close friend of Ben has been leaving flowers at Jennifer's address, which the perpetrator feels is a subtle form of intimidation as there is a recognised site elsewhere where people are able to leave flowers or pay their respects to Ben.

6.55 Children's social care have advised this DHR that Jennifer's three younger children were not offered support from Victim Support Homicide Service due to the perpetrator being the children's sibling therefore the children were not classed as victims. Children's social care has advised the DHR that this has resulted in the family and children feeling unsupported by the police. Whilst it is important that there should be clear eligibility criteria for a centrally commissioned service such as the Victim Support Homicide Service, there also needs to be a degree of flexibility when there appears to be a support need which may technically fall outside eligibility criteria. However, the DHR Panel felt that the children could have been referred for support from Victim Support locally.

6.56 Ben's daughter has advised the DHR that she felt a degree of discomfort when she saw Jennifer on a bus in the months following the homicide and expressed concern about where Callum would be living on his release from prison. However, the daughter received support from a Victim Support Homicide Worker and, as stated Callum will be subject to a licence condition preventing contact with Ben's daughter following his release from prison.

Good Practice

6.57 There was much expected practice in this case. Good practice has been harder to identify although MIND's prompt agreement to offer in-person counselling to Callum as the second wave of the Covid-19 pandemic became apparent, is worthy of mention.

7.0 Conclusion

7.1 The victim Ben was stabbed to death by his partner Jennifer's adult son Callum in the home Ben had shared with Jennifer and her children from previous relationships - including Callum - for several years. The incident took place during the early hours of the morning after Ben and Jennifer began arguing after consuming alcohol and Callum, who was in his bedroom, heard the victim and his mother arguing downstairs and, fearing for his mother's safety, armed himself with a combat knife he had purchased previously and confronted Ben. In the struggle which followed, Callum inflicted the wounds from which Ben died shortly afterwards. Ben was known to the police as a perpetrator of domestic abuse against Callum's mother and a previous partner. Callum was not known to the police.

7.2 Although Ben was known to the police as a perpetrator of domestic abuse towards Jennifer, no agency became aware of the tension which existed between Callum and Ben, nor was any agency aware of the fact that Callum had purchased a combat knife.

7.3 The DHR has received conflicting accounts of the dynamics within the household in which Ben, Jennifer, Callum and three of Jennifer's younger children lived. Ben's adult daughter – who had never lived in Ben and Jennifer's household – felt that her father was dependent on Jennifer for a roof over his head and that when their relationship deteriorated he had 'nowhere to go', and that Jennifer bullied and controlled him. Ben's daughter's account is supported by his close friend's account. In his contribution to the DHR, Callum described the impact of the domestic abuse his mother suffered at the hands of Ben and her previous partner which led to him largely secluding himself in his bedroom and internalising his feelings, including frustration that he was unable to protect his mother from abuse.

7.4 Although no agency in contact with the family could have anticipated the homicide, there is considerable learning arising from this case, particularly about the opportunities provided to children, young people and young adults to disclose the impact upon them of domestic abuse in their household to the range of professionals they could come into contact with.

8.0 Recommendations and lessons to be learned

Supporting children, young people and young adults impacted by domestic abuse in their household.

8.1 In his contribution to this DHR, Callum described the impact on his daily life of living in a household in which domestic abuse by two successive partners of his mother was present. He described feeling an obligation to protect his mother but also feeling a degree of powerlessness in this regard given his youth and his physical stature compared to the partners. He appears to have experienced a degree of guilt at what he perceived as his failure to protect his mother, which, as with other feelings such as his resentment and hostility towards the two partners, he appears to have largely internalised. He also described secluding himself in his bedroom to avoid conflict with the partners. Ultimately, his desire to protect his mother and the antipathy he felt for his mother's partner Ben appear to have been instrumental in his acquisition of a combat knife and the homicide of Ben.

8.2 When considering what might have prevented this homicide, the DHR Panel was drawn to the view that an intervention which enabled Callum – and possibly his siblings – to share with others the impact on their lives of living in a household in which domestic abuse was present and to have the opportunity to access support – was crucial. The interventions by children's social care, early help services and others in 2016 and 2019/20, when two child and family assessments were completed, may have been missed opportunities, particularly the second child and family assessment which took place after – but was not informed by - the three domestic abuse incidents reported by, or on behalf of, Jennifer in which she disclosed abuse by Ben.

8.3 As previously stated there is an impressive range of domestic abuse services which have been developed for children and young people in Tameside, which Callum may have benefitted from if they were available during his childhood and adolescent years. Clearly there is no lack of services available – the issue for the DHR is how Callum might have been supported to discuss the impact that domestic abuse between Ben and his mother and between his mother and her former partner was having on his life. Callum appeared very reluctant to speak to professionals about the impact of domestic abuse on his life and after school/college he did not enter employment and appears to have become somewhat isolated and disempowered until his initially promising engagement with MIND. For Callum to have engaged with the domestic abuse services for children and young people, he would need to have become aware of them, which emphasises the importance of positive, yet sensitive promotion of those services. For Callum to have been referred to any of the services it would have needed the professionals he was in contact with

to have provided the opportunity and encouragement for him to disclose the impact of domestic abuse on his life, which further emphasises the potential value of routine enquiry. And for Callum to have disclosed the impact of domestic abuse within his household on his life would have needed a supportive environment in which his concerns could have been sensitively and intelligently explored by professionals with an awareness of the impact of domestic abuse on children, young people and young adults.

8.4 By the time of the homicide, Callum was approaching 22 years of age. Although he was an adult, his daily life did not appear so different from his teenage years in that he continued to live at home, continued to spend much of his time in his room, had not gained employment, was not undergoing training, continued to be affected emotionally by the break-up of a relationship several years earlier and in his own words had become 'stuck'. Therefore, providers of domestic abuse services for children and young people may need to consider the needs of young adults such as Callum as part of continuing service development or adopt a flexible approach to the age ranges of people they engage with.

8.5 It is therefore recommended that Tameside Community Safety Partnership reviews the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people, to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.

Recommendation 1

That Tameside Community Safety Partnership review the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people, to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.

8.6 Given that the perpetrator Callum was a young adult at the time of the homicide, the DHR Panel felt that it would be appropriate for this DHR report to be shared with Tameside Adults Safeguarding Partnership Board.

8.7 Tameside Children's Social Care have been asked to consider a single agency recommendation to ensure that relevant reports of domestic abuse are considered

when completing children and families' assessments (see Appendix A – single agency recommendations).

Preventing people becoming perpetrators of domestic abuse

8.8 Callum was not recognised as a potential perpetrator of domestic abuse until he killed Ben. The conflict in Callum's relationship with Ben appears to have been unknown outside of family and friends. Had professionals become aware of the conflict, it seems unlikely that they could have anticipated the extreme level of violence Callum would use against Ben. However, looking back with the benefit of hindsight and accepting the account Callum has provided to this DHR at face value, one is able to observe several factors which contributed to him becoming a perpetrator of fatal domestic violence – in particular his experience of domestic abuse from his mother's previous partner, the mutual hostility between Callum and Ben, Callum's response to the domestic abuse and the conflict which was to isolate himself in his room to escape/avoid it and to internalise his feelings, the pressure he put on himself to be his mother's protector and his acquisition of a weapon – an action which, with hindsight - appears to have been a concrete step towards a physical confrontation.

8.9 Tameside Council is currently receiving Ministry of Justice funding to deliver a local pilot for children and young people using harmful behaviours either within a familial (child to parent or sibling abuse) or intimate relationship. This intervention is delivered by Talk, Listen, Change (TLC) who are a third sector organisation based in Manchester, with over 15 years' experience of delivering domestic abuse perpetrator programmes. The funding for this pilot runs until 31st March 2024. Recognising the need for behaviour change work with children and young people, Tameside Council has included this intervention in the specification for Domestic Abuse Support Services which will run from 1st April 2024.

8.10 The Domestic Abuse Support Services specification also includes an Adult Behaviour Change perpetrator intervention which is currently a gap in the offer in Tameside - as identified in a recent independent needs assessment of perpetrators of domestic abuse. The needs assessment highlighted other areas of focus for Tameside in addressing domestic abuse offending, for which a dedicated multi-agency task and finish group has been established to deliver against the recommendations. It is recommended that the learning from this DHR, in particular the factors which appear to have contributed to a young man who was unknown to the police and not perceived to be a violent or aggressive male becoming a perpetrator of fatal domestic violence, should inform the work of the task and finish group.

Recommendation 2

That Tameside Community Safety Partnership ensures that the learning from this DHR, in particular the factors which appear to have contributed to Callum becoming a perpetrator of fatal domestic violence – including the impact of domestic abuse on his life as a child, young person and young adult - should inform the local task and finish group developing the Adult Behaviour Change perpetrator intervention.

Routine enquiry

8.11 Callum's contacts with his GP in 2020 and 2021 and Healthy Minds and MIND in 2020 represented opportunities for 'routine enquiry' in respect of domestic abuse to have been made. Additionally, Jennifer visited her GP on two occasions during the period under review but there is no indication that potential non-physical causes of her condition such as stress were explored with her. This case also indicates the importance of 'routine enquiry' focussing not only on intimate partner domestic abuse but also familial domestic abuse.

8.12 The implementation of the IRIS programme to GP practices in Tameside is a very welcome development (Paragraph 6.20). The training for GP practices envisaged as part of this programme will undoubtedly emphasise the importance of routine enquiry. In the meantime, it is recommended that Tameside Community Safety Partnership requests Greater Manchester Integrated Care (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry.

Recommendation 3

That Tameside Community Safety Partnership requests Greater Manchester Integrated Care (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry.

8.12 However, GP practices would be in a stronger position to consider 'routine enquiry' if they were notified of reports of domestic abuse relating to their patients. As stated in Paragraph 6.19, Jennifer's GP would not have been aware of the three prior reports of domestic abuse involving Ben and Jennifer as none of the incidents had triggered a MARAC referral or been considered by the Multi-Agency Safeguarding Hub (MASH) – either of which would have generated GP contact. The DHR Panel felt that there was a case for informing GPs of all reported domestic abuse incidents relating to their patients even though this would be quite a significant undertaking. The Panel noted that many domestic homicides arise in cases which had not previously been assessed as 'high' risk.

8.13 Greater Manchester Combined Authority (GMCA) are conducting a Greater Manchester MARAC Review, supported by the Domestic Abuse leads from each of the ten Local Authorities. The review was initiated by the Greater Manchester Domestic Abuse Steering Group in October 2022 with a focus on five key areas:

1. Meetings and recommended partners
2. Governance processes
3. MATAC (Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse perpetrators)/MAPPA (Multi-Agency Public Protection Arrangements) and MARAC
4. What works
5. Systems, recording, tracking and processes.

8.14 The issue of notifying GP practices of reported domestic abuse incidents relating to their patients has been shared with working group 5 of the Greater Manchester MARAC Review in recognition of the fact that this is an issue for all ten Local Authority areas. As a consequence, a meeting has been held with the Associate Director of the NHS Greater Manchester Integrated Care Board and a Greater Manchester working group has been established between GMCA and the GM ICB to resolve this issue.

Recommendation 4

That Tameside Community Safety Partnership notes that the issue of notifying GP practices of reported domestic abuse incidents relating to their patients is currently being considered by a joint Greater Manchester Combined Authority /NHS Greater Manchester Integrated Care Board working group and that the Community Safety Partnership awaits the outcome of this piece of work before taking any further action in respect of this matter.

8.15 Tameside, Oldham and Glossop Mind have been requested to consider a single agency recommendation in respect of adopting 'routine enquiry' in respect of domestic abuse (Appendix A) as they have advised this DHR that they do not use 'routine enquiry' for domestic abuse if 'they are not aware of domestic abuse' and pointed out that there had been no mention of domestic abuse in the referral they received in respect of Callum (Paragraph 6.18).

Advising GP practices of the outcome of mental health referrals

8.16 After MIND 'withdrew' the counselling service to Callum, there is no indication that MIND informed his GP or, indeed, Healthy Minds. Given that Callum's GP made

the initial referral to Healthy Minds which resulted in Callum accessing a service from MIND, it would seem appropriate for the GP practice – as initial referrer and as the repository of patient's health information - to be advised of the eventual outcome of the referral (Paragraph 6.21). It is therefore recommended that the Community Safety Partnership requests Pennine Care NHS Foundation Trust to ensure that when GP Practices refer patients to Healthy Minds, the GP practice is always advised of the outcome, including any onward referrals. It is possible that this could be accomplished by fulfilling or amending existing contractual arrangements.

Recommendation 5

That Tameside Community Safety Partnership requests Pennine Care NHS Foundation Trust to ensure that when GP Practices refer patients to Healthy Minds, the GP practice is always advised of the outcome, including any onward referrals.

8.17 Tameside, Oldham and Glossop Mind have been requested to consider a single agency recommendation that they routinely notifying the client's GP practice when the client's engagement with Mind ends (Appendix A).

DASH risk assessments

8.18 As the percentage of familial domestic homicides is substantial there may be a case for the DASH risk assessment to more fully consider other members of the household who could be drawn into the conflict between the perpetrator and the victim. The DHR has been advised the questions asked in the DASH risk assessment relate almost exclusively to the risks to the victim and the risks presented by the perpetrator. A Domestic Abuse Risk Assessment (DARA) – which has been promoted by the College of Policing – and which incorporates the standard DASH risk assessment – also includes a question 'does anyone else present a risk?'. At the time of writing this DHR report the DARA had not been adopted by GMP, but the DHR has recently been advised that GMP now plan to implement the DARA. Once the DARA has been adopted the 'does anyone else present a risk' question will be asked as part of the process of assessing risk of domestic abuse. Asking this question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Recommendation 6

That Tameside Community Safety Partnership notes Greater Manchester Police's intention to implement the Domestic Abuse Risk Assessment (DARA) which will include the new question of 'does anyone else present a risk?'. Asking this question

has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Impact on the family of the accused or convicted perpetrator

8.19 From this DHR and previous reviews the independent author has become aware that the families of people accused or convicted of serious crimes – particularly where there is media attention - can often face abuse from relatives and friends of the victim and also abuse via social media. Paragraphs 6.52 to 6.56 summarise some of the adverse consequences experienced by Callum's family. It is therefore recommended that the issue of support which may be required by the families of Domestic Homicide perpetrators is raised with the Home Office so that this issue can be considered at a national level.

Recommendation 7

That Tameside Community Safety Partnership raises the issue of support which may be required by the families of Domestic Homicide perpetrators with the Home Office so that this issue can be considered at a national level.

References

(1) Retrieved from https://www.welshwomensaid.org.uk/wp-content/uploads/2017/06/Who-Does-What-to-Whom.pdf

(2) Retrieved from https://www.safehousecenter.org/the-intersection-of-domestic-violence-and-poverty/

(3) Retrieved from https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#domestic-homicide-reviews-trends-location-and-demography

(4) ibid

(5) Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7289929/

(6) Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0193397320302070#:~:text=Youth%20exposed%20to%20violence%20are,when%20controlling%20for%20substance%20use.

(7) Retrieved from https://www.gov.uk/government/publications/alcohol-applying-all-our-health/alcohol-applying-all-our-health

(8) Retrieved from https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/unseen-men

(9) Retrieved from https://www.ias.org.uk/wp-content/uploads/2022/07/The-COVID-Hangover-report-July-2022.pdf

(10) Retrieved from https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews#domestic-homicide-reviews-trends-location-and-demography

Appendix A

Single Agency Recommendations

Greater Manchester Police

- No recommendations

- GMP are asked to consider a single agency recommendation to remind officers to consider any children in the household when the incident takes place away from the family home (See Paragraph 6.38)

NHS Tameside and Glossop Clinical Commissioning Group (Greater Manchester Integrated Care (Tameside) since 1.7.2022)

- GPs to consider if Domestic Abuse is a factor when patients present with mental health issues or exacerbations of conditions where stress can be a trigger.

- GPs to exercise professional curiosity when presented with possible indicators of child neglect.

Pennine Care NHS Foundation Trust

- Ensure case are stepped up and stepped down at MDT if intervention does not make a positive difference to patient's health and wellbeing to review the pathway of care.

Tameside and Glossop Integrated Care NHS Foundation Trust

- Health professionals to evidence use of professional curiosity when dealing with blended families.

- Health professionals to consider wider environmental factors when there is evidence of neglect.

Tameside Children's Social Care

- Tameside Children's Social care is asked to consider a single agency recommendation to ensure that relevant reports of domestic abuse are considered when completing children and families' assessments.

Tameside, Oldham and Glossop Mind

- Tameside, Oldham and Glossop Mind have advised the DHR that they are in the continual process of ensuring all staff are trained in not using clinical language such as 'discharge' or 'withdrawal (of service), which is not language which aligns with their organisational values.

- They also advise that clients waiting for their services are made aware of operating services that can be accessed whilst waiting and receive referral confirmation email with additional Minds Matter online workshops available to them. These free to access additional online workshops include Sleeping Well, Boosting Confidence, 5 Ways to Wellbeing, and Overcoming Worries. In addition, Safe Tameside - a walk-in crisis service - is promoted along with other helplines to their Tameside clients.

- Placement counsellors now receive training and guidelines to provide remote/online counselling sessions as part of their counselling training. Tameside, Oldham and Glossop advise that current waiting time is approximately three months depending on the client's availability.

- Tameside, Oldham and Glossop Mind are asked to consider adopting 'routine enquiry' in respect of domestic abuse.

- Tameside, Oldham and Glossop Mind are asked to consider routinely notifying the client's GP practice when they are no longer receiving a service from Mind.

Glossary

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is a continuing 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.

Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

DASH (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and ‘honour’-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.

Tameside Community Safety Partnership

Domestic Homicide Review Executive Summary

Victim – Ben, who was unlawfully killed in August 2021

Independent Author – David Mellor BA QPM

Report completed on 20th October 2023

Final amendments following DHR QA Panel feedback on 26 July 2024

1.0 Introduction

1.1 This is an Executive Summary of a Domestic Homicide Review (DHR) undertaken by Tameside Community Safety Partnership following the unlawful killing of Ben (a pseudonym).

1.2 The victim Ben was stabbed to death by his partner's son, who will be referred to as 'Callum' in the home the victim shared with his partner, who will be referred to as 'Jennifer' - and her 4 children from previous relationships, including Callum. Callum was 21 at the time of the incident and his 3 younger siblings were aged 13 and under. The incident took place during the early hours of the morning after Ben and Jennifer began arguing after consuming alcohol and Callum, who was in his bedroom, heard the victim and his mother arguing downstairs and, fearing for his mother's safety, armed himself with a combat knife he had purchased earlier and confronted Ben. In the struggle which followed, Callum inflicted the wounds from which Ben died shortly afterwards. Ben was known to the police as a perpetrator of domestic abuse against Jennifer and a previous partner. Callum was arrested and charged. His subsequent plea of 'guilty' to manslaughter on the grounds of self-defence was accepted and he was sentenced to two years and seven months imprisonment.

1.3 The DHR process began with an initial meeting of representatives of Tameside Community Safety Partnership on 13th September 2021 when the decision to hold a DHR was unanimously agreed. All agencies that potentially had contact with the victim and/or perpetrator prior to the unlawful killing were contacted and asked to confirm whether they had involvement with them. The agencies which confirmed contact with the victims and/or perpetrator and were asked to secure their files.

1.4 The following agencies provided Individual Management Reviews to inform the review:

- Greater Manchester Police
- NHS Tameside and Glossop Clinical Commissioning Group (Greater Manchester Integrated Care Board (Tameside) since 1.7.2022) on behalf of the family's GP practice.
- Pennine Care NHS Foundation Trust
- Tameside and Glossop Integrated Care NHS Foundation Trust

The following agencies provided summary Individual Management Reviews to inform the review:

- Tameside, Oldham and Glossop MIND.

Additionally, the National probation Service shared relevant extracts from the pre-sentence report they completed in respect of the perpetrator.

1.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

1.6 The victim Ben's partner Jennifer and his daughter were advised that the DHR had been commissioned and invited to contribute to the DHR once criminal proceedings had been completed. Jennifer decided not to contribute to the DHR. Ben's daughter contributed to the DHR. She was offered the opportunity to meet the DHR Panel but said that she did not wish to do this. She decided not to read and comment on the DHR report although she has asked to be provided with a copy of the report once published. A close friend of Ben also contributed. The perpetrator Callum was invited to contribute to the DHR – which he did.

The DHR Panel Members

1.7 The DHR Panel consisted of:

Name	**Organisation**
Suzanne Antrobus	Head of Legal services, Tameside MBC
Emma Booth	Business Support Officer, Tameside MBC
Suzanne Fawcett	Detective Constable GMP Serious Case Review Unit
Luke Godfrey	Operations Manager, Victim Support
John Gregory	Head of Community Safety and Homelessness, Tameside MBC
Danielle Henniker	Deputy Services Manager, My Recovery drug and alcohol service provided by Change Grow Live
Karen Holden	Head of Nursing for Integrated Safeguarding, Tameside and Glossop Integrated Care NHS Foundation Trust.
Caroline Home	Independent Domestic Violence Advocate
Tracey Hurst	Designated Nurse Adult Safeguarding, Greater Manchester Integrated Care (Tameside).
Anna Jenkins	Principal Social Worker (Adults), Safeguarding, Quality and Practice Team
Darren Lawton-Edge	Named Professional Safeguarding Adults, Pennine Care NHS Foundation Trust
David Mellor	Independent Chair and Author
Vanessa Rothwell	Partnership Manager, Tameside MBC
Faith Scott	Senior Probation Officer, National Probation Service
Dave Smith	Partnership Manager, Tameside MBC
Anna Svarc	Designated Nurse, Greater Manchester Integrated Care Board.

1.8 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions: on 20th October 2021, 17th May 2022, 14th September 2022 and 17th November 2022.

Author of the overview report

1.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has ten years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

1.10 The independent chair and author was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

1.11 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.12 Whilst a member of Greater Manchester Police he served in Tameside from 1990 until 1992 but has no current connection to services in Tameside.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

7. 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;

8. 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;

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

10. 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;

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

12. Highlight good practice.

2.2 The case specific terms of reference are as follows:

m. How effectively were any disclosures by, or indications of domestic abuse to, the victim addressed by the agencies in contact with him?

n. How effectively were the risks to the victim presented by the perpetrator assessed and managed? The perpetrator's acquisition and storage of the weapon with which he unlawfully killed the victim should also be considered.

o. The victim domestically abused the perpetrator's mother on a number of occasions. Did professionals consider the dynamics of the relationship between the victim and the perpetrator's mother and consider whether there was any risk of the perpetrator becoming involved by intervening to protect his mother?

p. Initial information provided to this DHR indicates that no incident of domestic abuse involving the victim and the perpetrator was reported to any agency prior to the death of the victim. Therefore any barriers to the victim or the perpetrator accessing support will be explored.

q. How effective was the support offered or provided to the perpetrator in respect of his mental health needs including anxiety and low mood?

r. What support was offered or provided to the perpetrator in respect of education, employment or training?

s. The victim and the perpetrator's mother drank alcohol to excess on occasions which appeared to contribute to verbal arguments between them and also appeared to be a trigger to the victim becoming violent and abusive towards the perpetrator's mother. Were either the victim or the perpetrator's mother referred or signposted to, or offered or provided with support in respect of their use of alcohol?

t. Consider the lived experience of the three children living in the household with the victim, the perpetrator's mother and the perpetrator.

u. How effective was multi-agency working in this case?

v. Did the agencies in contact with the victim, the perpetrator's mother, the perpetrator or the children in the household communicate and share information effectively with each other?

w. Were there any specific considerations around equality and diversity issues in respect of the victim or perpetrator such as age, disability (including learning disabilities),

gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

x. Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect the victim, the perpetrator's mother or the perpetrator or impact upon the support provided or offered to them by agencies?

3.0 Summary Chronology

Background information (3.1-3.3)

3.1 Ben's relationship with Jennifer began in 2016. He had two daughters from an earlier relationship. One of Ben's daughter's has contributed to the DHR and she described her father as a lovely man who was very affectionate and loved his families. She went on to say that he cared for her 'so much' and had been very proud of her for being in work in a good job. She said that her father was a 'chatterbox' who enjoyed going out to the pub and being with people. She said that he 'wasn't perfect' as a younger man but he had grown up, matured and become a better person. The extent to which Ben assumed co-parenting responsibilities for the four children living with Jennifer, including the perpetrator is unclear. In his contribution to the DHR, Callum described a conflicted relationship between Ben and himself and two of his younger siblings, whilst Ben's daughter said that he loved Jennifer's three younger children and would pick them up from school after Jennifer found employment. However, Ben's daughter said that she was aware that her father and Callum were not 'fans' of each other, adding that Callum spent all his time in his room playing video games. Ben appeared to have been unemployed for some time and when he engaged with largely unsuccessful support to help him find employment, barriers to employment were stated to be dyslexia and literacy. His daughter said that he had earlier been employed as a painter and decorator and in manual work. He appeared to be in good health, attending his GP practice infrequently for asthma and minor health issues. It appears that he drank alcohol to excess on occasions but there is no indication that he was referred or encouraged to self-refer for support from alcohol services.

3.2 The perpetrator Callum lived with his mother Jennifer, his father and a younger sibling until his parents separated. Callum has advised this DHR that he had a difficult relationship with his mother's next partner, with whom she had a further two children. During this period of his life it appears that he grew accustomed to secluding himself in his bedroom to avoid his mother's partner. Callum was 16 years of age when his mother began her relationship with Ben. Callum also had a difficult relationship with Ben and continued to seclude himself in his bedroom. He attended a local high school and progressed to post 16 college but experienced difficulty in finding employment. He began to experience low mood and insomnia and sought help from primary care and mental health services. He appeared to have been very adversely affected by the break-up of an intimate relationship during his teenage years and when he sought help for his low mood, described himself as 'stuck'. He was asthmatic but this appeared to have been well controlled.

3.3 Jennifer was the mother of six children. Her first two children were born during her teenage years and appear to have been cared for by family members rather than Jennifer herself. It is not known whether this was as a result of formal proceedings or whether it was an informal arrangement. She went on have four more children, including the perpetrator Callum, all of whom were brought up by her. She appeared to struggle to parent the children effectively at times and when agencies became involved she sometimes proved difficult to engage with. Jennifer decided not to contribute to the DHR and so little is known about Jennifer's early life or her employment history. During the period in which she was bringing up the four children who lived with her, she was a lone parent at times, or assumed the bulk of the parenting responsibilities, particularly during her relationship with Ben, although Ben's daughter said that Ben began collecting the younger children from school after Jennifer found employment. Jennifer's youngest child described Ben as her mother's 'friend' to the School Nurse. Most of Jennifer's contacts with primary care in more recent years related to a condition and on two occasions she presented with acute exacerbation of her symptoms. It is difficult to take a fully informed view of the impact of domestic abuse on her adult life. In his contribution to this DHR, the perpetrator Callum stated that both Ben and her previous partner were abusive towards her. When incidents were reported to the police, she appeared reluctant to support a prosecution. It is unclear why this was the case. There is no evidence of controlling or coercive behaviour from Ben although, when asked, Callum replied that his mother could have been in fear of Ben, but he wasn't aware of this. It is noted that Ben had a tendency to return to her address intoxicated after she had told him to leave which could be construed as controlling behaviour by Ben, in that he may have been unwilling to countenance her ending the relationship. However, Ben's daughter has drawn attention to her father's long term lack of a permanent address which she feels created a dependency on Jennifer, and an opportunity for her to exercise control over him, as Ben's daughter said that if his relationship with Jennifer ended, he would have been homeless and reliant on the generosity of friends to allow him to 'sofa surf'.

3.4 It is understood that the relationship between Ben and Jennifer began in 2016, although it is not known when Ben permanently moved into the home Jennifer shared with four of her six children. Jennifer began her tenancy at the address in 2012 when her former partner (father of her youngest two children) was a joint tenant. Ben was never known to Jennifer's housing provider in respect of this address. When their relationship began Ben would have been 42 and Jennifer 38. The four children in her care at the time her relationship with Ben began were the perpetrator Callum (then 16) and his younger siblings. The youngest two siblings had been born to Jennifer and her previous partner. Callum and his eldest sibling were born to Jennifer and an earlier partner.

3.5 Children's social care became involved with the family in November 2016 when Callum's eldest sibling disclosed to a teaching assistant at his primary school that his mother had been punching him in the head and 'tummy' and that it made him feel sick, and as a result he went to bed. The school had not noted any injuries to this child, although there is no indication that the child was examined. The primary school contacted children's social care and informed them that the school felt that the family seemed to be 'borderline' for possible neglect issues in that the children looked somewhat unkempt at times 'as though they have

worn the same clothes all week' and there had been issues with head lice. The school spoke to Jennifer who denied 'ever laying a hand' on the children whilst acknowledging that things could be 'hectic' at home.

3.6 Children's social care completed a child and family assessment which recommended that the case was closed to children's social care and that the children's' needs should be met at the 'universal' level. Jennifer was said to have fully co-operated with children's social care and to have been open and honest. The extent to which Ben took on parenting responsibilities in respect of the four children in her care is unclear. In his contribution to the DHR, the perpetrator Callum stated that Ben 'never got along with him (Callum) and his siblings', adding that Ben treated his two younger male siblings 'like crap' and 'hated' him (Callum) and, as a result, Callum stayed away from him and kept to himself when Ben was in the house. However, Ben's daughter said that Ben loved the three younger children and began collecting them from school after Jennifer gained employment.

3.7 During the year before his relationship with Jennifer began – in October 2015 – Ben was arrested by the police after damaging a window at his ex-partner's address by throwing stones at the glass to attract her attention. The police cautioned Ben for the damage and officers issued him with a harassment warning notice in relation to him attending at his ex-partner's address.

3.8 The police were called to the first reported incident involving Ben and Jennifer in August 2017. Jennifer reported that she and Ben had separated two days earlier but Ben had visited her address whilst intoxicated, forced his way inside, gone upstairs and fallen asleep. Ben left the address when asked to do so by Jennifer prior to police attendance. The risk was assessed as 'standard' by the police, who referred Jennifer to Strive[10] but it appears that this service was unable to engage with her.

3.9 The second reported incident took place during the early hours of 1st January 2019 when the police received a call from a member of the public who reported that a male and female were arguing in a church yard in Ashton-under-Lyne and that the male was hitting the female who was on the floor. Officers attended and separated Ben and Jennifer. Jennifer initially stated that she had fallen over and denied any assault had taken place. However, after an officer contacted the caller who had witnessed the assault, Jennifer confirmed that she had been assaulted by Ben but did not wish to provide a statement. Jennifer was described as 'intoxicated' and was taken to her sister's address. Ben was arrested. When Jennifer was visited the following day she denied that any assault had taken place and said that she wanted Ben 'back home.' When interviewed Ben stated that he and Jennifer had both been drinking, had had a heated discussion resulting in Jennifer hitting him, he had retaliated and pushed her which caused her to fall due to her level of intoxication. In the absence of an account from Jennifer, it was decided to take no action. The DASH risk

[10] The STRIVE initiative involved 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.

assessment generated a 'standard' risk to Jennifer which the officer increased to 'medium' risk on professional judgement grounds. There is no indication that any referrals were made in respect of Jennifer or her children.

3.10 On 14th December 2019 the police attended a further domestic incident involving Ben and Jennifer. On this occasion it was documented that they had recently separated and Ben, whilst under the influence of alcohol, had gone to Jennifer's address and attempted to gain entry. When refused, he had picked up a brick and threatened to smash a window. When officers arrived at the location Ben was still in the area and was allowed to leave to stay at a friend's house for the night. After checking the domestic abuse history, officers recorded the incident as 'standard' risk. A DASH risk assessment was completed which did not indicate any areas of concern although Jennifer answered 'no' to most questions. The officer noted that the relationship had recently ended whilst recognising that it could recommence in the future.

3.11 The officer noted that there were two children at the address (all 4 of the children who lived with mother were documented including Callum) at the time of the incident and the schools the children attended were subsequently notified under Operation Encompass.[11]

3.12 On 27th January 2020 Jennifer saw her GP with acute exacerbation of a condition. A plan was developed, her medication was reviewed and she was commenced on a different medication. (Jennifer was again reviewed by her GP on 30th January 2020)

3.13 On 18th February 2020 Callum saw his GP and said that he had been struggling with his emotions after breaking up with his girlfriend 4 years previously and was finding it difficult to obtain employment. The GP documented that Callum had no thoughts of suicide or self-harm and diagnosed mixed anxiety and a depressive disorder. The GP prescribed sertraline[12] 50mgs once daily and subsequently referred Callum to Healthy Minds[13] for counselling citing mood changes, anxiety, depression and insomnia. On 3rd March 2020 Callum re-contacted his GP to say that he had not been taking the sertraline over concerns about the possible side-effects. After receiving reassurance from the GP, Callum decided to begin taking the medication. The GP planned to review him in two to three weeks.

3.14 On 5th March 2020 Healthy Minds discussed the GP referral in respect of Callum at their multi-disciplinary meeting (MDT) and agreed to invite him for a telephone assessment triage appointment and wrote to him on 9th March 2020. Callum accepted the invitation and gave permission for Jennifer to speak on his behalf.

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[11] Operation Encompass is a police and education early information safeguarding partnership enabling schools to offer immediate support to children experiencing domestic abuse and ensures that there is a telephone call or notification to a school's trained Designated Safeguarding Lead prior to the start of the next school day after an incident of police attended domestic abuse where there are children related to either of the adult parties involved.

[12] Sertraline is a type of antidepressant which is often used to treat depression and also sometimes panic attacks, obsessive compulsive disorder and post-traumatic stress disorder.

[13] Healthy Minds offers a range of talking therapies to support the person's mental health.

3.15 On 13th March 2020 Callum told his GP that he didn't want to continue taking sertraline and preferred cognitive behavioural therapy. He continued to report no thoughts of suicide or self-harm.

3.16 On 18th March 2020 the Healthy Minds telephone triage assessment took place during which Callum explained that he had felt very 'stuck' over the past three and a half years and had found it hard to move forward with his life. He went on to say that throughout high school he had a best friend, with whom he eventually began a romantic relationship. He said that he had 'lost her' in the last year of school and became upset when discussing this. The relationship had ended three and a half years previously. He reported difficulty in speaking to or trusting new people and said he avoided developing new relationships. He also described less enjoyment of his general activities. He said that he had struggled to find a job and had stopped sending out applications as he very seldom got interviews. He reported playing a lot of x-box games to fill his time, adding that he had previously played football but his friends were all busy working in full-time jobs and so he did not go out with them as often. He said he struggled to sleep, sometimes ruminating on the past and stayed awake until he eventually 'crashed'. He said his appetite had diminished. The PHQ 9 [Depression Test Questionnaire] assessment was completed. No significant risk of harm to self or others was identified. A safety plan and crisis numbers were discussed. Callum said he would return to his GP if his mood deteriorated. The agreed plan was for Callum to be referred to Tameside, Oldham and Glossop MIND for 'adjustment to loss' counselling – which can include support in respect of bereavement, the end of a relationship, losing a job or losing a home. Callum was accepted by MIND and on 26th March 2020 he was discharged by Healthy Minds and his GP informed.

3.17 The concerns about parental neglect referred to children's social care by the primary school in respect of Callum's eldest sibling (Paragraph 3.5 and 3.6) resurfaced in 2020. The child was attending secondary school by this time. In February of that year the secondary school referred the child to children's social care on the grounds of poor home conditions, lack of hygiene and (unspecified) additional needs. These concerns had been ongoing since September 2019 when the child transferred from primary school. The secondary school had struggled to engage with Jennifer despite sending a letter home and attempting a home visit. Children's social care completed a child and family assessment which noted that hygiene and head lice had been long standing issues for the 11 year old child and their two younger siblings (then 9 and 6 and attending the primary school their 11 year old sibling had previously attended) and that if nothing changed for them, this could affect their health, self-esteem, peer relationships and their learning. The assessment recommended that targeted support by Tameside Families Together (TFT)[14] should be provided, informed by an early help assessment (EHA) which had been commenced by the primary school. There was then a delay of three months in the case being sent to Tameside Families Together. Jennifer's engagement with them was described as poor and she cancelled several planned visits, saying she 'worked a lot'.

[14] The Tameside Families Together service provides family intervention work as part of the local multi-agency Early Help offer.

3.18 The primary school had also referred the youngest sibling (aged 6) to the School Nurse because of head lice infestation, which continued for twelve months despite the School Nurse working with the family, the school and the family's GP over that period. Although family contact for all agencies supporting the children was primarily with Jennifer, the School Nurse came into contact with the victim Ben on two occasions during her work with the family. The youngest sibling referred to him as her mother's 'friend'.

3.19 On 23rd March 2020 the first Covid-19 lockdown commenced. Jennifer had been working part-time at a cashier in a large store from Sept 2019 but she began self-isolating from the first Covid lockdown onwards because she was identified as at high risk of developing complications should she contract Covid-19. Thereafter she does not appear to have worked outside the home.

3.20 On 2nd April 2020 Jennifer again contacted her GP for an acute exacerbation of her condition which resulted in a clinical assessment, medical adjustment and commencement on antibiotics.

3.21 In October 2020 TFT closed the family's case after Jennifer said that she no longer required their support and she questioned why the schools had any raised concerns in the first place. The primary school were said to have reported that things were 'much better'. The primary school has also advised the DHR that they made weekly telephone calls to the family during the first Covid-19 lockdown and made sure that the family were accessing the food parcel scheme. In their contribution to the DHR, the secondary school questioned the effectiveness of the early help support earlier provided to the older child who transferred to their school describing this child as experiencing what the secondary school described as 'severe neglect' in that they had a strong smelling odour, general uncleanliness, a visibly filthy uniform and showed signs of hunger whilst at school.

3.22 On 9th September 2020 the MIND counsellor to whom Callum's referral had been allocated telephoned Callum to offer remote counselling either by telephone or online but Callum said that he wasn't comfortable with either of these options and preferred face to face (F2F) counselling. It was therefore agreed that he would be provided with six weekly F2F counselling from 16th October 2020. In the reports MIND shared with the DHR, they stated that the focus of the sessions was anxiety, low confidence and low self-esteem. MIND have shared his SWEMWBS[15] scores, which indicated a fairly substantial improvement in his mental wellbeing. In his contribution to the DHR, the perpetrator Callum said that the counsellor opened his mind to being happy in the future and he felt that he was in a better place as a result of the counselling.

[15] The SWEMWBS is **a** short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). The WEMWBS was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.

3.23 Callum attended F2F sessions with his MIND counsellor on 16th, 23rd and 30th October 2020. The counsellor was unable to attend the fourth F2F session scheduled for 6th November 2020 and telephoned Callum to offer to deliver this session by telephone instead. Callum declined this, saying he preferred to wait until the counsellor was available for further F2F sessions. Callum's mother then cancelled his resumed F2F session scheduled for 13th November 2020 and he did not attend the next session scheduled for 20th November 2020. MIND then withdrew their service from Callum as he had either missed or cancelled two sessions.

3.24 On 12th April 2021 Callum had a telephone consultation with his GP in which he reported low mood. He was documented to have no thoughts of deliberate self-harm. The GP prescribed fluoxetine[16] 20mg capsules – one to be taken each day. The GP advised Callum to take them for at least six months. A telephone review would be conducted after three weeks or as needed. The GP documented that Callum would contact MIND but MIND has advised the DHR that he did not make further contact with them. The GP also issued a fit note[17] on the grounds of Callum's depressive disorder.

3.25 On 4th May 2021 Callum spoke to his GP by telephone and said that he was 'managing on fluoxetine'. Callum again spoke to his GP by telephone on 25th May 2021 when he was documented to be 'happy' with fluoxetine and had had no thoughts of self-harm or suicide.

3.26 On a date in early August 2021 the police received a telephone call from Callum's eldest sibling to say that Callum had stabbed Ben at their home address. Callum then came onto the telephone line to say that Ben had attacked his mother Jennifer and that he (Callum) had run to the kitchen and grabbed a knife with which he stabbed Ben in order to defend his mother. Callum added that he was unable to recall where on his body he had stabbed Ben but he did not appear to be breathing. Police and paramedics attended the address and found Ben in a collapsed state on the floor of the lounge. Emergency medical intervention was attempted, and Ben was taken to Hospital 1 however life was pronounced extinct within an hour of his arrival at hospital.

3.27 Ben was found to have sustained a stab wound from the angle of his right jaw/right ear area through to, and penetrating from the left rear of his neck, with severe force thereby cutting the main vein in the neck. In addition, he had sustained a deep wound to the right upper back, also with severe force, which had cut through the right collar bone and had partially incised the inside of the right third rib. There were two wounds to the right side of his scalp. It is assumed that Ben would have bled to death very quickly.

[16] Fluoxetine is a type of antidepressant which often used to treat depression, and sometimes obsessive compulsive disorder and bulimia.

[17] If someone is off work sick for more than 7 days, their employer will usually ask for a fit note (or Statement of Fitness for Work) from a healthcare professional. Fit notes are sometimes referred to as medical statements or a doctor's note.

3.28 The police discovered the knife which Callum used to stab Ben under a sink in the kitchen of the address. The knife was a combat knife which was 18.5cm in length and 3.5cm wide. The sheath for the knife was located in Callum's bedroom and it was established that he had armed himself with the knife before leaving his bedroom and going downstairs to confront Ben. Callum was arrested and later charged with the murder of Ben. Callum maintained that he had purchased the knife some time earlier in order to start a collection of weapons. The murder weapon was the only knife he possessed at the time of the homicide.

4.0 Key issues arising from the review.

Supporting children, young people and young adults impacted by domestic abuse in their household.

4.1 In his contribution to this DHR, Callum described the impact on his daily life of living in a household in which domestic abuse by two successive partners of his mother was present. He described feeling an obligation to protect his mother but also feeling a degree of powerlessness in this regard given his youth and his physical stature compared to the partners. He appears to have experienced a degree of guilt at what he perceived as his failure to protect his mother, which, as with other feelings such as his resentment and hostility towards the two partners, he appears to have largely internalised. He also described secluding himself in his bedroom to avoid conflict with the partners. Ultimately, his desire to protect his mother and the antipathy he felt for his mother's partner Ben appear to have been instrumental in his acquisition of a combat knife and the homicide of Ben.

4.2 When considering what might have prevented this homicide, the DHR Panel was drawn to the view that an intervention which enabled Callum – and possibly his siblings – to share with others the impact on their lives of living in a household in which domestic abuse was present and to have the opportunity to access support – was crucial. The interventions by children's social care, early help services and others in 2016 and 2019/20, when two child and family assessments were completed, may have been missed opportunities, particularly the second child and family assessment which took place after – but was not informed by - the three domestic abuse incidents reported by, or on behalf of, Jennifer in which she disclosed abuse by Ben.

4.3 As previously stated there is an impressive range of domestic abuse services which have been developed for children and young people in Tameside, which Callum may have benefitted from if they were available during his childhood and adolescent years. Clearly there is no lack of services available – the issue for the DHR is how Callum might have been supported to discuss the impact that domestic abuse between Ben and his mother and between his mother and her former partner was having on his life. Callum appeared very reluctant to speak to professionals about the impact of domestic abuse on his life and after school/college he did not enter employment and appears to have become somewhat isolated and disempowered until his initially promising engagement with MIND. For Callum to have engaged with the domestic abuse services for children and young people, he would need to have become aware of them, which emphasises the importance of positive, yet

sensitive promotion of those services. For Callum to have been referred to any of the services it would have needed the professionals he was in contact with to have provided the opportunity and encouragement for him to disclose the impact of domestic abuse on his life, which further emphasises the potential value of routine enquiry. And for Callum to have disclosed the impact of domestic abuse within his household on his life would have needed a supportive environment in which his concerns could have been sensitively and intelligently explored by professionals with an awareness of the impact of domestic abuse on children, young people and young adults.

4.4 By the time of the homicide, Callum was approaching 22 years of age. Although he was an adult, his daily life did not appear so different from his teenage years in that he continued to live at home, continued to spend much of his time in his room, had not gained employment, was not undergoing training, continued to be affected emotionally by the break-up of a relationship several years earlier and in his own words had become 'stuck'. Therefore providers of domestic abuse services for children and young people may need to consider the needs of young adults such as Callum as part of continuing service development or adopt a flexible approach to the age ranges of people they engage with.

4.5 It is therefore recommended that Tameside Community Safety Partnership reviews the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people, to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.

Recommendation 1

That Tameside Community Safety Partnership review the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people, to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.

4.6 Given that the perpetrator Callum was a young adult at the time of the homicide, the DHR Panel felt that it would be appropriate for this DHR report to be shared with Tameside Adults Safeguarding Partnership Board.

4.7 Tameside Children's Social Care have been asked to consider a single agency recommendation to ensure that relevant reports of domestic abuse are considered when completing children and families assessments (see Appendix A – single agency recommendations).

Preventing people becoming perpetrators of domestic abuse

4.8 Callum was not recognised as a potential perpetrator of domestic abuse until he killed Ben. The conflict in Callum's relationship with Ben appears to have been unknown outside of family and friends. Had professionals become aware of the conflict, it seems unlikely that they could have anticipated the extreme level of violence Callum would use against Ben. However, looking back with the benefit of hindsight and accepting the account Callum has provided to this DHR at face value, one is able to observe several factors which contributed to him becoming a perpetrator of fatal domestic violence – in particular his experience of domestic abuse from his mother's previous partner, the mutual hostility between Callum and Ben, Callum's response to the domestic abuse and the conflict which was to isolate himself in his room to escape/avoid it and to internalise his feelings, the pressure he put on himself to be his mother's protector and his acquisition of a weapon – an action which, with hindsight - appears to have been a concrete step towards a physical confrontation.

4.9 Tameside Council is currently receiving Ministry of Justice funding to deliver a local pilot for children and young people using harmful behaviours either within a familial (child to parent or sibling abuse) or intimate relationship. This intervention is delivered by Talk, Listen, Change (TLC) who are a third sector organisation based in Manchester, with over 15 years' experience of delivering domestic abuse perpetrator programmes. The funding for this pilot runs until 31st March 2024. Recognising the need for behaviour change work with children and young people, Tameside Council has included this intervention in the specification for Domestic Abuse Support Services which will run from 1st April 2024.

4.10 The Domestic Abuse Support Services specification also includes an Adult Behaviour Change perpetrator intervention which is currently a gap in the offer in Tameside - as identified in a recent independent needs assessment of perpetrators of domestic abuse. The needs assessment highlighted other areas of focus for Tameside in addressing domestic abuse offending, for which a dedicated multi-agency task and finish group has been established to deliver against the recommendations. It is recommended that the learning from this DHR, in particular the factors which appear to have contributed to a young man who was unknown to the police and not perceived to be a violent or aggressive male becoming a perpetrator of fatal domestic violence, should inform the work of the task and finish group.

Recommendation 2

That Tameside Community Safety Partnership ensures that the learning from this DHR, in particular the factors which appear to have contributed to Callum becoming a perpetrator of fatal domestic violence – including the impact of domestic abuse on his life as a child, young person and young adult - should inform the local task and finish group developing the Adult Behaviour Change perpetrator intervention.

Routine enquiry

4.11 Callum's contacts with his GP in 2020 and 2021 and Healthy Minds and MIND in 2020 represented opportunities for 'routine enquiry' in respect of domestic abuse to have been made. Additionally, Jennifer presented with acute exacerbation of a condition to her GP on two occasions during the period under review but there is no indication that potential non-physical causes of this acute exacerbation such as stress were explored with her. This case also indicates the importance of 'routine enquiry' focussing not only on intimate partner domestic abuse but also familial domestic abuse.

4.12 The DHR has been advised that funding has been secured to procure the IRIS (Identification and Referral to Improve Safety) for Tameside GP practices. The IRIS programme was first implemented nationally in 2011 and is now an evidence-based specialist domestic abuse training, support and referral programme for general practices that has been positively evaluated. The positive outcomes include helping GP practices to deliver an improved quality of care for patients experiencing domestic abuse. The implementation of the IRIS programme to GP practices in Tameside is a very welcome development.. The training for GP practices envisaged as part of this programme will undoubtedly emphasise the importance of routine enquiry. In the meantime, it is recommended that Tameside Community Safety Partnership requests Greater Manchester Integrated Care (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry.

Recommendation 3

That Tameside Community Safety Partnership requests Greater Manchester Integrated Care (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry.

4.13 However, GP practices would be in a stronger position to consider 'routine enquiry' if they were notified of reports of domestic abuse relating to their patients. As stated in Paragraph 6.19, Jennifer's GP would not have been aware of the three prior reports of domestic abuse involving Ben and Jennifer as none of the incidents had triggered a MARAC referral or been considered by the Multi-Agency Safeguarding Hub (MASH) – either of which would have generated GP contact. The DHR Panel felt that there was a case for informing GPs of all reported domestic abuse incidents relating to their patients even though this would be quite a significant undertaking. The Panel noted that many domestic homicides arise in cases which had not previously been assessed as 'high' risk.

4.14 Greater Manchester Combined Authority (GMCA) are conducting a Greater Manchester MARAC Review, supported by the Domestic Abuse leads from each of the ten Local Authorities. The review was initiated by the Greater Manchester Domestic Abuse Steering Group in October 2022 with a focus on five key areas:

1. Meetings and recommended partners

2. Governance processes
3. MATAC (Multi-Agency Tasking and Coordination process of identifying and tackling serial perpetrators of domestic abuse perpetrators)/MAPPA (Multi-Agency Public Protection Arrangements) and MARAC
4. What works
5. Systems, recording, tracking and processes.

4.15 The issue of notifying GP practices of reported domestic abuse incidents relating to their patients has been shared with working group 5 of the Greater Manchester MARAC Review in recognition of the fact that this is an issue for all ten Local Authority areas. As a consequence a meeting has been held with the Associate Director of the NHS Greater Manchester Integrated Care Board and a Greater Manchester working group has been established between GMCA and the GM ICB to resolve this issue.

Recommendation 4

That Tameside Community Safety Partnership notes that the issue of notifying GP practices of reported domestic abuse incidents relating to their patients is currently being considered by a joint Greater Manchester Combined Authority /NHS Greater Manchester Integrated Care Board working group and that the Community Safety Partnership awaits the outcome of this piece of work before taking any further action in respect of this matter.

4.16 Tameside, Oldham and Glossop MIND has advised the DHR that they do not use 'routine enquiry' for domestic abuse if 'they are not aware of domestic abuse' and pointed out that there had been no mention of domestic abuse in the referral they received in respect of Callum. Had 'routine enquiry' been considered, Callum may have been reluctant to talk about his feelings towards Ben and his mother. The issues which he sought help with were the impact of the break-up of an important relationship and a feeling that he had become 'stuck' in his life having been unable to find employment. However, in his contribution to this DHR, Callum said that he planned to seek support in respect of the impact of Ben's behaviour on his mother and himself had the MIND counselling sessions continued beyond the initial three sessions. There is some doubt about Callum's stated openness to discussing these issues with the MIND counsellor as it was Callum who stopped attending the sessions. Mind have been requested to consider a single agency recommendation in respect of adopting 'routine enquiry' in respect of domestic abuse.

Advising GP practices of the outcome of mental health referrals

4.17 After MIND 'withdrew' the counselling service to Callum, there is no indication that MIND informed his GP or, indeed, Healthy Minds. Given that Callum's GP made the initial referral to Healthy Minds which resulted in Callum accessing a service from MIND, it would seem appropriate for the GP practice – as initial referrer and as the repository of patient's health information - to be advised of the eventual outcome of the referral. It is therefore recommended that the Community Safety Partnership requests Pennine Care NHS Foundation Trust to ensure that when GP Practices refer patients to Healthy Minds, the GP

practice is always advised of the outcome, including any onward referrals. It is possible that this could be accomplished by fulfilling or amending existing contractual arrangements.

Recommendation 5

That Tameside Community Safety Partnership requests Pennine Care NHS Foundation Trust to ensure that when GP Practices refer patients to Healthy Minds, the GP practice is always advised of the outcome, including any onward referrals.

4.18 Tameside, Oldham and Glossop Mind have been requested to consider a single agency recommendation that they routinely notifying the client's GP practice when the client's engagement with Mind ends (Appendix A).

DASH risk assessments

4.19 As the percentage of familial domestic homicides is substantial there may be a case for the DASH risk assessment to more fully consider other members of the household who could be drawn into the conflict between the perpetrator and the victim. The DHR has been advised the questions asked in the DASH risk assessment relate almost exclusively to the risks to the victim and the risks presented by the perpetrator. A Domestic Abuse Risk Assessment (DARA) – which has been promoted by the College of Policing – and which incorporates the standard DASH risk assessment – also includes a question 'does anyone else present a risk?'. At the time of writing this DHR report the DARA had not been adopted by GMP, but the DHR has recently been advised that GMP now plan to implement the DARA. Once the DARA has been adopted the 'does anyone else present a risk' question will be asked as part of the process of assessing risk of domestic abuse. Asking this question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Recommendation 5

That Tameside Community safety Partnership notes Greater Manchester Police's intention to implement the Domestic Abuse Risk Assessment (DARA) which will include the new question of 'does anyone else present a risk?'. Asking this question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Impact on the family of the accused or convicted perpetrator.

4.20 From this DHR and previous reviews the independent author has become aware that the families of people accused or convicted of serious crimes – particularly where there is media attention - can often face abuse from relatives and friends of the victim and also abuse via social media. Paragraphs 6.52 to 6.56 summarise some of the adverse consequences experienced by Callum's family. It is therefore recommended that the issue of support which may be required by the families of Domestic Homicide perpetrators is raised with the Home Office so that this issue can be considered at a national level.

Recommendation 6

That Tameside Community Safety Partnership raises the issue of support which may be required by the families of Domestic Homicide perpetrators with the Home Office so that this issue can be considered at a national level.

Good Practice

4.21 There was much expected practice in this case. Good practice has been harder to identify although MIND's prompt agreement to offer in-person counselling to Callum as the second wave of the Covid-19 pandemic became apparent, is worthy of mention.

5.0 Conclusion

5.1 The victim Ben was stabbed to death by his partner Jennifer's adult son Callum in the home Ben had shared with Jennifer and her children from previous relationships - including Callum - for several years. The incident took place during the early hours of the morning after Ben and Jennifer began arguing after consuming alcohol and Callum, who was in his bedroom, heard the victim and his mother arguing downstairs and, fearing for his mother's safety, armed himself with a combat knife he had purchased previously and confronted Ben. In the struggle which followed, Callum inflicted the wounds from which Ben died shortly afterwards. Ben was known to the police as a perpetrator of domestic abuse against Callum's mother and a previous partner. Callum was not known to the police.

5.2 Although Ben was known to the police as a perpetrator of domestic abuse towards Jennifer, no agency became aware of the tension which existed between Callum and Ben, nor was any agency aware of the fact that Callum had purchased a combat knife.

5.3 The DHR has received conflicting accounts of the dynamics within the household in which Ben, Jennifer, Callum and three of Jennifer's younger children lived. Ben's adult daughter – who had never lived in Ben and Jennifer's household – felt that her father was dependent on Jennifer for a roof over his head and that when their relationship deteriorated he had 'nowhere to go' and that Jennifer bullied and controlled him. Ben's daughter's account is supported by his close friend's account. In his contribution to the DHR, Callum described the impact of the domestic abuse his mother suffered at the hands of Ben and her previous partner which led to him largely secluding himself in his bedroom and internalising his feelings, including frustration that he was unable to protect his mother from abuse.

5.4 Although no agency in contact with the family could have anticipated the homicide, there is considerable learning arising from this case, particularly about the opportunities provided to children, young people and young adults to disclose the impact upon them of domestic abuse in their household to the range of professionals they could come into contact with.

6.0 Recommendations and lessons to be learned.

Supporting children, young people and young adults impacted by domestic abuse in their household.

Recommendation 1

That Tameside Community Safety Partnership review the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people, to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.

Preventing people becoming perpetrators of domestic abuse

Recommendation 2

That Tameside Community Safety Partnership ensures that the learning from this DHR, in particular the factors which appear to have contributed to Callum becoming a perpetrator of fatal domestic violence – including the impact of domestic abuse on his life as a child, young person and young adult - should inform the local task and finish group developing the Adult Behaviour Change perpetrator intervention.

Routine enquiry

Recommendation 3

That Tameside Community Safety Partnership requests Greater Manchester Integrated Care (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry.

Recommendation 4

That Tameside Community Safety Partnership notes that the issue of notifying GP practices of reported domestic abuse incidents relating to their patients is currently being considered by a joint Greater Manchester Combined Authority /NHS Greater Manchester Integrated Care Board working group and that the Community Safety Partnership awaits the outcome of this piece of work before taking any further action in respect of this matter.

Advising GP practices of the outcome of mental health referrals

Recommendation 5

That Tameside Community Safety Partnership requests Pennine Care NHS Foundation Trust to ensure that when GP Practices refer patients to Healthy Minds, the GP practice is always advised of the outcome, including any onward referrals.

DASH risk assessments

Recommendation 5

That Tameside Community safety Partnership notes Greater Manchester Police's intention to implement the Domestic Abuse Risk Assessment (DARA) which will include the new question of 'does anyone else present a risk?'. Asking this question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator.

Impact on the family of the accused or convicted perpetrator.

Recommendation 6

That Tameside Community Safety Partnership raises the issue of support which may be required by the families of Domestic Homicide perpetrators with the Home Office so that this issue can be considered at a national level.

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 review the current range of opportunities to recognise when children, young people and young adults may be affected by domestic abuse in their household and offer them support - in the light of the learning from this case - in particular the need to promote domestic abuse services for children and young people,	Local	Mapping of the current offer for children and young people as victims of domestic abuse to be finalised and promoted across agencies Briefings to be delivered on the role of the CHIDVA and how to refer Briefings on the children and young people who harm programme to be delivered including how to refer	DA Steering Group Bridges TLC	1. Mapping exercise underway lead by Team Manager from MASH and Safeguarding Lead for schools. 2. Briefings being developed on the role of the CHIDVA and updated referral pathway. 3. Briefings being developed by TLC on CYP who harm programme and associated	December 2023	1. Mapping exercise completed by CYP task and finish group in January 2024 and shared with Domestic Abuse Operational Delivery Group to improve awareness of current offer. 2. Briefing delivered for multi-agency partners on 8 December 2023 on CHIDVA offer. This was attended by 25 professionals from across social care, police, health, education

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**
	to facilitate referral of children and young people by promoting 'routine enquiry' and to consider the particular needs of young adults.				counselling offer		and VCSE. Further briefings delivered directly to children's social care and MASH. 3. Briefing delivered by TLC on CYP who harm offer on 1 December 2023 to multi-agency partners. The outcome of these actions will be an increase in the number of children and young people accessing domestic abuse support services at the earliest opportunity. This will be

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**
							monitored through domestic abuse dashboard.
2	That Tameside Community Safety Partnership ensures that the learning from this DHR, in particular the factors which appear to have contributed to Callum becoming a perpetrator of fatal domestic violence – including the impact of domestic abuse on his life as a child, young person and young adult - should inform the local task and finish group	Local	Learning from the DHR to be shared with the perpetrator task and finish group who are overseeing the implementation of the findings from the perpetrator needs assessment to inform local response	CSP	1. Learning from the review will be shared with the perpetrator task and finish group at the next meeting on 5 September 2023	September 2023	Learning from the review was shared with the Perpetrator task and finish group on 5 September 2023. This fed into the action plan for the task and finish group in terms of understanding the needs and lived experiences of perpetrators but also into the re-commissioning of domestic abuse support services which includes behaviour change work.

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**
	developing the Adult Behaviour Change perpetrator intervention.						
3	That Tameside Community Safety Partnership requests the Greater Manchester Integrated Care Board (Tameside) to highlight the learning from this DHR to all Tameside GP practices and emphasise the benefits of routine enquiry	Local	GM ICB to confirm that the learning from the DHR has been cascaded to GPs and the benefits of routine enquiry emphasised.	GM ICB		November 2023	Named GP for Safeguarding confirmed awareness raising has taken place via briefings, podcasts and newsletter. Learning also shared with IRIS Advocate Educator and Clinical lead to share in GP training. The outcome of this recommendation will be an increase in the understanding of domestic abuse and improved use of routine enquiry

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**
							across GPs in Tameside.
4	That Tameside Community Safety Partnership notes that the issue of notifying GP practices of reported domestic abuse incidents relating to their patients is currently being considered by a joint Greater Manchester Combined Authority /NHS Greater Manchester Integrated Care Board working group and that the Community Safety	Local	Learning point highlighted to the GM Group	CSP	1. Meeting held with Associate Director of Nursing and Safeguarding for GM ICB to raise the issue of MARAC and information sharing with GPs. Dedicated workgroup being established to progress across a GM footprint. 2. Information sharing agreements to	July 2023	1. Ongoing discussions underway at GM level regarding MARAC information sharing agreement. 2. New information sharing arrangements agreed to allow

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No	**Recommendation**	**Scope local or national**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	Partnership awaits the outcome of this piece of work before taking any further action in respect of this matter.				be developed to support information sharing between MARACs and GP's in Tameside.		MARAC information to be shared to and from GPs for MARAC cases. The outcome of this recommendation will be improved information sharing with GPs to ensure appropriate care and support is offered during routine appointments.
5	That Tameside Community Safety Partnership requests Pennine Care NHS Foundation Trust to	Local	PCFT to provide assurances and evidence to CSP of the mechanisms put in place to action	PCFT	This is usual practice; the NHS Talking Therapies will contact via letter the person referred and their	September 2023	September 2023. This now part of everyday practice. The outcome of this recommendation is the improved

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No	**Recommendation**	**Scope local or national**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	ensure that when GP Practices refer patients to Healthy Minds, the GP practice is always advised of the outcome, including any onward referrals.		this recommendation		General Practitioner.		awareness of the support being provided to a patient and the opportunity to follow up support needs if required.
6	That Tameside Community Safety Partnership notes Greater Manchester Police's intention to implement the Domestic Abuse Risk Assessment (DARA) which will include the new question of 'does anyone else	Local	This recommendation will be fed into the wider GM MARAC review.	GMP	Learning point feedback to GM MARAC review. Action will also be considered by local MARAC task and finish to request that this question is added to MARAC referral form as a prompt.	September 2023	GMP has stated that there aren't plans to implement DARA yet as changes are being to computer system which means move from DASH isn't possible yet. However, the learning has been fed back locally to the ODG to raise awareness of the

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**
	present a risk?'. Asking this question has the potential to prompt consideration of risks emanating from persons in, or linked to the household, other than the victim and the perpetrator						need to consider wider risks and has been incorporated into local MARAC training. The outcome of this recommendation will be an improved understanding of risk posed to a person allowing appropriate information sharing and safety planning to take place.
7	That Tameside Community Safety Partnership raises the issue of support which may be required by the families of Domestic	National	This recommendation will be highlighted when the review is returned to the DHR QA panel for consideration	CSP	Enquiry sent to national DHR network. Information provided on the offender's Families Helpline/ Helpline for prisoner's families which we	September 2023	Recommendation highlighted for National QA panel. Locally information on Families Helpline/Helpline for prisoners is included in relevant

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**
	Homicide perpetrators is raised with the Home Office so that this issue can be considered at a national level.		Enquiries to be made with the National DHR network about existing support available		can share with families to promote support		information to be shared. The outcome of this recommendation will be improved access to support for families of Domestic Homicide perpetrators.

Home Office

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Dave Smith
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2nd October 2024

Dear Dave,

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

The QA Panel were pleased that an attempt had been made to engage with Ben's family, his daughter, and his partner, and that his daughter had engaged and provided an insight to Ben.

The panel considered the report to be easy to read and felt that it contained helpful research as well as providing a good description of the range of support services currently available to children and young people in Tameside. It was also noted that the report avoided victim blaming and clearly stated the independence of all parties concerned.

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