OLDHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Elizabeth'

Date of death: March 2021

OVERVIEW REPORT
Final Version
December 2023

Chair and Author: Carol Ellwood-Clarke QPM
Supported by: Ged McManus

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Family tribute to Elizabeth

Intelligent, kind, caring, beautiful, full of life, warm and ambitious, just a few of the words used to describe Elizabeth in the sympathy cards received from family and friends.

We recognised all these qualities, but we also knew an anxious, vulnerable young woman, full of self doubt and insecurities. It was when she was alone, at her most vulnerable, her naivety allowed her to believe she had found a life that would give her time and space to heal, support her in her recovery and become the loving mother she had always intended to be. Tragically, it was at this time that her life, with all her hopes and dreams, was so brutally, cruelly and violently taken from her.

Her last letter to us at Christmas was so full of hope for the future, detailing the progress she was making and how much she was looking forward to rebuilding her life with her son and the family. She had delivered some very thoughtful, personalised gifts for [name redacted] to open on Christmas morning with a card expressing her everlasting love.

Your memories will be, forever
Kept bright and clear
nurtured and safe,
held tightly in our secure embrace
carried carefully,
woven into our family's future always.

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Elizabeth's family.

1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported, Elizabeth, a resident of Oldham, prior to her murder in Spring 2021.

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

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

1.5 In 2019, Elizabeth left Stockport to live in Oldham. In 2020, Elizabeth started a relationship with Tim. Tim was a known perpetrator of domestic abuse. In the spring of 2021, Elizabeth was found deceased at her accommodation. A Home Office post-mortem determined that the cause of death was as a result of multiple stab wounds.

1.6 In the summer of 2021, Tim pleaded guilty to the murder of Elizabeth and was sentenced to a minimum tariff of seventeen-and-a-half years in prison. In sentencing Tim, Judge Patrick Field QC stated: "There was cruelty here because you desecrated the body of the woman you had just killed in order to proclaim what you had just done.'

1.7 It is not the purpose of this DHR to enquire into how Elizabeth died. This is determined through other processes.

1.8 The Review Panel wish to thank Elizabeth's family for their contribution to the review.

2. TIMESCALES

2.1 On 5 March 2021, Greater Manchester Police notified Oldham Community Safety Partnership of the death of Elizabeth. Following a meeting on 5 March 2021, a recommendation was made to the joint Chairs of the Partnership that the case met the criteria for a Domestic Homicide Review, and this was agreed. On 12 March 2021, the Home Office was notified of the decision.

2.2 The first meeting of the Review Panel took place on 5 May 2021. This, and subsequent panel meetings, were held virtually during the Covid-19 pandemic – contact was maintained with the panel via email and telephone calls. In total, the panel met seven times.

2.3 The DHR covers the period from 1 January 2016 to 4 March 2021. The start date was identified to capture relevant information prior to Elizabeth's move to Oldham.

2.4 The Domestic Homicide Review was presented to Oldham Community Safety Partnership on 16 September 2022, with submission of documentation, including updated action plans, to the Home Office on the 30th March 2023.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, her child, perpetrator, and ex-partners: these were chosen by Elizabeth's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Elizabeth	Victim	29	White British female
Tim	Perpetrator	41	White British male
Josh	Child of victim	Pre-school age	White British
Jack	Previous partner of victim	35	White British male
Adult A	Previous husband of victim	N/K	White British male
Adult B	Previous partner of victim, and father of Josh	33	White British male

4. TERMS OF REFERENCE

4.1 The panel settled on the following Terms of Reference at its first meeting on 5 May 2021. These were shared with the family who were invited to comment on them.

4.2 The DHR panel set the period of review from 1 January 2016 through to 4 March 2021.

The purpose of a DHR is to:[1]

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

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

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

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

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

f] Highlight good practice.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) Section 2, Paragraph 7

4.3 **Specific Terms**

1. What indicators of domestic abuse did your agency have that could have identified Elizabeth as a victim of domestic abuse, and what was the response? (N.B. Please consider risks from previous relationships).

2. What knowledge did your agency have that indicated Tim and/or Jack might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Tim and/or Jack?

3. What were the key points or opportunities for assessment and decision-making in this case? Were those assessments and decisions reached in an informed and professional way?

4. Did actions or risk management plans fit with the assessment and decisions made?

5. What response did your agency undertake in relation to assessments and enquiries under Section 42 Care Act 2014? Were there any implications in relation to this case and the criteria for enquiries in relation to Section 42 Care Act 2014?

6. What knowledge did your agency have of any previous trauma and adverse childhood experiences of the subjects of the review? How was this information considered in relation to your engagement with the subjects of this review?

7. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

8. How did your agency understand the impact of domestic abuse on the child in this case? How did your agency record this impact, including the views of the child?

9. How did your agency respond to the lifestyle, including mental health and substance misuse use, of the subjects of the review?

10. How effective was the cross-border information sharing and working between agencies? Did that information sharing identify any known risks to the subjects of this review?

11. Did your agency have policies and procedures for domestic abuse and safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

12. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies?

13. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14. What learning has emerged for your agency?

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

16. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Oldham Community Safety Partnership.

5. METHOD

5.1 On date 25 March 2021, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Individual Management Reviews, and the others, short reports. The Chair provided training to Individual Management Review (IMR)[2] authors to assist in the completion of the written reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified and auxiliary information sought.

5.4 The DHR was complex and involved a significant amount of information being gathered during the review phase: across a range of agencies and cross boundary areas. In total, there were 30 agencies involved in the review, producing over 1000 pages of information which the Review Panel analysed. The Review Panel discussed the most appropriate way in which to analyse and report on the information – taking cognisance of the Home Office Statutory Guidance. The Review Panel acknowledges that the Overview Report is lengthy, but agreed that the content and the format provided a clear and concise overview of the case, on which to draw learning and recommendations.

5.5 The Chair wrote to Tim to inform him about the review, and invited him to contribute. The letter was delivered by his Offender Manager, who discussed the contents and DHR process with Tim. Tim declined to be involved in the review.

5.6 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the DHR to be completed. The Home Office was notified of the extension.

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

5.7 The Chair sought information from the police, gathered during the homicide investigation, to help inform the review. Particularly, in relation to friends and associates of Elizabeth.

5.8 Thereafter, a draft Overview Report was produced: this was discussed and refined at panel meetings before being agreed. The draft report was shared with Elizabeth's family who were invited to make any additional contributions or corrections. The family's responses to the draft report have been included within the report where relevant.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY.

6.1 The Chair wrote to Elizabeth's mother and father to inform them of the review, and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[3].

6.2 The Chair initially spoke to Elizabeth's parents via a video call. The family were supported in the process by their Victim Support Homicide Worker. The contact focused on the purpose of the DHR, timescales, and an agreement for further contact following the conclusion of the criminal case. Following this contact, updates on the progression of the DHR were provided to the family via the Victim Support Homicide Worker.

6.3 In October 2021, Elizabeth's parents were seen by the Chair and Author. The visit was undertaken in the presence of the Victim Support Homicide Worker. The family provided valuable information that has been captured within the report as necessary.

6.4 There was no direct contact with Josh, due to him being of pre-school age with limited ability to converse and understand the process. The review engaged with Children's Social Care to establish details of any direct work that had been undertaken with Josh; however, involvement had taken place when Josh was pre-verbal and therefore there was no relevant information held.

6.5 The Chair spoke with Elizabeth's brother and sister-in-law, who provided valuable information that has been captured in the report as necessary.

6.6 The Chair wrote to Jack and Adult B to inform them of the review and invited them to contribute. The Chair received no response to the letters.

6.7 The Chair spoke to Elizabeth's parents, who were in regular contact with Adult B, and they agreed to speak with Adult B regarding the DHR, and to see if he wished to be involved. Adult B informed Elizabeth's parents that he did not wish to be involved. The Chair discussed further engagement with Adult B, with Elizabeth's parents, towards the end of the DHR, but was informed that Adult B maintained his wish not to be involved.

[3] https://aafda.org.uk/

6.8 The Chair asked all agencies involved in the review whether there was any professional or agency currently in contact with Jack, or in possession of contact details, so that further attempts at contact could be progressed. No agency was working, or in contact, with Jack at the time of the DHR being undertaken.

6.9 The Chair received information that Jack visited a food bank held at a local church. Enquiries were made with the organisers of the foodbank to establish contact with Jack. This was unsuccessful. Jack was wanted by the police on an unconnected matter throughout the period of the DHR. All available opportunities to seek contact with Jack were explored. Unfortunately, contact was unsuccessful.

6.10 The DHR was unable to establish contact details for Adult A. No agency involved in this review were working with, or in contact with, Adult A. The Chair reached out to Adult A through social media channels to seek their engagement within the review. Adult A responded to this contact and spoke to the Chair via video conferencing. Relevant information from this contact has been included in the report as relevant.

6.11 The Review Panel was informed that during the police investigation, it was established that Elizabeth did not have many close friends, and that she spent most of her time with Tim and Jack. The police informed the review that Tim managed her behaviour and prevented Elizabeth from meeting new people. The police provided the review with copies of statements obtained during the criminal investigation. Relevant information from these statements has been included below.

<u>Neighbour 1</u>

6.12 Neighbour 1 had known Elizabeth for about 3-4 months prior to her death. The neighbour stated that they would hear Elizabeth more than they would see her. Elizabeth was heard crying, as though she was hurt. Shouting was also heard from Elizabeth's flat. The neighbour described never seeing Elizabeth on her own, and that she was always with Tim.

[There is no record of this information being provided to Nacro].

<u>Friend 1</u>

6.13 Friend 1 met Elizabeth through Tim. The friend was aware that Tim had a problem with alcohol, and used drugs, including crack cocaine. The friend

stated that they had previously witnessed Tim shouting and displaying aggressive behaviour. The friend described an incident in January 2021, when they had been at Elizabeth's flat. Tim was present and had been drinking alcohol. Tim had prevented the friend from going to the toilet. The friend said to Tim: 'Do you not trust me or something?' and Tim replied: 'I don't trust anyone with her'. The friend described this as bizarre behaviour. Later in the evening, Tim had 'passed out' on the settee. The friend spoke to Elizabeth and told her that she could use social media to make contact if she needed help. Elizabeth told the friend that Tim would not allow her to use social media, that he constantly checked her phone, and was paranoid about who she spoke to. The friend stated that a few days later, Elizabeth telephoned her: upset and in tears. Elizabeth stated that Tim was physically abusive to her. She sent the friend some photographs of previous injuries, which included a stab wound, black eye, and marks around her neck.

6.14 The Chair sought to engage with the friend and neighbour; however, they had moved out of their relevant addresses and there was no available up-to-date contact information. Agencies were no longer engaged or working with the individuals.

6.15 The Review Panel was provided with a copy of the book 'Women's Words of Wisdom'. This contained an inspirational collection of words from a group of Oldham women who found Inspire Women Oldham, and each other, during the Covid-19 Crisis in 2020. Within the document was a poem that had been written by Elizabeth. This has been included in the report, with the permission of Elizabeth's family.

'As I sit and watch the sunset
disappear beneath the sparkling ocean
all I could do was sit and wonder
what could have been
I couldn't tell if the fluttering
feeling in my stomach
nauseous or unbelievable feelings of joy'

6.16 Elizabeth was not in employment during the timescales of this review.

6.17 In April 2021, the Chair visited Elizabeth's family and shared a draft copy of the report. The family were supported by a Victim Support Homicide Worker. The family provided feedback to the Chair on the contents of the report: this has been included in the report where relevant.

7. CONTRIBUTORS TO THE REVIEW

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

Agency	IMR	Chronology	Report
Adult Social Care – Oldham	X	X	
Change Grow Live – Stockport	X	X	
Cheshire and Greater Manchester Community Rehabilitation Company (CRC)	X	X	
Children's Social Care – Derbyshire	X	X	
Children's Social Care – Stockport	X	X	
Clinical Commissioning Group – Derbyshire	X	X	
Clinical Commissioning Group – Oldham	X	X	
Clinical Commissioning Group – Stockport	X	X	
Department for Work and Pensions (DWP)			X
Derbyshire Police	X	X	
Early Help and IDVA Service – Oldham	X	X	
Greater Manchester Police	X	X	
Housing Strategy (Homelessness Service) – Oldham	X	X	
Jigsaw Homes	X	X	
Nacro	X	X	
Northern Care Alliance	X	X	
North West Ambulance Service	X	X	
Pennine Care NHS Foundation Trust (PCFT)	X	X	
Stockport NHS Foundation Trust	X	X	
Stockport Homes	X	X	
Stockport Without Abuse[4]	X	X	
Tameside Oldham Glossop (TOG) Mind	X	X	
Turning Point	X	X	
Cheshire Police			X

[4] This contained information from Freedom Project and Women's Centre, Stockport.

Children's Social Care – Oldham			X
Department for Work and Pensions			X
Hampshire Police			X
Ingeus			X
Inspire Women			X
National Probation Service			X
Petrus House			X

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained that they had no management of the case nor direct managerial responsibility for the staff involved with this case.

7.3 A summary of agencies that have contributed to the review is produced at Appendix C.

7.4 The following agencies were written to as part of the scoping process for the review, and returned a nil return:

- Cambridgeshire Police
- Cheshire East Children's Social Care

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel Members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Janine Campbell	Designated Nurse, Safeguarding Adults	Clinical Commissioning Group – Oldham
Sarah Crowe	Principal Housing Strategy Officer	Strategic Housing – Oldham Council
Hayley Eccles	Head of Strategic Safeguarding	Adult Social Care – Oldham Council
Carol Ellwood-Clarke	Independent Practitioner	
Julie Farley	Business Manager	Oldham Safeguarding Adults Board
Suzanne Fawcett	Detective Constable	Greater Manchester Police
Janice France	Assistant Chief Officer/Head of Cluster – Bury, Rochdale & Oldham	National Probation Service, Greater Manchester
Gemma Gerrish	Assistant Director	Children's Social Care – Oldham Council
Naz Ghodrati	Domestic Abuse Training Co-ordinator	Stockport Council
Gemma Goacher	Head of Quality and Safeguarding (Housing)	Nacro
Julian Guerriero	Complex Dependency & Reducing Reoffending Co-ordinator	Oldham Council
Lorraine Kenny	Head of Violence Reduction and Community Safety Services, Internal CSP DHR Lead	Oldham Council
Darren Lawtonedge	Named Professional for Safeguarding Adults	Pennine Care NHS Foundation Trust
Ged McManus	Independent Practitioner	
Eileen Mills	Designated Nurse, Safeguarding Children	Clinical Commissioning Group – Oldham
Sharon Moore	Assistant Director, Quality and Assurance	Children's Social Care – Oldham Council

Lisa Morris	Business Manager	Oldham Safeguarding Children Partnership
Abigail Pemberton	Strategic Safeguarding Manager	Adult Social Care – Oldham Council
Bruce Penhale	Assistant Director, Early Help	Early Help – Oldham Council
Amy Poulson	Head of Probation Delivery Unit – Oldham	National Probation Service
Sarah Radford	Safeguarding Families Specialist Practitioner	Pennine Care NHS Foundation Trust
Steve Simmons	Senior Operations Manager, Turning Point	Turning Point
Julie Wan Sai-Cheong	Named Nurse, Safeguarding Adults	Northern Care Alliance
Susan Warren	MASH Business Support Officer	Oldham Council

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

8.3 The panel met seven times. The circumstances of Elizabeth's death were considered in detail, with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic, panel meetings met virtually. Outside of the meetings, the Chair's queries were answered promptly, and in full, via email or telephone calls.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Greater Manchester) in 2017, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[5] .

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Greater Manchester). He served for over thirty years in different police services in England (not Greater Manchester). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships, including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: Local Child Safeguarding Practice Reviews; Safeguarding Adults Reviews; Multi-Agency Public Protection Arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA.

9.5 Neither has worked for any agency providing information to the review.

[5] https://safelives.org.uk/

10. PARALLEL REVIEWS

10.1 HM Coroner for Greater Manchester North opened and adjourned an inquest. HM Coroner was notified that a DHR was being undertaken. The inquest had not taken place at the time of the conclusion of the DHR.

10.2 Greater Manchester Police completed a criminal investigation following Elizabeth's death. Tim was charged with the murder of Elizabeth. Tim pleaded guilty to the murder of Elizabeth and was sentenced to seventeen-and-a-half years' imprisonment.

10.3 Greater Manchester Police referred themselves to the Independent Office for Police Conduct[6] (IOPC), following the death of Elizabeth. The Chair liaised with the Investigating Officer and informed them that a DHR had been commissioned. The IOPC investigation concluded during the DHR process. The IOPC requested that any dissemination, including the outcomes of their investigation, would not be shared with the Review Panel until after the conclusion of the inquest.

10.4 Nacro completed an internal Incident Management Review in line with their Incident Management procedure: this is completed following a fatality in their service. The learning from this process has been reflected within Nacro's learning for the DHR.

10.5 The review was not aware of any other investigations that have taken place since Elizabeth's death.

[6]https://www.policeconduct.gov.uk/
Every time someone has direct or indirect contact with the police when, or shortly before, they are seriously injured or have died, the police force involved must refer the matter to the Independent Office for Police Conduct (IOPC).

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].

- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[7]

11.3 Elizabeth had been diagnosed with anxiety and depression. Elizabeth was on prescribed medication for her mental health, and had regular monthly review meetings with her GP to review her health and medication. The review has seen the detailed entries within her health records of engagement and contact with her GP. In addition to the contact with her GP, Elizabeth was referred into specialist mental health services.

11.4 Elizabeth had a harmful and hazardous pattern of alcohol use, and had been referred into services to work with her to address her dependency. The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) specifically provide that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. In 2019, Elizabeth was assessed as being at high risk of malnutrition.

11.5 There was recognition of Elizabeth's vulnerability to abuse and violence during Elizabeth's engagement with Turning Point. Due to limited gender diversity in the team in Turning Point at that time, Elizabeth was allocated to the Senior PSI worker. Turning Point has identified learning around gender diversity within their team, and have made a relevant recommendation.

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

11.6 Tim has been alcohol dependent since 2002. In 2009, medical records show that Tim was diagnosed with depressive disorder. In 2016, Tim sustained a back injury whilst at work, which required surgery. Tim's health records show that he continued to suffer with this injury, and was referred into specialist services; however, he was continually discharged from specialist help due to non-attendance at appointments.

11.7 During engagement with TOG Mind, Tim completed an equality and diversity form on which he self-disclosed that he had a diagnosis of dyslexia. This was not a barrier to Tim's engagement with the appointment, and no adjustments were needed at the time. The review has seen no evidence that Tim was dyslexic or that he had reported this to other professionals.

11.8 There is nothing in agency records that indicated that any subjects of the review lacked capacity[8] in accordance with the Mental Capacity Act 2005. Professionals applied the principle of Section 1 of the Mental Capacity Act 2005:
'A person must be assumed to have capacity unless it is established that he lacks capacity'.

[8] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

11.9 Domestic homicide and domestic abuse in particular, is predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2021, the Office of National Statistics homicide report[9] stated:

'There were 362 domestic homicides recorded by the police in the three-year period between year ending March 2018 and year ending March 2020. This represents 19% of all homicides where the victim was aged 16 years and over during this period.
Of the 362 homicides, 214 (59%) were female victims who were killed by a partner or ex-partner. In contrast 33 (9%) were male victims who were killed by a partner or ex-partner. The remaining 115 (32%) were victims killed by a suspect in a family category'.

11.10 The Office of National Statistics produced a report – 'Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020'[10]. The publication presents data on domestic abuse from April 2020 onwards, using a range of sources to assess the impact of the coronavirus pandemic on domestic abuse in England and Wales. The main points in the report detail:

- Police recorded crime data show an increase in offences flagged as domestic abuse-related during the coronavirus (COVID-19) pandemic, however, there has been a gradual increase in police recorded domestic abuse-related offences over recent years as police have improved their recording of these offences; therefore, it cannot be determined whether this increase can be directly attributed to the coronavirus pandemic.
- There has generally been an increase in demand for domestic abuse victim services during the coronavirus pandemic, particularly affecting helplines as lockdown measures eased: this does not necessarily indicate an increase in the number of victims, but perhaps an increase in the severity of abuse being experienced, and

9 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2021

10 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020

a lack of available coping mechanisms such as the ability to leave the home to escape the abuse, or attend counselling.

- The total number of cases discussed at multi-agency risk assessment conferences (MARACs)[11] decreased in April to June 2020 compared with the previous quarter: this may reflect the difficulties high-risk victims faced when attempting to safely contact the police (the main source of referral to MARACs) during the lockdown period.

11.11 Agencies involved in the review informed the panel that information on equality and diversity is gathered during contact with individuals, and data collection is obtained to understand the demographics for people accessing services. The review found no evidence that the racial, cultural, linguistic, faith or diversity issues impacted on assessments and services provided to the subjects of the review.

11.12 All subjects of this review are white British, with English as their first language.

[11] Multi Agency Risk Assessment Conference

12. DISSEMMINATION

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

- The Family
- Oldham Community Safety Partnership
- All agencies that contributed to the review
- Greater Manchester Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, OVERVIEW AND CHRONOLOGY

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, input from Elizabeth's family, and material gathered by the police during their investigations.
Appendix D contains a summary of the combined chronology of agency involvement. It is not replicated in detail below. This section draws on that chronology to detail significant events during the timescales of the review. This section does not detail every contact within the period of this review.

13.1 Elizabeth

13.1.1 Elizabeth was the oldest of three siblings. Elizabeth was very much loved by her family. Elizabeth went to a small and very supportive private girls' school. The school suddenly closed in September 2005 due to financial difficulties, with only 24-hours' notice. A new school place was found at another private girls' school in the area: this was a larger school. The family stated that Elizabeth hated the new school. Elizabeth was very anxious about her GCSEs, she did not like school, and was not coping. The family sought support from a GP to help with Elizabeth's anxiety. Following her GCSEs, Elizabeth moved to a local college.

13.1.2 Elizabeth's parents described how they found her behaviour as a teenager to be challenging in a way that their other children were not. They provided examples of how Elizabeth would drink to excess at parties and become ill. Elizabeth reported to professionals that she had been sexually abused as a teenager. Elizabeth's family were not aware, at the time, of the trauma that Elizabeth had been through during her teenage years.

13.1.3 Adult A met Elizabeth whilst she was backpacking in Australia. Adult A described how he was 'head over heels' in love with Elizabeth, and when she went back to the United Kingdom, he saved his money to join her in England. Adult A stated that after their marriage, he and Elizabeth moved into their own home with the support of Elizabeth's parents. Adult A told the Chair that Elizabeth did consume alcohol, but he agreed to support and help Elizabeth. Adult A told the Chair of incidents when Elizabeth had been violent towards him when he had tried to prevent her from drinking

alcohol. Adult A stated that he had 'pushed' Elizabeth on two occasions during an argument. Adult A also stated that, as a couple, they found it difficult to maintain a stable relationship. Following the breakdown of their relationship, Adult A returned to Australia: he only spoke to Elizabeth on one further occasion, following the death of a mutual friend.

13.1.4 The review panel acknowledges that the above are the views of Adult A in relation to his relationship with Elizabeth, which have been included without comment.

13.2 Tim

13.2.1 Tim was born on the Isle of Wight and had been known to Hampshire Constabulary. In 1997, Tim was sentenced to 21-months youth custody for offences of kidnap, false imprisonment, and three counts of failing to surrender to custody. In February 2003, Tim was convicted for an offence of driving whilst under the influence of alcohol.

13.2.2 In 2005, Tim was a suspect in a domestic incident with his then partner: no further action was taken and no criminal offences were identified. Alcohol was a viewed as a significant factor precipitating his offending, and in September 2007, Tim received a 12-month community order with supervision and an alcohol treatment requirement. He was assessed for inpatient detox during this period. During an assessment in April 2008, following a conviction of s39 assault against a known male, it highlighted significant levels of grievance and retributive thinking when Tim perceived himself to have been wronged, as well as leading a fractious lifestyle underpinned by dependent alcohol consumption.

13.2.3 Between 2006 and 2008, Tim was linked to a number of offences. In 2008, Tim was arrested and charged with assault whereby he punched a male in the face. He was further arrested in May 2008 for an assault on an adult male, and rape of an adult female: no further action was taken with regard to these incidents due to evidential difficulties. In 2009, a further charge of assault, whereby Tim was the suspect, was discontinued.

13.2.4 In 2010, Tim was arrested, along with a female, for stabbing an adult female in the face, causing a small cut just above the lip: this was classified as wounding with intent to do Grievous Bodily Harm. No further action was taken due to evidential difficulties and contradictory accounts from witnesses as to who was responsible. In 2012, an ex-partner of Tim's reported that she had assaulted him, stating: 'he used to assault her'.

13.2.5 In 2015, Tim was charged with an assault on a vulnerable adult. The circumstances of this case have been the subject of a Multi-Agency Review commissioned by the Isle of Wight Safeguarding Adult Board: this was completed in 2018[12].

13.2.6 In July 2015, Tim assaulted an ex-partner who reported that Tim had put his hands around her neck and choked her until she was unable to breathe, before punching her several times to the face. The female reported a further assault two days later. Tim was arrested and charged.

13.3 Jack

13.3.1 The Review Panel has been unable to ascertain any contact with Jack, nor identify information from within agency records. Jack had no previous convictions or contact with the police prior to the incidents within this review.

13.4 Josh

13.4.1 Josh is the child of Elizabeth and Adult B.

13.4.2 Elizabeth's family described Adult B as a nice man who was supportive to Elizabeth. The family told the Chair that when Elizabeth became pregnant with Josh, her drinking and other health issues were suddenly under control; however, within two weeks of Josh's birth, Elizabeth started drinking again and things became worse.

13.4.3 The family stated that Elizabeth always sent nice gifts to Josh for Christmas. They described that on one occasion, they arrived home on Christmas Eve to find a very large box for Josh.

13.5 Events prior to timescales of review

13.5.1 In 2014, Elizabeth married Adult A. There was violence in this relationship, and Elizabeth was referred into MARAC on three occasions. Adult A was the aggressor. Elizabeth had contact with the police and alleged that she had been the victim of a serious sexual offence as a child. Elizabeth did not wish to pursue a criminal investigation at that time.

[12] Safeguarding Adults Reviews - Isle of Wight Safeguarding Adults Board (IOWSAB))

13.5.2 In 2015, Tim assaulted an ex-partner. Two days later, Tim assaulted the female again. The female detailed a pattern of control and abuse perpetrated by Tim. Tim was arrested and charged with the assaults. Tim denied the strangulation. Tim was sentenced to 16 weeks' imprisonment and released from custody in September 2015. Following his release, Tim did not attend appointments with his Offender Manager, and proceedings to recall him to prison commenced.

13.6 2016

13.6.1 In March 2016, Elizabeth was seen by a GP. The GP noticed bruising to Elizabeth's arm. When questioned, she became tearful and disclosed domestic abuse, stating: 'please help me and please don't make me go back home'. Elizabeth was married to Adult A at this time. Elizabeth told the GP that she did not want the police or relatives, including her husband, to be called. A DASH[13] was not completed. Elizabeth was not signposted to other agencies. After this appointment, Elizabeth was seen by her GP for monthly reviews.

13.6.2 On 10 June, Elizabeth called NHS 111 and reported that she had a nosebleed. A clinician spoke at length to Elizabeth, and she disclosed that she had been assaulted by Adult A. Elizabeth stated that she could not attend hospital as Adult A was controlling and that he had threatened to kill her if she told anyone of the assault. Contact was made with the police, who attended and arrested Adult A. Elizabeth was transported to hospital via ambulance. Elizabeth told the ambulance crew that the abuse had been happening over the last few months. The incident was initially risk assessed as high by the police, but following a review it was downgraded to medium. No referrals were made by the police. The ambulance crew made a referral to Adult Social Care. The hospital referred Elizabeth to Adult Social Care and MARAC. Following discharge from hospital, Elizabeth attended at a police station. Elizabeth declined to support a prosecution, so Adult A was released from custody.

13.6.3 The case was heard at MARAC on 28 June. It was noted in the MARAC that Elizabeth was keen to return to live with Adult A, and for him to seek help with anger management. The MARAC referral stated that it was not

[13] https://www.dashriskchecklist.co.uk/
Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model

safe to telephone Elizabeth as she did not have her own phone. No contact was made with Elizabeth. There were no actions from the MARAC, and the case was closed without Elizabeth being seen or spoken to. The police reviewed the risk assessment and increased the risk to high. Messages had been left with Elizabeth's family to inform them that the case had been referred to MARAC.

13.6.4 On 5 August, Elizabeth registered with a GP practice in Derbyshire.

13.6.5 On 12 August, Tim was arrested by the police for recall to prison; however, he was later released following advice from the Crown Prosecution Service (CPS). In September, Tim was in contact with his Offender Manager. This was the first contact Tim had had since his release from prison the previous year. On 30 September, Tim's order terminated, and he had no further contact with the CRC.

13.6.6 On 21 November 2016, Elizabeth was seen by a GP: she was in the early stages of pregnancy. Elizabeth was accompanied by Adult B. This is the first record held by agencies of their relationship.

13.7 2017

13.7.1 On 14 February, police received a report that Tim had assaulted a female. The female did not wish to pursue a complaint and no further action was taken regarding the assault.

13.7.2 In July 2017, Josh was born. Towards the latter part of 2017, Elizabeth was seen monthly by a GP in relation to her mental health. During one visit, Elizabeth told the GP that she had had a panic attack after seeing Adult A, which had resulted in her attending hospital. Elizabeth was referred into self-help services.

13.8 2018

13.8.1 For the first seven months of 2018, Elizabeth lived in Derbyshire. Elizabeth was seen regularly by a GP during this time. In February, Elizabeth attended a GP appointment, accompanied by Adult B. The appointment recorded that Elizabeth's anxiety was 'spiralling out of control' and that she had been thinking about suicide. Elizabeth disclosed domestic abuse in her previous relationship and that she had been the victim of a sexual assault as a child. Elizabeth was referred to the Crisis Team, and further records after this time, showed that Elizabeth engaged with the Community Mental

Health Team (CMHT). During some of the appointments with a GP, Elizabeth was seen to have self-harm injuries.

13.8.2 Health records documented that Elizabeth's family and Adult B were supportive. At the beginning of the year, Elizabeth started work as a 'carer', and over a period of time, she increased her hours of employment.

13.8.3 In the early hours of 6 June, Elizabeth contacted the police following an incident with Adult B. Elizabeth stated that she had been 'kicked out' of the house after things had got 'physical' with Adult B during an argument. Elizabeth had left the home and walked into the town centre. Elizabeth told the police that there was no previous history of domestic abuse and that she did not suffer from controlling or coercive behaviour from Adult B. A DASH risk assessment was recorded as standard. Elizabeth was taken to a hotel for the night and a referral was made to Derbyshire Children's Social Care.

13.8.4 Late evening, that same day, Elizabeth attended hospital following an episode of self-harm. Elizabeth identified an argument with Adult B, with his mother being the trigger. A full mental health and risk assessment was completed, which determined that Elizabeth did not require further input from secondary care mental health services – she was already engaged with services to develop preventative and coping strategies. Elizabeth was referred back to her GP and seen the following day.

13.8.5 Derbyshire Children's Social Care spoke with Elizabeth and Adult B. It was documented that Elizabeth had sought support through a GP. Josh was being cared for by maternal grandparents at this time. No further action was taken by Derbyshire Children's Social Care.

13.8.6 At a GP appointment on 20 June, Elizabeth requested to be seen alone. The following day, Elizabeth was discussed in a Multi-disciplinary team meeting at the GP practice. It was noted that Elizabeth was moving back to live with her parents: this was later recorded as being due to financial difficulties.

13.8.7 On 16 July, Elizabeth attended hospital following self-harming and overdose of medication with alcohol. Elizabeth had contacted friends stating that she was planning to end her life. Elizabeth had been staying in a hotel. The Emergency Department referred Elizabeth to STEM (Stockport Team for Early Management), and she was seen whilst at hospital. Adult B was also present. He provided additional information during the

assessment about Elizabeth, her presentation, and her financial and employment situation. Elizabeth was discharged from hospital and information was shared with her GP. The incident was referred to Derbyshire Children's Social Care. Josh was reported to be staying with maternal grandparents in the Stockport area. Derbyshire Children's Social Care discussed the incident with Adult B, who described to them a safety plan, and that as a family, they were moving to live with Elizabeth's parents. Adult B stated that he was satisfied that Elizabeth was receiving support. No contact was made with Elizabeth. This incident was not reported to Stockport Children's Social Care.

13.8.8 Three days later, Elizabeth was seen by a GP in Derbyshire. Elizabeth's hospital attendance was discussed. Elizabeth was provided with information on alcohol services in Derbyshire, and Cheshire, and advised she could attend Alcoholics Anonymous. By the end of July, Elizabeth had registered with a GP in Stockport. Elizabeth was living with her parents, along with Adult B and their child. Elizabeth's parents stated that they could see the situation spiralling out of control again. They persuaded Elizabeth and Adult B to come back to live with them so that, between them and Adult B, they could try to help her. The family described that on one occasion when the police were called, they were told by the police that they could not keep Elizabeth in the house and had to let her go.

13.8.9 In August, Elizabeth was referred to Change Grow Live (Stockport) for help with her alcohol use. Elizabeth was referred to Healthy Minds by her GP. The referral was accepted in September; however, Elizabeth was discharged from the service as she had not responded to an 'opt in' letter.

13.8.10 Over the following months, Elizabeth engaged with Change Grow Live on 1-to-1 sessions and group work. Adult B accompanied Elizabeth during these sessions.

13.8.11 On 13 October, Elizabeth attended hospital, via ambulance, having taken an overdose of prescribed medication. Elizabeth was referred to and seen by STEM. Elizabeth reported her current living conditions as being a trigger. Elizabeth was referred to her GP, and a referral was made to Stockport Children's Social Care, who commenced an assessment under Section 17 Children Act 1989.

13.8.12 On 18 October, during contact with Change Grow Live, Elizabeth stated that: 'things were difficult at home with tension and arguments over explicit messaging from her to an ex-partner'. In another session, at the

beginning of November, Elizabeth stated that she would find it helpful for her next session to take place without her partner present; however, she was worried it would lead to an argument as her partner could be controlling. Change Grow Live provided options to Elizabeth to support her attending the session alone.

13.8.13 On 13 November, Elizabeth and Adult B applied for rehousing with Stockport Homes. The application stated that overcrowding was leading to anxiety and mental health issues, which were being treated by a GP. The following day, Elizabeth self-referred to Healthy Minds. On 19 November, Stockport Children's Social Care completed their assessment and the case was stepped down to Early Help, at Tier 2. On 27 November, Elizabeth attended a face-to-face initial assessment with Healthy Minds.

13.8.14 On 9 December, Elizabeth reported to the police that Adult B had assaulted her. The incident had occurred three days earlier. Elizabeth stated that she had delayed reporting the incident due to them having a child (Josh). Elizabeth disclosed that there had been previous domestic abuse in their relationship. Adult B was arrested by police. Elizabeth declined to support a prosecution. The CPS declined to charge Adult B due to insufficient evidence, and he was released from custody. A DASH was completed, during which Elizabeth described an incident, when they had been living in Derbyshire, when Adult B had grabbed her around the throat. The incident was risk assessed as medium. Referrals were sent to Stockport Children's Social Care and Health. The case remained open with Stockport Children's Social Care.

13.8.15 On 12 December, Elizabeth informed Change Grow Live that she was going to stay in Liverpool with family. Elizabeth was provided with details of support agencies, and her case was closed.

13.9 2019

<u>January</u>

13.9.1 By January, Elizabeth had returned to live in Stockport. During an appointment with a GP, Elizabeth spoke of her 'low mood', and feeling trapped within her current living arrangements. Elizabeth stated that she was working with alcohol services to address her alcohol use. Elizabeth had contacted Change Grow Live to re-engage with the service: the case was later closed in February as Elizabeth did not engage. Elizabeth's

mother stated that Elizabeth had told her that she could not make it work with Adult B. Elizabeth's mother stated that she had advised Elizabeth that she should try to make it work, and that relationships sometimes were not easy.

February

13.9.2 A social worker visited Adult B and Josh. The social worker was informed by Adult B that Elizabeth was now living in a hotel, and that he was caring for Josh. Adult B stated that Elizabeth was drinking alcohol. The social worker made numerous attempts to contact Elizabeth, which were unsuccessful.

13.9.3 At the beginning of February, Elizabeth was seen by a Cognitive Behavioural Therapy[14] (CBT) worker. Elizabeth stated that she was now living in a hotel with a new partner (Jack), and that she was drinking heavily. Elizabeth was seen to have self-harm injuries and disclosed a suicide attempt whilst she had been living in Liverpool. Elizabeth was referred for an in-depth assessment with Healthy Minds. Information was shared between the social worker, CBT worker, Change Grow Live, and GP practice, which expressed professionals' concerns on Elizabeth's presentation (both physically and mentally), and her current living arrangements.

13.9.4 Healthy Minds held a clinical discussion after Elizabeth did not attend an appointment. It was determined that due to her increased alcohol use and dependency, which lead to the risk of impulsivity of deliberate self-harm, a referral was to be made to the CMHT. Elizabeth did not attend the appointment with CMHT.

13.9.5 On 12 February, a GP telephoned Elizabeth due her non-attendance at appointments with professionals. Elizabeth told the GP that she was struggling to attend the appointments as she was staying in a hotel.

13.9.6 On 21 February, Elizabeth approached Housing Options at Stockport Homes. Elizabeth stated that she had been living in a hotel with her new partner, Jack, since the end of January. Elizabeth was offered temporary

[14] Cognitive Behavioural Therapy https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/

accommodation. Elizabeth did not stay at the accommodation – she returned to the hotel with Jack.

March

13.9.7 At the beginning of March, Elizabeth telephoned Healthy Minds and stated that she had not received a letter, and was waiting for an appointment. Elizabeth was advised to continue to work with Change Grow Live to address her alcohol use. On 11 March, Elizabeth told a GP that she had taken out loans to pay for her accommodation, and that she had spent a couple of nights sleeping rough. Elizabeth referred herself to Change Grow Live. Her attendance during March was variable.

April

13.9.8 On 3 April, Adult B told a social worker that Elizabeth had assaulted him during a contact visit between Elizabeth and Josh. Adult B stated that, on another visit with Elizabeth, he had seen her with a black eye and injured hand. Elizabeth denied that she had been assaulted.

13.9.9 On 15 April, Elizabeth registered with The Wellspring. At this time, Elizabeth reported that she was sleeping rough in the town centre. The following day, Elizabeth was seen by a social worker. Elizabeth reported that she was 'doing better'. The social worker offered to help Elizabeth with housing applications.

13.9.10 On 18 April, police attended, at a hotel, a reported disturbance involving Elizabeth and Jack. The incident had been reported by hotel staff. Elizabeth stated that there had been an argument, as Jack had spent her money to purchase alcohol and cocaine. Elizabeth told police that her money was paid into Jack's account, they were both homeless, and had decided to use her universal credit to pay for a hotel. The incident was recorded as a verbal argument and risk assessed as medium. This is the first record of domestic abuse between Elizabeth and Jack. Information provided to the DHR from DWP, confirmed that Elizabeth's benefit money was paid into a bank account in Elizabeth's name. There is no record as to who had access to this account.

13.9.11 On 25 April, Elizabeth was admitted to a psychiatric ward following an attendance at an Emergency Department. Elizabeth had presented as anxious and tearful, which she put down to her social situation. Elizabeth described that she was homeless and living in a tent with her current

partner, Jack. Elizabeth reported fleeting suicidal ideation in the morning on waking, but denied any intent to harm herself. By the end of April, Elizabeth had returned to live with family.

May

13.9.12 On 3 May, Elizabeth attended an appointment with Change Grow Live. Jack had telephoned them to report that Elizabeth was being held against her will by Adult B. Elizabeth told professionals that she did not want to return home, as Adult B was making her go into work with him, and that he escorted her everywhere. Elizabeth told professionals that Adult B had told her that if she did not go back to reside in the family home, she would be unable to see her son. Adult B remained outside the premises whilst Elizabeth was at this appointment; however, on two occasions, he entered the building to enquire how long Elizabeth would be. Elizabeth remained at Change Grow Live throughout the day until a refuge place was identified in Oldham. Elizabeth was taken to the refuge by police. There is no record that any agency submitted a DASH for this incident. Elizabeth's parents told the Chair that they were partly relived when they heard that Elizabeth had been taken to a 'safe house', as they thought Elizabeth would now get some help and support. Elizabeth's family stated that this was the last time they had seen Elizabeth; however, they did receive four letters from Elizabeth over a period of time, which were positive in their tone.

13.9.13 During May, Elizabeth registered with a GP in Oldham. Elizabeth engaged with a keyworker from Jigsaw and was referred to the Freedom Programme. Elizabeth attended two out of 12 sessions – citing that she did not feel she fitted into the course, as she had left Adult B. Elizabeth decided that she wanted to remain living in Oldham so progressed housing options within the area. Elizabeth was still in a relationship with Jack, and spent nights away from the refuge to stay with him in a local hotel. Elizabeth had contact with Change Grow Live. She stated that she wished to remain engaged with the service, despite living in Oldham.

13.9.14 On 17 May, a female reported to the police that Tim had bitten her on her face during a sexual encounter. The female was taken to hospital. The female did not support a prosecution and no further action was taken.

13.9.15 At the end of May, Elizabeth was found in her room at the refuge having self-harmed. Elizabeth had disclosed suicidal ideation to staff at the refuge the previous day. Elizabeth was taken to hospital. Elizabeth told hospital staff that she had not been taking her prescribed medication for anxiety

and depression. Following assessment, Elizabeth was discharged from hospital. A request was sent to her GP practice to invite Elizabeth to attend for a review. Elizabeth's keyworker made a referral to Adult Social Care.

June

13.9.16 At the beginning of June, Elizabeth agreed for a transfer to Turning Point, Oldham, from Change Grow Live. Elizabeth progressed a housing application with First Choice Homes, and was supported by her keyworker from Jigsaw. During a session with her keyworker, Elizabeth stated that she had no money as she had been giving it to Jack: a food parcel and bus pass were arranged. On 12 June, Stockport Children's Social Care closed their case. Josh remained living with Adult B. There were no formal contact arrangements in place between Elizabeth and Josh.

13.9.17 On 18 June, Elizabeth was taken to hospital, via ambulance, following a fight at a family wedding, involving Adult B. Elizabeth was described as intoxicated. Elizabeth had sustained injuries to her feet. Referrals were made to Stockport Adult and Children's Social Care.

13.9.18 On 21 June, Elizabeth self-referred to Healthy Minds. On the same day, Elizabeth told her keyworker that she and Jack were separating. Three days later, Elizabeth attended hospital having been repeatedly assaulted by Jack over a three-day period – during which Jack had refused to let her leave a hotel room. Elizabeth described how she had been kicked and punched in the head, face and back, and that Jack had stamped on her feet to prevent her leaving. Elizabeth disclosed that Jack had taken money from her bank account. Elizabeth was admitted to hospital for observations. Elizabeth declined for the police to be contacted. Hospital staff made a safeguarding referral to Adult Social Care, and Elizabeth was seen by a social worker. Elizabeth returned to the refuge upon discharge. Elizabeth's keyworker discussed alternative accommodation options with Elizabeth. There is no record that a DASH was submitted by any agency for this incident.

July

13.9.19 At the beginning of July, Elizabeth attended her first session on the Alcohol Wellbeing programme. Elizabeth was accompanied by Jack, who she described as being her partner. Elizabeth attended nine sessions over the following five weeks. Elizabeth continued to progress alternative

accommodation and was referred by her keyworker to Housing First Domestic Violence Scheme: this referral was later rejected.

13.9.20 On 12 July, Elizabeth returned to the refuge after being away for several days. Elizabeth appeared to be under the influence of alcohol and drugs. Elizabeth became ill during contact with a keyworker, and disclosed that she has been sexually assaulted by Jack. Elizabeth was taken to hospital via ambulance. Elizabeth was found to have a tear to her liver: she was admitted to hospital. A safeguarding referral was sent to Adult Social Care.

13.9.21 A social worker visited Elizabeth in hospital. Elizabeth told the social worker that Jack had been to visit her, and that she had ended the relationship. She said that she would not see him again until he had sorted himself out with anger management. Elizabeth declined for the police to be contacted. Elizabeth was discharged after two days and returned to live at the refuge. Elizabeth continued to stay away from the refuge overnight. A DASH was not completed by any agency for this incident.

August

13.9.22 Throughout August, Elizabeth had sporadic contact with Turning Point. Elizabeth continued to spend time away from the refuge, often not disclosing where or with whom she was staying. On 21 August, Elizabeth was seen by her keyworker to have facial bruising. Elizabeth denied that she had been assaulted; she stated that she had fallen over.

13.9.23 On 22 August, Elizabeth attended an assessment appointment with Healthy Minds. Elizabeth's case was discussed at a Multi-disciplinary team meeting, and it was determined that Elizabeth was not currently stable in terms of her alcohol use, and that she should continue to work with Turning Point. Elizabeth was referred to Early Help, but the referral was not accepted as she was being supported by a keyworker from Jigsaw Homes.

13.9.24 Later that day, during contact with her keyworker, Elizabeth was asked again about the bruising to her face. Elizabeth started to cry when Jack's name was mentioned. Elizabeth was supported by her keyworker to contact the police to initiate a Domestic Violence Disclosure Scheme (DVDS)[15]. The police reviewed the request and checked local and national

15 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

police systems: they determined that there was no information held that could be disclosed under the scheme. Elizabeth was informed of this outcome. Elizabeth told the keyworker that she would be staying away for two nights with Jack: the keyworker tried to dissuade her from doing this. The keyworker ensured Elizabeth had a safety plan in place. Elizabeth had told the keyworker that she would be happy to move to another refuge. The keyworker progressed contact with refuges in Liverpool and Doncaster. These applications were not progressed due to Elizabeth's complex needs and a view by the refuges that Elizabth needed to stay local for access to her child.

<u>September</u>

13.9.25 On 4 September, Elizabeth returned to the refuge. She was seen to be unwell and told a keyworker that Jack had kicked her in the ribs. An ambulance attended the refuge, but Elizabeth refused to go to hospital. An appointment was made for Elizabeth to attend a walk-in centre later that day, which she attended with her keyworker. Elizabeth left the appointment prior to being seen. The following day, it was recorded that Elizabeth was seen by the police regarding the assault, but declined to make a complaint. The police have no record that Elizabeth was seen and therefore no crime report was recorded. A DASH was not completed by any agency for this incident.

13.9.26 Elizabeth continued to stay away from the refuge. By mid-September, Elizabeth had been referred to Petrus House[16] and, following a telephone assessment, was offered accommodation. Elizabeth stayed one night but returned to live at the refuge.

<u>October</u>

13.9.27 At the beginning of the month, Elizabeth told a GP that she was undergoing court proceedings with Adult B for contact with her son. The DHR has seen no evidence of these proceedings. Elizabeth attended appointments with Alcohol Wellbeing service, and it was reported by the end of the month that she had made a positive progress in addressing her alcohol intake.

[16] Women only communal accommodation offering housing and support for women with mental health issues and/or fleeing from domestic abuse.

13.9.28 On 25 October, Elizabeth was referred to Nacro and, following an initial assessment, was offered accommodation.

November

13.9.29 Elizabeth moved into Nacro accommodation. During a welfare visit, Elizabeth told staff that Jack, whom she described as her friend, was staying with her to help her settle in, as she felt anxious. Nacro was not aware of the previous incidents of domestic abuse with Jack.

December

13.9.30 By December, Elizabeth had settled into her accommodation at Nacro. She was provided with a food parcel and had a final support meeting with a keyworker from Jigsaw.

13.10 2020

January and February

13.10.1 On 16 January, Elizabeth informed her senior recovery worker of her positive progress in reducing her use of alcohol. Elizabeth enquired about applying to be a peer support worker; however, this was not progressed further.

13.10.2 Elizabeth complained to Nacro about problems with her neighbours (noise nuisance), which she stated had caused her anxiety, and resulted in her missing appointments with professionals. Elizabeth informed Nacro that Jack had been staying with her until the problems had been resolved. Nacro responded to the complaint.

13.10.3 On 25 February, Elizabeth contacted the police to report that she had been physically and sexually assaulted by Jack over a period of days. Elizabeth was taken to hospital and Jack was arrested. Elizabeth provided a statement to the police, but later stated that she would not support a prosecution. A DASH was completed that was initially risk assessed as medium; however, following a review, this was increased to high. A referral was made to MARAC. Hospital staff submitted a safeguarding adult concern. Jack was released from custody on conditional bail. Nacro arranged for additional safety measures and arranged for Elizabeth to move properties. It was at this time that Nacro became aware that Jack

had been Elizabeth's previous abuser prior to her move to Nacro accommodation.

March

13.10.4 At the beginning of the month, an IDVA (Independent Domestic Violence Advocate) attempted to telephone Elizabeth, however, the calls went to voicemail. On 11 March, the Housing Management worker was unable to carry out a session with Elizabeth due to her increased use of alcohol. Elizabeth was encouraged to contact Turning Point. An appointment was made for Elizabeth to attend Inspire Women: to support Elizabeth to access positive social networking and peer support.

13.10.5 On 12 March, a MARAC meeting was held. It was recorded that attempts to contact Elizabeth via telephone had been unsuccessful. An action was raised for Turning Point to send a letter to Elizabeth.

13.10.6 On 24 March, the police closed the crime investigation in relation to the physical and sexual abuse allegations from February. It was recorded that Elizabeth was provided with support and referral details for other services. Jack was released from his bail conditions.

13.10.7 By the end of March, Elizabeth had engaged with Turning Point. Elizabeth reported that she was binge drinking and using alcohol as a coping mechanism. Elizabeth stated that she felt she should be receiving more support from Turning Point. Elizabeth had cancelled some appointments earlier this month.

April

13.10.8 The majority of contact with Elizabeth, during April, was via telephone, due to the Covid-19 pandemic.

13.10.9 At the beginning of April, Elizabeth sent a text message to a support worker from Turning Point: it stated that she was struggling. The text was sent at 20:18. The support worker telephoned Elizabeth, who stated that she was receiving unsolicited calls from Jack. Elizabeth was advised to call the police. The following day, the support worker telephoned Elizabeth, but received no reply. Elizabeth sent a text message to the support worker which stated: 'no, my ex-partner beat the crap out of me'. Elizabeth then called the support worker, but ended the call suddenly as the ex-partner

had returned. The support worker telephoned the police, who attended at Elizabeth's address. Jack was at the property. Elizabeth stated that she had allowed Jack to stay due to him being homeless. The incident was closed. There was no investigation in relation to the allegation of assault and domestic abuse. A DASH was not completed by either the police or Turning Point.

13.10.10 On 11 April, following a team discussion held by Turning Point, a request was made to the police to undertake a welfare check on Elizabeth. The request was over the Easter period. The contact with the police was via 'live chat'. The police created an incident which they closed – citing that there was no further information or escalation of risk, the officers who had seen Elizabeth at the beginning of April had submitted a care plan, and that there had been a significant delay from the original report (six days) of the request being made.

May

13.10.11 Between May and July, Elizabeth engaged on the 'Finding Me Programme' with Inspire Women. The programme was held online, and Elizabeth was supported with top-up credit to her mobile phone to enable her to access the sessions. On 13 May, Elizabeth was referred to the Working Well Work and Health Programme by Job Centre work coaches. An initial assessment was undertaken that determined a set of actions to support Elizabeth towards employment. Elizabeth was assigned a keyworker.

13.10.12 On 26 May, Elizabeth sent a text message to a Housing Management worker which stated that she felt anxious and intimidated by other residents, and had asked Jack to stay with her. Nacro prepared a visitor's ban for Jack, and arranged to visit Elizabeth the next day.

13.10.13 The following day, Elizabeth telephoned 999 for the ambulance service. Elizabeth did not speak to the operator, and calls back to her were unanswered. An ambulance attended her address. Elizabeth disclosed that she had been assaulted by Jack and that she was scared. Jack was at the property. The crew communicated with Elizabeth via notes. Elizabeth declined to attend hospital or for the police to be called. Elizabeth consented for a telephone call with a GP. Upon leaving the property, the ambulance service contacted the police. The police sent a text message to Elizabeth's mobile asking her to attend at the police station. A response was returned that Elizabeth did not want to attend the police station, or have the police attend the address: contact via telephone was her

preference. The incident was reviewed, and an officer was tasked with attending at the address to see Elizabeth. An officer attended and spoke to Elizabeth, who declined to go to hospital. The police returned to the property a short time later and arrested Jack for assaulting Elizabeth. After Jack's arrest, Elizabeth told the police that she had also been sexually assaulted by Jack. Elizabeth disclosed that Jack had been adding vodka to her drink and food. The incident was risk assessed as high, and referrals were made to MARAC, IDVA, and Adult Social Care. Jack was later released on bail with conditions not to contact Elizabeth.

13.10.14 The next evening (28 May), the police attended at Elizabeth's property and found Jack at the address. Jack was arrested for breach of bail. An application was made for a Domestic Violence Protection Notice (DVPN)[17], but this was not authorised. Jack was released from custody with the same bail conditions. The crime investigation was later finalised, with no further action taken.

June

13.10.15 At the beginning of June, Adult Social Care gathered information from agencies in response to the safeguarding concerns received. Nacro discussed with Elizabeth a move to alternative accommodation with a higher level of support. Elizabeth declined to move but did agree to a visitor ban for Jack. Elizabeth spoke with an IDVA, via telephone, but declined support, citing that she was already engaged with two keyworkers.

13.10.16 On 18 June, a MARAC meeting was held. There was one action recorded for contact with Stockport Children's Social Care. On 22 June, Elizabeth moved properties. Adult Social Care closed the safeguarding concern.

13.10.17 On 23 June, Elizabeth contacted the police to report that Jack had assaulted her new partner, Tim. This was the first record of Elizabeth and Tim being in a relationship. Jack was arrested by the police and charged in relation to the assault on Tim. Elizabeth refused to complete a DASH, and the incident was risk assessed as medium; however, on review, the incident was closed, with a recording that it was not domestic abuse.

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

July

13.10.18 On 1 July, Jack contacted the police to report that Elizabeth had told him she was scared of Tim, and that he had been hitting her. Jack made a further call and stated that he had been to the address and seen Elizabeth, whom he described as being 'covered in bruises.' Police attended at Elizabeth's address. Tim was seen with facial injuries. Jack was arrested to prevent a breach of the peace. The incident was recorded as an assault on Tim by Jack. It was later finalised with no further action taken, as Tim did not support a prosecution and the injuries sustained were minor. The allegation of Elizabeth being assaulted was not investigated. There was no record of a DASH being completed for this incident.

13.10.19 On 6 July, Elizabeth told her worker at Turning Point of her new relationship with Tim. Elizabeth described him as having a history of assault, but not domestic abuse, and not on women. Two days later, a volunteer, whilst delivering a food parcel at Elizabeth's address, raised concerns as they had seen bruising to Elizabeth's arms. The concerns were discussed in a multi-agency meeting and a decision was made for Nacro to undertake a home visit. When Nacro visited, they found Tim hiding under a duvet, and blood was seen splattered on the walls. Nacro contacted the police. Elizabeth told the police that the blood was from the previous incident on 1 July, and the bruising had occurred when she intervened in the fight.

13.10.20 By the middle of the month, Elizabeth had been discharged from Healthy Minds due to no contact. Elizabeth had declined to engage with an IDVA. Elizabeth had one contact with Turning Point via telephone: further contact was then unsuccessful. Elizabeth told Turning Point that she had ended her relationship with Jack. Elizabeth described that the relationship had been destructive.

August

13.10.21 At the beginning of August, Turning Point sent a letter to Elizabeth regarding engagement in the service. Elizabeth responded to the letter and cited that she had been unwell. Elizabeth spoke of her new relationship with Tim.

13.10.22 On 13 August, a MARAC meeting was held following the incident in July. There were no actions from the MARAC.

September and October

13.10.23 During these months, Elizabeth did not engage with Turning Point, and so a closure letter was sent. By mid-October, Nacro had referred Elizabeth to Turning Point due to her binge drinking of alcohol; however, Elizabeth did not respond to further contact. Inspire Women attempted to contact Elizabeth during this time, but Elizabeth did not respond to texts and emails sent.

November

13.10.24 On 9 November, Elizabeth was seen by a Housing Management worker with a stab wound to her leg. Elizabeth was very thin and bruised. Hair was seen all over the property: this was described as being either cut or pulled out. Tim was at the property. Elizabeth was taken to hospital but she did not stay. Hospital staff contacted Elizabeth via telephone and raised concerns to the police and Adult Social Care. The police attended Elizabeth's address. She refused to let them inside the property, but agreed to speak to them inside their vehicle. Elizabeth told the police that she had recently become engaged to Tim, and denied she had been assaulted. The incident was not recorded as domestic abuse, despite the officers believing she had been assaulted.

13.10.25 The following day, Nacro undertook an unannounced visit to Elizabeth. Elizabeth was seen to have further bruising, which included a black eye. Elizabeth had not eaten for six days. Elizabeth told Nacro that the hair on the floor was from the washing machine. Elizabeth agreed to go out with the worker to have a coffee. Whilst out, Elizabeth disclosed that Tim had caused the stab wound. Elizabeth agreed to attend hospital, but left prior to being seen. Elizabeth's case was discussed at the daily risk management meeting. A referral was made to MARAC.

13.10.26 On 13 November, Elizabeth spoke to an IDVA via telephone. Elizabeth stated that she did not want support; she wanted to remain in the relationship to work things out as a couple. Elizabeth told the IDVA that they were both receiving support with anger management. It was agreed to close the case after the MARAC meeting.

13.10.27 At the end of November, Adult Social Care arranged a multi-agency strategy meeting to discuss Elizabeth's case. The meeting was arranged for 2 December.

December

13.10.28 Adult Social Care held a strategy meeting on 2 December. The meeting was not attended by the police or IDVA. The police submitted written information. A further meeting was arranged for January, however, this was cancelled due to capacity issues at that time.

13.10.29 The following day, a MARAC meeting was held. The police were tasked with contacting Elizabeth to ascertain how she had sustained her injuries, and record a crime if relevant. An officer telephoned Elizabeth and left a message to contact them if she wished to report a crime. No reply was received. The IDVA closed Elizabeth's case.

13.10.30 On 15 December, Elizabeth's case had been allocated to a new recovery worker at Turning Point; however, an appointment at the end of the month was cancelled due to competing demands in the workplace. At the end of December, Tim attended a drop-in telephone session with TOG Mind, for a low mental health assessment. During the call, Tim expressed a preference for counselling and anger management.

13.10.31 Elizabeth's parents stated that just before Christmas 2020, one of the letters they received from Elizabeth, included information that Elizabeth had met a man from the Isle of White (Tim).

13.11 2021

January

13.11.1 On 8 January, Tim was seen by TOG Mind. Tim stated that he was concerned that he could have bipolar disorder or schizophrenia, and that he was suffering with anxiety, depression, and possibly Post Traumatic Stress Disorder (PTSD). Tim also stated that he was experiencing stuttering and slurred speech; therefore, he thought he may have early-onset of Alzheimer's. During the appointment, Tim was recorded as having made a joke about his partner wanting to kill him. A referral was sent to the memory service, but this was rejected. Tim was referred to the Access Team, but later discharged as he did not respond to communication. On 13 January, during an appointment with TOG Mind, Tim stated that his children and partner were a protective factor.

13.11.2 On 18 January, Jack was issued bail conditions by Greater Manchester Magistrates Court in relation to the assault on Tim from June 2020. The conditions were:

1. Exclusion: Not to contact directly or indirectly Tim.
2. These conditions are only valid until 13:30hrs on 1 March 2021.

13.11.3 On 21 January, the police received an abandoned 999 call from Elizabeth, during which she stated: 'I need help'. Police attended at Elizabeth's address. Jack was at the property. Elizabeth told the police that she had been assaulted by Jack. Jack told the police that he had been assaulted by Elizabeth. The police took Jack to a tram stop. A crime report was raised for both assaults, which were finalised with no further action. The incident was risk assessed as medium; however, following a review by the MASH[18] triage, it was raised to high. A referral was made to MARAC.

February

13.11.4 At the beginning of the month, Adult Social Care was informed by Nacro that Elizabeth had not paid her rent for the last month. Elizabeth told Nacro that Tim had been taking money out of her account to order food, and that she had cancelled her card. Following the MARAC referral, Elizabeth was telephoned by an IDVA. Elizabeth declined support.

13.11.5 On 8 February, a MARAC case was held. There were no actions recorded. Three days later, Elizabeth contacted the police and reported that she had been assaulted by Jack. Elizabeth told the police that she had been drinking alcohol with Jack for the last two days. Jack was taken to another address by the police. Elizabeth told the police that she would not support a prosecution. The incident was risk assessed as medium, but increased to high upon review by a Specialist Officer. A referral was made to MARAC.

13.11.6 On 15 February, Elizabeth contacted the police via 999. Police attended at Elizabeth's address and found Jack and Tim present. Elizabeth and Tim had been assaulted by Jack. All persons had been drinking alcohol. Elizabeth described Jack as her ex-partner and stated that she had let him in as he was homeless. Elizabeth and Tim told the police that they did not support a prosecution, but would support a restraining order. Jack left the property. A crime report was created for the assaults. The crime reports

[18] https://www.oldham.gov.uk/info/200801/report_a_concern_or_abuse/1618/multi-agency_safeguarding_hub_mash

were finalised with no further action taken. Jack was in breach of his bail conditions issued in January 2021.

13.11.7 Three days later, the police received an abandoned 999 call from Elizabeth. This was the third call to the police from Elizabeth in a week. Elizabeth told the call taker that she had been grabbed on the wrists and neck by Tim. Elizabeth told the call taker that Tim had left the property, and she did not want a visit that day. An appointment was made to see Elizabeth the following day. Police telephoned Elizabeth and visited her address, but were unable to make contact. A crime report was created for the assault. The incident log was closed, without Elizabeth being seen or spoken to.

13.11.8 On 23 February, an IDVA telephoned Elizabeth. Elizabeth declined support.

March

13.11.9 At the beginning of the month, Nacro had unsuccessful attempts to contact Elizabeth. Elizabeth had not been seen by Nacro since 15 February. Nacro gained entry to Elizabeth's flat and found her deceased. Nacro informed the police, and a criminal investigation commenced.

14. ANALYSIS USING THE TERMS OF REFERENCE

The Review Panel recognised that this DHR was complex and that the panel had access to an extensive amount of information from those agencies involved. The following section of the report will seek to identify the key areas of agencies' involvement, and provide analysis to identify learning. This section will not analyse every agency contact.

14.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Elizabeth as a victim of domestic abuse, and what was the response? (N.B. Please consider risks from previous relationships).

Adult Social Care

14.1.1 Elizabeth was referred to Adult Social Care by agencies due to domestic abuse, self-harm, and alcohol use. The first concern was raised by Housing in May 2019. Thereafter, further concerns were raised by agencies. On 26 June 2019, Adult Social Care opened a safeguarding concern to consider all the information that had been received. This was the first of several safeguarding concerns over the following 18 months: these concerns related to domestic abuse, self-harm, and alcohol use. During contact with Adult Social Care, there were detailed conversations and information sharing between agencies: this provided Elizabeth and agencies with information as to how Elizabeth could seek support. Elizabeth was identified not to have care and support needs as defined by the Care Act 2014. Adult Social Care's response to the safeguarding concerns is covered under Term 5.

Change Grow Live

14.1.2 In September 2018, Elizabeth spoke about feeling isolated living at her parents. Elizabeth related this to past trauma. The following month, Elizabeth spoke of a 'personal event' which had led to an increase in her anxiety. Elizabeth was clear that she did not want to discuss this in front of Adult B. Whilst the comment was not directly linked to domestic abuse, the IMR author from Change Grow Live has stated that further exploration should have taken place to understand the context and the relationship between Elizabeth and Adult B. The Review Panel agreed with this analysis, as during another session in October, Elizabeth spoke of tensions at home and within her relationship that had resulted in verbal arguments,

and her taking an overdose. Elizabeth later reported that her relationship with Adult B had since improved.

14.1.3 In November 2018, Elizabeth requested to attend appointments without Adult B. Elizabeth had requested this during an unscheduled contact when Adult B was not present. From this time on, Elizabeth was then seen alone. Elizabeth shared that she felt worried about attending alone as Adult B could be controlling, but that she felt safe at Change Grow Live. The reason for Elizabeth wanting to attend without Adult B was not discussed with her. The Review Panel agreed that the information shared by Elizabeth at that time was an indicator of domestic abuse, in terms of coercion and control, and further exploration should have taken place with Elizabeth. The following month, Elizabeth disclosed that she had been physically assaulted by Adult B.

14.1.4 In May 2019, Change Grow Live were proactive when Elizabeth disclosed domestic abuse with Adult B. There was clear communication and evidence of good multi-agency working, which resulted in Elizabeth moving out of town to a refuge. The Review Panel agreed that the response by Change Grow Live was good, and showed clear recognition of understanding the risk associated with domestic abuse; however, no DASH was submitted following this incident. This is covered later in the report.

Stockport Children's Social Care

14.1.5 The referral to Children's Social Care provided clear evidence that Elizabeth was a victim of domestic abuse in her relationship with Adult B. A strategy meeting should have been held with agencies to consider child protection issues: this would have included safety planning for Elizabeth, as well as consideration of the safeguarding needs for Josh. The Greater Manchester Children's Safeguarding Procedures manual provides clear guidance around domestic abuse, and there are also clear processes in place within Stockport to provide support and advice to practitioners working with families where there are concerns regarding domestic abuse. The Review Panel was informed that there was inadequate management oversight of the case, which led to a lack of clear direction being provided to the social worker, and procedures not being followed.

14.1.6 The IMR author for Children's Social Care analysed that the case was not straightforward in that Elizabeth had a well-entrenched coping response, both to past and current trauma, which she was self-medicating with drugs, alcohol, and self-harming. These behaviours were seen as the main

risk to Josh, and responded to as such; therefore, the domestic abuse was not considered. There was a lack of a more in-depth assessment of the reasons why Elizabeth behaved in this way – her history, past relationships, and her relationship with her parents. There was also a lack of consideration of the way in which she and Adult B were responded to at critical times when domestic abuse incidents took place, to ensure that they were both safe, and that the arrangements for the care of Josh remained appropriate for his safety and well-being. This included a domestic incident that occurred during a contact visit with Josh.

Greater Manchester Police

14.1.7 Almost all the contact that Elizabeth had with Greater Manchester Police contained a domestic abuse element. Disclosures of abuse came when Elizabeth sought medical attention due to physical and sexual abuse, as well as during direct calls to the police. Elizabeth often disengaged with the police, and declined to provide the police with details of incidents. Elizabeth would, at times, not consent to information being shared with partner agencies; however, the police did make referrals, and Elizabeth's case was heard at MARAC five times between March 2020 and February 2021 – following incidents being assessed as high risk.

14.1.8 Over the period of the review, 10 incidents of domestic abuse were reported to the police. Two of these related to crimes involving ex-partners of Elizabeth – on both occasions, the perpetrator was arrested (Adult A – June 2016. Adult B – December 2018). The remaining eight involved allegations of abuse, with Jack and Tim being the named perpetrator. Below is a summary of relevant incidents:

Date	Incident	Outcome
18.04.19	Hotel staff reported argument between Elizabeth and Jack.	Elizabeth disclosed elements of financial abuse and that her money was paid into Jack's account which he had used to buy alcohol and drugs. This was not progressed further by police.
25.02.20	Elizabeth reported that she had been assaulted and raped by Jack.	Jack was arrested. Elizabeth later withdrew support for prosecution. No DVPN considered.

27.05.20	Elizabeth reported that she had been assaulted and raped by Jack	Jack was arrested. Elizabeth withdrew support for prosecution. No DVPN considered.
28.05.20	Breach of bail.	Jack was arrested. DVPN refused.
01.07.20	Elizabeth told Jack she had been assaulted by Tim. Jack assaulted Tim.	Jack was arrested for assault on Tim. Assault on Elizabeth by Tim was not progressed. No DVDS considered.
09.11.20	Call received expressing concern for safety of Elizabeth. Elizabeth had been seen with stab wound to leg.	Elizabeth reported her partner (Tim) needed help. Elizabeth did not disclose how she obtained her injury. MARAC referral. No DVDS considered.
21.01.21	Elizabeth was assaulted by Jack.	Jack removed by police.
11.02.21	Elizabeth was assaulted by Jack.	Jack removed by police.
15.02.21	Elizabeth was assaulted by Jack.	Jack removed by police.
18.02.21	Elizabeth was assaulted by Tim.	Log delayed for officer to attend. Elizabeth not seen.

14.1.9 The police have identified incidents where opportunities were missed, in terms of response to the domestic abuse perpetrated by Jack and Tim. This is addressed further in Term 2.

Jigsaw

14.1.10 The referral received on 3 May 2019, identified Elizabeth as a victim of domestic abuse from her previous relationship with Adult B. Elizabeth was offered support to establish a diary of the abuse, and was referred to the Freedom Programme. Elizabeth attended two sessions, stating that she did not feel that she needed this as she had left her relationship with Adult B. Elizabeth was re-offered the Freedom Programme when it transpired that her relationship with Jack was also abusive; however, she only attended one further session. Jigsaw identified the following indicators of domestic abuse from working with Elizabeth, and provided the following support:

Depression and anxiety – Elizabeth identified herself as suffering from depression, anxiety, and PTSD on entry to the refuge. Elizabeth was on medication but did not always take this. Elizabeth was supported with a chart to keep track of her medication, with making and attending GP appointments, and with a referral to Healthy Minds. However, Healthy Minds refused service due to her drinking heavily at the time: they advised that she would need to reduce her alcohol intake.

Self-harm and suicidal thoughts – Elizabeth was supported to attend hospital, and with subsequent GP appointments. Staff completed a safety plan with Elizabeth. Information on self-harm and on the Stay Alive app was given to Elizabeth, along with the RAID[19] number and Samaritans number.

Increased alcohol use – Elizabeth was supported to engage with Change Grow Live and Turning Point in Oldham, around her alcohol use. Information was also sought around accessing rehab, but Elizabeth decided that she did not wish to pursue this.

Physical injuries – Elizabeth was supported to access medical attention around her physical injuries. Staff discussed the risk posed by Jack with her, and carried out safety planning with Elizabeth to keep herself as safe as possible when she was staying out of the refuge.

Financial difficulties – Elizabeth had debts. It later transpired that she was giving money to Jack: staff spoke to her about this and told her that it was abusive, which she accepted. Staff supported her around managing her debts, advised her not to give money to Jack, and to put herself first. They also assisted her in safety planning around this, for example leaving her cash card at the refuge when she was going out.

<u>Oldham CCG</u>

14.1.11 Elizabeth registered with a GP in Oldham following her move to the refuge in May 2019. Elizabeth informed the GP practice that she was currently living in a women's refuge, therefore, there was a presumption that she was receiving all the support she required, at that time, in terms of domestic abuse. The Review Panel was informed that the GP practice do have a large number of patients registering at the practice when they move

[19] https://www.penninecare.nhs.uk/services
Co-ordinated care for people with mental health problems.

into the refuge – often these patients are from out of the borough, and these can be complex patients escaping very difficult circumstances. The Review Panel was informed that the GP practice rarely receives any information in terms of what involvement from statutory or voluntary sector services has been, or continues to be, in place. This has been identified as a single agency learning, and a relevant recommendation made

14.1.12 In June 2019, Elizabeth disclosed to her GP practice that she had been in an altercation, during which she sustained bruising to both of her feet. This was an opportunity to explore the current risks posed to Elizabeth, and to ensure Elizabeth was aware of the services available to her locally in terms of support and legal orders, such as a non-molestation order. This did not take place. The following month, Elizabeth told her GP practice that she was no longer in a relationship with her partner, and that she was involved with agencies; however, it was unclear in records as to the exact detail of who was involved, who they were supporting, and what their role was with Elizabeth.

14.1.13 In February and March 2020, Elizabeth's GP practice was informed that she had been assaulted, and that she was the subject of discussion at MARAC. The GP practice added a code to Elizabeth's record; however, when Elizabeth contacted the GP practice towards the end of March, there was no acknowledgement by the practitioner of the recent assault, and how this may have had an impact on the deterioration on her mental health.

14.1.14 In May 2020, Elizabeth disclosed that she had been assaulted by Jack. Elizabeth had refused to attend hospital, and concerns escalated when she did not answer telephone calls from the GP practice. The police were asked to undertake a welfare check. A DASH risk assessment was completed, which was in line with best practice, although there was uncertainty within the GP practice and across the partnership, as to how the risk assessment reached MARAC. There was no information in Elizabeth's GP records as to what the outcome of the MARAC referral was. Elizabeth's case was discussed at the GP practice meeting: this was acknowledged as good practice as the clinician was gaining supervision, as well as peer advice, on the management of the circumstances. Oldham CCG has identified learning around this incident in relation to recording, professional discussions, and challenges.

14.1.15 In November 2020, the GP practice had been informed that Elizabeth had attended at hospital following an injury. A DASH had been completed, and

a safeguarding concern had been raised. There was no acknowledgment of this information two days later when the GP practice undertook a medication review with Elizabeth. Whilst it may not have been appropriate to complete a DASH, it may have been beneficial to Elizabeth to have the discussion with a practitioner when the situation was calm, in order to ensure that Elizabeth had access to the support she wanted.

14.1.16 There was no reference to Elizabeth being a victim of domestic abuse in Tim's GP records. There was a reference in January 2021, when Tim was reported to have joked that his partner wanted to kill him. This was not challenged, or further clarification sought. This was an opportunity to demonstrate professional curiosity and ask probing questions about his relationship.

Stockport CCG

14.1.17 Elizabeth disclosed to her GP practice that she had been the victim of domestic abuse in her relationship with Adult A, which had resulted in physical injury on at least two occasions. Not long after, Elizabeth moved to Derbyshire with Adult B. There is an entry in her GP records, from Derbyshire, that Elizabeth had sought a consultation specifically without her partner being present. The review understood this to be Adult B. The Review Panel was informed that it is unusual for someone to need to specify this desire, as under normal circumstances one would expect a patient to book an appointment and to come alone if they wished to do so. The fact was that Elizabeth was so specific in her request, and this was not explored further. The panel agreed that this was a missed opportunity.

North West Ambulance Service

14.1.18 Elizabeth disclosed domestic abuse to attending NWAS staff. The first incident was in 2016, when Elizabeth had contacted the NHS 111 service with a nose bleed. The clinician probed beyond the basic triage questions used on the computer system, which allowed Elizabeth to disclose that she had been assaulted by Adult A. During this contact, Elizabeth described Adult A as controlling, would not let her attend hospital, or call a friend, as he had isolated her and made threats to kill her. The clinician sent an ambulance and requested the police attend. Adult A was arrested. Elizabeth consented for a referral to be completed.

14.1.19 The next contact with Elizabeth was three years later in June 2019, when a taxi driver called 999 as the female passenger, Elizabeth, had chest pains.

Elizabeth told the ambulance crew that she was living in a refuge, having left an abusive relationship, and that her child was living with his father. When asked, Elizabeth told the ambulance crew that the father of the child had been the man who had abused her. The ambulance crew raised a safeguarding concern for Elizabeth and her child.

14.1.20 In February 2020, Elizabeth made a 999 call and reported that she was suffering with pain in her shoulder. Elizabeth told the crew that she had been assaulted by her partner two days earlier, and that he had been arrested by police. It is known that this partner was Jack. Elizabeth was taken to hospital but refused for any onward referral. A referral was not made.

14.1.21 On 27 May, a 999 call was made to North West Ambulance Service. The call could not be triaged as the caller would not answer any questions. Three attempts were made to contact the caller. Due to the silence and reluctance to speak, the police were alerted to assist with gaining entry and an ambulance was dispatched. The crew contacted Elizabeth through the door, before gaining entry. Jack was present at the address. Elizabeth was reluctant to speak to the crew in the presence of Jack so the crew communicated with Elizabeth using written notes. Elizabeth disclosed that she was scared and there was nothing that would stop Jack from assaulting her. Elizabeth told the crew that she had a support worker. Elizabeth refused to attend hospital but agreed for contact to be made with her GP. The ambulance crew facilitated this call. Elizabeth remained at the house. The ambulance crew made a further call to the GP, once they were outside the property, and expressed their concerns from Elizabeth. The crew contacted the police and raised a safeguarding concern due to the significant risk that they felt Elizabeth was at. The ambulance crew overrode Elizabeth's consent to make the referral. The Review Panel agreed that this was an appropriate decision made by the ambulance crew. This has been recognised by the Review Panel as innovative practice. [See Term 15].

14.1.22 In the early hours of the following morning, Elizabeth contacted the ambulance service. Elizabeth was described by the attending crew as being fearful and anxious. Jack had been arrested for assaulting Elizabeth. Elizabeth was taken to hospital. On this occasion, Elizabeth refused to consent to a referral being made: it was confirmed by the crew that a referral had been made the day before. Whilst information was shared with the hospital at the point of handover, no additional referral was made.

14.1.23 The Review Panel reflected on all agencies' approaches to raising safeguarding concerns, where consent had not been obtained from the subject, and whether a decision should be made to override consent and share information. This is explored further in Term 5.

Northern Care Alliance

14.1.24 Elizabeth attended hospital on six occasions for treatment, as the result of assaults. A further attendance took place on 18 June 2019. On this occasion, Elizabeth did not disclose that her injuries were due to being assaulted. Elizabeth was seen and triaged in the Emergency Department by a Domestic Violence and Abuse (DVA) Nurse[20] who enquired as to the nature of the injuries and whether this was linked to domestic abuse. The DVA Nurse also contacted the police. This was good practice.

14.1.25 On 24 June, Elizabeth was admitted to hospital following a significant assault. Contact was made with the refuge and an adult safeguarding referral was completed, with staff citing domestic abuse. Elizabeth refused consent for police involvement. Elizabeth was seen by a hospital social worker who, along with staff, tried to persuade Elizabeth to report the assault to the police. As there was no reason to doubt Elizabeth's mental capacity, contact with the police was not made. This is analysed further under Term 5 in relation to whether a decision could have been made to override consent.

14.1.26 On 12 July 2019, Elizabeth was admitted to hospital following a further assault which, amongst other injuries, resulted in a laceration to her liver and a sexual assault. Elizabeth was in hospital for three days. Staff proactively attempted to encourage Elizabeth to report the assault to the police. It was recorded that Elizabeth appeared to minimise the seriousness of the assault and diverted conversations away around contacting the police. Elizabeth was also keen for staff not to discuss domestic abuse or her injuries with Jack, when he visited her on the ward.

14.1.27 The Review Panel recognised that, at this time, the abuse to Elizabeth was escalating in terms of the ferocity of violence. Elizabeth had been absent from the refuge for several days prior to her hospital admission. At this time, Elizabeth's wishes around minimisation and not wanting police involvement were recognised by the Review Panel as Elizabeth's way of safety planning and preventing further harm from Jack – had the police

[20] A DVA Nurse will have received additional training on domestic abuse and safeguarding.

and other agencies been involved. The Review Panel also reflected that Elizabeth would also have seen herself as being in a safe place whilst she remained in hospital.

14.1.28 In September 2019, hospital staff made a safeguarding referral after Elizabeth presented with breathing difficulties. Elizabeth disclosed to staff that she had been assaulted two days earlier and had attended hospital. There was no record of this hospital attendance. Elizabeth declined to provide information about the assault, but did tell staff that her partner waits for her outside the hospital when she attends, and also insists that she leaves. The panel recognised this behaviour as coercive control. Elizabeth was in a relationship with Jack at this time.

14.1.29 In February 2020, following an assault, staff completed an adult and child safeguarding referral and DASH on Elizabeth's attendance. The DASH scored 15, which identified Elizabeth as high risk: a referral was submitted to MARAC. A further DASH was completed in May 2020, following Elizabeth's attendance for physical and sexual assault.

14.1.30 In November 2020, Elizabeth left the hospital without having been seen by medical staff. The nurse contacted Elizabeth by telephone but she refused to attend. A male could be heard in the background and the nurse contacted the police. A DASH was completed and, whilst this scored 11, a decision was made based on professional judgement that the case should be referred to MARAC. The Review Panel acknowledged that this was good practice and demonstrated the awareness of domestic abuse, and consideration of previous risks and incidents to Elizabeth.

<u>Early Help and IDVA</u>

14.1.31 In August 2019, a referral was made to Early Help from Healthy Minds, which requested support for Elizabeth. Elizabeth had reported that Adult B was using her child as a weapon against her, and that she had not seen the child since April. Elizabeth was living in the refuge at this time. The referral was rejected as it was determined that the refuge was providing the relevant support for Elizabeth, and so it was not felt appropriate to duplicate this. The IMR author for Early Help has determined that this was an appropriate decision.

14.1.32 There were five MARAC meetings held between March and February 2021. An IDVA contacted Elizabeth on all but the first MARAC case. Elizabeth declined support from the IDVA on each occasion. During contact in June

2020, Elizabeth told the IDVA that she already had two keyworkers (housing and mental health) and did not want a third person involved. This is analysed further under Term 3.

14.1.33 On 8 July 2020, a foodbank volunteer reported that they had seen bruising on Elizabeth's arms whilst delivering a food parcel. At this time, the Early Help Team were supporting the Hubs during the Covid-19 pandemic. There then followed proactive work amongst agencies in response to this incident – with the concerns being discussed at the daily risk meeting the following day – and a decision was made for further contact to be made with Elizabeth: with the delivery of a further food parcel, and to facilitate passing on information about support services. The IDVA provided supporting information and questions for the Hub to establish if Elizabeth was safe to talk. A decision was made that a safe and well check would not be requested from the police as this could put Elizabeth in more danger – given that there were still lockdown restrictions. A request was also made for the housing worker from Nacro to visit Elizabeth. The Review Panel acknowledged that this was innovative practice.

14.1.34 On 10 November, Adult Social Care brought the case to the daily risk meeting after Elizabeth had attended hospital. An IDVA telephoned Elizabeth. Elizabeth stated that she had had lots of calls from professionals about domestic abuse in the past and that each time she had told them she did not want support. Elizabeth told the IDVA that she wished to remain in the relationship, she was getting support for anger management and wanted to work things through together as a couple, and did not want to discuss the matter further. Elizabeth was in a relationship with Tim. The IDVA recorded that they felt Elizabeth was playing down what was happening, so persuaded Elizabeth to save the IDVA number to her phone in case she changed her mind or things changed. The Review Panel has seen no evidence or details regarding the anger management that Elizabeth mentioned.

14.1.35 The Review Panel discussed this contact with Elizabeth and recognised that this was the second occasion that Elizabeth had told an IDVA about the number of calls and professionals that were involved in her case. The panel discussed what options were available at this point, and in response to Elizabeth's comments, and agreed that a multi-agency meeting should have been held to review all known information and consideration of identification of a Lead professional to be the single point of contact to co-ordinate agency contact with Elizabeth.

14.1.36 The Review Panel was informed of work that had commenced within Oldham to introduce a Tiered Risk Assessment and Management (TRAM) Protocol. The multi-agency protocol has been developed in partnership with members of the Oldham Safeguarding Adults Board (OSAB) and through communication with Rochdale Safeguarding Adults Board who have a similar process – Multi Agency Risk Management Process (MRM)[21]. The work to embed the TRAM is part of work across the Greater Manchester area to ensure a consistent approach in responding to complex cases. The protocol has been developed following learning identified from a thematic review of a number of Safeguarding Adults Reviews (SARs), in 2019. The Review Panel recognised that work was ongoing to address this area of learning.

14.1.37 The protocol is designed to support any practitioner working with adults where there is a high level of risk, that would benefit from joint multi-agency management and senior oversight of risk management strategies. The protocol has been developed in response to learning gained from several SARs, to enable a co-ordinated and collaborative multi-agency response to risk. It recognises that in complex cases, professionals are often dealing with long-term and entrenched behaviours that require multi-agency commitment to a longer-term, solution-based approach.

14.1.38 The protocol states the requirement for a Lead professional to be identified and agreed at the earliest opportunity for the effective management of cases involving multiple and/or complex risks that require a range of agencies to work together to achieve jointly agreed outcomes, and that the role of the Lead professional is to act as the single point of contact for the individual and the team involved in their support. The Lead professional should be the practitioner who has the best connection or a statutory duty to work with the individual, and that wherever possible, the individual must be involved in this decision. Whilst the Review Panel acknowledged the introduction of the TRAM, the Review Panel agreed that the multi-agency working, information sharing, and identification of a Lead professional was a key area of learning on this case, and have made a relevant recommendation. [Recommendation 1 and 2].

[21] https://www.rochdalesafeguarding.com/p/safeguarding-for-adults/multi-agency-policy-procedures-protocols-and-guidance

Housing

14.1.39 Elizabeth indicated that she was a victim of domestic abuse on her application to join the Council's housing register: this triggered the initial response to invite her to seek further advice from the Housing Options Team. Elizabeth consented to information sharing between the refuge and the housing service, which allowed for follow up of non-attendance at a pre-booked appointment. It has been identified that this contact could have been used to greater effect on other occasions – to drive along Elizabeth's housing/homelessness application, but mainly to help support her resettlement in Oldham. This has been identified as a single agency learning.

Pennine Care NHS Foundation Trust

14.1.40 Elizabeth identified that her presentation to hospital on 6 June 2018 for an episode of self-harm, was triggered following an argument with Adult B and his mother. Safeguarding referrals were completed. During assessments with Stockport Mental Health Liaison Team in June 2018 and April 2019, Elizabeth reported that she had been the victim of domestic abuse in previous relationships.

14.1.41 The IMR author from Pennine Care NHS Foundation Trust has identified that mental health practitioners at Stockport did not demonstrate enough professional curiosity to consider if Elizabeth was continuing to experience domestic abuse. The IMR author has determined that it would have been good practice to complete, or offer the completion of, a DASH to allow Elizabeth the time and space to consider domestic abuse, which may have triggered a referral to MARAC. In addition, consideration could have been given to a DVDS. The IMR author concluded that at the time of Elizabeth's admission, she would have been an adult with care and support needs (in relation to her mental health), she was at risk and/or experiencing abuse or neglect, and she may not have been able to protect herself due to her mental health and vulnerabilities, as she had previously experienced domestic abuse. This is analysed further in Term 3.

14.1.42 Elizabeth was taken to the Emergency Department on two more occasions, and was seen by the STEM team. The first occasion was in July 2018. Elizabeth disclosed the trigger was due to a previous sexual assault close to her family home. Elizabeth also spoke of the violence in her previous relationship with Adult A. There was no record that Elizabeth was asked if

she wanted to report the assaults, nor if she wanted support in relation to sexual assault. Elizabeth stated that she was involved with Change Grow Live, but there was no triangulation of this information to confirm if Elizabeth was engaging with the service.

14.1.43 Elizabeth was seen by the Mental Health Liaison Team on a further two occasions. On the first occasion, Elizabeth disclosed that she had experienced domestic abuse with Adult B. In June 2019, Elizabeth disclosed physical abuse in her current relationship (Jack). The mental health practitioner asked Jack to leave the hospital. A DASH was not completed. The name of the alleged perpetrator was not recorded: this would have helped other services and/or if she was re-admitted to hospital for similar issues. A safeguarding adult and child referral were not completed, nor was there any contact with PCFT safeguarding team. This has been recognised as a missed opportunity and a single agency learning identified.

14.1.44 On 21 June 2019, Elizabeth self-referred to Healthy Minds. Elizabeth reported that she was in a relationship where there was physical abuse. The clinician liaised with Elizabeth's support worker at the refuge and her GP. The clinician was informed by the support worker that they were aware of the abuse.

Stockport Without Abuse

14.1.45 In June 2016, a high-risk referral was received from Stockport NHS Foundation Trust, due to concerns around increasing domestic abuse incidents. These included physical assaults, threats to kill, and strangulation from Adult A. The referral stated that there were no direct safe contact methods for Elizabeth – as the number she provided in hospital was one her partner owned. Elizabeth told staff in hospital that she was keen to return to her partner, and for him to get help with anger management. The IDVA service deemed it not safe to contact Elizabeth, and informed agencies at MARAC of this decision. The case was closed after MARAC, with no further actions set in the meeting.

14.1.46 The Review Panel has been informed that current IDVA practice is to seek further engagement from other agencies who may have contact with a victim, such as her GP or other support services they may have engaged with. Due to the length of time since this interaction, all staff members who may have been involved in this referral, or in the management of the service, have not been available for comment. The Review Panel

recognised the changes in practice since this time and have not made a relevant recommendation to address the learning.

Turning Point

14.1.47 Turning Point was aware, from discussions with Elizabeth, that she had been a victim of domestic abuse. This was reported in both the record-keeping through her case notes and within the risk assessment and supporting risk management plan. In her risk assessment, Elizabeth was identified as high risk from violence from others. In April 2020, Elizabeth disclosed to a recovery worker that an ex-partner had been violent towards her. The recovery worker reported this to the police, and a visit was made. A DASH was to be completed by the recovery worker the following day; however, this was not done. The risk to Elizabeth was discussed, and a request was made to the police to carry out a welfare check with Elizabeth. The review has identified that this did not take place. Turning Point has identified single agency learning and made relevant recommendations.

Nacro

14.1.48 Elizabeth was referred to Nacro in October 2019 and moved into accommodation in early November. The referral detailed mental health, alcohol use, and domestic abuse. The referral stated: "Elizabeth has fled domestic violence relationship and is in our refuge". There was no risk level determined with the referral. There was no information on the details of the domestic abuse, nor that Elizabeth was in a relationship with Jack, who was a perpetrator of domestic abuse. This has been identified as a learning by Nacro. The Review Panel agreed that the learning around the detail level of information sharing was wider than single agency and was relevant for all agencies involved in the review. The Review Panel has made a relevant recommendation. [Recommendation 3].

14.1.49 During contact with Nacro, Elizabeth disclosed domestic abuse with Jack and Tim. A summary of that information is detailed below:

Date	Incident	Action
25.02.20	Pictures of self-harm and injury to Elizabeth. Elizabeth later disclosed physical and sexual abuse from Jack.	Police notified. Elizabeth taken to hospital. Jack arrested. The service Lead contacted the refuge to move Elizabeth. Elizabeth declined the offer as

		she no longer felt threatened as Jack was in custody.
26.02.20	Jack was released from custody.	Nacro arranged for additional safety measures at accommodation. Spy hole, chain, and moved to alternative flat. Move took place on 2 March. DASH submitted.
26.05.20	Elizabeth sent a text to her Housing Management worker advising that she felt anxious and intimidated by the other residents in the building, and had asked Jack to return to stay with her at the property.	Follow-up contact arranged for the 27 May.
27.05.20	Elizabeth alleged physical and sexual assault by Jack.	Reported to police. Elizabeth was taken to hospital. Jack was arrested.
01.06.20	Report of financial abuse made by Elizabeth to Ingeus. Elizabeth advised that Jack was taking money from her to fund his drug and alcohol use. Elizabeth stated that she had ended the relationship with Jack. Elizabeth declined to press charges.	Contact with Adult Social Care and police. Elizabeth offered referral to refuge or alternative Nacro service. Declined by Elizabeth. Visitor ban implemented for Jack. On 17 June, Elizabeth agreed to move to another Nacro property on condition that Jack was not informed of new address.
23.06.20	Elizabeth was with a new partner – Tim.	Elizabeth told Tim that he could not stay at the address.
29.06.20	Jack contacted Nacro to raise concerns for Elizabeth's welfare. Further text on 8 July received – Tim was now living with Elizabeth.	Police contacted. Visit scheduled.
09.07.20	Welfare concerns raised by food bank volunteer. Elizabeth had been seen with bruising.	Nacro carried out home visit. Tim seen. Elizabeth stated bruising from fight between Tim and Jack. Police contacted.

9.11.20	Elizabeth seen with stab wound. Elizabeth looked thin and bruised. Tim was at property.	Elizabeth was taken to hospital. Police contacted. Safeguarding report submitted.
10.11.20	Elizabeth seen with further bruising. Elizabeth's arms lacked movement and she was walking with a limp. Hair seen in the kitchen.	Elizabeth was taken to hospital. Police contacted.
15.02.21	Elizabeth reported that she had been assaulted by Jack.	MASH notified. Strategy meeting arranged for 10 March.
02.03.21	Nacro – unsuccessful contact attempt with Elizabeth.	Follow-up home visit arranged next day. No answer.

14.1.50 During early incidents in 2020, Nacro staff predominantly contacted the police and sought medical interventions to report their concerns and respond to incidents. There were attempts by Nacro in February and June to move Elizabeth to alternative accommodation; however, Elizabeth refused to move. Adaptations were made to Elizabeth's accommodation. When Elizabeth did move, this was on a condition that she did not tell Jack of her new address; however, this agreement was not achievable and was made without the recognition of the control that Jack had within the relationship with Elizabeth. Less than two weeks later, the police responded to a disturbance at Elizabeth's new address between Jack and Tim.

14.1.51 Nacro did make safeguarding referrals for Elizabeth, but this was only when there had been unsuccessful attempts to move Elizabeth, and following her non-engagement with the police. Nacro had identified that further multi-agency engagement should have taken place in early 2020 – through contact with Early Help, IDVA, and the refuge. Nacro has stated that there were challenges with the timing and co-ordination of the case, and was further impacted as they were not recognised as an agency that held relevant information. This resulted in Nacro not being invited to meetings such as MARAC and daily risk management meetings. The outcome was that Nacro often had to chase updates for safeguarding concerns. The Review Panel identified the importance of all agencies who are engaged with an individual, being involved in a multi-agency response to deal with the risks and case management. This has been identified as an area of learning and relevant recommendations have been made. [See 14.1.36 & 14.1.37 and Recommendation 1 and 2].

14.2 Term 2

What knowledge did your agency have that indicated Tim and/or Jack might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour by Tim and/or Jack?

Jack

14.2.1 Jack was not known as a perpetrator of domestic abuse until his relationship with Elizabeth. Elizabeth reported that she had been physically and sexually assaulted by Jack on more than one occasion. Elizabeth was admitted to hospital twice due to the extent of her injuries sustained from Jack. In April 2019, Elizabeth told the police of financial abuse within her relationship with Jack – she had no access to her bank card, and her money was being paid into his account. Whilst the Review Panel has now received information that Elizabeth's benefits were paid into her own account, the fact that she did not apparently have access to her bank card and account was potentially significant. The financial abuse was not recognised by the police, and no further action was taken. The cross-government definition of domestic violence and abuse is[22]:

> … any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:
>
> - Psychological
> - Physical
> - Sexual
> - Financial
> - Emotional

[22] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/context/

None of the offences resulted in Jack being charged with any criminal offences. The Review Panel acknowledged that these incidents were prior to the enactment of the Domestic Abuse Act 2021[23].

14.2.2 Jack was arrested twice. On both occasions, he was released on bail with conditions not to contact Elizabeth. In May 2020, Jack was found at Elizabeth's address having recently been released from custody a few hours earlier. Jack was in breach of his bail conditions, which resulted in him being arrested. Jack was later released from custody with the same bail conditions.

14.2.3 Elizabeth declined to engage with criminal prosecutions, by either providing a statement or details of the assaults that had taken place. In May 2020, Elizabeth did provide a statement but withdrew her support a short time later. It was not established as to whether Elizabeth's lack of engagement was due to coercion or control; however, it was acknowledged that the pattern of non-engagement had been present in previous relationships where Elizabeth had been a victim of abuse. The police stated that there was information from family that indicated Elizabeth would fabricate allegations in order to seek attention, and it was evident to the Review Panel that this information could have influenced the police response.

14.2.4 The police had the option to consider applying for a Domestic Violence Protection Notice (DVPN) on the occasions that Jack had been arrested. However, as Jack was released from custody with bail conditions, this prevented the application of a DVPN. The Review Panel was informed by the panel member from the police that there had been a recent case within Greater Manchester whereby magistrates had authorised a DVPO, alongside when the defendant was also subject to bail conditions. The reason for the DVPO being authorised was due to the fact that the DVPN/O procedure mandated victim welfare visits and perpetrator compliance checks throughout the duration of the DVPO. As these matters were not addressed by the bail conditions, the court was satisfied of the necessity of the DVPO being required. The Review Panel acknowledged that this was the exception and not normal practice.

14.2.5 In May 2020, after Jack had been arrested following the breach of bail, the police considered applying for a DVPN. The application was not authorised. The rationale for this decision recorded that Elizabeth had made it clear

[23] https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

that she did not support the application. After his initial release, Elizabeth and Jack had been in contact and eaten a meal together. There had been no suggestion of further violence and it was clear to the police that Jack intended to return to the address with the support of Elizabeth: this negated the purpose of the DVPN, which was to provide Elizabeth with a safe space and enable her to put in place strategies for safer living. The police considered the College of Policing Guidance in reaching this decision, citing that the threshold of proportionality, justification, and necessity were met. Whilst the application for a DVPN was not met – citing that it was known that Jack and Elizabeth would remain in contact – when Jack was released from custody, he was released with the same conditions, which included a condition not to contact Elizabeth. Therefore, the risk to Elizabeth was not being managed.

14.2.6 In the early part of 2021, Elizabeth reported that she had been assaulted by Jack on three separate occasions. On each incident, Jack was removed from the property. Whilst DASH risk assessments were completed and referrals made to MARAC, there was no proactive management of the incidents or consideration of other methods of safeguarding, including arresting Jack, consideration of applying for a DVPN, or a remand in custody. Apart from the police, Nacro was the only other agency who tried to manage the risk that Jack presented to Elizabeth – through target hardening and issuing him with a visitor ban.

14.2.7 The Review Panel considered what other options were available to respond to Jack's offending. The Review Panel saw no evidence, or consideration, of progressing the incidents of domestic abuse through an evidence-based prosecution – i.e. without the support of the victim. Whilst the Review Panel acknowledged the challenges around progression of such cases, there was evidence available to the police from professionals involved in the case – including the disclosure of abuse, and witnesses to injuries, during contact and in response to treating those injuries.

14.2.8 The Review Panel was informed that within Oldham there had been a perpetrator programme (Reframe) that had worked with high-risk perpetrators of domestic abuse. Reframe was a voluntary programme that relied on perpetrators agreeing to take part. The Review Panel was informed that the funding for the programme had since ceased and the programme was no longer available. Oldham is currently working towards commissioning a programme for perpetrators through Talk, Listen, Change.

14.2.9 Integrated Offender Management (IOM) is an overarching framework for bringing together agencies in local areas to prioritise interventions with offenders who cause crime in their locality. IOM provides areas with the opportunity to target those offenders of most concern in a more structured and co-ordinated way. Some areas have developed specific projects to target domestic abuse offenders, sometimes known as MATAC – Multi Agency Tasking And Co-ordination.

14.2.10 The Review Panel was informed that within the IOM framework, domestic abuse perpetrators can be managed within the framework, and in particular, when they have not been subjected by the court to attend a domestic abuse perpetrator programme, such as Building Better Relationships (BBR)[24]. The management of perpetrators would rely on the availability and accessibility of perpetrator programmes within the community; however, the Review Panel recognised the challenge in engaging perpetrators on these programmes where there is a reliance for them to voluntary attend (if they are not subject to a community order or licence with conditions).

Tim

14.2.11 Tim had an extensive history of violence, predominantly against adult males. Tim had received custodial sentences and been managed by the Community Rehabilitation Company.

14.2.12 On 27 July 2015, Tim was sentenced to 16 weeks in custody for an offence of criminal damage and three offences of common assault. One of the victims in this case was a vulnerable adult. Another victim was a female who was an ex-partner of Tim's. There was no pre-sentence report prepared at court. As the Crown Prosecution papers are not uploaded to ndelius[25], there were no details regarding the circumstances of the offence. There were no initial assessments completed or recorded within the OASys (Offender Assessment System) by Tim's Offender Manager. This has been identified as poor practice. Further assessments were also not completed. There was no information recorded regarding analysis, or assessment of risk and re-offending. The circumstances of this case have been subject to a Safeguarding Adults Review and will not be analysed further in this report. [See 13.2.5].

[24] https://risemutual.org/building-better-relationships/
[25] Case management system.

14.2.13 The female for the offence in 2015, described a detailed a pattern of control and abuse, stating that Tim controlled where she went and what she wore, not even allowing her to see her GP. Tim had threatened to kill her if she went to the police, stating that she would be "dead before they got here", and that she would be the fourth person that he had killed. Tim also made threats against her and had bragged that he had previously been involved in kidnap and violence. This victim was so fearful of Tim that she kept moving around and planned to keep doing so. The Review Panel recognised that the behaviour that the female described was that of coercion and control, as detailed within Section 76 of the Serious Crime Act 2015. This Act was not enacted at the time of the female's disclosures.

14.2.14 Jack reported to the police and Nacro that Tim had assaulted Elizabeth. The call from Jack contained information that Elizabeth had sent him messages and photographs that she had been assaulted by Tim. The police never asked Elizabeth about the allegations she had made to Jack. When the police attended at Elizabeth's home, their focus was on the assaults that had taken place between Tim and Jack: the assault on Elizabeth was not questioned further. The incident was not recorded as domestic abuse. The IMR author from the police told the Review Panel that the incident should have been classed as domestic abuse, and had this occurred, a full review of the incident would have taken place, including consideration of a referral to MARAC. There was a further opportunity for the police to review the incident, as two agencies referred the case to MARAC; however, this did not result in the police undertaking a further review of the incident.

14.2.15 This incident occurred at the start of Elizabeth's relationship with Tim, and gave an opportunity for Elizabeth to have been provided with disclosure on the risk that Tim posed – through a DVDS. This did not take place, nor was it considered. The Review Panel has identified this as an area of learning. [Recommendation 4].

14.2.16 In November 2020, Elizabeth attended hospital with a stab wound to her leg. Elizabeth had told her support worker that 'he needs help', which indicated that the injury was as a result of abuse. Whilst Elizabeth never disclosed that Tim had assaulted her, Tim was known to be living with Elizabeth at this time. The police spoke with Elizabeth in their car, as she refused to let officers inside the address. They recorded the conversation on body-worn video; however, they noted that Elizabeth had an answer/explanation of her injuries. Despite this, the police, support worker, and medical staff believed that the injuries were more than likely a

result of domestic abuse. Elizabeth told the police that she had recently become engaged to Tim and that everything was ok at home, and that she had a support worker and would speak to her if she needed any support/help. Whilst the attending officer had concerns that Elizabeth had been assaulted, a DASH was not completed. It was not until a MARAC referral was received from the hospital that the incident was reviewed. This provided another opportunity for a DVDS to have been considered.

14.2.17 In February 2021, Elizabeth disclosed that Tim had been violent and that she wanted him to leave the property. The initial call taker tried to engage Elizabeth to discuss the abuse. Elizabeth reported that Tim was suffering from a mental health episode, and that she believed he had seen something on the television that had caused a personality switch. Elizabeth also stated that Tim had consumed three litres of cider. Further contact was made with Elizabeth, and she stated that Tim had left the property. The incident was delayed for the following day. Several attempts were made to contact Elizabeth. A crime report was created, and the incident was eventually closed. The circumstances surrounding this incident are subject to an investigation by the IOPC; therefore, they will not be commented on further at this time.

14.2.18 During contact with Healthy Minds at the beginning of 2021, Tim expressed a preference for anger management support at the end of his appointment, despite not mentioning anger as a reason for seeking help (the focus of the appointment was his anxiety). This was not explored further with Tim at this time. The Review Panel has been informed that this was the first appointment that the practitioner had facilitated at this time. On reflection, and with hindsight, the panel identified that this should have been discussed further in that appointment.

14.2.19 The Review Panel discussed the opportunities in this case for agencies to have responded to the offending behaviour of Jack and Tim. The Review Panel agreed that there were opportunities for agencies to have been more proactive in the management of the domestic abuse that had been committed, and the risks that they presented to Elizabeth. This has been identified as an area of learning and a relevant recommendation made. [Recommendation 5 and 6].

14.2.20 Following access to the draft report, Elizabeth's family stated that they felt the indecisive actions by the police in relation to Tim and Jack, were a contributing factor in Elizabeth's death. The Chair shared this view with the IOPC, as per Section 2, paragraph 7 – Home Office Multi-Agency

Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016)[26].

14.3 Term 3

What were the key points or opportunities for assessment and decision-making in this case? Were those assessments and decisions reached in an informed and professional way?

14.3.1 There were significant key points and opportunities for assessments to have taken place on this case. The below summarises agencies' responses:

DASH

14.3.2 The Review Panel has identified that there were opportunities when DASH risk assessments should have been completed by professionals following disclosures from Elizabeth that she had been the victim of domestic abuse, including physical and sexual abuse. The reasons that these were not completed were various: firstly, that Elizabeth had not provided her consent; secondly, that professionals completed other referrals (such as a safeguarding referral to Adult Social Care); thirdly, that professionals did not have the access to be able to upload a DASH to a shared forum and therefore relied on other means for completion (which then could not be verified); and finally, that a DASH was just not completed.

14.3.3 The Review Panel reflected on the non-completion of the DASH and were informed by agencies involved in the review that, whilst professionals were trained and aware of the requirement of when to complete a DASH, there was no known reason as to why professionals did not comply with this policy. The Review Panel heard that some professionals were unsure as to whether a DASH could be completed without the victim's consent and that, on reflection, this may have accounted as to why a DASH was not completed. [See Term 5].

14.3.4 The Review Panel also reflected that professionals were, at times, responding to incidents when Elizabeth was seeking help and crisis

[26] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

intervention due to incidents of self-harm and overdose. On some of these occasions, Elizabeth had also been under the influence of alcohol. Whilst the Review Panel acknowledged that Elizabeth's presenting health needs were the primary response of professionals, there was still a requirement for a DASH to have been completed.

14.3.5 The Review Panel was unanimous in their view that opportunities were missed – the completion of a DASH is one of the first steps in the identification and management of risk, which would have provided further opportunities for multi-agency intervention and working to address and manage the known risk to Elizabeth. This has been identified as area of learning and a relevant recommendation made. [Recommendation 7].

MARAC

14.3.6 In the last 12 months of Elizabeth's life, Elizabeth had been referred to MARAC on five separate occasions. A further MARAC was due to be held on 4 March 2021. The below table details the dates and recorded actions for each of the five MARACs:

Date	Detail	Actions
12.03.20	Recorded that Elizabeth had a potential broken arm and broken nose. Elizabeth disclosed that the offender had raped her. Recorded that Elizabeth suffers from mental health and alcohol issues. There has been no IDVA contact.	Police – Establish the outcome of the offences. Turning Point – Send a letter to the victim to try and engage her.
18.06.20	Recorded that Elizabeth had disclosed to NWAS that she had been assaulted and previously raped. Details of police investigation. Elizabeth had declined IDVA support and safety planning. Josh's details shared. Recorded that Elizabeth suffers from mental health, drug and alcohol issues.	Children's Social Care to contact MASH in the area that the child was living.
13.08.20	Details of the assault on Tim by Jack shared. Recorded that Elizabeth had refused IDVA support. Josh living with Adult B and has no contact with	No actions.

	Elizabeth. Recorded that Elizabeth suffers with alcohol and drug issues.	
03.12.20	Elizabeth attended A & E with stab wounds. Elizabeth seen with bruising all over her body and face, and could hardly move. Elizabeth denied domestic abuse and left hospital. No crime recorded. Care plan created. Recorded that previous domestic abuse in the relationship. Recorded that Elizabeth suffers with alcohol issues. Both are being supported with anger management.	Police – to link in with Elizabeth, establish how she came by injuries, and record any relevant crimes.
08.02.21	Elizabeth does not support any prosecution. Elizabeth does not wish any support from IDVA.	Adult Social Care to link in with Housing with update.

14.3.7 The Review Panel reviewed the actions from the MARAC and determined that the MARAC actions were influenced by Elizabeth's decision that she did not wish to engage or seek support from an IDVA. The Review Panel agreed that the actions did not consider or address the ongoing risk to Elizabeth, and did not detail a multi-agency plan as to how the agencies were to respond to the risk and try to seek engagement with Elizabeth.

14.3.8 MARAC processes within Oldham were subject of a review by SafeLives towards the end of 2021. The review produced a detailed action plan that is now being implemented by the Domestic Abuse Partnership. The following is a summary of the recommendations contained within the SafeLives report:

- The MARAC should utilise SafeLives high volume exploration tool to reduce the volume of referrals to the MARAC.
- MARAC representatives should act as a SPOC for their organisation in terms of MARAC referrals, and provide a level of quality assurance to ensure referrals are clear and include a rationale and risk-focused information.
- Domestic Abuse Partnership should audit the time allocated for MARAC representatives, and ensure that all organisations are allowing allocated representatives the time required to prepare for the meeting.

- MARAC Information Sharing Agreement and Operating Protocol should be reviewed and updated – to include case discussion guidance for all representatives, including the role of the Chair.
- Training to be developed for all MARAC representatives, which includes an induction when they begin the role, and a minimum of one annual continued professional development session.
- Action planning and case discussion training to form part of the continued professional development sessions.
- Dip sample of cases on a quarterly basis.
- Development of MARAC Steering Group – with an agreed performance monitoring framework, including quality assurance mechanisms.

The Review Panel was satisfied that learning from the DHR is covered by existing recommendations in the MARAC review. For that reason, the Review Panel made no recommendations in relation to MARAC.

14.3.9 Elizabeth's GP practice did not receive any outcome of the MARAC discussions. The GP practice submitted a DASH risk assessment following disclosure by Elizabeth in May 2020; however, there was no feedback as to the outcome following the submission of the DASH. The Review Panel agreed that information from the MARAC should have been shared with Elizabeth's GP. The Review Panel recognised that there was learning around the information sharing pathways within the MARAC process, particularly in relation to GPs and the Clinical Commissioning Group. The Review Panel was informed that within the Domestic Abuse Partnership, work is currently taking place to address the information sharing processes between MARAC and GP practices, which will include the updating of the Operating Protocol. This area of learning has been incorporated into the Domestic Abuse Partnership action plan

<u>Responding to risk</u>

14.3.10 The Review Panel acknowledged that whilst the primary function of a MARAC is to review the risk to victims and agree a multi-agency plan to manage the risk, that in the absence of any other identified forum within Oldham, there was an opportunity for agencies to have considered the risk from the perpetrators, and how agencies could have worked together to respond to this risk directly with the perpetrator.

14.3.11 The Review Panel felt that this area of learning within the review needs to be addressed at a strategic level within Oldham, and in particular for those

perpetrators who commit domestic abuse and when their offending behaviour is not being addressed through a criminal justice route. The Review Panel has made a relevant recommendation to address this area of learning. [Recommendation 6].

14.3.12 Term 2 provides further analysis on the response by agencies to the perpetrators on this case, and therefore this will not be repeated here.

14.4 Term 4
Did actions or risk management plans fit with the assessment and decisions made?

14.4.1 This has been addressed within Term 1, 2 and 3.

14.5 Term 5
What response did your agency undertake in relation to assessments and enquiries under Section 42 Care Act 2014? Were there any implications in relation to this case and the criteria for enquiries in relation to Section 42 Care Act 2014?

14.5.1 Adult safeguarding referrals were completed for Elizabeth. However, after a review of the details, it was determined by a manager within Adult Social Care that Elizabeth did not meet the safeguarding criteria as set out in The Care Act 2014[27] – in relation to care and support needs. In addition, there were no care and support needs identified on the referral forms submitted, including information on Elizabeth's physical and mental health impairment. The Review Panel agreed that the outcome of the referrals was appropriate given the information provided at that time.

14.5.2 Adult Social Care rely on information contained within the referral form and the knowledge of the individual submitting the form to detail all relevant information to allow Adult Social Care to review the case against the criteria contained with Section 42 Care Act 2014. The Review Panel was informed that the referral form is currently being revised to provide the opportunity for referrers to provide detailed information that will inform decision-making when the referral is screened. In addition, a new process

[27] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

is now in place, which includes a review of the case when there have been three safeguarding referrals submitted. This process was not in place when referrals were submitted for Elizabeth.

14.5.3 When determining eligibility, Local Authorities must consider the following three conditions:

Condition 1
The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

This includes if the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

Condition 2
As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section 'Eligibility outcomes for adults with care and support needs'.

Outcomes for adults with care and support needs

- Managing and maintaining nutrition.
- Maintaining personal hygiene.
- Managing toilet needs.
- Being appropriately clothed.
- Being able to make use of the home safely.
- Maintaining a habitable home environment.
- Developing and maintaining family or other personal relationships.

Condition 3
As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

Local Authorities should determine whether:

the adult's needs impact on at least one of the areas of wellbeing in a significant way or

the cumulative effect of the impact on a number of the areas of wellbeing means that they have a significant impact on the adult's overall wellbeing.

14.5.4 The Review Panel saw no evidence that Elizabeth's care and support needs had been assessed. The Review Panel concluded that Elizabeth did meet the criteria under condition 2 in three areas:

- Managing and maintaining nutrition.
- Being able to make use of the home safely.
- Developing and maintaining family or other personal relationships.

The Review Panel also agreed that Elizabeth's needs had a significant impact on her overall wellbeing as determined under condition 3. The Review Panel acknowledged that this decision was reached in hindsight – after reviewing the totality of information that had been provided to the DHR.

14.5.5 The Review Panel agreed that the circumstances of this case reached the criteria of a Safeguarding Adults Review, as detailed within Section 44 Care Act 2014[28]. The Review Panel recognised the need to avoid duplication of processes and therefore have made a recommendation for the learning from this review to be shared with Oldham Safeguarding Adults Board. [Recommendation 8].

14.5.6 The Review Panel agreed that there may have been an opportunity for Adult Social Care to have progressed a non-statutory safeguarding approach with Elizabeth, and for agencies to have used discretional powers in response to the referrals and concerns raised by professionals. The Review Panel heard about a multi-agency forum within Oldham that responds to adults who are deemed to have multiple complex needs. The forum brings together representatives from a number of agencies – Greater Manchester Police, Adult Social Care, NHS Oldham CCG and NHS Trusts, strategic housing services, Turning Point, accommodation and support services commissioned by the Local Authority, The Probation Service, as well as other organisations in Oldham – to discuss the safety, health and well-being of individuals with complex lifestyles. The objectives of the forum are:

[28] The Care Act 2014 [enacted on 1st April 2015] introduced new responsibilities for Local Authorities and safeguarding adult boards. Section 44 of that Act requires a Safeguarding Adult Board to arrange for a review of a case involving an adult in its area with needs for care and support when certain criteria are met.

1. To share information to increase the safety, health and wellbeing of high-risk individuals.
2. To ensure there is a lead agency identified, and that there is a multi-agency risk management plan in place that provides professional support to all those at risk.
3. To discuss barriers in practice and see if agencies can identify any solutions.
4. To develop and gather insights on trends and gaps in service delivery.

14.5.7 The Review Panel was informed that the forum was not in place during the timeframe of this review, but following a 3 – 6 month pilot, further work is taking place to embed the process into practice. The Review Panel recognised this as an area of learning and have made a relevant recommendation. [Recommendation 1].

14.5.8 Hospital staff were advised by a social worker that Elizabeth, following her admission to hospital with injuries due to domestic abuse, had specifically expressed that she did not want the police to be notified. The advice given at that time may also have hindered the nursing staff in completing a DASH on professional judgement. Advice was sought from the hospital safeguarding team who advised the nursing staff to establish if Elizabeth had an IDVA and to ask for consent to contact the IDVA: if no consent was given, then to offer to refer to Victim Support and provide Elizabeth with helpline numbers, whilst also continuing to encourage Elizabeth to report the matter to the police.

14.5.9 The Review Panel felt that there was a lack of understanding and clear direction as to how and when referrals could have been made without the consent of Elizabeth. This also included professionals contacting the police to report the physical and sexual abuse that Elizabeth had disclosed. The Review Panel acknowledged that Elizabeth did not provide her consent for referrals to be made, or for engagement with the police; however, the Review Panel concluded that professionals did not fully explore this with Elizabeth, or consider if her wish to not provide consent was due to ongoing coercion and control within her relationships.

14.5.10 The Review Panel agreed that when professional's override consent to make referrals or contact the police, that this can increase the risk to victims, and also means that a victim withdraws support and engagement with agencies. The Review Panel concluded that there were incidents in this case, when Elizabeth had suffered significant harm, that should have

been referred to agencies, including contacting the police: this would have allowed for safeguarding measures to have been considered, including the opportunity for the police to have considered options to reduce the risk to Elizabeth, and address the offending behaviour of the perpetrators.

14.5.11 The Review Panel agreed that professionals needed to have access to information as to how and when referrals could be made, including contacting the police to report a crime where a victim has been assaulted but does not provide their consent. The Review Panel has made a relevant recommendation to address this area of learning. [Recommendation 9].

14.6 Term 6

What knowledge did your agency have of any previous trauma and adverse childhood experiences of the subjects of the review? How was this information considered in relation to your engagement with the subjects of this review?

14.6.1 Elizabeth disclosed to professionals that she had been the victim of a serious sexual assault as a teenager. The incident occurred close to her family home and was perpetrated by a peer. Elizabeth told a practitioner from STEM, that this was a trigger for her to want to end her life. Elizabeth reported the sexual assault to the police when she was an adult; however, she stated that she did not want to progress the allegation through a criminal process.

14.6.2 Elizabeth described how she felt isolated at her parent's house. During contact with Oldham Healthy Minds, Elizabeth stated that her parents placed high expectations on her for educational achievement. Elizabeth stated that her mother worked away a lot, and she described her father as being unsupportive. The sexual assault had taken place near to the family home, which was in a rural location. Elizabeth stated that this resulted in her not being able to leave the home. Professionals provided Elizabeth with coping mechanisms for times when she was alone in her home.

14.6.3 In February 2018, Elizabeth told a GP that she had been sexually assaulted as a teenager, and had experienced domestic abuse in a previous marriage. Following the disclosure, Elizabeth was not signposted directly to specific third sector support services at that time, such as SAIL[29] or

[29] Sexual Abuse and Incest Line

SV2[30]. These services offer counselling and other therapies to assist survivors recover from their past experiences. During sessions with Jigsaw, Elizabeth told professionals that she found the relationship with her parents difficult. Children's Social Care told Jigsaw that Elizabeth's parents loved her but did not know what to do with her.

14.6.4 Elizabeth's family told the Chair that Elizabeth was loved, but that they felt let down by agencies as they were not involved in key decisions and information sharing for Elizabeth, particularly when Elizabeth was a teenager. Elizabeth's family explained how they wanted to receive information on how they could help and support Elizabeth, but this was not forthcoming from agencies: the reason given was that Elizabeth was old enough to be seen alone and make her own informed decisions. The family described how these decisions left them not knowing what information had been shared, and/or what plans had been put in place to help Elizabeth with her mental health and alcohol consumption. Elizabeth's family felt that it would have been helpful if professionals had given them help or direction to support Elizabeth. For example, on one occasion the family stated that Elizabeth was supposed to do CBT, but she found it too hard. Elizabeth's mother stated that she would have been able to help her if she had been given some direction.

14.6.5 Following access to the report, Elizabeth's family wished to reiterate that the current regulations that exclude parents from discussions with GPs regarding their child's mental health at 16, make it impossible to:

- understand treatments being offered
- how best to support them appropriately
- guide children whilst negotiating the maze of mental health services
- follow up cancelled appointments and lack of continuity in care being offered.

Elizabeth's family stated that whilst they appreciate and respect the right to patient confidentiality, the lack of any communication with their main carers, at such a vulnerable time for young people, leave parents in the dark as to how to best help. Elizabeth's family commented further that

https://www.sailderbyshire.org.uk/

[30] https://www.sv2.org.uk/

with such a strain on the resources for these services, they feel parents could play a greater role in supporting recovery if only they were considered part of the 'team', as they are there for them 24 hours of the day, and no service, no matter how professional or committed, will have the same incentive to protect these young people as their parents.

14.6.6 The Review Panel discussed the response of the family. The Review Panel recognised that Elizabeth at the age of 16, was of an age to have the right to make her own decisions, as long as the principles within the Mental Capacity Act had been satisfied. This was also in accordance with the law in relation to human rights and confidentiality. The Review Panel saw no evidence that the decisions that Elizabeth was making, at that time, were unsafe decisions for herself, or placed her or others at risk, that would have required the implementation of safeguarding processes and the overriding of her consent in sharing information with her family.

14.6.7 The Review Panel was informed by Turning Point that support is available for carers/family members, regardless of a client's wishes/consent. This takes place in the form of an intervention, which is for the benefit of the carer, not the client. Facilitators of the intervention are not involved in the client's case, so remain impartial. The intervention is also available for carers whose loved ones are not in treatment.

14.6.8 The Review Panel was provided with a copy of the handbook that is used by facilitators. The training and model is provided by AFINet[31] UK (formerly UK Alcohol, Drugs & the Family [ADF] Group). The intervention was developed by Professors Jim Orford, Richard Velleman & Alex Copello; Lorna Templeton & Dr Akan Ibanga. It is used for working with families/loved ones/carers who are affected by the problems of alcohol or drug use of a relative/friend/partner, etc. The following is a summary of the steps that are used within the model:

1 – About the carer and the problems they are experiencing.
2 – Increasing the carers' knowledge and understanding of substance misuse.
3 – Ways in which the carer can respond to their loved one.
4 – Ways in which the carer can get help from others.
5 – Additional support for carers if required.

[31] https://www.afinetwork.info/

The AFINet website also provides information, resources and organisations to help family members[32].

14.6.9 The Review Panel was also provided with a copy of a Practitioner Learning Brief from Rochdale Safeguarding Adult Board, which focuses on 'Engaging with Family and Friends in cases of Adult Self-Neglect'. The Review Panel agreed that the document provided relevant information for this review. The Review Panel identified learning around the awareness of information for families and friends who are supporting someone who is affected by alcohol and drug use, and have made a relevant recommendation. [Recommendation 10].

14.6.10 The review found significant examples of good practice by Turning Point to proactively support Elizabeth to reflect on previous trauma, the impact this had on her levels of anxiety, and consequent alcohol use and involvement in unhealthy relationships. Elizabeth was regularly reminded to engage with Inspire Women and TOG Mind.

14.6.11 Elizabeth was encouraged to participate in the Freedom Programme in order for her to understand the patterns of behaviour exhibited by perpetrators, and what abuse was.

14.6.12 On the 11 December 2019, Elizabeth disclosed to Nacro that she had an eating disorder, had experienced sexual abuse as a child, and that she had attempted suicide in the past. This information was not known to Nacro when Elizabeth had been referred into the service. Nacro acknowledged that Elizabeth had an estranged relationship with her family and used the disclosure from Elizabeth to tailor the approach when working with Elizabeth – through a person-centred and trauma-informed approach with her Housing Management worker. At the point of a decline in Elizabeth's appearance and increased alcohol use, this was recognised as potential symptoms of continued trauma, and Elizabeth was encouraged to seek help from external support through Turning Point, Ingeus, and Jigsaw.

14.6.13 Elizabeth did not have custody of Josh. The review has been informed that Elizabeth was seeking to have contact and hoping to gain custody. Elizabeth told professionals that she recognised that her anxiety, depression, and alcohol use impacted on her wellbeing, and that this in turn would have an impact on Josh. Elizabeth told professionals that it was

[32] https://www.afinetwork.info/documents#family

her priority to sort out her mental health and alcohol use, before progressing contact with Josh. Elizabeth's family told the review that Josh's welfare was their primary concern and that they had tried to manage any adverse impact on Josh, whilst at the same time trying as a family to manage Elizabeth's well-being.

14.6.14 The panel recognised that events taking place following her move from Stockport to Oldham, would have had a significant impact on her health and mental well-being. Elizabeth had lost stability in her life – through accommodation, personal relationships, and contact with her child.

14.6.15 There was no record held by agencies that Tim had been subjected to adverse childhood experiences.

14.7 Term 7

When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

14.7.1 The Review Panel has seen evidence that the wishes and feelings of the subjects of this review were ascertained and considered. The Review Panel agreed that, at times, the wishes and feelings of Elizabeth influenced how professionals responded to incidents of domestic abuse, including physical and sexual assaults. The Review Panel has identified learning for professionals who are in contact with victims, and in particular around overriding consent to share information with other agencies. [See Term 5 and Recommendation 9].

14.7.2 Elizabeth was referred to agencies and provided information on services that were available. There was no evidence that these services were not accessible to any of the subjects of the review. At times during the review period, Elizabeth made the decision not to engage with services and/or professionals. Whilst professionals respected this decision, the Review Panel has seen no evidence that Elizabeth considered that this decision was made due to coercion and control.

14.7.3 Elizabeth made it clear to professionals on occasions, that she did not wish to engage with them as she was already involved with other professionals. The Review Panel discussed the possibility that Elizabeth may have been unable to cope with the number of professional contacts that she experienced at times, and this may have affected her ongoing engagement with agencies. This has been identified as a learning. [See Term 1 and Recommendation 1].

14.7.4 Following access to the draft report, Elizabeth's family stated that on the few occasions that Elizabeth encouraged them to be involved with an agency (Change Grow Live), they felt that they were ill advised and completely misled. Elizabeth's family stated that they attended two meetings where they thought they were finally being given an opportunity to relay their experiences regarding Elizabeth's mental health condition, her self-medication with alcohol, and the care received to date (as it was understood at that time). Elizabeth's family stated that at the end of the second meeting they were led to believe that they were wrong and being judgemental to worry that attending a range of meetings with people experiencing other addictions could leave Elizabeth more vulnerable, and that they had, in their words, to 'let her fall and hit rock bottom'. Elizabeth's family stated that they questioned this advice at the time: understanding how dangerous this was for someone like Elizabeth with her addiction to alcohol, and knowing that she had not been able to break this addiction with the support she had been given so far.

14.7.5 Elizabeth's family concluded that they felt the response from Change Grow Live did not acknowledge or demonstrate an understanding of the bigger picture. They believe it left Elizabeth more vulnerable than she had ever been, and that the miscalculation of the serious consequences of Change Grow Live's response, left Elizabeth isolated from her family – whilst introducing her to people who had the potential to cause her further harm – without the ability to ensure that she would be properly protected by a robust system of care, which led to Elizabeth's murder.

14.7.6 The family stated that they recognised that Change Grow Live may have been following agreed procedures, but would welcome a review of these procedures. The family concluded that closer communication amongst agencies, including the police, National Health Service and the family, need to be prioritised – together with a comprehensive policy for the care of vulnerable individuals, with safety as well as treatment recognised as a priority.

14.7.7 The review panel reflected on the views of the family. The IMR from Change Grow Live submitted as part of the DHR process, detailed how a triage assessment was undertaken with Elizabeth prior to the provision of services. This included a risk assessment and risk management plan: the outcome of which, was appropriate to the information gathered. Elizabeth was given appropriate information to aid her decision-making and was fully involved in planning her treatment. Elizabeth undertook group work as well as 1-1 sessions. There was no evidence that Elizabeth's participation in group work escalated any risks.

14.7.8 The Review Panel sought further information from Change Grow Live in relation to the matters raised by the family. Those areas and responses are detailed below:

1. Did the Change Grow Live triage assessment consider the appropriateness of group sessions, in regard to the potential for association with other individuals who were also experiencing addiction, thereby increasing Elizabeth's vulnerability and potentially escalating risk levels?

Response – All adult service users are fully assessed in relation to their substance use; social situation; physical and mental health; vulnerability/risks; mental capacity; and individual goals. A menu of available interventions is discussed with all service users, at the beginning, and throughout their treatment journey, and service users are encouraged to determine their own plan of action/treatment. Participating in a group provides services users with an opportunity to be with people who are likely to have a common purpose and likely to understand one another, and in feeling less lonely, isolated, or judged, being able to talk openly and honestly about feelings; in improving skills to cope with challenges; in staying motivated to manage chronic conditions and stick to treatment plans; in finding a sense of empowerment, control, or hope; and in obtaining practical feedback about treatment options and coping strategies. Elizabeth was consulted with; fully assessed and referred to the treatment/intervention of her choice.

Whilst service users are encouraged to determine their own plans/treatment, if it is determined that a person is too vulnerable (exploitation, previous acquaintances; emotional/physical wellbeing; disruptive), to make informed decisions, then other support options are encouraged, which may result in a person being removed from a group and offered sessions in a different way (1:1, an alternative group; online or digitally; other relevant therapies – alternative/counselling). Group workers

are skilled in delivering therapeutic activities, identifying such risks; and managing dynamics - there was no evidence of this in Elizabeth's care.

2. Was there any evidence of increased vulnerability or escalation of risk due to Elizabeth attending the group sessions?

Response – There was no evidence that attending any of the group sessions increased the vulnerability of Elizabeth from other attendees at the group sessions. Elizabeth advised she felt 'safe whilst attending at Change Grow Live' and it was noted her engagement was positive and appropriate. It was noted that group sessions gave Elizabeth the opportunity to be seen without her partner (groups do not allow partners of service users to attend with them).

Following a session on 6 November 2018, Elizabeth requested some support at the end of the group session. The Review Panel was informed that this is common, and additional time was accommodated. Elizabeth stated that she felt 'deflated' in her mood. The disclosure was discussed with her recovery co-ordinator who recorded that Elizabeth advised of no suicidal ideation. Elizabeth disclosed that she did not look forward to going home, and that she felt being seen on her own in 1:1 sessions with Change Grow Live was more helpful than her partner accompanying her. Elizabeth stated that she was concerned that requesting this might cause an argument with her partner as he could 'be controlling'. Solutions were sought to manage and support Elizabeth with this, and two options were given for Elizabeth to consider – advising her partner he was unable to attend with her, or to see her immediately after group as to exclude him. On 9 November 2018, Elizabeth sent a text to advise that she would be attending on her own on the 11 November for group and her 1:1 session: this took place as planned.

14.7.9 The Review Panel reflected on the further analysis and information provided by Change Grow Live, and concluded that the learning and recommendations identified on this case would address the family's views in relation to multi-agency working. [Recommendation 1 and 2].

14.8 Term 8

How did your agency understand the impact of domestic abuse on the child in this case? How did your agency record this impact, including the views of the child?

14.8.1 Josh was born in 2017. Josh was 11 months old when Elizabeth disclosed domestic abuse by Adult B. Two referrals were made to Derbyshire Children's Social Care from Health and police, following an incident on 6 June 2018. Elizabeth, Adult B and Josh were living in Derbyshire at this time: not long after, they moved to live with Elizabeth's parents. The referral from Health related to Elizabeth's attendance at hospital and her mental health, overdoses of medication and/or alcohol, and self-harming by cutting. The police referral detailed the argument between Elizabeth and Adult B. Derbyshire Children's Social Care spoke to Adult B in response to both referrals. The contact focused on Elizabeth's mental health. Adult B assured Derbyshire Children's Social Care that detailed plans were in place to keep Josh safe, with support from family members. Elizabeth was not spoken to. The incident of domestic abuse was not discussed, and no further assessments were undertaken in relation to Josh. The Review Panel felt that this was a missed opportunity.

14.8.2 In October 2018, Stockport Children's Social Care commenced a Section 17 Children Act 1989[33] assessment under Child in Need. The assessment focused on Elizabeth's mental health and self-harming behaviours, and the impact on Josh. As part of the assessment, Elizabeth and Adult B identified each other as their main source of support, and were positive about the support they received from Elizabeth's parents. Josh's basic needs were being met and it was recorded that Elizabeth and Adult B were working with the health visitor to improve their confidence as parents, especially in the area of tantrum control and sleeping routines. There was no domestic abuse known or identified at this time. The IMR author from Stockport Children's Social Care identified that due to the pattern of self-harm, a more detailed conversation would have been useful to ensure parents and grandparents were equipped to safeguard Josh. Grandparents were not part of the assessment. The IMR author has identified that it would have been useful to have involved them as they were an important part of the safety plan for Josh. The Review Panel agreed with this analysis.

14.8.3 On 19 November, the assessment concluded with a decision to step the case down to a Tier 2[34] plan led by the health visiting service – as Elizabeth

[33] https://www.legislation.gov.uk/ukpga/1989/41/section/17

[34] http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2017/04/Stockport-Multi-Agency-Guidance-on-Levels-of-Need.pdf
LEVEL 2: These are children and young people whose needs require some extra support from a targeted intervention/service. This may be short term but requires a co-ordinated response from additional services, these children and young people will benefit from an

was accessing support, and both Adult B and her parents were providing care for Josh. The assessment also stated that Elizabeth was managing her mental health well and was very motivated to get better. This decision was reversed in December 2018, as a referral was received from the police following a reported incident of domestic abuse by Adult B on Elizabeth: the case was then allocated to a social worker.

14.8.4 In reviewing the decision-making at this time, the IMR author for Children's Social Care has concluded that a strategy meeting should have been held with partner agencies to discuss child protection issues – as this would have included safety planning for Elizabeth, including consideration of a referral to MARAC, as well as considering the safeguarding needs for Josh. The Greater Manchester Children's Safeguarding Procedures[35] manual provides guidance on domestic abuse[36] and the processes in place, within Stockport, to provide support and advice to practitioners working with families where there are concerns regarding domestic abuse.

14.8.5 On 1 February 2019, a social worker visited Adult B and Josh; by which time, Elizabeth was living in a hotel with Jack. The social worker discussed the domestic abuse incident from December with Adult B. The social worker accepted Adult B's explanation that he got angry because Elizabeth wanted to carry on drinking. The Child in Need plan specified that Adult B should supervise any contact Josh had with Elizabeth. The IMR author from Stockport Children's Social Care concluded that it would have been appropriate for the social worker to have completed a risk assessment around the contact with Josh as well as a domestic abuse risk assessment, to understand further, the risk associated with the abuse between Adult B and Elizabeth. The Review Panel agreed with this analysis.

14.8.6 The risk to both Josh and Elizabeth continued – Adult B told the social worker of a fight that had taken place in the car with Elizabeth during a contact visit with Josh. Adult B described to the social worker how Elizabeth had punched him in the face and pulled his hair, and that she had only stopped when he pointed out that Josh was in the car. The social

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EHA/TAC episode to ensure that needs are met and risk of escalation of need is minimised. An EHA will also ensure that information is held centrally and visible to other Professionals who may also have concerns.

[35] https://greatermanchesterscb.proceduresonline.com/chapters/contents.html

[36] https://greatermanchesterscb.proceduresonline.com/chapters/p_dom_abu.html?zoom_highlight=domestic

worker asked Adult B to bring Elizabeth to see her as she had not responded to her attempts to meet up. The IMR author has stated that this action was very concerning given the coercive nature of the relationship, and that this should have been identified by the social worker. The Review Panel agreed with this analysis, in that this was not an appropriate request to have been made.

14.8.7 Elizabeth did disclose her fear of Adult B to professionals, and this was shared with Children's Social Care. It was important for the social worker to speak to Elizabeth to explore the domestic abuse incidents, her fears, and safety plan for her and Josh. In addition, maternal grandparents should also have been part of the discussion and assessment; however, this did not take place. On 16 April 2019, four months after the initial referral, Elizabeth met with the social worker. Elizabeth told the social worker that she was bidding on properties, and hoped to become a bigger part of Josh's life in the future. The social worker offered to support Elizabeth's housing application and provided her with information about women's centre services. The domestic abuse and impact that this had on Elizabeth and Josh was not explored further. The social worker visited Elizabeth at the refuge for the last time on 7 June 2019. Elizabeth reported that she was working with alcohol services to become alcohol-free. The reason for Elizabeth staying at the refuge was not discussed, and the case was subsequently closed by Children's Social Care.

14.8.8 The IMR author from Stockport Children's Social Care concluded that the case was not straightforward, in that Elizabeth had a well-entrenched coping response (both to past and current trauma), which was through self-medicating with drugs and alcohol and self-harming. It was these behaviours that were incorrectly seen as the main risk to Josh – with the risk of domestic abuse not being recognised. There was a lack of a more in-depth assessment of the reasons why Elizabeth behaved in this way – her history, past relationships, and relationship to her parents. There was also a lack of consideration and response at critical times, when further domestic abuse incidents took place, to ensure that Elizabeth and Josh were safe, and that the arrangements for the care of Josh remained appropriate for his safety and well-being.

14.8.9 The Review Panel was informed that the case has been discussed with the social worker involved at that time, who has reflected on their actions. Since this time, the social worker's practice has developed, and their knowledge and skills regarding domestic abuse have increased. The Review Panel was informed that it would have been expected practice for

the social worker's Team Leader to have guided them through the case, given its complexity. The Team Leader is no longer employed by Stockport Council; therefore, it has not been possible to discuss the case and their involvement. The Review Panel agreed that there was inadequate management oversight of the case, which led to no clear direction being provided to the social worker nor procedures being followed. The Review Panel agreed that there were opportunities throughout this period to establish a more joined-up approach. However, as domestic abuse was not part of the intervention or plan, this did not occur.

14.8.10 Stockport Children's Social Care informed the Review Panel that domestic abuse training, via the multi-agency safeguarding arrangements and individual learning circles, is provided throughout the year to ensure that Social Work teams have knowledge and skills to work with families affected by domestic abuse. Since the time of this case, a more comprehensive induction offer for new starters has been implemented to ensure that they have all the relevant information they need about support available to them. The IMR author from Children's Social Care has identified learning from this review and made relevant recommendations.

14.8.11 The Review Panel has seen evidence that agencies submitted safeguarding referrals and notifications to Children's Social Care in response to domestic abuse incidents, even when Josh was not living with Elizabeth. The Review Panel acknowledged that this was good practice and highlighted that professionals recognised and understood the impact of domestic abuse on children, even when they were not living or present during domestic abuse incidents. Within the MASH screening in response to the referrals, information sharing took place with the Local Authority where Josh was residing at that time.

14.8.12 Following access to the draft report, Elizabeth's family stated that Adult B had been known to the family for almost two and a half years and had lived at the family home for almost eight months. During which time, he demonstrated loyalty, patience, and total commitment to providing a safe, secure family life for Elizabeth and their child. The family were very clear, in their view, that Adults B's actions, far from being coercive and controlling, were actions taken to keep them all safe, and in particular to support Elizabeth's recovery by:

- Ensuring she regularly attended support groups.
- Providing safe transport, sometimes as far away as Liverpool.

- Limiting her ability to take out payday loans, which had been used in the recent past to buy alcohol online.
- Uppermost keeping their son safe, whilst encouraging the relationship between Elizabeth and her son at such a crucial stage in his development.

The support and commitment extended to Adult B's wider family, providing Elizabeth with flexible employment, training and childcare.

14.8.13 Elizabeth's family questioned why, if the situation with Adult B was understood to be such a risk for Elizabeth that it required her immediate removal from the area, then what consideration was given to her son and his immediate safety? Elizabeth's family stated that there was a child protection issue at this time.

14.8.14 The Review Panel considered the views of the family in relation to Adult B, and also the reference to child protection issues for Elizabeth's child. The review panel was clear that the actions of Adult B, as described by Elizabeth's family, was their view and understanding of the situation. The review panel has not been able to speak or engage with Adult B, and therefore has not been able to analyse his role or involvement further.

14.8.15 The Review Panel reflected on the views of the family. The Review Panel was unanimous in their view that where an allegation of domestic abuse is made, then professionals have a duty to respond by listening to the allegations and taking appropriate action. The Review Panel discussed the concerns of the family around the child protection issues and agreed that this area of learning had been identified by Stockport Children's Social Care, as detailed within Term 8. [14.8.2 – 14.8.10].

14.8.16 Jigsaw supported Elizabeth to seek access with Josh, which included accompanying her to meetings with a social worker and Elizabeth's solicitor. The Review Panel was informed that Elizabeth's solicitor arranged for mediation with Adult B; however, it was reported that Adult B did not attend. Jigsaw supported Elizabeth by liaising with her solicitor, and sending letters to apply for legal aid. Jigsaw also helped Elizabeth to provide presents for Josh.

14.8.17 During contact with Stockport Mental Health Liaison Team, Elizabeth stated that she had placed Josh with her parents to lessen the impact on him, due to her mental health and alcohol issues. On another occasion, Elizabeth reported that she was no longer in contact with Josh because she was

homeless, but was hoping to resume contact once she was settled in a permanent address. Referrals were made to the Local Authority in which Josh lived at that time.

14.8.18 Elizabeth and Tim had told professionals (TOG Mind and GP practice Oldham) that they had children, and they were protective factors that prevented them from harming themselves. However, as Elizabeth and Tim did not disclose domestic abuse to these professionals, no safeguarding referrals were made. In January 2021, Tim spoke to a GP. Tim had thoughts to end his life and told the GP of 'kids being a protective factor'; however, there was no record regarding the details of these children, nor any referrals to ensure the safety and welfare of any children involved. This has been identified as a learning by the Clinical Commissioning Group and relevant recommendations made.

14.9 Term 9
How did your agency respond to the lifestyle, including mental health and substance misuse use, of the subjects of the review?

14.9.1 Throughout the time period of this review, Elizabeth was known to services in relation to her mental health and substance misuse. Elizabeth had a long history of anxiety and depression. Elizabeth had been referred into services, and she also self-referred into services. At times, her engagement was sporadic, and she was discharged from services back into the care of her GP. Elizabeth's non-engagement was linked to her experiencing crisis in her life, including domestic abuse and the lack of contact with her child. Elizabeth informed professionals that her use of alcohol was a way of her responding to her mental health and anxiety. Elizabeth received support through secondary care provision, and had been referred for Cognitive Behavioural Therapy (CBT) and Eye Movement and Desensitisation Reprocessing (EMDR)[37]

Turning Point

[37] Eye movement and desensitisation reprocessing. https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/treatment/

14.9.2 Elizabeth entered treatment with Turning Point to address her alcohol use. She made good progress, and was eventually discharged to Tier 2 aftercare support through psychosocial interventions and 1-1s with a recovery worker. The service exceeded contractual and pathway requirements during this period of treatment, stepping up interventions to support Elizabeth to get to a point where alcohol was manageable, and she would engage in mental health support for PTSD. When Elizabeth re-entered treatment in 2020, the focus of the care plan was to support her to reduce her alcohol use. At this point, Elizabeth was not assessed as dependent or high risk in terms of her alcohol use. The Review Panel was informed that this was an accurate assessment.

14.9.3 During the MARAC held in February 2021, information was discussed regarding the relationship between Elizabeth's use of alcohol and the reported abuse within her relationships. Turning Point did not follow this information further with Elizabeth: this fell below their expected practice. Turning Point has identified this as a learning and made a relevant recommendation.

Change Grow Live

14.9.4 Change Grow Live provides early intervention and recovery services for adults who experience substance misuse issues within Stockport. Treatment provided to Elizabeth was delivered in a combination of 1-1 sessions and through a group work offer. At times during her treatment, Elizabeth showed positive progress in line with her treatment goals. Mutual aid was also explored, and Elizabeth was supported to attend – with her case being transferred to Turning Point. Liaison also took place with Healthy Minds Stockport.

Stockport Children's Social Care

14.9.5 Children's Social Care's involvement focused on Elizabeth's mental health and substance misuse, and the impact that this had on Josh. The IMR author for Children's Social Care identified that the response to mental health and substance misuse of Elizabeth should have been more joined-up, with regular meetings in place to look at Elizabeth's progress and service appropriateness – this could have been part of a more in-depth intervention through children's services if Elizabeth had been identified as being a victim of domestic abuse. This has been analysed in Term 8.

Oldham CCG

14.9.6 Elizabeth had contact with a GP 18 times between May 2019 and January 2021, in relation to her mental health and use of alcohol. Elizabeth was prescribed anti-depressants and benzodiazepines for anxiety. Elizabeth was referred on to secondary mental health services and counselling services. Despite Elizabeth not attending some appointments during this timescale, on the whole Elizabeth appeared to have engaged with mental health and substance misuse services.

14.9.7 There were numerous times noted within the GP records, where Elizabeth appeared to be struggling with her anxiety and depression. She actively sought support from her GP, who prescribed medication, and it was recorded that she engaged with psychological therapies. At times, Elizabeth informed the GP that she had consumed alcohol, when she did not want to, as nothing appeared to be working for her. The Review Panel was informed that the GP was reluctant to prescribe benzodiazepines for Elizabeth's anxiety on a long-term basis due to the risks of addiction. The GP did seek advice from mental health services, with the outcome being for diazepam to be continued to be prescribed.

Northern Care Alliance

14.9.8 During the triage process when Elizabeth attended the Accident and Emergency Department, it was identified that Elizabeth was experiencing mental health issues: she was referred to the on-site mental health liaison team. There was no record that Elizabeth had been referred to the alcohol liaison service, despite Elizabeth presenting as intoxicated on several occasions. Northern Care Alliance has identified this as a missed opportunity to counsel Elizabeth, and offer her management advice and referral to community alcohol services.

14.9.9 The Review Panel has seen evidence that Tim was referred to the alcohol liaison team following attendance at hospital in January 2021. However, there was no record that Tim was seen. The Review Panel was informed that this attendance was over a weekend, and therefore it could have been possible that Tim had been discharged before he had been seen by the alcohol liaison service. Had this been the case, then Tim should have been contacted by telephone at the earliest opportunity. If contact was not achieved, then a letter should have been sent to provide details of the local community service and how they could be contacted. There was no evidence seen by the Review Panel that these subsequent actions took place.

Early Help/IDVA

14.9.10 Early Help/IDVA were aware of Elizabeth's mental health and substance misuse, and how this could impede their relationship and connection with Elizabeth. There were repeated attempts to contact Elizabeth by telephone. The Review Panel was informed that this method of contact was the only option available due to the restrictions put in place during the Covid-19 pandemic. The Review Panel was told that had the restrictions not been in place, contact would have been attempted through other services and places that Elizabeth was visiting, such as substance misuse clinic. The Review Panel agreed that alternative methods of contact should have been considered to engage with Elizabeth, including utilising professionals who were in contact with Elizabeth at this time. This included professionals from non-statutory agencies. This has been identified as an area of learning. [Term 1 and Recommendation 1].

Healthy Minds – Stockport

14.9.11 During the initial assessments with Healthy Minds, it was noted that Elizabeth did not fully engage. When she was seen by a practitioner, it was identified that Elizabeth had been self-harming and had increased her alcohol intake. A multi-disciplinary team discussion was held, and due to Elizabeth's increased alcohol use and dependency leading to risk of impulsivity of deliberate self-harm, it was agreed to hold a discussion with the Access Team/Consultant Psychiatrist to consider referring into Community Mental Health Team. An appointment was also made for Elizabeth to have a mental health assessment by a Healthy Minds duty worker. The Review Panel was unable to establish if these agreed actions were followed up. Elizabeth was subsequently discharged for non-engagement with the services.

Stockport Homes

14.9.12 Elizabeth was accepted as potentially meeting the vulnerability criteria in accordance with Housing Act 1996[38], and was offered accommodation. The Housing Act introduced duties for Local Authorities concerning homeless people and the circumstances in which such duties arise. Interim

[38] https://www.legislation.gov.uk/ukpga/1996/52/contents

accommodation must be made available for those applicants who have a 'priority need' as defined in Section 189, which states:
'…a person who is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside.'

Nacro

14.9.13 Nacro responded to Elizabeth's lifestyle by proactively encouraging her to engage with mental health services and Turning Point. Nacro monitored Elizabeth's well-being during housing management visits, and provided the professionals, working with Elizabeth, with updates of any concerns. Nacro was assertive and had discussions with Elizabeth when they observed evidence of self-neglect, such as apparent excess alcohol use and poor self-care.

14.10 Term 10

How effective was the cross-border information sharing and working between agencies? Did that information sharing identify any known risks to the subjects of this review?

14.10.1 The Review Panel has seen evidence that information sharing did take place between agencies, including evidence of cross-border information sharing and agency working. However, there were opportunities during the timescales of this review when the information sharing could have been improved to include a multi-agency approach to share all known risks and co-ordinate support. There were times when information was not shared, as Elizabeth had not provided her consent, and this has been addressed within Term 3.

14.10.2 Change Grow Live contacted Turning Point, by telephone, when Elizabeth's case was transferred to Oldham, however, it was not clear in records as to what information had been shared at the point of transfer. This is a learning point and recommendation for both agencies.

14.10.3 When Elizabeth moved to Oldham, Josh remained living in Stockport with Adult B. Contact with Elizabeth from Stockport Children's Social Care was managed through family. The review has identified that Children's Social Care had not recognised the risk of domestic abuse that Elizabeth was

exposed to: this resulted in no information sharing taking place with agencies who were working with Elizabeth to support her to manage the risk. When contact was made to Stockport Children's Social Care by agencies, the information shared was limited to Elizabeth's mental health and alcohol use, and not domestic abuse.

14.10.4 When Elizabeth's GP records transferred between GP practices and CCGs, this would have allowed the GP practice to have access to previous GP and secondary care services involvement: this would also have included MARAC notifications. There was no evidence within the records of information sharing from any other agency, apart from mental health and substance misuse services.

14.10.5 When Elizabeth moved from Derbyshire to Stockport, it was unclear in her GP records as to whether Elizabeth's psychological care had been transferred. Elizabeth's GP records identified that she had been referred in July 2018. However, in December 2018, it was recorded that Elizabeth was 'having counselling and therapy', yet this contradicted an entry the following month where it was recorded that she was 'awaiting CBT and EMDR'. Whilst it was known that Elizabeth had started EMDR in Derbyshire, it was not clear as to whether this was completed in Derbyshire, or if a subsequent referral in Stockport was to re-start or complete her course.

14.10.6 The Police National Database (PND) and Police National Computer (PNC) provide the police with access to information held by all police forces in England, Wales and Scotland[39]. Tim had criminal convictions and was recorded as a perpetrator of domestic abuse. Research was not undertaken to identify Tim's criminal background, and the risk that he presented to Elizabeth. This information was also not disclosed to Elizabeth through a DVDS. [See Term 2].

14.10.7 Northern Care Alliance identified that there was confusion around the legality of sharing information when Elizabeth had been admitted to hospital following a serious assault, as she had been explicit in not providing her consent for contact and information to have been shared with the police and other agencies. This presented a challenge for agencies in balancing patient consent and sharing information due to 'making safeguarding personal'. This has been addressed under Term 5.

[39] Police Scotland information held only in PNC.

14.10.8 At the point that Elizabeth was referred to Turning Point, only basic information was shared: this did not include information to help Turning Point enable risk identification. Elizabeth was referred into the service twice. During the second episode, there was no contact made with other supporting agencies who were working with Elizabeth. This has been identified as a learning by Turning Point.

14.10.9 Nacro was the primary housing provider for Elizabeth, and the Housing support worker had a good relationship and contact with Elizabeth. Nacro was the agency who had the most contact with Elizabeth, and held valuable information. The Review Panel agreed that Nacro, and in particular the Housing support worker, should have been utilised as a channel of communication between Elizabeth and agencies; however, Nacro's role was not recognised by agencies. It was not until December 2020 that Nacro was invited to contribute and be present during multi-agency discussions. The Review Panel has identified this as a strategic area of learning. [Term 1 and Recommendation 1].

14.11 Term 11

Did your agency have policies and procedures for domestic abuse and safeguarding, and were these followed in this case? Has the review identified any gaps in these policies and procedures?

14.11.1 The Review Panel has seen evidence that agencies had in place policies and procedures for domestic abuse and safeguarding. The following analysis will cover those agencies where there has been an identified gap, where the policies and procedures have not been followed, or where work has commenced to update policies and procedures.

<u>Change Grow Live</u>

14.11.2 The process for working with and supporting people around domestic abuse is currently managed by the Safeguarding Adult Policy. The Review Panel was informed that work is being undertaken to produce a separate Domestic Abuse Policy within Change Grow Live. The Review Panel did not identify that the lack of a separate policy on domestic abuse affected engagement with Elizabeth. During the completion of this review, the Review Panel was provided with the Domestic Abuse Policy that has now been implemented. The Review Panel was informed that this was part of a broader approach to reviewing the whole response to domestic abuse – to

better meet the needs of beneficiaries, which includes the new policy and other supporting tools.

Stockport Children's Social Care

14.11.3 The review has identified that the policies on domestic abuse within the Greater Manchester Children's Safeguarding Procedures were not followed on this case. [See Term 8]. This will not be repeated under Term 11.

14.11.4 The Review Panel was informed of ongoing developments in the area of domestic abuse through the Safer Stockport Partnership by the Domestic Abuse steering group, which sits under the Children's and Adult's Safeguarding Partnership. A daily risk meeting has been established within the Multi Agency Safeguarding and Support Hub[40] (MASSH), which enables consideration of high-risk domestic abuse incidents and the agreed multi-agency plan/response.

In 2018, Stockport Safeguarding Partnership was successful in their bid for funding to develop and expand domestic abuse services across the partnership and community. The following is a brief overview of the developments so far:

- Increased capacity in ASPIRE to enable the team to provide increased support in complex cases.
- Development of a domestic abuse tool kit for practitioners to ensure that recent research and knowledge informs front-line practice.
- Funding for a Young Persons IDVA who works in schools and with groups of young people.
- Established a 'Caring Dads' programme which works with perpetrators of domestic abuse. At the time of this review, the programme has been completed by 10 men, none of whom have re-offended.
- Funding for an IDVA based in hospital.

[40] https://www.stockport.gov.uk/contacting-the-massh

- Update of domestic abuse awareness training, to include coercive control.

- Development of community awareness with engagement through community groups.

- Training professionals in relationship trauma and the impact of domestic abuse on children.

- Training of Independent Reviewing Officers in safety planning.

Cheshire and Greater Manchester CRC

14.11.5 Policies and procedures were in place, and staff involved in the case had received training on domestic abuse and safeguarding. It was recorded throughout this review, and within the IMR submitted by the CRC, that the policies and processes were not followed in this case. The Review Panel has not been able to identify why this occurred, as the staff involved in this case, at the time, are no longer working for the CRC.

Jigsaw

14.11.6 In 2020, all staff received updated training on safeguarding, which included the process to identify safeguarding issues. Staff are expected to enter safeguarding concerns on to a case management system, which is then escalated to a manager to review. At the time of this case, some staff did not have access to SharePoint to upload MARAC referrals, which resulted in staff having to email referrals to the police for them to upload to the system.

14.11.7 In July 2019, following an incident between Elizabeth and Jack, Jigsaw referred Elizabeth to the IDVA service; however, the referral was not accepted as the IDVA service determined that Jigsaw was providing the relevant support to Elizabeth. The case was high risk, and a referral should have been made to MARAC, but this did not take place. The Review Panel has been informed that the process has now changed, and all staff now have access to SharePoint to upload referrals directly.

Oldham CCG

14.11.8 The CCG promotes primary care to complete a DASH risk assessment following disclosures of domestic abuse. However, there have been

occasions when professionals have completed a referral to Adult Social Care, as opposed to a DASH. All professionals have access to advice and support from the CCG Safeguarding Team.

NWAS

14.11.9 NWAS has a Vulnerable Adults policy, which is in date and includes domestic abuse. Since 2019, all patient-facing staff within NWAS receive safeguarding training to Level 3, which covers coercive and controlling behaviour. The Review Panel was informed that work has commenced, through the NWAS area learning forums, around the promotion of professional curiosity when assessing mental health presentations – to ensure that this is not masking the effects of domestic abuse. The work within the learning forums is attended by area leads and disseminated to local teams.

Pennine Care NHS Foundation Trust

14.11.10 The PCFT Safeguarding Adult and Children Policy was replaced with the Safeguarding Families Policy (2019). All policies reference the management of domestic abuse disclosures. Information is available to all staff via the Trust intranet safeguarding page.

14.11.11 Since July 2019, the Trust Safeguarding Team has implemented a new model. The Review Panel was informed that there was evidence that more services and staff were contacting the team for advice and guidance. PCFT has identified that the Safeguarding Families Policy should be reviewed, and consideration given to a standalone domestic abuse policy for staff to support managing disclosures. PCFT has made a recommendation to address this area of learning.

Turning Point

14.11.12 Turning Point has organisational policies around safeguarding and domestic abuse. The Rochdale Oldham and Recovery service (ROAR)[41] has local processes for referring into the relevant Local Authority, and referring to multi-team reviews when a safeguarding concern is raised. Turning Point has identified a gap in their knowledge and procedure in relation to the completion of a DASH when a victim does not consent. This is of relevance

[41] https://www.ourrochdale.org.uk/kb5/rochdale/directory/service.page?id=ulbO0kp1Vj0

to the contact they had with Elizabeth in April 2020 and January 2021. Turning Point has made a recommendation to address this area of learning.

Nacro

14.11.13 Nacro had the required policies and procedures in place, and these were followed by the Housing Management worker and service Lead. For example, raising safeguarding concerns and exceeding minimum contact protocol. However, as detailed in Term 12, the minimum contact procedure was not fully observed at the end of February/beginning of March 2021. The Review Panel has been informed that robust controls to manage cover for high-risk service users during staff absence have since been put in place.

Overall analysis

14.11.14 The Review Panel has seen evidence that Elizabeth was a victim of domestic abuse. This not only included disclosures she made directly to professionals, but also from professionals' concerns arising around Elizabeth's presentation and responses to physical injuries. The Review Panel was concerned regarding the lack of DASH risk assessments that were completed during the timeframe of this review, and agreed that whilst individual agencies had identified learning around the completion of a DASH, this was a strategic area of learning for all agencies involved in this review. [Recommendation 7].

14.12 Term 12

Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies?

Adult Social Care – Oldham

14.12.1 Elizabeth did not have a face-to-face visit from Adult Social Care, during the time frame of their involvement, due to the restrictions that were in place due to the Covid-19 pandemic. Contact with Elizabeth was undertaken via telephone. In May 2020, there was an opportunity for a social worker to have seen Elizabeth whilst she was in hospital; however, Elizabeth had been discharged prior to a visit taking place. The Review Panel has seen evidence of Adult Social Care working with other agencies

and gathering and sharing of information via telephone and email, following safeguarding concerns being raised by agencies.

Jigsaw

14.12.2 Elizabeth's keyworker at Jigsaw was part-time. In September 2019, during a support session, Elizabeth asked for a full-time keyworker; however, it was recorded that Elizabeth then changed her mind, stating that she valued the relationship that she had with her allocated keyworker and did not want a change. The Review Panel was told by Jigsaw that there was no evidence to suggest that by having a part-time worker this adversely affected Elizabeth's support, as there were other members of staff always on hand to support Elizabeth and provide feedback to her keyworker. The Review Panel has seen evidence of Elizabeth having contact with other workers from Jigsaw when her keyworker was not available.

Oldham CCG

14.12.3 From March 2020, until the time of Elizabeth's death, NHS services had been responding to the Covid-19 pandemic. As a result, GP practices, as well as other NHS services, had altered practice in terms of carrying out an increased number of telephone consultations instead of face-to-face appointments. The Review Panel recognised that telephone consultations with patients who had multiple complex needs, could be a challenge – as the GP would not have been able to assess Elizabeth's non-verbal communication and presentation in the same way as a face-to-face appointment. During this timeframe, Elizabeth made contact with the GP practice nine times: all contacts were through a telephone call. There was no contact between Tim and the GP practice until December 2020, when his physical and mental health appeared to deteriorate. The Covid-19 pandemic did not appear to have made any impact on the care Tim received.

Northern Care Alliance

14.12.4 The Review Panel was informed that the Corporate Safeguarding Adult Team was currently under resourced, and that this had been placed on the Trust risk register – with representations in the form of business cases being escalated to the NCA Safeguarding Committee.

14.12.5 The resourcing issues had impacted on the NCA's ability to attend at MARAC, which had been highlighted to the partner agencies via the

Domestic Violence Partnership and the Clinical Commissioning Group. The MARAC capacity issue had also been added to the Trust risk register.

14.12.6 The ability to ensure effective on-site training has been adversely affected by the Covid-19 pandemic, and whilst efforts were made to advertise and promote attention to the domestic violence and abuse agenda, it was reported that this was challenging. The Review Panel was informed that the NCA Safeguarding Teams promoted attention to the likelihood of increased incidences of domestic violence and adult safeguarding. This was done in the form of regular communications and a safeguarding seven-minute briefing, throughout the Covid-19 pandemic. In addition, NCA developed a virtual training session for children and adult safeguarding, which included domestic abuse, in order to keep the momentum for improved skills.

Early Help and IDVA

14.12.7 There were some capacity issues in the IDVA service due to the increase in referrals over the previous two years; however, this did not impact on the service's ability to work with other agencies. The capacity to telephone Elizabeth at different times of day to check her welfare, was impacted during lockdown conditions: this then had to be balanced with Elizabeth's safety in mind, and to ensure that contact was not escalating her risk.

Housing

14.12.8 The 'triage' system operated by First Choice Homes Oldham (FCHO), impacted on the service provided to Elizabeth, in that a homelessness assessment should have been triggered and taken at the drop-in service in May 2019. However, procedures in place at the time, were to re-book applicants for appointments to undertake the assessments. Elizabeth missed the subsequent appointments, which then led to her not receiving a full service, despite her having requested assistance at the drop-ins.

14.12.9 On 1 July 2019, FCHO transferred to Oldham Council. Two of the five permanent Housing Pathway Advisors transferred from FCHO to Oldham Council, and the remaining vacancies were supplemented by agency staff. This had an impact on the service provided to Elizabeth. Also, an opportunity was missed to re-offer a homelessness assessment / review the historic case notes. The Review Panel has been informed that this transition has now been fully implemented, with effective housing systems and clear markers on client files.

Stockport Homes

14.12.10 Elizabeth received an appropriate level of service from the Housing Options Team. The Review Panel was informed that a specialist domestic abuse worker role has also just been recruited to work within Stockport Homes Group.

Tameside Oldham Glossop – MIND

14.12.11 Both Elizabeth and Tim were seen within the six-week target, between referral and first appointment. This target is set by NHS England for all IAPT services (primary care talking therapies services) across the country.

Turning Point

14.12.12 On 30 December 2020, an appointment was booked with Elizabeth, but this had to be cancelled due to the recovery worker needing to cover the duty worker role. A follow-up call should have taken place with Elizabeth on 13 January 2021, to check on her engagement with the Psychological Interventions (PSI) group work; however, this did not take place. The Review Panel was informed that, at that time, the recovery worker was managing a high caseload with multiple service users requiring crisis intervention and emergency responses, including hospital admissions: this had an adverse impact on diary, appointment scheduling and management. In addition, the service was also unable to offer face-to-face appointments due to Covid-19, and therefore visual clues that may have assisted in making a fuller assessment of Elizabeth were not taking place. The Review Panel was informed that caseloads remain high, there are still staff shortages, and agency staff have been used to cover the vacancies. Turning Point is a commissioned service and this matter has been placed on the relevant risk register.

Nacro

14.12.13 The Review Panel was informed that the average caseload in the service is 16 tenants per full time equivalent post, which is considered reasonable for an Intensive Housing Management Service. The Housing Management worker had regular contact with Elizabeth (daily at some stages) to support her to address the domestic abuse that she was experiencing. The level of contact on numerous occasions exceeded the minimum requirement; however, there was a gap in contact of nine working days, which was due

to staff annual leave and cover arrangements being affected by staffing levels in the service.

14.12.14 Nacro now keeps a shared track of service users' risk level (low, medium and high) which is accessible by all staff members. Whilst staffing issues continue, the system ensures that those higher-risk service users continue to have a welfare check if their assigned staff member is unexpectedly not at work. The welfare call process is overseen by the service manager, and the management team are involved in carrying out the welfare checks if needed due to unexpected staff absence. Nacro is working with agencies for longer-term vacancies.

MARAC

14.12.15 The Review Panel was informed that the MARAC agenda had been growing within the borough of Oldham, and a higher level of harm acuity had been recorded over the previous 12-18 months. This was further compounded by capacity saturation within the Oldham IDVA service – leaving only those at the highest risk with a service. This area of learning has already been addressed by the SafeLives report, and recommendations have been made. [See 14.3.8].

14.13 Term 13

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

14.13.1 The analysis for this Terms of Reference is contained within Section 11.

14.14 Term 14

What learning has emerged for your agency?

IMR INFORMATION NOT FOR PUBLICATION

14.15 Term 15

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

14.15.1 At the beginning of May 2019, Elizabeth disclosed to staff at Turning Point that she was a victim of domestic abuse. The perpetrator, Adult B, was outside of the premises where he remained throughout the day. Practitioners were proactive in ensuring Elizabeth's safety: this included liaising with agencies to secure a place in a refuge for Elizabeth out of the area, preventing Adult B being able to speak with and communicate with Elizabeth, and contacting the police to ensure that Elizabeth could safely access the refuge placement. Practitioners stayed in work outside of usual working hours to ensure Elizabeth's safety and a timely transfer to the refuge.

14.15.2 In May 2020, the ambulance service used a range of methods to seek engagement and gather information from Elizabeth regarding domestic abuse. At the time, Elizabeth was in the presence of the perpetrator. The methods used were innovative. The ambulance service recognised the presenting risks to Elizabeth and correctly made a safeguarding referral, overriding Elizabeth's consent.

14.15.3 In June 2020, a volunteer saw Elizabeth with bruising whilst they had been delivering a food parcel. The volunteer reported their concerns. Information sharing and discussions took place between the foodbank/Early Help Hub and IDVA, via the daily risk meeting. A decision was made for contact to be made with Elizabeth via her support worker at Nacro, rather than through statutory agencies, such as the police. This was a good example of agencies working together to engage with Elizabeth – through non-statutory routes, and with an agency who had daily contact with her.

14.16 Term 16

Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Oldham Community Safety and Cohesion Partnership?

14.16.1 The Review Panel was informed that a review is currently taking place, looking at the oversight and management by PCFT and Turning Point in terms of dual diagnosis for individuals who may have mental illness and

substance misuse. This review is taking place to address learning from previous SARs and DHRs.

14.16.2 The following learning has been identified in previous SARs and DHRs:

- Non-statutory safeguarding.
- Completion of DASH.
- Multi-agency working with regards to developing risk management processes for adults at risk.
- The impact on victims where children have been removed.
- Understanding and recognition of coercive and controlling behaviours, and the impact on a victim's ability to accept services' support.

15. CONCLUSIONS

15.1 Elizabeth was a vulnerable woman who had been a victim of domestic abuse in previous relationships. In 2019, Elizabeth moved to Oldham. Elizabeth left behind her young child. Elizabeth initially moved into a refuge. Around this time, she met and formed a relationship with Jack. There was physical and sexual violence in this relationship, which resulted in Elizabeth seeking medical treatment and admission to hospital due to the injuries sustained. Jack was the perpetrator of the abuse. Incidents were reported to agencies; however, Jack was not prosecuted for any criminal offences. Jack had no previous convictions, and was not known to the police prior to his relationship with Elizabeth.

15.2 In the summer of 2020, Elizabeth met and started a relationship with Tim: ending her violent relationship with Jack. Tim was a perpetrator of domestic abuse. Tim had previous convictions for offences of violence, and had served previous custodial sentences. Alcohol was a precipitating factor in Tim's offending behaviour. Tim's criminal history was not known to Elizabeth. There was violence in Tim and Elizabeth's relationship. Tim was the aggressor. The relationship ended when Tim murdered Elizabeth.

15.3 Elizabeth suffered with her mental health and alcohol use, and had been referred to agencies to support her: at times her engagement was sporadic. Elizabeth disclosed to professionals that she was a victim of domestic abuse in her current and previous relationships. At times,

Elizabeth named the perpetrator of the abuse; however, she did not give her consent to professionals reporting the abuse to the police.

15.4 The risk of domestic abuse to Elizabeth was high. Elizabeth's case was heard at MARAC on five occasions, between March and February 2021. Despite this multi-agency approach, the abuse to Elizabeth continued. The risk was not managed.

15.5 There were opportunities for Elizabeth to have been provided with information to help her make informed decisions about the risks that she faced; however, this information was not shared. There were incidents when professionals involved in the case were not aware of the abuse that Elizabeth had suffered, or was currently suffering, including the names of the perpetrators of that abuse. This resulted in those professionals being unable to support Elizabeth to manage the risk.

15.6 Elizabeth's parents stated that there was no mechanism for their voice to be heard, and that they did everything possible to support Elizabeth within their knowledge and capabilities – had agencies included them in plans, they would have been able to do much more.

15.7 Elizabeth's mum said: "No agency would have been able to provide the 24/7 love and support that we and our extended family would have been able to provide. We wanted to help Elizabeth, but we were in the dark" Elizabeth's parents are very angry that Elizabeth was not found until two weeks after her death and find it difficult to understand how she could have been left alone for two weeks. They were under the impression Elizabeth was living somewhere safe where she was being supported by Professionals and therefore question what support she was receiving. Elizabeth's parents stated that despite her difficulties, Elizabeth strived to do the best she could and they would find it difficult if people said "she put herself in that position".

15.8 The Review Panel has been informed about changes to policies and procedures in Oldham that focus on individuals who are vulnerable and have complex needs, and multi-agency working to address these areas of risk. The Review Panel has identified learning from the review that has been embedded into recommendations.

15.9 Elizabeth's family contributed to the DHR, and the Review Panel wishes to extend their thanks for their contribution and engagement in the process.

16. LEARNING IDENTIFIED

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

16.1.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies as detailed under Term 14. Each lesson is preceded by a narrative that seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross reference is included within the header.

Learning 1 [Panel recommendation 1, 2 and 12]
Narrative
There were opportunities in this case for the multi-agency working and information sharing to have been improved in responding to the risk and complex needs of the case. This included the identification of a single point of contact to ensure that information sharing on key decisions took place, and that the individual could make informed decisions on key outcomes and engagement with services.
Learning
In cases where the individual has identified complex needs, or where there are significant numbers of agencies involved, there is a requirement for a co-ordinated approach to ensure that agencies are working together with the individual to agree desired outcomes. The multi-agency response will ensure that the individual will, through an identified point of contact, be able to contribute to the multi-agency working and be informed of key decisions and outcomes.

Learning 2 [Panel recommendation 3]
Narrative
Information was held within agency records that identified concerns, risks, and evidence of domestic abuse. The full content of this information, including detailed disclosures and the names of the perpetrators of the abuse, was not shared during referrals for housing accommodation. This resulted in the information not being considered when decisions were made regarding the authorisation of individuals residing in supported accommodation.
Learning
Information sharing between agencies must contain explicit details regarding risks and disclosures of domestic abuse, including details of

those who are perpetrators of the abuse, and whom pose a risk to individuals.
Learning 3 [Panel recommendation 4]
Narrative
There were opportunities in this case for the victim to have been informed of their right to ask for information on any known risks from the person with whom they were in a relationship. In addition, professionals had opportunities to be proactive and initiate a 'Right to know' application through the Domestic Violence Disclosure Scheme.
Learning
The sharing of information through the Domestic Violence Disclosure Scheme provides victims the opportunity to make an informed decision on any presenting risks, and seek support to understand and respond to those risks.

Learning 4 [Panel recommendation 5 and 6]
Narrative
There were opportunities in this case for the consideration of proactive management of the perpetrators through the criminal justice system and civil remedies. This would have provided an opportunity for the presenting risk to the victim to have been responded to during the management of the perpetrators.
Learning
Proactive management of perpetrators who commit domestic abuse, will seek to respond to the risks presented to victims and address offending behaviour.

Learning 5 [Panel recommendation 7]
Narrative
There were opportunities in this case when incidents of domestic abuse were disclosed to professionals during contact with the victim. This provided professionals with the opportunity to gather further information surrounding those disclosures, the presenting risks within the relationship, the requirement to complete a DASH risk assessment, and to share with partner agencies in order to work collectively to respond to those risks.
Learning
The completion of a DASH risk assessment allows professionals to identify risk factors, and to inform information sharing and multi-agency management of those risks, including the identification and signposting of support for victims.

Learning 6 [Panel recommendation 9 and 11]
Narrative
There were incidents in this case which identified the victim had suffered significant physical harm as a result of domestic abuse. These incidents and risks were not shared with agencies as the victim had not provided their consent, and it was deemed that the risk level was not high. This resulted in safeguarding measures not being implemented to manage and reduce the risk.
Learning
Professionals need to have access to information as to how and when they can override consent and share information with agencies when incidents of significant harm have occurred. In addition, agencies need to have in place managerial oversight which provides them with assurance that professionals are following safeguarding procedures when disclosures of abuse have been made.

Learning 7 [Panel recommendation 10]
Narrative
Elizabeth's family informed the review that they did not have access to information in order that they could have provided support to Elizabeth whilst she engaged with services in response to her mental health and alcohol use. The family described how they felt that they were in the dark as to how they could help Elizabeth respond and work with agency intervention.
Learning
It is important for families and friends who are supporting individuals who are affected by substance and alcohol misuse, to have access to information to help them understand how they can support that individual.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That Oldham Community Safety Partnership ensures that the learning from this review is shared to inform the ongoing work in relation to the implementation of Adult Tiered Risk Assessment and Management (TRAM) Protocol.

Number	Recommendation
2	That all agencies provide evidence and assurances to Oldham Community Safety Partnership as to how they respond to the complex needs of individuals, including: • The identification of a Lead professional • Ensuring there is a multi-agency approach, including the engagement of statutory and non-statutory agencies.
3	That all agencies provide evidence to Oldham Community Safety Partnership that accurate information (which includes the exact details of known risks), disclosures of domestic abuse, and details of known perpetrators are being shared between agencies where safeguarding concerns are known.
4	That the Domestic Abuse Partnership should scrutinise the application of the Domestic Violence Disclosure Scheme to understand the source of applications, and identify training opportunities to address any gaps in knowledge and application of the scheme – through targeted training and awareness raising.
5	That Greater Manchester Police provide evidence and assurances to Oldham Community Safety Partnership that perpetrators of domestic abuse are being proactively managed in terms of reducing the risks that they present, and in response to their offending behaviour.
6	That the Domestic Abuse Partnership reviews the strategic response to the management of perpetrators of domestic abuse. This should include the availability of intervention opportunities, including: • non-convicted perpetrator programmes • multi-agency approach to reduce offending • application of statutory processes such as MAPPA, or court mandated intervention.
7	That the Domestic Abuse Partnership undertakes a multi-agency audit regarding DASH completion, and uses the findings of this audit to target training and awareness raising to address any identified gaps in DASH completion.
8	That Oldham Community Safety Partnership ensures that the learning from this review is shared with Oldham Safeguarding Adults Board.
9	That Oldham Community Safety Partnership ensures that information is available for professionals, which details how

Number	Recommendation
	information can be legally shared, and consent overridden in cases where adults are deemed to have capacity but have been identified as being at risk of significant harm.
10	That Oldham Community Safety Partnership ensures that information is available to members of the community who are supporting individuals who are affected by mental health, and substance / alcohol use.
11	That all agencies involved in this review provide evidence to Oldham Community Safety Partnership that they have in a place managerial oversight which provides evidence that professionals working within their Organisation are following safeguarding processes when disclosures have been made.
12	That the Domestic Abuse Partnership ensures that there is a referral pathway in place which allows for repeated cases that have been heard at MARAC, to be referred to a multi-discplinary risk management process that will review and work in partnership to respond to identified risks.

17.2 Single agency recommendations

17.2.1 Single agency recommendations are contained within the action plan at Appendix E.

IMR INFORMATON NOT FOR PUBLICATION

Appendix A

Definition of Domestic Abuse
Domestic violence and abuse: as in place at time of review

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

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

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

Coercive behaviour

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

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship
A Selected Extract from Statutory Guidance Framework[42]

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

Types of behaviour

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

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;

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

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

SUMMARY OF AGENCIES WHO CONTRIBUTED TO THE REVIEW

Adult Social Care – Oldham

The Adult Contact Team provides the first point of contact for adult social care services. Whether you need support for a short or long period of time we can assist you with advice, information, and advocacy in your time of need. We work with a number of services such as, education, health, housing and police, to help you access the right service. We also work hard to understand your day to day difficulties and requirements, so that you receive the right level of support.

Change Grow Live – Stockport

We have two strands to our service. First, the Early Intervention Service. This is for people whose drinking or drug use is beginning to cause them problems. The second is our Recovery Service. This is for people who have reached their chosen goals and want ongoing support. We'll encourage you to be vocal about what you want from us, and we'll work with you to figure out what you want to achieve.

Cheshire and Greater Manchester Community Rehabilitation Company

Cheshire and Greater Manchester CRC unified with the Probation Service on 26 June 2021 and all CRC contracts were terminated forming Greater Manchester Probation Service.

Children's Social Care – Derbyshire, Stockport & Oldham

Children's Social Care respond when –
A child needs protection – if a child is suffering harm, neglect or abuse, we can investigate and act to protect the child.
A family is under stress – offer support and advice and help families access support from other services.
A child is seriously ill or disabled – arrange an assessment of the child's and family's needs and provide support.

Clinical Commissioning Group – Derbyshire

NHS Derby and Derbyshire Clinical Commissioning Group brings together the combined expertise of 112 local GP practices, split between eight different places, to commission health services on behalf of over 1,065,000 patients in Derbyshire.

Clinical Commissioning Group – Oldham

We are a membership organisation, with every family doctor in Oldham as our members. A Governing Body makes the overall decisions about what services to spend NHS money on. This Governing Body is made up of local doctors and other

health Professionals as well as lay representatives, all of who, had to apply for a role. All local doctors have signed an agreement with the Governing Body, which demonstrates their commitment to delivering our aims, objectives and plans.

Clinical Commissioning Group – Stockport
NHS Stockport Clinical Commissioning Group (CCG) is a group of GPs from every practice in Stockport with responsibility for designing and buying health services for the local population.

Early Help and IDVA Service – Oldham
In accordance with Oldham's Continuum of Need framework, children and families with continuing multiple and complex unmet needs can be supported by Oldham's targeted early help teams. The approach in Early Help is to work with all the presenting issues rather than pass people around services and systems, which causes more confusion and delay for families. Early Help works with a multitude of issues including; homelessness and eviction, work and skills, substance misuse, mental health, school behaviour and attendance and relationship issues.

Oldham has a team of specialist Independent Domestic Violence Advisors, which includes a specialist officer who deals with cases of so called honour based violence (including forced marriage and FGM).

Derbyshire Police
Derbyshire Constabulary is the territorial police force responsible for policing the county of Derbyshire, England. The force covers an area of over 1,000 square miles with a population of just under one million.

Greater Manchester Police
Greater Manchester Police is the territorial police force responsible for law enforcement within the metropolitan county of Greater Manchester in North West England. GMP is the fourth largest police service in the United Kingdom; and is the second largest force in England and Wales.

Housing Strategy (Homelessness Service) – Oldham
Offer advice and support to Oldham residents at risk of becoming homeless.

Jigsaw Homes
Jigsaw Homes Group is a housing association with more than 34000 homes across the North West and East Midlands. Jigsaw provide a number of support services, including homelessness services, 24/7 supported accommodation, outreach support and refuge provision for victims fleeing domestic abuse.

Nacro

Nacro is a social justice organisation that provides a variety of supported housing services. The service provided in Oldham is a housing management service offering tenancy sustainment support of up to one hour per tenant per week.

Northern Care Alliance

The Northern Care Alliance is an NHS Group formed by bringing together two NHS Trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust. The NCA Group provides a range of healthcare services including five hospitals and associated community services - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury, Rochdale Infirmary and North Manchester General Hospital.

North West Ambulance Service

NWAS serve more than seven million people across approximately 5,400 square miles – the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire and Glossop (Derbyshire). They receive approximately 1.3 million 999 calls and respond to over a million emergency incidents each year. NWAS make 1.5 million patient transport journeys every year for those who require non-emergency transport to and from healthcare appointments. NWAS deliver the NHS 111 service across the region for people who need medical help or advice, handling more than 1.5 million calls every year.

Pennine Care NHS Foundation Trust

We're proud to provide mental health and learning disability services to people across Greater Manchester. Our mental health teams provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illnesses such as schizophrenia and bi-polar disorder. We run Healthy Minds (psychological therapies), drug and alcohol services, psychiatric intensive care, rehabilitation services, military veterans' services and many more.

Stockport NHS Foundation Trust

We hold a unique position in the Stockport community as the provider of healthcare and we are one of its largest employers. We are an integrated provider of acute hospital and community services to the people of Stockport, as well serving the populations of East Cheshire and the High Peak in North Derbyshire.

Stockport Homes

We manage the housing stock owned by Stockport Council. We are also committed to building new homes across Stockport and helping to transform the lives of our customers.

Stockport Without Abuse
We are a local charity who offer a range of services to help and support women, men and children who are affected by domestic abuse.

Tameside Oldham Glossop Mind
Tameside, Oldham and Glossop Mind provide a variety of services for our clients. We pride ourself on finding new and effective ways to help people with their mental wellbeing in the way which best suits them.

Turning Point
Rochdale And Oldham Active Recovery provide an integrated drug and alcohol service across the boroughs of Rochdale and Oldham.

Cheshire Police
Cheshire Constabulary is the territorial police force responsible for policing the English unitary authorities of Cheshire East, Cheshire West and Chester, Halton and Warrington. The force is responsible for policing an area of 946 square miles with a population of approximately 1 million.

Department for Works and Pensions
The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service department, it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers.

Hampshire Police
Hampshire Constabulary is the territorial police force responsible for policing the counties of Hampshire and the Isle of Wight in South East England, United Kingdom.

Ingeus

The Working Well Work and Health Programme was funded through the Greater Manchester Combined Authority (GMCA) and aimed at participants with health issues who are struggling to gain sustained employment. Referrals are made through Job Centre Work Coaches.

Inspire Women
Inspire Women is a tapestry of the interwoven lives and experiences of a group of Oldham women, their stories contributing to the writing of a new story, an inspiring story of women helping women, of women hoping for and enabling change, of women re-defining their stories, their previously unheard wisdom shaping a dynamic, co-created organisation that encompasses and celebrates Heart Centred

Leadership.

The Probation Service
The Probation Service (formally the National Probation Service) for England and Wales is a statutory criminal justice service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties.

Petrus House
The Petrus Community is a registered charity providing residential and day support services for people in housing need throughout the Borough of Rochdale (including Heywood and Middleton), Rossendale and Oldham

Appendix D

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the Domestic Homicide Review. It is drawn up from material provided by the agencies that contributed to the review.

Date	**Events Prior to TOR**
16.05.14	MARAC case held.
14.06.14	Cheshire Police – responded to incident with Elizabeth, during which she alleged being a victim of rape as a child.
18.11.14	MARAC case held.
10.01.15	Tim registered with GP in Oldham.
16.06.15	MARAC case held.
July 2015	Tim assaulted ex-partner. Received custodial sentence.
08.09.15	Tim released from custody.
22.09.15	Tim recall to prison process commenced.
Date	**Events within TOR**
2016	
Feb 2016	Tim arrested for prison recall.
04.03.16	Elizabeth seen by GP (Stockport). Evidence of panic attack, alcohol use. Discloses domestic abuse. Medication prescribed.
08.03.16	Elizabeth seen by GP (Stockport) for review.
22.04.16	Elizabeth seen by GP (Stockport) for review.
12.05.16	Elizabeth seen by GP (Stockport) for review.
10.06.16	Elizabeth contacted NWAS NHS 111, following assault by Adult A. Ambulance attended and transported Elizabeth to hospital. Adult A arrested by police. Letter sent to GP who spoke to Elizabeth via telephone. Referral sent to Adult Social Care (Stockport). Adult A released without charge. MARAC referral raised by hospital
16.06.16	Tim attended hospital following accident at work.
28.06.16	MARAC case held.
05.08.16	Elizabeth registered with GP practice in Derbyshire.
Aug 2016	Tim arrested for recall to prison. Later released from custody.
15.09.16	Contact between police and CRC regarding Tim's prison recall.
16.09.16	Tim seen by CRC.
20.09.16	Tim seen by CRC.
21.09.16	Tim seen by CRC.
26.09.16	Tim's case transferred to another officer in CRC.
28.09.16	Tim spoken to by police following incident on Isle of Wight.
30.09.16	Tim's order terminated.
21.11.16	Elizabeth seen by GP (Derbyshire), with partner. Early stages of pregnancy.
2017	
14.02.17	Female reported to Hampshire Police that she had been assaulted by Tim. No further action taken.

28.02.17	Tim seen by Hampshire Police.
20.07.17	Josh was born.
23.07.17	Tim seen by GP (Oldham) due to problems with earlier back injury.
14.08.17	Elizabeth seen by GP (Derbyshire) for anxiety review.
18.09.17	Elizabeth seen by GP (Derbyshire) following panic attack.
25.10.17	Tim referred to chiropractor/physio due to back injury. Did not attend and later discharged from service.
18.11.17	GP practice (Derbyshire) received letter. Suicidal ideation of Elizabeth.
20.11.17	Elizabeth seen by GP (Derbyshire) for anxiety review.
2018	
03.01.18	Elizabeth seen by GP (Derbyshire) for anxiety review.
18.01.18	Elizabeth seen by GP (Derbyshire) for anxiety review.
20.02.18	Elizabeth seen by GP (Derbyshire) regarding anxiety.
27.02.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
05.03.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
13.03.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
28.03.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
21.04.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
06.06.18	Elizabeth contacted police (Derbyshire) following an incident with Adult B. Later that day, Elizabeth attended hospital, via ambulance, following episode of self-harm. Full mental health and risk assessment completed. Elizabeth identified an argument with Adult B, with his mother being the trigger. Elizabeth was admitted to psychiatric ward. Referral sent to Children's Social Care (Derbyshire). Letter sent to GP.
07.06.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
14.06.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
20.06.18	Elizabeth seen by GP (Derbyshire). Requested to be seen alone.
21.06.18	GP practice (Derbyshire) held Multi-disciplinary team meeting.
12.07.18	Elizabeth seen by GP (Derbyshire) for anxiety and depression review.
16.07.18	Elizabeth attended hospital, via ambulance, following self-harm, and overdose of medication with alcohol. Elizabeth referred to and seen by STEM. Elizabeth discharged home. Referral to Children's Social Care. Letter sent to GP.
19.07.18	Elizabeth seen by GP (Derbyshire) for review. Information to be shared with GP (Stockport).
29.07.18	Elizabeth seen by GP (Stockport).
02.08.18	Elizabeth did not attend appointment at Buxton Hospital. Referred back to GP.
04.08.18	Change Grow Live received referral for Elizabeth from GP.
16.08.18	Elizabeth seen by GP (Stockport) for review.
22.08.18	Elizabeth referred to Healthy Minds.
28.08.18	Healthy Minds referral not accepted due to insufficient information.
03.09.18	Healthy Minds accepted referral following receipt of further information.
04.09.18	Elizabeth attended first appointment with Change Grow Live.
10.09.18	Tim seen by GP (Oldham), due to back pain. Recurring attendance at GP practice.

11 & 12.09.18	Elizabeth attended appointment with Change Grow Live.
17.09.18	Healthy Minds triaged referral for Elizabeth.
17.09.18	Elizabeth seen by GP (Stockport) for review.
18.09.18	Healthy Minds send 'opt in' letter to Elizabeth. Later discharged from service as no contact received. Referred back to GP.
19.09.18	Change Grow Live – appointment cancelled.
25.09.18	Elizabeth attended appointment with Change Grow Live.
03.10.18	Elizabeth attended appointment with Change Grow Live.
08.10.18	Elizabeth seen by GP (Stockport CCG) for review.
11.10.18	Elizabeth attended appointment with Change Grow Live.
13.10.18	Elizabeth attended hospital, via ambulance, following overdose of medication. Elizabeth referred to and seen by STEM. Elizabeth discharged home. Letter sent to GP. Referral sent to Children's Social Care.
15.10.18	Elizabeth seen by GP (Stockport) for review.
15.10.18	Children's Social Care (Stockport) commenced assessment under Section 17 Children Act 1989.
16 & 18.10.18	Elizabeth attended appointment with Change Grow Live.
29.10.18	Elizabeth seen by GP (Stockport) for review.
30.10.18	Elizabeth attended appointment with Change Grow Live.
02/06/09. 11.18	Elizabeth attended appointment with Change Grow Live.
13.11.18	Stockport Homes – Elizabeth applied for rehousing with Stockport Homes. Elizabeth attended appointment with Change Grow Live. Elizabeth seen by GP (Stockport) for review.
14.11.18	Elizabeth self-referred to Healthy Minds.
19.11.18	Healthy Minds send appointment letter to Elizabeth. Children's Social Care (Stockport) complete assessment. Case stepped down to Early Help Tier 2.
19/21/26. 11.18	Elizabeth attended appointment with Change Grow Live
27.11.18	Elizabeth seen by GP (Stockport) for review. Elizabeth attended appointment with Healthy Minds.
28.11.18	Elizabeth attended appointment with Change Grow Live
03.12.18	Elizabeth attended appointment with Change Grow Live
04.12.18	Elizabeth cancelled appointment with Change Grow Live.
05.12.18	Medical assessment completed for Stockport Homes.
06.12.18	Elizabeth attended appointment with Change Grow Live
09.12.18	Police (GMP) received call from Elizabeth that she had been assaulted by Adult B. Adult B was arrested; however, CPS declined to charge due to insufficient evidence. Referrals sent to Children's Social Care, Health, and Mental Health.
10.12.18	Children's Social Care agreed to keep case open. Elizabeth telephoned Change Grow Live to inform them of the incident.

11.12.18	Change Grow Live telephoned Elizabeth. No answer.
12.12.18	Change Grow Live speak to Elizabeth via telephone.
17.12.18	Change Grow Live closed case.
21.12.18	Elizabeth seen by GP (Stockport) for review.
2019	
08.01.19	Elizabeth seen by GP (Stockport) for review.
14.01.19	Healthy Minds made appointment for Elizabeth regarding EMDR.
23.01.19	Elizabeth telephoned Change Grow Live to re-engage with service.
01.02.19	Children's Social Care (Stockport) completed home visit to Adult B and Josh.
04.02.19	Elizabeth did not attend appointment with Change Grow Live.
06.02.19	Elizabeth seen by GP (Stockport CCG) for review. Elizabeth attended appointment with CBT professional in company of partner, Jack.
07.02.19	Change Grow Live had contact with social worker and Elizabeth.
11.02.19	Healthy Minds held clinical discussion regarding Elizabeth's alcohol use. Contact with Change Grow Live.
12.02.19	Elizabeth did not attend appointment with Healthy Minds.
12.02.19	Elizabeth did not attend appointment with Change Grow Live.
12.02.19	Telephone call with Elizabeth by GP practice (Stockport) due to non-attendance at appointments with Healthy Minds, GP practice, and social worker.
18.02.19	Elizabeth cancelled appointment with Change Grow Live. Case closed. Elizabeth did not attend appointment with Healthy Minds. Later discharged from service.
19.02.19	Elizabeth seen by GP (Stockport).
21.02.19	Elizabeth contacted Stockport Homes. In company of Jack. Elizabeth offered temporary accommodation, pending a full homeless assessment. Elizabeth did not stay at accommodation.
01.03.19	Elizabeth attended for homeless assessment with Stockport Homes.
05.03.19	Elizabeth telephoned Healthy Minds.
06.03.19	Elizabeth attended hospital via ambulance. Left before treatment commenced.
11.03.19	Elizabeth seen by GP (Stockport).
12.03.19	Elizabeth attended appointment with Change Grow Live following self-referral. Contact made with Children's Social Care. Social worker contacted for update on Elizabeth's progress.
19.03.19	Elizabeth attended appointment with Change Grow Live.
26.03.19	Elizabeth did not attend appointment with Change Grow Live.
28.03.19	Change Grow Live telephoned Elizabeth.
01.04.19	Elizabeth cancelled appointment with Change Grow Live.
03.04.19	Social worker visited Josh, Adult B and family.
05.04.19	Elizabeth seen in outpatient's department. Discharged.
15.04.19	Elizabeth registered with The Wellspring.
16.04.19	Social worker met with Elizabeth.
18.04.19	Police (GMP) attended domestic incident between Elizabeth and Jack. Elizabeth cancelled appointment with Change Grow Live.

23.04.19	Elizabeth seen by GP (Stockport). Recorded she is homeless.
25.04.19	Elizabeth attended hospital. Admitted to psychiatry ward. Referrals submitted for Children's Social Care. Full mental health assessment and risk assessment completed. Signposted to suitable services to support her housing situation.
30.04.19	The Wellspring recorded Elizabeth living with family.
03.05.19	Elizabeth disclosed domestic abuse with Adult B during contact with Change Grow Live. Elizabeth referred to Jigsaw. Police attended and took Elizabeth to refuge in Oldham. Liaison with Stockport Homes, Stockport Women's Aid, Stockport Without Abuse, Children's Social Care, and Greater Manchester Domestic Abuse Helpline.
07.05.19	Stockport Homes and Change Grow Live spoke to Elizabeth via telephone.
08.05.19	Initial support session with keyworker from Jigsaw.
09.05.19	Adult B contacted Children's Social Care regarding incident on 3 May.
10.05.19	Elizabeth attended support sessions with keyworker from Jigsaw. Elizabeth submitted application to Oldham Housing.
13.05.19	Elizabeth attended support session with keyworker from Jigsaw. Elizabeth attended drop-in service at First Choice Homes, Oldham. Elizabeth registered with GP practice in Oldham.
14.05.19	Elizabeth had telephone contact with Change Grow Live.
17.05.19	Elizabeth attended Freedom Programme session.
17.05.19	GMP received complaint from female that she had been assaulted by Tim. No further action taken.
20.05.19	Elizabeth attended support session with keyworker from Jigsaw. Jack told The Wellspring, Elizabeth was now living in a refuge.
21.05.19	Elizabeth seen by GP (Oldham). Elizabeth attended appointment with Change Grow Live.
22.05.19	Keyworker from Jigsaw contacted Housing and social worker. Elizabeth told keyworker of financial matters.
24.05.19	Elizabeth attended Freedom Programme session.
28.05.19	Elizabeth contacted keyworker at Jigsaw.
29.05.19	Elizabeth disclosed suicidal thoughts to keyworker at Jigsaw.
30.05.19	Elizabeth attended hospital, via ambulance, after being found by keyworker having self-harmed. Elizabeth seen by mental health team. Discharged with GP follow-up.
31.05.19	Keyworker from Jigsaw spoke with Elizabeth following incident on 30 May. Adult Social Care received referral from keyworker. Advice given. Elizabeth contacted by Change Grow Live.
01.06.19	Elizabeth attended support session with keyworker from Jigsaw.
03.06.19	Elizabeth attended drop-in service at First Choice Homes, Oldham.
04.06.19	Elizabeth agreed for transfer to Turning Point, Oldham. Transfer request made.
06.06.19	Elizabeth attended support sessions with keyworker from Jigsaw. Case reviewed by senior keyworker. Safety plan to be completed. Meeting with social worker.
07.06.19	Elizabeth seen by GP (Oldham) for anxiety and depression review.

	Elizabeth seen by social worker.
11.06.19	Elizabeth did not attend homelessness assessment.
18.06.19	Elizabeth taken to hospital via ambulance. Referral made for Josh and Elizabeth by ambulance. Discharged. Letter sent to GP.
19.06.19	Elizabeth cancelled appointment with Change Grow Live. Oldham MASH contacted keyworker at Jigsaw regarding incident on 18 June. No further action taken by MASH.
20.06.19	Change Grow Live closed case. Elizabeth issued with appointment at Turning Point. Email sent to social worker.
21.06.19	Elizabeth seen by GP (Oldham). Self-referral made to Healthy Minds. Letter sent to Elizabeth. Elizabeth attended support session with keyworker from Jigsaw.
24.06.19	Elizabeth admitted to hospital for observations. Letter sent to GP. Adult safeguarding referral completed. Welfare check, via telephone, by keyworker from Jigsaw.
25.06.19	Elizabeth seen by hospital social work team (Section 2). Social worker contacted partner agencies.
26.06.19	Elizabeth seen by CMHT – no suicidal ideation. Adult safeguarding concern closed. Elizabeth returned to refuge. Support session with keyworker.
27.06.19	Social worker contacted keyworker. Support safety plan completed. Appointment made for Elizabeth with Healthy Minds – 22 August 2019.
28.06.19	Letter sent to GP from Nutrition and Dietetics. Elizabeth assessed as high risk of malnutrition.
01.07.19	Elizabeth attended first session of Alcohol Wellbeing programme. Further attendance and non-attendance during July 2019. Elizabeth referred into Housing First Domestic Violence Service.
04.07.19	Elizabeth attended Civic Centre seeking housing advice.
05.07.19	Elizabeth seen by GP (Oldham).
06.07.19	Elizabeth attended support session with keyworker from Jigsaw.
10.07.19	Elizabeth attended drop-in at GP practice (Oldham). Elizabeth attended 20-minute drop-in at TOG Mind. Elizabeth was staying out of refuge.
12.07.19	Elizabeth attended support session with keyworker from Jigsaw. Became ill during session, and alleged assault – ambulance called and admitted to hospital for observations. Adult safeguarding referral completed.
13.07.19	Elizabeth disclosed domestic abuse to hospital staff. Transferred ward.
15.07.19	Contact between keyworker, social worker, Turning Point and IDVA. Adult safeguarding concern closed. Elizabeth discharged from hospital.
16.07.19	Elizabeth attended support session with keyworker from Jigsaw.
23 & 31. 07.19	Elizabeth stayed out of the refuge.
03.08.19	Elizabeth returned to refuge. Further episodes in August of Elizabeth not staying at refuge.
06.08.19	Elizabeth attended Civic Centre to enquire about housing application.

07.08.19	Elizabeth attended recovery work appointment at Turning Point. Missed appointments in August. Housing First Domestic Violence referral refused.
21.08.19	Elizabeth seen by keyworker with facial bruising. Denied being assaulted.
22.08.19	Elizabeth attended wellbeing appointment at Healthy Minds. Case brought to Multi-disciplinary team. Not suitable for engagement at this time. Elizabeth re-offered Freedom programme, and advised regarding DVDS, by keyworker.
25.08.19	Elizabeth had telephone contact with NHS 111.
26.08.19	Elizabeth attended support session with keyworker from Jigsaw.
27.08.19	Referral to Doncaster refuge refused.
28.08.19	Elizabeth informed of outcome of assessment with Healthy Minds. Agreed for referral to Early Help. Referral made to Early Help & IDVA Oldham. Referral not accepted. Discharge letter sent to GP from Healthy Minds.
29.08.19	Elizabeth had contact with keyworker from Jigsaw.
Sept 19	Elizabeth had periods of not staying at refuge and returning days later throughout this month.
04.09.19	Elizabeth returned to refuge after being absent for few days. Elizabeth unwell, ambulance called, and Elizabeth taken to hospital. Left prior to being seen. Letter sent to GP.
05.09.19	Elizabeth seen by police. Declined to make a complaint. Keywork agreed a weekly working agreement with Elizabeth. This was not maintained.
06.09.19	Elizabeth attended Freedom Programme.
09.09.19	Elizabeth seen by GP (Oldham) for review. Elizabeth seen by keyworker from Jigsaw.
10.09.19	Elizabeth attended Alcohol Wellbeing Group. Did not attend further sessions that month.
18.09.19	Referral completed for Petrus House – supported accommodation. Elizabeth assessed the following day.
23.09.16	Petrus House offered placement to Elizabeth.
26.09.19	Elizabeth attended support session with keyworker. Elizabeth stated that she did not want to move.
30.09.19	Elizabeth told keyworker she needed to 'put an order' on Jack.
Oct 2019	Elizabeth attended four Alcohol Wellbeing sessions. Elizabeth spendt nights away from the refuge.
01.10.19	Elizabeth attended support session with keyworker from Jigsaw. Elizabeth seen by GP (Oldham) – review. Referred to Crisis Team. Request for MINDS counsellor to work with Elizabeth. Elizabeth attended appointment with recovery worker from Turning Point.
02.10.19	Elizabeth attended 20-minute drop-in with TOG Mind.
03.10.19	Elizabeth referred to Access by GP. Elizabeth did not attend. Elizabeth discharged.

17.10.19	Elizabeth did not attend support session with keyworker from Jigsaw.
24.10.19	Elizabeth attended support session with keyworker from Jigsaw.
25.10.19	Nacro received referral from Jigsaw for Elizabeth.
28.10.19	Elizabeth had contacted with keyworker from Jigsaw.
29.10.19	Elizabeth seen by GP (Oldham). Assessment with Nacro for supported housing. Placement offered.
29.10.19 – 03.11.19	Elizabeth attended three sessions with Alcohol Wellbeing.
01.11.19	Elizabeth signed up for flat with Nacro.
11.11.19	Nacro undertook risk assessment with Elizabeth.
12.11.19	Nacro undertook home visit to see Elizabeth.
02.12.19	Elizabeth seen by GP (Oldham) for review.
03.12.19	Elizabeth attended support session with keyworker from Jigsaw.
09.12.19	Elizabeth attended recovery work appointment with Turning Point.
18.12.19	Final support meeting with keyworker from Jigsaw.
2020	
16.01.20	Elizabeth telephoned by senior recovery worker from Turning Point.
22.01.20	Elizabeth cancelled pre-arranged home visit with Nacro.
28.01.20	Elizabeth complained to Nacro regarding noise nuisance and intimidation from another residency.
30.01.20	Elizabeth seen by GP (Oldham).
25.02.20	Oldham CCG – GP practice 4 – letter from Royal Oldham Hospital, in regard to the assault.
25.02.20	Elizabeth notified Housing Management worker of self-harm injuries and injuries due to assault. Police informed. Elizabeth taken to hospital, via ambulance, following assault two days earlier. Jack arrested. Nacro referred Elizabeth to Jigsaw. Referral to Children's Social Care. MARAC referral submitted.
26.02.20	Nacro arranged for safety measures at property, as Jack was released on conditional bail.
27.02.20	Case allocated to IDVA.
04.03.20	IDVA attempted to call Elizabeth. Rang to voicemail. No message left.
09.03.20	IDVA attempted to call Elizabeth. Rang to voicemail. No message left.
11.03.20	Housing Management worker unable to carry out session with Elizabeth. IDVA attempted to call Elizabeth. Rang to voicemail. No message left. Elizabeth contacted Turning Point and left message on voicemail.
12.03.20	Turning Point arranged meeting with Elizabeth for 16 March. Elizabeth later cancelled appointment.
12.03.20	MARAC meeting held.
13.03.20	IDVA telephoned Elizabeth. Rang to voicemail. No message left.
20.03.20	Telephone review with Elizabeth by GP (Oldham).
25.03.20	Telephone consultation with support worker from Turning Point.
27.03.20	Telephone consultation with support worker from Turning Point.
April 2020	Elizabeth introduced to Inspire Women.

01 & 02.04.20	Welfare calls by Turning Point.
03.04.20	Telephone review with Elizabeth by GP (Oldham).
03 & 04.04.20	Telephone contact with support worker from Turning Point. Elizabeth disclosed assault from Jack. Police attended and spoke to Elizabeth. Incident closed.
08.04.20	Telephone contact with support worker from Turning Point.
09.04.20	Professional discussion held by Turning Point (Internal).
11.04.20	Turning Point requested welfare visit by police. Police have no record of visit.
15 & 17.04.20	Telephone contact with support worker from Turning Point.
20.04.20	Elizabeth seen by GP (Oldham).
May – July 2020	Elizabeth engaged on Finding Me Programme with Inspire Women.
01.05.20 - 07.05.20	Telephone contact with Elizabeth by support worker from Turning Point.
13.05.20	Elizabeth referred to Employability Programme.
16/22/23. 05.20	Telephone contact with Elizabeth by support worker from Turning Point.
26.05.20	Elizabeth text Housing Management worker, stated feeling anxious and intimidated by residents. Had asked Jack to stay. Visitor ban prepared for Jack.
27.05.20	Elizabeth called ambulance service via 999. Ambulance attended and saw Elizabeth. A paramedic spoke with GP. Elizabeth disclosed domestic abuse. Police requested to attend. Elizabeth refused to attend hospital. Jack arrested by police. Safeguarding referral made. MARAC form completed. Safeguarding referral closed.
28.05.20	Elizabeth taken to hospital via ambulance. Police were also in attendance. Elizabeth refused to speak to police: it was agreed that police would attend later that day to speak to Elizabeth. Elizabeth refused to give consent for safeguarding referral to be submitted by ambulance. Elizabeth admitted to surgical triage unit. DASH completed. Referral sent to Adult Social Care who recommended for hospital social worker to see if Elizabeth appeared to have care and support needs. Jack was released from custody. Elizabeth discharged from hospital. Police attended in the evening to speak to Elizabeth and found Jack at the address. Jack was arrested.
29.05.20	Worker from Employability Program telephoned Adult Social Care. MARAC referral received.
01.06.20	Adult Social Care gather information from partner agencies. Social worker telephoned Elizabeth. Call not connected. Elizabeth disclosed financial abuse by Jack.
02.06.20	Housing Management worker visited Elizabeth. Nacro contacted Adult Social Care for advice.

	IDVA spoke to Elizabeth via telephone.
03 & 04.06.20	Recovery worker from Turning Point spoke to Elizabeth on telephone.
03.06.20	Police shared information to Adult Social Care.
05.06.20	Contact with Elizabeth and delivery of food parcel attempted.
08.06.20	Elizabeth seen by GP (Oldham).
10.06.20	Elizabeth referred to Oldham Access Team by GP. Referral screened to Healthy Minds.
12.06.20	Elizabeth assessed by nurse at Turning Point.
15.06.20	Elizabeth seen by recovery workers from Turning Point.
18.06.20	MARAC meeting held. Elizabeth had telephone call with recovery worker from Turning Point.
22.06.20	Adult Social Care had contact with partner agencies and Elizabeth. Case closed. Elizabeth seen by GP (Oldham). Unsuccessful contact with Elizabeth by Turning Point. Elizabeth moved property with Nacro.
23.06.20	Police attended incident between Elizabeth, Jack and Tim. Jack arrested for assaulting Tim.
29.06.20	Jack contact Nacro, via text, and raised concerns about Elizabeth's welfare.
30.06.20	Turning Point – unsuccessful contact with Elizabeth.
01.07.20	Housing Management worker contacted Turning Point – requested more support for Elizabeth. Elizabeth contacted and stated that she would call back. Police attended incident between Elizabeth, Jack and Tim. Ambulance attended. Tim had facial injuries, refused to go to hospital.
03& 06.07.20	Turning Point – unsuccessful contact with Elizabeth.
06.07.20	Turning Point contacted Nacro.
07.07.20	Elizabeth text Turning Point requesting appointment.
08.07.20	Jack sent text to Nacro regarding Elizabeth and Tim. Home visit scheduled by Nacro and police. Elizabeth cancelled visit. Volunteer took food parcel and noticed bruising to Elizabeth. MARAC referral made.
09.07.20	Social worker informed Nacro of concerns raised on 8 July. Nacro carried out home visit and reported concerns back to social worker. Tim at property. Elizabeth refused to move to refuge. 'Nacro contacted the police to report concerns. The police attended, and spoke to Elizabeth.' Elizabeth spoken to by recovery worker from Turning Point. Oldham Access referral triaged as suitable for a Low Intensity Screening appointment.
10.07.20	Case discussed at daily risk meeting. Agreed to take further food parcel to Elizabeth.
14.07.20	Elizabeth discharged from Healthy Minds.
15.07.20	Adult Social Care contacted IDVA regarding DASH.

16.07.20	Turning Point – unsuccessful contact with Elizabeth. Contact made with Nacro to express concerns.
20.07.20	Recovery worker from Turning Point had telephone call with Elizabeth.
21.07.20	Adult Social Care contacted Nacro. IDVA telephoned Elizabeth: she refused to speak.
22/27/28.07.20	Turning Point – unsuccessful contacts with Elizabeth.
02.08.20	Turning Point – unsuccessful contact with Elizabeth. Letter sent.
04.08.20	Elizabeth telephoned recovery worker from Turning Point.
07.08.20	Inspire Women spoke to Elizabeth on telephone.
13.08.20	MARAC meeting held.
25.08.20	Elizabeth telephoned Turning Point, stated that she wanted to continue to work with them.
27.08.20	Inspire Women telephoned Elizabeth – no response.
02/07/11.09.20	Turning Point – unsuccessful contact with Elizabeth. Closure letter and pack sent.
Sept/Oct	Inspire Women – included in all group texts/emails, no active engagement
12.10.20	Turning Point received referral from Nacro.
22.10.20	Turning Point – unsuccessful contact with Elizabeth.
23.10.20	Turning Point – unsuccessful contact with Elizabeth. Letter sent to Nacro.
04.11.20	Turning Point sent letter to Elizabeth.
09.11.20	Elizabeth seen by Housing Management worker with stab wound to leg. Police contacted. Elizabeth taken to hospital. Elizabeth refused to stay at hospital. Hospital telephoned Elizabeth. Safeguarding concerns raised. Contact with Adult Social Care. Letter sent to GP.
10.11.20	Housing Management worker undertook an unannounced visit. Elizabeth seen with further injuries. Case discussed at daily risk meeting.
11.11.20	Elizabeth seen by GP (Oldham) – medication review. MARAC referral received. Inspire Women spoke to Elizabeth via telephone.
12.11.20	Nacro contacted Adult Social Care for update, following referral on 9 November.
13.11.20	Turning Point completed initial screen and booking for comprehensive assessment. IDVA spoke to Elizabeth via telephone.
25.11.20	Adult Social Care contacted IDVA.
26.11.20	Adult Social Care arranged strategy meeting for 2 December.
30.11.20	Telephone call with Elizabeth by Programme Facilitator from Inspire Women.
01.12.20	Turning Point completed comprehensive assessment with Elizabeth.
02.12.20	Multi-agency strategy meeting held.
03.12.20	MARAC meeting held.
04.12.20	Tim attended hospital. Discharged for referral to outpatients. Letter sent to GP.

	Early Help and IDVA closed case.
07.12.20	Turning Point held Professional discussion.
09.12.20	Inspire Women text Elizabeth.
09.12.20	Elizabeth seen by GP (Oldham).
15.12.20	Recovery worker intervention – new worker introductory meeting held with Elizabeth.
17.12.20	Tim seen by practice nurse.
30.12.20	Recovery worker intervention appointment cancelled due to competing demands in workplace.
31.12.20	Tim attended drop-in with TOG Mind.
2021	
05.01.21	Elizabeth had telephone call with recovery worker from Turning Point.
07.01.21	Tim taken to hospital via ambulance. Elizabeth present. Elizabeth seen by GP (Oldham) – review. TOG Mind spoke to Tim via telephone. Referred to Healthy Minds. Crisis information and safety plan sent via email.
08.01.21	Tim seen by TOG Mind at GP practice (Oldham).
13.01.21	Tim seen by TOG Mind at GP practice (Oldham). TOG Mind completed referral to Healthy Minds for Tim. Oldham Access received referral from MIND.
14.01.21	Access Team request additional medical information.
17.01.21	Tim admitted to hospital for observations. Discharged following day. Letter sent to GP.
19.01.21	Adult Social Care received information from Nacro, following contact with Elizabeth on 22 December.
21.01.21	Elizabeth assaulted by Jack. Police attended incident. MARAC referral made. Oldham Access sent letter to Tim to arrange appointment.
22.01.21	Adult Social Care received information from Stockport Children's Social Care.
28.01.21	MARAC referral. Case to be heard on 8 February 2021.
01.02.21	Adult Social Care emailed Nacro for update, which was received the following day.
05.02.21	Early Help and IDVA telephoned Elizabeth.
08.02.21	MARAC case held.
11.02.21	Elizabeth assaulted by Jack. Police attended incident. Tim discharged from Oldham Access.
12.02.21	Police reviewed incident from 1 February 2021.
15.02.21	Police attended incident between Elizabeth, Jack and Tim. Nacro informed MASH of incident between Elizabeth and Jack.
18.02.21	Elizabeth contacted police and reported that she had been assaulted by Tim. An appointment was made for the following day. Police were unable to contact Elizabeth. Incident was closed without contact with Elizabeth.
22.02.21	Early Help and IDVA received MARAC referral from police. Case to be heard on 18 March.

23.02.21	Early Help and IDVA telephoned Elizabeth.
24.02.21	Nacro received invite to strategy meeting on 10 March.
02.03.21	Nacro attempted to contact Elizabeth.
03.03.21	Nacro attempted to contact Elizabeth.
March 21	Elizabeth was found deceased.

Appendix E

'Elizabeth' Combined Single Agency Action Plans

REMOVED - IMR INFORMATION NOT FOR PUBLICATION

Appendix F

'Elizabeth' Multi-Agency Action Plan

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That Oldham Community Safety Partnership ensures that the learning from this review is shared to inform the ongoing work in relation to the implementation of Adult Tiered Risk Assessment and Management (TRAM) Protocol.	Local	The learning to be shared with the Safeguarding Adults Board	Community Safety Services	TRAM has been launched and there is a rolling programme of feedback and training in place to support to embed into practice. OSABS audit programme will be able to consider if there is evidence of effective use of TRAM present, when completing targeted audits on other specific themes.	September 2022	**Completed September 2022** The learning has been shared through the Safeguarding Adults Board. The Board Manager was a member of the DHR Panel and has been fully sighted on learning and recommendations throughout the process.
			All partners to feed into the working model for the TRAM Protocol.	Safeguarding Adults Board	This will be a regular item on the SAB agenda and partner engagement/activity will be recorded in the minutes.	September 2022	**Completed September 2022.** The TRAM Protocol is now embedded in practice.
			Reporting through the Domestic Abuse Partnership on internal audit processes with a	Safeguarding Adults Board / Health and Social Care Services	This will be a regular agenda item on the Domestic Abuse Partnership.	January 2024	**December 2023 Update** To be discussed at Domestic Abuse

DHR Panel Recommendations							
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			focus upon executive function in relation to relationship choices and self-assessment of risk. Case studies on embedded practice of TRAM in relation to DA.				Partnership in January 2024.
			TRAM training to include vulnerability arising from domestic abuse, risk assessments and referral pathways.	Safeguarding Adults Board / Health and Social Care Services.	Ensure the training includes a specific slide referencing vulnerability due to DA.	December 2023	**Completed December 2023**  OSAB Tram Protocol.pdf
			Ensure partner services are aware of the TRAM protocol and the training offer.	Safeguarding Adults Board	Annual training calendar link made available to all partners.	March 2023	**Completed March 2023** New calendar for 2023/24 will be circulated as per standard practice.
			Safeguarding Children's Partnership Training Calendar	Safeguarding Children's Partnership	Annual training calendar link made available to partners.	March 2023	**Completed March 2023**

DHR Panel Recommendations							
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			to be shared with Jigsaw and NACRO.				New calendar for 2023/24 will be circulated as per standard practice.
2	That all agencies provide evidence and assurances to Oldham Community Safety Partnership as to how they respond to the complex needs of individuals, including: - The identification of a Lead professional - Ensuring there is a multi-agency approach, including the engagement of statutory and non-statutory agencies.	Local	Case audits through DHR Governance and Scrutiny Group. Scoring matrix to be introduced - Outstanding - Meets Expectations - Requires Improvement - Inadequate	DHR Governance and Scrutiny Group and Domestic Abuse Partnership	Clear evidence of timely information sharing between agencies. Improvements seen in day to day practice with all cases either assessed as 'Outstanding' or 'Meeting Expectations'	March 2024	**December 2023 Update** The DHR Governance and Scrutiny Group will meet bi-monthly from January 2024. The development of case audits to include exploration of the response to complex needs, is a Scrutiny Group agenda item for the meeting on the 11th January 2024. Information sharing as a thematic area of learning in multiple cases will also be on the agenda for the January meeting. The first case audits will take place at DHRGSG in March 2024.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Update on single agency action plans to be provided DHR Governance and Scrutiny Group.		Scheduled updates in work plan diary.	January 2024	**December 2023 Update** All agencies have provided updates on plans. Will be further scrutiny of embedded practice through DHR Governance and Scrutiny Group in 2024.
			Introduction of new multi-disciplinary response to repeat high risk high harm cases. Application of SARA (Scan, Analysis, Response and Assessment) to identify core issues in situation that response can be built around.		Funding and resource to coordinate activity identified.	March 2024	**December 2023 Update** Funding identified for a 3-year fixed-term post. Recuitment to be completed by March 2024.
					Identification of appropriate cases for wider problem-solving.	April 2024	**December 2023 Update** Subject to recruitment, the new system will be operational by April 2024. The Homicide Timeline and MARAC repeat referrals data will be used to inform cases for wider problem-solving.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	That all agencies provide evidence to Oldham Community Safety Partnership that accurate information (which includes the exact details of known risks), disclosures of domestic abuse, and details of known perpetrators are being shared between agencies where safeguarding concerns are known.	Local	Case audits through DHR Governance and Scrutiny Group will assess accuracy of information. Scoring matrix to be introduced - Outstanding - Meets Expectations - Requires Improvement - Inadequate	DHR Governance and Scrutiny Group and Domestic Abuse Partnership	Clear evidence of accurate information sharing between agencies. Improvements seen in day to day practice with all cases either assessed as 'Outstanding' or 'Meeting Expectations'	March 2024	**December 2023 Update** The DHR Governance and Scrutiny Group will meet bi-monthly from January 2024. The development of case audits to include exploration of the response to complex needs, is a Scrutiny Group agenda item for the meeting on the 11th January 2024. Information sharing as a thematic area of learning in multiple cases will also be on the agenda for the January meeting. The first case audits will take place at DHRGSG in March 2024.
			Review of Information Sharing Protocol. Move to a non-consent legal basis	Community Safety Services (MASH)	All partners signed up to new Protocol.	December 2023	**Completed December 2023** The review of the Multi-Agency Safeguarding Hub (MASH) Information

DHR Panel Recommendations							
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			for information sharing as reflection of public duties.				Sharing Protocol (non-consent legal basis) was completed.There is a further piece of work ongoing to expand on this.
			Explore information sharing pathways particularly from the health sector where there are no care and support needs identified. Ensure connectivity to the TRAM process and other support opportunities.	Health and Social Care Services	There are alternative options for partnership discussions and referrals for support for cases which do not meet the MARAC threshold and/or where there are no identified care and support needs.	May 2023	**Completed May 2023** There is a new DA engagement offer within the Early Help Service. Further opportunities for standard and medium risk cases continue to be explored.
			Review of risk management meetings and thresholds.	Domestic Abuse Partnership	Mapped meetings with clear terms of reference in place for each one	January 2024	**December 2023 Update** The work was informed by the SafeLives Review which was undertaken in the borough and the

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
					Information circulated to raise awareness of partnership meetings, purpose and thresholds.	January 2024	local/regional MARAC process review. The MARAC Steerinmg Group continues to explore areas for service (partnership) improvement. The Homicide Timeline will also be utilised to identify escalating levels of risk. The new multi-disciplinary response will provide a route for escalation. For further discussion/sign off at Domestic Abuse Partnership in January 2024.
					There is an effective challenge process which colleagues are confident in using where there is a difference of opinion thresholds are not deemed to be met.	January 2024	
			Clear and accessible information available for professionals. Consideration of Sharepoint Information Page.		Updated information circulated to raise awareness of partnership meetings, purpose and thresholds.	January 2024	**December 2023 Update** To be discussed at Domestic Abuse Partnership in January 2024

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
4	That the Domestic Abuse Partnership should scrutinise the application of the Domestic Violence Disclosure Scheme to understand the source of applications; and identify training opportunities to address any gaps in knowledge and application of the scheme – through targeted training and awareness raising.	Local	Data on numbers of Right to Know disclosures to be reviewed as standard agenda item at Domestic Abuse Partnership.	Domestic Abuse Partnership	Scheduled as regular agenda item.	January 2024	**December 2023 Update** New protocol to be discussed/agreed at Domestic Abuse Partnership in January 2024.
			Audit of Right to Know applications and outcomes.		Domestic Abuse Partnership sub-group established to undertake audits on quarterly basis. Increased numbers of applications and sharing of information with outcomes monitoring.	January 2024	**December 2023 Update** New protocol to be discussed/ageed at Domestic Abuse Partnership in January 2024.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Cascade information on Right to Know pathways across the partnership.		Updated information circulated. Explicit reference in DA training offer.	April 2023	**Completed April 2023** Included in Domestic Abuse Training.
5	That Greater Manchester Police provide evidence and assurances to Oldham Community Safety Partnership that perpetrators of domestic abuse are being proactively managed in terms of reducing the risks that they present, and in response to their offending behaviour.	Local	Greater Manchester Police to provide updates on disruption activity at each Domestic Abuse Partnership meeting. Information should include quantative and qualitative information.	Greater Manchester Police	Case studies provided to evidence disruption activity. Data provided on: - DVDS Right to Ask and Right to Know disclosures - DVPN/DVPOs applications and Orders made - Restraining Order applications and Orders made - Order applications - Stalking Protection Order applications and Orders made	May 2023	**Completed March 2023** The Spotlight Integrated Offender Management Team have training in place which includes the management of domestic abuse perpetrators. They have also set up a new domestic abuse arrangement's review team which are looking at MASH triage, DVPO and DVPN processes, structure, and training within MASH to manage domestic abuse more effectively. The proactive management of high-risk domestic abuse perpetrators is a riority along with this. They have analysed processes in

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
							Cheshire including the 10 key offenders of the area programme and are going to apply this to all districts. The Domestic Abuse Partnership will provide continual scrutiny of disruption activity.
			DA Scrutiny Group to be established to review unsuccessful applications for protective Orders	Domestic Abuse Partnership	DA Scrutiny Group meeting quarterly. Identified learning to improve application outcomes.	January 2024	**December 2023 Update** To be discussed at Domestic Abuse Partnership in January 2024.
6	That the Domestic Abuse Partnership reviews the strategic response to the management of perpetrators of domestic abuse. This should include the availability of	Local	Ensure this is included in the strategy as a key priority and is reflective of the actions in recommendation 5.	Domestic Abuse Partnership	MAPPA and Spotlight processes are explicitly referenced in the strategy.	December 2024	**December 2023 Update** This will be included as a priority when the new Strategy is developed in 2024; however, in the meantime intervention opportunities are explored through MAPPA and

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	intervention opportunities, including: • non-convicted perpetrator programmes • multi-agency approach to reduce offending • application of statutory processes such as MAPPA, or court mandated intervention.						Spotlight as a matter of course in relevant cases.
			Consider long-term objectives around the development of perpetrator programmes in the strategy, ensuring they are considerate of underly trauma/ACES and the trio of vulnerability and the impact of these upon presenting behaviours.		Perpetrators programmes are effective and unmet needs are identified and responded to. Mechanisms to secure engagement are used learning from existing practice e.g reflecting the impact of DA on children.	May 2023	**Completed May 2023** There is a bespoke commission in place with TLC – contract being extended until March 2025. Further opportunities for perpetrator programmes continue to be explored, including how these would be funded.
			Develop a pre-custody release engagement programme.	Greater Manchester Police / Early Help Service	Joint GMP/Early Help Service prison visits undertaken 3 to 6 months pre-release to identify opportunities for engagement.	March 2024	**December 2023 Update** To be discussed at the Domestic Abuse Partnership in January.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Ensure prison release information is shared with relevant housing provider pre-release.	Greater Manchester Police	Risk and intervention plan in place at point of release. Housing provider can use tenancy enforcement powers as lever to engagement with intervention services.		
			DA Scrutiny Group to explore impact of court mandated interventions and identify and correlators of success which can be built upon.	Domestic Abuse Partnership	Report provided to Domestic Abuse Partnership. Learning expanded upon and reflected in local non-statutory interventions. Areas for improvement or challenge from court mandated interventions escalated through criminal justice system.		
7	That the Domestic Abuse Partnership undertakes a multi-agency audit regarding DASH completion; and uses the findings of this audit to target training	Local with potential for National	DA Scrutiny Group to undertake audit and include response to DASH and referrals to MARAC. Audit will consider:	Domestic Abuse Partnership	Scrutiny Group will provide report on findings to Domestic Abuse Partnership.	January 2024	**December 2023 Update** The use and value of the DASH in practice must be considered fully. It has been recognised previously that DASH, as a victim-based tool, does not allow for risk

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	and awareness raising to address any identified gaps in DASH completion.		- impact on scoring matrix for older victims or those without children - number of cases where threshold reached on professional judgment rather than scoring - academic research - information from the College of Policing Domestic Abuse Risk Assessment (DARA) in relation to controlling and coercive behaviour.				scoring of offender behaviours and the scoring matrix can negatively impact some victims based upon their personal circumstance. Whilst the DASH may be the recognised model of best practice, its fitness for purpose remains under consideration. Any necessary changes, or the roll out of an entirely new model to improve the outcomes in DA cases must be actioned.

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		Local	Consideration of central repository of information to highlight repeat cases which have not met MARAC threshold.	Domestic Abuse Partnership	Partner organisations will have a mechanism to record cases (limited detail) which is accessible to other services, so enabling identification of repeat victims as early as possible.	January 2024	**December 2023 Update** This is a significant piece of work which may require an IT solution. Resources to implement and manage the system would need to be identified. Requires further consideration regarding feasibility. To be discussed at Doemstic Abuse Partnership in January 2024.
8	That Oldham Community Safety aPartnership ensures that the learning from this review is shared with Oldham Safeguarding Adults Board.	Local	The Safeguarding Adults Board Manager, as a member of the DHR Panel will share the learning with the Board.	SAB Board Manager	All Safeguarding Adults Board Managers are sighted on the findings and recommendations and are able to monitor the implementation of any learning in conjunction with the Community Safety Partnership.	September 2022	**Completed September 2022** The learning has been shared through the Safeguarding Adults Board. The Board Manager was a member of the DHR Panel and has been fully sighted on learning and recommendations throughout the process.

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9	That Oldham Community Safety Partnership ensures that information is available for professionals, which details how information can be legally shared, and consent overridden in cases where adults are deemed to have capacity but have been identified as being at risk of significant harm.	Local	Review of Information Sharing Protocol. Move to a non-consent legal basis for information sharing as reflection of public duties.	Community Safety Services (MASH)	All partners signed up to new Protocol.	June 2023	**Completed Summer 2023** The review of the Multi-Agency Safeguarding Hub (MASH) Information Sharing Protocol (non-consent legal basis) was completed.There is a further piece of work ongoing to expand on this.
			Training is provided to ensure practitioners always act in the best interest of a vulnerable adult and are aware of factors which can impact upon decision making: - executive functioning - fluctuating capacity - coercive and controlling behaviour	Safeguarding Adults Board and Safeguarding Children's Partnership	Explicit training offer available within annual partnership training calendar.	May 2023	**Completed May 2023** Executive functioning guidance is in place in the Safeguarding Adults Board training. Fluctuating capacity covered in. Mental Capacity Act Training which is in the Safeguarding Adults Board training Coercion, control and gaslighting covered in the

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			- gaslighting				Safeguarding Children's Partnership training.
10	That Oldham Community Safety Partnership ensures that information is available to members of the community who are supporting individuals who are affected by mental health, and substance / alcohol use.	Local	Review what information is already available and how it is shared/accessed.	Turning Point	Information is available online and in public buildings GPs, libraries etc. Residents can easily access the information and seek support and advice when needed.	December 2022	**Completed December 2022** Turning Point offers advice and support groups for family members affected by drug and alcohol misuse whether there loved one is in treatment or not. People can self-refer or be referred in to Turning Point. Details available online at: https://www.turning-point.co.uk/services/drug-and-alcohol-support/family-and-friends-referral There is also a national charity ADFAM that offer resources and support to families and carers. Details are available online:

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							https://adfam.org.uk/ Turning point are looking to recruit a family worker. This is subject to commissioning with completion expected April 2023.
11	That all agencies involved in this review provide evidence to Oldham Community Safety Partnership that they have in a place managerial oversight which provides evidence that professionals working within their Organisation are following safeguarding processes when disclosures have been made.	Local	Review of single agency action plans and continued audit through DHR Governance and Scrutiny Group. Scoring matrix to be introduced - Outstanding - Meets Expectations - Requires Improvement - Inadequate	DHR Governance and Scrutiny Group and Domestic Abuse Partnership	Clear evidence of management oversight seen in practice. Improvements seen in day to day practice with all cases either assessed as 'Outstanding' or 'Meeting Expectations'	January 2024	**December 2023 Update** The DHR Governance and Scrutiny Group will meet bi-monthly from January 2024. The development of case audits to include exploration of management oversight as a measure, is a Scrutiny Group agenda item for the meeting on the 11th January 2024. The first case audits will take place at DHRGSG in March 2024.

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12	That the Domestic Abuse Partnership ensures that there is a referral pathway in place which allows for repeated cases that have been heard at MARAC, to be referred to a multi-disciplinary risk management process that will review and work in partnership to respond to identified risks.	Local	Introduction of new multi-disciplinary response to repeat high risk high harm cases. Application of SARA (Scan, Analysis, Response and Assessment) to identify core issues in situation that response can be built around.	Domestic Abuse Partnership	Funding and resource to coordinate activity identified.	March 2023	**December 2023 Update** Funding identified for a 3-year fixed-term post. Recuitment to be completed by March 2024.
					Identification of appropriate cases for wider problem-solving.	April 2024	**December 2023 Update** Subject to recruitment, the new system will be operational by April 2024. The Homicide Timeline and MARAC repeat referrals data will be used to inform cases for wider problem-solving.