OLDHAM COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Under section 9 of the Domestic Violence, Crime and Victims Act 2004

Into the death of Jenny

OVERVIEW REPORT

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Preface

The Domestic Homicide Review Panel and the members of the Oldham Community Safety Partnership would like to offer their sincere condolences to the family and friends of Jenny, for whom this Review has been undertaken. Jenny is remembered with love and great affection by her children, her family, and her close friends.

In addition to agency involvement the Review will examine the past to identify any relevant background or trail of abuse before Jenny's death; whether support was accessed within the community and whether there were barriers to accessing any support. By taking a holistic approach the Review seeks to identify appropriate solutions to address the lessons learned.

This Review examines the agency responses received about Jenny, a resident of Greater Manchester, prior to early 2022. The Review Panel agreed two scoping periods: 1st of January 2014 to 31st of October 2017, and from 26th of July 2021 to February 2022. These periods have been agreed to enable identification of relevant background information or any trail of abuse, prior to Jenny's death. The time periods were selected because Jenny had been a known victim of domestic abuse from at least 2014 up until [redacted] 2017 and after [redacted] 2021.

The key purpose for undertaking the DHR is to enable lessons to be learned, where in this case a young woman was subject to serious domestic abuse, which escalated two days before she tragically died. In order for lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, where opportunities were missed and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Statutory Guidance Section 2(7) states the purpose of the Review is to:

'Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result. Apply these lessons to service responses including changes to policies and procedures as appropriate; and prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working. Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

Albeit Jenny's death did not meet the criteria for a DHR according to Statutory Guidance, under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004, she experienced serious abuse in the days leading to her death and the Oldham Community Safety Partnership felt that there were important lessons to learn. Her case was considered at a Safeguarding Adult Review Panel and screening took place on the 29th of March 2022. The decision of the SAR Panel was that a SAR should not be undertaken. The group agreed that the learning themes discussed as part of the screening should be taken to the DHR panel for consideration as part of the drafting of Terms of Reference. This was also agreed by the Community Safety Partnership.

The Review is not an inquiry into how Jenny died or who is culpable; that is a matter for HM Coroner and the criminal Court. The Act states that there should be a "*review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-*

(a) a person to whom she/he was related or with whom she/he was, or had been in an intimate personal relationship, or
(b) a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:
"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional".

And that:

Controlling behaviour is *a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is 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"* [1]

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1.Introduction

1.1 Jenny, a mother, and daughter was aged 35 at the point of her death. [redacted]

[redacted]

1.3 A male, herein known as Ian, was known to GMP from 2007, with 13 convictions for assault, public order, drugs, theft, criminal damage and driving offences, resulting in several custodial sentences. [redacted]
GMP were aware that Ian presented high risk in relation to domestic abuse.

1.4 Ian had possibly met Jenny in August 2021, [redacted] following a call from a private address, an ambulance attended and found Jenny unresponsive. She was found with numerous bruises to her head and her body and pronounced dead at Fairfield Hospital. Her sudden death was reported to GMP. Ian was sentenced on the 18th of August, 2022, to 4 years imprisonment, with an extended licence period of two years, for offences of False Imprisonment and Assault Occasioning Actual Bodily Harm against Jenny.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised December 2016) Section 2(5)(1)

[redacted]

Timeframe

1.5 The Review process began on 21st of February 2022 and a first panel meeting took place on 12th of July 2022. The review was concluded in January 2025, which includes the period for the completion of this Overview Report, and Home Office Quality Assurance period. Following appointment of the DHR Chair in July 2022, agencies who confirmed involvement were asked to provide a chronology of contacts. Some individual agency chronologies held inaccuracies with regards to dates of events and some IMRs required supplementary information. The commencement of the DHR was delayed, as was the completion of a final, combined chronology, subsequently finalised by organisations in January 2023. An IMR with new information was presented from GMP, in July 2023 with the outcomes of the IOPC investigation.

Confidentiality

1.6 The findings of each Review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication, however, where early learning has been identified, this should be responded to immediately. To protect the identity of the victim, perpetrator, and their family and friends, the following pseudonyms have been used throughout this report, which are Jenny and Ian.

Age and ethnicity

1.7 The victim: Jenny was aged 35 years at the time of her death. [redacted]: Ian was aged 33 years at the time of the offence. Jenny was of mixed European ethnicity and Ian was of white British ethnicity.

Terms of Reference

1.8 The Terms of Reference for this Review are:

a) How did your service/organisation assess the impact of previous events; domestic abuse; accommodation needs; health issues and substance misuse relating to the victim, between January 2014 and 2017, [redacted] in 2021?

b) How and why did your service/organisation assess the impact of Jenny's ongoing family relationships and how may the outcomes of this, have contributed towards her vulnerability and the choices she made?

c) In your service/organisation's contact with the victim and/or perpetrator, did your response meet their needs, in relation to support and interventions, giving due recognition to: i) Jenny's particular vulnerabilities associated with her previous history; domestic abuse; mental health; substance abuse; accommodation needs; engagement, post release adjustment, risk assessment and risk management; ii) Jenny's voice and what she was seeking/asking for, from services; and iii) the particular risks in regard to the perpetrator's history and risk management?

d) Did your service/organisation give consideration under the Care Act 2014 to determine if Jenny should be assessed as to whether she was an 'adult at risk'. If so, what was the outcome and the rationale for the decision making? If not, were the circumstances such, that consideration should have been given to such an assessment?

e) Was communication and information sharing between your service/organisation, individuals, and other agencies timely and effective enough to inform the safety and needs of the victim and any support needs of the perpetrator?

f) Were there any resource issues, policy, procedure, systems working, that affected service response, or the way in which personnel managed their roles?

Methodology

1.9 The Chair of the Oldham Community Safety Partnership was informed of the fatal incident by the GMP on the 16th February 2022 and the decision was taken to conduct the review following a screening exercise. The initial notification of the death was sent to the [redacted] Community Safety Partnership, which is where the death occurred; however, it was agreed that the Review should be conducted in Oldham due to this being Jenny's main place of residence. Consideration was given as to the best way forward managed, in order to maximise learning. A shared methodology i.e., a Safeguarding Adult Review /Domestic Homicide Review, was considered and it was agreed that a Domestic Homicide Review was the most appropriate way forward. The Home Office was notified of the decision on the 8th April 2022. A total of 19 local agencies were contacted. One agency reported no information on file having had minor contact with Jenny and 18 agencies confirmed contact and were asked to secure their files.

1.10 At the first Panel on the 12th of July 2022 the review draft terms of reference were discussed and agreed. Four Panel meetings were held during the review period, two of which were held face to face. This Overview Report was signed off by the Panel on 9th January 2024, with subsequent amendments made following feedback from the Home Office DHR Quality Assurance Panel.

1.11 Various and relevant research to inform this review has been accessed, which is cited throughout by footnotes, with references set out in the bibliography and for ease key learning points throughout the chronology, have been identified. These are further explored in the sections marked Conclusions and Lessons Learned.

Involvement of Family

1.12 Jenny's Mother was invited and participated in the Review, and Jenny's two sisters were invited but declined. Jenny's Mother did not express a preference with regard to the choice of name for the Review. The Panel agreed that a copy of the draft report would be shared with Jenny's mother and her partner, however they explained that they did not wish to read it. [redacted] however the paternal grandmother [redacted] participate. The draft report was also shared with [redacted] paternal grandmother, (who read it) and the foster carer of [redacted] (who also read it). The draft report was offered to be shared with [redacted] did not wish to read it but wanted a verbal synopsis, which was provided by Deborah Stuart-Angus, with appropriate support provided to the two children. [redacted] Terms of Reference were also offered to be shared.

1.13 It is important to Jenny's Mother, that her that her views are reflected, which are: that her daughter (one of 4 children), did not have a problem with substance use, but with alcohol use. Jenny was outgoing and had a very big heart. Her Mother advised that her daughter '*enjoyed a drink'* from the age of 14. Jenny had lived with her mother on several occasions as a young woman, and [redacted] occasionally stayed at their Grandmother's home. [redacted] Jenny's Mother is of the profound view that services '*never helped'* her daughter, [redacted] She was aware of her daughter's disengagement with services.

1.14 Jenny's Mother feels that [redacted] was not listened to by services and Jenny's mother remains distressed with regard to the events that occurred on the weekend in question, and it is important to her to be represented accurately. It is her view that when she made efforts to locate her daughter, by phone and got through to Ian's phone, that Ian had '*been battering her all weekend*.' When Ian answered one of the calls from Jenny's mother his response was "*game over*", and then he called Jenny's Mother back to tell her that her daughter was dead.

1.15 [redacted] fully participated in the Review, despite their immense grief and distress. Two meetings took place to enable their involvement, held at their pace. This was exceedingly difficult for both. [redacted], owing to personal distress and grief, and wanted his paternal

Grandmother to represent his views, which are set out below. [redacted] had good contact with their Mother, prior to her imprisonment and visited her, occasionally in prison. Jenny always maintained family contact time with [redacted] and their mutual love and commitment was evident. [redacted] describe their Mum as a beautiful woman, with a huge personality; full of fun and love, and *'once you had met her you would never forget her'*.

1.16 It is important to [redacted] include herein that when they collected their Mum on her release day in 2021, they were very happy to see her and made a video of them hugging, singing, and laughing together. It is the view of [redacted] that their Mum *'did not get the help she needed'*, when released but both agreed that Mum gained insight from therapeutic intervention in the prison, saying: *'she should have received that when she was out."* It is evident that Jenny loved her children, and they loved her, unconditionally, and albeit Jenny wanted very much to be a good parent, the previous traumas she had suffered, and her difficulties with mental ill health, drugs, and alcohol, impacted upon her ability to prioritise her children's needs.

1.17 From paternal Grandmother's perspective, Jenny *'put up with abusive relationships because she wanted love'* and was a person who could show two different sides to her personality. It is her view that Jenny should never have been moved from the Approved Premises back to her Mother's home, and once this had happened, intensive support should have been provided.

1.18 Leaflets from the Home Office explaining DHRs, and information on Advocacy After Domestic Abuse explaining the support available from this specialist service, were provided by the Community Safety Partnership, to support the family throughout the DHR review process.

1.19 The perpetrator has subsequently been convicted of an Extended Determinate Sentence of 4 years imprisonment with an extended licence period of 2 years for an offence of Section 18 Wounding with intent and remains in Prison. The DHR Panel did not consider that his contribution to this Review was appropriate, given that the focus that needed to be on Jenny.

Contributors to the Review - Organisations involved

1.20 The following table demonstrates the contributing agencies and the nature of their contributions.

1	Greater Manchester Police (GMP)	Chronology, IMR 1 and IMR 2 (re-submitted 23/7/23)
2	Independent Domestic Violence Advocacy (IDVA)	Chronology, IMR
3	Oldham Children's Social Care (OCSC)	Chronology, IMR
4	Oldham Housing Options	Chronology, IMR
5	Probation Service (including 3 Prisons)	Chronology, IMR
6	Turning Point (Oldham & Rochdale Addiction Services)	Chronology, IMR, Risk Assessment Documents
7	Pennine Care Foundation Trust (PCFT)	Chronology, IMR, Patient Disengagement Policy
8	Northern Care Alliance NHS Group	Chronology, IMR
9	Greater Manchester NHS Integrated Care (Oldham)	Chronology, IMR
10	Greater Manchester NHS Integrated Care (Bury)	Chronology, IMR
11	Victim Support	Chronology, MR
12	Bury Children's and Young Person's Department	Chronology, IMR
13	NHS Lancashire & South Cumbria Trust Integrated Team	Chronology, IMR
14	NHS Lancashire & South Cumbria Integrated Care Board	Chronology, IMR
15	Approved Premises	Chronology, IMR
16	North West Ambulance Service (NWAS)	Short report
17	Oldham Adult Social Care (OASC)	Short report
18	Manchester University NHS Foundation Trust	Chronology, IMR
19	Achieve (GMMH)	Short Report

1.21 The authors of the Independent Management Reviews (IMRs) were independent of contact with the parties to this DHR and all were independent of the line management of frontline practitioners.

1.22 IMRs were sent to the Community Safety Partnership throughout 2022 and 2023.

Review Panel Members

1.23 The following were members of the Review Panel undertaking this review:

Deborah Stuart-Angus	Independent Chair/Author
Lorraine Kenny/Nigel Hudson	Oldham Council - Community Safety Services
Alison Troisi	Greater Manchester Police - Serious Case Review Team
Lisa Morris, later Sharon Moore	Oldham Safeguarding Children's Partnership
Julie Farley	Oldham Safeguarding Adult's Board
Amy Poulson	HM Prison and Probation Service
Tanya Farrugia	Oldham Council - Family Connect Service (IDVA and Early Help)
Hayley Eccles	Oldham Council - Adult Social Care
Sharon Moore	Oldham Council - Children's Social Care
Fiona Carr	Oldham Council - Housing Services
Angela Moreland	Pennine Care NHS Foundation Trust
Greg Dimelow	Pennine Care NHS Foundation Trust
Julie Wan-Sai-Cheong	Northern Care Alliance
Kristy Atkinson	Greater Manchester Integrated Care (Oldham)
Chelsea Whittaker	Turning Point
Tahira Zulfikar	Bury Council- Domestic Violence and Abuse Coordinator
Janine Campbell	Greater Manchester Integrated Care (Bury)
Cherry Collison, later Amanda Godfrey	NHS Lancashire and South Cumbria Foundation Trust
Rachel Holyhead	NHS Lancashire and South Cumbria Integrated Care Board
Chris Davies	Bury Children's Social and Young Peoples' Department
Amanda Mullen	Bury Housing Services
Beverley Johnson	Bury Adult Social Care
Catherine Entwistle	Approved Premises – North West Division
Luke Godfrey	Victim Support

The Panel members were independent of the case and had no contact with the parties involved.

The Independent Chair of the DHR and Author of the Overview Report

1.24 Deborah Stuart-Angus is Chair and Author of this Review. She is an experienced Safeguarding Adult Review Chair and Author and the Independent Safeguarding Adult Board Chair for both the Essex Safeguarding Partnership and Southampton City Partnership. Latterly, Deborah was Chair of Kent & Medway Adult Safeguarding Board for 5 years, working closely with Kent prisons, having focused on partnership safeguarding strategies and dovetailing regional strategy with Domestic Abuse Boards; Community Safety and the Health & Well Being Boards.

1.25 She is Chair of the Eastern Region for the Safeguarding Adult Chair's National Executive and an Independent Safeguarding Consultant. She holds a Certificate of Qualification in Social Work, and a post graduate Diploma in Applied Social Studies, where she studied acute mental illness, and its impact on families and children. She holds a Bachelor of Science Honours Degree, focused on social policy, psychology, statistical analyses, and criminology, and a post graduate Post-16 Certificate in Education, focused on quality management; curricula design; adult learning and associated pedagogy.

1.26 Deborah gained extensive experience of working to prevent domestic abuse in practice; as a national advisor and a Senior Consultant to Women's Aid, during a Home Office and (former) Office of the Deputy Prime Minister national two-year project, aiming to increase capacity and set performance standards in the voluntary sector. She led the joint Steering Group for the same, with Women's Aid; Broken Rainbow and Refuge to name some, working beside the Cardiff Women's Safety Unit, and previously, as part of Surrey's domestic abuse and safeguarding county training team. In the

past she has held positions as Head of Strategic Safeguarding for several local authorities; a regional acute mental health manager and led the CSE Enquiry for Peterborough Adult Social Care, in relation to 28 young victims, at Adult Social Care.

1.27 She was the Director of Surrey's Local Authority Trading Company, providing services for people with autism; dementia; ABI; and learning disability. As a CEO, she founded two learning companies specialising in training services on domestic abuse, safeguarding, mental health and mental capacity, for 9 years. She led the adult safeguarding training programme at Haringey, post the Baby Peter case for 4 years, as one of over 50 authorities where she provided training and learning events on safeguarding. Deborah has published two educational text books on safeguarding, preventing abuse and the principles and responsibilities of care practice.

1.28 Deborah Stuart-Angus meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of the experience required for the role, and her learning and training which she regularly updates. She is independent of any agencies in Oldham.

Parallel Processes

1.29 A Death Under Supervision Review[3] has taken place and a Coroner's Inquest was held on September 6th, 2023, with the cause of death determined to be drug toxicity. In line with policy, the Probation practitioners line manager completed a death under supervision (DUS) review, providing relevant information as to Jenny's circumstances at the time of their death and in the 12 months prior. This included information on relevant background and management, identified needs, sentence and licence conditions. The report identified learning from the review to inform practice changes and support prevention of future deaths. A recommendation of this report was to offer additional co work support with complex cases to allow for a higher level of oversight. The report additionally identified examples of best practice. The review identified a high level of information sharing and action in response to a decline in engagement. The DUS report was submitted to the regional DUS team for regional co-ordination and oversight. All necessary paperwork was submitted to the Coroner as in line with standard practice. The Independent Office of GMP Conduct held an investigation into GMP actions in February 2022, which has now concluded.

Equality and Diversity

1.30 In relation to the Equality Act 2010, a duty is placed on local authorities to eliminate unlawful discrimination, harassment, and victimisation; to advance equality of opportunity between people who share a protected characteristic and for those who do not share it and to develop good relations between people who share a protected characteristic, and for those who do not share it. The protected characteristics covered by the Equality Duty under s4 of the Act are age; disability; gender reassignment; marriage and civil partnership (but only in respect of eliminating unlawful discrimination); pregnancy and maternity; race (which includes ethnic or national origins, colour or nationality, religion or belief which includes lack of belief, gender/sex, and sexual orientation). Mental ill health, gender and ethnic origin is relevant for consideration in this review.

1.31 One of the protected characteristics considered to have relevance to this DHR was the disability that Jenny experienced. The Equality Act states that disability is about having a physical or mental impairment that has a substantial, adverse, and long-term effect on the ability to carry out normal day-to-day activities, focus being on the effect of the mental health problem, rather than the

[3] A Death Under Supervision Notification is submitted for all deaths which occur whilst a person is subject to probation supervision. Within 2 days of the death the notification includes an initial review, identifying any concerns or risks linked to the person's death. Immediate actions are taken to safeguard others if necessary. Should it be that there are vulnerability or risk factors linked to the death of the individual, that required mitigation, a full review would then be undertaken, unless it is believed all reasonable steps were taken to actively address these. The death under supervision process requires the practitioner to note the category of death, circumstances, background, and relevant factors linked to the person on probation's sentence management. Considerations are given to pre-release planning and contact with other services to address identified need. Accommodation, substance use, domestic abuse history, ACCT info, drug testing and enforcement action will all be considered if relevant to the circumstances of the death within the full review. A determination as to whether there is learning from the death is given, what the perceived mitigations should have been, with actions set to address. The death under supervision report is provided within the Interested Party information submitted for review to the Coroner.

diagnosis. Jenny's anxiety, depression and the experience of an Emotionally Unstable Personality Disorder had a significant effect on her daily life, vulnerability and decision making. This had lasted longer than a year and she was unlikely to have made a full recovery, with 'substantial' and 'long term' negative impact on her vulnerability, and consequent decision making in relation to risk.

1.32 Exploration of the apparent links between domestic abuse, deterioration of her mental health; increasing substance and alcohol use and harm and transient living will be examined in how Jenny was safeguarded, given that she had left prison; had been released on parole and was in the process of being recalled.

1.33 In relation to 'marital status', Jenny was single and beyond this the review this did not identify any learning of significance.

1.34 Jenny's ethnicity as a British Mixed-Race Female did not appear to be a factor in services she received, but what was of note was that different services described Jenny's mixed-race origin in different ways, some referring to her as: '*of mixed Asian race'*, whilst others referred to her as 'of *mixed European race.'*

1.35 80% of victims of Domestic Abuse are women, as confirmed by the recent Home Office Analysis.[4] 73% were abused by a partner or ex-partner; 27% had more than one vulnerability, such as mental ill health, substance and or alcohol abuse and of the 34% with mental ill health, 26% had depression, 16% had suicidal thoughts,14% had attempted suicide and 14% had low mood or anxiety.

1.36 In relation to perpetrators 71% had a vulnerability, most common being: illicit drug use, mental ill-health, and problematic alcohol use, 31% were affected by mental health issues, with 23% experiencing depression and 21% had suicidal thoughts. Approximately 60% had previous offending history; 75% had previously abused previous partners and 33% had abused family members (this includes a small number who had abused both).

Dissemination

1.37 In addition to family members, the following will receive a copy of this Review: all agencies. contributing and represented on the DHR Panel, partner agencies of Oldham Community Safety Partnership and parallel Boards in accordance with local arrangements, including the Domestic Abuse Partnership, Oldham Adults Safeguarding Board, Oldham Safeguarding Children's Partnership, Oldham Health & Well Being Board and The Mayor of Greater Manchester.

[redacted]

1.29 [4] Analysis of Domestic Homicide, Home 2022

[5] The CRC was contracted separately by the Ministry of Justice to provide Probation Supervision for low and medium risk of serious harm offenders.

[redacted]

1.44 In February 2022, staff at Fairfield Hospital contacted GMP to report a sudden death within suspicious circumstances. Jenny had been pronounced dead by Hospital Doctors 1 and 2, after being admitted with extensive bruising to her head and her body. The Ambulance Service had collected Jenny from an address in Manchester, during the afternoon, where three males were present and there was evidence of drug use. GMP attended and arrested Ian and two other males.

1.45 This was linked to a reported GMP incident the previous day, where Jenny's Mother had contacted GMP reporting that Ian had been *'battering'* her daughter '*all weekend'* and was now holding her at an address against her will.

1.46 A Forensic Pathologist completed a Home Office Post-Mortem the following day, where initial findings disclosed that Jenny's cause of death required further investigation. There was very strong evidence of assault, possibly within last few days. Further tests were undertaken and identified that Jenny also had a number of illicit and prescription substances in her body at the time of her death.

[redacted]

[redacted] Multi-Agency Risk Assessment Conference held October 10th, 2014 - actions were to make checks on Partner 2's (Jenny) Alcohol Treatment Order; agency involvement with Jenny to try and gain her consent for IDVA involvement. Property had been offered but she did not attend meeting or viewing.

[7] A health service to support people who have had psychotic episodes or similar experiences.

[redacted]

[redacted]

1.52 Tables of Relationships to Jenny and Ian

Name as called herein	Relationship to Jenny
Child 1	Her first-born child
Child 2	Her second born child
Child 3	Her third born child
Mother	Jenny's Mother
Parental Grandmother	Parental Grandmother of Child 3
Partner 1 (Jenny)	Ex-Boyfriend and father of Child 3
Partner 2 (Jenny)	Ex-Boyfriend
Partner 3 (Jenny)	Ex-Boyfriend
Partner 4 (Jenny) & Friend to Ian	Ex-Boyfriend and future cohabitee to Ian
Ian	Boyfriend
Victim 1	Victim
Victim 2	Victim

Name as called herein	Relationship to Ian
Partner 1 (Ian)	Ex-Girlfriend
Partner 2 (Ian)	Ex-Girlfriend
Partner 3 (Ian)	Ex-Girlfriend
Partner 4 (Ian)	Ex-Girlfriend
Partner 5 (Ian)	Ex-Girlfriend
Partner 6 (Ian)	Ex-Girlfriend
Partner 7 (Ian)	Ex-Girlfriend
Partner 8 (Ian)	Ex-Girlfriend
Partner 9 (Ian)	Ex-Girlfriend
Partner 10 (Ian)	Ex-Girlfriend

[8] The Thinking Skills Programme, managed by Probation services, aims to enable offenders to reduce their offending behaviours by using cognitive skills

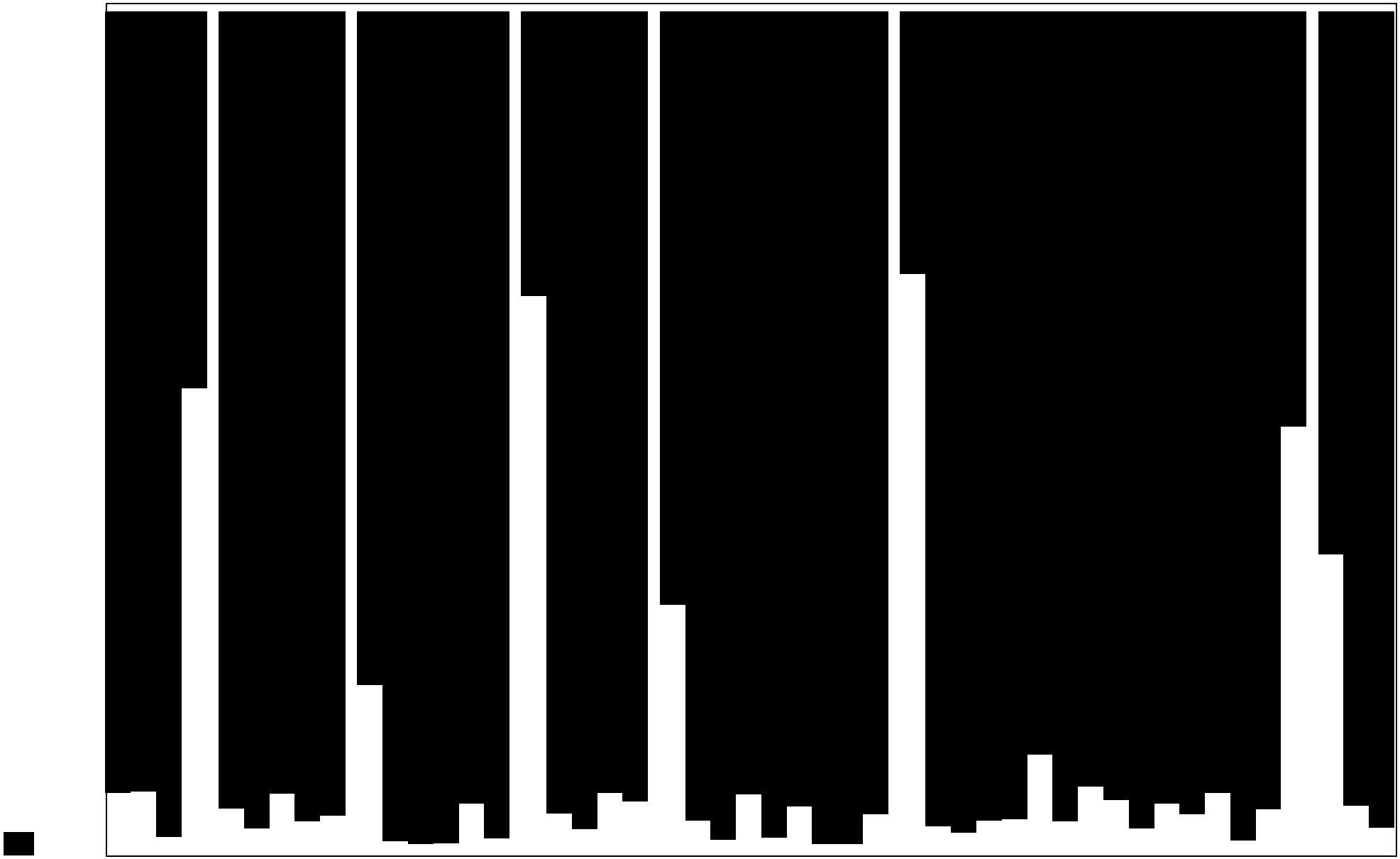
Partner 11 (Ian)	Ex-Girlfriend
Partner 12 (Ian)	Ex-Girlfriend
Friend 2 (Ian)	Friend

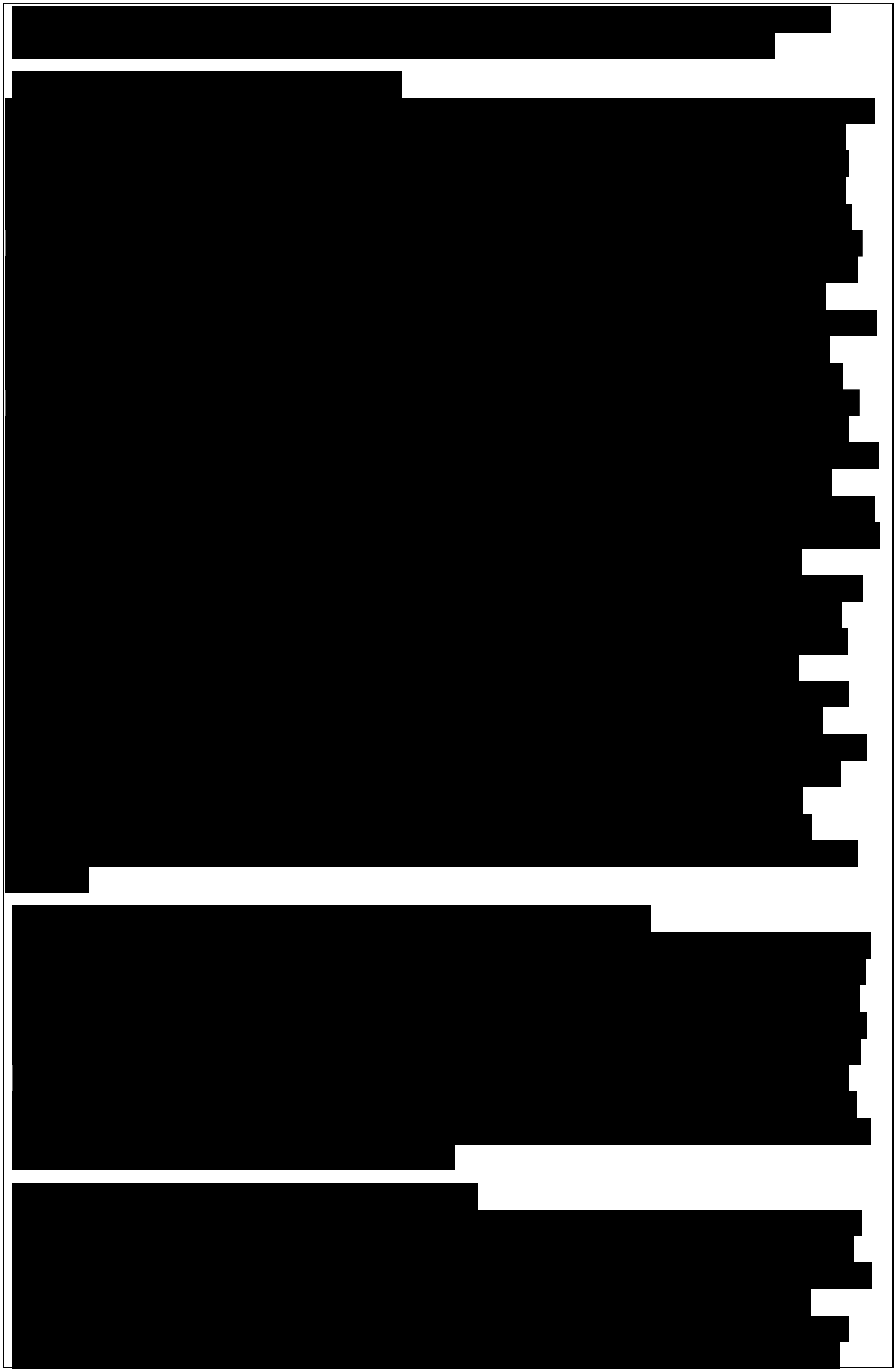
[redacted]

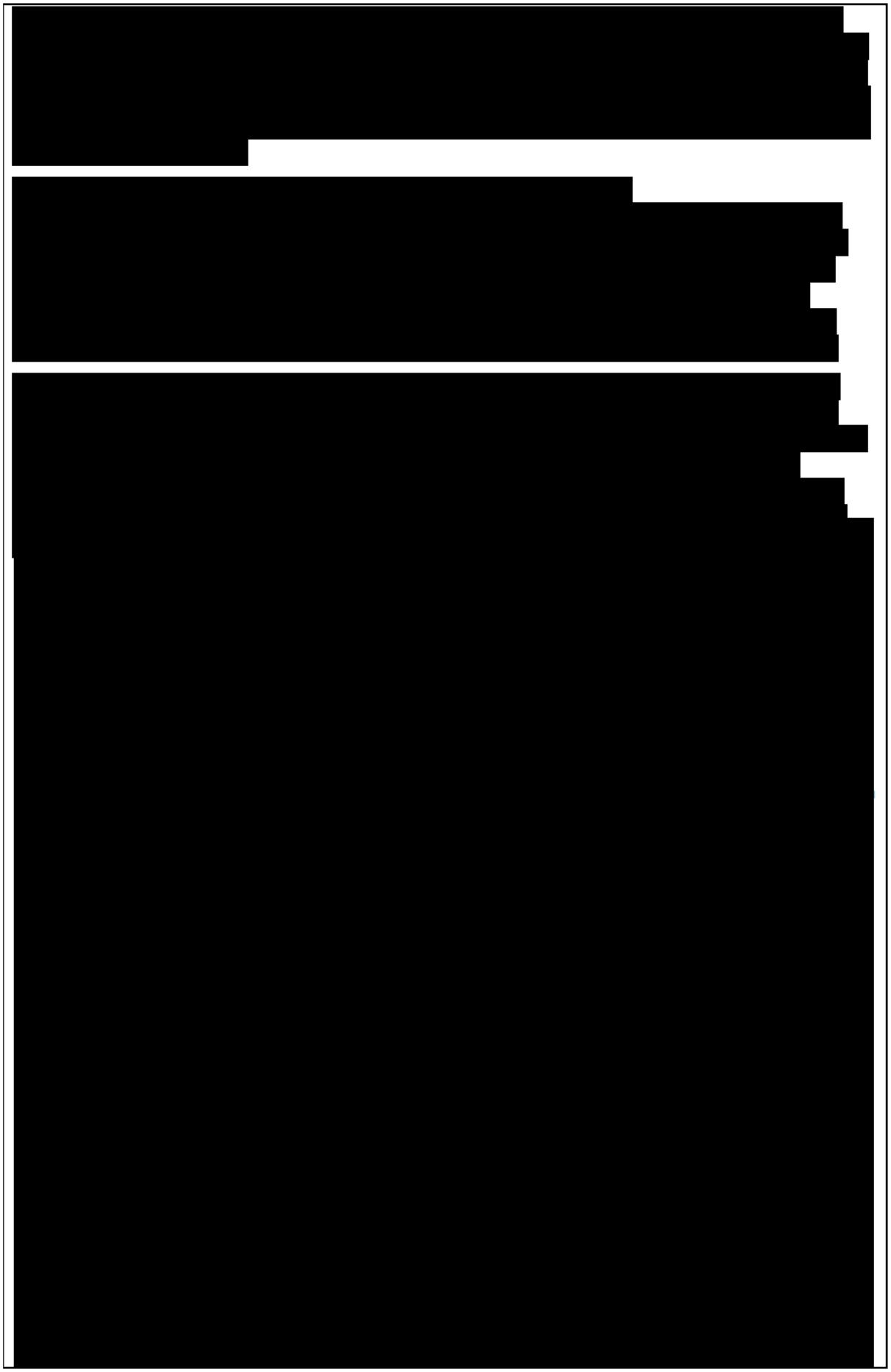
[9] The Offender Assessment System (OASys) (main assessment tool used by Probation) analytically documents factors linked to offending and the risk of serious harm; risk assessment; the risk management plan and the sentence plan.
[10] The dynamic RoSH assessment provides a forensic assessment of criminogenic and lifestyle factors and considers imminency and the level of harm a person may cause.

[11] Criminal Mental Health Justice Team, offer advice, assessment and risk assessment and provide some short-term interventions for those with mental health problems, if that person has committed an offence, or shows signs of offending behaviour. They also provide a service for vulnerable adults who are referred by Greater Manchester Police, which could include access to appropriate services and diversion away from the criminal justice services.

[12] MHLS are based in local hospital ED departments to assess people over 16, who are either inpatients, in Intermediate Care, or who have presented in to ED experiencing problems with their mental health). The team of mental health practitioners and psychiatrists in the MHLS cover the hospital 24 hours-a-day, seven days-a-week.



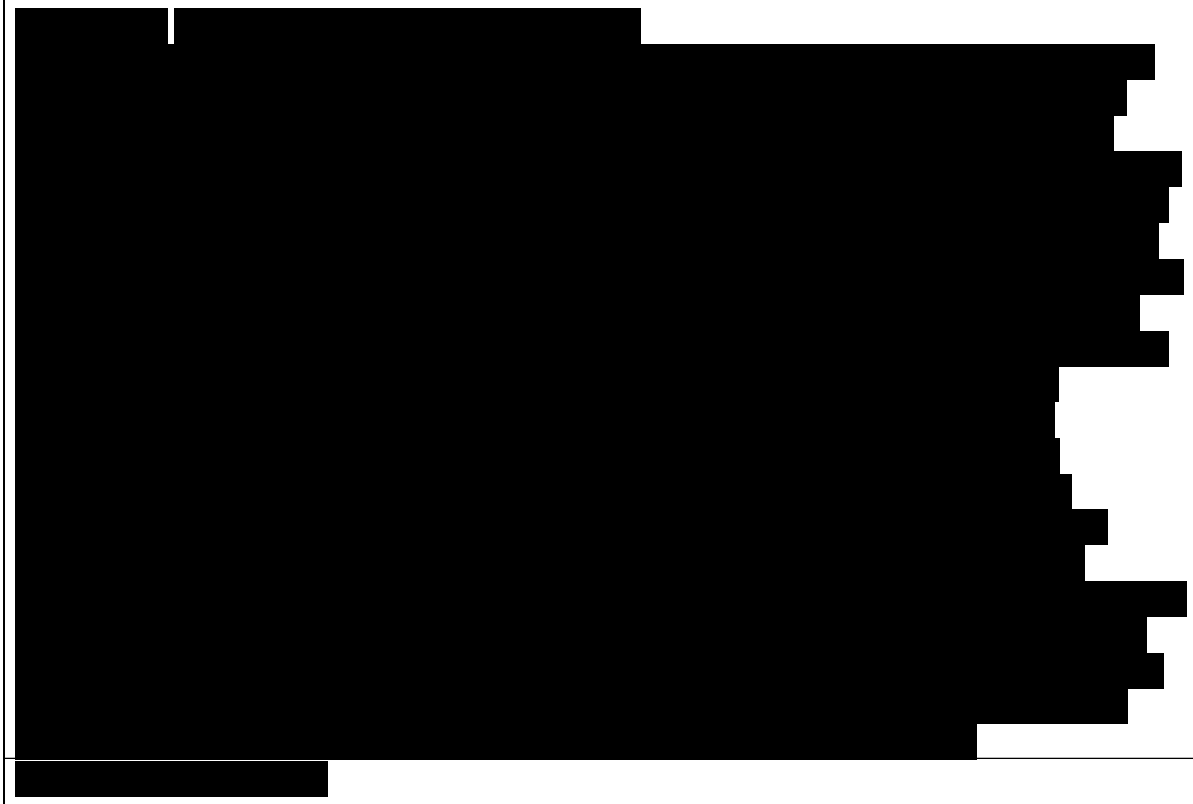




[13] Quetiapine is an atypical antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder.

On 2022 at 15:49 NWAS Paramedic Emergency Service was contacted by 999 call made by a male who was with Jenny, reporting that she was "*on floor, and not breathing*". Control Log notes state the occupants of the address sound intoxicated and there was concern about drug use. Three agitated males were at the scene and gave inconsistent and unreliable accounts in relation to what Jenny

may have consumed, and what they also may have consumed. Advanced life support was undertaken, and Jenny was then transported to hospital utilising blue lights and sirens, and the hospital was pre-alerted. On arrival at hospital Jenny's medical care was handed over to hospital staff, along with the confused and unsure history of a cardiac arrest. NWAS had face to face contact with Jenny only on the event of the cardiac arrest. At this time the sequence of events leading to cardiac arrest were unknown, and crew appropriately questioned the males, and it was recorded that the information provided could not be relied on as fact. On time critical incidents such as this, the focus of NWAS staff is always on the complexities of advanced life support.



[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Learning Points
Impact on client motivation by administrative errors
Value of medication reviews following patient medication requests

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point
Making connections with overdoses and possible domestic abuse

[redacted]

[redacted]

Learning Points

Where a service user is assessed using the DASH RIC tool with an outcome of "visible high risk" or based on professional judgement, or where 3 incidents of Domestic abuse from a perpetrator in 12 months have occurred, agencies can refer into the MARAC.

[redacted]

Learning Point
Prescribed medications and addictions

[redacted]

Learning Point
Prescribed medications and overdose

[redacted]

Learning Point
Safeguarding Adults Referrals and Care Act responsibilities

[14] Healthy Minds is a Pennine Healthcare Trust Mental Health Service

[redacted]

[redacted]

Learning Points

The value of DVDS disclosures

The importance of accurate risk assessment

[redacted]

[redacted]

Learning Points

[15] the written document outlining the disclosure was stored centrally and is no longer available. Current GMP policy on DVDS requires the disclosure document is uploaded onto the police IT system and attached to the associated DAB documents.

[16] Greater Manchester Police note that this is a continuous problem in cases of domestic abuse, and they have recently created a guidance check list for officers to use when considering Evidence Led Prosecutions (previously referred to as victimless prosecutions) which gives officers a better understanding of what evidence they need to gather to work towards an Evidence Led Prosecution.

18 GMP now have clear policies and procedures in place (Think Victim and Think Victim 2) and have recently reviewed and updated their Domestic Abuse Policy and Procedures to provide greater clarity to police officers on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigation. This policy sets out expectations on how GMP tackles DV at every level.

Where a service user is assessed using the DASH RIC[18] tool with an outcome of "visible high risk"'- or based on professional judgement, or where 3 incidents of Domestic abuse from a perpetrator in 12 months have occurred - agencies can refer into the MARAC

[redacted]

[redacted]

Learning Point

The value of women being educated in how coercive and controlling relationships impact on them.

[redacted]

Learning Points

Any service can request MARAC meetings.
Safeguarding adult referrals and Care Act responsibilities
Overdose and possibility of domestic abuse
The value of risk flags

[redacted]

[18] The DASH RIC is designed to be used for those suffering current domestic abuse. It should be completed as close to the time of an incident as possible, within a safe environment and with enough time given to complete the assessment – www.Safelives.org.uk

[19] A revised GMP DA Policy was introduced in May 2015 to August 2022. The policy gave specific instruction for officers attending DA incidents. At every DA incident, officers are to complete a DASH risk assessment. Details of all children or other vulnerable persons who reside at the address and their location at the time of the incident are to be recorded and linked to the PPI. Taking into account the circumstances of the incident, the vulnerability of the victim and the history of the perpetrator, officers will grade the risk as high, medium, or standard and appropriate safeguarding measures need to be taken endorsing the PPI with the RARA model. Remove, Avoid, Reduce and Accept. RARA is a risk management tool used by GMP to help officers record their decision-making rationale. Officers also recorded the Trio of Vulnerabilities (formerly known as Toxic Trio) *Prior to 2015, there was no requirement for police to complete RARA and Toxic Trio when attended domestic incidents. (GMP DA Policy introduced 2010 revised 2013 with new definition, revised Oct 2014. The new Policy provided specific guidance to officers in circumstances when the DASH was refused. it stated that officers should use professional judgement and include their own opinions regarding the demeanour of the victim.

[redacted]

Learning Points
Enforcement action and motivation
Support, substance, and alcohol abuse
Mental health intervention after a significant number of drug overdose
Relationships and routine enquiry

[redacted]

Learning Points
Information sharing, mental health, GMP referrals, routine enquiry, and domestic abuse
Enforcement and motivation

[redacted]

Learning Points
Illicit drug use and addiction
Accommodation issues and instability

[redacted]

[20] P3 Justice services are tailored to unique needs of people involved in the criminal justice system, including those on probation, providing intensive support to reduce the risk of re-offending and to get their lives back on track.
[21] RAMP is a local programme to address substance misuse.
[22] Police Act 1996

[redacted]

[redacted]

Learning Point
Information sharing, safeguarding referrals and co-ordinated multi agency risk management

[redacted]

[redacted]

Learning Point
Safeguarding referrals and Care Act responsibilities for adults at risk

[redacted]

[23] Target hardening is a term used to describe improving the security of a property to reduce the risk of crime and in the context of domestic abuse it can be carried out by domestic abuse support services; partnership agencies, and social landlords, to improve a victim's safety.
[24] Public Protection Investigation Document
[25] Positive and Negative Syndrome Scale used for measuring symptom severity of patients with schizophrenia. Kay, Stanley. R. Opler, L. Fiszbein, A. 1987 - Trust 1's approved risk assessment tool, which incorporates a well -being care plan, along with other Trust approved tools.

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point
Enforcement and substance abuse

[redacted]

[redacted]

[redacted]

Learning Point
Safeguarding referrals and risk prevention

[redacted]

[redacted]

[redacted]

[redacted]

[26] Trazadone is an antidepressant medication -https://www.nhs.uk.
[27] MDMA (Ecstasy) – a psychoactive stimulant that increases the release of dopamine and serotonin in the brain. https.//www.recovery.org

[redacted]

Learning Point
Risk Management and accessing information

[redacted]

Learning Point
Safeguarding referrals, DVDS and risk prevention

[redacted]

Learning Point
Information gathering, address checks and risk management

[redacted]

Learning Points
Information gathering, enforcement, risk-management, and MARAC referral.
Sign posting, communication and information sharing with health services.
Home visits and verifying information in risk management

[redacted]

[redacted]

[redacted]

Learning Point
Safeguarding, information gathering and sharing and address checks in risk management

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point
Up to date Information gathering and checking out information is vital to risk assessment and safeguarding individuals

[28] Warrington Adult Liaison Team
[29] Drug and Alcohol Service

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point
Safeguarding referrals, DVDS and risk prevention

[redacted]

[redacted]

[redacted]

[31] SARA – Spousal Assault Risk Assessment
[32] This is standard required practice at the end of a period of statutory supervision and historical information on flags can still be accessed and are not removed as such, but de-activated to ensure a fresh assessment is made at the start of any subsequent period of supervision.

[33] PCFT Mental Health Services
26 Greater Manchester Drug and Alcohol services
[35] DVDS - ibid

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point

Up to date Information gathering and checking out information is vital to risk assessment and safeguarding individuals

[redacted]

[redacted]

[36] Normally this information would have been given face-to-face, but it was provided by phone owing to Covid.

[redacted]

Learning Point
Consideration should be given to psychiatric review or alternatively contact with the GP, to discuss a medication review.

[redacted]

[37] It is the IMR author's view that this should have been recorded as a domestic incident and a safeguarding referral and DAB form completed and sent to Adult Social Care and that due to Ian's previous domestic history, steps should have been taken to carry out a risk assessment on Partner 11 (Ian). GMP have clear policies and procedures in place (Think Victim and Think Victim 2) and have recently reviewed and updated their Domestic Abuse Policy and Procedures to provide greater clarity to officers on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigation. From November 2022 GMP implemented the Domestic Abuse (DA) Matters Training programme aiming to create long term, sustainable improvements, and consistency in the response to domestic abuse. It will tackle all issues relating DA and has been designed to transform the police response to DA.

[38] START - Specialist Triage, Referral, Assessment and Treatment Team

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Learning Point
The value of Multi-agency working and appropriate information sharing when managing risk.

[redacted]

[redacted]

[redacted]

Learning Point
The value of multi-agency working when managing risk

[redacted]

[39] An App based, non-structured approach to recovery from drugs such as cocaine and cannabis.

[redacted]

Learning Point
The value of enforcement action and managerial oversight

[redacted]

[redacted]

Learning Point
The impact of Jenny's vulnerability over time and her ability to maintain positive change.

[redacted]

[redacted]

[40] CMHT: Service Operational Plan

[redacted]

Learning Point
The importance of discussion around psychological support being in place, supported by a Health and Social Care Needs Assessment and plan (not in place).

[redacted]

[41] Together Women Support Project
[42] Probation advises the Review that where a breach of licence has reached the threshold for a possible recall, a recall discussion should take place between the operational manager and the senior manager with the senior manager ultimately deciding if recall is necessary or if alternative enforcement action should be taken with additional measures put in place to manage any increase in risk.
[43] SIOM and Spotlight have been used as terms interchangeably. Spotlight is Greater Manchester's approach to Integrated Offender Management (IOM) which is a partnership approach to reducing re-offending of those who commit most harm in communities. The Probation Service and Police are lead agencies in IOM, working collaboratively together.

[redacted]

[44] Benzoylecgonine – a major metabolite of Cocaine

45 Frequently a wide range of agencies were involved with Jenny, with quick changes needed, from one provider [redacted] accommodation support, made more complex by multiple accommodation options often having to be referred into, before a suitable option was secured.

[46] CAS-3" accommodation was utilised on an exceptional basis only and Jenny would not usually have been eligible for it, but commissioners agreed to place her there on a temporary basis, pending another option being found, given that the accommodation meting her needs in immediate crisis period.

[47] A scheme to help the unemployed

[48] Jigsaw is a Housing Association in Greater Manchester

[49] Focused Care - Patients are referred by professionals into this service when a care plan does not appear to be working. The Practitioner works with the patient's household to unpick situations, assessing need and using local health and community contacts to begin to bring stability to an often, chaotic situation. They bring together agencies and patients and establish accountability for the patient and for the agencies involved, meaning that appointments are attended, practical support is provided. It works on a team basis, with regular meetings to review cases. Based inhouse, typically, working 2 days per week per surgery, alongside the practice team. All activity is recorded on the surgery clinical system so all staff are aware of the patient's current situation. The practice team and FC worker discuss cases monthly, to allow co-ordination of clinical intervention, social intervention and allows creative solutions to emerge. This is the bedrock of the process through which perceptions of the patient are changed. https:/444/focusedcare.org.uk/what-is-focused-care/ cited April 25th, 2023.

[50] A Personal Independence Payment is a non-means tested benefit which can be made to a person aged 16 up to state pension age, to help with the extra costs of having a long-term health condition or a disability - www.gov.uk > *Benefits and financial support if you are disabled or have a health condition.*

[51] Department of Work and Pensions

[redacted]

[redacted]

Learning Point
Up to date Information gathering and checking out information is vital to risk assessment and safeguarding individuals

[redacted]

[redacted]

[redacted]

[52] The Thinking Skills Programme, HM Government, February 2010

[redacted]

[redacted]

Learning Point
Up to date Information gathering and checking out information is vital to risk assessment and safeguarding individuals

[redacted]

[redacted]

Learning Point
The importance of checking systems information about offenders
Information sharing, safeguarding and co-ordinated multi agency risk management.

[53] A CFO Hub is an activity centre aiming to provide a comprehensive framework of support to encourage desistance, help participants to overcome barriers into work and reintegrate into their local communities, when on licence, and are run by the Centre for Justice Innovation.
[54] Tax Services for Survivors of DA

[55] THRIVE - Threat, harm, risk, investigation, vulnerability, and engagement. A model used to assess the right initial police response to a call for service. It allows a judgement to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of that decision. HMICFRS

[56] Initial arrest attempts are conducted by response policing officers for the first twenty-four hours. Following this period, if attempts are incomplete or have been unsuccessful, then the responsibility for the arrest passes to Spotlight. If attempts to detain the recalled subject continue over a prolonged period of time, risk assessment should become an ongoing process.

[57] Force Wide Incident Number

[redacted]

[58] Oldham protocol when dealing with a person who has been recalled is that a FWIN is created, and the incident is dealt with by response officers in the first 24 hours. If the person has not been arrested in that timeframe, the incident is sent to the Spotlight Police Officer Team for them to continue the enquiries. In this case due to resourcing issues, no action was taken by patrol in the first 12 hours.

[59] THRIVE – ibid.

[60] [redacted]

[61] SPO - Senior Probation Officer

[redacted]

3. Analysis

Theme 1 – The impact of domestic abuse on Jenny

3.1 There is strong evidence that by October 2014 Jenny was the victim of high-risk domestic abuse. NHS LSCFT have commented that her vulnerability[62] from childhood contributed to laying foundations for the risk she experienced from serious violence; [redacted] and the potential for her to be either a victim or perpetrator of violence.

3.2 Greater Manchester Integrated Care (GMIC) Oldham advised that Jenny's '*social circumstances'* were not seen by GP1 as a '*primary care function'* and focus was made on medication and recognition of [redacted]. Domestic abuse and physical assaults were recorded on the 7th and 16th July 2013; the 16th of August 2013; the 2nd of October 2014 and on the 8th and 13th November 2015.The model of routine enquiry, (launched 2008[63]) was introduced to General Practice as Clinical Guidance on February 26th, 2014, [64] but was not robust and no evidence of follow up or raising safeguarding alerts was apparent,[65] (under No Secrets Guidance[66] pre-2015). Post Care Act implementation, domestic abuse incidents experienced on November the 8th and 13th 2015, also did not provoke follow up, nor did they initiate a welfare discussion in relation to the injuries Jenny had sustained. GMIC Oldham have assured the Review that today, the practice response would be very different, given that routine enquiry[67] is now in place, and all GP Practices are aware of the principles and practice of safeguarding adults and children, in relation to domestic abuse, (guidance for health professionals son the Five R's of Routine Enquiry is addressed below from Safe Lives: Recognise and Ask; Respond; Risk Assess; Refer and Record).The IMR advises that best practice of conducting routine enquiry and making relevant safeguarding adult's referrals to Adult Social Care, is now evident in GP practice.[68]

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[62] NHS LSCFT refer to the value of exploring the concept of vulnerability.. their view being that vulnerability is not about being weak but is inherently linked with choice, and the less choices a person has then the more vulnerable they are.

[63] Routine Enquiry - People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion - National Institute of Clinical Excellence Guidance, Domestic violence and Abuse, Quality standard [QS116] Published: 29 February 2016

[64] National Institute of Clinical Excellence Guidance PH50: https://www.nice.org.uk/guidance/ph50

[65] Pre-2015, adult safeguarding had not been placed on the 2015 statutory footing and Integrated Care Service 1 has acknowledged that safeguarding practice was not strongly embedded in the culture of General Practice, at that time.

[66] No Secrets Guidance - set out a code of practice for the protection of vulnerable adults. It explained how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures, stating that they should collaborate with the public, voluntary and private sectors and they should also consult service users, their carers, and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

[67] Routine Enquiry – Safe Lives Guidance : https://safelives.org.uk/wp-content/uploads/Domestic-abuse-guidance-for-virtual-health-settings-C19.pdf - The Five R's of Routine Enquiry: Recognise and ask; Respond; Risk Assess; Refer and Record.

[68] It is important to note that the Royal College of General Practice did not issue guidance to GPs, setting out duties and expected practice to protect adults with vulnerabilities, until 2017.

[redacted]

3.3 Probation support the view that Jenny was seen as both victim and perpetrator in the context of domestic abuse, and that this was not always born out in their practice[69]. During the scoping periods, 19 incidents were logged at Probation involving Partner 2(Jenny) and Partner 3 (Jenny), alongside a series of incidents from 2004-2017 involving Jenny, [redacted] It is acknowledged that assessments from 2014-17 lacked quality, completion, and review. Probation state that their management plans failed to address *'significant criminogenic factors'* that Jenny presented with. There was a lack of professional curiosity where practitioners did not fully respond to the risks posed by domestic abuse; the harm she consequently experienced, [redacted] appear to have been viewed in isolation, from cause, accumulative effect, and the impact on her, as an adult at risk. It is however fair to say that post 2017 and running up to the time of Jenny's death, the IMR detailed greater depth and detail in assessments once the case was managed by the NPS (and now PS). There was also increased recognition of trauma, the impact of domestic abuse and her vulnerabilities, [redacted] For balance, recognition can be given to significant improvement in assessment quality since 2017.

3.4 GMP confirm that almost all of their contact with Jenny contained a domestic abuse element and a pattern emerged, where she quickly formed new relationships with men, followed by reports of domestic abuse, however when further details of the abuse were sought, she would choose to disengage. After Jenny started a new relationship with Partner 2 (Jenny) in 2014, 8 domestic incidents were attended by GMP in a 5-month period. GMP advise that in January 2016, following the incident between Partner 3 (Jenny) and Jenny that a crime report should have been submitted for Assault; that Partner 3's (Jenny) arrest should have been considered due to the escalation of incidents and that Jenny could have been referred to MARAC[71] and or a DVPN[72] or a DVPO[73] could have been considered.

3.5 When Jenny was referred to [redacted] in July 2014, and disclosed that she was in an abusive relationship and her 'boyfriend' was believed to be waiting for her, no routine enquiry took place. [redacted] which was a missed opportunity to offer her support and learn more about her. PCFT are of the view that there was *'more of a focus on Jenny as a perpetrator, as opposed to a victim of Domestic Abuse'*. There was no evidence that PCFT made a referral to MARAC about Jenny's July disclosure,

3.6 In September 2014, when Jenny attended Royal Oldham Hospital, [redacted] whilst she was living with Partner 2 (Jenny) and there was a missed opportunity to safeguard her because it is not evident that: follow up was planned or [redacted] were considered in relation to safeguarding - or if a safeguarding concern was raised under No Secrets Guidance 2000 (guidance prior to Care Act implementation in April 2015).

3.7 Twenty-three days later when Jenny attended North Manchester General Hospital, in October 2014, following a further assault from Partner 2 (Jenny), and Jenny [redacted], it is not evident she was given domestic abuse advice, albeit staff were asked to do so, [redacted] Five weeks later, following Jenny's admission to Royal Oldham Hospital, this incident was also perpetrated by Partner 2 (Jenny). The October incident was both significant and serious, and there is no evidence that this was ever discussed with Jenny, or that she was considered as a domestic abuse victim at subsequent appointments[74].

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[70] BMA 2007; Golding 1994; Shepherd 1990 cited in Sanderson, C. Counselling Survivors of Domestic Abuse. June 6th, 2004; Jessica Kingsley, UK.
[71] In September 2020 the Multi-Agency MARAC Operating Protocol was reviewed and updated and gives clear recommendations when MARAC referrals should be made.
[72] Domestic Violence Protection Notice - A DVPN is the initial notice of immediate emergency protection that is issued by police.
[73] DVPO – Domestic Violence Protection Order
[74] It would appear that if particular Practitioners were not able to access paper records, they would not necessarily have been aware of the history.

3.8 On the 13th of November 2016, after Partner 3 (Jenny) was arrested for assaulting Jenny, and she attended the emergency department at Royal Oldham Hospital, with an injury, it is noted that Jenny was clerked into the Emergency Department but did not wait to be seen or be assessed for treatment. Had she been seen by the Triage Nurse, it would now be expected that enquiry about domestic abuse would be made, and advice given, which was not routine in 2016.

3.9 Northern Care Alliance (NCA) noted there was correlation with assaults [redacted] from Jenny's presentations at both the North Manchester General Hospital and the Royal Oldham Hospital. (From agency information shared with the Review, it would seem possible that Jenny had experienced [redacted]). NCA advised that they did not have a Domestic Abuse Policy in place until 2017and training for DASH risk assessment was implemented in 2018, and that staff held limited knowledge. In 2017 level 3 adult safeguarding training was redesigned with a focus on The Care Act and included enhanced domestic abuse awareness – which is now mandatory for all qualified staff and can be accessed by unqualified staff. A hospital IDVA is based at Fairfield Hospital with plans to replicate this across the NCA.

3.10 In April 2017 when Jenny was seen at EIT, her *'fiancé'* was noted to be with her (likely to have been Partner 3 (Jenny), with whom she also had an abusive and controlling relationship) and there is no evidence of routine enquiry. In 2017, Jenny made a short series of attendances at the out-of-hours service, which appears to have been a critical period for her in terms accommodation; her relationship; [redacted], physical health issues and the circumstances leading to [redacted]. GMIC Oldham have related that these matters were not always reviewed holistically by GP1, which was a missed opportunity to safeguard her.

3.11 Victim Support's engagement with Jenny was unsuccessful and they were aware she sometimes gave consent for one service to act, but not another. Ordinarily Victim Support would have signposted Jenny to appropriate agencies, but this did not happen. Given the volume of assault referrals received by the service, professional concern and some level of holistic review would have benefited their insight into sharing information with statutory services, particularly with Adult Social Care, in relation to the duty to safeguard an adult at risk, under the Care Act 2014 and its associated regulations.

3.12 Jenny had sporadic engagement with the IDVA Service, and her needs were consequently not assessed, however efforts were made to try and safeguard her, however an individual safety and support plan was not able to be completed.

3.13 During the period of involvement from NHS Lancashire and South Cumbria Foundation Trust in 2021, concerns regarding domestic abuse were not identified and routine enquiry was not documented, in accordance with their policy[75]. However, it is of note that NHS LSCFT were not in receipt of accurate or relevant information which would have prompted exploration. NHS LSCFT were involved with Jenny for 8 weeks, from 26th July to 6th October 2021, following release. START assessed Jenny and advise that her domestic abuse history was not considered, and their enhanced risk assessment completed in October did not include reference to the impact of domestic abuse.

3.14 During 2021, Probation was assisted by Jenny's psychological formulation[76], which recognised the impact of childhood trauma and vulnerability, to help her with positive change. However, from 26th of July 26th, 2021, to February 2022 warning signals in relation to assessing the risk of domestic abuse that Jenny had faced were not always noted: e.g., on 19th of January, 2022, Jenny disclosed she [redacted] and Probation knew that Ian was her partner and domestic abuse to his partners and his risk to their children was documented.

[75] LSCFT Domestic Abuse Policy (SG006) and Nice Guidance (PH50) – endorses the practice of clinicians undertaking a routine enquiry into the possibility of domestic abuse, irrespective of this being indicated, due to the prevalence of domestic abuse within society.

[76] A formulation is written by a psychologist to assist the practitioner to know how best to engage positively with a person, in a psychologically informed way. The formulation will be mindful of the impact of trauma on the way a person behaves. The formulation does not inform the risk assessment, it is a guide/tool to working positively with an individual to help positive change.

3.15 In January 2022, [redacted] was concerned for Ian being '*out of his depth'* in his relationship with Jenny, when Riverside Housing had reported that he had assaulted Jenny that day and no follow up was apparent.(It is Probation's view that Jenny presented a high risk of serious harm to adults, particularly with men with whom she came into conflict with, [redacted] and that the Responsible Officer was rightly concerned about the risk of this happening again, as well as the risk of Jenny being harmed. This comment suggests a lack of awareness of the risk that Ian presented to Jenny). On the 1st of February when Ian presented at Probation with Jenny and she had facial injuries, no appropriate follow up action was taken. Probation have advised if a more investigative approach had been taken and licence conditions had more focus, that the domestic abuse and the incident could have been better assessed and managed, recognising that Jenny was also assessed as presenting a high risk of serious harm to adults, including men with whom she was in a relationship).

3.16 Post release, in 2021 Jenny was assessed a 'PIPE suitable'[77] to help her with '*emotional regulation'*. A '*trauma informed approach'* was used to enable learned skills (from the two-year therapeutic Prison intervention programme) to '*increase compliance and retain access to interventions from agencies to support desistence and promote positive change.'* It was, however, not evident that her '*skill*' set had been tested or that she had learned about the impact of abusive relationships, or the impact of [redacted] on her, albeit she had seemingly found the programme helpful. Approved Premises gained Jenny's history from Probation, and they worked closely together. Both had access to Jenny's reports from psychological interventions in prison and both advise that the impact on Jenny of domestic abuse, accommodation issues, health, and [redacted]ssues were taken into account, but Probation seemed unaware in their practice, on several occasions, of the degree and longevity, of the abuse that Jenny had experienced.

3.17 When the placement at the Approved Premises started to break down after 12 weeks in 2021, Probation advised the Spotlight Integrated Offender Manager (GMP Officer) that Jenny was a victim of historic domestic abuse from the relationship with Partner 3 (Jenny). However, Jenny had experienced possibly three domestically abusive relationships up to that point. Probation have advised the Review that they were aware of previous violent relationships, as the information was captured in assessments made at the time. A risk assessment was shared with Spotlight Integrated Offender Management Team (GMP Officer), in October 2021.

3.18 It is not evident that holistic multi-agency co-ordinated risk management was considered to assist Jenny and her Children, to be supported in the community in relation to the risk of her experiencing domestic abuse as a repeat victim.

3.19 When Jenny was registered with GP3 from the 17th of November 2021 a referral was received for Focused Care[78] from Probation, with regard to her support needs, [redacted] and trauma from [redacted] but no reference was made to the historical domestic abuse she had suffered.

3.20 Jenny had one '*comprehensive'* phone assessment from Turning Point, and she was asked if she had suffered emotional, physical, or sexual abuse but she chose not to make a disclosure. However, Turning Point advise they were aware of her domestic abuse history, due to the risk management plan shared by Probation.

3.21 When searching for Jenny in February 2022, GMP advise that the focus was on her being arrested for recall and both Jenny and Ian knew they were wanted by GMP from the 27th of January 2022.

3.22 It is Probation's view that assessments from 2017 onwards recognised the vulnerabilities that Jenny experienced from childhood trauma and domestic abuse, and the impact this had on her

[77] ibid
[78] ibid

[redacted], as did the work from the therapeutic programme that she participated in, whilst in custody. However, it is the view of NHS LSCFT that her vulnerability probably reduced choices for Jenny, which in turn may have affected the decisions she made, also affecting some professional insight into the causes of her [redacted] and the impact from continued engagement in abusive relationships (e.g.: numbing, potential for further abuse and habituation[79]).

Theme 2 - The impact on Jenny of health issues and [redacted]

3.23 Jenny's [redacted] was prevalent and recognised, by both GP Practices from 2014-17 and 2021 -22. Weekly prescriptions were issued, or small doses and by exception, only one additional dose of medication was issued based on the clinical judgement at the time of Jenny's presentation. Prescribed medication was compared to available guidance at the time and there were good levels of awareness of 'the analgesic ladder'.[80] [81] Regular medication reviews took place. GP1 believed Jenny's problems were set within with her [redacted] She also showed positivity about support from the Focused Care Practitioner.

3.24 GMIC advised that in both General Practices, "*it is unclear how inclusive they were in respect of Jenny's increasing* [redacted] *indicators of domestic abuse and her later presentations to ED* [redacted] GP3 however advised that Jenny found that prison psychological therapies on the [redacted] of benefit which helped her to break away from adverse behaviours and events she had experienced before her imprisonment having been: '*very open about this, and she felt she was hoping for a fresh start in life*'.

3.25 [redacted] by Jenny and her partners would appear to have contributed to domestic abuse, from 2014 to mid-2015, and when she entered the relationship with Partner 3 (Jenny), [redacted]. From April 2016 onwards, GMP described Jenny's behaviour as '*spiralling out of control*' believed to be due in part to [redacted], being arrested three times for assaults on members of the public and being the target of assaults, placing herself in vulnerable situations [redacted]

3.26 Northern Care Alliance were aware of some of Jenny's health needs, secondary to [redacted], but held no evidence that she was receiving support for them. From the start of Jenny's PCFT, NCA Trust and Royal Oldham Hospital records, she had been offered appropriate referrals to [redacted]

3.27 Due to continued non-engagement with [redacted], Jenny never benefited from any meaningful, sustained work. (It is of note that on the 24th of October 2014, it was evident that Partner 2 (Jenny) was also known to the same [redacted] presenting a missed opportunity to have linked them together).

3.28 When Jenny met with EIT in 2017 for exploration of a [redacted] offending behaviours and traumatic events in her childhood, but she did not disclose the serious nature and impact of the domestic abuse and harm she had experienced from at least two, maybe three violent relationships. [redacted] seemed unknown to EIT, along with the [redacted] - some of which was known and recorded by the [redacted]. However, that service did not access the PARIS electronic system, (nor are they any longer part of PCFT, with service having been transferred to Turning Point in 2017). Albeit the connection may not have been obvious, applying

[79] Mental and physical health effects of intimate partner violence on women and children, Campbell, J. C., Lewandowski, L.A., Johns Hopkins University School of Nursing, Baltimore, Maryland, USA. Review: 1997 Jun;20(2):353-74.
[80] The Analgesic Ladder – World Health Organisation, 1986
[redacted]

professional curiosity could have enabled EIT to establish that Jenny had been under the care of the [redacted]

3.29 In April 2017, Jenny was offered further assessment by EIT, owing to concerns that she had a [redacted] and had contacted EIT, twice in May worried about [redacted] at which point she was signposted to her GP, when the appointment could have been brought forward (which has been acknowledged). After she failed to attend the offered appointment in May and deterioration [redacted] was noted, it took 12 days to advise Probation. Post contact with Probation, EIT placed an alert on Jenny's health record for '*risk to others'* but it was not evident that an alert was considered for safeguarding or domestic abuse.

3.30 Achieve[82] had one contact with Jenny in March 2017, after she [redacted] and an admission to hospital was agreed with Jenny, but given the medical team's opinion that an observation period was advised, and Jenny left – it was a missed opportunity to have considered possible [redacted] was considered in relation to her decision to leave.

3.31 Probation was aware that Jenny was [redacted] from September 2017. Newhall Prison were of the view [redacted] impacted on her propensity for violent behaviour. Probation Services were very positive about the interventions from the Prison, which designed services to help Jenny identify strategies that she could apply, to manage her own risk. Positive reports were made from the Parole Board about the intervention and by Jenny herself, as work had focused on enabling her to identify the links between previous traumatic experiences, her coping strategies, and her offending behaviour.

3.32 Prison services concluded that Jenny: *'lacked belief in her own ability to care for herself …had a need for dependency, heightened by anxiety; pessimism and a strong sense of guilt and disappointment*' and that her difficulty in coping and reliance on [redacted] was aggravated by being unable [redacted] In addition, they noted that her inability to meet the goals she set for herself was impacted on by her desire to self-harm, reducing her feelings of self-efficacy and self-worth; *'all of which contributed to a negative self-image.'*

3.33 Jenny disclosed to Probation varying [redacted] When Jenny left prison she recognised that '*gaining temporary peace of mind'* and *'feeling numb from issues'* that caused her anxiety, were short lived, and had started to view this as a critical risk factor linked to offending and self-care. Albeit monitoring [redacted] ongoing part of Probation's OASys assessments, they have acknowledged that not enough importance was given to [redacted]. In late 2021, [redacted] however Probation's approach was open to giving mixed messages to Jenny. This was because it allowed several missed opportunities for enforcement action, coupled with Jenny's pattern of non-attendance at [redacted] other appointments.

3.34 When Jenny was released in 2021, a comprehensive assessment was in place, albeit it is not clear if this considered the impact of domestic abuse on Jenny, however it was pertinent and important, but did not appear to fully inform the 2021-2 licence period, in order to help decisions about her ability to maintain licence conditions. When Jenny moved from Preston to Oldham, and post placement breakdown, she was supervised: '*under crisis management* [redacted] in Oldham, at the point of when she moved because she had not registered with a local GP. This should have been shared with GP3 and

[redacted]

caused delays in appropriate referrals being made and a referral to PCFT's to Democratic Therapeutic Community[84] for support that may have helped her. Jenny was referred to START[85] on the 23rd of July, who referred her to the [redacted] contacted LSCFT, but it is unclear if thorough information was transferred.

3.31 Jenny was referred to START[1] on the 23rd of July, and subsequently assessed as requiring support from [redacted] LSCFT) however, her sporadic attendance meant she received little therapeutic intervention .Following her move to Oldham, the GP3 referral was made in December 2021, to PCFT but the appointment made for January 2022, was not attended , so effectively, Jenny did not see a [redacted] when she left Newhall. This is of concern given that a licence condition was to: *'attend all arranged appointments arranged for her with* [redacted] *and or medical practitioner and co-operate fully with any care or treatment they recommend'.*

3.35 NHS LSCFT acknowledge that a planned transfer of care to a [redacted] in Oldham did not take place, in October 2021 nor did they know who was supporting Jenny with accommodation. Their completed risk assessment followed the Trust risk tool which they have acknowledged had limited scope. They note that several key issues remained unresolved prior to Jenny's discharge such as review of her medication; [redacted] and a new GP registration. NHS LSCICB advise that Jenny's [redacted] may have been compromised, if viewed through a *'trauma informed lens'*, as the impact of physical abuse and sexual violence, may have compromised her ability to recognise unsafe relationships and situations, complicated more so [redacted]

3.36 PCFT were unaware that Jenny had been released from prison in 2021 and attempts to engage her were unsuccessful. When her case was raised at the Access Team multi-disciplinary meeting there was no information from the [redacted]. It was not until the 24th of December 2021, after GP3's intervention that it seemed to be realised that a [redacted] transfer referral had not been made when Jenny moved to Oldham. PCFT advised that they were aware of Jenny's ongoing contact with Probation Services, and it was a positive example of joint working. PCFT consider that [redacted] presented an outstanding health need for Jenny and note that *'her voice was not strongly represented'*. There were occasions when referrals to [redacted] were not always made.

[redacted], how this influenced her offending and emotional regulation, and several referrals were made via Probation to [redacted] which largely Jenny did not attend. After struggling to comply with the regime Jenny quickly returned to [redacted] Requests were made to Probation for Licence Warnings to be issued when Jenny [redacted] which was inconsistent, and concerns were highlighted about [redacted] which were not always tested for. Jenny also had not consented to sharing information [redacted] which given her licence conditions, seemed odd that such consent was required.

3.38 Approved Premises had concerns about Jenny being [redacted] whilst taking prescribed medication and targets were set to access support from health services and to [redacted] had identified that she had a known difficulty and inability, to meet the goals she set for herself. She clearly found goals very difficult to comply with and may have needed more intense support in order to succeed. There is recognition that the Approved Premises were managing difficult circumstances and dynamics in the house, which *'felt chaotic* [redacted] added to by Jenny having previous issues with some residents, resulting in aggressive outbursts.

[redacted]

3.39 In September 2021, when Jenny [redacted], no discussion with Probation was apparent to progress a recall for non-compliance, given that her licence required disclosure of relationships [redacted] After she moved to live at her Mother's address, (known not to be sustainable), it would appear that contacts with [redacted] support providers, effectively stopped. Approved Premises advise there was a possibility that more could have been done to pro-actively enable Jenny to engage with support services.

3.40 Turning Point put a risk management plan together, helped by information from Probation, with a focus on [redacted], however the information from Probation was based on some incomplete assessments.

3.41 The impact of domestic abuse, [redacted] and health issues were considered by Oldham's Children's Social Care only in direct relation to the impact on Jenny's Children and note that her response in addressing [redacted] relationship issues '*presented a mixed picture with changing levels of motivation'* but they remained firmly of the view that Jenny clearly loved her children.

3.42 NWAS had contact with Jenny on 5th of June 2017, having responded to a 999 call, when she had [redacted]. Between 26th of July 2021 and February 2022, two 111[86] contacts were recorded owing to [redacted] made at Approved Premises. The last contact was in February and advanced life support was given before she was 'blue lighted' to Fairfield Hospital. NWAS provided appropriate and supportive intervention in an attempt to save Jenny's life.

<u>Theme 3 - The impact of accommodation issues on Jenny</u>

3.43 Jenny had faced long term accommodation problems for several years, starting prior to 2014. In 2014, 6 weeks after having taken [redacted] her housing application was moved to a lower banding, but it was not explored as to why this happened. In May 2017 Jenny told PCFT that her mood was affected by her housing issues, previous evictions were not explored. On the occasions when she lived with her parents, their role as possible carers was not considered and a Carer's Assessment was not offered. PCFT acknowledge there was a lack of a Think Family Approach[87] [88] [89]and have considered that Jenny was possibly overwhelmed with being homeless.

3.44 In prison Jenny referred to the importance of her living environment, saying it was 'critical' to her because she felt if she was perceived by others as vulnerable, she could feel threatened, and would defend herself [redacted] verbal threats, and intimidation. When she was placed in an open prison it unsettled her and was quickly returned to closed conditions. With hindsight bias this places into question, if Jenny was ready for release into the community, in July 2021. The Community Offender Manager reports, supported a period of release on temporary licence (ROTL), believing that an immediate full-time placement could prove too intense for her, however in May 2021 the Parole Board directed full release.

3.45 Probation have recognised that early accommodation issues were not always linked to Jenny's risk of harm or re-offending, until 2017. Significant efforts were made to address accommodation issues by Probation and to engage with her, with numerous housing referrals being made, albeit they

[86] The 111 service signposts patients to meet specific need at that time, this is known as the "disposition". Patients are assessed by a series of questions, generating the appropriate disposition (or outcome) for the patient – NWAS IMR statement.
[87] Think child, think parent, think family: a guide to parental mental health and child welfare: Think Family as a concept, and its implications for practice: The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of 'Reaching out: think family' (18):
-No wrong door: contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.
-Looking at the whole family: services working with both adults and children take into account family circumstances and responsibilities. For example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.
-Providing support tailored to need: working with families to agree a package of support best suited to their particular situation.
-Building on family strengths: practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities
https://www.scie.org.uk/publications/guides/guide30/references.asp#18 December 2011, cited April 25th 2023
[88] Think Child, Think Parent, Think Family, SCIE 2011: https://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp
[16] Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children, London, DCSF 2010, 2018 and 2020

were not aways followed through by Jenny. Efforts to secure accommodation were impeded by Jenny's lack of acceptance that [redacted] could not stay with her.

3.46 When the placement broke down at the Approved Premises, move on accommodation was sought. With hindsight bias, it would have been beneficial for planning to have taken place earlier, which may have prevented Jenny having to move back to her Mother's address, which ultimately caused further instability. Probation have commented on the difficulty they faced *'when left with no option, and assessments of suitability are outweighed by immediate need'* and have acknowledged that: '*there should have been wider information sharing with the Senior Probation Officer and challenge to the request for move-on accommodation*' but did believe Jenny and her Mother wanted to develop a positive, supportive relationship with each other.

3.47 When Jenny moved to her Mother's home, Spotlight Integrated Offender Management (GMP Officers) gave support via visits and the allocation of a particular Officer, but monitoring was challenged owing to Jenny not always making herself available for visits, which were not part of her licence conditions.

3.48 Turning Point discussed accommodation at their assessment. Jenny reported that she was living in temporary accommodation with a planned move to supported accommodation the following week.

3.49 GP3 first became aware of Jenny's housing issues after receiving an e-mail from a housing provider, requesting information for a section 184 homeless decision, but tragically, Jenny's notification of death was received the following day.

<u>Theme 4 – The impact of Jenny's family relationships on her decision-making and choices.</u>

3.50 PCFT held limited information about Jenny's family relationships, and there is little evidence that family dynamics were explored with her and lacked professional curiosity to do so. PCFT considered that some relationships may have been a barrier to her accessing support.

3.51 GMP noted the close relationship between Jenny and her Mother, however, there were tensions and arguments, usually minimised by her Mother, but ultimately their relationship sustained, albeit within turbulent, and strained at times. Jenny was assessed as a person who craved emotional warmth and protection, and it is Probation's view that Jenny struggled to decide if her Mother's home was a stable and protective environment, or not, causing tension when she was trying to make decisions to resettle, frequently deciding that residency with her Mother was a contingency, when she thought no other options were available.

3.52 Clearly Jenny's relationships with [redacted] were of huge significance to her. The Approved Premises were aware of the contact agreement with Oldham Children's Social Care, and it is evident that challenges existed in managing circumstances where the relationship could be fully facilitated. This was likely to have been made more difficult by Jenny's poor parenting skills and at times, irresponsible decision making, where she did not put the safety [redacted] before her own needs. Approved Premises raised safeguarding concerns regarding Jenny's inability *to 'reflect on the impact of her behaviour in f*[redacted] and joint meetings with Probation, and Social Worker 3 were in place. [redacted] very much wanted to stay with their Mum, advising the DHR that they very strongly felt the need to protect their Mum from Ian, and '*voted with their feet*'. Jenny wanted [redacted] having been in prison [redacted], and frequently broke her licence conditions because of this.

[redacted]

Given the age of [redacted], a managed medium-term plan, cognisant of risk, may have helped, as opposed to what seemed tantamount to a constant battle between Jenny and Oldham Children's Social Care.

3.54 When Jenny was recalled, her behaviours had deteriorated, [redacted] in the company of Ian – who as a coercive, controlling, and violent male and Jenny was [redacted] Any agency could have referred Jenny to GMP for a Domestic Violence Disclosure with regards to Ian, or GMP could have decided to advise Jenny about this, but this did not happen. Jenny may not have been fully aware of the level of risk that Ian posed both to herself and her Children, nor did the Responsible Officers or Social Worker 3.

3.55 With GP3, Jenny made no reference to family relationships and there was no evidence on record of child protection interventions. In the short time Jenny was known to GP3, the Practice was unaware of any events in Jenny's personal circumstances that may have been relevant to her death but felt she was an intelligent woman, keen to start a new life and that she tried to make significant changes in trying to re-integrate, following prison release.

3.56 NHS LSCFT held limited information about Jenny's relationships. Post release, the Oldham CMHT (PCFT) knew that Jenny had [redacted] risk assessment was not carried out, nor was contact made with agencies who were supporting Jenny, which would have been expected practice. PCFT have acknowledged this. When Jenny moved back to her Mother's address, Jenny felt she had "*taken a step back*" and PCFT acknowledged that this was a missed opportunity for them to have explored family circumstances with her and assessed the impact on her mental health and vulnerability.

3.57 The IDVA Service were aware of the impact on Jenny, after [redacted] care and were aware of her involvement with violent offenders.

3.58 Victim Support identified Jenny's Mother as a key relationship but knew little about other relationships,

3.59 Oldham Children's Social Care considered Jenny's family relationships [redacted]

Theme 5 – The management of risk assessment in respect of Jenny and Ian

Jenny

3.60 The impact of Jenny's relationships, trauma and consequent risk were not always explored with her by professionals involved in her care. She had at least two known relationships with violent men, prior to meeting Ian, both of whom [redacted], and numerous missed opportunities existed to have discussed the impact on her, of this, in relation to safety planning, [redacted], and safeguarding. Probation (as the lead agency for [redacted] Jenny's supervision) are of the view that examination of professional input '*was over-ridden by crisis led interventions,*' but to have considered the wider impact of trauma on Jenny's vulnerability, may have helped various professionals to support her.

3.61 It seemed difficult for the supervising professionals to balance enforcement actions with Jenny's [redacted] In September 2021, she [redacted] and assumptions were made without verification. There was no evidence to suggest that regular consultation with Probation management took place regarding enforcement action, given the accumulative nature of [redacted] This was added to when in the same month, an Officer tried to establish if [redacted] and outcomes seemed unclear, and a final warning was issued. The decision appears to have been made in isolation, with no consideration of recall. Probation have advised that

the propensity of the decision was towards '*leniency'*, paralleled by '*failure to fully consider the range*' of risk related issues affecting Jenny was coupled with a lack of senior management oversight.

3.62 Jenny was not seen as an adult risk and consequently the Care Act 2014 and the provisions it sets out for duties to safeguard an adult at risk, were not consistently met by all agencies.[90] Probation advise that Jenny could make '*impulsive and violent responses and developed learned behaviours not through any specific lack of capacity'* and '*there was never any indication which would trigger an assessment under the Care Act 2014*'. However, Jenny fulfilled criteria as being an adult at risk, with care and support needs, and her circumstances met the criteria for Section 42 Enquiries [91] to have taken place, on numerous occasions, which meant in turn there were missed opportunities for multi-agency safeguarding planning to have taken place. Throughout years of dealing with Jenny, GMP advise that they *'gave limited consideration under the Care Act 2014 to determine if she should be assessed'* and that *'based on the information they held,* that 'if a *holistic approach had been taken, it would have been clear that CLB was an adult at risk due to* [redacted] *with the relationships she formed with violent men',* which increased her vulnerability.

3.63 When allocated Spotlight Integrated Offender Management (GMP Officers) first became aware of Ian they failed to carry out detailed GMP checks which would have shown him to be a high-risk domestic abuse perpetrator, and when Spotlight Integrated Offender Management Team (GMP Officers) received [redacted] information about him, they did not check to confirm that the information was accurate. (Officers within Spotlight deal with many offenders where there is a history of domestic abuse and as such safeguarding and risk should have been a priority). The GMP [redacted] advises that the information should have been shared with partner agencies, including Oldham Children's Social Care, as a matter of urgency, so that new risk assessments could have been carried out for Jenny and her children, and consideration given for a DVDS disclosure. Information should also have been shared with Adult Social Care.

3.64 The above circumstances would have benefited from a shared and co-ordinated multi-agency risk management process and forum (given such processes are normally led by the supervising agency, it would not however have precluded any agency raising this matter with the supervising agency).

3.65 When Spotlight Integrated Offender Management (GMP Officers) were aware of Jenny's recall to prison and she could not be located for arrest, nor did she hand herself in, GMP suggest that other strategies to locate and arrest her could have been adopted, adding that when trying to locate her, Spotlight Integrated Offender Management Team (GMP Officers) did consider safeguarding and domestic abuse, but that their fears were somewhat allayed when Jenny had denied the level of assault - as reported by her Mother. (Following the IOPC investigation it was noted that the address where she was found was not linked to either her or Ian).

3.66 Practice in raising safeguarding alerts by GMP was inconsistent, but present. Referrals were made on 5th of February and 22nd of April, 2016, and 19th of March 2017, but not made on 11th of December 2015; 8th of January or 11th of May and 19th of June 2016.

3.67 Pre 2017, the IDVA Service did not regard Jenny as an adult at risk, creating missed opportunities to have engaged Adult Social Care and Jenny was not defined as a repeat or persistently targeted victim from the referrals received.

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[90] In reference to this part of the analyses, it is important to note that Section 14.91 of the Care Act[90] Statutory Guidance[90] states: *A criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and personal wishes of the adult will be considered throughout, even if they do not wish to provide any evidence or support a prosecution. The welfare of the adult and others, including children, is paramount and requires continued risk assessment to ensure the outcome is in their interests and enhances their wellbeing.* Section 14.95 states: *'The first priority should always be to ensure the safety and well-being of the adult. The adult should experience the safeguarding process as empowering and supportive. Practitioners should wherever practicably seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry. Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency'.*

[91] S42 Safeguarding Enquiry, Care Act 2014 (ibid)

3.68 Pre 2017, Victim Support acknowledge that with regard to the risk faced by Jenny, their approach did not always treat her with the care and consideration she needed as a victim of violent crime.

3.69 PCFT did not always make safeguarding referrals for Jenny, and records do not suggest that Jenny was considered for a Care Act assessment, and they considered it unlikely that Jenny would have met statutory criteria (see Care Act Regulations set out below)[92] however it would appear from reviewing the Regulations, that Jenny met (1)(a, b and c); (2)(e, f, g, h and j); 3(a) and (4). PCFT missed the opportunity and have acknowledged that professional curiosity was lacking and to have made a safeguarding adult referral to Adult Social Care for a s42 Enquiry.

3.70 Oldham GMIC have acknowledged that they found it difficult to clarify Jenny's support needs and that there was a missed opportunity in October 2015, when she presented with physical injury. On January 4th, 2017, when she attended with a '*support worker*' the reason for this was not explored. She was not considered as an Adult at Risk post April 2015, not helped by a lack of joined up risk management, which was a further missed opportunity to have made a safeguarding adult referral to Adult Social Care.

3.71 Turning Point felt that limited contact with Jenny made it difficult to have considered the value of a Care Act assessment, and on reflection thought a safeguarding adult referral could have been considered.

3.72 Other than the MARAC held in 2014, Oldham Children's Social Care had not considered that Jenny may have needed safeguarding as an adult at risk, [redacted] and this constituted a further missed opportunity to have made a safeguarding adult referral to Adult Social Care and a 'Think Family' was not fully deployed, albeit some advice was given to Jenny by the Family contact Time workers.

3.73 LCSCIB are of the view that missed opportunities presented to professionals to have explored Jenny's [redacted], outcomes of which, may have supported a safeguarding adult referral, and thus a further missed opportunity.

3.74 Referrals made were not always acted on by agencies, and Domestic Abuse Policy at the time did not always ensure that appropriate escalation was in place with regard to risk management. On February 5th, 2016, following a high-risk DASH outcome for Jenny, GMP made referrals to Adult Social Care and [redacted], but focused Adult Social Care follow up and response is not evident. (When Jenny denied the assault it negated the requirement to refer her to MARAC as her risk level changed to medium, however a referral was made to the IDVA).

3.75 Between 28th of March and 11th of May 2017, when GMP believed that Jenny and Partner 3 (Jenny) were exploiting two vulnerable adults, it is not evident that safeguarding referrals were

[92] Care and Support (Eligibility Criteria) Regulations 2014
Needs which meet the eligibility criteria: adults who need care and support.
2.(1) An adult's needs meet the eligibility criteria if—
(a)the adult's needs arise from or are related to a physical or mental impairment or illness.
(b)as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and
(c)as a consequence there is, or is likely to be, a significant impact on the adult's well-being.
(2) The specified outcomes are—
(a)managing and maintaining nutrition (b)maintaining personal hygiene(c)managing toilet needs(d)being appropriately clothed (e)being able to make use of the adult's home safely (f)maintaining a habitable home environment (g)developing and maintaining family or other personal relationships.
(h)accessing and engaging in work, training, education, or volunteering (i)making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and (j)carrying out any caring responsibilities the adult has for a child.
(3) For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult—
(a)is unable to achieve it without assistance; (b)is able to achieve it without assistance but doing so causes the adult significant pain, distress, or anxiety;(c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
(d)is able to achieve it without assistance but takes significantly longer than would normally be expected.
(4) Where the level of an adult's needs fluctuates, in determining whether the adult's needs meet the eligibility criteria, the local authority must take into account the adult's circumstances over such period as it considers necessary to establish accurately the adult's level of need.

made.[93] [94] [95] .Oldham Multi-Agency Procedures (2022) suggest that today such circumstances would warrant a referral to the MASH.

3.76 Jenny developed a pattern of not supporting prosecutions against men who had hurt her and failed to engage with several support services which increased her risk. She was domestically assaulted on at least two known occasions by Partner 2(Jenny); on at least 7 known occasions by Partner 3(Jenny) and by least twice by Ian, on known occasions, over a total period of three years. It would seem that the violence imposed upon her created understandable fear, within these controlling and coercive relationships, and an incapacity for her to take affirmative action. The IDVA Service recognise that they may have been able to have helped more, along with the need for recognition from all agencies that Jenny was a repeat victim.

3.77 PCFT advise that no significant work was undertaken with Jenny because of the inability to engage her, within the timeframe, and that where conventional methods of engagement did not work, there was no evidence that adjustments were considered. PCFT add that there was a focus on her as a risk to others, rather than her being a potential victim, coupled with a lack of professional curiosity about her relationships. It was a possibility that a practitioner considered a safeguarding referral to Adult Social Care, but it is not apparent that this took place.

3.78 Jenny cancelled appointments in the 8-week period when she was known to LCSFT in 2021, and particular assessments were therefore unable to be carried out (such as a health and social care needs assessment; a crisis and contingency plan and a safeguarding risk to children assessment)[96]. Regular contact was attempted but it was not established if forensic or multi-disciplinary planning had been considered. Domestic abuse was not identified as a '*risk feature'* by their CMHT, albeit a Domestic Abuse Policy[97] was in place and the NICE guidance [98] endorsed that staff undertake routine enquiry due to increased risk of domestic abuse for patients with mental health needs. The CMHT identified that Jenny was likely to be experiencing [redacted] and Trust Policy is clear about how staff are to work with such patients, to include robust multi-agency joint working and information sharing [100] [101] - particularly between [redacted] as a priority. The Trust's Assessment and Management of Clinical Risk in [redacted] Policy, and Procedure [102] refers to the expectation that practitioners must apply professional curiosity when working with [redacted], however the [redacted] lead was unable to find documented evidence that this occurred, possibly which limited by the short time that NHS LSCFT knew Jenny. They did not consider the need to refer Jenny for a Care Act assessment, or to make a safeguarding adult referral, and did not hold information about involvement from other agencies. They have acknowledged that a referral for a Care Act assessment *'may have supported a more holistic assessment of her needs and signposting to support agencies'.* LCSIC commented that post release, Jenny's vulnerability warranted more focus and that closer multi-agency working and advice from other agencies - as per the Think Child, Think Parent, Think Family[103] approach, '*may have generated intervention* 'to produce greater visibility of the relationship between [redacted] and Jenny.

3.79 GMIC Oldham note that Jenny disclosed previous [redacted] and information was held in different

[93] MARAC Criteria and DASH Assessment: https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf at Safelives.org.uk info@safelives.org.uk Updated June 2018

94 Police Domestic Abuse Policy in 2015, introduced RARA and Toxic trio to be used to inform risk.

[95] The Oldham Multi-Agency Domestic Abuse Policy (2022) advises that if an Adult is: a)subject to controlling/coercive behaviour (e.g. financially/locked in property/withholding of medical treatment /isolated from family /friends /social contacts or b) is frequently assaulted e.g. physical, sexual, rape and FGM or c) subject to stalking/harassment; or d) is being threatened with Honour Based Abuse, Forced Marriage or death and or is experiencing any of the aforesaid, then such circumstances are a high alert for adult safeguarding, and that referral to Domestic Abuse Services is warranted. In addition, it advises that a referral to MASH must be made if the person has care and support needs and following the decision of making a high-risk professional judgement, a referral to MARAC should be made.

[96] LCSFT Safeguarding Children and Adults Policy SG007

[97] Policy Number SG007

[98] PH50, ibid

[99] https://www.nice.org.uk/guidance/ng58/documents/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-.

[100] National Institute of Clinical Excellence, 2016 NG58: *Coexisting severe mental illness and substance misuse: Community Health and Social Care Services - best practice guidelines for health and social care agencies in delivering care to individuals who have a dual-diagnosis.*

[redacted]

[102] CL028 March 2021

[103] ibid

places. Jenny's history of experiencing domestic abuse however was not referenced in GP1 notes and there were no flags on her records to highlight her vulnerabilities. Routine enquiry, however, was not part of everyday practice pre-2017; but she was seen promptly by both GPs and careful prescribing practices were deployed. [redacted], often face-to-face by both practices. [redacted]. Following a consultation on the 17th, the GP recognised that Jenny would benefit from a referral to [redacted] (carried out on the 24th). Jenny was also offered support from the Focused Care Practitioner, albeit Jenny did not engage well.

3.80 In 2021, Turning Point started to assess Jenny's needs. It was clear she wanted to be a good Mum and have help with cravings. Harm reduction and considerations for her [redacted] were discussed. She was advised to engage with her GP and was allocated a [redacted] and multi-agency meetings were planned but they did not take place in December owing to staff sickness, and Jenny did not attend the January 2022 appointment.

3.81 'Think Child, Think Parent, Think Family'[104] was not always applied in contact decisions for Jenny and her Children, nor when assessing the risk posed by Ian. Jenny updated Oldham Children's Social Care about her relationship status and circumstances, but it was not clear if she was advised to access domestic violence services, and a safeguarding adult referral was not made to Adult Social Care, which was a missed opportunity. Oldham Children's Social Care are of the view that Jenny's voice was heard by social workers, when she wanted to see more of [redacted], which '*required a fine balance to ensure that the children were safeguarded'* but proved difficult to manage as [redacted] '*voting with … feet'* who was *'spending increasing amounts of time with their Mum'*. OCSC held no information with regard to Ian until after Jenny had tragically died.

Ian

[redacted] Ian's violence and offences to women, should have contributed more potently to assessments, [redacted] The addition of a safeguarding flag to his records was not made until July. [redacted] medium risk because no domestic abuse flags were on his risk registers, but further investigation, research of previous records and a more in-depth discussion with GMP may have influenced decision-making, particularly when there was awareness that Ian was involved with Jenny in 2022.

3.83 Their assessments did not appear to always take into account the range of information regarding domestic abuse about Ian, that was held by supervising and other agencies and assessments were not always made within review periods, however it is fair to say however that [redacted] did recognise him as a perpetrator of domestic abuse and linked this to risk. GMP recorded on January 2nd, 2015 Ian had assaulted Partner 2 (Ian) [redacted] on the 8th of January 2015, [redacted]; on the 19th of January 2015 [redacted] was added to his custody record; in June 2015 he was assessed [redacted] as posing a risk of serious harm, [redacted] to Ian's record owing to concerns; on the 21st of July 2016, [redacted] reviewed [redacted] owing to remaining concerns; on the 3rd of June 2019 [redacted] did not refer to his recent arrest or the risk he posed to Partner 7 (Ian); a Restraining Order was in place until September 2019 but was not found listed on his records and no action was taken in relation to his breach of this and in September 2020

[104] ditto

flags were added for domestic abuse; [redacted] knew about Ian's violence and the risk he posed, however serving professionals did not appear to always access or utilise the information.

3.84 It is significant that no domestic abuse call outs for Ian had been recorded on [redacted] since 2018 which may have influenced officers in their decision-making, however when Jenny, Ian and [redacted] at Jenny's newly offered accommodation in January 2022, assessment of a range of ongoing vulnerabilities and concerns could have instigated senior leadership oversight. In addition, if Jenny's behaviours had been considered in light of her previous actions, there would have been no other option, other than to have recalled her. When Spotlight Integrated Offender Management (GMP Officers) informed [redacted] that Jenny and Ian were together in early January, the information accessed by [redacted] did not give a full picture of Ian's offending history. If a GMP check had been carried out at the time it would have highlighted that Ian was a high-risk domestic abuse perpetrator in previous relationships and continued to be a risk to any female he was in a relationship with.

3.85 When Jenny advised [redacted] 19th of January 2022, followed by a Probation appointment where Ian attended with her (recorded on the 26th of January) his residency details were not queried. The attendance was also a missed opportunity to have raised the issue of [redacted] which would have contributed to the assessment of risk, given that Jenny was then in a relationship with Ian. Not declaring an intimate relationship also gave grounds for enforcement action towards Jenny. [redacted] albeit Ian and Jenny both knew they were '*wanted*' from the 27th.

[redacted] This was a missed opportunity, given the pattern of violence he had developed towards partners and girlfriends. [redacted] '*undermined the capability to monitor onward risk of serious harm*', which may have been a contributory factor, but it is not withstanding that recorded evidence existed regarding the risk he posed in relation to serious violent harm in domestic abuse.

3.87 Basic safeguarding checks in relation to Ian were not always undertaken throughout both scoping periods, by various agencies which increased risk. Relationships were not always explored by supervising practitioners, underpinned by a lack of professional curiosity, regarding who Ian was with, or where he was living, exacerbated by a lack of home visits and address checks. This became a theme, adding difficulties to the effectiveness of written communications and appointment planning and creating missed opportunities [redacted]. In October 2018, when Partner 6 (Ian) disclosed contact with him, his address remained unclear. Safeguarding concerns were not considered and the safeguarding check request from [redacted] was not timely. By the 24th of March, the lack of address and relationship checks continued; again, on the 2nd and 14th of April 2019, and [redacted] April 2019. There were also no checks made into an alleged GMP investigation that Ian had mentioned. Additionally, no checks were made regarding safeguarding of Partner 7 (Ian). In May 2021, when re-assigned [redacted] and living with Partner 12 (Ian), again no safeguarding checks were undertaken. In June and July that yea [redacted]

In September 2021, [redacted] de-registered the MARAC risk flag on his records and 4 months later when he left Partner 12's (Ian) home in December that year, no checks were undertaken about her safety. [redacted], and an unannounced visit took place, no questions were asked about Partner 12 (Ian). [redacted], known to [redacted], and Ian refused to provide an address, investigative

action into the Friend 1 (Ian) did not take place. Between 29th of December 2021 and 12th of January 2022, [redacted] staying between various addresses, which also remained unchecked.

[redacted] but there was a lack of rigorous monitoring and despite [redacted], his status with [redacted] was not checked and *'no apparent change or risk concerns'*, was recorded, [redacted] No assessment was made about the impact on those at risk of Ian's violent behaviours, or the link between [redacted] and the consequent impact on his behaviours. When he was sofa surfing and there was a lack of safeguarding checks and management oversight appeared to dwindle. When a home visit did take place [redacted] was not questioned, nor were the incidents that had occurred with Partner 11 (Ian). In 2021 when [redacted], a lack of professional curiosity prevented this from being explored. In February 2021 managerial instructions to several [redacted] appeared no to be followed regarding regularity, location, and the method of engaging with Ian.

3.89 GMP have acknowledged they failed to check their own historical record systems evidencing Ian as a violent offender, which had a critical impact in failing to safeguard Jenny. [redacted] have acknowledged that: from the 21st of January 2022 '*things very quickly spiralled out of control*', stating that a lack of risk oversight and knowledge gaps lead *to 'less stringent oversight and risk monitoring";* and *'a lack of regard on focused risk assessment by Officers, and a lack of multi-agency working, increased the risk that Ian posed'*.

[redacted] but the Practice was unaware of the domestic abuse in his relationships. [redacted] Given that the GP was aware that Ian [redacted] professional curiosity about his relationships may have helped to broaden knowledge of Ian.

[redacted] Child Protection Plan could have been clearer about what support was available for Ian in relation to domestic violence, his actions, behaviours, and risk. The department was aware of Ian's history and how this impacted on his ability to be around his own Children and those of his partners. [redacted] that *'the risks he posed to his relationships and children were all well assessed and known'*; however, what was not particularly evident was what was known by whom, and when, as some agencies were unaware of this risk.

[redacted] PCFT noted that it would have been of concern if Ian had had access to children or was in an intimate relationship, given his status as a known perpetrator of violence, but little curiosity was shown about family dynamics or his relationships, and that Think Family [105] was not always deployed by their practitioners.

[105] ibid.

Theme 6 – Information Sharing, communication, response co-ordination and multi-disciplinary working

Jenny

3.93 Holistic information sharing was not always well-implemented in relation to Jenny's increasing vulnerability and the lack of co-ordination of internal and external information sharing at CRC and Probation appeared to increase her risk. There is also evidence of inconsistent and mixed responses from agencies with regard to information sharing; timely and effective communication and as stated, a lack of joint multi-disciplinary approach to inform Jenny's safety and support needs and shared, agreed, and co-ordinated multi-agency risk management for both victim and perpetrator.

3.94 Probation acknowledge that between 2014 and 2017, '*information sharing was not requested in respect to her vulnerability'* and in 2016 when Jenny [redacted], referrals were not always made to her GP. The '*lack of focus'* on [redacted] has been acknowledged. There was also however the issue of [redacted] of which the GPs did seem aware, and managed.

3.95 In 2014, the IDVA service engaged with GMP, Adult Social Care, Probation and One Recovery[106] and participated in the MARAC meeting, where information was shared about Jenny. The service did not meet her needs, nor did they develop an ongoing relationship with her, but they did contact Oldham Adult Social Care in February 2016 regarding Jenny's case. The IDVA Service also asked GMP to make a MARAC referral, following the assault on Jenny on 5th of February 2016, but this did not happen because Jenny had retracted her GMP statement, which at the time meant a referral to MARAC would not take place.

3.96 In 2016, Victim Support had a high number of referrals from GMP and little engagement with Jenny and there was a lack of professional curiosity as to the ongoing demise of her situation, when she had been assaulted many times by Partner 3 (Jenny), and there was every possibility that GMP believed Jenny was accessing their support. They acknowledge that changes in address, phone numbers and circumstances impeded their attempts to engage with Jenny, along with the inability to share information with her. This was exacerbated by examples of internal poor practice, lacking a person-centred approach, failing to explore access to appropriate [redacted], or barriers that may have prevented Jenny accessing support. When, from February 2016, it was identified Jenny was potentially at risk of domestic abuse and she wanted face-to-face support from a female, with a call back the next day, the call was not made until 8 days later. When a text message was sent, there was no record that confirmed that this was a safe form of contact for Jenny. Victim Support acknowledge that whilst many referrals were actioned in line with agreed contact methodologies at the time, referral management fell short of expected standards and multi-agency working was not deployed to any level of substantive or positive effect.

3.97 In relation to Adult Social Care, GMP records state on 5th of February, 2016, following domestic abuse incidents on the 1st, 4th, and 5th from Partner 3 (Jenny) a DASH assessment showed high risk and a referral was made to Oldham Adult Social Care, but a response was not evident. On March 20th, 2016, a GMP record noted that a safeguarding referral was made via a PPI[107] to Oldham Adult Social Care, following Jenny [redacted], and a response was not evident. An IDVA record states on June 11th, 2016, following an assault on Jenny by Partner 3 (Jenny) Adult Social Care were informed, and the GMP were asked to refer Jenny to MARAC, and the response is not clear. GMP made a further referral on March 19th, 2017, again they did not receive a response.

3.98 START[108] referred Jenny into the Oldham [redacted] following GP3's referral to them, in December 2021 and the [redacted] are of the view that information sharing would have been valuable in relation to Jenny's social and risk history and previous mental health assessments. The possibility of whether the

[106] One Recovery – addiction treatment centre in Oldham
[107] Public Protection Investigation Document
[108] START – ibid NHS LCSFT

input of [redacted] had been explored was not documented. (Jenny's prison release took place 3 days after the first referral into NHS LSCFT [redacted] had been received, which concurs with the finding herein that her release date from prison was different to what was recorded on the information and referrals received).

3.99 GMIC noted evidence of information sharing between agencies at various points, [redacted]

3.100 LCFST have acknowledged that communication between their [redacted] and GP3 was ineffective in 2021 -with limited evidence of multi-agency planning for her release, and no evidence of direct communication between Jenny's Probation Officers and the [redacted] attempted to speak with Probation and when Jenny was to be discharged.

3.101 Turning Point advised that communication and information sharing between agencies was of a good standard in 2021, with communications to Probation, followed by phone call or email on the same day, supported by attendance at the twice weekly Spotlight meetings, held by GMP.

3.102 Oldham Children's Social Care records demonstrate that information sharing with Probation and '*other services'* took place, but was '*ad-hoc'*, lacking consistency and co-ordination. There are examples however of good communication and information sharing between Social Worker 3 and Jenny's Responsible Officer, from Probation from Jenny's release date in 2021, and during the attempts made to locate her in February in 2022. It is important to note the views of [redacted] and their foster carer, which are that Social Worker 3 '*went beyond the extra mile'* for Jenny.

3.103 BCYPD held information regarding the risk that Ian posed to adults and children and information about his violent offending history. This was referred to [redacted] as being '*regularly shared'*, however [redacted] remained unaware of this information, yet BCYPD had previously shared information via multi-agency strategy meetings; courts; CAFCASS; reviews, case conferences and 'core groups' for risk management of his Children. There is some evidence that [redacted] services contacted BCYPD regarding Ian, but it is not clear what was shared or sought. BCYPD have recognised the need to share information with agencies in other areas, when high risk perpetrators move between Local Authorities, given that in this case they were unaware of his new relationship with Jenny. BCYPD held substantial and significant information about the risk Ian posed to partners, and his Children, as did GMP and Warrington and Bury Probation teams, which was not always jointly shared.

3.104 Post placement breakdown in 2021 there was a delay in PCFT being notified that Jenny had returned to the area, and an appointment was consequently not offered until the 18th of January 2022, which she did not attend, despite attempts to contact her. PCFT reflect that given Jenny's extensive history and vulnerabilities, that liaison with her GP would have been a useful way to make contact. They have considered that a further referral to the [redacted] may have provided short-term intervention. It is not clear why such a referral was not made, but this could have been affected by the short space of time they were involved in 2021-2.

3.105 Approved Premises found maintaining Jenny's placement challenging in view of her behaviours, relationships with staff and conflict with between residents,[109] which contributed to the immediacy of finding her a suitable address and inability to confer with partners. It could be argued however, that the move increased Jenny's risk, given that from that point onwards, she never managed to live in stable accommodation, also noting her lack of availability when Spotlight Integrated Offender Management Team member (GMP Officer) tried to visit her when she moved in with her Mother.

[109] There is research that supports PIPE effectiveness and research that questions it. Brader (Personality Disorders in Prison and Probation: Are Specialist Units Working? House of Lords, May 15th, 2023) referred to the review of thousands of prisoners in England who required support from custodial mental health services (between July and September 2021) and one of those services included Psychologically Informed Planned Environments (PIPEs) designed to support offenders with personality-related difficulties. An evaluation of PIPEs was commissioned by HM government and considered former work on the Evaluation of Psychologically Informed Planned Environments, from 2022. The report noted that the evaluation's methodology had several limitations, including limited scope and small sample sizes, meaning that some findings should be viewed with a degree of caution. Preliminary evaluation of findings from HMPPS, stated that: '*researchers were unable to provide a "robust" conclusion on the effectiveness of PIPE approved premises, owing to implementation difficulties of the PIPE model caused by violence, drugs and staff restructuring. Some residents said they had received support to make positive progression, but residents did not attribute success to the premises specifically. In conclusion, the report said future research was needed to identify whether the PIPE model could be applied effectively in community settings.*' The *Evaluation went on to state that there were "no reliable findings" and as such further work has been recommended on this matter. This is a view supported the Offender Personality Disorder Pathway and work is currently being undertaken to examine the viability and methodology of future research projects.*

3.106 Approved Premises found maintaining Jenny's placement challenging in view of her behaviours, relationships with staff and conflict with between residents, which contributed to the immediacy of finding her a suitable address and confirm more effectively with partners.

3.107 The knowledge of risk appertaining to Ian and Jenny in General Practice was limited, and information was not routinely shared with them by services supervising the couple. Following Jenny's release from prison and whilst under her terms of licence, she had regular contact with Probation and later, had various levels of contact with GMP and Turning Point. Contact with other partner agencies was inconsistent. Spotlight Integrated Offender Management (GMP Officers) held weekly meetings to work together and share information. Probation met with staff from Approved Premises regularly and Social Worker 3 had started to join Probation meetings in late 2021, so some information was being shared, some of the time, with some of the partners. However, a joint forum was not in place for wider involvement, particularly in relation to health partners, which prevented information being consistently and jointly shared, holistically.

3.108 When Jenny moved to her mother's address in October 2021, there was awareness the situation carried a high risk of break down and it was not discussed with Oldham Children's Social Care. In 2021, Spotlight Integrated Offender Management (GMP Officers) visits did not form part of Jenny's licence conditions [110] but information was shared at twice weekly meetings with Turning Point and Probation and visits to Jenny were increased to twice a week to provide her with additional support.

Ian

[redacted] was lacking and multi-agency working, and consequent information-sharing would have been beneficial to have reduced the risks that the gaps in practice had created. From April 2016, GMP systems recorded Ian was a high-risk domestic abuse offender and "*any female he was in a relationship with was at risk'* which they have acknowledged '*should have been shared with partner agencies as a matter of urgency so a risk assessment could have been carried out'.*

[redacted] no concerns were raised, GMP held information that concerns had been raised by Bury Children's and Young Person's Department. [redacted] it was not evident that the GP knew that Ian was involved with [redacted] and multi-agency working could have been more joined up.

3.111 Ian had appropriate flags and markers in relation to domestic abuse added to his nominal record on GMP IT systems and there was evidence of managing Right to Know disclosures for partners, under the Domestic Violence Disclosure Scheme in 2015, 2019 and 2020.

Ian and Jenny

3.112 MARAC and MAPPA referrals were made for Jenny by [redacted] Social Worker 3 was updated with information but not always about decisions. GP3 was contacted but a multi-agency meeting forum was not in place for thoughts and plans to be contributed to. [redacted]

3.113 When information was shared, it was not always timely. [redacted] shared information with Spotlight Integrated Offender Management (GMP Officers) on the 17th of January 2022 when they became aware of Jenny's relationship with Ian, and there was a 48-hour delay in the Spotlight Integrated Offender Manager advising [redacted] that they had already met Ian with Jenny. [redacted]

[110] In October 2022 a new local protocol was introduced in Oldham where Spotlight Police Officers appointment visits formed part of the licence conditions and following evaluation considerations will be given to the possibility of implementation across all Spotlight Police departments in Greater Manchester Police.

[redacted] and Probation decided to recall Jenny from the 27th.

3.114 Following the reported domestic abuse incident in February 2022, the co-ordination of Probation's response seemed confused. [redacted] This was not shared with GMP, which was a missed opportunity to safeguard Jenny. On the 1st of February, Social Worker 3 confirmed to [redacted] reported that Jenny had facial injuries and was being held against her will by Ian. This was shared with GMP by Oldham's Children's Social Care in a timely way, but it is not clear if this information was shared by GMP or Children's Social Care [redacted] which is of significance, as Probation have confirmed that Jenny was the injured female, who arrived with Ian that afternoon, at their office.

3.115 When on the 1st of February, at 14:49 [redacted] but this information was not shared with GMP. Whilst it is accepted that emails may not have been read in time [redacted], prior to Ian and Jenny arriving in the office together on the [redacted] it is of concern that efforts were not made to check and communicate information in advance. It is not clear on that date, if [redacted] or SPO 3 updated [redacted] and or vice versa, nor is there any record of GMP being informed. Efforts to have separated Jenny and Ian that afternoon, may have proved beneficial.

3.116 It is not evident how the [redacted], became advised of information about the incident. At 16:50 on the 1st, a record refers to the social work 'safeguarding contact' for children being contacted by Responsible Officer 10 (formerly Responsible Officer 8) however it is not clear a) which social worker this was b) which children this contact referred to or c) if all relevant social workers were contacted, regarding all of the Children for both Jenny and Ian. It was only at 16:56 that day that the contact with Ian and Jenny was shared by [redacted] with Responsible Officer 5 (for Jenny), but not shared with GMP. [redacted] have confirmed they did not request a full disclosure from GMP about the risk that Ian posed to share with Jenny.

Theme 7 – Resources, policy, procedural and personnel issues that affected service response.

[redacted] experienced changes in IT, processes, and locations, which could have contributed to professionals focusing on trying to achieve target driven objectives, as opposed to attaining quality and effective practice - [redacted] failing to include wider areas of risk or assessment completions. A lack of structured management oversight on lower risk cases [redacted] It was also affected by CRC and the National Probation Service undergoing transition through multiple versions of delivery models during Covid-19, affecting frequency and type of client contact, which affected the relationship with Ian. [redacted] at the point of unification impacted on creating high caseloads. Missing contact information, a lack of weekly appointments and inconsistencies were noted when Jenny moved from the Approved Premises and safeguarding management fell below expected practice levels.

3.118 GMP advise that there is always demand on GMP resources and the need to effectively risk assess and prioritise incidents, and policies for Incident Allocation and Escalation, are in place to address such issues. However, GMP have acknowledged that on January 27th, 2022, when Jenny was

recalled and GMP were notified, no enquiries were made for 12 hours owing to resource issues and she was not located or arrested, but the log was allocated to an officer the following morning to commence enquiries. When Jenny had not been apprehended, the enquiry was passed to the Spotlight Integrated Offender Management Team (GMP Officers) to continue. Jenny was never traced or arrested, and GMP acknowledge that Spotlight Integrated Offender Management (GMP Officers) *'became focused on dealing with this matter as a recall to prison'.* They confirm however, that the incident log created following the phone call from Jenny's Mother in February, was responded to as Grade 1 high priority in line with target response time (requiring attendance at an incident within 15 minutes of the log being opened) and albeit when a crime was recorded, and the incident log was closed[111], the recall log remained open.

3.119 GMP made a self-referral to the Independent Office for GMP Conduct (IOPC) owing to Death or serious injury[112] criteria having been met in these circumstances and the investigation has concluded that there was no indication that any GMP officer may have behaved in a manner that would justify the bringing of disciplinary proceedings or committed a criminal offence.

3.120 PCFT have acknowledged that there was no Domestic Abuse Policy or domestic abuse training in place until 2017 to support staff in the recognition and response to domestic abuse, which has now been rectified.

3.121 Victim Support have acknowledged that from the hundreds of monthly referrals received from GMP, many have incorrect contact details, which delays a support offer, but processes now include annual Service Equality Impact Assessments. They advise that there was no framework within their organisation that allowed them to: '*establish on-going consent from victims to enable such support to be offered*'. They also advise that '*they do not hold a remit for high-risk cases'* but correctly liaised with other services and deferred to the IDVA Service, regarding MARAC[113]. Given the high number of referrals received regarding her welfare, this should have caused concern, reflection, and action, with regard to information sharing, given that Jenny was a repeat victim of crime.

3.122 The IDVA Service acknowledge that a number of operational issues[114] were apparent at the time, such as inconsistencies in the quality of recording of personal details; spelling of names; gaining details of perpetrator's contacts; understanding how and why services may have been involved with a victim and system recording limitations[115] and that practice lacked oversight and sign off by managers[116].MARAC actions were not always uploaded to individual agency case files.

3.123 PCFT acknowledge that their Patient Engagement Policy resulted in patients being discharged from services if they did not attend appointments, regardless of their vulnerabilities,[117] which is now under review.

3.124 General Practice for both Jenny and Ian found no evidence of any resource, or system issue that affected service response, however the lack of routine enquiry did affect response to Jenny.

3.125 NHS LSCFT advise that the average waiting period to see a [redacted] review between August and October 2021 was approximately 84.8 days, and in view of this contact with Jenny's GP and Probation Officer would have been beneficial, in order to address her identified,

[111] Police advise that it would not have been possible to task patrols, via use of the incident log to revisit the address.

[112] A 'death or serious injury matter' means any circumstances (unless the circumstances are or have been the subject of a complaint or amount to a conduct matter) in which:

1. a person has died or sustained serious injury and,
2. at or before the time of death or serious injury the person had contact of any kind – whether direct or indirect – with a person serving with the police who was acting in the execution of his or her duties, and
3. there is an indication that the contact may have caused – whether directly or indirectly – or contributed to the death or serious injury.

[113] The information from the Greater Manchester Victim Support website could be consequently misleading as it states: *"We give emotional and practical help to people who have been affected by crime in Manchester. We're an independent charity and you can contact us for support regardless of whether you've contacted the police, and no matter how long ago the crime took place. We'll help you for as long as it takes to overcome the impact of crime'.*

[114] practice standards have now been introduced.

[115] Now replaced.

[116] Now amended.

[117] A new policy is in development, where it's proposed that this will address risk associated with any patient disengaging (or refusing care and treatment) and is to include conversations with families; carers and significant others, in order to gather views and explore concerns, and liaising with multi-agency partners, to share information.

and unmet needs. This may also have enabled links to be made with her long-term accommodation issues, GP registration, and care co-ordination and would have improved the outcome of the discharge planning process.

3.126 Turning Point did not note any resource or system issue that effected operational delivery.

3.127 Oldham Children's Social Care did not note any resource or system issue that effected operational delivery.

3.128 BCYPD advise that their decisions were reviewed by management, but escalation processes could have been timelier, particularly in relation to child protection, and staff changes were greater at some points than others, but not excessive.

3.129 Housing Options at Oldham Council experienced a lack of suitable accommodation to meet Jenny's needs.

4. Multi-Agency Lessons Learned and Conclusions

Conclusion 1

Agencies did not always link 'risk to harm' for Jenny nor consider the impact of domestic abuse, and accommodation issues.

4.1 Prior to her imprisonment, Jenny's lack of permanent accommodation; ; her health issues, and the very serious risk posed by two abusive partners in successive relationships, were not always linked to harm. This undoubtedly had a negative impact on her made worse by a lack of full and participative multi-agency working to have enabled a shared approach to safeguarding, risk assessment and management. At times there was correlation between physical assault from domestic abuse and Jenny is recognised that her volatility acted as a barrier to her receiving appropriate . However, as PCFT were not in place, the Trust were not always aware if Jenny was able to make balanced decisions in relation to the number of times she left hospital before being seen by

4.2 Prior to 2017, Jenny was not always perceived as a victim of Domestic Abuse by PCFT and its services which impacted on missed opportunities to support and safeguard her. From 2014 to 2017 PCFT's assessments lacked professional curiosity and routine enquiry about domestic abuse which negatively impacted on Jenny, and safeguarding concerns were not raised. PCFT were aware that Jenny and experienced a serious assault. A thorough approach to multi-agency working was not evident, which increased her risk. Jenny The alert placed by PCFT on Jenny's health record regarding her being a risk to others, was paralleled by the lack of importance given to her as a victim of serious and significant domestic abuse, and no endorsement by flagging for safeguarding or domestic abuse concerns. There were few safeguarding alerts being made and Jenny's pattern of non-attendance impacted on her ability and warranted exploration. (A PCFT Domestic Abuse Policy was not in place at this point, which has now been remedied).

4.3 Therapeutic intervention for Jenny, from Prison Services and support from Probation, appeared to make a positive, but short-lived impact on Jenny. Concern was cited in Probation's that the formulation[118] made was not used as effectively as it could have been in order to have managed Jenny's non-compliance with her licence. Post release Probation made concerted attempts to secure accommodation for Jenny and to secure her attendance to

[118]

appointments and made relevant referrals, but the approach was inconsistent and lacked managerial oversight.

4.4 Missed opportunities existed for discussions about Jenny's welfare to take place in General Practice, and consequently options were also likely to have been missed, particularly in respect of her [redacted] not evident that the reviews were pa[redacted] services were made, but usually boycotted by Jenny's disengagement.

4.5 In 2016, Victim Support and IDVA Services failed to engage with Jenny and as such, her support needs were not assessed.

4.6 In 2021, Approved Premises provided a support programme for Jenny which she struggled to comply with, failing to benefit from the advantages it could have provided. Greater focus could have been placed on her as a victim of domestic abuse, who needed help to recognise coercive and controlling relationships, capable of causing [redacted] harm.

Conclusion 2
Health Transfers and signposting were not well managed for Jenny and Ian by some partners.

4.7 Responsibility for Jenny's [redacted] to have seamlessly continued post post-release, as part of a 'prison to community' transition was placed with NHS LSCFT and was made via a [redacted] from the Prison to the Trust. However, it is not clear if relevant documentation such as Jenny's [redacted] were also transferred, or whether they had to be requested. It is also not evident that she was referred into a Democratic Therapeutic Community as part of the [redacted]. When she later moved to Oldham it would appear that there was no transfer in place from by Preston's [redacted], because Jenny did not register with a local GP, which contributed to Jenny being unable to access [redacted] which was one of her licence conditions. The Practitioner from LSCFT had to request support from Oldham Probation Service for Jenny to register with a GP, which did happen but not until November 2021.

[redacted]

4.9 General Practice saw evidence that Jenny wanted a fresh start and barriers posed to her by her [redacted] made it very challenging for her to cope with readjustment. The only time Jenny actually [redacted]. GP3 made several referrals to START for Jenny, both in July and December but through various issues, this did not become a viable CMHT offer, until January 2022, and was never accessed by Jenny, owing to her missing the January appointment.

Conclusion 3
A lack of professional curiosity, routine enquiry, accurate research into records and a lack of safeguarding adult referrals under Care Act 2014 responsibilities, increased Jenny's risk of domestic abuse.

4.10 Jenny did not refer to herself as a victim of domestic abuse and did not always advise practitioners about the harm she experienced, however domestic abuse and trauma had a serious impact on her [redacted], her self-esteem, her ability to become independent, and on her ability to make informed decisions, when trying to manage goals. Professional curiosity did not support the safeguarding of Jenny by exploring relationships, where she was staying and who she was with.

4.11 A lack of professional curiosity prevailed throughout the attempt to risk assess and manage Ian in the community from some services. [redacted] was insufficient in a number of respects, but they were aware of the risk he posed in relation to domestic abuse and '*may not have been effectively acted on'*. However not all [redacted] seemed operationally aware of this and there is a substantial difference between the organisational ownership of knowledge and the knowledge of individual officers, which thus affects practice delivery.

4.12 Records were not always flagged in various services in relation to Jenny's risk of domestic abuse but were sometimes flagged in relation to risk she posed to others. GMP flagged both Jenny as a victim of domestic abuse and flagged Ian as an offender of domestic abuse.

4.13 Pre 2017, Victim Support lacked professional curiosity about the high volume of referrals and there was a lack of professional follow up, which increased risk.

4.14 Pre 2017, a lack of routine enquiry into domestic abuse served to increased risk at Probation; General Practice; START; PCFT; NHS LSCFT and Turning Point (2021).

4.15 PCFT did not refer Jenny to the [redacted] may have enabled improved support for Jenny, and an assertive multi-agency approach was not in place. There was also a lack of professional curiosity about Ian's relationships despite knowledge that he posed risk to women and seemingly a lack of knowledge that he posed risk to children.

4.16 Oldham Children's Social Care missed opportunities for professional curiosity to have been deployed in relation to the risk faced by Jenny from the impact of domestic abuse; substance use and accommodation concerns before and after her release from prison in 2021.

Conclusion 4
Deployment of Oldham Multi-Agency Safeguarding Adult and Children's Policies and Procedures were not always considered by all partners.

4.17 At times it is evident that various services, lacked consideration to safeguard adults and children at risk, to prevent domestic abuse and failed to put into place the checks and balances required in the management of community safety, which at times included the failure of Adult Social Care to appropriately implement the Multi-Agency Adult Safeguarding Policy and Procedure (see Conclusion 6).

Conclusion 5
A co-ordinated multi-agency risk management plan was not in place post Jenny's release in 2021, which would have provided the forum for information to have been shared.

4.18 Significant events and incidents were recorded in Jenny's history and held in various places by various services, [redacted] and information was not drawn together. This was both at the supervising organisation's level and multi-agency level, increasing risk for Jenny. There were missed opportunities for a wider level of joint working and shared risk management when agencies knew that Ian and Jenny were together. When Spotlight Integrated Offender Management (GMP Officers) advised Probation on 17th January that Jenny and Ian were together, if a GMP domestic abuse check had been carried out then Ian's history would have become apparent and where there is a history of domestic abuse Spotlight Integrated Offender Management (GMP Officers) must make safeguarding and risk a priority.

Conclusion 6
Jenny was not always perceived as an 'adult at risk' and the Care Act 2014 was not always applied to safeguard Jenny[119] and when safeguarding referrals were made they were not always responded to.

[119] Northern Care Alliance have stated that Conclusion 11 was a key issue that impacted on all other decision-making.

4.19 Jenny fulfilled the criteria for a Care Act[120] assessment by Adult Social Care to be carried out and for safeguarding adult referrals to be made, both of which would have increased the opportunity of multi-agency discussion: joint risk management and consideration of deploying s42 safeguarding enquiries. GMP made several adult safeguarding referrals to Adult Social Care which frequently lacked an appropriate response. The GMP and IDVA were the only agencies, after 2014, who referred Jenny to Adult Safeguarding in Adult Social Care. This occurred on March 20th, 2016 (GMP); June 11th, 2016 (IDVA) and March 19th, 2017, (GMP). It is not evident that any response was received from ASC and yet Jenny met the regulatory lawful criteria as an 'adult at risk', or for a s42 Enquiries and Care Act Assessments to have been considered. The lack of safeguarding adult referrals from other agencies, over both time frames, and the lack of response from the lead agency with statutory safeguarding adult responsibility i.e., Oldham Adult Social Care, culminated in a range of missed opportunities for section 42 Enquiries to have been considered and to thus effectively safeguard Jenny.

Conclusion 7

Some resource issues, policy, procedural, systems working, and the way some personnel managed their roles, affected service delivery.

4.20 There were some operational, policy, procedural, safeguarding and resource concerns that emanated from various services which affected some delivery and some response.

Conclusion 8

A lack of settled accommodation, [redacted] and family influences affected Jenny's vulnerability, increasing her risk.

4.21 The lack of settled accommodation in Jenny's life was a constant source of distress to her and added to her vulnerability. The decision to move Jenny to her Mother and stepfather's home was not likely to be sustainable and move-on accommodation planning did not start early enough. Jenny's personal trauma, [redacted], instability of residence and [redacted] increased her vulnerability to abusive relationships with violent men and negative outcomes for her [redacted]

4.22 Some of Jenny's decisions were influenced by wanting to [redacted] which demonstrated [redacted] Probation, and the Approved Premises, all found it difficult to [redacted] and intensity wanted by Jenny [redacted] and there could have been opportunities to try and develop medium term plans for Jenny [redacted], in relation to the future contact and its management. Various agencies failed to apply 'Think Child, Think Parent, Think Family'[121] in practice, which may have hindered exploration of the impact of Jenny's relationships [redacted]

Conclusion 9

Jenny was not safeguarded by a DVDS disclosure, with regard to Ian's offending history and the risk he posed to her, and her children.

4.23 It is not clear why agencies, did not approach Jenny to discuss the importance of her accessing a DVDS disclosure, regarding Ian's offending history in relation to domestic abuse, and the consequent

[120] The Care Act 2014

[redacted]

risk he posed to her and her Children[122] [123]. Had this have taken place it may also have strengthened multi-agency knowledge and safeguarding for Jenny, given that the process involves multi-agency decision-making[124].

Conclusion 10

[redacted] were not used to protect and safeguard Jenny.

4.24 It would appear that [redacted] may not have considered detainment under the [redacted] in order to treat and safeguard Jenny, possibly affected by Jenny leaving the hospitals concerned.

4.25 The lawful requirements of the [redacted] on several occasions, were not deployed by various services in relation to some of the high-risk decisions that Jenny made, where her [redacted] seemed to go unquestioned by professionals in relation to her ability to judge associated risk.

5. Single Agency Conclusions[126]

5.1 Probation

5.11 Conclusion 1

Some Officers in Probation were challenged in trying to manage Jenny as a complex offender with a history of domestic abuse and [redacted], and their practice and decision making would have benefited from senior management input and help from other specialist service professionals[127]

5.12 Jenny had developed a clear pattern of behaviour where dis-engagement from services became the norm, which prevented her from accessing the help and support she needed, which warranted exploration.

5.13 Probation did not take a consistent and robust approach to enforcement action, and decisions lacked senior management input and review and help from other specialist service professionals.

5.14 Relevant contact was not always made with primary care in respect of [redacted]

5.15 Jenny's lack of a permanent address appeared to pose a barrier in her being able to access [redacted]

5.16 Conclusion 2

Some assessments were of poor quality and lacked managerial oversight.

5.17 Up to her conviction in 2017, Jenny's pattern of long-term disengagement, [redacted] contributed to her behaviours growing out of control, at times resulting in dangerous offending, [redacted] and increased personal vulnerability, which did not always appear to be understood. Post release she [redacted], owing to her vulnerability and struggle with maintaining positive change. Post release assessments

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[122] Claire's Law, ibid

[118] https://www.gmp.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha/request-information-under-clares-law/ (cited July 13th, 2023)

[124] Greater Manchester Police have now revised their Policy in relation to DVDS.

[redacted]

[126] Single Agency Conclusions were submitted by Probation Services only and it was felt important to add them to the Report.

[127] Advice from Probation states that this matter related to one practitioner rather than several, and that an officer did not follow policy or formulation, and was overly influenced by a therapeutic approach, losing sight of risks on occasion. Whatever the case, managerial oversight remains in question.

[redacted]

improved to consider a wider range of concerns, with recognition of the impact of trauma on Jenny, but did not fully explore the impact of her being a repeat victim of domestic abuse [redacted] It could be said that the leniency afforded to Jenny post release, from Probation, was in part contributed to by the adoption of the trauma informed approach, which in turn would appear to have affected the lack of enforcement decisions.

5.18 In relation to Ian, risk was not fully explored regarding the danger he posed to women and children. Numerous opportunities were missed, increasing the risk he posed to domestically abuse women, placing them and their children at risk.

5.19 There was a lack of rigorous monitoring, inconsistent management oversight and officers not always following managerial instruction, that allowed missed opportunities for enforcement action in relation to Ian, [redacted], increasing the risk he posed to others.

5.20 Conclusion 3
Enforcement actions lacked consistency.

5.21 There were missed opportunities for enforcement action in relation to Ian and Jenny and the thresholds for such decisions lacked management oversight.

6. Good Practice

6.1 Manchester University NHS Trust - North Manchester General Hospital
6.2 A doctor raised the safeguarding concern in 2014 to Adult Social Care and Oldham Children's Social Care and Jenny's case was discussed with the Public Protection Investigation Unit and rated as high-risk domestic abuse.

6.3 Thames Valley Police
6.4 In 2019, Thames Valley GMP were made aware that [redacted] a DVDS Disclosure was made, [redacted]. An urgent response marker was considered, and a MARAC referral was made to GMP in August.

6.5 Greater Manchester Police (GMP)
6.6 Right to Know disclosures for Ian's partners were made under the Domestic Violence Disclosure Scheme in 2015 and 2020.

6.7 Following an assault of Jenny in 2014 Partner 2 (Jenny) was charged and appeared at court where he was found guilty of Section 47 assault and a 'Protection from Harassment Order' was also given to protect Jenny and a referral made to MARAC.

6.8 When from April 2016, GMP systems recorded Ian as a high-risk domestic abuse offender and appropriate flags and markers in relation to domestic abuse were added to his nominal record on GMP IT systems,

6.9 March 2017 Jenny approached GMP in Oldham and [redacted] a safeguarding referral was made to Oldham Adult Social Care.

6.10 May 2017 May, GMP raised '*a concern for safety',* for Victim 2 because Jenny and Partner 3 (Jenny) were living in his house.

6.11 February 2018, Ian had assaulted Partner 4 (Ian) a crime submitted was submitted for a s47 assault; a MARAC referral was made, information put onto SharePoint and a referral made to BCYPD.

6.12 In 2021 Jenny moved to her Mother's home, a particular Spotlight Integrated Offender Manager (GMP Officer) was allocated to visit Jenny, providing an opportunity to build rapport with Jenny. The GMP Spotlight Team frequently went the extra mile to support Jenny.

6.13 PCFT

6.14 When in 2017 Jenny failed to attend the EIT appointment and was uncontactable, EIT informed Probation and flagged Jenny's record as 'risk to others.'

6.15 When in 2017 PCFT tried to improve Jenny's engagement with their service and she left ED without waiting for treatment, they liaised with Jenny's Probation Officer, contacted GMP for safe and well checks; [redacted], wrote to her GP (the latter which was carried out after each of her attendances) and liaised with EIT.

6.16 When in December 2021, GP3 raised a referral for Jenny to PCFT, they responded quickly and confirmed arrangements in a timely manner.

6.17 Greater Manchester Integrated Care (General Practices 2 and 3 - for Jenny)

6.18 When Jenny's [redacted]

6.19 When in 2016-17 Jenny used the out of hours GP service there is evidence of timely information sharing between the acute and out of hours services with GP1.

6.20 When throughout both scoping periods, Jenny's [redacted] by both GP Practices, who were always responsive to Jenny.

[redacted]

6.22 When in 2021 GP3 noted there had not been a [redacted] handover from services in Preston to Oldham, a request was made for her to be reviewed by local secondary [redacted] in Oldham, and queries were raised with PCFT with regard a plan for her care and support, along with queries about interventions that had been made with Jenny when she was in Prison.

6.23 When in 2021, Jenny did not attend three appointments with Focused Care at GP3 Practice, follow up was prompt.

6.24 There was timely information sharing between the acute and out of hours services with GP1.

6.25 Victim Support

6.26 When in 2016 it was established that a MARAC had not been held since 2014 and IDVA was contacted, supported by caseworker follow-up, and the referrer was informed that the case was closed.

6.27 IDVA Service

6.28 When IDVA contacted Oldham Adult Social Care in 2016 and were advised that Jenny's case was closed, they then contacted Oldham Public Protection Investigation Unit (PPIU)to request history of domestic abuse with regard to Partner 3 (Jenny), along with warning information.

6.29 Probation

6.30 [redacted], given previous information received about Partner 2 (Ian) receiving threatening calls.

6.31 When in 2021, Approved Premises raised concerns with [redacted] regarding Jenny visiting a male's house who [redacted] sought clarity on the extent of Jenny's actions.

6.32 When in 2021, Social Worker 3 spoke [redacted] concerns, a joint meeting was set up to include Jenny.

[redacted]

6.34 When Jenny required increased support in 2021, post release, Probation made a Focused Care referral to GP3 to support her with prescription management and her health needs.

6.35 When in January 2022, Jenny attended Probation appointment, with Ian [redacted]

6.36 When from October 2021, Probation made significant efforts to secure accommodation for Jenny which when impeded by her actions and decisions, support was requested from P3.

6.37 When in January 2022, MARAC and MAPPA referrals were made for Jenny; Social Worker 3 was kept updated and Jenny's history was shared with GP3 by [redacted]

6.38 Good practice was evidenced in the trauma informed approach taken by Jenny's supervising Probation Officer, balancing Jenny's need and managing risk.

6.39 A robust risk management plan was in place after the Parole Board directed Jenny's release, which was used to manage co-ordination of the agencies involved, particularly when Jenny left Approved Premises; and when the relationship between Jenny and Ian was discovered. Once a recall decision was made there was constant liaison with GMP IOM to try to find and arrest Jenny and to manage the risk that was clearly escalating.

6.40 There was a level of genuine commitment in Probation, to caring for the well-being of those being supervised and a genuine desire to assist people to receive the support they needed to make changes. There were efforts to encourage a sense of self and motivate others in positive life goals, albeit this did not always result in positive outcomes, but practitioners tried to balance managing risk, whilst building relationships with those supervised and encourage change.

6.41 Approved Premises

6.42 Good links between the Approved Premises and Probation and information sharing with some partner agencies, and a good level of appreciation to the challenges faced by Jenny.

6.43 When in 2021, Approved Premises updated Oldham [redacted].

6.44 When in 2021, appropriate support was put into place for Jenny's [redacted]

6.45 When in 2021, [redacted] were discussed with her, and appropriate support was put into place.

6.46 When in 2021, Jenny was visiting a male's house, [redacted]

6.47 When in 2021, Jenny attended the [redacted] and was she supported by the staff at Approved Premises, to do so.

6.48 When in 2021 the referral to Inspire was chased.

6.49 When in 2021 reports from the prison [redacted] develop support for Jenny.

6.50 Oldham Children's Social Care

6.51 When in 2021, Social Worker 3 shared with Probation that a day out was planned for Jenny with her mother [redacted] and the Social Worker's expectations were clear.

6.52 When in 2021-22, Social Worker 3 maintained good communications and shared information with Probation.

6.53 When in 2021, Social Worker 3 joined probation meetings with Jenny.

6.54 NHS LSCFT - CMHT

6.55 Alternative appointments were offered when Jenny did not attend.

6.56 Regular contact with Jenny was attempted by the practitioner.

6.57 NHS LSCICB

6.58 Referral of Jenny to the [redacted]

6.59 Turning Point

6.60 When Jenny failed to attend Turning Point in 2021 they informed Probation and communications and information sharing was of a good standard, followed up by phone or email on the same day, supported by their attendance at the twice weekly Spotlight meetings held by GMP, and attendance at multi-agency meetings was timely and effective.

6.61 Northern Care Alliance

6.62 When in 2014, Jenny was offered the opportunity to commence [redacted]

6.63 Staff requested safe and well checks from the GMP when Jenny left the department before treatment.

6.64 BCYPD

6.65 When in 2014-17, information was shared information via multi-agency strategy meetings; courts; CAFCASS; reviews, case conferences and 'core groups' for the risk management of his children.

[redacted]

7. Recommendations - *(all recommendations below have been made by the agency concerned, unless otherwise stated).*

7.1 Probation

1. To arrange a practitioner briefing regarding assessing 'risk to self' and relevant Care Act Assessments.
2. To review current practice of Officers involved with Jenny, who remain in practice.
3. To hold reflective discussion with one of Jenny's practitioners regarding the use of the MAPPA framework, when faced with managing a case with multi-agency involvement and challenging timescales to work to.
4. To gain assurance of full risk information sharing, underpinning management oversight.
5. To review [redacted] with reference to 'end therapy' and formulation implementation (in relation to the final prison where Jenny resided) with the Insight Band 6 Manager to consider Prison Director Group sessions with practitioners, focusing on implementation of a trauma informed approach.
6. To review information from 6-week review audits and Root Cause Analysis Tool to ensure purposeful home visits are taking place, in line with policy framework and at a point of transition.

7.2 Approved Premises

1. Probation Service to audit implementation of SaSP and CARE policy.
2. Develop increased partnership working [redacted]
3. Bed withdrawal review systems to be implemented.

7.3 Greater Manchester Police

1. Officers should be reminded of the guidance document check list for use when considering Evidence Led Prosecutions.
2. Officers should be reminded of the required action to upload the DVDS disclosure form onto the GMP system following a disclosure.
3. Updated training in Domestic Abuse Matters to be provided for all front-line officers.
4. Updated Domestic Abuse, DVDS and vulnerability training for Spotlight /Offender Management officers.
5. A standardised system to be in place for the storage of documents/information for Spotlight Units.

7.4 Victim Support

1. To advise victims that they cannot be guaranteed or offered face to face support or assessment, due to capacity restraints.
2. Vulnerability was not linked throughout, or considered in attempts to make first contact which must improve.

7.5 Oldham Independent Domestic Violence Advocacy

1. To continue with the move to an improved 'fit for purpose' case recording system.
2. To continue with improvements in the quality of case recording and consistency of recording names and addresses.
3. To continue to upload all MARAC actions and to develop systems for management oversight and sign off of casework.
4. To continue to maintain current increased staff resourcing and increased management capacity.

7.6 Greater Manchester Integrated Care

1. Improved coding of 'victim of domestic abuse'.
2. Ensure routine enquiry in cases of [redacted] help to ascertain risk and impact of potential Domestic Abuse and complete appropriate risk assessment.
3. Consider who reviews [redacted]
4. Recognise patients who present with support needs; vulnerability and an adult at risk and refer appropriately for those needs and/or safety to be assessed.
5. Recognise vulnerability in patients who present with [redacted]
6. Learning to be shared amongst Safeguarding GP leads across Oldham and GM ICB and presentation of learning to take place in GP safeguarding lead engagement sessions.

7.7 MFT

MFT had no involvement with the victim at this time of her life.

7.8 Northern Care Alliance

1. Hospital based IDVA on each of the NCA's sites to support staff with the recognition and response to domestic abuse and improve patient experience and outcomes.
2. Domestic abuse strategy including training offer for staff.
3. Continue to work towards required staff compliance for level 3 adult safeguarding training.
4. Continue to advocate the application of the Mental Capacity Act in clinical practice in relation to non-concordance.

7.9 NHS LCSFT

1. To ensure all clinically registered staff within Preston East [redacted] are compliant with L3 Think Family mandatory training and are applying the principles of Think Family within the context of practice.
2. All [redacted] will attend future Dialog+ 4-day training.

3. Where a person has [redacted], multi-agency working and or signposting should be considered.
4. A learning brief will be disseminated to the team after the DHR has completed.

7.10 NHS LSCICB

1. Routine enquiry about domestic abuse should be included in consultations for patients [redacted] enquiry about potential risk to others should be explored.
4. If not already in place, GP practice should consider introducing a pathway for managing patients whose vulnerabilities put them at risk of harm or exploitation to include consideration of when a face-to-face consultation may be appropriate.
5. Sharing the lessons learned from the DHR with the individual Practice and across the Lancashire and South Cumbria Primary Care Networks will be implemented.

[redacted]

7.12 Pennine Care Foundation Trust (PCFT)

1. Consideration of how the OSAB new Tiered Risk Assessment and Management Protocol is embedded and implemented in both the organisation and in existing policies and procedures.
2. Safeguarding Team to deliver level three adult safeguarding training, encompassing the importance of professional curiosity and '*so what*' questions; domestic abuse, MARAC processes and the 'Think Family Model'.
3. Safeguarding Team to continue to operate a duty system, promoted via intranet and corporate induction.
4. Monitoring and clinical audit, (biannually) of the Disengagement From Services Policy (put into in place 2022 throughout PCFT), reportable to the Quality Group via the Clinical Effectiveness and Quality Improvements Team.

7.13 Housing Options (Oldham Council)

1. Ensure [redacted] are considered when undertaking housing assessments and support.
2. Ensure capacity, [redacted], is taken into consideration when issuing notification supported by training.

7.14 Achieve

No recommendations made.

7.15 Turning Point

1. Face to face assessment appointments to be implemented.
2. Provide on-going support over holiday periods to prevent delays in appointments.

7.16 Oldham Children's Social Care

1. Oldham Children's Social Care have frequent interactions with vulnerable parents, and it is important that all staff have a clear understanding of adult safeguarding pathways and the [redacted] in order to support them in their role, with their safeguarding responsibilities towards parents of the children they work with.
2. Professional networks should consider key relationships and which relationships may be trusted and best placed to deliver key messages for victims of abuse. Where there is concern regarding domestic abuse, professionals should create opportunities to speak to the victim

alone. Multi-agency meetings are key to co-ordinating information and agreeing the approach across the professional network.

3. Practitioner curiosity is important, and when information is received this should be interrogated through further questioning and triangulated with other information to support the practitioner in developing a clear understanding of the situation and inform the approach to support. Analysis of how key relationships function is essential to understanding family dynamics.
4. There needs to be ongoing consideration through assessment and planning of the relationship between [redacted]
5. It is the view of Oldham Children's Social Care that the third and fourth bullet points should apply to the partnership as a whole.

7.17 Bury Children's and Young Person's Department

1. Services for perpetrators of domestic abuse are to be robustly targeted, planned, and reviewed when part of intervention to protect children and victims, to improve outcomes for all.
2. BCYPD accept the Review's advisory recommendation: to ensure the recording of multi-agency decision making and information sharing, across boundaries.

7.18 Oldham Adult Social Care

1. Roll out the Safeguarding Adult RAG rating system across ASC for safeguarding concerns.
2. Update the safeguarding workflow on the electronic recording data base, to support timely responses.
3. Implement dedicated safeguarding audit cycles to include audit of the quality of safeguarding responses made by ASC.
4. ASC accept the Review's advisory recommendation: to work to ensure that when adult safeguarding referrals are received that they are dealt with in a timely and appropriate manner[129].

7.19 North West Ambulance Service

No recommendations made.

8. Community Safety Partnership – Review Advisory Recommendations

1.Through the Domestic Abuse Partnership, agencies are reminded: a) that when a contact is made or attempted, with a victim of domestic abuse, that perpetrators can control the victim's movements and their communications b) of the importance of accurate record keeping c) to make the right referrals, at the right time to the right place, in order to reduce risk, and that receiving agencies acknowledge receipt and make contact with the referrer regarding any next steps.

2.Through the Oldham Safeguarding Adults Board (OSAB) there is oversight of the implementation and effectiveness of the Adult Safeguarding and Exploitation Strategy, the TRAM Protocol and the NWADASS Complex Safeguarding Strategy, to ensure issues affecting a person that relate to domestic abuse, including accommodation, health, and [redacted], are taken into account, and that Care Act 2014 assessments are undertaken where appropriate.

3.Through the OSAB and OSCP there is scrutiny through audit processes to ensure single agency decision making is compliant with multi-agency safeguarding policies and that single agency domestic abuse policies are checked to ensure that they recognise that a perpetrator can also be a victim.

[129] ASC wish to add that this recommendation relates to historical practice and that an IMR was not requested from them by the DHR – which was owing to their very limited involvement, the DHR requested information via responses to queries, which were provided, and this was deemed sufficient.

4.That the OSAB and OSCP work with partner organisations to review the current multi-agency training offer, including accessibility and frequency, and develop a minimum standards training framework which includes: [redacted], routine enquiry; repeat victimisation; perpetrator as victim; [redacted]the importance of information sharing and multi-agency co-ordinated risk management; application in practice of the [redacted],Think Family and Think Parent, Think Child, MARAC processes/ referrals and adult safeguarding Care Act duties - with an associated quality assurance framework, to that ensure learning is embedded into practice through management oversight and supervision.

9. Oldham Safeguarding Adults Board

OSAB have already put some improvements into place, which can be found at Appendix 2.

10. Wider Board Circulation

This DHR should be shared with: Bury and Warrington Community Safety Partnership; The Oldham, Bury and Warrington Adult Safeguarding Boards; Oldham, Bury and Warrington Children's Safeguarding Arrangements; HM Inspectorate of Probation Services and the Mayor of Greater Manchester.

11. Single Agency Lessons Learned

The lessons learned by single agencies are attached at Appendix 1.

Appendix 1 - Single Agency Lessons Learned

(This section has been copied and pasted from single agency IMRs and any slight changes have only been made for grammatical purposes).

1.Lessons Learned - Probation

1. Oasys assessments were sometimes incomplete and there were insufficient assessments of risk.
2. Risk management plans were sometimes lacking identified agencies who were required to support risk management or a demonstration of understanding of what would increase or manage risk and not countersigning assessments within CRC did not assist learning.
3. The issue of home visits and when to undertake them.
4. MAPPA thresholding could have been considered when a decision was made to move Jenny at short notice to her Mother's home, which could have supported the co-ordination of services within a forum where actions could be monitored, however there was emphasis on involving other agencies throughout the management of Jenny's case on her release, with time and effort put into this.
5. There have been issues highlighted where case recording has not been sufficient and communicating with other agencies has not been timely enough. Issues mainly lay with individuals who are either no longer in the service or who are in different roles. That said, these should be areas of practice where regular training has been provided by the newly formed Probation Service for practitioners more generally.
6. [redacted]
7. Probation is of the view that they shared and acted on information in a timely manner and the practitioners who could have acted sooner within this review, are all-in different roles or have left the service. However, this is an area of practice that the service should repeatedly promote.
8. [redacted]

What Probation has already put into place

Significant supportive measures and changes have taken place since the formation of the new Probation Service, in an aim to improve quality of practice, to include:

- A countersigning framework for completed assessments to improve quality assurance.
- A program of regular case audits to be undertaken by supervising line managers and 1-1 intervention to be provided by Quality Development Officers to improve assessment practice and identify poor practice.
- Briefings by Quality Development Officers on assessing the risk of self-harm.
- A revision of the home visiting policy to develop a true picture of an individual in the community, with clarity about where and when home visits are mandatory (for example at

the start of any period of supervision) and when they should be further considered (for example where there are instances of significant change). The implementation of this policy has been prioritised with input for learning and development for all staff and the implementation of monitoring to ensure practice consistency.

- The Touch Point Model has been set out to outline minimum expectations regarding management oversight, ensuring that MAPPA Category 1 cases, (high risk and complex medium risk) have formal management oversight reviews between the practitioner and supervising manager at least every six months and all risk registers are checked and reviewed. (It is note-worthy to highlight that both Jenny and Ian would have fallen under this model as cases to be reviewed at the point of reunification, which would have led to closer monitoring and oversight by an SPO).
- In terms of case recording, service level measures have brought focus on cases that are either not being recorded as having been given enough scheduled appointments or highlighting where records are not being updated, re-addressing some case recording issues.

2.Lessons Learned - Approved Premises

At the time of Jenny's release to Approved Premises, there had been significant organisational changes in Probation and CRC, which impacted on the formation of Community Accommodation services, under which Approved Premises now sit. A significant amount of work is currently being undertaken to look at the Approved Premises Manual, updating and refreshing information and practice instructions.

What Approved Premises have already put into place:

- uploading documentation is now better embedded to assist with reviewing cases and add to the sharing information.
- Concerns about engagement [redacted] and Approved Premises are seeking to have internal clinics, [redacted]
- Implementation of bed withdrawal monitoring will go into place with consideration of individual needs, and planning to review this with all relevant agencies, particularly with regard to the serving of a notice to quit, to allow a time frame to explore most suitable option.
- Staff training has been developed about the implementation of the SaSP and CARE model, now embedded, offering a robust model for the management [redacted]
- A significant recruitment and training programme has been funded to increase capacity, better equip the workforce, and to support and manage increasingly complex individuals.

3) Lessons Learned and what Greater Manchester Police have already put into place

- The need for recognising and addressing vulnerability will be re-emphasised to IOM staff, along with the need to complete ongoing risk assessments, to and around associates and partners of a managed offender. Spotlight guidance will be amended to reiterate this, and the message will be reiterated through the monthly IOM Sergeant's Meeting and monthly joint leads meeting with Probation:
  "Spotlight teams will conduct research into any known associates and partners of their nominal as standard practice. This information should be recorded on the Spotlight Management Care Plan and any queries or concerns brought to the attention of partner agencies. This information may prove vital in safeguarding your nominal for which you have a duty of care, as well as supporting breaches of licence conditions and risk assessments when conducting visits."
- In relation to the concerns raised during this review about the record keeping and storage of information by Spotlight Units, It has been confirmed that at the moment the Spotlight Management CAP record is the best place to record information. An audit of all Spotlight

Teams showed they are all storing their MAP and MACC minutes on the district shared drive but recording any concerns on the CAP record. Whilst the minutes of the meeting are not accessible to all on the shared drive specific concerns and meetings with an individual should be recorded on the CAP, which will indicate the existence of further information, which could then be obtained if required.

- A working group has been set up with Probation, GMP, and IOM administration, to improve the process of recording information and exploring other options. It is recognised that there are some issues with GMP's current computer system, iOPS and plans are in place to replace this.
- GMP have already begun the process of increasing the safeguarding awareness of IOM staff and they will be receiving further training to improve awareness around domestic abuse, vulnerability, and risk management.
- All IOM officers completed a Domestic Violence Continuous Professional Development training day in July 2021. This course focussed on Domestic Abuse and its relation to safeguarding all vulnerable persons. (The course also included an input on DVDS, specifically relating to *what it is; how to identify it; right to ask and right to know; who is involved and why we do it).*
- Manchester Women's Aid provided Domestic Abuse training input to IOM officers, which contained information on perpetrator typologies and victim behaviours, which would help officers identify potential levels of risk. This input also contained Sanctuary Scheme information and district specific information.
- There is a recognition that training needs to be continuous and current and it has been agreed that the Detective Inspector's responsible for the District MASH Teams will co-ordinate a familiarisation session about what the MASH Team does, the referrals process, the correct process for the recording of care plans and how the MASH Team can assist other units, including Spotlight Units. This training should further enhance the knowledge of officers whose primary responsibility is the management of offenders to recognise the type of situation where referrals are required, where a DVDS may be appropriate, and they should be better equipped to effectively manage such situations.
- At the present time an IOM bespoke core skills course is being developed which includes a Safeguarding module, which includes risk management.
- In November 2022 GMP launched DA Matters training and launched a new DA Policy. to provide greater clarity to GMP officers on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigation. This latter policy sets out expectations on how GMP tackles DV at every level.

4.Lessons Learned - Victim Support

- Contact methodologies varied according to crime type; victim preference and information available, and on at least one occasion, there was a failure to follow Jenny's wish for a call back at a particular time. If this was not possible, it should have been explained to her and attempts made to reduce barriers to accessing the service. It is assumed this was due to human error; capacity issues; lack of training or the time spent on the call itself.
- At various points contact with Jenny did not demonstrate a person-centred approach which would be a matter for performance improvement discussions. Standard and enhanced training are available for particular crime types; inclusion; accessibility and safe contact with Domestic Abuse Victims. At various times Jenny had limited opportunity or was at risk by speaking, which should have been seen as a heightened risk factor, as opposed to an opportunity to close the referral due to lack of her engagement. If best practice was followed at all times, professional curiosity deployed and persistent endeavours made, it is reasonable to assume that this would have increased opportunities for engagement between 2013 and 2016.

- There was limited evidence of effective information sharing focused around the MARAC process.
- There is no evidence that [redacted] how they may have impacted on support were explored.
- Victim Support could not establish consistent engagement for any length of time with Jenny which prevented a complete understanding of her risks and engagement with her mother was not translated into effective action or as a contact method to benefit Jenny in the future. A simple change could have improved this such as asking her Mother to call Victim support, with Jenny, if she visited the property and was in need of support.

What Victim Support have already put into place

- A consistent contact methodology is in place for domestic abuse cases, (minimum of two contact attempts and texts are used where safe to do so), supported by the Domestic Abuse Procedure and Safeguarding Policy.
- An established process with GMP is in place to retrieve missing information from referrals, or to find alternatives to incorrect contact details.
- All staff receive Domestic Abuse training as well as regular professional development relevant to specialist areas, to include establishing safe contact.
- All team managers are trained to Safe Lives Service Manager standards.
- Trauma informed training packages are being introduced to build on existing, mandatory training to include motivational interviewing, to improve response to those with multiple traumatic experiences.
- At the time of substantive interactions with Jenny, Victim Support caseworkers were expected to liaise with public sector housing providers, provide limited advice and guidance. Victim Support now has access to specialised housing advice for clients and the ability to refer them for specialised housing advocacy (at a cost).
- Previously, Caseworkers in relation to domestic abuse, were and expected to complete a DASH, refer into MARAC (if high risk existed), and complete limited safety planning. Now, standards extend to completing an individualised Safety and Support Plan and a holistic needs assessment. (It is also notable that since receipt of Jenny's referrals, there is no current dedicated support offer for standard or medium risk victims of domestic abuse in Oldham (from 22.03.2021 to the time of writing 18.08.2022), which reduces the opportunity to intervene before risk levels in abusive relationships escalate).
- Caseworkers are offered trauma informed and [redacted] and employs qualified ISVA's in roles where commissioned to do so.
- Victim Support has appointed a national Equality, Diversity and Inclusion lead and there are multiple training packages to assist the offer of appropriate support, as well as guidance on the correct agencies to involve, if it appears that a victim requires medical assessment. It is now possible to [redacted] on internal systems so that it is visible to current or future caseworkers, with vulnerabilities and barriers to accessing help and support highlighted.
- The First contact did not suit Jenny's preferences, but limited capacity prevents the service from being fully accessible to all victims, however part of Victim Support's processes does include annual Service Equality Impact Assessments.

5.Lessons Learned - Oldham Independent Domestic Violence Advocacy

- The Oldham IDVA Service identified some areas where operational procedures were deficient at the time.

What the Oldham IDVA Service have already put into place:

- A more fit for purpose case recording system with improvements in the quality and consistency of recording.

- Uploading all MARAC actions and systems for management oversight and sign off of case work.
- Resources within the team have been significantly increased, from three IDVAs to seven, together with increased management capacity.

6. Lessons Learned - Greater Manchester Integrated Care

- It is important for staff to remember that a patient's Summary Care Record is accessed by others e.g., PCFT and Out of Hours Services and it that essential information will be visible to them using Special Notes as well as by keeping 'Problem Lists' updated. Staff are to be advised to think of their most complex patient/family and then to check notes to see if a Locum in the practice or the Out of Hours team would be alerted to potential risks and improving the coding of 'victim of domestic abuse' is necessary.
- Ensure routine enquiry takes place in cases of [redacted] to help ascertain risk and impact of potential domestic abuse and complete an appropriate risk assessment.
- Consider how and who reviews notifications received for patients in the surgery; whether potential Safeguarding issues are picked up and are highlighted to the Safeguarding Lead within the practice.
- Recognise patients who present with support needs/vulnerability/adults at risk and refer appropriately for those needs and/or safety to be assessed.
- Recognise vulnerability in patients who present [redacted]

What Greater Manchester Integrated Care has already put into place

- Routine Enquiry is variable across Primary Care but has much improved since the review period at GP Practice 1, with the development of guidance and learning events across the safeguarding platform.
- Changes have occurred in Primary Care with the introduction of NICE [redacted]

7) Lessons Learned - MFT

MFT had no involvement with the victim at this time of her life therefore no action plan was completed.

8) Lessons Learned - Northern Care Alliance

NCA have not suggested any lessons learned.

9) Lessons Learned - NHS LCSFT

- Appropriate assessment, care planning and 'handover' of [redacted] at the point of case closure did not occur in line with expected practice [redacted] - Service Operational Procedure MH003) and a number of key issues remained unresolved despite the service users' known complexities and vulnerabilities.
- There is a possibility that the input of the Preston [redacted] was impacted on by Jenny's cancelled appointment; the unplanned moves that took place during the period of involvement and the effectiveness of the joint working between the [redacted] and GP, and the [redacted] and Probation.
- Domestic abuse was not highlighted as a risk within this case and routine enquiry into the possibility of domestic abuse was not evidenced albeit such practice is endorsed within NHS LSCFT Domestic Abuse Policy (SG006) and NICE Guidance (PH50).

- A Safeguarding Children Risk Assessment was not completed which would be expected practice given the indication that Jenny had resumed contact with her children and the known risks. (NHS LSCFT Safeguarding Adults and Children Procedure SG007).

What NHS LSCFT have already put into place

- [redacted]. NHS LSCFT has a programme of transformation underway to deliver on this model and the advent of [redacted], with a diverse range of partners including statutory and voluntary sector agencies, which will enhance care delivery for service users and their families within respective localities.
- Since May 2022 a newly developed Initial Response Service (IRS) has been in place in Central and West Lancashire, operating as a single point of contact for referrals [redacted] operating 24/7 with a multi-disciplinary team.
- The [redacted] has introduced changes to discharge management via Clinical Decisions Meetings, held weekly, with the multi-disciplinary team, to include views and wishes from service users and carers, supported by senior management availability and clinical leadership, alongside improved operational oversight, governance, and quality.
- Work to integrate more closely with other services and teams (e.g., physical health) to provide additional support to service users and carers, with commissioned peer support from a range of voluntary sector partners to enhance care plans.
- The NHSE Guidance and the Care Programme Approach position statement[131] recognised replacement with person centred and effective therapy and the Trust is actively transitioning away from care co-ordination with detailed plans to support the changes.
- Ongoing work to develop alternative ways of working include the Dialog+ model[132] which will support the above transition[133]. Phase 1 commenced on in October 2022 and involves 13 CMHTs, including Preston[134].
- New investment means that the Trust will a) review the configuration of teams b) develop more staff training, with increased input from [redacted] and specialist teams, with clinical staff able to access more advanced [redacted] and [redacted]
- Access to improved technology is enabling care plans to be completed with patient/carer in real time.
- A Health & Social Needs Assessment improvement collaborative has been commissioned, to look at improving access and completion of this assessment and seeks to also improve the quality of the assessment. Phase 1 started January 2022 and is in the design phase.
- [redacted]

[redacted]

[131] Care Programme Approach: NHS England/ NHS/I Position statement 1/07/21 V1, July 2021

[132] regarded as a more meaningful person-centred approach to assessment and care planning and has been developed with input from service users and carers.

[133] This is a new person-centred assessment tool to guide multi-disciplinary conversations, care plans and support professionals understanding of what is important for the person.

[134] All staff will receive face-to-face training which includes Dialog+, what it is, how to use it and why we are using it; solution focussed therapy – a instrumental aspect of using Dialog+ and trauma informed care. Staff with a professional registration will also receive clinical risk training and care planning to coincide with a new care plan template. Dialog+ will see a move away from care co-ordination, and towards key working. Whoever is leading on an aspect of a person's care will be the key worker at that time, so the person will change depending on what care and support is being provided. As part of the roll out of Dialog+, from the 1st of Sept 2022, the Trust are introducing training around safety plans which will replace crisis, contingency and [redacted] The expectation is that these are collaborative and focus on strengths, [redacted], hope, and empowerment. All service users should be supported to develop a safety plan, shared via LPRES with other agencies.

- Raising awareness and strengthening practice in relation to domestic abuse and the application of Routine Enquiry is a key priority area, supported by a Domestic Abuse Operational group and a detailed operational work plan for 2022- 23.
- Understanding links between [redacted] ACEs, trauma, and 'vulnerability' is a key feature of the various types of Domestic Abuse training offered.
- The Trust has introduced "Think Family" mandatory training for clinical staff, focusing on strengthening the evaluation of safeguarding risks and needs within families and the impact of [redacted] within this context.
- Reconnect - care after custody programme will create an effective link between prison and community in order to:

- increase access to and uptake up of healthcare or relevant support services for vulnerable individuals who would otherwise struggle to engage
- reduce health inequalities for prison leavers
- ensure the health needs of individuals who are leaving prison are met, and
- ensure a safe transition from prison to community-based healthcare and support services and to provide follow-up to ensure engagement is maintained.

10) Lessons Learned - NHS LSCICB

- There was no routine enquiry about domestic abuse, and NICE Guideline PH50 recommends that enquiry about domestic abuse should be made in patients [redacted]
- Intent to harm others was not explored which would have been good practice in view of Jenny's [redacted].
- Safety netting advice was limited. This should include advice to seek further help if the situation deteriorates and avenues of crisis support (NICE Guidance NG222)
- Jenny continued to be [redacted]
- Although Jenny's social circumstances and vulnerabilities were documented but no evidence they were considered to inform a holistic management plan, however Jenny was registered with GP2 for a short period of time.
- All of Jenny's GP appointments were by phone and face-to-face may have yielded further relevant information.
- Routine enquiry about domestic abuse should be included in consultations for patients presenting [redacted]
- [redacted] Where appropriate enquiry about potential risk to others should be explored
- A management plan should be in place for patients [redacted]
- If not already in place the practice should consider introducing a pathway for managing patients whose vulnerabilities put them at risk of harm or exploitation to include consideration of when a face-to-face consultation may be appropriate.

11) Lessons Learned - Greater Manchester Integrated Care (Bury - [redacted])

There are no lessons learned or recommendations for GMIC (Bury).

12) Lessons Learned - Pennine Care Foundation Trust (PCFT)

- There was a lack of professional curiosity about the identities of Jenny's partners, boyfriends, and fiancé; or who was important to her and what family dynamics were like, and deeper exploration was warranted with regard to these relationships.

- There was some acknowledgement that Jenny had been affected by trauma experienced in her childhood and understanding about adults who have experienced adverse childhood experiences, however, this may not have been applied across the emergency, crisis, and one-off services [redacted].
- Past records were not checked and had they been, they would have shown that Jenny was a victim of domestic abuse subject to the MARAC process, thus her vulnerabilities as a victim in relationships and past trauma experienced were not discussed or considered.
- She disclosed she was living with Parents which was affecting her mood, but it was unknown as to why this was impacting her and not documented if she was being supported with housing.
- There was a lack of professional curiosity and exploring the reasons, barriers why an individual may not engage. After GP3 referred Jenny in December 2021, she was to attend an appointment on January 13th, 2022, and did not attend and was she sent a further appointment, dated after her death. Given her history it may have been beneficial for practitioners to check address details and inform her GP that appointment was not attended.
- PCFT acknowledged that Jenny he had been affected by past trauma in childhood, but it is. not clear what this trauma was. There is no record of relationships or impact on her and a lack of professional curiosity and use of the Think Family Model.
- Jenny was seen as an individual rather than a person with significant relationships and it is not evident in records that Jenny was seen as being at risk as a victim of domestic abuse, however there was a focus that she could be a potential perpetrator of violence, reflected in her care plans, with the aim to keep staff and service users safe.
- In 2017, consideration could have been made to complete or refer for a Care Act Assessment for Jenny and, a Carer's Assessment for her Mother, to ascertain if her Mother was a carer and willing and or able, to continue in that role.
- Although the Tiered Risk Assessment Management Protocol did not exist in Oldham at the time of Jenny's involvement with PCFT, a multi-agency meeting may have been appropriate, due to Jenny, having [redacted] as a previous victim of domestic violence. (It must be acknowledged that Jenny did not work consistently with services which made it difficult for therapeutic, proactive work to take place).
- There was no communication or information sharing following the disclosure from Jenny that she was in an abusive relationship. Sharing this information with agencies working with her at the time and seeking advice form the PCFT Safeguarding Team would have enabled her to be offered support in a timely manner i.e., before the serious assault that occurred in October 2014. During 2017 there is evidence that EIT liaised with Probation. The purpose of this contact was to share information and for the Probation worker to pass on details of appointments (to try and promote engagement). This was appropriate and timely communication.
- Although Jenny was referred to PCFT within the second time period she was never actually 'seen' due to non-engagement. The Access Team attempted to contact her on three occasions via phone but there was no response, a letter was sent with a further appointment. Communication with the referrer at this point would have been useful to not only ascertain contact details but also to inform them that the appointment had not been attended. The GP may have been able to enable Jenny to attend subsequent appointments.
- [redacted]
- Ian was noted to be a moderate risk to known women, [redacted] and safety concerns of any children should have been considered.

- [redacted]
- Jenny [redacted] GPs were informed when they were discharged from services. Where there are concerns of engagement and [redacted] phoning with a referral about concerns is timelier and can be more beneficial in aiding information sharing.
- There is nothing to indicate the PCFT services did not follow pathways for Jenny [redacted] when they did not engage with services. However, there was no professional curiosity displayed as to the barriers that may deter the subjects form accessing services. There was no evidence of reasonable adjustments being put in place for [redacted] Jenny, taking into consideration transient lifestyles [redacted]
- New policy will consider these risks and be embedded across services in PCFT.
- Audits will ensure that new process are followed.

13) Lessons Learned - Housing Options (Oldham Council)

- Jenny's family relationships appeared to significantly impact on her decision making in terms of her housing, and potentially wider than this. Jenny clearly conveyed her desire to live with her [redacted] but long-term prospects did not appear to have been explored and managed, or Jenny supported with this. If they had been, potentially Jenny would have been more receptive to reasonable offers of accommodation and been able to move more quickly and children in foster care must be considered when undertaking housing assessments and offers of support.
- When Jenny was given warnings and, ultimately a discharge of duty letter after the incidents in her temporary accommodation placement(s) on 26th and 27th January 2022 she was [redacted] unreachable by phone and email. It is therefore unknown whether she understood and received the correspondence. Unfortunately, Jenny left her temporary accommodation placement in a taxi before staff could have any meaningful conversation could be had with Jenny but usually understanding of these warnings and letters should be established [redacted].

14) Lessons Learned - Achieve

- No recommendations have been made.

15) Lessons Learned - Turning Point

- The time between the assessment and the offered face-to-face appointment for Jenny could have been shorter, especially as it was over the Christmas period which can be a high-risk time for clients.

What Turning Point have already put into place

- Face to face contact for assessments are now offered as this is no longer affected by Covid risk.

16) Lessons Learned – Oldham Children's Social Care

- There are some lessons identified in relation to awareness of adult safeguarding by OCSC staff. There were points (particularly during the period 2014-17) where information was shared by Jenny that raised welfare concerns for her, and this does not appear to have triggered any form of safeguarding response or signposting for support in any consistent way. There are potentially missed opportunities during this period where key professionals may have had opportunity to connect with Jenny and help her to access support.

- Jenny was consistent in attending family time contact and it appears that she generally had positive relationships with family time staff and at times confided in them or sought their advice and support about how to share information with her children.
- Jenny's life was characterised by abusive relationships yet there appears to have been a lack of curiosity when she shared information about new relationships. There may have been opportunities at key points to support her to access domestic violence disclosure or support as a victim of domestic abuse. It is recognised that the challenges she faced were multi-faceted. There is one social work record detailing the social worker supporting her and a historic partner (later considered at MARAC) to attend their housing office with transport provided by the social worker. Although this was intended as a supportive gesture, lack of information about this individual could have placed this social worker at risk.
- The risk assessments in relation to family time arrangements are included within single assessment documents and they do not appear to triangulate information, for example partner searches. Although Jenny's partners did not attend family time their relationship with her at times impacted her presentation and her emotional wellbeing, as a victim of domestic abuse, which in turn impacted family time.
- Following her release from prison in 2021 it was clear that the relationship with her children remained extremely important to her, [redacted] through multi-agency forums to ensure a co-ordinated approach. An assessment of this contact should have considered whether there was a safe way of supporting the relationship that may have had a positive impact for both Jenny and [redacted]
- [redacted] Perhaps ongoing consideration of parental circumstances through assessment and the opportunity of continued support available to parents would facilitate durable relationships [redacted] It is recognised that many parents will not be in a position to want to share information or access support, however creating a culture 'where the door is not closed' can only have positive impact [redacted]

[redacted]

- The recording of multi-agency decisions and information sharing should be more consistent, with evidence shown as to how this information will be used. This area has seen huge improvement across this review and practice in Bury recently, however it is still a learning point, making sure that multi-agency information is shared. It also needs to be used to manage risk, offer support, and make decisions.

18) Oldham Adult Social Care

Oldham Adult Social Care have advised that the following has been put into place and embedded into care practice:

- A dedicated safeguarding front door was put into place in 2022 for adult safeguarding referrals (Adult MASH)

- The aim to work consistently in accordance with Oldham Safeguarding Adults Board Multi-agency Policy and Procedures
- The aim to triage safeguarding referrals within 24 hours from the date of receipt.
- A RAG rating system has been trialled to ensure that the highest risk cases are allocated in a timely manner.
- ASC staff receive safeguarding training appropriate to their roles.
- The Adult Safeguarding and Exploitation Strategy is a local policy to inform how adult social care works together locally with partners to support, manage risk, and respond and has been endorsed through the Safeguarding Adults Board.
- The NWADASS Complex Safeguarding Strategy supports one consistent response to complex needs across the whole of the north-west region.
- The TRAM protocol has been developed and amended based on feedback from people with lived experience and partnership colleagues, as evidence of continuous improvement. The Assurance Report provides some feedback from the partnership. The protocol enables shared risk and ownership from the partners and the person at the centre of the work, and feedback on it has been very good, both locally and nationally.


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Item 12 Embedding the OSAB Tiered Ris


NWADASS Adult Complex Safeguardi


Adult Safeguarding and Exploitation Str

19) Lessons Learned - North West Ambulance Service

No lessons learned or recommendations were made by NWAS

'Jenny' Combined Single Agency Action Plan

Approved Premises (NW) - HMPPS							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Probation Service to audit implementation of SaSP and CARE policy	Peer and manager audits of work completed to be undertaken. QDO to review and identify any outstanding required training	Ensure all staff have completed the face-to face-training	Better ability to support complexities associated with accidental / non accidental self-harm.	[redacted]	Reviews ongoing and training for all staff	
2.	Develop increased partnership working with substance misuse services	Progress on site interventions Engage in central work re: knowledge working with substance misuse. Work closer with partners to support residents	Interventions on site operational Monitoring of plans to address substance misuse	Support for residents and staff to better understand and address issues of substance misuse in a timely way	[redacted]	By Feb 2023	
3.	Bed withdrawal review systems to be implemented	Area manager oversight to ensure these are embedded.	Feedback to be reported to HoPP	Staff will be supported in decision making to confirm plans for suitable move on.	All area managers who will report to HoPP	Implementation to be fully embedded Nov 2022 and reviews ongoing	
4.	Seek and secure opportunities to improve multi-agency working and information sharing practices	NW has introduced pre-release surgeries and will continue to widen the scope for these and engage with partners and better stare information. Utilisation of new residence plans to support	HoPP to monitor facilitation of meetings and feedback from these. Residence plans will form part of performance monitoring for completion and quality	Increased opportunityties to engage with partners. Evidence of engagement with partners in the planning and	All staff, monitored by AP managers and Area Managers and HoPP. All staff to contribute to plan,	Ongoing work in all aspects of multi agency working and information sharing	

		pre-release and ongoing multi agency working Work to ensure implementation of Nation directions re: mulit agency working and information sharing	Ensure active communications are shared from the National Team and that staff use Equip – our point of contact for all up to date policies to ensure compliance with these.	intervention delivery for People in Approved Premises Evidence of attendance at prescribed multi-agency meetings	monitoring by SLT and Performance and Quality Team. SLT to ensure compliance and confidence with processes.		
Childrens Social Care – Oldham Council							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Children's Social Care have frequent interactions with vulnerable parents, it is important that all staff have a clear understanding of adult safeguarding and Mental Capacity Act to support them in their role and safeguarding responsibilities towards the parents of children they work with.	Training on Adult Safeguarding Procedures and Mental Capacity Act to be available to practitioners and managers within CSC and EH. A briefing on the learning from this case to be disseminated service wide.	The offer to be visible in the CSC and EH Training Calendar.	CSC staff to have a basic understanding of adult safeguarding and how this can be applied to working with parents. CSC staff to ensure engagement with professionals providing services to adults dult colleagues to support stronger collaborative working and	[redacted] Principal Social Worker	September 2023	To be built into Training Calendar for July to September 2023

				information sharing			
2	Professional networks should consider key relationships and which relationships may be trusted and best placed to deliver key messages. Where there is concern regarding domestic abuse professionals should create opportunities to speak to the victim alone.	Genograms and ecomaps to be used as part of ongoing assessment. Practitioners will engage with relevant professionals involved supporting parents or carers where domestic abuse is suspected or known. Practitioners will ensure that they take up consultation and advice offer by IDVA.	Case Audit and Thematic Reviews	We will have a greater understanding of significant relationships around children and their parents.	[redacted]	28/7/23	This is a developing practice, and we are embedding the use of genograms Team Around You planning meetings are being used at an increased level and there is ongoing work to establish a recording pathway in MOSAIC.
3.	Practitioner curiosity and inquisitively is important, when information is received this needs to be interrogated through further questioning and triangulated with other information to support the practitioner in developing a clear understanding of the situation and inform approach to support.	The use of Learning Circles as a method of group reflection will be used where complex family relationships are a barrier to improving outcomes for children and young people -including where domestic abuse is known or suspected.	Quality Assurance processes	Robust assessments and plans will evidence a greater level of curiosity and sense making. Learning circles will evidence case progression where these are held.	[redacted]	June 2023	Systemic management training is planned in April 2023. This has been commenced and there is further work required to embed this culture.
4.	There needs to be ongoing consideration through assessment and planning of the relationship between	Practitioners and managers need to ensure that relevant professionals are fully engaged in the	Quality Assurance Processes and Management Oversight of	Reviewing officers will use the review process to have oversight	[redacted]	October 2023	Conference and review model is in the process of being developed and as part of this

	children looked after and their parents and where there are multi-agency professionals working with parents the co-ordination of plans for parents and children may support situations [redacted]	assessment and care planning process. The IRO Service needs to ensure that robust oversight is in place to ensure partnership contribution to safeguarding and care planning is strong.	assessments and plans. Case Conferences and Reviews	of multi agency involvement, working together and the assessment underpinning the plan.			work partner reports will be reviewed.

Childrens Social Care – Bury Council

No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1.	Work with perpetrators of domestic abuse needs to be robustly targeted, planned, and reviewed when part of intervention to protect children and victims and improve outcomes for all.	Undertake further training around the creation of SMART and risk specific planning for cases where domestic abuse is an assessed factor. Update knowledge about what services are available to support perpetrators (and victims) of domestic abuse within the local area. Use of supervision/quality assurance to review plans where domestic abuse is a factor to ensure targeted and effective support is on offer.	Update on the learning and development offer made around planning and domestic abuse. Creation and review of a resource library and local offer of services that practitioners can use. Update on the quality assurance findings around plans and domestic abuse practice within Bury.	Plans to be more targeted to provide support for behavioural change around domestic abuse behaviours and risks. More meaningful changes to be made through support that can be sustained, improve outcomes, and be reviewed as to ensure	Director of Social Care Practice and Principal Social Worker With support from Work Force Development Team	30/03/2023	The recording of plans within the LCS system has been updated and the plans are now more SMART and outcome focussed. This has seen an improvement in plans. Auditing of plans takes place regularly and improvements are being noted as part of the QA framework. Local Service Offer/Library is

				safety is being created. Practitioners know what support is on offer at the right time and place.			being updated and due for completion by 30/04/2023.
2.	Ensuring the recording of multi-agency decision making and information sharing is more robustly recorded.	Ensure that the recording forms are supporting practitioners to effectively capture information sharing and decision making. Training to be offered around effectively recording and multi-agency decision making.	Update on the learning and development offer made on effective recording and Working Together policies. Update on the quality assurance findings around recording.	Multi-agency information sharing and decision making to be robustly recorded to inform decision making and review of current safety/plan progress. Practitioners feel more confident in working in a multi-agency way to promote safeguarding.	Director of Social Care Practice and Principal Social Worker With support from Work Force Development Team	30/12/2022.	Child Protection LCS forms have been updated and require clearly recording that is more risk focussed. Training on Strategy Discussion and s.47 enquiries has been completed. Multi-agency audit is taking place around the recording of core groups with a completion date of March 2023.
3.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	Training to be offered around effectively recording and multi-agency decision making. Multi-agency audits to be completed across the Bury	Update on the quality assurance findings around multi-agency working and work on closing the loop of the learning from this. This audit is both	Multi-agency information sharing and decision making to be robustly	Director of Social Care Practice and	01/10/2023	Implementation of the Family Safeguarding Model is progressing within Bury and will be launched later on

		partnership around the quality and impact of multi-agency working and information sharing. Implementation of the Family Safeguarding model of practice that has a focus on multi-agency support for families.	social care and wider multi-agency audit with our partners. Implementation and review of the Family Safeguarding model, which involves training across staff groups and through the BISP partnership.	recorded to inform practice Practitioners feel more confident in working in a multi-agency way to promote safeguarding.	Principal Social Worker With support from Work Force Development Team		in 2023. This model supports multi-agency working within teams to provide support to children and parents. As part of this domestic abuse support is to be offered to drive change within families. Multi-agency audit is taking place around the recording of core groups with a completion date of March 2023. This work will continue, with differing themes for the partnership to address and learn from. Learning from this audit will inform training opportunities provided through the BISP partnership.
Greater Manchester Integrated Care - Oldham							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update

1.	Improved coding of 'victim of domestic abuse'.	Include in newsletter highlighting when and why coding should be in place for patients at risk of domestic abuse to be circulated across Primary Care safeguarding leads and practice managers Include topic in Safeguarding leads engagement session	Copy of newsletter shared  FW_ Important [redacted]  220915 GP Safeguarding newslet Agenda and learning materials delivered  GP learning session March 23.pptx	Improved coding of records across Oldham Primary Care Sharper focus on patients at risk who visit the practice who may require consideration of routine enquiry Improved identification of patients at risk across out of hours services.	Designated Professional Safeguarding Adults	Completed May 2023	
2.	Ensure routine enquiry in cases of anxiety, low mood, depression, and suicidal ideation to help ascertain risk and impact of potential Domestic Abuse and complete appropriate risk assessment.	Produce 7MB to be included in newsletter across Primary Care Safeguarding leads and practice managers Include topic in Safeguarding leads engagement session and encourage leads to share the 7MB within their organisations Work with key partners to develop a system of identification, referral, and support for victims of	Copy of 7MB  7 minute briefing Routine Enquiry.pdf Copy of newsletter shared  FW_ Important updates from Shelly C  Weekly Safeguarding Update - w_e 13 Janu	Sharper focus on patients at risk who visit the practice who may require consideration of routine enquiry Embed Routine Enquiry into business-as-usual practice across Primary Care	Designated Professional Safeguarding Adults Lead GP for Safeguarding Public Health consultant (Health and social care partnership) Strategic Domestic Abuse	Completed May 2023	

		Domestic Abuse in primary care	 220915 GP Safeguarding newslet Agenda and learning materials delivered  Primary care IDVA Powerpoint.pptx IDVA workplan and progress  IDVA workstream.xlsx	Embed Routine Enquiry into business-as-usual practice across Primary Care	Manager (Local Authority)	Completed	
3.	Consider who reviews notifications received for patients in surgery.	To include best practice within the newsletter in that potential Safeguarding issues are picked up and highlighted to the Safeguarding Lead within the practice Include topic in Safeguarding leads engagement session	Copy of newsletter shared  FW_ Important updates from Shelly G  220915 GP Safeguarding newslet Agenda and learning materials delivered (Action 2)	Embedded practice of reviewing notifications from partner agencies with a safeguarding emphasis	Designated Professional Safeguarding Adults	Completed May 2023	
4.		To include best practice within the newsletter in	Copy of newsletter shared	Improve recognition of	Designated Professional	Completed	

	Recognise patients who present with support needs/vulnerability/adult at risk and refer appropriately for those needs and/or safety to be assessed.	that potential Safeguarding issues, housing and social care needs are appropriately referred to the correct agency or signposted Include topic in Safeguarding leads engagement session	 FW_ Important updates from Shelly G  220915 GP Safeguarding newslet Agenda and learning materials delivered (Action 2)	vulnerability in patients and pathways to report concerns	Safeguarding Adults	May 2023	
5.	Recognise vulnerability in patients who present with substance misuse, both with prescribed and illicit substances and links to deteriorating mental health.	To embed NICE Opioid detoxification guidance (2019), NICE guidance on Benzodiazepine and Z Drug withdrawal (updated 2022) into the newsletter Reinforces networks of support for vulnerable patients including Focussed Care, pharmacy and substance misuse services in Safeguarding leads engagement session	Copy of newsletter shared  FW_ Important updates from Shelly G  220915 GP Safeguarding newslet Agenda and learning materials delivered (Action 2)	Improve opportunities for patients who misuse substances to access sources of available support	Designated Professional Safeguarding Adults	Completed May 2023	

6.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	GM ICB interim Safeguarding policy in place including guidance on information sharing practices plus Training Needs Analysis of safeguarding training that must be undertaken in order that all staff can meet their safeguarding responsibilities Include Multi agency working and information sharing on Safeguarding leads engagement session	 nhs-gm-safeguarding-children-young-pec		NHS Quality and Safeguarding executive director Designated Professional Safeguarding Adults	Completed May 2023	
Greater Manchester Integrated Care – Bury							
No.							
1.	Primary care to review the recording of clinical risk assessments of patients who may be experiencing mental disorder and where there is a risk to themselves, children or the wider public. Following the review, primary care must embed a system to ensure decision making	Liaise with mental health services to develop a risk assessment tool for non-mental health practitioners.	Launch the tool in primary care through a development session alongside a 7-minute briefing to describe the use and purpose of the tool.	Improve GP assessment and recording of risk that is clear to partner agencies.	Designated Nurse Safeguarding Adults with support from the Primary Care Team.	September 2023	

	is clear within patient records.						
2.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	GM ICB interim Safeguarding Policy in place including guidance on information sharing practices plus Training Needs Analysis of safeguarding training that must be undertaken in order that all staff can meet their safeguarding responsibilities. Include multi-agency working and information sharing on Safeguarding Lead's engagement session	PDF nhs-gm-safeguardin g-children-young-pec		NHS Quality and Safeguarding Executive Director Designated Professional Safeguarding Adults	Completed April 2023	
Greater Manchester Police							
No.							
1.	Officers should be reminded of a guidance document check list for officers to use when considering Evidence Led Prosecutions	Evidence led prosecutions	Public Protection Governance Unit (PPGU) to review training and ensure understanding and application of the process is effective.	Increase awareness in Evidence led prosecutions	PPGU		Update Feb 2023 GMP DA Policy launched August 2022. The new policy contains guidance on evidence led prosecutions and contains other evidential matters to be considered. To be reinforced by DA matters

							Training in relation to why victims find it difficult to support a prosecution.
2.	Officers should be reminded of actions of uploading DVDS disclosure form onto the police system following disclosure	Actions following DVDS disclosure	Public Protection Governance Unit (PPGU) to review training and ensure understanding and application of the process is effective	Increase awareness in actions following DVDS disclosure	PPGU		GMP DVDS policy relaunched in August 2022 in relation to IOPS updates . Policy states that the disclosure document is to be uploaded onto the DAB record documents tab.
3.	Updated training in DA Matters for all front-line officers	New training in DA matters	Public Protection Governance Unit (PPGU) to review training and ensure understanding and application of the process is effective	Increase awareness of DA implementing DA Matters training to all front-line officers.	PPGU		Update February 2023 GMP DA Policy launched August 2022. The new policy contains guidance on when to add repeat victim markers to those who are subject to domestic abuse. DA Matters mandatory training launched Nov 2022 for all officers Forcewide incorporating reinforcement of the agreed definitions. Risk Factors to consider in

							domestic abuse This section contained with the new DA Policy outlines that the process of risk. In GMP we use a method of structured professional judgement in assessing risk. This is done by conducting the DASH risk assessment and then also considering other factors or information we may be in possession of. This follows the principles of the National Decision Model.
4.	Updated DA, DVDS and vulnerability for Spotlight / offender management officers	Ensure the awareness of Spotlight Officers around DA and vulnerability is increased	IOM Review Strategic Lead / VSC Review – DCI Bradley has reviewed and provided updates	Increase awareness of DA issues and improve risk assessment around this.	[redacted]		Spotlight officers are considered front line officers and as such have completed Mandatory “Think Victim”, “Think Victim 2” and “DA Matters” training through 2022 and into early 2023. GMP’s revised DA policy was

							launched Aug 2022, providing greater clarity to police officers on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigation.
5.	A standardised system for the storage of documents/information by Spotlight Units	Ensure accurate record keeping with a way for all officers to be aware of their existence and to have access when necessary	IOM Review Strategic Lead / VSC Review – DCI Bradley has reviewed and provided updates	Increase awareness of the need to store documents, increase transparency and ensure that officers have access to necessary information when required.	[redacted]		The IOPS system facilitates the creation of a Spotlight Management Plan. This system can be readily viewed by all officers so that a up-to-date Management Plan can be viewed and reviewed.
HMPPS – Including Prison Service							
No.							
1.	Probation Service to arrange a briefing to practitioners regarding assessing 'risk to self' and relevant Care Act Assessment	SLT consider learning from IMR with view to commissioning Performance & Quality Team to develop briefing for all practitioners to cover assessing risk to self. This should include how to present this information within the Risk Summary Should pay some focus on assessing risk to POPs	Evidence of planned or delivered briefings via email from QDO outlining offer , and then evidence of delivery through feedback from QDO and practitioners.	Increased ability to focus on risk to self when completed ROSH sections of OASys. This will allow for a clear action within the RMP to manage that risk and protect	[redacted]	Agreement to be reached with SLT by end November 2022 with briefing to be undertaken by end Dec 2022.	Death Under Supervision and Inquest briefings note issues specific to risk to self. To be expanded upon to reflect full learning in this case. Support given by SLT to briefing. Prep of briefing

		who are also victims of DV. Briefing to be mandatory through the clinics already offered by QDO Briefing to include considerations for Care Act Assessment if relevant		vulnerable victims of DV, who also may be perpetrators.			allocated to the Performance & Quality Team (SPO Kevin Bulman) preparation underway but delay due to HMIP inspection, will update with timescales asap.
2.	Review of current practice of practitioners involved within the review who remain in practice.	This should pay specific focus to quality of OASys, including risk assessments. Recoding practice on NDelius including registrations. Communication with other agencies, including timeliness of referrals. Enforcement – content of disclosure during management consultation detailing all relevant information regards to concerning behaviours.	This will be provided by SPO who dip samples the work. Dip sample 3 cases or provided evidence through RCAT audit if cases are identified.	Satisfy that practice changes are embedded once full learning is shared.	SPOs for all relevant practitioners	By end December 2022.	COMPLETED 1 practitioner in post, Oldham PDU. Dip sample of 3 cases (EK, JR, KQ) using NDelius case recording system & OASYs assessment system. Findings from case review gives re-assurance on areas of practice concern. 2 cases (EK and KQ) similar profile to CBW. High levels of multi-agency working in both, regular consultation with manger, prompt enforcement action with EK, KQ compliant so

							no enforcement action needed. MAPPA referral made for KQ and managed at level 2. JW MAPPA Cat 1, level 1 compliant and successfully completed licence. In all 3 cases OASYs assessment to a good standard. Further detail can be provided on request.
3.	Reflective discussion with CBW's last practitioner regarding the use of MAPPA framework when faced with managing a case with multiple agencies involved and challenging timescales to work to. Assurance as to full risk information sharing underpinning management oversight	Reflective discussion between the probation practitioner and their Line manager. Auditing of cases to review holistic nature of information sharing where trauma focused approach is adopted	Feedback from discussion/supervision notes Audit findings	PP will have space to consider MAPPA processes and when these should be implemented. Focus on collaborative working and decision making in this case. Knowledge of significant information to share with managers for purpose of decision making.	Line manager for PPs overseen by [redacted]	Nov 30th 2022	COMPLETED Supervision session between line manager and with CBWs last practitioner Dec 2022, reflective discussion around use of MAPPA framework, why MAPPA referral was not progressed at point of move-on and how she might approach decision making different if faced with same scenario.

4.	Review IMR, specifically with reference to Rivendell end therapy and formulation implementation, with Insight Band 6 manager to consider PDG sessions with practitioners focused on implementation of trauma informed approach	Meeting with Insight team Consideration of findings for practitioner knowledge re implementation of trauma informed formulations Development of PDG session allowing for reflective discussion with practitioners in GM	Action points set from meeting. PDG session activity	Effective practice knowledge re trauma informed practice and responsivity to need/risk of harm/serious harm	[redacted]	Meeting 30th Nov 2022. PDG sessions in 2023	ONGOING Insight Team commissioned to deliver PDG session focused on achieving effective dynamic between risk management and therapeutic relationship. Briefing in development, implementation date not yet confirmed.
5.	Review information from 6-week review audits and RCAT to ensure purposeful home visiting taking place in line with policy framework and at point of transition	Gain assurance all practitioners have awareness of policy framework. In OPF meetings request information on findings from audits re home visiting and set actions should not be in line with expectation	RCAT and 6 weekly audit findings OPF minutes	Effective use of home visits	[redacted]	December 2022	Warrington- ONGOING (awaiting data / update from PDU head) Oldham - COMPLETED Oldham: Current Home Visits policy launched Nov 2021, supported by briefings and communication. Oldham PDU Home Visit performance highest in the region Dec 2022 and Jan 2023, as evidenced by blended supervision data

							and Aug MEG audit.
6.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	Drive local improvements in Integrated Offender Management (IOM) Delivery. Increase MAPPA training completion rates for Probation Staff and Duty to Co-Operate partners	IOM performance dashboard Probation Service line manager update from Mylearning system Data on MAPPA training attendance from MAPPT.	Reductions in re-offending in IOM cohort. Increased understanding and confidence around information sharing.	[redacted]	Update April 2023 but should be ongoing commitment.	ONGOING Multi-agency working and information sharing is ongoing.
Housing Options – Oldham Council							
No.							
1.	Ensure children in foster care are considered when undertaking housing assessments and support	Update actions in Personal Housing Plans	Personal Housing Plan template	Reduced refusals of reasonable offers	[redacted]	April 2023	Action to be carried out as part of wider refresh of PHPs; target date moved
2.	Ensure capacity, including with regards to drugs and alcohol, is taken into consideration when issuing notifications	Ensure housing staff attend relevant training: substance misuse, trauma informed working, Care Act	Training records	Reduction in review decisions over discharge of duty	[redacted]	May 2023	TRAM Protocol procedures and training opportunities circulated to team members; recruitment and training ongoing Partner agencies invited to team meetings including Changing Futures Exploring Co-Location with Homeless

							Addiction Treatment Support Service (HATSS)
3.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	As per Homelessness Strategy Delivery Plan, seek opportunities to co-fund and co-locate services for residents experiencing multiple disadvantage	Role profiles; service descriptions	Increased resident retention within service	[redacted]	May 2023	As above, HATSS co-location is already being explored including a jointly funded officer (expected March 2023) A Homelessness Prevention Officer is being co-located at Oldham Hospital 1 day per week from 01/03/2023 with further joint hospital work planned Co-location between housing and IDVA service already in place (April 2022) Aforementioned 'CAS-3' service promotes joint working / integration with Probation – recently extended to March 2025.
IDVA Service – Oldham Council							

No.							
1.	Seek and secure opportunities to improve multi-agency working and information sharing practices	Initiate team around the adult meetings for clients with multiple disadvantages. Participate in MARAC steering group.	Evident in practice Recorded on case files and in supervision. Attendance at the MARAC steering group to develop and improve the MARAC processes in line with good practice	Clients with multiple disadvantages are supported in a bespoke way. Increase victim and their family's safety. Appropriate multi-agency actions recorded	[redacted]	Completed Completed	Completed Completed
Northern Care Alliance							
No.							
1.	Hospital based IDVA on each of the NCA's sites to support staff with the recognition and response to domestic abuse and improved patient experience and outcomes.	Funding to be identified. Continue work with GMCA to advocate for health based IDVAs in line with GM Gender Based Violence strategy. Request support from Oldham CSP and DA partnership group to promote the importance of role with key commissioners	Funding secured. Increase in recognition and subsequent completed DASH's. Increase in good quality, appropriate referrals to domestic abuse services. Improved direct support for service users and patients affected by domestic abuse.	Increased recognition and response to domestic abuse and improved patient experience and outcomes Earlier intervention to reduce repeated abuse and harm	[redacted]	April 2023	

2.	Domestic abuse strategy including training offer for staff	Development of domestic abuse strategy	Strategy Training dates and numbers of staff	Increased recognition and response to domestic abuse and improved patient experience and outcomes	[redacted]	April 2023	NCA Take 5 domestic abuse pres NCA Take 5 - DASH.pptx NCA Recognition and Response Train
3.	Continue to work towards required staff compliance for level 3 adult safeguarding training	All identified qualified staff to attend mandatory level 3 adult safeguarding training	Trust and care organisation compliance	Increased recognition and response to domestic abuse and improved patient experience and outcomes	[redacted] Adult safeguarding team	January 2023	
4.	Continue to advocate the application of the Mental Capacity Act in clinical practice in relation to non concordance.	MCA training for all staff MCA audits of compliance	Training compliance Audit compliance	Patients are supported to make decisions if required and best interest decisions are made and documented as identified	[redacted] Adult safeguarding team	January 2023	
Pennine Care Foundation Trust							
No.							
1.	Consideration of how the Oldham Safeguarding Adult Board's new Tiered Risk Assessment and Management Protocol is embedded /	OSAB are to roll out training on the TRAM Protocol	Evidence will be available on completion of training.	Practitioners to be aware to the TRAM protocol. To contact safeguarding	Oldham Safeguarding Adults Board / [redacted] – Adults.	28/04/2023	.

	implemented within the organisation and existing policies and procedures.			team if further support needed			
	Professional curiosity	Safeguarding team deliver level three safeguarding which encompasses the importance of professional curiosity and 'so what'		Increase awareness and ensure staff can access Trusts safeguarding team.	[redacted] Named Professional Adults	28/04/2023	Safeguarding team are in the process of reviewing training packages – Will take any information from learning events into account. PCFT Current Virtual LAC L3 traini PCFT CURRENT REVISED Virtual L3 PCFT CURRENT Level 3 Safeguardin PCFT Current L3 Children and Adults Team are in the process of completed 'lets talk about safeguarding ' walks throughout PCFT
	Domestic Abuse Awareness	Safeguarding team to continue to promote	Percentage figures of compliance.	Increased awareness	[redacted]	28/04/2023	Safeguarding team have

		domestic violence module available on the intranet. Safeguarding to continue to deliver level three safeguarding training. This training encompasses Domestic violence and MARAC process Safeguarding operates a duty system that is promoted via intranet and corporate induction. Practitioners could access this if supervision needed. Practitioners need to be aware of	Evaluation forms - link is sent to all participants. Practitioners are aware of how to complete DASH and refer to MARAC as necessary. Safeguarding Team collate themes of what is discussed on duty process - this is transposed into the safeguarding annual report.	from practitioners, that is reflected in practice and evaluations.	Named Professional Adults		recently provided more training sessions to ensure compliance percentages are met. PCFT are currently on the at risk register due to not having a representative for MARAC in each borough- The Model being used in Stockport in being looked at to see if it can be replicated- Stockport have a representative
	Disengaging patients	Development of a disengagement policy with PCFT.	Implementation of disengagement policy. This will enable practitioners to consider risks associated with a patient who does not engage with services, exploring reasons why and what can be put in place to try and engage patient.	Risks are considered when working with patients who are not engaging. This will ensure that any discharge is done as safety as possible. Looking at the reasons why	PCFT	28/04/2023	Trust are in process of completing disengagement policy.

				patients do not engage will enable practitioners to put in reasonable adjustments.			
	Think Family Approach	Safeguarding to continue to deliver level three safeguarding training. This training encompasses the 'Think Family Model'	Record audits reflect that that the whole family/network around an individual has been considered. This should be clear in biographical section and risk assessments.	The whole family are included in assessments and risks considered i.e., in relation to children. Practitioners are confidently able to utilise the Think Family approach in assessment and safety planning.	Safeguarding Team. [redacted] Named Professional Adults	Completed	
	Seek and secure opportunities to improve multi-agency working and information sharing practices.	Pennine are committed to working with partner agencies to meet the needs of complex individual with multiple health and social needs.	Safeguarding level three training packages have been revised and it is threaded throughout the importance of communication and multi- agency working. SAR, DHR are covered including lessons learnt from information sharing and working with others.	Successful multi agency working to take place – that benefits client and promotes good quality risk assessments and high-level care.	PCFT all boroughs Safeguarding Team – Pennine.	Completed.	7-minute briefing on information sharing has been disseminated via network Quality forums. Level three training delivered to all qualifies staff and some additional unqualifies staff in high-risk areas – sessions

			7-minute briefing shared with all Pennine staff – that pertain to multi agency working. Staff offered supervision / consultation as required. Pennine Safeguarding team have duty system 5 days a week (Mon- fri 9-4.30), that offers support to all Pennine staff Record audits look at level of multiagency working and risk assessments Staff have access to clinical supervision. Recent 7-minute briefing published by Pennine in respect of information sharing.				increased so that percentage of compliance is increased.
Turning Point							
No.							
1.	Face to face assessment appointments to be implemented post Covid 19 risk assessment.	Turning Point have already moved back to offering face to face assessment appointments.	Assessment process	We are able to assess clients physical presentation, body language and ask personal questions in a safe environment.	[redacted]	Already completed	

2.	Provision to provide on-going support over holiday periods to not enable delays in appointments.	To generate and provide clients with a harm reduction booklet and guidance on who they can contact during these periods for support.	Physical access to the booklet, lesson learnt log.	Increase support on offer over holiday periods for clients and guide them as to where they can access support when services are closed.	[redacted]	18/12/2022.	Action completed. Booklet updated and shared with service users over holiday period 2022-23.
3.	Seek and secure opportunities to improve multi-agency working and information sharing practices.	To have representation at key strategy/review/partnership meetings.	Minutes of meetings.	Strengthening partnerships to lead to improvements to multi-agency working and information sharing practices.	[redacted]	30/04/2023	

Appendix 2

Oldham Safeguarding Adults Board

The OSAB Business Unit has led on the development and implementation of:

- Availability of section 42 safeguarding referral training for all safeguarding partners
- A Tiered Risk Assessment and Management Protocol
- A Critical and High-Risk Panel and associated training to support multi-agency risk management.

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.	Through the Domestic Abuse Partnership, agencies are reminded: a) that when a contact is made or attempted, with a victim of domestic abuse, that perpetrators can control the victim's movements and their communications b) of the importance of accurate record keeping c) to make the right referrals, at the right time to the right place, in order to reduce risk, and that receiving agencies acknowledge receipt and make contact with the referrer regarding any next steps.	Local	Data to be provided to the OSAB by Greater Manchester Police on the delivery of the Domestic Abuse Matters training to Police Officers, which focuses upon controlling and coercive behaviour. Production of 7-minute briefing regarding coercive and controlling behaviour and impact on communication, risk recognition and decision making. Reference activity and resources already available for use, including Walking on Eggshells film.	Greater Manchester Police Oldham Council (IDVA/CSS) OSCP OSAB	100% existing staff base have received training. DA Matters is delivered to student Police Officers as part of training prior to taking up front line duties. Product finalised and circulated across services. Confirmation of roll out to staff received. Six-monthly report provided by OSAB on viewings of Walking on Eggshells film.	31/12/24 Ongoing – six monthly data updates to OSAB. 30/06/24 30/09/24 Ongoing	

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**
			Seek assurance through audit mechanisms that controlling and coercive behaviour is recognised in practice and that there are adequate supervision methodologies to ensure it is responded to appropriately.	OSAB/OSCP	Embedded practice considered as standard within existing OSAB and OSCP audit frameworks, where domestic abuse is an identified factor in a case.	Ongoing	
			Lancashire and South Cumbria ICB to roll out EMIS prompts relating to domestic abuse routine enquiry, which will include controlling and coercive behaviour. This implementation of this will be monitored through	Lancashire and South Cumbria ICB	Roll out by April 2023 Update report to OSAB on results of implementation	April 2023 31/03/25	

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**
			LSC ICB mechanisms.				
			7-minute briefing to be produced and circulated with letter from CSP to to ensure the following is recognised: - clear purpose of record keeping; - importance of accurate record keeping; - implications and impact of errors in record keeping; - workload planning and time management to allow for record keeping; - importance of 'slow down – give time' opportunity for record keeping; and	Oldham Council (CSS) OSAB OSCP	Product finalised and circulated across services. Confirmation of roll out to staff received. Embedded practice considered as standard within existing OSAB and OSCP audit frameworks, where domestic abuse is an identified factor in a case. Reduction in identified errors through supervision and audit exercises.	30/06/24 30/09/24 Ongoing Ongoing	

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**
			- risks and dangers of copying and pasting without fact-checking.				
			Completion of current work to develop clear pathway structures relating to domestic abuse, which include 'close the loop' referral feedback on resulting actions.	Oldham Council (IDVA Service)	Pathways document completed and published.	30/06/24	
2.	Through the Oldham Safeguarding Adults Board (OSAB) there is oversight of the implementation and effectiveness of the Adult Safeguarding and Exploitation Strategy, the TRAM Protocol and the NWADASS Complex Safeguarding Strategy, to ensure	Local	The Oldham Safeguarding Adults Board (OSAB) regularly seek assurance from its partner agencies of the effectiveness of the implementation of the Adult Complex Safeguarding and Exploitation Strategy and	OSAB	Reports/data considered by OSAB through existing plan and structures.	Ongoing	

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**
	issues affecting a person that relate to domestic abuse, including accommodation, health, and mental health, are taken into account, and that Care Act 2014 assessments are undertaken where appropriate.		Tiered Risk Assessment and Management (TRAM) Protocol, to ensure issues affecting a person that relate to domestic abuse, including accommodation, health, and mental health, are taken into account when supporting individuals/victims. Learning from the local implementation of the NWADASS Complex Safeguarding Strategy (the development of which was led by the work in Oldham) is shared outside of Oldham	Oldham Council (Adult Social Care) and OSAB	Sharing opportunities identified.	Ongoing	

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**
			through networking arrangements. Adult Social Care undertake regular audits in relation to the completion of appropriate assessments of an adult's needs for care and support in line with section 9 of the Care Act 2014.	Oldham Council (Adult Social Care)	Audit reports provided to OSAB.	Ongoing	
3.	Through the OSAB and OSCP there is scrutiny through audit processes to ensure single agency decision making is compliant with multi-agency safeguarding policies and that single agency domestic abuse policies are checked to ensure that they recognise that a	Local	There is scrutiny through OSAB and OSCP audit processes to ensure single agency decision making is compliant with multi-agency safeguarding policies.	OSAB OSCP	Embedded practice considered as standard within existing OSAB and OSCP audit frameworks, where domestic abuse is an identified factor in a case.	Ongoing	

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**
	perpetrator can also be a victim.		Letter from CSP to organisations to ensure that single agency domestic abuse policies are checked to ensure that they recognise that a perpetrator can also be a victim and assurance is provided to the Oldham Domestic Abuse Partnership with evidence provided to CSP/OSAB and OSCP.	Oldham Council (CSS)	Letter issued. Evidence received.	30/04/24 31/07/24	
4.	The OSAB and OSCP work with partner organisations to review the current multi-agency training offer, including accessibility and frequency, and develop a minimum standards training framework which	Local	The partner agencies of OSAB and OSCP work together to review the current training offer in Oldham to ensure staff are afforded the opportunity to develop competency in	Oldham Council (CSS) OSAB OSCP	Training audit undertaken. Opportunities for training swap (multi-agency) identified. Links between training and local delivery offer/pathways identified.	30/06/24 30/06/24 30/06/24	

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**
	includes: EUPD; self-harm; attempted suicide; domestic abuse, routine enquiry; repeat victimisation; perpetrator as victim; substance and alcohol use; mental ill health; the importance of information sharing and multi-agency co-ordinated risk management; application in practice of the Mental Capacity Act 2005,Think Family and Think Parent, Think Child, MARAC processes/ referrals and adult safeguarding Care Act duties - with an associated quality assurance framework, to that ensure learning is embedded into practice through		relation to EUPD; self-harm; attempted suicide; domestic abuse, routine enquiry; repeat victimisation; perpetrator as victim; substance and alcohol use; mental ill health; the importance of information sharing and multi-agency co-ordinated risk management; application in practice of the Mental Capacity Act 2005, Think Family and Think Parent, Think Child, MARAC processes/ referrals and adult safeguarding Care Act duties.		Gap analysis undertaken. Forward plan agreed regarding areas for development and/or improvement.	30/09/24 31/12/24	

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**
	management oversight and supervision.		OSAB and OSCP to regularly seek assurance from their partner agencies concerning the efficacy of their quality assurance frameworks and supervision models.		Embedded practice considered as standard within existing OSAB and OSCP audit frameworks, where domestic abuse is an identified factor in a case.	Ongoing	

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October 2024

Dear Lorraine,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jenny) for Oldham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 18th September 2024. I apologise for the delay in responding to you.

The QA Panel noted that the report was well informed with relevant research cited throughout. They also commended the consideration given to family involvement and noted that the report gives a good sense of who Jenny was and the adversities she experienced throughout her life.

A clear and appropriate scope was agreed and a suitable timeframe chosen. The chronology of events and the analysis was clearly developed thoughtfully and is easy to follow.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Health transfers and signposting were not well managed for victim and perpetrator – this was seen in the mental health care plan between 'prison to community' transition and between area mental health services.

- Assessments by the GP lacked professional curiosity and routine enquiry about domestic abuse and missed opportunities about the victims' welfare.

- The victim was never referred to adult social care as a vulnerable adult despite having contact with lots of agencies, safeguarding her was not considered.

- There are breaches in confidential information which need to be amended to ensure anonymity:
    - Paragraph 2.114 contains reference to child 1's gender.
    - The date of death is detailed within the report in numerous places *(front title page, 3rd paragraph of the preface, paragraphs 1.4, 1.14, 1.29, 1.44 and in the chronology).*
- There is no information on whether the family were involved in selecting the pseudonyms used, which should be clarified.
- The report should include some information as to why a joint Safeguarding Adult Review/DHR was not undertaken due to the victim's vulnerabilities.
- The report details that a 'Serious Further Offence Review' was conducted and completed on 15 September 2017. This date should be reviewed given the dates of this case.
- The report explains that a 'Death Under Supervision Review' was taking place at the time of this DHR. The report should explain what this review is and who is conducting it and provide an update prior to publication if possible.
- The dissemination list at 1.37 should include the Mayor for Greater Manchester.
- The report is missing an overview section to summarise the information known to agencies and professionals about the victim and perpetrator. This should be added.
- Please provide more clarity on the coroner's findings if possible.
- There is no contents page in the Executive Summary which should be added. The contents list in the Overview Report should also include page numbers.
- The report requires a thorough proofread.

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

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

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This

should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

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

Yours sincerely,

Home Office DHR Quality Assurance Panel

Actions Taken in Response to Feedback

Health transfers and signposting were not well managed for victim and perpetrator – this was seen in the mental health care plan between 'prison to community' transition and between area mental health services.	This was considered during the Review. Detail added by the Author.
Assessments by the GP lacked professional curiosity and routine enquiry about domestic abuse and missed opportunities about the victims' welfare.	This was considered during the Review. Detail added by the Author.
The victim was never referred to adult social care as a vulnerable adult despite having contact with lots of agencies, safeguarding her was not considered.	This was considered during the Review. Detail added by the Author.
There are breaches in confidential information which need to be amended to ensure anonymity:	All checked and rectified by the Author.
Paragraph 2.114 contains reference to child 1's gender	Checked and rectified by the Author.
The date of death is detailed within the report in numerous places	Exact dates removed by the Author.
There is no information on whether the family were involved in selecting the pseudonyms used, which should be clarified.	This was considered during the Review. Detail added by the Author.
The report should include some information as to why a joint Safeguarding Adult Review/DHR was not undertaken due to the victim's vulnerabilities.	This was considered during the Review. Detail added by the Author.
The report details that a 'Serious Further Offence Review' was conducted and completed on 15 September 2017. This date should be reviewed given the dates of this case.	Following discussion with the CSP Lead, it is recognised that inclusion of the SFO Review has caused

	confusion. Reference has been removed as the SFO refers to a separate and distinct matter, not relevant to the Review. Detail removed by the CSP Lead.
The report explains that a 'Death Under Supervision Review' was taking place at the time of this DHR. The report should explain what this review is and who is conducting it and provide an update prior to publication if possible.	This was considered during the Review. Detail added by the Author and CSP Lead.
The dissemination list at 1.37 should include the Mayor for Greater Manchester.	Detail added by the Author.
The report is missing an overview section to summarise the information known to agencies and professionals about the victim and perpetrator. This should be added.	Detail added by the Author.
Please provide more clarity on the coroner's findings if possible.	Detail added by the CSP Lead.
There is no contents page in the Executive Summary which should be added.	Detail added by the Author.
The contents list in the Overview Report should also include page numbers.	Detail added by the Author.
The report requires a thorough proofread.	Completed by the Author and corrections made.