

**OLDHAM COMMUNITY SAFETY AND COHESION
PARTNERSHIP**

DOMESTIC HOMICIDE REVIEW IN THE CASE OF JAMES

**TIME PERIOD UNDER REVIEW: 1st JANUARY 2012 TO DATE OF
DEATH IN DECEMBER 2016**

SEPTEMBER 2019

DHR CHAIR AND REPORT AUTHOR: MAUREEN NOBLE

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1. INTRODUCTION AND BACKGROUND

1.1 Key People

This Domestic Homicide Review relates to the death of James. James was in his mid-fifties when he was murdered by his wife Sharon in early December 2016. The names James and Sharon are pseudonyms chosen at random by the DHR panel.

This report also refers to Sharon's son, who will be referred to as Mark.

The DHR panel offers its sincere condolences to James' family and friends on their tragic loss.

1.2 Incident Leading to the DHR

On the day of the fatal incident Greater Manchester Police (GMP) received an emergency call from Sharon. She said that her husband James had collapsed and was unconscious. Sharon told the call handler that she and James had been drinking and that James had hurt his chest, but that she didn't know what had happened.

Police responded to the call and notified North West Ambulance Service (NWAS). Police officers arrived at Sharon's address five minutes after receiving the call, they noted that Sharon was hysterical and that James was lying on the floor in a pool of blood.

Ambulance crew arrived at the address minutes after the police. Paramedics examined James and confirmed that he had two puncture wounds to his chest and abdomen. James was pronounced deceased by paramedics within two minutes of their arrival at the scene.

Sharon was arrested and subsequently charged with James' murder.

A Home Office post mortem confirmed that James had died as a result of knife wounds to his chest, leading to internal bleeding. James had also sustained a knife wound to his arm which the pathologist described as a 'classic defence wound'.

Sharon appeared for trial in June 2016 and was found guilty of manslaughter (see 1.6 below).

1.3 Background to James

Note: Much of the information contained in this part of the report is drawn from witness statements as only one family member, Sharon's son Mark, has been involved in the review. The review recognises that witness statements can be subjective and are taken for a different purpose. The review does not therefore suggest that this information is factually accurate, however it is provided to give an indication of how James and Sharon presented to others.

James had grown up in the local area and, according to witness statements made by members of his family, he had been particularly close to one of his brothers and to his mother. In witness statements James is described as a quiet man who kept himself to

himself, worked hard and supported his family. He was said by family members to have been a good husband to Sharon. They had been married for more than thirty years.

Both James and Sharon had had previous relationships. Sharon had two children when she met James. James' brother and his mother said in statements made to the police that James brought up Sharon's two children as his own, and that they treated him as their father.

In 2004 James and Sharon moved to live abroad, the review has been unable to ascertain the reason for this move. There is no information regarding James' and Sharon's financial status at this time or whether they owned or rented their property abroad. The review saw information in a witness statements indicating that both James and Sharon had jobs when they lived abroad.

The review has not seen any medical records for either James or Sharon for the period in which they lived abroad. As far as the review can ascertain, James did not have any significant physical or mental health issues during this period. There is no evidence of any criminal activity, nor is there any indication that there was domestic abuse in the relationship between James and Sharon during this time. One witness statement recounts that James was involved in a motorbike accident whilst living abroad and spent time in hospital (which it was observed he would not have liked as 'he didn't ever go to the doctors').

In December 2010 Sharon's older son died unexpectedly of respiratory failure, and Sharon returned to the UK, whilst James remained abroad. Following this Sharon and James returned briefly to live in the UK and then returned to their home abroad.

Tragically the death of Sharon's older son was followed a year later by her younger son (known in this report as Mark), being seriously injured in a road traffic incident. He suffered life limiting injuries, which resulted in him requiring intensive care for a long period after the incident.

Mark's medical and social support needs continued throughout the period under review. Sharon then remained in the UK to be in close proximity to Mark, who was living in residential care. Mark was unable to live independently as a result of his injuries and this was reported to professionals by Sharon as a cause of ongoing anxiety and distress to her.

It appears that James and Sharon maintained contact with each other, although they resided in different countries, and that they visited each other from time to time and spent holidays together.

There is conflicting information regarding whether James returned to live permanently in the UK before August 2016, although there are indications that James may have spent long periods of time in the UK between 2014 and 2014.

There is a note in police records that James registered with an employment agency in the UK in August 2013. The review has also seen information from the Benefits Agency which indicates that James was claiming benefits and also working in the UK during 2014. This

information cannot be corroborated although a witness statement from James' mother indicates that he did return to live in the UK in 2014 but that she was uncertain regarding dates. Note: During this period Sharon was reporting to some agencies that James was not living with her in the UK.

The review has been unable to ascertain whether James and/or Sharon had any financial assets from their property abroad.

In August 2016 James returned to reside in the UK, this may have been triggered by the death of one of his brothers in April 2016. James obtained a job at a local warehouse. The panel has been unable to confirm if this was a temporary visit or whether James intended to remain in the UK.

James' employer confirmed that he worked for the company for a short time from August 2016 until his death.

In statements to police Sharon and other family members said that James spent every Sunday with one of his brothers; they would go fishing and then go to the pub. Sharon later told agencies that it was on these occasions that James would become aggressive, which she said was as a result of excessive alcohol consumption.

As far as the review can ascertain, until an incident that took place in September 2016, James had never disclosed domestic abuse to any agency, to any family member or to friends. A witness statement given to police implies that James had spoken to his brother regarding Sharon losing her temper, however this cannot be corroborated.

1.4 Background to Sharon

Information taken from medical records indicates that Sharon had a long history of anxiety and depression, for which she was treated in primary and secondary care. It appears from historic information provided to agencies by Sharon, that she had a difficult childhood and that she had self-harmed at an early age. It is recorded that she first attempted to take her own life at age 10 and that there were subsequent suicide attempts recorded.

Information from witness statements confirms that Sharon married and had two children before she met James. James and Sharon met in their 'thirties and set up home together. James raised Sharon's two sons as his own children. There is no indication at this time of any violence or disharmony between the couple. They were said to have socialised with friends and family and led an 'ordinary' life in the local area, according to witness statements.

The couple moved abroad in 2004. Family members said in witness statements that they enjoyed their life together abroad, and the review has seen no evidence that Sharon experienced any physical or mental ill health issues whilst residing there.

Sharon returned briefly to the UK following her son's death in 2010. In November 2011 following Mark's tragic accident referred to above, Sharon returned to live permanently in the UK.

When she returned to live in the UK, Sharon registered with the same GP practice she had used before moving abroad. She informed the GP about the two tragic incidents that had occurred over the past eighteen months. The GP noted that Sharon was experiencing a bereavement reaction that was impacting her mental health.

At this time Sharon appears to have lived temporarily with a family member, however this did not last. Sharon was then registered as homeless for a period of time (the review believes she may have been staying with a friend at this time) but also appears to have lived in a hostel in a neighbouring borough.

In February 2012 Sharon secured a tenancy with a local housing provider, where she lived until the fatal incident took place. James was never registered as a tenant at this property.

During the period under review Sharon had frequent contact with her GP, Mental Health Services and housing services (as set out in Section 3 below). On two occasions in 2012 Sharon was sectioned under the Mental Health Act (S2 and S136¹). On a number of occasions police were contacted by family and friends of Sharon who were concerned about her mental health and potential for self-harm.

It is apparent from Sharon's medical records that she reported fluctuating alcohol use and may have used alcohol as a coping mechanism. She reported this to her GP and specialist mental health services. There are anecdotal reports, made retrospectively by Sharon that James also drank heavily at times (Note: This cannot be corroborated by the review). However, until James returned to the UK in September 2016, neither he nor Sharon appeared to have been offered or sought any form of treatment or support in relation to alcohol problems. Sharon's GP asked Sharon about her alcohol consumption on a regular basis and noted changes in consumption, however the GP did not make any referrals to alcohol support services.

Sharon continued to maintain her own tenancy, she was registered as the sole tenant throughout the period under review. Sharon's housing provider was unaware that James spent time living at Sharon's flat and, as far as any agency was aware at that time, James did not live with Sharon. Note: When Sharon was referred to the Independent Domestic Violence Advisor she told them that she and James spent a few days a week together at her flat, but for the rest of the time James lived with his mother. However there are indications that James was spending more time with Sharon than was disclosed to the housing provider or to other agencies, and that James may have been living with Sharon at her rented property. It has not been possible for the review to corroborate this.

1.5 Time Period under Review

¹ Section 2 of the Mental Health Act enables 28 day stay in hospital for mental health assessment. **Section 136** gives the police the power to remove a person from a public place, when they appear to be suffering from a **mental disorder**, to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

The time period under review was agreed as being January 2012 (shortly after Sharon returned to the UK from living abroad with James) to December 2016 when the fatal incident occurred.

A contemporaneous chronology of contact with services during this period was compiled for the review. From this chronology key contacts and events have been identified from which the learning in this review will be drawn.

During the course of this review the panel became aware of historic events and contacts that may have impacted James' and Sharon's relationship. These events and contacts are included in the body of the report, but are not analysed in detail in the report.

1.6 Police Investigation and Criminal Proceedings

Sharon was arrested and subsequently charged with James' murder. Sharon initially entered a plea of not guilty to murder and entered a plea of guilty to manslaughter on the grounds of diminished responsibility. This plea was not accepted by the Court and the matter went to trial.

Sharon was subsequently found guilty of manslaughter due to loss of control in June 2017. In July 2017 Sharon was sentenced to six years imprisonment.

In his summing up the judge noted that there had been violence in the relationship between James and Sharon, however the judge did not rule that Sharon had killed James in self-defence.

1.7 Coronial Matters

The Coroner was informed by letter of the commencement of the DHR and received updates on the progress of the review.

At the time of writing no inquest has taken place.

1.8 Parallel Processes

Police made a referral to the Independent Police Complaints Commission (IPCC²) regarding aspects of their involvement with the case. The IPCC referred the case back to Greater Manchester Police to conduct their own internal investigation.

The Professional Standards Branch of GMP opened an internal review which was completed on 9th June 2017. The terms of reference for the internal review were as follows:

- a) The full circumstances surrounding the incidents reported to the police.
- b) The appropriateness of the police responses, the interactions that took place between attending/investigating officers and James and Sharon.

² Now the Independent Office for Police Conduct (IOPC)

- c) If any concern was raised, or should have been raised, about any threat, harm or risk Sharon posed to herself and others, in particular to James and what measures were put in place to mitigate risk.
- d) Consider conclusions of the Home Office Pathologists in relation to cause of death.
- e) Identify any opportunities for individual or organisational learning which may arise out of this incident,
- f) Consider whether or not the dealings that GMP had with James amounted to a contravention of the European Convention on Human Rights, under Article 2 the right to life
- g) Provide a report of your findings for the IPCC.

The author of the internal police review concluded:

- *I have not identified anything that would suggest that GMP should have been able to identify any imminent risk, nor foresee the death of James.*
- *I have not identified any police actions, omissions or decisions that could be considered to be a direct or indirect cause or contributory factor to the death of James.*
- *I do not consider that GMP's dealings with James amounted to a contravention of Article 2 ECHR, right to life.*

The DHR is satisfied that GMP acted appropriately in relation to the IPCC's request and that a report has been submitted to the IPCC.

1.9 Family Involvement in the Review

In April 2017 at the commencement of the review, James' mother and brother were informed by letter that a DHR was taking place. The letter explained the purpose of the DHR and indicated that, following the criminal proceedings they would be invited to participate in the review. No response was received to the first communication.

The family were contacted again following the criminal proceedings however no response was received from them. Note: The Chair will contact family members again prior to publication to give them an opportunity to read the report.

In addition to Sharon's son Mark, another member of Sharon's family was also invited to participate in the review. This invitation was declined.

The panel felt it important that Sharon's son Mark should be given an opportunity to participate in the review, provided it was not deemed to be harmful to his wellbeing. Liaison took place between the Lead Commissioner of the review and Mark's current social worker. The Social Worker deemed that it would not be detrimental to Mark's wellbeing to invite him to participate in the review.

The Social Worker spoke to Mark at the Care Home where he is living at present. Mark was asked whether it would be OK to speak about what had happened with his mum and step-father and he said that he was OK with that.

Mark was asked if he ever saw any fights or arguments at home between his mum and step dad and he said, very clearly, no. Mark was asked if he was OK with being asked some further questions and he said yes and gave no verbal clues indicating that this was not OK.

Mark was asked if he ever thought that one of them might be hurting the other and he said no. Mark was then asked if either his mum or step dad might be frightened of the other – he said that mum was always fighting and arguing and step-dad punched mum. Mark was asked if he had seen this and he said no. He said that his mum had told him this.

Despite the panel's efforts to involve other family members in the review it has not been possible to do so, therefore information relating to family relationships and daily life has been taken from witness statements given to police during the criminal investigation to build a picture of James' and Sharon's life together.

1.10 Perpetrator Involvement in the Review

On conclusion of the criminal proceedings the panel made enquiries via Sharon's Offender Manager with regard to her being invited to participate in the review. The panel was informed by the Offender Manager that Sharon was experiencing considerable distress and that her mental health was fragile. The review was informed that Sharon had not come to terms with what had happened and could not accept that James was dead. The Offender Manager therefore recommended that it would not be in Sharon's best interests to be involved in the review. On that basis the panel agreed not to invite Sharon to participate in the review.

At the end of February 2018 the Chair of the review was contacted by the Consultant Psychiatrist responsible for Sharon's care, to inform the review that Sharon's mental health had improved, and that she was fit to be interviewed.

The Chair made contact with the secure unit where Sharon is serving her sentence to invite Sharon to participate. The review was initially informed that Sharon wished to participate in the review and an arrangement was made to meet with her, however the Chair was then informed that Sharon had become unwell and that the clinical advice was that she should not be interviewed in relation to the review. It was agreed that no further approaches would be made to Sharon, to enable the review to be completed.

1.11 Equality and Diversity

The Review considered the nine protected characteristics set out in the Equality and Diversity Act (2010).

The conclusions made by the review indicate that practice in relation to James as a victim of domestic abuse fell below expected standards and that agencies should consider the protected characteristic of 'gender' in their practice in relation to domestic abuse.

The review noted that Sharon had received treatment for mental health issues and was diagnosed with a severe and enduring mental illness. From records seen by the review, Sharon's mental health was given consideration by agencies with whom she had contact and her diversity needs were taken into account in this context.

2. CONDUCT OF THE DHR

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)³. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

The DHR was commissioned by Oldham Community Safety and Cohesion Partnership (CSCP) in February 2017 and began in April 2017 following the appointment of an Independent Chair. The Review has been completed in accordance with the regulations set out by the Act and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.⁴

The panel noted the revised definition of domestic abuse to ensure that all aspects of domestic abuse were addressed in the terms of reference and in the reports provided by agencies.

Revised guidance produced by Home Office in November 2016 has been followed in conducting this review.

2.1 Terms of Reference and key lines of enquiry

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

³<https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004>

⁴ <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

2.2 Rationale for the Review and Specific Terms of Reference

The rationale for the DHR is to ensure that the review derives learning about the way agencies responded to the needs of the victim.

It is the responsibility of the panel to ensure that the daily lived experience of James is reflected in its considerations and conclusions and, wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's daily life.

The review aims to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide, violence and all forms of domestic abuse.

Learning from the review will help to improve services to victims of domestic abuse and a multi-agency action plan is appended clearly setting out the actions that agencies should undertake to improve service delivery.

The review is aware of the potential for hindsight bias to influence reports and statements and has taken this into account in reviewing and presenting material.

The following key lines of enquiry were agreed:

1. What if any indicators of domestic violence and abuse did your agency have in respect of either or both the subjects?
2. What was the response in terms of risk assessment and risk management?
3. How did your agency ascertain the wishes and feelings of the adults involved in respect of domestic violence and abuse and were their views taken into account when providing services or support?

4. What knowledge did your agency have of alcohol, substance or other prescribed medicine misuse by either James or Sharon?
5. What knowledge did your agency have of the mental health and/or other medical conditions suffered by either James or Sharon?
6. Were there any barriers in your agency that might have stopped either James or Sharon from coming forward to seek help for domestic violence and abuse?
7. Were there any barriers in your agency that might have stopped either James or Sharon from coming forward to seek help for debt management?
8. In your organisation what support was available at the time of your involvement with either James or Sharon?
9. What knowledge did the family, friends and employers have of the adults' relationship, that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?
10. Were single and multi-agency policies and procedures followed; are the procedures embedded in practice, and were any gaps identified?
11. How effective was inter-agency information sharing and cooperation in response to the needs of James or Sharon and was information shared with those agencies who needed it?
12. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to James or Sharon?
13. How effective was your agency's supervision and management of practitioners involved with the response to the needs of James and Sharon, and did managers have effective oversight and control of the case?
14. Were there any issues in relation to capacity or resources within your agency or the Partnership in the period under review that affected your ability to provide services to James or Sharon?
15. Was support offered to Sharon and James in relation to bereavement and carer support?
16. Did agencies recognise and respond appropriately to James as a male victim of domestic abuse? Note: This term of reference was reviewed after submission of initial IMRs and given specific focus at each panel meeting to ensure that it remained central to the review.

2.3 The DHR Panel

A DHR Review Panel was established by the CSCP and met on six occasions to oversee the review process. The Panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner's Office.

The CSCP appointed Maureen Noble as independent Chair and Author to oversee and direct the review and to write the overview report. The Chair/Author has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair/Author has extensive experience relating to domestic abuse having been the strategic lead for domestic abuse whilst employed as Head of Crime and Disorder Reduction for a large metropolitan council. The Chair/Author has also served as a member of the NICE national programme management group on domestic abuse which produced the current NICE guidance, and has worked on the production of domestic abuse service standards with NICE.

The Chair had no contact with the victim or perpetrator in this case and had no professional or personal contact with any of the agencies involved in the DHR prior to the incident occurring. The Chair has never been employed in any capacity by the commissioning organisation.

In line with Home Office guidance a panel of senior officers was appointed to conduct the Review. Panel members were selected based on their seniority within relevant agencies and ability to direct resources to the review and to oversee implementation of review findings. The names and roles of DHR panel members are set out below:

Maureen Noble	Independent Chair	Independent
Lorraine Kenny	Community Safety Manager (Internal Chair	Oldham Council
Janine Campbell	Designated Nurse Safeguarding Adults	NHS Oldham Clinical Commissioning Group
Jeanette Meadowcroft	Named Nurse Safeguarding Adults	The Pennine Acute Hospitals NHS Trust
Helen McGawley	Interim Criminal Justice Mental Health Team Manager	Pennine Care NHS Foundation Trust
Paula Field	Community Legal Manager	First Choice Homes Oldham
Gary Oulds	Director of Service Delivery	One Recovery Oldham
Jackie Hall	Vice-Chair Oldham Domestic Violence and Abuse Partnership	Independent
PC Gemma Hall	STRIVE Police Officer	Greater Manchester Police
DCI Chris Downey/ DCI James Falkner	Public Protection Lead	Greater Manchester Police

Tanya Farrugia	Early Help (including IDVA ⁵) Service Manager	Oldham Council
Janice France	Senior Probation Officer	Her Majesty's Prison and Probation Service
David Potts	Practice and Development Manager	TLC: Talk, Listen, Change
Emma Davidson	Serious Case Review Team	Greater Manchester Police
Julian Guerriero	Complex Dependency & Reducing Reoffending Co-ordinator	Oldham Council

2.4 Focus on Male Victims of Domestic Abuse

A local agency (TLC) with knowledge of working with male victims of domestic abuse attended three panel meetings and was asked to comment on the final report before it was submitted to the Home Office for quality assurance. Comments made by the agency were incorporated into the final report.

2.5 Statement of Confidentiality

The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals not involved in the DHR process. NB It should be noted that the review complied with information requests made by HM Coroner.

2.6 Methodology

At its first meeting, the DHR Panel approved the use of a locally devised Individual Management Report (IMR) template and integrated chronology template. The Chair of the Panel contacted each participating agency, as appropriate, and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was excellent.

The IMRs and integrated chronology were used to determine the nature and frequency of contact each participating agency had with James (and Sharon).

2.7 Sources of Information to the Review

Agencies that had significant, relevant and/or prolonged contact with James and/or Sharon were asked to provide Individual Management Reports. Other agencies were asked to provide short reports.

There were no conflicts of interest recorded during the review. Authors of Individual Management Reports and short reports were not directly connected to the parties and did not sit on the Review Panel.

IMRs and short reports were received from the following agencies:

⁵ The local IDVA service is provided by Oldham Council

Agency/Format	Role
Oldham Clinical Commissioning Group Individual Management Report	GP for Sharon James had registered with a local GP but never attended
Adult Social Care Oldham Individual Management Report	Adult Social Care Services
Pennine Care Individual Management Report	Mental Health Services
Pennine Acute Hospitals Trust Individual Management Report	Nil Return (No contact with either James or Sharon)
Salford Royal Foundation Trust Individual Management Report	Referral to Mental Health Services
Greater Manchester Mental Health Individual Management Report	Mental Health Services
First Choice Homes Oldham (FCHO) Individual Management Report	Housing Provider to Sharon
One Recovery (ADS) Individual Management Report	Substance Misuse Service
Oldham Council Independent Domestic Abuse Advisory Services (IDVA) Individual Management Report	Support to victims of domestic abuse
Greater Manchester Police Individual Management Report	Police services

North Manchester General Hospital/Manchester Royal Infirmary Short Report	Treated James for injuries on 25 th September 2016
North West Ambulance Service Short Report	Attended incidents at Sharon's home address

Panel members acted as single points of contact in reviewing agency reports, IMRs and other information and took the opportunity to clarify information and request additional information from report authors.

Each agency was asked to make single agency recommendations based on learning from the review. Each agency contributed to the compilation of the multi-agency action plan provided at Appendix 1.

2.8 Additional Information Sought by the Review Panel

2.8.1. Witness Statements

The DHR Panel had sight of witness statements made by relatives and friends of James and by a friend of Sharon. The panel were mindful of the purpose of witness statements and their objectivity in relation to the review. The panel therefore used information contained in witness statements to supplement the agency information they had about James' and Sharon's day to day lives and background as they were unable to speak to anyone who knew James or Sharon but did not interpret information contained in the statements as being without bias. Note: Sharon's son Mark contributed to the review, however due to Mark's additional needs it was necessary to structure questions put to him, rather than to ask him to give an account of the lives of James and Sharon.

2.8.2 Benefits Agency

The review sought information regarding benefits paid to James whilst in the UK, this was done to enable full consideration of any financial issues that may have contributed to potential difficulties in the relationship between James and Sharon.

The review learned that James was resident in the UK during the first six months of 2015 which was unknown to other agencies at the time and was not reported to any agency by Sharon.

The review received confirmation that Sharon was in receipt of housing benefit during the period under review. This was based on her status as the sole tenant of her flat. The review has also confirmed that Sharon did not receive any other benefits (including Disability Living Allowance for which she had discussed a claim in 2014).

2.8.3 Mark's Care Home

Sharon had frequent contact with the care home where Mark lived. The lead officer from Oldham Council held a meeting with the manager of the Care Home to determine whether there were any disclosures of domestic abuse in their interactions with James and Sharon, and whether Mark had ever spoken of domestic abuse or disharmony in the relationship between his mother and step-father.

The Care Home confirmed that Sharon was a frequent visitor to Mark, and had been so since he was admitted. The Care Home also reported that James had accompanied Sharon on her visits on many occasions. The manager made general observations about James and Sharon's presentations when they were seen at the home, both together and individually.

James was observed to be a quiet individual who was polite but did not really interact with staff when he came to visit. He usually sat in Mark's room reading the paper whilst they were visiting. The care home staff did not witness any disharmony between James and Sharon on these visits. There was no evidence at any time that either James or Sharon were under the influence of alcohol or drugs.

The manager said that Sharon's presentation was variable. There were occasions on which she presented as being very agitated, anxious and sometimes verbally aggressive to staff and other family members (although this was not observed in her relationship with James). The Care Home staff had expressed concern to each other about Sharon's mental health on more than one occasion, however they did not have any safeguarding concerns regarding her interactions with Mark.

2.8.4. James' Employer

The panel contacted James' employer to establish whether they were aware of domestic abuse. The employer wrote to the panel confirming that James had worked for the company for a short time and that they had no awareness of domestic abuse. They were aware that police had come to visit James at his workplace after the incident that took place on the 25th September 2016. They confirmed that the company has a domestic abuse policy. There was no indication that James had discussed domestic abuse with any of his co-workers.

2.8.5. Immigration/Border's Agency

The panel sought information regarding James' and Sharon's movements between the UK and their home abroad. No response was received.

2.8.6. Family Involvement

As set out elsewhere in this report Sharon's son Mark participated in the review.

2.9 Dissemination of the Final Report

Following quality assurance by the Home Office, the final report will be disseminated to all agencies who participated in the review. In line with Home Office guidance the report will be published on the website of the local CSCP.

Sharon's son will be informed by his carer of the publication of the report and a summary of the findings will be available to him via his carer according to his needs.

2.10 Timescales for the Review

The review commenced in April 2017. Due to the complexities of involving family members (Sharon's son has additional needs; and this was considered when finding the best time to involve him) and the involvement of the perpetrator (this took time to arrange due to Sharon's mental health, ultimately Sharon did not engage), the production of a final draft report was delayed.

The first final draft report was submitted to the Home Office in May 2018 and a response was received from them in March 2019. The Home Office requested additional detail be added to the report, this was completed and submitted to the Home Office in July 2019.

The Oldham CSCP received confirmation from the Home Office on 12th September 2019 that they were satisfied that the report could be published.

3 CONTACT WITH AGENCIES DURING THE PERIOD UNDER REVIEW

It should be noted that for some periods of time covered by this review, both James and Sharon were living outside of the UK. The review has not seen medical or other records relating to these periods of time.

3.1 Overview of Contacts – James

Prior to the period under review James registered with a GP in 2004 (before he moved abroad with Sharon) however there is no record of him ever having consulted his GP or any other health service whilst residing in the UK during this period.

Between January 2012 and September 2016 James had no recorded contact with any agency (other than the Benefits Agency in 2014) in the UK. The review has not seen records from abroad, therefore little is known about James's daily life during this period, other than information drawn from witness statements.

As referred to above, the review has seen evidence that James spent an extended period of time in the UK during 2014, however it has not been possible to establish whether James lived with Sharon during this period.

Following his return to the UK in August 2016 James did not re-register with a general practitioner, nor did he use any other medical services until late September 2016, when he received treatment at a nearby hospital for a knife wound that he had sustained in an incident that took place on 25th September 2016.

3.2 Overview of Contact – Sharon

Sharon had numerous contacts with agencies during the period under review all of which were detailed in the contemporaneous chronology. Not all of these contacts are contained or analysed in this report. The review identified key agency contacts and has analysed the contacts which are deemed to be of most significance to the review.

3.3 Contacts in 2012

James had no contacts with services in the UK during this period.

In 2012 Sharon had 28 contacts with her General Practitioner. She was being treated with diazepam for depression (and had previously presented as 'suicidal'). During the same period Sharon had 13 contacts with mental health services.

In January 2012 Sharon attended her GP for a 'depression review', she was accompanied by a family member. She said that she was homeless and that she felt unwell and that she was anxious and restless. This information was shared with Mental Health Services. Sharon had two further appointments with her GP for reviews in that same month.

In February a friend of Sharon's contacted police to say that they were concerned about Sharon as she had made threats to end her life. The following day Sharon presented at the A&E department of a hospital in a neighbouring borough (where Mark was being treated). The A&E department noted Sharon's mental health history and appropriately referred her to the Home Treatment Team (HTT) pathway.

One day later Sharon was brought by police to the A&E department of a local hospital after being missing overnight. She was assessed as having no immediate risk factors (suicidal ideation) and was referred to the Home Treatment Team (HTT).

One week later Sharon moved into a new tenancy with a local housing provider FCHO. During February she had further contacts with her GP and mental health services.

In March GMP received a call from Sharon's neighbour saying that she was concerned about Sharon as she had felt suicidal about Mark's condition.

Between March and May Sharon had a number of review appointments with her GP and attended an appointment with a Consultant Psychiatrist who diagnosed anxiety and depression and allocated Sharon to the Community Mental Health Team (CMHT) with a note to review treatment in 4 months' time and to bring forward the review if necessary.

Two weeks later Sharon took an intentional overdose of medication with alcohol. Sharon was unable to say why she had taken an overdose. She was reviewed by mental health services and referred to the Home Treatment Team.

One week later Sharon's friend reported to GMP that she was concerned about Sharon as she was stockpiling medication. Sharon had locked herself into the house which had caused her friend concern. The Housing Association and GMP visited Sharon and had to drill into the locks to gain entry. The house locks were changed for additional security and the incident was referred to the Alcohol and Drug Information Service in Oldham.

Two days later Sharon was picked up by police in the local town centre, she was behaving in a 'bizarre' manner, shouting at people and appeared to be confused. Sharon was made subject to a Section 136⁶ order and subsequently detained under Section 2⁷ of the Mental Health Act. Sharon remained an inpatient at the Royal Oldham Hospital until 12th June when was granted Section 17⁸ leave to go on holiday to see her husband. Ten days later Sharon returned from holiday and was discharged to support by the Home Treatment Team (she mentioned in this encounter that she was annoyed that her husband would not come back to the UK to live with her).

During June and July Sharon continued to have contact with her GP for mental health reviews. In August she saw the GP for a review and reported that her husband was currently in England and that he was returning abroad at the end of August. On 31st August Sharon was seen by a Senior House Officer in Mental Health Services and was diagnosed with Bi-Polar Affective Disorder.

Over the next three months Sharon saw her GP on three occasions for reviews, her mood was stable but by October Sharon reported that she felt lower in mood and said that Mark's health had deteriorated. She was seen by Mental Health Services

Two days later Sharon rang GMP reporting that her brother had assaulted her but that she was uninjured. The altercation had involved alcohol. GMP shared information and classified Sharon as a vulnerable person.

Over the next ten days Sharon had three contacts with her GP, she felt lower in mood and said that Mark was deteriorating, she reported that her alcohol consumption had increased.

At the end of October Sharon contacted GMP saying she felt low and that Mark's health was in decline. She mentioned that she had no support and that her husband was living abroad. GMP visited Sharon at home and noted that Sharon was not a risk to herself or others. The contact was noted by the Public Protection Investigation Unit (PPIU) and a referral was made to Adult Social Care (ASC).

ASC noted the referral in their records however no action was taken as a result of the referral.

In early November Sharon was seen by Mental Health Services for an urgent review due to a recurrence of acute psychotic distress exacerbated by heavy alcohol misuse.

Sharon had four further appointments with her GP that year, she was prescribed Risperidone (an injectable anti-depressant). Her mood improved and she said Mark's health was improving.

3.4 Contacts in 2013

James had no contact with services in the UK during 2013.

⁶ <https://www.legislation.gov.uk/ukpga/1983/20/section/136>

⁷ <https://www.legislation.gov.uk/ukpga/1983/20/section/2>

⁸ <https://www.legislation.gov.uk/ukpga/1983/20/section/17>

In 2013 Sharon had 3 contacts with her General Practitioner regarding medication. She had nine contacts with Mental Health Services to review her treatment and mental health.

There were no significant episodes or concerns regarding Sharon's mental health during this period.

Sharon had contact with the housing support worker for general support and advice in relation to her accommodation.

3.5 Contacts in 2014

James is noted by the Benefits Agency to have worked in the UK in the latter part of this year, indicating that he was at this time residing in the UK.

There were no other recorded contacts with James by any agency during this period.

In 2014 Sharon had 7 contacts with her General Practitioner. In the early part of 2014 several attempts were made to contact Sharon to arrange reviews and a Care Planning Approach (CPA) but these were unsuccessful.

At the end of February the GP recorded in Sharon's records that Sharon had a diagnosis of Bipolar Affective Disorder and presented a 'high suicide risk'. Throughout this period Sharon's GP continued to monitor Sharon's mood and medication.

Sharon had 7 contacts with Mental Health Services during this period. She was recorded as responding to treatment and her mental health was noted to have stabilised. In September Mental Health Services discussed allocation to a community support worker and Sharon agreed to this, saying that she did not feel that she needed to continue engagement with the Community Mental Health Team and that she would be happy to be discharged.

In October Sharon contacted FCHO regarding an application for Disability Living Allowance (DLA). Note: It appears that Sharon did not pursue this claim; the review has confirmed with the Benefits Agency that Sharon did not receive DLA.

At a GP consultation in October Sharon was asked about alcohol consumption and reported that she was not drinking any alcohol at this time.

In November Sharon had a planned discharge to her GP from Mental Health Services.

During 2014 Sharon had frequent contact with a support officer from her housing provider FCHO. Sharon paid for this additional service which appears to have been beneficial to her.

Sharon had no contacts with any other agency until April 2015.

3.6 Contacts in 2015

James had no recorded contact with any agency in the UK during 2015.

In 2015 Sharon had 7 contacts with her General Practitioner. Sharon had been discharged from Mental Health Services and her mental health needs were managed in primary care.

In April Sharon had a mental health review with her GP and said she felt much better and that Mark was improving and was able to walk with a frame.

At subsequent reviews with her GP Sharon reported feeling 'low' despite Mark's improvement. She reported that James was due to come to England in September, but that he was now unable to do so and that she would be going to visit him abroad for a week in September. Note: This information cannot be corroborated however there are indications from witness statements that James was living in the UK at this time.

In October Sharon reported to her GP that James was coming to England for a while and she felt better.

Throughout the year Sharon had numerous contacts with the housing support officer from FCHO.

3.7 Contacts in 2016

In 2016 James had seven contacts with agencies, all of these contacts took place from the 25th September 2016 onward when the first precursor incident was reported to police. These contacts are detailed below at 3.6.1.

In 2016 Sharon had 15 contacts with her General Practitioner. Sharon's mental health continued to be monitored through primary care.

In January at a review with the GP she said her husband had been over for Christmas (2015). Sharon said that Mark was doing well but that her mood was up and down.

Around that time Sharon told the housing support worker that she sometimes thought about suicide and about different ways of killing herself. The support worker discussed befriending services and made an internal referral to the befriending service within the organisation.

In late March Sharon consulted her GP and told him that her brother in law had died the previous night. She said she was upset by this and the GP offered another appointment to see Sharon the following day, which she attended. Over the next three weeks Sharon saw the GP three times and reported that she was drinking 20 units of alcohol each week.

Sharon presented to her GP in May reporting that she felt very dizzy. Her medication was reviewed and changed. At a second visit in May Sharon said her husband had been ill but was OK now, she reported that he was abroad at this time. This information cannot be corroborated.

In July Sharon saw her GP on two occasions. At the first consultation she reported increased shaking and dizziness. On the second visit she reported reduced alcohol consumption.

In August James started work as a warehouse-man at a local company. Note: Information from witness statements suggests that James lived with his mother at this time and that he was visiting Sharon and staying with her for a few nights each week. This cannot be corroborated as set out earlier in this report.

In early September Sharon saw her GP and reported that she had been experiencing shaking and pain for 2-3 months. The GP examined Sharon and no abnormalities were noted. The GP made a note to keep Sharon's reported symptoms under review.

During this time Sharon continued to have frequent contact with the housing support officer from FCHO.

Note: The period between the 25th September 2016 and the date of James' death is particularly important as a number of incidents occurred that generated contact with agencies. These are set out in detail below:

3.7.1 25th September

On the 25th September Sharon called an ambulance to attend her home address as James was injured and she didn't know what had happened. James then spoke to the call handler and told them that an ambulance was not required. At this point the ambulance was stood down. Sharon then came back onto the phone and said that an ambulance was needed.

Police and paramedics attended Sharon's home address and spoke to James. James had sustained a knife injury. He told them that the injury was an accident that had happened during an argument, when Sharon was peeling vegetables. She had turned around quickly and shouted go away, and had accidentally prodded James in the chest with the knife. James told them that he did not want to make a complaint against Sharon or take the matter any further.

Police completed a DASH risk assessment where James refused to answer any questions. The attending officer noted that both parties were intoxicated at the time of the incident, that neither appeared to be alcohol dependent and that Sharon reported that she had 'bi-polar' disorder. Due to the nature of the offence the officer rated the risk as 'high' (resulting in an automatic referral to MARAC)

A full set of clinical observations were recorded by the paramedic. James was noted to be hypertensive (blood pressure was recorded at a higher level than the expected normal range). All other clinical observations fell within normal parameters.

On examination of the chest, James was noted to have a half inch stab wound to the upper left side of the chest between the second and third rib. The knife was noted to be serrated and had been cleaned prior to the arrival of the ambulance with no blood visible on the knife. The knife was noted to be five inches long. The depth of the wound was unknown but appeared to be full thickness (had gone through all layers of tissue). The wound was bleeding slightly and James stated he was pain free.

Due to the nature of the wound the NWS Trauma Cell were contacted (the Trauma Cell is manned by an Advanced Paramedic, who can provide clinical advice if needed and decide the best location for the patient based on their injuries). The Trauma Cell advised that James should be transported to Manchester Royal Infirmary (MRI) and a red standby call was placed (a standby call alerts the hospital to the arrival of a patient who may require specialist emergency treatment).

James was transported to MRI by ambulance. He attended Accident and Emergency at 21:52 hours. MRI confirm that this was his first ever attendance at MRI A&E. Sharon did not accompany James to the hospital.

On arrival at A&E James was taken to the resuscitation area and found to have a 2cm wound to his chest which was sutured. An x-ray to his chest showed that he had no trauma to his chest or lungs. James gave very little information to staff other than to reiterate that the stabbing was an accident. It was planned for James to be admitted for observation, however he refused admission stating that he would prefer to walk home than be admitted. There is no record that James was asked any questions in relation to domestic abuse.

Police were in attendance at the hospital and spoke with him. As he was clinically well and no other injuries were found he was discharged home with follow-up from his GP if required. He was escorted home by the police.

3.7.2 26th September

Police went to speak to James at his workplace on the 26th September. He told officers that he did not wish to pursue a complaint against Sharon, and that she had struck him by accident.

Police interviewed Sharon in relation to the incident. She told officers that she had no recollection of what had happened and did not remember striking James with a knife. She told police that she and James had been drinking and that they often argued when they were intoxicated.

At a formal interview with a solicitor on the 26th September, Sharon said that she had no memory as to how James had sustained the wound. She recalled that they had been arguing at home and she had slapped his face, and that he had responded by slapping her. Sharon said this had caused a small scratch over her top lip. It was noted that Sharon also had bruising under her breast.

During the interview with police, Sharon said that she had been the victim of repeated physical abuse at the hands of James, generally on a Sunday when he had been out drinking. She said she had been punched and slapped on these occasions, but that she had never previously disclosed this to any agency or to family or friends because she didn't want to cause trouble in the family.

Police made a referral to the Independent Domestic Violence Advisor (IDVA). They also made a vulnerable adult referral to Adult Social Care.

James continued to refuse to pursue a complaint against Sharon. Police referred the matter to the Crown Prosecution Service who subsequently decided that there would be little prospect of a successful prosecution and that no further action should be taken. Note: The rationale for the decision not to prosecute was James' unwillingness to act as a defence witness.

The IDVA Service attempted to contact James by phone (they later wrote to James having received no response).

3.7.3 29th September

On the 29th September Sharon consulted her GP and disclosed that she had been the victim of domestic abuse from James. Sharon showed the GP a number of injuries and said James had assaulted her and that she had retaliated and stabbed him in the shoulder. She informed the GP that James had been violent towards her over many years. Sharon had bruising to her upper body which she said had been caused by James hitting her. The GP recorded this information and noted that Sharon was in contact with police and had been referred to the alcohol service. Sharon was given a further appointment for review in a couple of days. The GP did not make contact with any agencies in relation to Sharon's disclosure.

That same day the IDVA Service wrote to James offering contact as a victim of domestic abuse (as they did not have a contact telephone number), no response was received from him.

3.7.4 4th/5th/6th October

On the 4th October a police officer visited James and Sharon at home to discuss the incident on the 25th September with them. They reported that they were in a rut and that both felt they needed to change to improve their relationship. They said they had begun to do more things together following the incident. The officer noted that it was his view that they both needed help and support from services. The officer also noted that James exhibited some controlling behaviour in the conversation with him, but he did not specifically highlight the nature of this behaviour. The officer made a referral to One Recovery for both James and Sharon.

On the 5th October the IDVA received information from the MARAC Coordinator (as part of the research for the MARAC meeting) that Sharon had disclosed in her interview with police that she had been a victim of domestic abuse from James over many years.

One Recovery wrote to both James and Sharon on the 6th October. James did not respond to the letter from One Recovery. Sharon contacted them and made an appointment to see a worker on the 18th October.

3.7.5 13th October

On the 13th October a MARAC meeting was held (resulting from the incident on the 25th September in which James was the victim). The MARAC meeting was attended by relevant agencies who had involvement with James and Sharon including police, IDVA, and One Recovery. It is not clear whether the GP or ASC were invited to the meeting, neither was in attendance. ASC were notified of the meeting (see below). The meeting received information through the MARAC research document that James had sustained a knife wound in the incident. The research also said that Sharon had disclosed in a police interview that she had been subjected to assaults by James over many years. She had told police that these assaults took place on a Sunday night after James had been drinking, and that she

would lock herself in the bathroom until he went to sleep to protect herself. She had also said that she put up with this behaviour because for the rest of the week she had a good relationship with James.

On the basis of this information the MARAC meeting concluded that 'presumably Sharon had stabbed James in self-defence'. The MARAC meeting recorded that James should be recorded as being a perpetrator of domestic abuse and Sharon should be recorded as a victim. The MARAC actions for agencies present at the meeting were that the IDVA would make contact with Sharon, that 'Health' would check records to ensure that they had the correct date of birth for Sharon and that One Recovery would also check their records. There is no indication that communication was made with either James or Sharon's GP.

3.7.6 14th October – Early December

On the 14th October, approximately three weeks after the first incident of domestic abuse, police received a call from Sharon saying that she and James had been arguing after drinking alcohol and that things had become heated. Sharon rang back ten minutes later saying that she had locked herself in the bathroom; James could be heard in the background telling Sharon to get off the phone. Police attended Sharon's address and found her to be in an agitated state; James was present and was sitting on the sofa. Sharon said that it had been a drunken argument and that both parties were responsible. Police spoke to them both and closed the log as a vulnerable adult incident.

James was seen and spoken to by police. He was noted to be calm and said that Sharon's health was deteriorating. Sharon said that she was suffering from mental health problems and that the argument was 'six of one and half a dozen of the other'. She also said that things between them became difficult when they had been drinking. Police noted both parties as vulnerable adults but that no further action was required. No DASH risk assessment was undertaken as there were no indications or complaints of domestic abuse. Police made a vulnerable person referral to ASC in respect of Sharon. No vulnerable adult referral was made on behalf of James.

On the 17th October Sharon met with the IDVA who discussed the history of abuse and current risk factors. Sharon said she did not want to leave James, but agreed to restrict him entering her flat by taking his key away. The IDVA discussed a plan for other safety measures and referral to bereavement counselling to which Sharon agreed.

The following day Sharon attended an appointment at One Recovery where a full history was taken and work began on a care plan. Sharon talked about a long history of alcohol misuse and domestic abuse. The worker discussed with Sharon the referral to IDVA and Sharon told the worker she had met with them. A further appointment was arranged for the 25th October (Note: Sharon did not attend this appointment).

On the 21st October One Recovery wrote to James to invite him for an appointment. James did not respond to the letter.

On the 28th October the IDVA spoke on the phone with Sharon who reported that she had discussed matters with James, and that she had agreed to see him on certain days. Sharon also reported that she had had contact with the GP and bereavement service and that she was attending One Recovery.

Sharon attended a further appointment with One Recovery on the 1st November where she discussed history and relationships. She also referred to a debt that she was concerned about. She had a further appointment for the 10th November which she cancelled due to clash with a GP appointment.

On the 4th November ASC received a vulnerable person referral from GMP in relation to the call-out that took place on 14th October citing Sharon as the victim. The referral contained information gathered by police at the incident, including information from Sharon that she had Parkinson's disease and possible dementia and bi-polar disorder. James had said that Sharon was deteriorating and that she took lots of medication. ASC noted that a MARAC meeting had taken place and that One Recovery and the IDVA were involved. This referral was logged for information.

The IDVA had a further telephone contact with Sharon on 11th November, Sharon said things had improved and that she understood that, as she wanted to continue her relationship with James, the IDVA Service would no longer be involved. The IDVA Service then closed the case.

On the 4th December police received a call from Sharon saying that she and James had been arguing and he had become violent. Police attended Sharon's address and found James to be asleep. A DASH risk assessment was completed in which Sharon said that she was in fear of James becoming violent. She told the attending officer that James drank alcohol to mask other problems. Sharon also told the officer that she had been arrested some months ago for stabbing James, but that this was in self-defence. Police removed James to his mother's address. Sharon reported to the police that she was attending 'AA' in relation to her drinking. The officer rated the risk as 'medium'. The incident was recorded as a domestic incident which created a document identifying Sharon as a vulnerable person.

On the 5th December Sharon attended One Recovery and talked about the incident and her concerns about James' drinking and the potential for abuse. The worker advised Sharon regarding safety planning and contact with the IDVA, and a possible Domestic Violence Protection Order (DVPO). Sharon said she was concerned about James being 'locked up' and losing a day's pay. A DVPO was therefore not considered to be appropriate due to Sharon wishing to remain in the relationship with James.

That same day One Recovery rang the IDVA Service to inform them of the incident, and that James had been staying over with Sharon. Sharon had said in her meeting with One Recovery that she would support a restraining order and the IDVA Service were informed of this. The following day the IDVA attempted to contact Sharon by phone but received no response.

The following day the incident leading to this review took place.

4 LEARNING FROM THE REVIEW

4.1 Addressing the Terms of Reference

1. What indicators of domestic abuse, if any, did agencies have in relation to James or Sharon?

There were three incidents that were logged as domestic abuse 'call-outs' by police. These took place on the 25th September, the 14th October and the 4th December 2016. The call out on the 14th October did not result in any complaint from either party and therefore was not subject to DASH risk assessment or rating.

Indicators of domestic abuse were known by agencies in relation to both James and Sharon following the incident on 25th September 2016. There are indications that James and Sharon argued when they had been drinking, that Sharon sometimes had aggressive outbursts in public (not in the presence of James) and Sharon said that James assaulted her when he had been out drinking on Sundays.

Prior to the incident that took place on the 25th September 2016, in which Sharon stabbed James, neither of them were known to any agency as either a victim or a perpetrator of domestic abuse. Following the incident James was identified as a victim of domestic abuse by police, James required hospital treatment for his injuries and was referred to MARAC. Sharon also had injuries (she had a cut on her lip and bruising under her breast) at the police interview which she reported had been inflicted by James.

Sharon presented to her GP four days after the incident with injuries that she said had been inflicted by James during the incident on the 25th September. She disclosed that she had been subjected to physical assaults by James over many years and that James was drunk at the time of these assaults. The GP did not share this information with any agency. This was a missed opportunity by the GP to refer Sharon to a specialist domestic abuse agency, and to share information regarding Sharon's disclosure with other agencies.

Sharon later reported that James had told her that if she told anyone about the abuse that she would be 'locked up' as she would be considered to be 'mental'. She also said that the abuse only took place on one day each week and that for the remainder of the time James was a good husband. She said she had remained in the relationship because she was prepared to put up with one bad day a week.

During the MARAC meeting the ambulance call was replayed and Sharon could be clearly heard to say that she had stabbed James. The MARAC record contains information that Sharon had reported that James drank alcohol every Sunday and that she was in fear of him returning home as he was always drunk and he punched and slapped her. She said that she locks herself in the bathroom until he falls asleep. Sharon said that she had never reported this to police although it had gone on for thirty years, she said she has also never told anyone in the family or friends as she did not want to fall out with them.

The MARAC concluded that the incident in which James was stabbed by Sharon was 'probably in self-defence'. This conclusion influenced the way the case moved forward, with James being indicated as a perpetrator, rather than as a victim of domestic abuse (despite having been stabbed by Sharon).

From the MARAC there were no police actions (other than to clarify Sharon's date of birth). There were actions for the IDVA to follow up based on Sharon being the victim.

In summary the MARAC was ineffective at offering further safety planning or interventions to James as a victim of domestic abuse. The MARAC did not explore the complexity of the relationship and the potential for James and Sharon to continue to be both victim and perpetrator of abuse in the relationship.

Despite both James and Sharon having been identified as perpetrators of domestic abuse, neither were offered interventions, such as perpetrator programmes, which are designed to raise awareness, modify behaviour and reduce incidence of domestic abuse. Consideration of referring both James and Sharon to a perpetrator programme would have been good practice.

There is no indication from statements made to the police as part of the police investigation that any member of James' or Sharon's family or friends were aware of domestic abuse in the relationship. Sharon told police that she had never reported domestic abuse or spoken of it to family members as she did not want to cause trouble.

The review found no indications of financial abuse, although witness statements indicated that the couple had experienced some financial hardship and debt.

A police officer noted James exhibited controlling behaviour when he spoke to them both at home, however there were no specific indications of the nature of the behaviour.

2 Did agencies recognise and respond appropriately to James as a male victim of domestic abuse?

The incident of the 25th September in which James was identified as a high risk victim of domestic abuse was appropriately dealt with by police. The officers attending the incident appropriately identified James as the victim and a DASH risk assessment was undertaken. James refused to answer any of the questions in the DASH. There is no indication that the officer administering the assessment gave specific consideration to factors which may have prevented James from answering the questions accurately (i.e. that male victims of domestic abuse may be in fear of further abuse, that they may disguise abuse because of male stereotypes, or that they may feel that they would not be believed if they disclosed abuse).

NWAS attended the incident and transferred James to hospital, however they did not make a safeguarding referral on behalf of James. It is not known whether the attending paramedic did not recognise that James was a victim of domestic abuse, however the failure to make a

safeguarding referral in these circumstances is not in line with expected practice and was a missed opportunity to identify James as a victim of domestic abuse and to share information with other agencies.

When James attended MRI with a police officer for treatment of the stab wound, he was not asked any questions by attending professionals in relation to domestic abuse. There was no targeted enquiry and no apparent consideration that James may have been a victim of domestic abuse. . This was a missed opportunity to enable James to disclose domestic abuse. There was no curious enquiry made by staff, despite the nature of the injury, nor any attempt to corroborate James' account of the incident. NICE guidelines⁹ in relation to targeted enquiry and disclosure were not followed.

The review learned that the MRI has a clear policy and staff guidance in relation to encouraging disclosure and supporting victims, however it is unclear why this procedure was not followed at this contact with James. This may have been because James insisted that the injury was accidental, however there was no evidence of professional curiosity and James' denial of an assault was taken at face value.

Police followed up the incident by seeing James at his workplace the following day. This was good practice and offered James a further opportunity to make a disclosure and make a complaint against Sharon. However James continued to insist that he had been injured by accident.

As a result of the incident police referred James and Sharon to support agencies and the case was automatically referred to MARAC which was good practice.

The case was heard at MARAC three weeks after the incident. The MARAC meeting had clear evidence that Sharon had assaulted James and that he had been identified as the victim. However, based on information given by Sharon at a subsequent interview with police, the MARAC meeting drew the conclusion that James was in fact the perpetrator of domestic abuse in the relationship rather than the victim.

This decision resulted in a lack of safety planning for James. No consideration was given to the possibility that both Sharon and James might be both victim and perpetrator, and that both were potentially at risk when either one or both had been drinking alcohol.

No consideration was given to risk factors for male victims, nor was any weighting given to the severity of the injury sustained by James. An opportunity was missed to bring professionals together outside of the MARAC meeting to discuss risks to both James and Sharon and to appropriately involve other agencies.

Future contact with James and Sharon by the IDVA was predicated on the conclusion drawn by the MARAC meeting that James was a perpetrator of domestic abuse and, that the knife injury caused by Sharon was in self-defence.

⁹ <https://www.nice.org.uk/guidance/ph50>

The review has seen no evidence that agencies gave specific consideration to factors that may have prevented James from disclosing that he was a victim of domestic abuse.

3. What was the response to domestic abuse in terms of risk assessment and risk management?

Police appropriately undertook DASH risk assessments at each incident they attended. On the first occasion the DASH was administered with James as the victim. James refused to answer any of the DASH questions and told police that his injuries were accidental. Despite James being unwilling to answer any of the DASH questions police graded the risk as high due to the use of a weapon, and the case was referred to MARAC.

Sharon presented to her GP on the 29th September. She disclosed domestic abuse and showed the GP her injuries. Sharon told the GP that the matter was known to the police. The GP did not contact any agency in relation to Sharon's disclosure nor did they take any action to provide safety planning for Sharon. This was a missed opportunity to both ensure that appropriate action was being taken to protect Sharon and to inform other agencies that Sharon had presented with injuries which she said were related to domestic abuse.

Following the MARAC meeting on the 13th October police and the IDVA Service recorded Sharon as the victim of domestic abuse; this information was shared with Adult Social Care and with One Recovery.

At the second incident attended by police in October both Sharon and James said that they had been arguing. Neither reported domestic abuse and no offence was committed. Police did not undertake a DASH risk assessment, which was an appropriate response in the presenting circumstances.

At the third incident attended by police on the 4th December, Sharon was identified as the victim of domestic abuse and a DASH risk assessment was completed. During the completion of the DASH Sharon said that she had stabbed James in September 'in self-defence' and this was recorded on the document. The assessment rated Sharon as medium risk and it was noted that she was in contact with other agencies.

Sharon engaged with the IDVA Service and with One Recovery. Both services were focused on safety planning for Sharon, however, Sharon ultimately decided that she wanted to remain in a relationship with James, although she did indicate that she would regulate the time that they spent together.

James did not engage with either service resulting in no further risk assessment or safety planning taking place.

4. How did agencies ascertain the wishes and feelings of James and Sharon in respect of domestic abuse? Were their views taken into account when providing services or support?

Both James and Sharon were present on each occasion when police were called out to domestic abuse incidents at Sharon's home address. It is not apparent whether police spoke to both parties separately or together at the first incident, however police did accompany

James to the hospital and spoke to him separately there. Following the first incident police saw James again at his workplace and tried to encourage him to pursue a complaint, however he refused to do so.

Of particular note is the visit made by a police officer on the 4th October in which he spoke to both James and Sharon about their relationship and needs in relation to alcohol, mental health and domestic abuse. Both James and Sharon said that they wanted to improve their relationship. The officer advised that both would benefit from support with reducing alcohol consumption as this was a trigger for arguments and domestic abuse incidents.

When police were called out to Sharon's address in October no DASH risk assessment was undertaken. Both James and Sharon said that this had been an argument that had got out of hand and neither wished to make a complaint about the other. A referral was made for Sharon to ASC but not for James as the focus was Sharon's mental health rather than domestic abuse.

At the incident on the 4th December a DASH risk assessment was undertaken which was rated as medium risk. During this assessment Sharon reported that she experienced mental health difficulties and also told the attending officer that she had previously stabbed James 'in self-defence'.

It appears that James was unwilling to engage with support services, the review is unable to ascertain why this was the case. Sharon did engage with alcohol services, with her GP and with the IDVA Service, although her engagement with One Recovery and the IDVA was inconsistent.

Sharon appears to have decided at her last appointment with One Recovery that she was prepared to seek an injunction against James, however this did not progress due to the fatal incident taking place two days later.

5. What knowledge did agencies have of alcohol, drugs or other prescribed medicine misuse by either James or Sharon?

Sharon's GP and specialist Mental Health Services were aware that Sharon used alcohol to excess at times. When reporting this to practitioners Sharon indicated that it was a means of coping with the loss of her son and the ongoing impact of Mark's accident. Sharon's GP did not conduct a formal assessment of her alcohol consumption or make any referrals to specialist services, this was a missed opportunity to assist Sharon in addressing her alcohol misuse.

Following the MARAC meeting Sharon engaged with One Recovery and appeared willing to address her alcohol consumption and underlying issues. She also discussed James' alcohol consumption with the service and said that this is what made him violent towards her. She indicated that James did not believe that he had a 'problem' with alcohol.

Following the incident on the 25th September Sharon told police and other agencies that James' drinking was a problem and caused him to be violent. The first DASH risk assessment

notes that both James and Sharon were intoxicated when the officer attended the incident. This was also the case when officers attended Sharon's address on two further occasions.

Family statements indicate that James 'liked a drink' and that he and Sharon spent time socialising at a local pub. There are no indications that James perceived himself to have problems with his use of alcohol nor are there any presentations to any agency in relation to alcohol use. The Care Home Manager who saw James when he attended visits with Sharon had never suspected that James was intoxicated at any of the visits.

Although James did not wish to pursue a complaint against Sharon the incident on the 25th September resulted in James and Sharon being referred to a local substance misuse service in relation to their heavy use of alcohol. A referral was also made to the IDVA Service who made contact with James. James did not engage with either service.

6. What knowledge did agencies have of the mental health and physical health of James and Sharon?

James

James did not present with either physical or mental health problems to any service in the UK during the period under review. James' only contacts with health services came after the incident on the 25th September.

Sharon

Sharon had a long history of mental health issues stemming back to her childhood. Sharon's mental health issues were deemed to be exacerbated by the tragic incidents involving her two sons. She experienced significant depression and anxiety following these incidents which brought her into contact with mental health services. She received appropriate treatment and care from primary and specialist services at this time and there was good liaison between specialist and primary care services.

Sharon's mental health declined further following the traumatic incident in which her son Mark suffered life limiting injuries. Sharon's GP responded by conducting regular reviews of Sharon's mental health in primary care and by liaising with specialist mental health services where Sharon was receiving treatment. Sharon's mental health appeared to stabilise during the period 2014/15 when she was living in her own tenancy. She was receiving support from a housing officer, which appears to have been beneficial to her.

Information provided to the MARAC indicated that Sharon had told police on the 4th October that she had 'bi-polar' disorder. She also said that she had Parkinson's disease and that her GP was investigating whether she had dementia. The MARAC meeting had no reason to query this information, however the review has learned that Sharon was not diagnosed with Parkinson's disease, nor were investigations taking place regarding dementia.

Neither James nor Sharon appear to have experienced any significant or lasting physical health issues, although Sharon had presented to her GP in the three months before the fatal

incident saying that she was experiencing symptoms of dizziness and shaking. The GP could find no cause for these symptoms and agreed to keep them under review.

7. Were there any barriers in agencies that might have stopped James or Sharon seeking help in relation to domestic violence and abuse?

No barriers were indicated. It is not possible to say why James did not want to avail himself of services following the incident on the 25th September when he was identified as a victim of domestic abuse.

National research in relation to male victims of domestic abuse indicates that males are unlikely to make disclosures or seek support in relation to domestic abuse for a number of reasons (see point 16 below).

8. Were there any barriers in agencies that might have stopped James or Sharon seeking help in relation to debt management?

This original TOR has been modified as the review has not found any substantive evidence that either James or Sharon had substantial debts (although this was alluded to in the scoping material for the review).

9. What knowledge did the family, friends and employers have of James and Sharon that could help the DHR Panel understand what was happening in their lives. Did family and friends know what to do with any such knowledge?

As far as the review has been able to ascertain neither Sharon nor James discussed domestic abuse with family/friends or employers. The family did not wish to participate in the review, other than an interview with Mark, however the review could see no reference to domestic abuse in any of the witness statements made by the family.

10. Were single and multi-agency policies and procedures followed; are the procedures embedded in practice, and were any gaps identified?

The review has identified the following instances of agency policy and procedures not being followed:

The care provided to Sharon by her GP with regards to alcohol misuse, did not promote what would be deemed as current best practice. There is no evidence to suggest that the GP discussed the possibility of referral to specialist services, i.e. the Community Alcohol Team or the Early Help Team.

Best practice in relation to sharing information following disclosure of domestic abuse by Sharon to her GP was not followed.

Not all NWS policies and procedures were followed to an expected standard by the attending clinicians. The Safeguarding policies and procedures are embedded within the Trust, and the Author of the IMR report for this review is working with the Advanced Paramedic Team to establish if the attending staff require further safeguarding training.

Clinical guidance in relation to targeted enquiry into domestic abuse was not followed by MRI when they saw James with a stab injury in September 2016.

11. How effective was inter-agency information sharing and cooperation in response to the identified needs of James and Sharon. Was information shared in a timely manner based on need?

Information sharing between agencies was of an expected standard with the exception of the three instances set out below. Notable examples of effective practice are the sharing of information between Sharon's GP and Mental Health Services and the sharing of information between police and the IDVA following referral.

The review has identified three areas in which information sharing could be improved as follows:

The GP did not share information with other agencies following a disclosure of domestic abuse by Sharon in September 2016.

The MARAC meeting missed an opportunity to seek further information from agencies regarding Sharon's allegations of historic abuse by James.

There is no indication that any agency sought further information regarding the identification or response to male victims of domestic abuse.

12. How did agencies take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator.

There were no diversity issues identified by any agency. The review noted that Sharon was diagnosed with a severe and enduring mental illness in 2012.

13. How effective was agency supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

All agencies involved in the review demonstrated clear arrangements for the management and supervision of practitioners. The review has not identified any gaps in this area.

14. Were there any issues in relation to capacity or resources within agencies in the period under review that affected the ability to provide services to the victim?

None of the agencies participating in the review indicated that capacity or resources affected their ability to provide services.

15. Was support offered to Sharon and James in relation to bereavement and carer support?

Sharon was offered bereavement support from a number of agencies, although it is not clear whether she attended any bereavement support or counselling.

James was not living in the UK at the time and was therefore not offered support services.

4.2 Overview of Key Learning

4.2.1. Male Victims of Domestic Abuse

The primary learning in this case relates to how agencies perceive, identify and respond to male victims of domestic abuse.

There are several specific encounters with services where opportunities were missed to identify and respond to James as a victim of domestic abuse.

NWAS should have raised a safeguarding concern in relation to James when they attended the incident that took place on the 25th September. This would have been in line with expected practice and would have identified James on their system as a victim of domestic abuse.

MRI missed an opportunity to make a targeted enquiry in relation to domestic abuse when James presented with a stab wound which, although he reported that the injury had been accidental, had clearly been inflicted by Sharon. There is no explanation as to why a targeted enquiry was not made on this occasion.

The panel cannot assume that the lack of enquiry was gender related, however the panel expressed the view that had a female victim presented with a similar injury, then it is likely that more effort would have been made to support disclosure in line with NICE guidance.

It is clear that within the MARAC process, agencies lost focus on James as a victim, which set the tone for subsequent involvement and interventions with James and Sharon.

The information regarding Sharon's allegations of historic and ongoing domestic abuse was considered at the MARAC meeting and influenced the decision to record James as a perpetrator of domestic abuse and Sharon as a victim. This decision was made on the basis of presumption of self-defence by Sharon in the incident on the 25th September. The information was not cross referenced or checked with sources, and the risks to James based on the assault in which he was stabbed were not taken into consideration.

The MARAC should have asked for further multi-agency information to substantiate Sharon's allegations and to review safety planning for both James and Sharon. This was a missed opportunity. James' needs as a victim of domestic abuse were not given primacy which led to a lack of focus on James as a victim of domestic abuse.

Learning from specialist agencies who provide support to male victims, from national research and from other DHRs where the victim was male, indicates that male victims may be reluctant to disclose domestic abuse due to harmful stereotypical perceptions of gender. The review highlighted that practitioners do not routinely question themselves or others in relation to potential harmful stereotypes about men as victims of domestic abuse.

Understanding the factors that deter male victims from engaging with services is particularly important in this regard. Whilst many agency policies are not gender specific, understanding of the prevalence and impact of domestic abuse may be skewed towards the experience of women. There is a need to ensure that agencies and practitioners are supported to respond appropriately to incidents involving male victims, and that systems and processes for assessment, referral and interventions are not gender biased. The review has identified a need to strengthen practice in this area.

Staff in all settings should apply the NICE guidance regarding targeted enquiry irrespective of the gender of the potential victim.

The review makes a recommendation in relation to raising awareness amongst local agencies regarding male victims of domestic abuse, and relationships where there may be domestic violence and abuse between partners, to inform professional decision making regarding risk management and safety planning. (Recommendation 1).

NB: In March 2019 the Home Office produced its first cross-government position statement in relation to male victims of domestic abuse.¹⁰ Although not available when this review was conducted, this statement reinforces the reviews findings in relation to the prevalence of gender based domestic abuse and the reasons why some men may find it difficult to make disclosures.

4.2.2. Responding to domestic abuse in the context of complex relationships

It is not possible for the review to comment on whether there was domestic abuse between James and Sharon when they lived in abroad as records were not available to the review. However, the review learned that preparation for the criminal trial indicated that neither of them were known in relation to domestic abuse when they were living abroad.

The review also highlights the complexity of a long-standing relationship in which both partners demonstrate significant risk behaviours, whilst also wishing to remain in a relationship, despite these risk factors. This highlights the need for professionals to go beyond routine enquiries and to exercise greater curiosity and challenge themselves and others, to explore beyond what is presented at face value.

Sharon's long-standing mental health issues emanating from her childhood were exacerbated by tragic events relating to her two sons. Throughout their relationship it appears that James and Sharon may have followed an established pattern of alcohol consumption leading to physical abuse, and coercive and controlling behaviours. It is not possible for the review to confirm Sharon's accounts of long-standing abuse perpetrated by James, however it is clear that in the twelve months prior to James' death, the couple experienced a change in their relationship, which may have been precipitated by James permanently moving back to the UK and spending time living with Sharon.

¹⁰

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783996/Male_Victims_Position_Paper_Web_Accessible.pdf

When Sharon presented to her GP on the 29th September and made a disclosure of domestic abuse, showing the GP her injuries, the GP missed an opportunity to alert other agencies of the disclosure and to initiate a safeguarding concern.

4.2.3. Learning in relation to Mental Health Issues as a risk factor

The review could find no evidence that James experienced any mental health issues during the period under review.

Sharon's mental health was appropriately managed between primary care and specialist mental health services and her GP regularly reviewed her mental health when she was treated in primary care.

The review cannot say definitively that Sharon's mental health was a specific risk factor for domestic abuse in the relationship with James, however, both James and Sharon referred to Sharon's mental health when spoken to by police. The inference in these interactions was that Sharon experienced times of stress and anxiety and that James felt Sharon's mental health was deteriorating.

Pennine Care has identified a single agency action in relation to ongoing assessment of risk factors in relation to harm to others.

4.2.4 Learning in relation to alcohol as a risk factor

Both James and Sharon appear to have used alcohol on a frequent basis. Both appeared intoxicated at domestic abuse incidents and both were considered to be in need of services to address their alcohol use.

James did not discuss his alcohol use with any agency, although he did say that he wanted to change his lifestyle when visited by a police officer on the 4th October. The review cannot determine from the available information whether James drank to the extent that Sharon reported when she spoke to professionals. Police officers who attended incidents at Sharon's address reported James to be intoxicated on each occasion, thereby suggesting that Sharon's accounts of James' drinking had some credibility.

Sharon discussed her alcohol consumption with her GP and with One Recovery. Sharon's GP asked Sharon on a regular basis about her alcohol consumption but did not take the opportunity to discuss referral to a specialist service with her. Whilst the GP could not have been expected to refer Sharon to an alcohol service without her consent, discussing whether she would benefit from a referral would have been an opportunity to open a conversation with Sharon regarding help and support in managing her alcohol use. This would have been good practice.

Sharon responded positively to referrals to alcohol services, although her attendance was sporadic, and she identified alcohol as a factor in the arguments between herself and James. One Recovery appropriately worked with Sharon in relation to addressing alcohol misuse as a risk factor and appropriately shared this information with the IDVA as a risk factor.

The review noted that the CSCP has identified a pattern in previous DHRs where licensed premises in the area tolerate excessive alcohol consumption and associated anti-social behaviour.

4.2.5 Learning in relation to multi-agency working

Multi-agency working took place and there was good liaison and information sharing between services following the first domestic abuse incident in September 2016.

However, opportunities for further joint working and information gathering regarding Sharon's allegations of historic abuse were not taken.

A multi-agency meeting (emerging from MARAC) would have assisted professionals in gaining a clear picture of all the risk factors, the potential for mutual aggression and risk and in devising a safety plan that addressed the needs of both James and Sharon.

The review highlights opportunities to further strengthen agency engagement in MARAC and to ensure that actions emerging from MARAC are clear and followed up by the MARAC chair.

4.2.6 Learning in relation to vulnerable adults

During the period under review Sharon experienced episodes of severe mental ill health and had significant support needs regarding her role as a carer for her son Mark.

The housing provider (FCHO) arrangement for providing support, at additional cost, appears to have worked well for Sharon. She engaged with the work and it appears that she achieved a degree of stability as a result of this constructive relationship. The review has noted good practice in this area.

Sharon was identified as a vulnerable adult by police following the incident on the 14th October, however ASC logged this for information rather than following up with a visit to Sharon. ASC has identified a single agency action to strengthen the system for identifying and following up referrals for vulnerable adults.

James was not identified or referred as a vulnerable adult on any occasion. The review highlights opportunities for practice to be strengthened in this area (linked to the identification and referral of males as victims of domestic abuse, and recognition of potential vulnerability).

4.2.7 Learning in relation to MARAC

As set out above the review highlights several opportunities to strengthen practice in relation to MARAC. The information gathered for the MARAC meeting contained a number of important misconceptions that were not cross referenced to establish facts. This led to a presumption on the part of the meeting that Sharon was suffering from medical conditions, for which there was no foundation in truth.

The MARAC meeting did not give consideration to the possibility that James and Sharon's roles as victim and perpetrator may be interchangeable and situational.

The issues highlighted in this report regarding maintaining a focus on male victims when receiving new information about counter allegations (from partners) should be embedded in local practice. A recommendation is made in this regard.

4.3 Single Agency Learning and Recommendations

Agencies providing reports to the review were asked to consider their own learning from practice. Single agency action plans were provided by ASC, CCG, GMMH, IDVA Service, NWS, Pennine Care and one recovery. These plans are attached at Appendix 2.

It should be noted that single agency plans incorporate specific learning from the review and in the case of One Recovery also include general learning about practice in the organisation. The review felt it was appropriate to include non-specific actions in this case, as the learning emerged from the review process.

5 MULTI AGENCY RECOMMENDATIONS

Recommendation 1

The CSCP should be assured that domestic abuse training highlights specific issues, some of which are raised by this review, in relation to male victims of domestic abuse.

Recommendation 2

The CSCP should initiate a brief review of MARAC based on the learning from this review.

This should include assurance that:

- MARAC meetings are provided with reliable and well researched information to enable robust decision making that results in appropriate safety planning and clear case management.
- All relevant agencies attend MARAC on every occasion and that single agency actions are clear and are followed up.
- That decisions made by MARAC in relation to the designation of victim and perpetrator are based on sound evidence.

Recommendation 3

The CSCP should be assured that systems for identification and referral in relation to vulnerable persons are robust and fit for purpose.

6 Research References

1. Quality standards in domestic abuse services¹¹
2. NICE Guidance Intimate Partner Violence¹²

¹¹ <https://www.nice.org.uk/guidance/qs116/chapter/List-of-quality-statements>

¹² <https://www.nice.org.uk/guidance/ph50>

3. Guidance for GPs in relation to domestic abuse¹³
4. APP Guidance Domestic Abuse¹⁴
5. Adult Safeguarding and Domestic Abuse/Care Act (2014)¹⁵
6. Mankind – Research and Statistics – Male Victims of Domestic Abuse
<http://www.mankind.org.uk/>

¹³ <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx>

¹⁴ <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/>

¹⁵ <https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf>

'James' Domestic Homicide Review – Multi-Agency Action Plan – April 2018

	Recommendation	Scope of Recommendation	Action to Take	Lead Agency	Key Milestones Achieved in Enacting Recommendation	Target Date	Date of Completion and Outcome
1.	The CSCP should be assured that MARAC meetings are provided with reliable and well researched information to enable robust decision making that results in appropriate safety planning and clear case management. The CSCP should be assured that decisions made by MARAC in relation to the designation of victim and perpetrator are based on sound evidence.	Local	A review of the MARAC process will be undertaken Improvements will be made to the recording of discussions within the MARAC process with clear rationale for decision making explained.	GMP	MARAC Review Process agreed by 30/06/18 MARAC Review completed by 30/09/18 Evidence of rationale for decision making contained seen within MARAC action plans by 30/09/18	30/09/18	30/09/18 The brief review was undertaken however the MARAC continues to be subject to ongoing review by the MARAC Inspector who came into post following the conclusion of the DHR. The development of the Multi-Agency Safeguarding

	The CSCP should initiate a brief review of MARAC based on the learning from this review.						Hub in Oldham has also created an opportunity for partners to discuss high risk cases in a partnership environment outside of the MARAC process. This includes a daily meeting to discuss cases, assess risk and agree actions with lead officers/ organisations. Actions agreed have a clear rationale and are detailed in the MASH documentation.
2.	The CSCP should be assured that domestic abuse training highlights specific issues,	Local	All partnership training relating to domestic violence and	Domestic Violence and Abuse Partnership	Training content reviewed and revised where necessary by 30/06/18	30/06/2018	30/06/18 A review of the training offer has confirmed

	some of which are raised by this review, in relation to male victims of domestic abuse.		abuse will be reviewed to ensure that learning in relation to male victims is included and a seven minute briefing will be produced.				that within the existing domestic violence and abuse training offer through the LSCB there is a specific exercise on vulnerability and male victims. Male victims are also considered within the offender typology element of the training. The post-course reading also includes a breadth of information from the Men's Advice Line. Delegates are also provided with a comprehensive list of services
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							and helplines for male victims. The seven minute briefing has not yet been completed however this will be prioritised and designed to reinforce the information provided within the training.
3.	The CSCP should be assured that systems for identification and referral in relation to vulnerable persons are robust and fit for purpose.	Local	The referral process for vulnerable victims will be reviewed through the MASH.	Adult Social Care	Referral review process agreed by 30/04/18 Review into MASH processes completed by 31/07/18	31/07/18	31/07/18 All referrals into the MASH come through a 'single front door'. This enables early identification of vulnerable victims and allows for dynamic

[illegible]