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SAFER CHESHIRE EAST PARTNERSHIP

DOMESTIC HOMICIDE REVIEW IN THE CASE OF ‘Pam’

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2017 to AUGUST 2019

EXECUTIVE SUMMARY

Independent Author: **John Doyle BSc (Hons)**

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Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family of Pam for their loss. The Chair also extends particular thanks to Pam's family, particularly her Son and her Daughter, for agreeing to support the Panel with the completion of the Review and for sharing their perspectives on the case and their memories of Pam.

The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

1. The Review Process

This Review, commissioned by the Safer Cheshire East Partnership (SCEP), has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004) and with the revised guidance issued by the Home Office in 2016 to support the implementation of the Act.

At the initial meeting of the Domestic Homicide Review Panel, held virtually, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2017 to the date of the incident in August 2019.

The agencies and services invited to participate and make submissions to the Review were reminded that if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, then such information should still be submitted in order to provide context for the case.

Also, at its first meeting, the DHR Panel approved the use of a locally devised Individual Management Review (IMR) template and integrated chronology template. The Chair of the Panel, via the Commissioning Officer, 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 Pam and the Perpetrator.

Together with the Commissioning Officer from CEC, the Chair/Author provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office, December 2016). The IMR Authors were not directly involved with the subjects of this case. IMR reports were quality assured by a senior manager countersigning the report

Copies of IMRs were circulated to all the DHR Panel members prior to the scheduled meetings. The IMRs were then discussed and scrutinised by the Panel and significant events were cross referenced and any clarifications that were considered necessary from the IMR author were invited via the independent author of the Overview Report.

1.1 The Proposed timescale

The first meeting of the DHR Panel was held on the 28th of August 2020. The Panel met again in November 2020, in February 2021, April 2021, July 2021 and October 2021. The SCEP approved the final draft of the Overview Report at its meeting on the 29th of October. A summary of the final draft was shared with Pam's family and the feedback received from them was also incorporated into the final draft copy.

At the first meeting, in August 2020, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

At the second meeting, the Panel considered the process being conducted by the IOPC, began the process of scrutinising the submissions received from participating agencies and the draft integrated chronology. Additionally, progress concerning the involvement of the family was considered.

At the third meeting, the Panel continued to scrutinise submissions from participating agencies, sought clarifications from previously submitted reports, considered the draft text concerning the narrative of the case, initial responses to the terms of reference and Key Lines of Enquiry and the second version of the chronology.

At the fourth meeting, the Panel considered the submission from Pam's family, draft single agency action plans, a draft of the key themes emerging from the Review and the first draft of the Overview Report.

At the fifth meeting of the Panel, held in July 2021, the Panel considered the second draft of the Overview Report and the draft multi-agency action plan.

The third draft of the Overview Report was approved by the Panel at a meeting on the 5th of October 2021. A summary of the final draft was shared with Pam's family and the feedback received from them was also incorporated into the final draft copy.

1.2 Incident leading to the Domestic Homicide Review

On a day in August 2019, Cheshire Police were informed that the Perpetrator had unlawfully killed his girlfriend, Pam. The Perpetrator had contacted a member of his family, told them what had happened and they had contacted the Police. Enquiries were undertaken and the Police attended a flat in an area of Cheshire. The Police entered the premises and Pam was found. She was pronounced dead at the scene of the assault.

The Perpetrator was arrested and interviewed. He was later charged with the manslaughter of Pam and investigations were commenced. His trial started in February 2020. The Panel was informed that the Perpetrator, due to his health condition, was considered as unfit to enter a plea or stand trial. Consequently, instead of being asked to rule on whether the Perpetrator was guilty of manslaughter, the evidence in the case – presided over by a Judge – was presented to the Jury and they had to decide if he was responsible for the death of Pam. The jury considered the evidence and concluded that the Perpetrator was responsible for Pam's death and he was found guilty. In April 2020, the Perpetrator was sentenced to an indefinite Hospital Order.

1.3 Significant people in this case

Both pseudonyms and the name for the victim in this case, chosen by Pam's family, have been used in relation to the subjects of this case. This is done to protect their identities and those of their family members. The significant people referred to within this Overview Report are described, in brief, below:

Name or pseudonym	Relationship to subject (if applicable)
Pam	Victim. Name chosen by the family
The Perpetrator	Partner of Pam at the time of the incident. Pseudonym chosen by the Panel
M2	Previous partner of Pam. Pseudonym chosen by the Panel
F2	Previous partner of the Perpetrator. Pseudonym chosen by the Panel
F3	Previous partner of the Perpetrator. Pseudonym chosen by the Panel
F4	Previous partner of the Perpetrator. Pseudonym chosen by the Panel

1.4 Contributors to the Review

Following the notification of the death of Pam, the Safer Cheshire East Partnership informed the Home Office that they would undertake a Domestic Homicide Review and they would commission this Review under the auspice of Cheshire East Council.

The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

1.4.1 Author of the Overview Report

The Commissioning Authority (Cheshire East Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John has no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

1.4.2 The agencies contributing to the Review

The agencies submitting information to the Review – along with the nature of that submission – are set out below:

Agency invited to submit information	Nature of Submission
Cheshire Constabulary	Chronology and IMR
Domestic Abuse Family Safety Unit (including the IDVA services)	Chronology and IMR
Cheshire Clinical Commissioning Group	Chronology and IMR

Change Grow Live (Specialist Substance Misuse Service)	Chronology and brief submission
Cheshire and Wirral Partnership NHS Trust	Chronology and IMR
Cheshire East Housing Options Services	Chronology and IMR
Cheshire Adult Social Care	Chronology and IMR
East Cheshire NHS Trust	Chronology and Short Report
Greater Manchester Police	Chronology and Short Report
North West Ambulance Service	Chronology and Short Report
Manchester NHS Foundation Trust (incorporating Manchester Royal Infirmary; South Manchester Hospital (Wythenshawe Alcohol Team).	Chronology and Short Report
Manchester City Council	Short Report and brief submission
Huntington's Disease Association	Chronology and Short Report
Greater Manchester Mental Health Trust	Chronology and Short Report
HMP Forest Bank	Chronology and Short Report
HMP Manchester	Chronology and Short Report
HMP Altcourse	Chronology and Short Report
HMP Liverpool	Chronology and Short Report
Birmingham and Solihull Mental Health Trust	Confirmed no contact

2 The Review Panel Members

Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to support the panel. The members of the Panel are described in the table below:

Panel Member	**Organisation**
Author	Independent
Director of Adult Social Care	Cheshire East Council (CEC)
Head of Service Adult Safeguarding	CEC
Locality Manager – Community Safety	CEC
Domestic Abuse & Sexual Violence Development Lead Advisor	CEC

Head of Service Safeguarding Children and Families	CEC
Detective Constable Review Officers	Cheshire Police
Associate Director of Safeguarding	NHS Cheshire Clinical Commissioning Group
Head of Adult Safeguarding	Cheshire and Wirral Partnership NHS Foundation Trust
Head of Housing	CEC
Operations Manager	My-CWA (Cheshire Without Abuse)
Designated Nurse Adult Safeguarding	NHS Cheshire Clinical Commissioning Group
Named Lead Safeguarding Adults	Cheshire and Wirral Partnership NHS Foundation Trust
Homeless Relief Officer	CEC Housing Options
Homeless Relief Officer	CEC Housing Options
PA to the Director of Adult Social Care	CEC

3 The Terms of Reference for the Review

The Panel approved these specific terms of reference and key lines of enquiry at its initial meeting in August 2020 and agreed to keep them under review as the process evolved. This was to ensure that they could be amended in order to capture any additional information revealed as a part of the Review process.

The Panel also noted that the over-arching purpose of a Domestic Homicide Review (DHR) which is to:

- 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;
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

3.1 The specific Key Lines of Enquiry for the Review

In order to undertake a critical analysis of the submissions made, the Panel approved these key lines of enquiry:

a. To establish what contact agencies had with Pam.

1. Did any agency know or have reason to suspect that Pam was subject to domestic abuse at any time during in the period under review?
2. Had any mental health issues been self-disclosed by Pam or any mental illness diagnosed by an agency working with Pam?
3. Were there any complexities of care and support required by Pam and were these considered by the agencies in contact with her?
4. Were assessments of risk and, where necessary, referral of Pam to other appropriate care pathways considered by the agencies in contact with her?
5. Were issues of race, culture, religion and any other diversity issues considered by agencies when working with Pam?

b. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Pam.

6. What actions were taken to safeguard Pam and were the actions appropriate, timely and effective?
7. What happened as a result?

c. To establish what contact agencies had with the Perpetrator.

8. Was the Perpetrator known to any agency as a perpetrator of domestic abuse?
9. If so, what actions were taken to assess his risk to himself and/or others?
10. Had mental health issues been self-disclosed by the Perpetrator or mental illness diagnosed by any agency for the him?
11. Were the mental capacity of the Perpetrator and the complexities of the care and support required assessed by agencies in contact with him?
12. Was the Perpetrator known to misuse drugs or alcohol, including misuse of prescription medication?
13. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with the alleged perpetrator?

d. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for the Perpetrator.

14. What actions were taken to reduce the risks presented to Pam (or others) and were the actions appropriate, timely and effective?
15. What happened as a result?

e. To establish whether there were other risks or protective factors present in the lives of Pam or the Perpetrator.

16. Were there any other issues that may have increased Pam's risks and vulnerabilities?
17. Were there any matters relating to safeguarding other vulnerable adults or children that the review should take account of?
18. Did Pam disclose domestic abuse to her family or friends? If so what action did they take?
19. Did the Perpetrator make any disclosures regarding domestic abuse to his family or friends? If so, what action did they take?

f. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

20. Were effective whistleblowing procedures in place within agencies to provide an effective response to reported concerns about ineffective safeguarding and/or unsafe procedures.

g. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan

h. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

4. Summary chronology

2000 to 2005
Between 2000 and 2005 there were reports of criminality regarding the Perpetrator. These offences included fighting, the use weapons and driving offences. At this time, the Perpetrator was in a relationship with a woman called 'F4'.

2014
During 2014, the Perpetrator spent time in HMP Forest Bank and in HMP Manchester.

Pam attended the A&E department at her local Hospital following an overdose of paracetamol. Pam reported that "things had been getting on top of her".

2015
The Perpetrator was arrested by Cheshire Police for a historic domestic assault and criminal damage against F4. No further action was taken as F4 did not wish to support a prosecution.

The Perpetrator was admitted to HMP Manchester on the 4th of December. There was also an alert risk concerning the Perpetrator being a perpetrator of domestic violence.

2016
In May, the Perpetrator arrived at HMP Liverpool following a court appearance for the charges of: Criminal Damage, Common assault, Breach of a restraining order; Theft; Driving while disqualified. The Perpetrator left HMP Liverpool on the 3rd of June 2016

2017
Greater Manchester Mental Health NHS Foundation Trust (GMMH) was informed, by Shelter (Housing), that the Perpetrator was homeless and had been offered a place at a local Hotel but he was unable to stay because he was unable to get up the stairs.

The Manchester City Council (MCC) Housing Service attempted to contact the Perpetrator. The Perpetrator stated he was of no fixed address. He confirmed there were times when he had slept outside. The Perpetrator was strongly advised to re-engage with Housing services in Cheshire East or Manchester and Shelter.

In **February**, Cheshire Police reported that the Perpetrator had smashed his way into the house of a woman referred to in the Review as "F3". Later the same day, another call was received relating to the same incident from a friend of F3. The information alleged that the Perpetrator had been to the home of F3 on two occasions and that she was frightened and had locked herself into her home.

In **March**, Cheshire Police arrested the Perpetrator for a serious assault on F3. F3 withdrew her co-operation for the subsequent investigation. F3 stated that she was terrified by the Perpetrator, and declined accommodation at a Women's Refuge. A Vulnerable Person Assessment (VPA) was submitted.

At the end of March, the Magistrates Court in Cheshire imposed a Non-molestation Order on the Perpetrator regarding F3. The Order was scheduled to expire in September 2017.

In **May**, the Perpetrator approached the Housing Options Service at Cheshire East Council (CEC). The Perpetrator stated he was homeless and was assessed under the Housing Act 1996 – Part VII. The Housing Officer assessed that he was legally homeless, and eligible for assistance and likely to be in priority need due to his medical conditions. He was provided with emergency interim accommodation under S.188 of the Housing Act 1996. This accommodation ran from the 5th of May 2017 to the 24th of May 2017 at which point he appeared to have returned to his former property. The Perpetrator refused assistance from Adult Social Care Services at Cheshire East Council (CEC).

Pam contacted GM Police to report a domestic incident with her partner, M2. Pam was checked by paramedics who found no evidence of any injury and Pam declined further medical treatment. A crime was recorded. Pam did not support an investigation and no further action was taken.

In mid-May, Cheshire Police arrested the Perpetrator for an assault against F3. F3 stated that she was frightened of the Perpetrator. The Police returned to speak with F3 later in the day and F3 refused to make a formal complaint. A friend of F3's – who witnessed the assault – also refused to make a complaint. F3 stated she was going to move away from the area. A Domestic Violence Protection Notice (DVPN) was authorised and a Domestic Violence Protection Order (DVPO) was granted until the 12th of June 2017. This Order was served on the Perpetrator on the **17th of May** but he dismissed it. On the 15th of May 2017, a Serial Domestic Abuse Perpetrator (SDAP) nomination form was issued concerning the Perpetrator, a VPA was submitted, a referral was made to the Independent Domestic Violence Advocate (IDVA) service, a re-nomination to the Multi-Agency Risk Assessment Committee (MARAC) was made and there was a referral to Adult Social Care.

In mid-May, the Perpetrator was seen at the A&E Department reporting suicidal ideation. The Psychiatric Liaison Service from Cheshire and Wirral Partnership NHS Trust (CWP) attended to him and reported that the Perpetrator was brought to A&E after his girlfriend (this was not Pam) had called the emergency services and stated that he was "acting bizarrely; throwing furniture around, talking to himself and was hearing voices".

A number of incidents occurred over the period from the **22nd to the 23rd of May**. F3 contacted the Cheshire Police to report that the Perpetrator was "coming to get her". The Police attended her address and she confirmed that the Perpetrator had attended her home. F3 did not provide a statement to prove a breach of the DVPO. F3 was contacted by a Social Worker and referrals to the IDVA service and Children's Social Care Service were made. At the end of May, F3 was residing in a refuge in Cheshire.

In June, GM Police noted that the Perpetrator was rough sleeping in Piccadilly Gardens, Manchester and associating with "spice" users in that area.

In late **October**, Pam was admitted onto Acute Medical Assessment Unit (AMU) at the Manchester NHS Foundation Trust for observation and treatment. She was then referred to the Alcohol Liaison team (ALT). Pam's GP was informed and they noted that Pam had been accepted by the Alcohol team for an in-patient detoxification programme. Pam attended the Chapman-Barker Unit, (the detoxification centre, part of the GMMH NHS Trust) on the **28th of October** and left the unit on the **3rd of November** 2017. Throughout her stay the following notes concerning Pam were made:

- Mild withdrawal symptoms evident;
- Disclosed history of abusive relationships but reported that she had been single for the previous 18 months;
- engaged well with the in-patient team;
- compliant with medication regime;
- attended multiple group therapy sessions;
- reported long standing low mood issues and childhood trauma that caused her issues with anxiety;
- treated for low mood by her GP (in 2016), and she took prescribed medication for 6 months;
- no previous contact with mental health services;
- no history of self-harm or thoughts to harm self.

After Care arrangements were made with Stockport Services and an appointment with the Alcohol Team was made for the 6th of November 2017

By mid-November, Pam reported to the Chapman Barker Unit (CBU) that she had relapsed and was drinking heavily. She reported her partner, M2, continued to consume 12-14 cans daily, which wasn't helping her situation.

2018

In **March**, the Huntington's Disease Association noted that the Perpetrator was on the Healthcare Wing of HMP Liverpool but following assessment they returned him to a standard wing. The Prison reported that the Perpetrator was suffering with weight loss and swallowing problems (associated with his Huntington's Disease).

East Cheshire NHS Trust record that Pam scored 27/40 on the AUDIT alcohol screening tool (indicating possible dependency) and an appointment was made for her to be seen by the Alcohol treatment service.

CWP saw Pam on the **27th of March**. She reported that she had received an alcohol detoxification in December 2017, but had relapsed. Prior to admission Pam reported drinking 1/2 bottle of wine after work. Pam reported that her partner was a dependent drinker and encouraged her to drink. She advised that she felt confident that she could stop going out and reported that her children were very supportive. Relapse prevention medications were discussed and an appointment arranged for the 29th of March. Pam did not attend the appointment. A request was made for Pam to be re-booked. On the 3rd of April, because Pam had not attended the appointments, her case was closed.

In late May, Cheshire Police receive a call from one of Pam's children concerning an assault on Pam by M2.

M2 was arrested for the assault and became problematic for officers and was charged with criminal damage. Pam's Son (who made the call to Police) came to collect Pam from the scene. Pam refused to make a complaint but provided an account of the incident. M2 was interviewed and denied assault. However, M2 was charged and bailed for trial on the 2nd of October 2018. A summons was issued but it was not served on Pam due to her whereabouts being unknown. The assault case was later dismissed at Stockport Magistrates Court. There was a known and extensive Domestic Abuse history between Pam and M2 and a VPA was submitted, along with a referral to the IDVA service and a nomination to MARAC.

The IDVA service tried 5 different telephone numbers and made multiple calls to Pam. When a call was answered, a man spoke and the IDVA created a fictitious name to avert attention.

At the end of May, CWP received a referral from Pam's GP requesting support to reduce Pam's alcohol consumption. A referral letter was sent to Pam requesting an appointment for her to be seen. An appointment was given to attend on the 18th of June. Pam did not attend and there was no answer when she was contacted and no further message received to cancel or re-arrange the appointment. The decision was taken to discharge Pam from the service. CWP advised Pam's GP to re-refer if requested.

From intelligence shared, the Panel believe that Pam and the Perpetrator began to form their relationship in July 2018.

The Cheshire Police contacted Pam and Pam stated that she would be happy to talk to the IDVA and would be a witness in the prosecution of M2. Pam stated that the relationship with M2 was over.

On the **1st of November**, Pam attended the Manchester Foundation NHS Trust. Manchester NHS Foundation Trust noted that Pam had attended East Cheshire NHS Trust in late October due to a fall and they had diagnosed a fractured left humerus which was to be treated in a sling. Manchester FT noted that Pam's partner (the Perpetrator) was "very rude, and lay down on the bed with her whilst being examined". The Trust did not record the partner's name because they did not share that information. The Trust reported that Pam self-discharged against medical advice.

On the **7th of November** 2018 a friend of Pam contacted Cheshire Police and stated that Pam had contacted them and informed them that the Perpetrator had just burst into her home and locked her in the house. The caller told police that the Perpetrator had previously beaten Pam up because she wouldn't engage in a relationship with him.

Officers attended Pam's home address. She was not present. Pam was located at the Perpetrator's home address where she informed officers that she had not been harmed in any way, (she did not have any visible injuries) and had not been held against her will. She had called her friend as a precautionary measure because she needed time away from the Perpetrator and was unsure as to how he would react due

to his Huntington's disease. No offences were disclosed. Pam was taken to the caller's home address.

A critical marker was placed on Pam's home address. A VPA – graded Medium – was issued along with a Domestic Abuse, Stalking and Harassment (DASH) assessment.

The Domestic Abuse Family Support Unit (DAFSU) noted the VPA and recorded that this was the first reference they had received concerning the Perpetrator. Pam declined the support offered in relation to this incident, but was re-assured that she could ring them at any time. It was recorded that Pam said thank you but stated that she was 'absolutely fine'.

On the **18th of November**, Cheshire Police receive a call stating that the Perpetrator has assaulted Pam. He had left the address and she had locked the doors. This was recorded as a Section 47 assault. Pam stated that she did not wish to be in a relationship with the Perpetrator but was struggling to leave because he became aggressive and she feared for her safety.

Pam declined to make a formal complaint and did not wish the Perpetrator to be spoken to. A VPA (graded as high risk) was submitted and a referral made to the Cheshire office of the National Centre for Domestic Violence (NCDV) and a specialist unit assigned. Arrest attempts were made for the Perpetrator. Pam wanted the Perpetrator to be told that she hadn't made a complaint. An urgent Domestic Violence Disclosure Scheme (DVDS) action was put in place for Pam and the Perpetrator was arrested on the 20th of November. A Domestic Violence Protection Notice (DVPN) was authorised by a Superintendent from the Cheshire Police service and this was set in place until the 19th of December.

It was noted that the Perpetrator was a Serial Domestic Abuse Perpetrator (SDAP). A VPA and a DASH were submitted and a critical marker was placed on another address listed for Pam. A 'Use of Force' form was completed.

On the **20th of November** a DVDS - right to know disclosure – was given to Pam regarding the previous offences of the Perpetrator. Pam later shared her distress at the content with the IDVA. At the time of the disclosure, Pam stated that she wished to have an injunction and was signposted to 'Domestic Violence Assist'. It was noted that Pam had not made a statement and didn't wish to. The IDVA noted that 'Domestic Violence Assist' needed to see bank statements and a tenancy agreement as proof for an application for legal aid.

CWP received a referral from the Cheshire Constabulary suggesting that Pam would benefit from an assessment within the Single Point of Access (SPA). The referral described that Pam had presented with low mood and also stated increased anxiety as a response to being a victim of a recent domestic assault.

CWP advised that Pam's needs could be met, firstly, within the alcohol services. Hence, Change, Grow Live (CGL) received the referral. CGL contacted Pam with an appointment date. Pam didn't respond and did not attend the appointment. Therefore, after two weeks, CGL closed the case.

On the **14th of December**, a call was made to Pam by a specialist Police service duty officer, as requested by the IDVA. Pam stated that she was okay but felt stressed about the DVPO conditions ending on the 19th of December. The Perpetrator had not breached these but Pam was scared that he would turn up the day after as there is nothing in place to stop this. The duty officer asked about the non-molestation order, and Pam said she had sent the documents to DV Assist but hadn't heard anything.

Just prior to Christmas, the IDVA service had a conversation with Pam who stated she was safe at her home address over Christmas. She stated she would accept a referral to the alcohol services after Christmas but would like to receive a detoxification at the Chapman Barker Unit. Pam agreed to a home visit from the IDVA after Christmas.

2019

CEC Housing were informed that the Perpetrator had been issued with a notice to leave his supported accommodation by the 25th of January. The accommodation service stated that he has been given notice due to incidents of fighting with another resident at the accommodation, entrapment of his girlfriend, failure to comply with house rules, and removal of communal furniture. An alternative provider withdrew their offer of accommodation because the Perpetrator failed to disclose his conviction when asked.

On the **14th of January**, NWAS contacted the Police to report that Pam had reported that she had been assaulted by the Perpetrator. Pam reported that she had been punched and kicked multiple times and had pain to the right side of her chest and ribs. NWAS reported that Pam refused transport to A&E and stated she would see her GP the next day and signed a refusal statement to this effect.

Police Officers attended and obtained differing accounts from Pam – she stated that she did want the Perpetrator to be arrested and was in fear of him and feared for her life. Officers noted that the Perpetrator was nominated to be seen by the Integrated Domestic Abuse Team (IDAT) and also a serial Domestic Abuse Perpetrator, with a MARAC history. Officers also noted that the IDVA service had been trying to work with Pam after the expiry of the DVPO.

The IDVA and IDAT officers visited Pam on the **15th of January** to ask if she would make a statement to support the prosecution. Pam was adamant that she didn't want to do this although she believed that the Perpetrator would kill her. Pam was also clear that she did not wish to take out a restraining order as she would have to supply evidence for legal aid and doesn't feel she could complete this task. Pam stated that she would consider going into refuge if the IDVA could find a space for someone with alcohol issues. The IDVA found that the nearest refuge supporting alcohol affected clients was in Chorley. The IDVA gave the numbers to Pam and advised her to make a call as they needed to speak to her. The IDVA updated the refuge. Pam did not go into the refuge – she said it was too far away for her and she couldn't get there.

The Perpetrator's GP noted that he refused consent for the GP to contact Adult Social Care on his behalf, that he didn't want input from mental health services or the neurological team; the Perpetrator stated that he wanted to look out for himself and be left alone.

On the **30th of January**, the CWP Single Point of Access (SPoA) received an urgent referral from Pam's GP. CWP made telephone contact with Pam and she reported that she was 'alright, just having a bad day yesterday'. Pam reported to be feeling low in mood but would pick herself up. Pam stated that she had lots of social stressors as triggers. Pam stated that she was unable to make the urgent appointment on the previous day due to having to get buses and reported that she was unable to come that day and asked whether SPoA could contact her on Monday. CWP said that the GP had requested an urgent assessment, but Pam did not feel she was mentally unwell and did not need one. CWP attempted to explore issues, including the reported domestic abuse issues, but Pam put the phone down and ended the call.

Manchester NHS Foundation Trust noted that Pam was brought into the ED, via NWAS, with a 4-day history of chest pain on inspiration. Pam disclosed at triage that her partner had kicked her in the back and ribs. Pam left the department before being seen by medical staff.

On the **12th of February**, Cheshire Police IDAT notified Greater Manchester Police that the Perpetrator had been provided with temporary accommodation in Stockport. The Perpetrator was noted as being a violent offender with several domestic abuse incidents where the victim would not or could not support prosecution. It was noted that he was known to Greater Manchester Police. The intelligence detailed his medical condition once more and also that he was in a relationship with Pam who may be with him.

On the **25th March** Pam's friend contacted Cheshire Police to report that they believed Pam was going to meet the Perpetrator at their flat on that day. They were concerned because Pam had previously been assaulted by the Perpetrator and they were frightened to go home if the Perpetrator was going to be there.

The Force Control Centre (FCC) operator confirmed that Pam was not at the address of the caller but requested a telephone number for Pam from them. This number was provided and the operator contacted Pam. She confirmed that she was safe and well. She stated that she had been with the Perpetrator earlier in the day but was not with him now. Pam confirmed that she had not been assaulted and knew to ring the police should any problems arise.

On the **27th of March** , Cheshire Police received a call from a taxi driver stating that he was at a supermarket and that the Perpetrator was attacking Pam. The taxi driver had driven off with Pam but believed that the Perpetrator had taken all her money. Police attended the scene and spoke to Pam and received an account from the taxi driver. There was no complaint from Pam, no independent witnesses prepared to make a statement, and no CCTV. A VPA and DASH were submitted.

On the **11th of April**, Pam contacted Cheshire Police to report that she had been assaulted by the Perpetrator. Officers attended to Pam and established that the alleged assault had taken place in an hotel in the Greater Manchester Police force area and, following initial evidence gathering and safeguarding, the case was passed to Greater Manchester Police.

GM Police responded and contacted Pam. The officer from GM Police documented that Pam did not wish to support a prosecution and signed the officer's pocket note book to that effect. Pam was taken to a friend's address and refused offers of support.

On the **12th of April**, Pam spoke with officers from Cheshire Police confirming that the Perpetrator had assaulted her causing injuries to her face and neck. Pam signed the officer's note book to this effect and she signed a medical consent form. Arrangements were made for photographs to be taken of her injuries.

The Police officer contacted Pam the following day and Pam stated that she did not want to speak about the incident at that time and would be going to a friend's house and turning off her phone. Pam requested that she be contacted the following week at which time she may provide a statement.

The Police made a referral to the IDVA service and a re-referral to MARAC.

Between the **12th and 18th of April**, a MARAC was held to discuss the incident on the 11th of April; Pam was contacted to ask if she would make a complaint or provide a statement and to ascertain if she was engaging with the IDVA service. GM Police were contacted to provide an update.

On the **26th of April**, an officer from GM Police contacted Pam and she agreed to provide a statement and also indicated that further offences had occurred as she had been receiving calls from the Perpetrator making threats towards her.

On the **30th of April**, CWP saw the Perpetrator and he stated that he felt that everything had "come to a head" and that nobody would help him and that he had developed suicidal ideation. The CWP Staff Nurse spoke to the homelessness officer at Cheshire East Council. They advised that they were aware of the Perpetrator and his difficulties and reported that the Perpetrator had been offered accommodation that meets his needs but has either rejected it or acted in a way that means he is no longer allowed to stay there.

Pam contacted Greater Manchester Police with concerns in relation to the lack of progress with the incident in April. A supervision officer spoke with Pam noting that the statement had been taken by Cheshire Police and GM Police were waiting to receive a copy. Several arrest attempts were made and the Perpetrator was detained on the 04/06/19. Following an interview, the Perpetrator was released 'under investigation' as a more detailed statement was required.

On the 13th of May, Pam called the IDVA service saying that she had made a statement, and that she was currently staying with M2 for safety reasons.

The Huntington's Disease Association (HDA) received a call from the Perpetrator stating that the Council had told him to go to Crewe because they had a flat for him. When he arrived, he was told that he was there for an assessment. The Perpetrator stated that he wanted to end his life. The HDA contacted the Social Care Service and stated that:

> *they had known the Perpetrator for 11 years and that he has been deteriorating cognitively over the last 5 years. He struggles with instructions and can become*

irritable quickly and lash out, resulting in Police presence and reduced relationships.

The HDA made a telephone call to the National Homeless Advice Service concerning the Perpetrator. They suggested that the Perpetrator – or his advocate – could speak to the Civil and Legal Team to take things forward and see if a Section 213 could be issued (Cheshire East was asking Manchester to co-operate and offer support). The HDA received a telephone call from CEC Social Care Service wanting more information about the Perpetrator and the services the Huntington's Disease Association could offer. The Social Care Service explained what they had offered, why things had not yet worked out and that the Perpetrator had housing arrears so may struggle to secure Housing Association accommodation.

On the **23rd of May**, Cheshire Police receive a request from GM Police for arrest attempts to be made for the Perpetrator concerning the assault on Pam in April. The GM Police request stated that their file was "arrest ready".

On the **3rd of June**, Cheshire Police arrested the Perpetrator. Officers from GM Police attended to deal with the consequences of the arrest. The Perpetrator was released under investigation.

Cheshire and Wirral Partnership NHS Trust (CWP) saw the Perpetrator at the Custody Suite and recorded the following points:

- He was brittle and irritable when declining help. Capacity was not formally assessed, but it was clear he understood the nature of the screening.
- A Senior Social Worker attended the Custody Suite to act as an Appropriate Adult.

On the **18th of June**, Pam contacted Cheshire Police. Pam had been in contact with GM Police and they had told her that they had sent an email to Cheshire requesting a further statement. An appointment was made for 11am on the 19/06/2019 and a statement was taken on the 20/06/2019 and sent to GM Police. Of note, in her statement to the Cheshire Police, Pam said: '....if the Perpetrator continues to get away with doing these sorts of things, he will end up killing somebody'.

On the **22nd of June**, Pam contacted Cheshire Police and stated that M2 had assaulted her. Police attended and arrested M2 at the scene. M2 was interviewed and provided checkable information. Pam was contacted the following morning and she refused to provide any complaint or allow officers to look at her medical records (which were evidential in this case). Consequently, M2 was released on conditional bail and ultimately no further action was taken.

On the **7th of July**, Pam called Cheshire Police and requested that they attend her location. Officers attended and M2 was arrested for assault (which he denied in the interview). At this time, M2 was still on police bail from the incident recorded on the 22nd of June. Pam refused to make a complaint against M2 and refused to provide images of injuries or medical consent. Pam stated that she had attended his address to get away from the area where the Perpetrator frequents because she is fearful of him seeing her.

On the **10th of July**, Pam was interviewed by CEC Housing (Home-Choice) over the telephone. Pam explained that she was fearful of returning to her previous address. Pam was asked about her health and she stated that she was alcohol dependent. Pam also stated that she was suffering with depression and that she had suicidal thoughts, but what keeps her going are her children. Options were discussed with Pam and it was agreed that a referral for a women's only project would be made and until that time she was happy to remain at a friend's house.

CEC Housing arranged for Pam to be assessed by a Housing service for a space at a women's project. Unfortunately, Pam wasn't able to attend and said that she would call the Housing service to re-arrange the appointment. A new assessment date was arranged, but Pam did not attend. The Housing service attempted to contact Pam via phone and text but didn't receive a reply. This was the last contact with Pam for this service

On the 19th of July, Pam's case was heard at the eMARAC and it was decided that a full MARAC would be required. The risks to Pam were deemed not to have been mitigated and this was the 5th MARAC where Pam had been discussed. The IDVA had suggested a professionals meeting with Pam present to discuss her options and explain what support was available. It appeared at the MARAC that current attempts to keep her safe were not being effective and Pam was considered to be making choices of her own which were putting her at risk. The decision was that Pam should be heard at the MARAC on the 23/07/19.

On the **24th of July**, the IDVA manager made a call to Pam. She said she was looking forward to becoming a grandmother, has reduced her alcohol intake and planned to continue on that course. She said she was very grateful for the support from the IDVA.

On the 1st of August, the Social Worker assigned to the case of the Perpetrator completed a 'Legal Gateway' referral, and sent an email to the Multi-Agency Public Protection Arrangements (MAPPA) lead. The Social Worker obtained information from the Public Protection Unit (PPU) for the Legal Gateway referral. The Perpetrator was flagged as a serial domestic abuse perpetrator.

On the 12th of August, Pam attended the Emergency Department (ED) at Manchester NHS Foundation Trust following a collapse earlier in the day. Pam reported that she "felt shaky and unwell". Pam was re-referred to the Alcohol Liaison Team (ALT) for an outpatient follow up. A chest infection was diagnosed and Pam was discharged home. On the following day, Manchester NHS Foundation Trust sent a letter to Pam's home inviting her to be seen as outpatient by ALT.

Approximately one week later, the critical incident occurred and Pam was murdered by the Perpetrator.

5. Key issues arising from the Review

The key issues emerging from this Review include the considerations and deliberations of the Panel – focusing upon the submissions received from the agencies in contact with the subjects of this Review and also the submissions from Pam's children. These themes are not set out in any order of priority.

5.1 Pam's health, vulnerability and engagement with health services

5.1.1 The Panel recognised that evidence clearly suggests that poor mental health can either effect domestic abuse or be a significant risk factor for victimisation[1].

5.1.2 Pam had a long history of anxiety and depression and on one reported occasion, an episode of suicidal ideation (this was disclosed to East Cheshire Trust). Pam also disclosed adverse childhood experiences when she was in contact with Greater Manchester Mental Health Services NHS Trust (GMMH).

5.1.3 In March 2018, Pam was seen by the alcohol team for an assessment during her admission to Macclesfield General Hospital (this admission concerned reported pneumonia). During this assessment Pam advised that her social life revolved around alcohol and stated that her partner drank heavily and encouraged her to drink. Despite attempts to engage Pam in drug and alcohol support services, Pam declined to attend appointments and was discharged in June 2018. In January 2019, an urgent referral was received by CWP from Pam's GP. However, Pam declined to attend two appointments and was discharged from the service in February 2019.

5.1.4 The Panel considered that a key characteristic of Pam's engagement with services was contact with a service during a period of crisis, then a period of complexity that led to missed appointments, then a disengagement from the service and then the service would close her case.

5.2 Assessing risk and safeguarding

5.2.1 Between 2018 and 2019, Pam was discussed at the Cheshire Multi-Agency Risk Assessment Conference (MARAC) on 5 separate occasions. During this period, the Domestic Abuse Family Support Unit (DAFSU) received 9 Vulnerable Person Assessments (VPAs).

5.2.2 Nevertheless, it is clear that not all of the services that Pam was in contact with were aware that she was a victim of domestic abuse and violence, either at the time of her contact or at any point in her past. The majority of the services did know – DAFSU, Cheshire Police, Greater Manchester Police and her GP had access to all the information shared at the MARAC – but Greater Manchester Mental Health Trust didn't know and the Cheshire and Wirral Partnership had an incomplete picture of Pam's life. Additionally, of course, the Adult Social Care (ASC) Service had no contact with Pam, and received no VPAs.

[1] See Trevillion, et al, 2012, published by Safe Lives in 2015

5.2.3 The Panel formed the view that Pam would, in all likelihood, have reached the threshold to be considered as an adult in need. However, the ASC service was not in a position to institute Care Act proceedings.

5.2.4 As the Panel noted, there was no guarantee that because a VPA had been submitted, the Social Care Services would automatically be informed. Consequently, not all of the services in contact with Pam were prompted to undertake a specific domestic abuse and violence assessment.

5.2.5 With regard to the Perpetrator, the Social Worker contacted the PPU for information to assist them to support the housing needs of the Perpetrator and to be able to share this information at the Legal Gateway. It was via this contact that the Social Worker discovered that the Perpetrator had been heard at the MARAC in November 2018 and April 2019.

5.3 The offer of Refuge

5.3.1 Pam was offered refuge on several occasions. However, she declined these offers – either changing her mind because her circumstances may have changed, or deciding that the refuge facilities were too far away for her to travel. The Panel noted that one offer of refuge – an accommodation that could offer refuge and support for Pam's needs – was approximately 50 miles away and Pam declined this offer because of the distance from her home. Specialist domestic abuse advisers on the Panel highlighted that, though 50 miles may sound disproportionate, in the context of the need to provide specialist support, such provision would be considered as local.

5.4 The health of the Perpetrator and his engagement with services

5.4.1 The Adult Social Care (ASC) service had difficulty contacting the Perpetrator and maintaining contact with him. When they did, their focus was to resolve, in partnership with a number of other service, the Perpetrator's accommodation needs. The Perpetrator's homelessness is a recurring theme in this Review. Manchester City Council, Stockport Council and Cheshire East Council all attempted to resolve this matter.

5.4.2 The Specialist Adviser from the Huntington's Disease Association (HDA) suggested that, on occasion, referral to ASC was difficult – suggesting that there is a tendency for agencies to refer to the client's physical needs as paramount, rather than their mental health needs and this is often cited as the reason for not engaging the client.[2]

5.4.3 The Perpetrator was admitted to custody on a number of occasions. Whilst in HMP Manchester, in March 2016, the Perpetrator refused food and refused to engage with staff to resolve this issue. Additionally, an alert notification was made on one occasion concerning self-harm. The Perpetrator stated that because his illness was deteriorating, he wanted to die.

[2] By way of example, in January 2017 the Adviser from the HDA made a referral to the Community Mental Health Team within Manchester Central Social Services. This referral was refused as they felt the Perpetrator's needs were physical not mental health.

5.4.4 The Housing Options Service in Cheshire (HOS) noted in their submission that their understanding of Huntingdon's Disease was limited and there was room for a more pronounced grasp of the prognosis and the impact on behaviour and capacity as the condition deteriorates.

5.4.5 The Panel learned from the submission made by the HOS that the Perpetrator was provided with an extensive and high level of service by the Housing Options Team over a long period of time. However, in the view of the HOS, there came a point where it became clear that the Perpetrator's needs were more complex than could be provided by the Housing Options Service alone. HOS suggested that, at this point, a multi-agency meeting should have been called and the Perpetrator should have been referred to Cheshire East Council 'Hard to House' Panel.

5.4.6 Between June 2017 and January 2018, the Perpetrator was a client of the Criminal Justice Liaison (CJL) Service provided by the Cheshire and Wirral Partnership NHS Trust (CWP). He was seen twice and was noted to engage very poorly with practitioners and in January 2018 the Perpetrator was discharged from CJL due to his failure to engage with the service.

5.5 The Perpetrator was a Serial Domestic Abuse Perpetrator (SDAP)

5.5.1 Intelligence submitted to the Panel from both the Cheshire Constabulary and the Greater Manchester Police supports the assertion that the Perpetrator had a history of assaults against women.

5.5.2 Setting aside the violence against Pam, prior to her murder by the Perpetrator, information was received by the Panel describing the assaults perpetrated against women referred to in the Review as "F2", "F3" and "F4".

5.5.3 The Perpetrator refused to engage with the Cheshire Integrated Domestic Abuse Team (IDAT – a service that aims to prevent further incidents of assault by perpetrators of domestic abuse) and the equivalent service in Greater Manchester. The Panel noted that engagement with these services is not mandatory.

5.5.4 The Panel noted the work of Laura Richards[3], the criminologist who developed the DASH assessment. Taking note of her work, the Panel recognised the merit of focusing upon serial abusers. Laura Richards suggests that a focus has been placed upon repeat victims and that some shift needs to occur to focus upon serial high risk perpetrators – i.e., those who cause the harm – and that public services need to act together upon the information that is already available to them (including sharing information), in order to identify, assess and manage the perpetrators and for there to be consequences for their behaviour *before* it escalates to assault or murder.

5.6 Professional curiosity and sharing information

5.6.1 The Panel noted the reference to the NICE Domestic Abuse Quality Standard (QS116) referred to in the submission from the East Cheshire NHS Trust.

[3] www.laurarichards.co.uk

5.6.2 East Cheshire NHS Trust highlighted that symptoms of depression, anxiety, suicidal tendencies or self-harming and alcohol or other substance misuse are common indicators of Domestic Abuse and should trigger a concern in health care staff and prompt them to enquire about domestic abuse. However, according to Pam's patient record, her presentation did not always trigger staff to consider Domestic abuse.

5.7 The domestic abuse and violence endured by Pam and the reluctance to pursue prosecution

5.7.1 From the submissions received, it appeared that Pam had been subjected to domestic violence and abuse for more than a decade. Formerly, when she was in a relationship with M2, then when she was in a relationship with the Perpetrator in this case and, following the incident in April 2019, Pam re-acquainted with M2 and was again assaulted by him.

5.7.2 The Panel noted that, following allegations of assault, Pam would often be reluctant to provide a statement in order to support the process of prosecution and would not encourage the Police to arrest the alleged perpetrator of the assault.

5.7.3 The Panel has highlighted the circumstances associated with what it considered to be five key allegations of assault and noted that on one occasion – following an assault at a hotel in Manchester – Pam positively pursued the prosecution of the Perpetrator.

5.8 Having a full account of the violent history of the Perpetrator, holding him to account, and supporting a prosecution.

5.8.1 The Perpetrator's long history of assault and criminal damage was recorded by both Greater Manchester Police and Cheshire Police.

5.8.2 In April 2019 Pam made a call to Cheshire Police reporting that she had been assaulted by the Perpetrator at an hotel in Manchester. This appeared to the Panel to be a pivotal incident. A crime was recorded (a Section 47 assault – assault occasioning actual bodily harm)**.** However**,** the attending officer recorded that Pam, at that precise point in time, did not wish to support a prosecution and had signed the officer's note book to that effect.

5.8.3 The author of the submission from GMP stated that, given the history of domestic abuse by the Perpetrator, that an arrest at the scene may have been the most appropriate course of action. The lack of arrest at the scene may have left Pam feeling unsafe and vulnerable and unable to return to her home because she was in fear of the Perpetrator. If the Perpetrator had been arrested, there remained a possibility that the Perpetrator would have been released under investigation, without a statement from Pam. However, the fact of the arrest may have assisted Pam in deciding whether or not she would provide a statement to support a prosecution

5.8.4 There appeared to be a pattern exhibited in the behaviour of the Perpetrator and this pattern was entrenched. Agencies and Panel members noted that there

are long standing frustrations in the limitations faced by the wider Criminal Justice system, and other agencies, to hold serial perpetrators to account and to provide effective opportunities for behaviour change.

5.9 Sharing information and Liaison

5.9.1 The Panel recognised that this theme arises in a number of Homicide Reviews, Safeguarding Reviews, and Serious Case Reviews.

5.9.2 In this case, there are specific examples to consider: the circulation of 'Vulnerable Person Assessments' (VPAs) and what agencies are expected to do when they receive a VPA; discharge summaries from secondary care to primary care; details shared by MARAC; the accuracy of information requested for clients at MARAC; accessing case notes held by other agencies; etc.

5.10 Supporting victims with complex needs

5.10.1 Agencies submitted that a successful pathway for a client is dependent on the willingness of the client to follow through on agreed actions and the time taken by those services to offer appointments and support, particularly when clients do not attend (DNA). This can create a barrier to help, particularly when a client is motivated one day but is fragile and changes perspective the next. In turn, this may lead to specialist domestic abuse services (or other specific services that complex clients engage with) supporting complex clients when they do not have the specialist expertise to do so. Having a better multi-agency response to complexity would potentially improve outcomes for clients who live with domestic abuse.

5.10.2 The Perpetrator may also have benefited from a multi-agency plan to address his use of drugs/alcohol and his accommodation needs, and to put exclusions in place to prevent him from making contact with specific named people.

5.11 Adverse Childhood Experiences (ACE)

5.11.1 The Panel noted that on one occasion – during her engagement with GMMH – Pam disclosed ACE. The Panel recognised that trauma and traumatic abuse is described by MIND as:
"going through very stressful, frightening or distressing events is sometimes called "trauma".

5.11.2 The national charity NAPAC (National Association for People Abused in Childhood) recognises that childhood trauma, in all forms, has a significant impact on the lives of victims, as children and into adulthood.[4]

[4] www.napac.org.uk

6. Conclusion

6.1 The Review learned that Pam had a long history of struggling with her mental health – living with anxiety and depression for more than ten years.

6.2 The Panel considered that a key characteristic of Pam's engagement with services was contact with a service during a period of crisis, then a period of complexity that led to missed appointments, then a disengagement from the service and then the service would close her case. However, it was noted that Pam had good, though infrequent, contact with her GP and her GP saw Pam in the Practice, made contact via the telephone and her GP also conducted home visits.

6.3 Between 2018 and 2019, Pam was discussed at the Cheshire MARAC on 5 separate occasions and during this period, DAFSU received 9 Vulnerable Person Assessments (VPAs). However, it was clear that not all of the services that Pam was in contact with were aware that she was a victim of domestic abuse and violence. Additionally, the Adult Social Care (ASC) Service had no contact with Pam, and received no VPAs. The Panel formed the view that Pam would, in all likelihood, have reached the threshold to be considered as an adult in need. However, the ASC was not in a position to institute Care Act proceedings.

6.4 The Perpetrator was a Serial Domestic Abuse Perpetrator (SDAP). The Perpetrator's long history of assault and criminal damage was recorded by both Greater Manchester Police and Cheshire Police. Despite a number of attempts, the Perpetrator refused to engage with the IDAT and the equivalent services in Greater Manchester. The Panel noted that engagement with these services is not mandatory

6.5 Agencies and Panel members noted that there are long standing frustrations in the limitations faced by the wider Criminal Justice system, and other agencies, to hold serial perpetrators to account.

6.6 The Perpetrator's homelessness was a recurring theme in this Review. Manchester City Council, Stockport Council and Cheshire East Council all attempted to resolve this matter.

6.7 From the submissions received, it appeared that Pam had been subjected to domestic violence and abuse for more than a decade.

6.8 The Panel noted that, following allegations of assault, Pam would often be reluctant to provide a statement in order to support the process of prosecution and would not encourage the Police to arrest the alleged perpetrator (neither M2 nor the Perpetrator in this case) of the assault.

This was a tragic case resulting in the untimely death of Pam and leaving four children without their Mother. The thoughts of the Panel are with these surviving children.

7. Lessons to be learned from the Review

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are the lessons learnt that have been identified by the agencies that had contact with Pam and/or with the Perpetrator.

7.1 Clinical Commissioning Group (CCG)

From the perspective of the GP Practice perspective, they noted that they do not always have a full account of all the information from outside health agencies. This can make consultations with patients challenging when a clear picture of other external consultations is not readily available.

More generally, when the usual lines of communication are truncated, this can have an impact on automatically generated lines of communication made to a patient (invites for routine appointments, invites for tests and vaccinations, etc). A clear and prompt process of ensuring the Practice is kept up to date with all relevant information will help prevent families receiving inappropriate contact during a difficult time.

Domestic Abuse Family Support Unit (DAFSU)

DAFSU considered that the key learning from the review is that multi-agency meetings must always be considered when dealing with complex cases. Additionally, these meetings should be initiated promptly and be organised to focus upon the key issues identified to meet the needs of the client.

DAFSU also noted that the Perpetrator may also have benefited from a multi-agency plan to address his use of drugs/alcohol, and to put boundaries in place to prevent him from contacting Pam and others.

Adult Social Care (ASC)

Adult Social Care noted that it was only when they had an extensive overview of all the support, interactions, meetings and discussions that had taken place with regard to both the Perpetrator and Pam over the period of the Review (that is, during the Review process) that they became fully informed of the severity and unpredictability of the Perpetrator's behaviour and the vulnerability of Pam in all her relationships.

ASC noted that the Perpetrator was quick to blame his Huntington's Disease for any violence or aggression that he may have inflicted on others, including Pam.

Pam was not known to Adult Social care and ASC were unaware of the relationship between her and the Perpetrator during their interactions with him. From the chronology, it appears that from January 2019, Pam had at least 6 VPA's activated, yet none of these appear to have been received by Adult Social Care. ASC noted a comment from a meeting of the MARAC held on the 13th of May 2019 suggesting that the IDVA service was waiting for a joint visit to Pam with Adult Social Care, but that she did not hear from them. As Adult Social Care had no information on Pam, or received any VPAs, this contact was obviously not made and there was no follow up from the IDVA

Manchester Foundation Hospitals NHS Trust (MFT)
Action was not taken to attempt to speak to Pam alone when there were concerns around her partner's behaviour. This was a missed opportunity to risk assess the situation and offer support to Pam.

The MFT discharge summary document has been highlighted as an area for improvement and is listed for review as part of the development of the new electronic patient record system.

The management of missing and absconding patients has been highlighted as a concern in the past. Since this incident occurred, a new policy has been put in place to ensure that staff are aware of the actions to take when a patient goes missing from the Department.

Greater Manchester Mental Health NHS Trust (GMMH)
The staff at the Chapman Barker Unit (CBU) could have shared information from the call they had with the Stockport Community Alcohol Team (CAT). CBU Staff advised Pam to discuss her concerns directly with the CAT & relied on her to do that. Good practice would have been to call the CAT in advance.

GMMH also noted that by mid-November 2017, Pam reported to the Chapman Barker Unit (CBU) that she had relapsed and was drinking heavily. Pam reported that she had a partner, whereas during the admission, she reported she was single. GMMH considered this to be a missed opportunity to explore any relationship difficulties with her current partner.

Cheshire Police
Aside from the incident in the hotel in Manchester (that occurred in April 2019), Pam was reluctant to make a formal complaint against the Perpetrator. It was acknowledged, from the accounts provided by Pam, that she was frightened of the Perpetrator, frightened of what he was capable of and frightened of what he would do to her. This may be the reason she so vocally told police in his presence that she didn't want to make a complaint and that she hadn't been assaulted.

Understanding domestic abuse is complex and one response clearly will not 'fit' all clients in all circumstances. One process which is meant to safeguard victims of domestic abuse, (the Domestic Violence Protection Notice – DVPN, for example) may in fact do the opposite. Knowledge and understanding of the complexity of this issue is key to the response.

Cheshire Police issued a number of DVPNs regarding Pam. Following this case, lessons have been identified regarding the DVPN process. For example, there was one occasion where it was felt that a DVPN was not appropriate. The rationale for this was based upon the assessment that Pam and the Perpetrator would breach the subsequent order and not comply with the conditions. Cheshire Police recognise that they had the means (i.e., the DVPN) to act to safeguard Pam, and had the authority to pursue, via the court, any breaches that occurred.

The learning from this specific example will wrest upon the conditions and the procedures that lead to a DVPN not being authorised.

There were also examples identified by the Police concerning the non-submission of VPAs. This is an on-going training issue, which is reflected in the action plan described later in the Report

East Cheshire NHS Trust
The need for respectful enquiry for more covert signs of domestic abuse will be made more explicit in training and in the Domestic Abuse Policy and this will be cascaded to staff via the Safeguarding Champions

Huntington's Disease Association (SHDA)
The HDA attempted to engage with statutory services in relation to the Perpetrators mental health. It is not uncommon for seemingly appropriate services to reject referrals regarding Huntington's disease. This can be due to the patient's lack of engagement with services due to poor insight and denial of symptoms, or the fact that some services do not consider that HD fits their criteria.

Cheshire and Wirral Partnership (CWP)
CWP noted that a positive multi-agency response would begin to be initiated but, often, Pam was unable to take up and maintain the offer of support from CWP.

The importance of sharing correct demographic details for those to be discussed at MARAC has been noted in the Report. Pam was recorded as not known by CWP (when in fact she had been known to them since 2014).

Cheshire East Housing Options Service (HOS)
HOS underlined the importance of a multi-agency response to support both victims and perpetrators of domestic abuse. HOS also noted that their internal processes and procedures specifically in relation to complex clients and domestic abuse need to be reviewed to ensure an easy and consistent approach across the service.

Greater Manchester Police (GMP)
Following the incident in April 2019 in the Manchester area, the attending officers had the opportunity to take positive action and to arrest the Perpetrator. They chose instead to take Pam to another address and not to arrest the Perpetrator at the time of the incident. The author of the GMP submission considered that this may not have been the most effective course of action and that an arrest would have better supported Pam in removing her from the risk.

8. Recommendations from the Review

The Panel noted that the Independent Office for Police Conduct had completed their Review in the Summer of 2020 and that this review, along with its potential learning, had been sent to the Chief Constable of both Cheshire Constabulary and Greater Manchester Police. Both Police services noted, when submitting their single agency action plans, that they were cognisant of the duty placed upon them to apply the IOPC learning. Consequently, the recommendations described below are drafted in light of this and has avoided duplicating the learning proposed by the IOPC.

Set out below are the Recommendations made by the Panel, accompanied by the rationale for each Recommendation.

These Recommendations are NOT in any order of priority.

	Rationale	**Intended outcome**	**Recommendation for action**
1	A number of Vulnerable Person Assessments (VPAs) were issued by the Police service. These VPAs concerned Pam and the allegations of assault against the Perpetrator. It appeared to the Panel that not every agency considered by the Panel as necessary to receive VPAs received them.	The intended outcomes are: • All agencies that need to receive a VPA, should receive them; • The VPA should contain all relevant intelligence about the client referred to on the VPA; • The receiving agency knows what to do with the VPA when they receive it – this means that a system is in place to either respond directly, or escalate the VPA; record the actions taken for the client; and feedback this information to the referrer and to other agencies on the VPA.	The recommendation focuses upon training, enhancing awareness, and re-enforcing knowledge about the roles and responsibilities of the services available to support people. The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Work with the Adult Social Care, Childrens Social Care and Domestic Abuse Services to analyse the referrals they have received from the Cheshire Constabulary over a period of 24 months. Adult Social Care, Children's Social Care and the DA Services will report to the Safeguarding Adults Board (SAB) and SCEP a description of the nature of these referrals with a reflection on the application of safeguarding legislation within those referrals; • Ensure that appropriate officers within the Cheshire Constabulary (and other organisations, as necessary) are aware of the relevant Adult and Children safeguarding and mental health legislation to assist in enabling them to define an 'Adult at Risk' and so make efficient and effective referrals to other services; • Enable Cheshire Police and Adult Social Care across Cheshire to revise the current VPA form to ensure Adult Safeguarding Concerns are correctly incorporated into the

			VPA, and clear indicators of where the VPA has been sent. • Ensure that Training is provided to all Agencies following the roll out of the new revised VPA • Work with the Safeguarding Adult Board (SAB) to facilitate the provision of, for example, multi-agency training / professional briefings / guidance / fact-sheets on substance misuse, mental capacity and the Care Act. This training will also clarify the roles and responsibilities of agencies on the SCEP, their referral pathways and what constitutes an Adult Safeguarding concern under the Care Act 2014 and the expected outcomes. This training must ensure that all agencies are aware of how to report a safeguarding concern whether using the new electronic "First Account Form" or via a VPA. • Cheshire Police to inform Partner agencies about the VPA, who issues them, and their purpose. It is for the receiving agency to make appropriate decisions depending on the information contained within the VPA. • Cheshire Police Should establish clear algorithms to describe who must receive copies of a VPA and what those agencies are expected to do when they receive them.
2	A number of the agencies involved in this Review referred to the possibility of initiating "Professional Meetings" in order to discuss Pam's needs and specifically, the possibility of discussing the needs of the Perpetrator at a meeting of the legal gateway. The Panel also discussed: • the threshold for Pam (and the Perpetrator) to be considered an	The outcome is focused upon ensuring that safeguarding referrals are in line with relevant legislation and are received in a timely and efficient manner.	The Panel recommends that the Safer Cheshire East Partnership (SCEP) works with the Safeguarding Adults Board to achieve the following: • To note the work being undertaken by the Safeguarding Adults Board to develop a new "First Account Form" for people to raise a Safeguarding concern in line with the Care Act; • Support the Safeguarding Adults Board to: ○ Review the implementation of the revised referral form via the Quality and Audit Subgroup; ○ Ensure that all partners have a clear understanding of the Care Act criteria prior to completing a

	adult in need, under the conditions of the Care Act; • the development of a revised referral form to improve the flow of safeguarding alerts		Safeguarding Concern Form, i.e.: • *An adult has care and support needs, whether they are currently in receipt of community services or not;* • *Is experiencing, or is at risk of, abuse or neglect / self-neglect;* • *Is unable to protect themselves.* ○ Advise organisations that are unable to utilise the new form, by suggesting necessary changes to their own forms (e.g. VPA / NWAS Forms, etc.) to include the criteria described above. • Work with other organisations and services in order to offer training and professional development to relevant staff concerning Safeguarding Adults to ensure "Safeguarding is Everyone's Responsibility"; • Work with their partners to develop a new system or enhance an existing system in order to discuss safeguarding cases in a timely way or call / attend a Multi-Agency Professionals Meeting.
3	A number of services involved in this Review reported that they had difficulty engaging with the Perpetrator when they were attempting to meet his complex needs, including his accommodation. Additionally, of course, the Review noted that the Perpetrator did not engage with the Cheshire IDAT (nor the equivalent in Greater Manchester) and there were few attempts to directly address, with him, his serial domestic violence.	The outcome here is about further improving performance from sources of published evidence and sharing best practice about engaging with a serial perpetrator of domestic abuse. As described within the Report, the Panel noted the work published by Laura Richards. Taking account of this, it is important that the outcome focuses upon learning how to engage with serial perpetrators, knowing who the serial perpetrators are, sharing intelligence about serial perpetrators and sharing best practice on how to engage with them, hold them to account, and to prevent their abuse escalating to serious harm,	The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Examines the published models and evidence based practice regarding services for people who are homeless and have other needs concerning their mental health. For example, "better care for people with co-occurring mental health and alcohol/drug use conditions – a guide for commissioners" (Public Health England 2017); • Considers the research undertaken by Safe Lives and Gentoo examining the role of housing providers in helping victims of domestic abuse and holding perpetrators to account. • Considers the procedure adopted by the Greater Manchester Safeguarding Board and use this to

		homicide, manslaughter or unlawful killing. These outcomes also turn on the ability for agencies to share with one another information arising from risk assessments undertaken with serial perpetrators of abuse. The rationale for the sharing of this information – in an appropriate forum – is to work together to prevent a serious crime.	inform a procedure for Cheshire East[5] The Panel noted the work being undertaken on a national scale, led by NHS Digital, to develop the National Summary Care Record system. The Panel also noted that during the previous 18 months, the pilot projects described by NHS Digital have shown considerable promise regarding the sharing of patient information between Mental Health and other health services. The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Encourages practitioners who are providing a service to a patient or patients, to share information regarding any risk assessment profiles and safeguarding concerns with all other agencies involved with the same patient or patients; Taking account of the Domestic Abuse Act 2021, coupled with the research cited in this report, the Panel recommends that the Safer Cheshire East Partnership (SCEP): • Considers establishing a 'Panel' (or extending the remit of an existing forum) to share information from MARAC, ViSOR, MAPPA and other sources in order to identify and engage with serial perpetrators of domestic abuse.
3a	Adult Social Care (ASC) services reported that they would have appreciated the sharing of information concerning the Perpetrator (and his relationship with others) from the Mental Health Services.	The intended outcome is focused specifically upon enhancing the system for the sharing of information between two specific services – adult social care and adult mental health services.	The Panel learned that the Adult Social Care service has a standard operating procedure for designated staff to attend the local MARAC. The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Work with the Adult Social Care service to ensure attendance at MARAC and that cases and risks are recorded on Liquid Logic (their client case record system).

5 https://greatermanchesterscb.proceduresonline.com/chapters/p_deal_uncooperative_fam.html?zoom_highlight=persistent+non+engagement+with+early+help

			The Panel also learned that the Cheshire and Wirral Partnership (CWP) are in the process of commissioning a new case recording system. The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Work with CWP to consider offering additional access to the First Point of Contact Teams in Adult Social Care • Work with Cheshire and Wirral Partnership NHS Trust to agree a Standard Operating Procedure to ensure that a process is in place (a simple form of application) whereby, with an appropriate CWP Sponsor, Adult Social Care Teams (external to CWP) can apply for access to records strictly on the basis of safeguarding adults from harm. • Note the work of the Safeguarding Adults Board (SAB) concerning its revision of their Information Sharing Protocol and that once completed the SCEP invite the SAB to share this revision with the partners on the SCEP.
4	Pam reported to Greater Manchester Mental Health Services NHS Foundation Trust (GMMH) that she had endured 'adverse childhood experiences' (ACE) and these experiences had affected her adult life.	The outcome here concerns public service organisations generating an ambition to become "trauma informed" in their day-to-day practice and develop a knowledge base and best practice procedures concerning the impact of Adverse Childhood Experiences on adult clients and how to make professional enquiries concerning their impact	The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Ensures that training and education opportunities are made available to SCEP Partners; and • Will support a submission to the Office of the Police and Crime Commissioner (OPCC) to seek funding and support for the provision of this CPD opportunity.
5	The Review identified that a specific issue arose concerning the request made by the Cheshire MARAC to one service for information concerning Pam. The Review found that the details held on record by the MARAC differed from the details held by the service. This resulted in	The intended outcome is to ensure that when clients are discussed at MARAC (or other multi-agency forums), <u>all</u> agencies are confident that the details concerning the client under discussion are in accordance with the precise details held by all other MARAC agencies.	The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Seeks assurance that the template currently used to request and share MARAC information is effective and efficient; and • Secures this assurance when a system and a template that allows for the sufficient triangulation of client specific identifiers is achieved and approved by all partners;

	the information that was able to be shared being incomplete.	It should be a shared aspiration to work to ensure that the risk of sharing inaccurate client identifiers is driven to the lowest point possible	• Invites the MARAC to institute a procedure that all partners check and correct any discrepancies regarding client details at the beginning of every MARAC meeting
6	NICE Guidance (PH50) and Quality Standard (116) concerning domestic abuse and violence contains a number of recommendations to assist agencies to improve the service they offer to clients.	The intended outcome is that front line staff in all agencies are trained to recognise the indicators of domestic violence and abuse and to ask relevant questions to help people disclose their past or current experiences of such violence or abuse.	The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Seek assurance from all partner services, including specialist mental health services, that their policies and practice concerning domestic abuse means that they and their staff are able to properly assess clients for the presence of domestic abuse and that they are in accordance with NICE guidance PH50 and Quality Standard 116.
7	Prior to her death, Pam was assaulted by the Perpetrator on a number of occasions. The Perpetrator had a history of assaulting women. Pam, and the ex-partners of the Perpetrator, were reluctant to support his prosecution following his arrest for these assaults. They may have done this due to a sense of loyalty, a degree of sympathy for the Perpetrator's Huntington's Disease, but most likely a pronounced sense of fear.	Reluctance to support prosecutions and/or share disclosures of domestic violence with relevant authorities is a longstanding and vital issue. There are complex reasons why women do not pursue a prosecution and there may be ways to provide better support to women who do wish to prosecute. The primary outcome is to deliver the best option for the victim – and invariably that is for the abuse to stop. This outcome centres upon attempting to learn and understand what encourages or discourages women from reporting abuse and supporting a prosecution when the abuse has been reported.	In principle, this recommendation is about the process of prosecution and how this can be made more accommodating and supportive for survivors of abuse. Inevitably, this recommendation turns on the SCEP facilitating a process of research and development; and of the dissemination of best practice and evidence based delivery. The Panel recommends that the Safer Cheshire East Partnership (SCEP): • Undertakes a review of relevant cases to identify examples of successful domestic abuse prosecutions that have occurred across the Cheshire Constabulary. • Considers establishing a 'focus group(s)' or equivalent to involve survivors of abuse, their advocates, domestic abuse specialists and criminal justice representation in order to answer the question: "can prosecution help achieve the best outcome for women living with abuse?" • Utilises the intelligence gathered from the focus group(s) to make the process of prosecution more achievable for those who wish to pursue it;

			• Utilises the intelligence gathered to provide briefings, guidance and direction to all SCEP partners concerning the available legal sanctions – including the process of prosecution – when they are working with people living with or attempting to escape domestic abuse;