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Scrutiny Committee

Agenda

Date:	**Thursday, 4th September, 2025**
Time:	**10.30 am**
Venue:	**Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings will be uploaded to the Council's website

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

   To note any apologies for absence.

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary interests, other registerable interests, and non-registerable interests in any item on the agenda.

3. **Minutes of Previous Meeting** (Pages 3 - 8)

   To approve as a correct record the minutes of the previous meeting held on 26 June 2025.

4. **Public Speaking/Open Session**

   There is no facility to allow questions by members of the public at meetings of the Scrutiny Committee. However, a period of 10 minutes will be provided at the beginning of such meetings to allow members of the public to make a statement on any matter that falls within the remit of the committee, subject to individual speakers being restricted to 3 minutes.

For requests for further information
Contact: Jennifer Ashley
E-Mail: CheshireEastDemocraticServices@cheshireeast.gov.uk

5. **Suicide Prevention and Mental Health Community Support** (Pages 9 - 38)

   To consider the attached report.

6. **Domestic Homicide Review: EMMA** (Pages 39 - 64)

   To consider the attached report.

7. **Substantial Development or Variation of Service (SDV) - Stage 1 Process** (Pages 65 - 70)

   To consider the attached report.

8. **Work Programme** (Pages 71 - 74)

   To consider the Work Programme and determine any required amendments.

Membership: Councillors S Adams, L Anderson, D Brown, C Bulman (Vice-Chair), S Corcoran, N Cook, B Drake, J Pearson, H Seddon, M Sewart, M Simon, J Smith and L Wardlaw (Chair)

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Scrutiny Committee**
held on Thursday, 26th June, 2025 in the Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

Councillor L Wardlaw (Chair)
Councillor C Bulman (Vice-Chair)

Councillors S Adams, S Corcoran, N Cook, B Drake, J Pearson, H Seddon, M Sewart, M Simon and D Edwardes

OFFICERS IN ATTENDANCE

David Tesse – Probation Service
Rebecca Lane – Probation Service
Richard Burgess – Cheshire East Place, NHS
Jill Broomhall - Director of Adult Social Care Operations
Sandra Murphy – Head of Service, Adult Safeguarding
Richard Christopherson – Localities Manger, Safer Communities
Katie Small - Democratic Services Manager
Jennifer Ashley - Democratic Services Officer

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Lata Anderson.

Councillor David Edwardes attended as a substitute.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 13 March 2025 be approved as a correct record.

4 **PUBLIC SPEAKING/OPEN SESSION**

There were no registered public speakers.

5 **APPOINTMENTS TO SUB-COMMITTEES, WORKING GROUPS, PANELS, BOARDS AND JOINT COMMITTEES**

RESOLVED:

That Councillor Liz Wardlaw and Councillor Carol Bulman be appointed to the Cheshire and Merseyside Integrated Care System Joint Health Scrutiny Committee for the 2025/26 municipal year.

6 **EARLY RELEASE FROM PRISON**

The committee received a presentation from Rebecca Lane and Davie Tesse from the Probation Service which provided details of the Prison Early Release Scheme.

Members were informed of the support those released from prison were provided with, along with details of housing offers, employment opportunities and health related services, including mental health support. It was highlighted that pre-release multi agency meetings are held to ensure that an appropriate accommodation plan is in place to ensure no one released is homeless.

It was confirmed that Cheshire East Council works closely with the Probation Service to ensure the impact on services and the community is minimal however, if necessary, Multi Agency Public Protection Arrangements are implemented.

RESOLVED:

Members that representatives for their attendance and noted the presentation.

7 **CHESHIRE AND MERSEYSIDE NHS PROPOSALS FOR HARMONISED FERTILITY TREATMENT POLICY**

The committee received a report from the NHS Cheshire and Merseyside Integrated Care Board (ICB) that informed the Committee that at the ICB meeting on 29 May 2025, the ICB approved the recommendation that the ICB commences a period of public consultation regarding the proposal to harmonise the existing 10 Fertility Policies in place across the nine Local Authority Place areas in Cheshire and Merseyside into a single policy for Cheshire.

The ICB had a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believed the proposals constituted a substantial change to NHS services, known as a Substantial Development of Variation of Services (SDV).

The committee were informed that proposals included changes to:

- the number of NHS funded IVF cycles available to patients, with proposals resulting in no change for people registered with a GP Practice in Cheshire East
- changes to eligibility with regards Body Mass Index and Smoking, with proposals resulting in no change for people registered with a GP Practice in Cheshire East
- changes to definition of childlessness, which would result in a change for patients registered with a GP Practice in Cheshire East
- changes to Intra Uterine Insemination commissioning, which would not be a change to patients registered with a GP Practice in Cheshire East
- wording on the lower and upper ages for fertility treatment, which would result in a change to Cheshire East, however, would bring policy in line with National Institute for Health and Care Excellence guidance.

Following discussions, Councillor Seddon proposed that the proposals did constitute a Substantial Development of Variation of Service. Councillor Pearson seconded the motion. The committee voted 4 for the proposal, 6 against. Therefore the motion was lost.

RESOLVED:

That the Committee AGREED that the proposals did not represent a substantial development or variation to services in relation to Cheshire East and would therefore not be part of further discussions on the matter with the Joint Health Scrutiny Committee.

In addition, the Committee AGREED that an item be added to the work programme for September relating to the process of presenting any future SDV proposals to the Scrutiny Committee.

8 **REVIEW OF PREVENT AND CHANNEL GUIDANCE - STATUTORY DUTIES**

The committee received a report on the changing landscape and statutory responsibilities in relation to PREVENT.

The committee were updated that Local Authorities, alongside partner agencies listed in the Counter Terrorism and Security Act 2015, have a statutory responsibility to comply with the Prevent Duties. The Local Authority is also responsible for delivering the multi-agency Channel Panel Programme.

As a result of missed opportunities prior to recent events, such as the Southport killings in 2024 and the death of David Ames MP in 2021, significant changes had been made to the Channel Panel and PREVENT, and local strategies and policies had been updated to reflect national changes.

It was noted that Cheshire East Council was subject to an annual assessment by the Home Office on their PREVENT duties, and Cheshire East had exceeded or met every assessment level.

Cheshire East Council was to submit a funding bid to Home Office to allow for the provision of training in schools and colleges to make students more aware of the risks of accessing extreme content online, and would extend this training to older individuals with learning difficulties in higher educational establishments.

RESOLVED:

That the content of the report and presentation be noted.

9 **DOMESTIC HOMICIDE REVIEW**

The committee received a Domestic Homicide Review report that had been commissioned by the Safer Cheshire East Partnership in 2021 following the murder and suicide of Mr and Mrs S.

Members were informed that the purpose of the report was to establish what lessons could be learnt from the way in which local professionals and organisations works individually and together to safeguard victims.

Although the Domestic Homicide Review did include areas of good practice and projects that were initiated during and post COVID, the review also made several multi agency recommendations which included:

- Carers identification and recording by all agencies
- Completion of Carers Assessments
- Dementia Awareness Training
- Legal literacy – particularly using the Mental Capacity Act
- Suicide Awareness – including its impact
- Assertive interventions by Professionals, rather than leaving people alone
- Recognition of Domestic Abuse in the context of Dementia or other longer term conditions vs Carer Stress

RESOLVED:

(1) That the content of the report be noted;
(2) That a letter be sent on behalf of the committee to the Home Office to raise concerns of the length of time it is taking for Home Office Quality Assurance processes to be concluded.

10 **WORK PROGRAMME**

The committee considered the work programme.

RESOLVED:

That the work programme be noted and the following items be added:

- Safer Cheshire East Partnership Action Plan / Annual Report
- Leighton Hospital Expansion Programme – update relating to implementation of new systems at A & E

In addition, it was agreed that Officers would seek further information relating to the commissioning of services detailed in the Commercial Determinants of Health paper that was recently presented to the Health and Wellbeing Board to determine if it appropriate for the Scrutiny Committee to consider.

The meeting commenced at 10.30 am and concluded at 1.00 pm

Councillor L Wardlaw (Chair)

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OPEN

BRIEFING REPORT

Scrutiny Committee

Thursday, 4 September 2025

Suicide Prevention and Mental Health Community Support

Report of: Director of Public Health

Report Reference No: 1698SC/19/24-25

Purpose of Report

1 The Scrutiny Committee has asked for information in relation to suicide prevention - *what services are available across Cheshire East, including wider support for families impacted by those with mental health issues, how services are accessed, and are support services working?*

This report and the appendix set out a response to this question.

Executive Summary

2 There are two Boards that have oversight of this thematic area, the Self Harm and Suicide Prevention Board and the Mental Health Partnership Board. Both Boards report up to the Health and Wellbeing Board and prioritise work in accordance with the priorities set out in the Joint Local Health and Wellbeing Strategy Health and Wellbeing Board

3 Officers who are involved in both of these Boards have led and contributed to this update to the Scrutiny Committee. Appendix One is a summary of the key support services available to the community. These services are delivered or commissioned in response to identified need. The Joint Strategic Needs Assessment is a key element in the evidence base that informs priorities and thus required services. There are a number that relate to mental health Mental wellbeing

Recommendation

That the Scrutiny Committee review and scrutinise the information provided in relation to self-harm, suicide prevention and mental health support services.

Background

4 The Scrutiny Committee as part of its work plan has asked for a report on 'Suicide Prevention and what services are available across Cheshire East, including wider support for families impacted by those with mental health issues, how services are accessed, and are support services working?'

5 The report and appendix set out a response focussed upon the relevant activities across four areas: Self-Harm and Suicide Prevention; Mental Health; Carers and Children and Family Services.

Briefing Information

6 The Self-Harm and Suicide Prevention action plan Cheshire East Self Harm and Suicide Prevention Action Plan 25-27 sits as part of the Cheshire East Place All Age Mental Health Plan (2024-2029), overseen by the Mental Health Partnership Board Cheshire East Place Mental Health Plan

7 Suicide Prevention is a significant concern for the Cheshire East Health and Care system. The Self-Harm and Suicide Prevention Board has an action plan for 2025-2027, agreed at the Health and Wellbeing Board in March this year (alongside a review of the 2023-2025 action plan). The Self-Harm and Suicide Prevention Board is a multi-agency Board that brings together all those interested and involved in work to deliver the actions.

8 Appendix One sets out the priorities of the Mental Health Plan and the connectivity with the Self-Harm and Suicide prevention work. It also highlights key services and sources of information for residents. There is additional information specifically in relation to support for carers and children and families. A Mental Health Spotlight Review report focussed upon children and families went to the Children and Families Committee in November 2023 CEC Report Template

9 Whilst there are support services available and significant work is underway to raise awareness of these, there continues to be concern regarding levels of mental ill health, self-harm and suicide. Officers and partners continue to work hard to counter this, but service capacity continues to be an issue.

Implications

Monitoring Officer/Legal

10 There are no direct legal implications associated with this briefing paper.

Section 151 Officer/Finance

11 There are no financial implications, or changes required to the MTFS, as a result of the recommendations in this report. All services detailed in this report are delivered through existing service budgets.

Human Resources

12 There are no HR resources implications in relation to this briefing paper.

Risk Management

13 There are no specific risk management implications of this briefing paper.

Impact on other Committees

14 There are no impacts in relation to other Committees in relation to this briefing paper.

Policy

15 The services set out in the Appendix are primarily contributing to the 'Improving health and wellbeing' commitment. However, an individual's mental wellbeing can significantly impact upon their educational opportunities and ability to gain and retain employment, secure housing etc. so there is a link to 'Unlocking prosperity for all'.

16 As set out above there are also links to the Joint Local Health and Wellbeing Strategy.

Commitment 1: Unlocking prosperity for all **Yes**	**Commitment 2: Improving health and wellbeing** **Yes**	**Commitment 3: An effective and enabling council**

Consultation

Name of Consultee	Post held	Date sent	Date returned
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	21/07/25	Click or tap to enter a date
Janet Witkowski	Acting Monitoring Officer	21/07/25	22/07/25
Legal and Finance			
Roisin Beressi	Principal Lawyer	21/07/25	23/07/25
Nikki Wood-Hill	Finance Manager	21/07/25	22/07/25
Other Consultees: *Executive Directors/Directors*			
Helen Charlesworth-May	Executive Director	21/07/25	Click or tap to enter a date
Rod Thomson	Interim Director of Public Health	21/07/25	

Access to Information	
Contact Officer:	Guy Kilminster guy.kilminster@cheshireeast.gov.uk
Appendices:	Appendix One: Summary of support services for Carers/Family members
Background Papers:	Cheshire East Joint Local Health and Wellbeing Strategy Layout 1

	Cheshire East Place Mental Health Plan Cheshire East Place Mental Health Plan Cheshire East Self-Harm and Suicide Prevention Plan 2025-2027 Cheshire East Self Harm and Suicide Prevention Action Plan 25-27

Appendix 1

OPEN/NOT FOR PUBLICATION
By virtue of paragraph(s) X of Part 1 Schedule 1of the Local Government Act 1972.

Report for Scrutiny Committee Meeting
4th September 2025

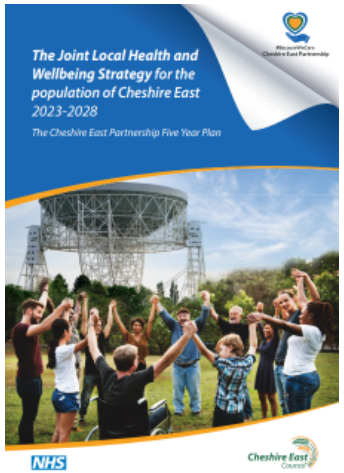
Summary of support services for Carers/Family members

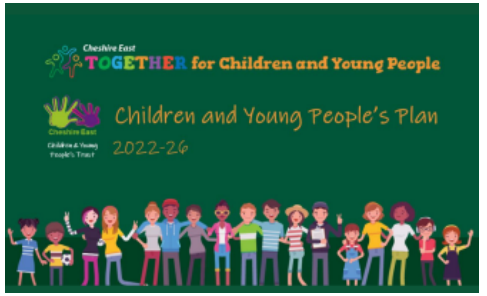
Updates from lead officers:

- ***Mental Health Partnership Board***
- ***Self Harm and Suicide Prevention Board***
- ***Cheshire East Carers Hub***
- ***Children and Families***

Contents

1. Governance, Partnership and Collaboration
2. Mental Health Partnership Board – update
3. Self Harm and Suicide Prevention Partnership Board – update
4. Cheshire East All Age Carers Hub – update
5. Children and Families – update





Governance, Partnership and Collaboration

Both the Self Harm and Suicide Prevention and Mental Health partnership work together aligning priorities to the Joint Health and Wellbeing Strategy

- Cheshire East Self Harm and Suicide Prevention Action Plan 25-27
- Cheshire East Place Mental Health Plan 2024-2029
- Children and Young People's Plan
- Cheshire and Merseyside ICB Children and Young People's Mental Health Plan

Mental Health Partnership update

Mark Hughes - Programme Lead: Complex Needs (Learning Disabilities, Mental Health and Neurodiversity

Keith Evans - : Head of Service Mental Health and Learning Disability

Cheshire East Place Mental Health Plan (2024-2029)

The plan covers how we will strengthen our efforts to help people in Cheshire East stay healthy and thrive, whilst addressing the fact that we need to do more to support people with mental health problems, including those that live with severe and enduring mental illness.

The plan is monitored by the Mental Health Partnership Board, which consists of partners from across health, social care, the voluntary sector, carers and people with lived experience.

Six key priorities that have been developed to deliver the plan vision:

[Cheshire East Place Mental Health Plan]

Priority 1- Children and Young Peoples Mental/Wellbeing

- Undertake a **joint strategic needs assessment** to help us better understand the emotional and mental wellbeing needs of children and young people and ways we can support and work with families to improve emotional and mental wellbeing. This will include areas such as the impact of social media and bullying.
- Deliver a **more enhanced Early Intervention** Children and Young People Mental Health Service to bring together colleagues from early years, education, health and the voluntary sector to support children, families and professionals
- Deliver Multi-agency Institute of Health Visiting (IHV) Perinatal and Infant Mental Health Training via Champions to **promote understanding of the concepts of perinatal and infant mental health**, the impact it can have for the developing baby, infant, parents, wider family and society and what we can do to support good family mental health and wellbeing from the Antenatal period.
- Development of **Family Hubs** - with a focus on improving maternal mental health in pregnancy and during parenthood and children and young people's mental health
- Roll out a range of **evidenced based programmes** including the My Happy Minds Programme in Cheshire East to support all Local Authority primary schools and academies to deliver an effective curriculum that teaches children and young people the skills to thrive and the skills to bounce back when challenge hits.
- Develop **the connectivity between community mental health services and early help provision** to reduce the number of children who need additional support and care in hospital.
- Give **children, young people, their parents, and carers more opportunities to have their say** and ensure they become fully embedded in the development of mental health services at place and across the Integrated Care System.

Priority 4 - Building Sustainable Communities

Reduce mental health inequalities across communities in Cheshire East

Actions – Increase mental health support for carers
Measured by - increase in the % of adult carers who report as much social contact as they would like (Fingertips Public Health data)

Progress update: Feedback from the Parent Carer Forum in Cheshire East has been that carers are experiencing a rise in mental health concerns. The forum are seeking greater collaboration and support with the Cheshire East Carers Hub to address this.

Self Harm and Suicide Prevention Partnership update

Guy Kilminster - Public Health Improvement Head of Service
Lori Hawthorn – Public Health Improvement Officer

Priority 3 – Early Intervention and Prevention

The Self Harm and Suicide Prevention Partnership action plan is part of **our all-age Mental Health Plan; priority 3**, early intervention and prevention.

Lead officers provide quarterly updates at the mental health partnership board are provided to achieve the best outcomes for Cheshire East.

Support after a Suicide - Postvention

Amparo is our immediate support service shared when there has been a death by suspected suicide.

2 wish offer support for those who have experienced a sudden death of a child or young person.

We have a lived experienced peer led support service called SoBS based in Crewe and a new group opened in 2024 in Macclesfield.

Papyrus / Samaritans

Papyrus are key members of the Self Harm and Suicide Prevention Partnership Board.

A debrief service is available, for everybody after they've had an encounter with suicide.

To debrief with one of our suicide prevention advisers, call **HOPELINE247** on 0800 068 4141, text 88247 or email pat@papyrus-uk.org. We are here for you 24 hours a day, 365 days a year.

Step by Step is a Samaritans service providing practical support to help schools prepare for and recover from a suspected or attempted suicide.

Step by Step | Samaritans

HOPELINE247
0800 068 41 41

PAPYRUS
PREVENTION OF YOUNG SUICIDE

Pilot project: Keep Safe Cope Well plans

Parents can receive support from professionals to use the plan at home with their child.

An early intervention framework used in 8 Primary schools to prevent poor mental health in teenage/ adulthood.

Key outcomes are for children to have understanding and awareness:

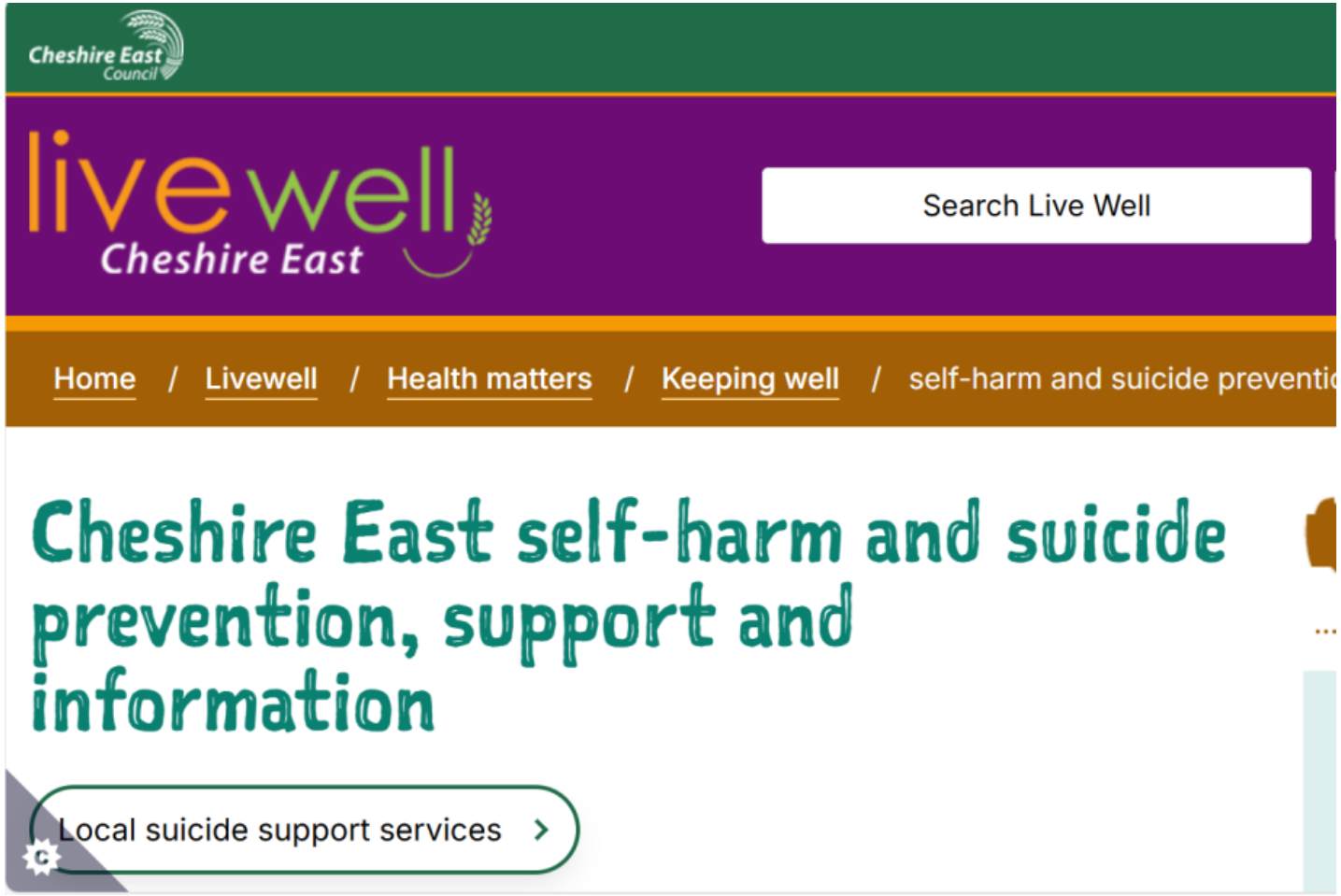
1. **Coping well**
2. **Keeping safe**

Longterm outcomes: decrease rates of mental health crisis in children presenting at A&E with self harm/suicidality.

Evaluation Autumn 2025.

Keep safe and cope well plan

Local and National support



self-harm and suicide prevention and support

Cheshire East All Age Carers Hub update

Alice Clark - Programme Lead

Cheshire East All-Age Carers Hub

Cheshire East Council commissions Making Space to run the Cheshire East All-Age Carers Hub. The service provides a single point of access for unpaid carers in Cheshire East including young carers (age 5 to 18), adults (18+), and parent carers (caring for a child with additional support needs).

Key service aims include:

- Ensuring unpaid carers of all ages have timely access to information, advice and a range of support services including an opportunity to take a break from their caring role.
- To improve the mental health and wellbeing of carers, including preventing and reducing occurrence of carer breakdown.
- Identifying unpaid carers across the borough

Professionals can refer a carer to the Carers Hub (or carers can self-refer) by completing their **online form** https://cheshireeastcarershub.co.uk/ or via **telephone on 0300 303 0208**. They are based at Cheshire East Carers Hub, Crewe Business Park, Crewe, CW1 6GL.

Cheshire East All-Age Carers Hub: The Service Offer

Undertaking statutory Carers Needs Assessments on behalf of the Council, (for adult carers only, young carer assessments are undertaken by the Council's Young Carers Service).

Information and advice

1-1 support over the phone and face to face

Group based support / peer support/ activities – including Coffee and chat groups, activity/hobby sessions, male carers group, peer support/activity groups for young carers. These take place regularly across the borough see the Carers Hub newsletter for more details

Take a Break Service -enabling carers to get a break from their caring role

Access to the Living Well Fund – funding to enable the carer to access support, activities, specific items that enable the carer to have a break from their caring responsibilities and promotes their health and wellbeing.

Developing emergency and contingency plans with carers

Access to tailored training to support people in their caring role, such as: understanding the cared for person's diagnosis; caring skills and coping strategies; managing challenging behaviour; managing stress; manual handling; lasting power of attorney.

Cheshire East All-Age Carers Hub: Outcomes for carers

Improved knowledge and understanding through having access to relevant information, signposting, statutory and universal services and social capital that can support them in their caring role.

Maintain carer health, wellbeing and independence, with a life outside of their caring role.

Young carers will have the support they need to learn, develop, thrive and enjoy positive childhoods

Increase opportunity to remain in education, training and employment.

Increased levels of confidence through feelings of being recognised for their contribution as a carer, and actively involved in decisions which affect them and the person that they care for.

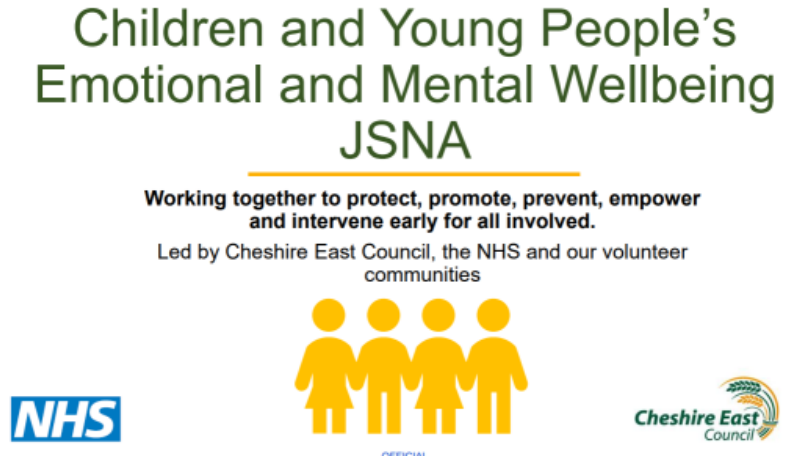
Improved physical health, enabling carers to make healthy lifestyle choices such as physical activity, falls / accident prevention, moving and handling and a healthy balanced diet

Increased levels of wellbeing through having opportunities to access services that provide a break from their caring role, reducing stress and isolation.

Children and family services update

Susie Roberts - Lead Public Health Consultant

Emotional and mental wellbeing need across Cheshir



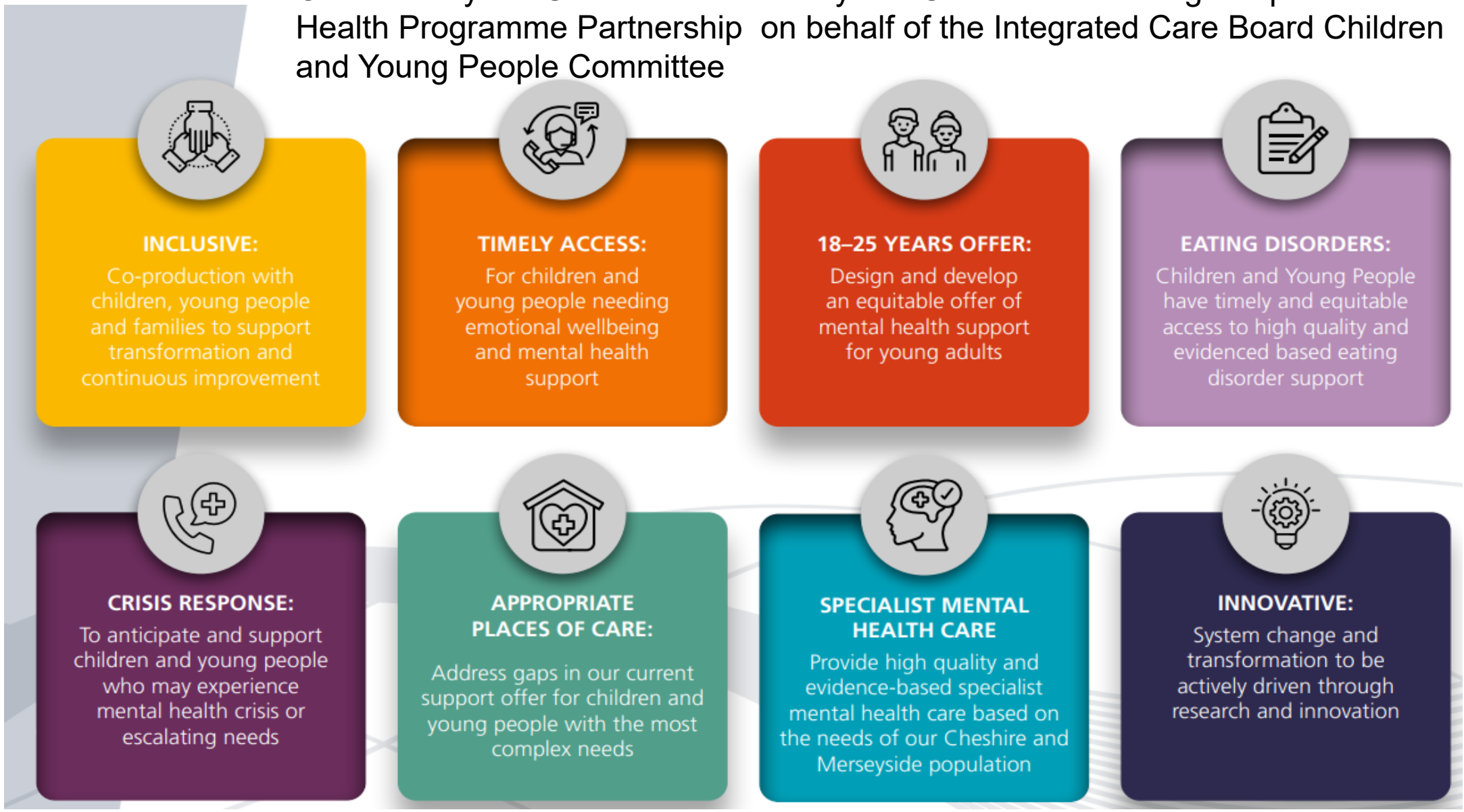
The review involved extensive collaboration, triangulation of data, consultation, engagement with children, families and profession and service mapping.

Joint strategic needs assessment review has highlighted that across Cheshire East we need to:

- Work holistically to support the physical and mental wellbeing needs of the child, their families and professionals that work with them.
- Promote protective factors and resilience robustly.
- Intervene early on risk factors for mental health problems before mental health issues arise.
- Consider root causes as part of mental health presentations.
- Integrate care so it is easy to navigate and that empowers children and their families.
- Provide care for all with greater support to areas in greatest need.
- Continue to monitor emotional and mental wellbeing and robustly evaluate interventions put in place.

Cheshire and Merseyside Children's Mental Health Plan 2024-2026

Overseen by the Cheshire and Merseyside Children and Young People's Mental Health Programme Partnership on behalf of the Integrated Care Board Children and Young People Committee

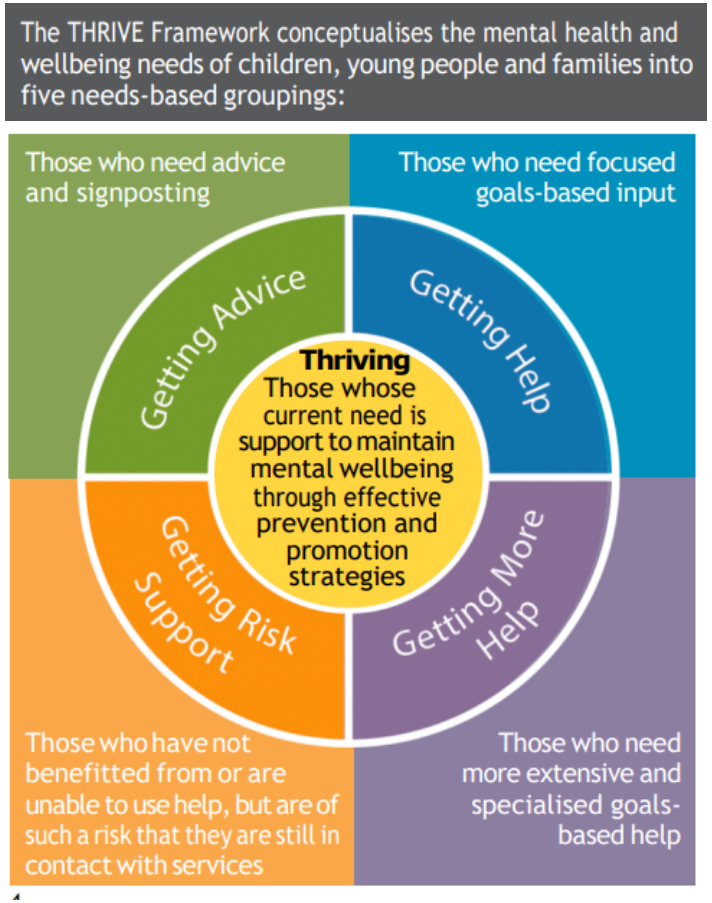


What does this look like so far in Cheshire East?

The THRIVE Framework conceptualises the mental health and wellbeing needs of children, young people and families into five needs-based groupings:

- **i-Thrive** is a system wide approach to navigate children and young people's mental health support.
- **Healthy Young Minds Service launched April 2024**
- Representatives from across Cheshire East including Integrated Care Board/ NHS trusts/Council/ VCFSE feed in to the **Healthy Young Mind's Alliance** and Senior Mental Health Lead Network and connections with the CESCP/Early Help Board/Self Harm and Suicide Prevention Board/SEND Partnership Board also. The goal of this is to increase connectivity and enhance early intervention Regular updates are provided to the **Mental Health Partnership Board.**

Key providers include supporting emotional and mental wellbeing in children and young people



- Schools and their Senior Mental Health Leads/Mental Health Support Teams where available
- Wellbeing for Education support to implementation of the Whole School Approach and the iThrive directory for schools.
- New digital offer for proactive support for children and young people who may be neurodivergent
- Family hubs, including the family hubs digital offer and Solihull Approach resources
- 0-19 service: face to face support, telephone support, text support.
- Visyon and Just Drop In
- Primary care
- Cheshire and Wirral Partnership NHS Foundation Trust for further specialist input via the Children and Young People's Mental Health Service (formerly known as CAMHS) including signposting and advice via the Wellbeing Hub
- In future- Families First Partnerships

Giving Children, young people, their parents, and carers more opportunities to have their say and ensure they become fully embedded in the development of mental health services at place and across the Integrated Care System.

- Children, young people, their parents, and carers are fully embedded in the development of services at place and across the Integrated Care System
- **Actions -**Increasing the involvement of young people on the Cheshire East Mental Health Partnership Board, Engagement and Co production to capture voice via Parent Carer Forum and Youth Groups on future service development
- **Measured by** - Engagement and Co production to capture voice via Parent Carer Forum and Youth Groups on future service development
- Parent Carer Forum continue to play a key role in the development of the MH Partnership Boar, providing the carer voice and ensuring this is included in future service development.

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Agenda Item 6

OPEN

Scrutiny Committee

Date: 04 September 2025

Domestic Homicide Review: EMMA

Report of: Helen Charlesworth May Exec Director – Adults Health and Integration

Report Reference No: SC/04/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Scrutiny

Purpose of Report

1 The purpose of this briefing report is to inform Scrutiny Committee Members, about the Domestic Homicide Review following the suicide of Emma who died in September 2021. The Review was commissioned by the Safer Cheshire East Partnership in April 2022, signed off by SCEP on 27/4/23 and approved by the Home Office on 22/5/25. The Report is now ready to be published on the Councils Safer Cheshire East Partnership (SCEP) Website.

2 The purpose of a Domestic Homicide Review is to:

3 Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.

4 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.

5 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

7 A DHR is not an inquiry into who is culpable, this is for the court or coroner to decide.

8 One of the objectives of the Councils Corporate Plan is for Cheshire East to be a place where a “Everyone feels safe and secure, difference is celebrated, and abuse and exploitation not tolerated”. Therefore, it is important to look in depth at the circumstances leading to this tragedy and the lessons learned and what has been implemented since the Review.

Executive Summary

9 The full Domestic Homicide Review Report is found in the supporting documentation. It will be published on the SCEP Website and should be read in conjunction with this Briefing Paper.

10 Emma was 30 when she died and had 3 children. Emma had been struggling with her mental health. Her father had taken his own life a few years previously. In November 2021 the Police were called to the home address by a former partner who had found Emma deceased having committed suicide.

11 Statutory Guidance produced in 2013 defines the criteria for undertaking a Domestic Homicide Review as follows:

12 Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

13 To note that the scope and definitions relating to DHRs is currently under review and will become known as Domestic Abuse Related Death Reviews. This is due to the high numbers of cases involving suicide, where a person has been subject to Domestic Abuse and has taken their own lives because of the abuse.

14 It is important to hear the voice of family members and friends who contributed to the Review and some of the comments are quoted below:

"Our *Emma was bubbly and confident and always there for everyone."*

"*Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."*

"Emma was bubbly and lucky and would talk about college, excited about her future."

15 The DHR Review panel met 5 times to consider how Agencies worked with Emma. The Review made 8 recommendations which will be highlighted later, together with the actions that have been completed since the conclusion of the Review.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

Scrutinise and note the learning and recommendations from the EMMA – Domestic Homicide Review.

Background and Context:

16 Key findings from the Home Office analysis of domestic homicide reviews: September 2021 to October 2022 Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK considered 129 completed DHR's referred to the Home Office Quality Assurance Panel, involving 132 victims.

17 In the 129 DHRs reviewed there were 132 victims: 24% had a familial relationship with the perpetrator(s), for 50% the relationship with the perpetrator was partner or ex-partner. Twenty-six per cent were victims who died by suicide.

18 The average age of familial abuse victims was 55 years, older than the average age of familial perpetrators which was 35 years. Intimate partner victims were on average younger (38 years) and younger than

preparators (43 years). The average age of victims who died by suicide was 36 years.

19 Where victims were in an intimate partner relationship or who had died by suicide, 86% and 88% respectively were female. This was different where there was a familial relationship where 53% of the victims were female.

20 Considering nationality, 69% of familial victims were British; 80% of intimate partner victims were British and where the victims died by suicide 91% were British.

21 The number of cases which have met the criteria for a DHR to be undertaken in Cheshire East has increased in recent years with the majority of cases identifying suicide resulting from domestic abuse being the factor.

22 In 2024 SCEP commissioned a Thematic Review of DHR's resulting in Suicides to understand the learning from the circumstances involved.

23 The Thematic Review highlighted a number of key themes for agencies and partners to consider in their dealing with those at risk of domestic abusive relationships.

24 To break the cycle of domestic abuse, women and girls need access to essential resources and support.

25 Collaboration between statutory agencies and local organisations is crucial to addressing emotional, legal, and financial needs. When victims have readily available information and know where to turn for help, they are empowered to seek assistance, helping society break the silence around domestic abuse and promoting awareness.

26 Establishing age-specific and comprehensive support systems is crucial to addressing the needs of domestic abuse survivors and reducing the risk of suicide.

27 Effective collaboration among domestic abuse organisations, mental health services, and statutory agencies is essential for providing adequate support to vulnerable individuals.

28 Victim-survivors of domestic abuse may experience a heightened risk of suicide when they lose custody or contact with their children.

29 The complexity of custody disputes in domestic abuse cases requires a thorough understanding of abuse dynamics and the specific risks to children

30 Increasing awareness of the interplay between mental health and domestic abuse is vital for fostering informed communities and encouraging intervention

31 A copy of the full Thematic review approved by SCEP in April 2025 and is attached to this report for further information.

32 The key themes which emerged from Emma follow those highlighted in the Thematic Review. However, each set of circumstances are unique and the impact on families and friends and professionals cannot be underestimated.

33 Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, were raised by her parents, who lived outside Cheshire

34 Emma’s childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. a family memebr believed that children's services, which were aware, should have intervened but left them in a dangerous environment.

35 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.

36 Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.

37 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children

38 Emma’s family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.

39 Ian returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive towards her.

40 The police arrested Ian for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home

41 Emma had told her friends and family about Ian's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.

42 Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021, emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.

43 Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.

44 Recommendations: The Review made several multi agency recommendations which can be seen at the end of the full Report and in the 7-minute briefing. These include the following.

45 Training for officers focused on recognising indicators of coercion and control.

46 To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators.

47 When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure.

48 To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.

49 Suicide Awareness – including its impact

50 Actions: The Safer Cheshire East Partnership seeks assurances from Partner Agencies about their responses to the learning from DHRs and oversees Action Plans. Whilst the Home Office approved the publication of this DHR in May 2025, the following actions have already been put into place.

51 The SCEP commissioned Professor Jane Monckton Smith a respected specialist in the file of Domestic Abuse to provide Training to partner professionals in November 2024 on the Suicide Timeline.

52 Engagement with victims of Domestic Abuse to ascertain details of their journey and experiences in dealing with the effectiveness of partner agency support.

53 Training has been introduced by several partner agencies to spot the signs of Domestic Abuse together with Controlling and coercive behaviour.

54 The introduction of Suicide Prevention Training available to professional staff within Cheshire East Council every 4/6 weeks.

55 The Domestic Abuse Strategy is being refreshed.

56 The Panel and Cheshire East wishes to record its condolences to the family of Emma for their loss.

Consultation and Engagement

57 No consultation is required for this report

Reasons for Recommendations

58 This Report sets out the learning and recommendations from the Domestic Homicide Review to ensure that service delivery is improved and to prevent further incidents of harm. The Safer Cheshire East Partnership will oversee the Action Plan.

Other Options Considered

59 There are no other options to consider as the Safer Cheshire East Partnership has met its Statutory Duties to undertake a Domestic Homicide Review and to share the learning.

Option	Impact	Risk
The Domestic Abuse Act places statutory duties on public bodies to identify and report Domestic Abuse in order to protect victims and pursue and prosecute offenders.	Domestic Abuse impacts 1 in 4 adults in the UK. The numbers of Suicides related to Domestic Abuse is increasing and we hold a Corporate Duty to see Safeguarding as Everyone's Business	Without conducting Domestic Homicide Reviews, the risk to victims will increase and services will fail to improve.

Implications and Comments

Monitoring Officer/Legal/Governance

60 Under Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004 a Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from Domestic Abuse. It is held with a view to identifying the lessons to be learnt from the death.

61 The Safer Cheshire East Partnership (SCEP) is responsible for commissioning DHRs under the Domestic Violence, Crime and Victims Act 2004.

62 The report ensures compliance with the statutory duties placed on SCEP.

Section 151 Officer/Finance

63 There are no financial implications or changes required to the MTFS because of the recommendations in this report. Implementation of learning from this review will be carried out by the service within existing resources.

Human Resources

64 There are no HR resource implications for this report.

Risk Management

65 There are no Risk Management Implications for this report. The learning from the DHR is being shared via the Safer Cheshire East Partneship, and forms part of the Suicide Prevention and Domestic Abuse Strategy.

Impact on other Committees

66 There are no impacts on other committees.

Policy

67

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

68 The learning from the DHR is applicable to all.

Other Implications

69 The learning from the DHR is applicable to all communities.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	18/06/25	21/08/25
Janet Witkowski	Acting Monitoring Officer	Click or tap to enter a date	Click or tap to enter a date

Legal and Finance			
Nikki Woodhill	Finance Manager	18/06/25	24/06/25
Roisin Beressi	Principal Lawyer	18/06/25	29/07/25
Other Consultees: *Executive Directors/Directors*			
Helen Charlesworth May	Executive Director Adults Health and Integration	04/08/25	27/08/25

Access to Information	
Contact Officer:	Richard Christopherson – Locality Manager Richard.christopherson@cheshireeast.gov.uk
Appendices:	Appendix 1 – Cheshire East DHR – Emma – Summary Report Appendix 2 – Learning Brief Cheshire – EMMA
Background Papers:	Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK

Domestic Homicide Review

Executive Summary for the death of Emma November 2021

Parminder Sahota: Independent Chair and Author
Completed: 27 April 2023

Preface

The Independent Chair and Review Panel send their deepest condolences to all those impacted by Emma's (pseudonym) untimely death and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand the events in each instance to fully and effectively absorb these lessons and identify the necessary changes to reduce the probability of domestic abuse-related deaths.

The chair thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

"Emma was bubbly and confident and always there for everyone."
Sarah

"*Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."*
Toby

"Emma was bubbly and lucky and would talk about college, excited about her future."
Laura

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Section One: the Review Process

1.1.1 Introduction and Agencies Participating in the Review

1.1.2 The summary outlines the procedures the Safer Cheshire East Partnership (SCEP) took to review the death of Emma, who died in November 2021; she was a thirty-year-old White British female resident of Cheshire.

1.1.3 The following pseudonyms have been used in the review, as approved by Emma's ex-partner:

- The victim: Emma
- Eldest Child: Child A, eleven years old
- Middle Child: Child B, eight years old
- Youngest Child: Child C, six years old
- Ex-Partner: Scott
- Sister: Laura
- Friend: Jean
- Friend: Toby
- Friend: Rebecca
- Paternal aunt: Kirsty
- Ex-Boyfriend: Ian

1.1.4 Emma was discovered deceased by Scott–pseudonym at her home address.

1.1.5 The coroner's office confirmed that the coroner would likely set a date for the inquest once the domestic homicide review (DHR) was complete.

1.1.6 SCEP commissioned the DHR on 20 April 2022, following the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (2016).[1]

1.1.7 The independent chair was commissioned on 1 August 2022. Safer Cheshire East Partnership approved the completed report on 27 April 2023.

1.1.8 The panel convened for the first time with the chair on 12 October 2022. The review panel received its final feedback on 12 April 2023.

1.1.9 The review exceeded the six-month deadline outlined in the statutory guidance. The reason for this was as follows:

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

- The Local Authority must implement a procurement process to appoint an independent chair and author. The commencement of the Review is delayed until this process is completed, which necessitates a certain amount of time.
- The necessity to reconcile agency demand and the number of current reviews.
- The coroner was asked to furnish the council with material that would enable them to understand Emma's history comprehensively.
- Emma's family was granted additional time to review the report and provide and receive feedback.

1.1.10 SCEP informed Scott, Emma's ex-partner and father to their three children, about the review and the process for participating in a letter dated 16 September 2022. The chair contacted Scott via telephone, and he provided details of Emma's family and friends.

1.1.11 Scott and Laura, Emma's sister, approved the terms of reference. The chair contacted Kirsty, Emma's paternal aunt and three of her friends, Jean, Toby and Rebecca. Emma's mum was contacted via phone and letter; however, no response was received.

1.1.12 Scott and Laura were provided with a copy of the overview report and encouraged to provide feedback. The report was appropriately modified in response to their feedback.

1.1.13 The following agencies and independent panel members contributed to the review:

Name	Role	Organisation
Jill Broomhall	Director Adults Social Care	Cheshire East Council
Richard Christopherson	Locality Manager – Community Safety	Cheshire East Council
Sandra Murphy	Head of Adult Safeguarding	Cheshire East Council
Emma Storey	Domestic Abuse & Sexual Violence Development Lead Advisor	Cheshire East Council
Nicky Brown	Detective Constable Review Officer	Cheshire Constabulary
Sarah Martin	Associate Director of Safeguarding	NHS Cheshire Clinical Commissioning Group
Bev Wrighton	Operations Manager	My CWA (Cheshire Without Abuse)
Lindsay Ratapana	Designated Nurse – Adult Safeguarding	NHS Cheshire and Merseyside Integrated Care Board (ICB)
Sara Scott	Head of Safeguarding	Cheshire and Wirral Partnership NHS Foundation Trust
Veronica Clarke	PA to Jill Broomhall, Director of Adult Social Care	Cheshire East Council
Kathryn Royal (joined the panel following the 1st overview draft report)	Research Officer	Surviving Economic Abuse

1.1.14 Parminder Sahota, an independent reviewer with eleven years of experience in Safeguarding and Domestic Abuse, completed DHR Chair training from Advocacy After Fatal Domestic Abuse in 2021.

1.1.15 She had been employed as a Mental Health Nurse in the NHS for more than two decades, with a particular emphasis on crisis work and working with individuals diagnosed with personality

disorders. She was also the Director of Safeguarding and the Prevent and Domestic Abuse Lead for an NHS Trust in London.

1.1.16 Before this review, Parminder Sahota had no contact with the family members. She is independent of the Safer Cheshire East Partnership and participating agencies.

1.2.1 The Purpose and Terms of Reference

1.2.2 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in November 2021 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Emma.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Emma’s voice is heard regarding her lived experiences and the impact of the domestic abuse on her mental health. Allowing her journey to be told and identifying the lessons that may be learnt.

1.2.3 The review assessed Emma's final years (March 2019–November 2021) to identify any history of abuse, access to community support, and obstacles faced in obtaining that support. The goal was to develop strategies to reduce the risk of deaths related to domestic abuse.

1.2.4 The panel agreed on fifteen terms of reference for this case.

Section Two: Background, Agency Contact and Evidence of Domestic Abuse

2.1.1 Background

2.1.2 Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, including Laura, were raised by her parents, who lived outside Cheshire.

2.1.3 Emma's childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. Laura believed that children's services, which were aware, should have intervened but left them in a dangerous environment.

2.1.4 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.

2.1.5 Emma and Scott met in 2009 and have three children. Following their separation in 2019, Scott maintained an active role in their children's lives and remained close friends.

2.1.6 Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.

2.1.7 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children.

2.1.8 Emma's family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.

2.1.9 Two days before Emma died, her cat was fatally injured, and she informed Ian that she required solitude. However, Emma’s family reported Ian went out drinking and inundated her with abusive messages, which prompted her to block him and end the relationship.

2.1.10 Emma agreed that Ian should spend the night in her shed as he had no alternative accommodation. She left the shed key outside for him to use and explicitly stated that he could not access the house.

2.1.11 Ian returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive. Emma contacted the police to report that Ian had broken into her home.

2.1.12 The police arrested Ian for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home.

2.1.13 The children were with Scott as scheduled, and Emma met with her friend the evening before she died.

2.1.14 Ian contacted Scott on the day Emma was discovered deceased, as he conveyed concern about his inability to contact her. Scott arrived at Emma's home and found her deceased.

2.2.1 Agency Contact

2.2.2 Emma received input from the following agencies during the period under review:

1. Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry
2. GP Practice
3. Leighton Hospital, Emergency Department
4. Police
5. School

2.2.3 In March 2019, Emma reported to the police that a female individual, who was wearing an electronic monitoring tag, was at her door, threatening to harm her and damage her vehicle. Emma described the female as "obsessed" with her and reported that they had previously argued about the female's former partner. The female was arrested for a public order offence. The female had made a false claim that Scott assaulted Emma, and Emma had assaulted her children. The outcome was no further action, and Emma was satisfied with this.

2.2.4 Cheshire and Wirral Partnership Foundation Trust, Liaison Psychiatry assessed Emma in June 2019 after she visited the Emergency Department (ED) at Leighton Hospital because of a self-harm incident.

2.2.5 The risk of suicide was assessed by liaison psychiatry, which determined that the self-harm was a reaction to her dad's death the week prior. Emma cited her children from her previous relationship and her positive relationship with her boyfriend of a few months as protective factors.

2.2.6 She was referred to Change Grow Live[2] (CGL) for alcohol support, and the Mental Health Re-Enablement Team[3] at Cheshire East Council: Adult Social Care (ASC) for financial assistance. The mental health re-enablement team supports individuals with goal planning, self-esteem, social inclusion, and coping. It also includes housing, debt, social clubs, and volunteering support.

2.2.7 CGL discharged Emma due to their inability to communicate with her.

2.2.8 ASC conducted three home visits but received no response. They sent Emma a letter to encourage her engagement but did not receive a response, so they closed her to the service.

2.2.9 Psychiatry contacted the school nurse to enquire about the children's welfare, and the assessment was shared with them and Emma's GP. Emma was informed about the Well-Being Hub[4] (talking therapies) and DOVE bereavement counselling.[5] She was subsequently

[2] https://www.changegrowlive.org/drug-alcohol-service-cheshire-east/crewe
[3] https://www.cheshireeast.gov.uk/livewell/living-independently/homecare/reablement.aspx
[4] https://livewellservices.cheshireeast.gov.uk/Services/5576/The-Wellbeing-Hub-I
[5] https://thedoveservice.org.uk/

discharged from Cheshire and Wirral Partnership Foundation Trust and had no further contact with Emma.

2.2.10 No information was provided to the panel to confirm that Emma had contacted bereavement services.

2.2.11 In November 2019, North West Ambulance Service contacted the police to report that Emma had consumed alcohol and drugs and might need their assistance. She was taken to the ED by ambulance; no police intervention was required. Emma did not wait to be seen at the ED, prompting the staff to call the police. Police contacted her the next day, and she expressed her intention to visit her GP.

2.2.12 Emma told her GP she took seven aspirin due to anxiety about her dad's inquest. She received antidepressants and reported she had a supportive partner. The practice referred her to Children's Social Care (CSC) for a welfare check, and no immediate safety concerns for the children were found.

2.2.13 CSC informed the children's school of the above, and they subsequently engaged in a conversation with the children to discuss their wishes and feelings, a toolkit to encourage them to express their thoughts, feelings, and experiences. No issues were identified.

2.2.14 The school continued to support the children using the toolkit and conducted home visits during the COVID-19 pandemic.

2.2.15 Emma continued to experience symptoms of depression following her dad’s death. In October 2021, she disclosed this information to her GP and initiated a trial of antidepressants. She reported that she had increased her medication dosage to good effect, as she had found it beneficial, and her last visit to her GP was nine days before her death.

2.2.16 The school contacted Emma three days before her death about child B's lateness. She was offered free access to the breakfast club, and they discussed arranging a meeting to discuss punctuality support.

2.2.17 Emma's cat was hit by a car two days before her death. She called Scott to say Ian had not paid the vet bill, forcing her to use her Christmas savings. The children did not attend school. The school contacted Emma and informed them they had received distressing news. The family link worker called Emma and left her a message.

2.2.18 The children did not attend school the following day, and Emma advised the school that they were still processing the news. The family link worker attempted to call Emma but received no response.

2.3.1 Evidence of Domestic Abuse

2.3.2 The school completed the feelings and wishes toolkit with Child A and B in March 2020. Child A reported that Ian was *"not very nice; he ignores me*." Child A was recommended for the next steps of intervention, and the school agreed to continue monitoring the children.

2.3.3 In November 2020, Emma sought police help to remove Ian from her home, feeling vulnerable and fearful due to his controlling behaviour, where he limited her time with family and demanded her attention. Emma reported they had both been drinking; however, she was dissatisfied with the relationship and had difficulty ending it.

2.3.4 Emma declined to make a complaint about the controlling and coercive behaviour, believing their relationship would last since there was no violence. The police completed a Vulnerable Person Assessment[6] (VPA), which was recorded and recorded. Emma repeatedly said, *"You have to see it to believe it,"* but offered no details, expressing difficulty ending the relationship.

2.3.5 Ian stated Emma called the police out of spite and was experiencing mental health issues. Emma reported suicidal ideation and depression after completing the domestic abuse, stalking and 'honour'- based abuse risk assessment[7] (DASH), a standard risk was identified, with no further references to domestic abuse or controlling and coercive behaviour. Referrals were made to Cheshire CARES[8] (enhanced support for victims to cope and recover from crime) and CSC.

2.3.6 CSC notified the school of the above. They completed the toolkit, and Child C described Ian as "Angry; he is unkind to me. He keeps shouting, and when I ask for a cookie, I say, "Please," and he says no. Mummy—She cuddles me." The school shared the information with CSC.

2.3.7 In August 2021, Emma told her friend Toby that Ian was becoming controlling and obsessive after cheating on her and installing an Alexa, hallway and bedroom cameras, and a Ring doorbell. Toby discussed the cameras with Ian and noted that while Ian was a gadget enthusiast, Emma was unfamiliar with these devices.

2.3.8 Emma told Toby she had ended the relationship with Ian.

2.3.9 Emma phoned the police the day before her death after her ex-boyfriend broke into her home. The police conducted a DASH risk assessment and referred her to the domestic abuse hub.

Section Three: Key Issues

Coercion and Control

3.1.1 Victims/survivors or agencies do not always recognise coercion and control and the tactics used in this. The offence of controlling or coercive behaviour is defined under Section 76 of

[6] https://www.cheshire.police.uk/SysSiteAssets/media/downloads/cheshire/hyg/sharing-assessments-about-vulnerable-people.pdf
[7] https://safelives.org.uk/resources-for-professionals/dash-resources/
[8] https://www.cheshire-pcc.gov.uk/support-for-victims/cheshire-cares/

the Serious Crime Act 2015.[9] Consequently, the statutory guidance for coercion and control[10] must be implemented with a focus on the identification of the offence.

3.1.2 Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021,[11] thus emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid[12] emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.

3.1.3 Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.

Self-Harm and Domestic Abuse

3.1.4 Emma had one ED visit following self-harm; she was assessed by psychiatry, and the self-harm was viewed as a response to her dad's recent death. At this assessment, Emma reported a positive relationship with her partner. Emma's family and friends reported there had been additional instances of self-harm, which they believed she had sought help for.

3.1.5 Self-harm is a behaviour that some people employ to cope with internal anguish. According to research, there is a link between domestic abuse and self-harm. In addition, females who had separated from their partners were more prone to taking overdoses.[13]

3.1.6 The NICE guideline recommends that individuals who present with comparable symptoms to Emma receive routine enquiries regarding domestic abuse. The review determined that Emma had described her partner in a positive light during the presentation to ED and the subsequent psychiatric assessment. Furthermore, she had communicated the same to her GP. Therefore, the enquiry may not have felt appropriate.

Familial Suicide

3.1.7 Parental suicide has been linked to increased suicide and suicide attempts.[14] Emma's dad's death was a substantial risk factor, and according to her family and friends, she felt lost without him. Psychiatry had notified Emma of bereavement counselling, and her GP had prescribed anti-depressant medication.

[9] hhttps://www.legislation.gov.uk/ukpga/2015/9/section/76
[10] https://assets.publishing.service.gov.uk/media/642d3f9e7de82b001231364d/Controlling_or_Coercive_Behaviour_Statutory_Guidance_-_final.pdf
[11] https://www.legislation.gov.uk/ukpga/2021/17/part/6/crossheading/controlling-or-coercive-behaviour
[12] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

[13] Dalton TR, Knipe D, Feder G, et al Prevalence and correlates of domestic violence among people seeking treatment for self-harm: data from a regional self-harm register emergency Medicine Journal 2019;36:407-409.
[14] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/offsprings-risk-for-suicidal-behaviour-in-relation-to-parental-death-by-suicide-systematic-review-and-metaanalysis-and-a-model-for-familial-transmission-of-suicide/C450526CAF5F329AF48E656660DEB6A7

3.1.8 Emma informed her GP in November 2021 that she had increased her antidepressant medication and continued to be affected by her dad's death, which occurred in May 2019. The record did not contain any discussions regarding bereavement counselling or whether she had independently accessed it.

3.1.9 Cheshire and Merseyside have issued their suicide prevention strategy[15] (2022-2027), which addresses several risk factors, such as family-related difficulties. Locally conducted workshops to raise awareness of suicide, risk factors, and how to make the community safer were part of the strategy.

Section Four: Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the death of Emma in November 2021 and 'articulate life through the eyes of the victims.'[16]

4.1.2 Emma was a single parent of three children, and their father, Scott, continued to provide and care for them. Since 2019, Emma has been in a relationship with Ian.

4.1.3 Emma experienced a challenging childhood; her dad had a heroin addiction, and she and her siblings frequently accompanied him to crack houses. The siblings also observed domestic abuse that her dad inflicted on their mum.

4.1.4 Emma attended three primary and two high schools; however, she was frequently absent due to her parent's inability to take her to school. The children remained in the family home, though the children's social care was aware of her and her siblings and the home environment. Consequently, Laura and her siblings lost confidence in the organisations that were supposed to protect them, as they were left in an unsafe environment.

4.1.5 Emma was forced to leave home at fifteen or sixteen after her mum learned about her stepfather's physical abuse. Emma's mum disbelieved her and instructed her to leave.

4.1.6 Emma's friends and family all felt that her dad's passing in 2019 was a significant risk factor for her. Emma kept her dad's ashes because she wanted to be buried with them and felt lost without him. Her friends and family had encouraged her to seek support.

4.1.7 Emma's friends described her as sociable, but after her dad died and with the lockdown, she spent more time at home and was isolated. Following her dad's death, her family and friends also observed an increase in her self-harm. Emma informed her friend, Kirsty, that she had discussed self-harm with her GP. The GP, however, did not have a record of this.

4.1.8 A report exploring the impact highlighted isolation as a significant risk factor for victims of domestic abuse and the lack of face-to-face contact.[17] A study also discovered that restrictions kept victims in abusive situations and that partner and family abuse worsened. In addition, the

[15] https://champspublichealth.com/wp-content/uploads/2022/11/Suicide-Prevention-Strategy-2022-2027-compressed.pdf
[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[17] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf

lockdown permitted the perpetrators of domestic abuse, controlling, and coercive behaviour to increase or hide their abuse.[18]

4.1.9 Laura, Emma's sister, observed that Emma would seek emotional support from her dad; however, his death rendered this support obsolete. The lockdown further exacerbated Emma's isolation, which diminished her opportunities to interact with others and remained in the house with her children and Ian. School staff visited the family at their doorstep following the lockdown regulations.

4.1.10 Emma had told her friends and family about Ian's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.

Section Five: Recommendations

5.1.1 Recommendation One: Coercion and Control

Cheshire Police

1.a Cheshire police to implement training for officers focused on recognising indicators of coercion and control, as well as ensuring adherence to domestic abuse risk assessments for all victims and survivors of domestic abuse.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice, Leighton Hospital, Emergency Department, and My CWA

1.b To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators. With a particular emphasis on the mental health of the victims/survivors being targeted by perpetrators and the significance of coercion and control within the homicide and suicide timeline.

Safer Cheshire East Partnership (SCEP)

1.c SCEP to collaborate with victims/survivors of domestic abuse to create awareness campaigns/resources that highlight and address the realities of coercion and control.

5.1.2 Recommendation Two: Self-Harm and Domestic Abuse

Safer Cheshire East Partnership (SCEP)

[18] https://www.ukri.org/about-us/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/#:~:text=Key%20findings%20and%20recommendations&text=domestic%20abuse%20problem-,restrictions%20kept%20victims%20in%20abusive%20relationships%20for%20longer,partner%20and%20family%20abuse%20increased

2.a SCEP and DAFSU to develop supplementary guidance to the DASH risk assessment for risks associated with suicide.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

2. b When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure. This may include facilitating referrals for the victim/survivor or making referrals on their behalf. Additionally, it is essential to consider reporting victims/survivors to MARAC and obtaining guidance for those who do not consent to domestic abuse agency referrals.

5.1.3 **Recommendation Three: Familial Suicide**

Public Health

3.a. Continue to deliver training on the suicide strategy and raise awareness of the risks that may lead to suicide.

Cheshire Police, Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

3. b. To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.

Cheshire and Wirral Partnership Foundation Trust Liaison Psychiatry, GP Practice and Leighton Hospital Emergency Department

3. c. To provide accessible information on support services to at-risk people and identify potential barriers to accessing support.

Learning Brief – Emma

Background

Emma, aged 30 and a single mother of three, experienced a childhood marked by domestic abuse and parental substance misuse. She moved to Cheshire to be near her father, whose suicide in 2019 significantly impacted her mental health.

Emma's relationship with Ian was characterised by coercive control and emotional abuse. Days before her death, Ian broke into her home, leading to his arrest.

Key Learning Points

Missed Early Interventions: Services did not respond to Emma's childhood vulnerabilities.
Impact of Bereavement: Lack of support worsened Emma's mental health.
Coercive Control Risks: Ian's escalating abuse highlights the dangers of manipulation and dependency.
Suicide Prevention: Emma's trauma and declining mental health required proactive intervention.

This case highlights the importance of a trauma-informed, multi-agency safeguarding approach.

Learning for Practitioners

Emma's case highlights the following key lessons:

Early Intervention is Crucial – Childhood adversity, including domestic abuse, parental substance misuse, and school absences, should trigger proactive safeguarding responses to prevent long-term harm.

Recognising Coercive Control – Coercive and controlling behaviour is a high-risk factor for homicide and suicide. Practitioners must identify non-physical forms of abuse, ensuring victims are aware that coercive control is a crime.

Routine Enquiries for Domestic Abuse – Self-harm and mental health struggles are often linked to abuse and coercion. Routine screening in healthcare settings, especially after self-harm or relationship breakdowns, is essential.

Suicide Risk and Bereavement Support – Parental suicide increases vulnerability. Mental health professionals and GPs must ensure consistent follow-up, offer bereavement support, and assess ongoing risk factors.

Multi-Agency Collaboration – Effective safeguarding requires enhanced coordination among healthcare, law enforcement, and social care. Risk assessments, information sharing, and early intervention can help prevent harm.

Coercion and Control

Coercive control is a criminal offence under Section 76 of the Serious Crime Act 2015 and is recognised as domestic abuse in the Domestic Abuse Act 2021. It involves manipulation, isolation, and control, often without physical violence.

A high-risk factor in suicide and homicide, coercive control must be identified early, with agencies improving awareness, intervention, and victim support.

Self-Harm and Suicide

Self-harm is often a coping mechanism for emotional distress and is linked to domestic abuse, particularly in women who have separated from partners. NICE guidelines recommend routine domestic abuse enquiries for individuals presenting with self-harm.

Emma's self-harm was initially attributed to bereavement, and no concerns were raised due to her positive portrayal of her relationship. This highlights the need for consistent and proactive questioning in healthcare settings to identify and address hidden risks.

Familial Suicide

Parental suicide is a significant risk factor for suicide and self-harm. Emma's father's death deeply affected her, yet there was no recorded follow-up on bereavement counselling.

The Cheshire and Merseyside Suicide Prevention Strategy (2022-2027) highlights family-related risks and promotes community awareness. This case underscores the need for proactive support, regular follow-ups, and improved access to bereavement interventions.

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Agenda Item 7

OPEN

Scrutiny Committee

Thursday, 4 September 2025

Substantial Development or Variation of Service (SDV) - Stage 1 Process

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Report of: Acting Governance, Compliance and Monitoring Officer

Report Reference No: SC/10/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Decision

Purpose of Report

1 The purpose of this report is to seek the views of the committee in relation to streamlining the process for determining Substantial Developments or Variation of Service (SDV).

Executive Summary

2. NHS Cheshire and Merseyside Integrated Care Board (ICB) are currently reviewing numerous policies that may or may not impact residents of Cheshire East.

2.1 The ICB has a duty to engage with Local Authority Health and Overview Scrutiny Committees (HOSC) to seek confirmation as to whether the HOSC believes this proposal is a substantial change to NHS services.

2.2. As outlined within the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) regulations, and covered within the Cheshire and Merseyside protocol for the establishment of joint health scrutiny arrangements, where a proposal on changes to NHS services impact on more than one Local Authority area, it is for each individual authority to reach a view on whether the proposal is deemed to be a Substantial Development or Variation (SDV) for that Local Authority area, and where more than one Local Authority agrees that it does (for the same proposal) then regulations place a requirement on

those local authorities to establish a joint overview and scrutiny committee for the purposes of considering the proposal.

2.3 The Cheshire and Merseyside protocol deals with the proposed operation of such arrangements for the Local Authorities of Cheshire and Merseyside. Details of the protocol are attached at Appendix 1 - Cheshire and Merseyside Joint Health Scrutiny Arrangements Protocol.pdf.

2.4 Due to a review of a significant number of policies administered by Cheshire and Merseyside ICB, it is anticipated that a number of SDV considerations will be required by the Scrutiny Committee. To help deal with the SDV's in a timely manner, the committee are asked to consider streamlining 'Stage 1' (initial consultation phase) of the process.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

1. Delegate authority to the Statutory Scrutiny Officer, in consultation with the Chair and Vice Chair of the Scrutiny Committee, to decide whether a proposal represents a "substantial" change.

Background

3. Several proposals relating to health service developments or variations are expected in the coming months. Each proposal that could impact Cheshire East residents will require initial consideration by this Committee.

3.1 The Committee's role during the initial consultation phase is limited to determining whether the proposals constitute a "substantial" change for Cheshire East residents.

3.2 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not. The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This stage will remain unchanged.

3.4 It is acknowledged that due to the number and nature of service change proposals that are expected, there may be circumstances where the first phase, including the initial decision, may need to be expedited to allow for timely second stage and detailed consideration of the proposals by the place-based, or ad hoc joint health scrutiny committee in line with statutory health scrutiny requirements. To facilitate such cases, it is proposed that the Scrutiny Committee consider an option for streamlining its approach to the initial consideration of proposals where appropriate.

3.5 The Committee is recommended to delegate the decision on whether a proposal represents a “substantial” change to the Statutory Scrutiny Officer (or their representative), in consultation with the Chair and Vice Chair of the Scrutiny Committee.

3.6 In each case, the Statutory Scrutiny Officer, Chair, and Vice Chair may still decide convene the full committee to make this decision when deemed appropriate. When exercising delegated authority, they will report their decision back to the committee at the next available meeting, providing their reasoning for the determination of proposals as substantial, or not substantial.

3.7 This delegation will not affect the second phase of scrutiny for any proposals identified as substantial, which will continue to be examined in detail by either this Committee for proposals affecting only Cheshire East, or by a Joint Health Scrutiny Committee if the proposals affect two or more areas in Cheshire and Merseyside.

Consultation and Engagement

4. No consultation is necessary for this report.

Reasons for Recommendations

5. To ensure efficient and timely consideration of SDV proposals which will support the ongoing review of NHS Cheshire and Merseyside ICB policies.

Other Options Considered

Option	Impact	Risk
Do nothing – continue with current process	Potential delay in providing response to NHS consultations	Reputational damage and increased pressure on partner working arrangements

Implications and Comments

Monitoring Officer/Legal/Governance

6. The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) regulations place a requirement on relevant individual scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area. The proposed change to the process will delegate authority to the Statutory Officer, in consultation with the Chair and Vice Chair of the Scrutiny Committee, to make initial decisions on whether the proposal is substantial or not in order to expedite the process considering an expected influx of policy changes. Decisions will still be reached using the same criteria and will be reported back to Committee together with the reasoning behind those decisions, which provides assurance. This does represent a shift in decision making but with Member involvement remaining and is a means by which to ensure that decision are made in a timely and effective manner given NHS consultation deadlines and that scrutiny committee time is focused on substantial proposals which require individual or joint scrutiny committee attention.

Section 151 Officer/Finance

7. Streamlining the process for determining Substantial Developments or Variation of Service (SDV) will have no impact on the council budget or the MTFS however, it will avoid potential additional costs arising from any additional meetings needing to be arranged to enable a representative from the NHS to attend.

Human Resources

8. There are no implications to Human Resources.

Risk Management

9. There are no implications to Risk Management.

Impact on other Committees

10. There will be no impact to any other Committees.

Policy

11.

Commitment 2: Improving health and wellbeing	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

12. There are no Equality, Diversity or Inclusions implications of this report.

Other Implications

13. There are no implications relating to Rural Communities, Children and Young People, Public Health or Climate Change.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	20/08/25	27/08/25
Janet Witkowski	Acting Monitoring Officer	20/08/25	20/08/25
Legal and Finance			
Julie Gregory Nick Finnan	Head of Legal Services Principal Accountant	06/08/25	11/08/25

Other Consultees: *Directors*			
Name	Job title	Click or tap to enter a date	Click or tap to enter a date

Access to Information	
Contact Officer:	Jennifer Ashley, Katie Small jennifer.ashley@cheshireeast.gov.uk, katie.small@cheshireeast.gov.uk
Appendices:	Appendix 1 - Cheshire and Merseyside Joint Health Scrutiny Arrangements Protocol.pdf
Background Papers:	Section 244 - National Health Service Act 2006 Scrutiny Committee - December 2024 - Proposed SDV Gluten Free Prescribing Scrutiny Committee - June 2025 - Proposed SDV Fertility Treatments

Scrutiny Committee Work Programme 2025/2026

Report Reference	Scrutiny Committee	Title	Purpose of Report	Lead Officer	Consultation	Equality Impact Assessment	Cheshire East Plan Commitment	Part of Budget & Policy Framework	Exempt Item
SC/04/2025-26	04/09/25	Domestic Homicide Report - EMMA	The purpose of the Report is to share the Learning from the Domestic Homicide Review relating to EMMA.	BROOMHALL, Jill	N/A	No	Improving health and wellbeing	No	No
AH/42/2025-26 & SC/07/2025-26	04/09/25	Safeguarding Adults Review - BELLA	The purpose of the Report is to scrutinise relevant learning from a Safeguarding Adults Review involving a young woman with Autism who was hit by a train	BROOMHALL, Jill	No	No	Improving health and wellbeing; Unlocking prosperity for all	No	No
SC/19/24-25	04/09/25	Suicide Prevention and Mental Health Community Support	At the request of Scrutiny Committee, to provide information about the services and interventions available to support people's mental	KILMINSTER, Guy	N/A	No	Improving health and wellbeing	No	No

			health and prevent self-harm and suicide in the community.						
SC/10/25-26	04/09/25	Substantial Development or Variation of Service (SDV) - Stage 1 Process	To consider proposals for Stage 1 of a potential SDV, to be considered by the Statutory Scrutiny Officer, Chair and Vice Chair, outside of a formal scrutiny committee meeting.	SMALL, Katie	No	No	Effective and enabling council	No	No
SC/10/24-25	11/12/25	Primary Care / Community Services	To receive an update on the Primary Care Estates Programme from East Cheshire NHS Trust and potential changes to community services across the borough		No	No	Improving Health and Wellbeing	No	No
SC/16/24-25	11/12/25	Cheshire & Merseyside Health Partnership	Following the setting of a number of objectives, how is the partnership meeting the 2		N/A	No	Improving Health and Wellbeing	No	No

			objectives of 'improving population health and health care', and 'tackling health inequalities', – have they been achieved, and what is being done to achieve them?						
SC/17/24-25	11/12/25	Domestic Abuse Related Deaths and Inquests at Coroners Courts	The committee to scrutinise why it can take a significant amount of time for an inquest to be undertaken.	BROOMHALL, Jill	N/A	No	Improving Health and Wellbeing	No	No
SC/06/25-26	11/12/25	Safer Cheshire East Partnership Action Plan / Annual Report	To scrutinise the SCEP Action Plan and Annual Report	CHRISTOPHERSON, Richard	N/A	No	Unlocking prosperity for all	No	No
SC/14/24-25	To be agreed	Right Care, Right Person	Following its implementation, review a year on, the impact it has had on residents and policing across the Cheshire East area.	BROOMHALL, Jill	N/A	No	Improving Health and Wellbeing	No	No
SC/08/2025-26	To be agreed	Leighton Hospital Expansion	To receive an update on progress and		No	No	Improving health and wellbeing	No	No

		Programme - A&E update from implementation of new systems	details of new systems implemented in A&E providing online waiting times						
SC09/2025-26	To be agreed	Housing Partners	To provide details of support provided to residents by Housing Partners on Anti Social Behaviour		No	No	Improving health and wellbeing	No	TBC