ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the death of

ETHEL

OVERVIEW REPORT

Chair and Author: David Hunter

Supported by: Paul Cheeseman

Date: 14 November 2019

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1. INTRODUCTION

1.1 This report examines agencies' knowledge and response to the events leading to the homicide of Ethel[1] who lived with her husband Roger and their three children in Rochdale. The couple had been married for about 15 years.

1.2 About 11.30 pm on a day in late October 2017, Child 1 found his mother on the floor of her bedroom. He was unable to wake her and called his grandparents. They arrived and contacted North West Ambulance Service and reported Ethel had been stabbed. The attending paramedics confirmed that Ethel was dead.

1.3 The initial account from Child 1 revealed that his parents had been arguing for a couple of weeks because dad thought that mum was seeing someone else and dad wanted to see mum's mobile telephone.

1.4 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer'.[2]

1.5 'The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future'.

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[1] All the names in the report are pseudonyms agreed with the victim's family.
[2] Home Office Guidance Domestic Homicide Reviews December 2016

2. TIMESCALES

2.1 Greater Manchester Police notified Rochdale Safer Communities Partnership of the homicide on 6 November 2017.

2.2 Rochdale Safer Communities Partnership considered the referral and decided it met the criteria for a domestic homicide review. David Hunter was appointed as the independent chair and author on 20 December 2017.

2.3 The first panel meeting was held on 23 January 2018 when a time table was set to deliver the review by 17 August 2018. This is outside of the six month target for completing reviews and was approved by the Chair of Rochdale Safer Communities Partnership to take account of the restrictions placed by Greater Manchester Police on seeing family, friends and employers until after the trial planned for mid-April 2018.

2.6 The domestic homicide review was presented to Rochdale Safer Communities Partnership on 22nd of January 2019 and sent to the Home Office on the 22nd of May 2019.

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3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications April 2014.

3.2 The Panel Chair notified Ethel's family of the review. The pseudonyms used in this report to protect identities were selected by the family. Professionals are referred to by an appropriate designation.

3.3 The Panel was grateful to Greater Manchester Police for the assistance it gave in engaging the family.

3.4 This table shows the age and ethnicity of the victim and offender at the time of the homicide. Also included are other people.

Name	Who	Age	Ethnicity
Ethel	Victim	39	White British
Roger	Offender	40	White British
Child 1	Child of Ethel and Roger	In education	White British
Child 2	Child of Ethel and Roger	In education	White British
Child 3	Child of Ethel and Roger	Not in education	White British
Ben	In relationship with Ethel	-	White British
Fiona	Friend of Ethel	-	-

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4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 23 January 2018. They were not shared with Ethel's family at that time because the police Family Liaison Officer felt the family was not ready for engagement. Subsequent to the engagement the family has seen and contributed to the overview report, including the terms of reference.

The purpose of a DHR is to:[3]

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

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

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

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

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

f] Highlight good practice.

Timeframe under Review

The DHR covers the period: 6 October 2014 to 29 October 2017

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Ethel and/or the children as victims of domestic abuse and what was the response?

2. What services did your agency offer the victim and/or children and were they accessible, appropriate and sympathetic their needs and were there any barriers in your agency that might have stopped Ethel from seeking help for the domestic abuse?

[3] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

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3. What knowledge or concerns did the victim's family, friends and employers have about Ethel's victimisation and did they know what to do with it?

4. What knowledge did your agency have that indicated Roger might be a perpetrator of domestic abuse and what was the response?

5. Did your agency follow its child safeguarding policy in the 48 hours following Ethel's death?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Ethel and Roger?

7. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Ethel and Roger, or on your agency's ability to work effectively with other agencies?

8. What learning has emerged for your agency?

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

10. Does the learning in this review appear in other domestic homicide reviews commissioned by Rochdale Safer Communities Partnership?

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5. METHODOLOGY

5.1 The first meeting of the domestic homicide review panel decided the period under scrutiny should begin on 6 October 2014 when Roger attended accident and emergency with a head injury which he said altered his behaviour. The end date was set at 29 October 2017 to ensure the children were safeguarded after their mother's death and father's arrest.

5.2 In September 2017 Rochdale Safer Communities Partnership asked twelve agencies what relevant information they held on the subjects of the review. Seven, including education, replied that they held no information relevant to a domestic homicide review.

5.3 Four agencies held some information and provided individual management reviews. One agency [children's services] held relevant information obtained after the homicide.

5.4 The written material was distributed to panel members and used to inform their deliberations. During the course of those deliberations additional queries were identified and supplementary information sought.

5.5 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The family's contribution is reflected in it.

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

6.1 The panel chair drafted letters to be sent to Ethel's parents [divorced] and was advised by the police family liaison officer that it would be inappropriate to give the letters to the family at this time because they were too traumatised.

6.2 The police family liaison officer alerted the panel chair when the time was right to engage with the family. This resulted in him sending a letter to Ethel's sister. The letter included the Home Office Domestic Homicide Review leaflet for Families, and the Advocacy After Fatal Domestic Abuse[4] leaflet and terms of reference.

6.3 The review chair/author met with Ethel's sister, her father and a nephew and explained the review process. The family provided good information and helpfully made an introduction to Ben[5] who was also spoken to and also provided useful information.

6.4 The family saw the overview report before it was finalised and the final version included their feedback.

6.5 Ethel's employers were written to and John, a senior manager, responded. Several people who worked with Ethel have also contributed to the review. Their recollections are included in the report.

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[4] www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support

[5] This is the pseudonym agreed with the male who was in a relationship with Ethel.

7. CONTRIBUTORS TO THE REVIEW.

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

Agency	IMR[6]	Chronology	Short Report
Greater Manchester Police	✓	✓	
Pennine Care NHS Foundation Trust	✓	✓	
Pennine Acute NHS Trust	✓	✓	
Heywood, Middleton and Rochdale Clinical Commissioning Group	✓	✓	
Rochdale Borough Council Children's Social Care			✓
Salford Royal NHS Foundation Trust			✓

7.2 The panel recognised that agencies held very little information on Ethel and Roger. This is fairly unusual in domestic homicide reviews. The information they held was of limited use in trying to understand what happened to Ethel.

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

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Name	Job Title	Organisation
Alex Atkinson	Head of Safenet Domestic Abuse Services	Safenet[7]
Paul Cheeseman	Support to Panel Chair	Independent
Helen Delamare	Head of Service CP and Care Proceedings	Children's Social Care Rochdale Borough Council
Janet Emsley	Cabinet Member for Neighbourhoods, Community & Culture	Rochdale Borough Council
Andrea Edmondson	Safeguarding Practitioner	North West Ambulance Service
Janice France	Senior Probation Officer	National Probation Service
Chris Highton	Principal Community Safety Officer	Rochdale Borough Council
David Hunter	Panel chair/author	Independent
Sue Fawcett	Detective Constable	GMP
Ian Jolley	Homelessness Manager	Rochdale Borough Council
Alison Kelly	Lead Designated Nurse	Heywood, Middleton & Rochdale Clinical Commissioning Group
Hazel Lord	Business Support	Rochdale Borough Council
Jeanette Meadowcroft	Named Nurse Safeguarding Adults	Pennine Acute Hospitals NHS Trust
Rebecca McGeown [until 28.06.18]	Named Nurse Safeguarding	Pennine Care NHS Foundation Trust
Louise Hamer [from 29.06.18]	Named Nurse Safeguarding	Pennine Care NHS Foundation Trust
Chantelle Thompson	Operations Manager	Victim Support
Jane Timson	Head of Safeguarding and Practice Assurance Rochdale Adult Care,	Rochdale Borough Council
Alison Troisi	Detective Sergeant Serious Case Review Unit	Greater Manchester Police
Karl Ward	Detective Inspector	Greater Manchester Police

[7] SafeNet protects victims and survivors of domestic abuse through the provision of safe refuge and support services, and promotes the prevention of further harm, through various initiatives including, working to build safe and healthy relations and promote equality. www.safenet.org.uk

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8.2 The chair of Rochdale Safer Communities Partnership was satisfied that the panel chair was independent. In turn the panel chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met four times and the circumstances of Ethel's homicide were considered in detail to ensure all possible learning could be obtained from her death. Outside of the meetings the chair's queries were answered promptly and in full.

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9. AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 set out the requirements for review chairs and authors. In this case the chair and author was the same person, a position permitted by the guidance.

9.2 The chair competed forty one years in public service, the military and a British police service, retiring from full time work in 2007. Since then he has undertaken the following types of reviews:
child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

9.3 He has undertaken previous domestic homicide reviews, safeguarding adult reviews and child serious case reviews in Rochdale. The last domestic homicide review was 2017. He has never worked for any agency providing information to the current review.

9.4 The chair was supported by Paul Cheeseman, an independent practitioner, with a similar professional background and experience.

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10. PARALLEL REVIEWS

10.1 HM Coroner for North Manchester opened and adjourned an inquest pending criminal proceedings. There will be an inquest on a date to be fixed.

10.2 Greater Manchester Police completed a criminal investigation and prepared a case for the Crown Prosecution Service and court.

10.3 The Review panel did not identify any other reviews in connection with Ethel's death.

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11. EQUALITY AND DIVERSITY

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

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

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

[1] A person [P] has a disability if—
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[8]

11.3 Neither Ethel, Roger nor the children had any known disabilities. The misuse of alcohol is statutorily excluded from the definition of disability under the Act.

11.4 The panel found evidence that Ethel and Roger accessed local services and concluded that neither of them faced any barriers.

11.5 There is no suggestion that either of them lacked capacity and professionals applied the first principle of Section 1 [2] Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.6 Roger was assaulted in 2014 and there was a suggestion he suffered a personality change consequent to the attack. He complained to his doctor of headaches and dizzy spells. A consultant neurologist excluded the assault as a cause of the symptoms. There was no change in his pattern of daily activity and he continued with his normal routine.

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

12. DISSEMINATION

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

- The victim's family
- The perpetrator's Offender Manager National Probation Service
- Rochdale Borough Council Children's Services
- Rochdale Safer Communities Partnership's membership

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13. BACKGROUND INFORMATION

13.1 Ethel met Roger about 16 years ago. The family described Roger as someone who never really integrated with the extended family despite being included in all their activities.

13.2 Roger never worked and relied on Ethel for his income. He could not fairly be described as a house husband as his practical contribution to the daily running of the household was almost nil; everything was left to Ethel. This pattern continued after the births of their three children.

13.3 The family say Roger was a binge drinker whose time was frittered away watching television and playing on a game console. When in drink he got into fights with other males.

13.4 There was one recorded incident between them. In June 2010 Ethel was driving home following a family gathering. Roger and the eldest child were in the car. Ethel was pregnant with their second child. Ethel described Roger as being very drunk and he just, 'flipped' in the back of the car. He became agitated and was verbally aggressive. Ethel felt unsafe to continue her journey so stopped her vehicle. Roger got out of the vehicle and started to climb on the car. Ethel's sister who was travelling in convoy, was concerned about Roger's behaviour and contacted the police who arrested Roger to prevent a breach of the peace. He remained in custody over night and was released without charge the following morning. While the incident was recorded on the public protection investigation database it was not classified as domestic abuse and no referrals were made to any agency.

13.5 In October 2014 Roger attended the Urgent Care Centre at Rochdale Infirmary and reported having been assaulted the previous night by a group of people who got out of a car and started hitting him whilst he was walking home from the pub. He said he had been punched, kicked and hit with a bat. He sustained: bruising to both eyes; deformity to his nose and a fractured left arm. He was referred to specialist medical services. Roger was discharged with head injury advice and pain relief. He did not report the incident to the police at the time. The family say the assault on Roger followed an argument he had in the pub.

13.6 About six weeks later Roger contacted the police to report the assault, suggesting it was unprovoked. An investigation did not identify the assailants. There is some suggestion that as a result of the injuries suffered during this assault Roger's personality changed. There is no medical evidence to say he sustained a personality changing brain injury, albeit he did tell his doctor he suffered from headaches after the assault.

13.7 Ethel worked as a deputy manager in an establishment that cared for children with behavioural problems and was very well regarded by all her manager and colleagues.

13.8 In June 2017 Ethel and a work colleague, Ben, commenced a relationship that was initially unknown to Roger. After he discovered the situation he moved out of the matrimonial home for a few days before returning and

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agreeing to make a go of the marriage. Unbeknown to Roger, although suspected by him, the relationship between Ethel and Ben continued. Some members of Ethel's family were aware of the continued relationship.

13.9 Roger became increasingly suspicious and began monitoring Ethel's movements and attempted to enlist the help of her friends to check up on her. Roger found text messages on Ethel's telephone that confirmed his suspicions and from then on he threatened Ben through text messages.

13.10 In early October 2017 Roger got a job in an abattoir through a friend who thought it would be good for him and distract him from other matters.

13.11 It appears that Ethel was resolved to end the marriage and said so to Roger. He wanted to continue with it. On the night of the homicide Roger had been out drinking. He returned home and committed the murder and fled the scene leaving his eldest child to find his mother's body.

13.12 Ethel's family believe that Roger would not accept his marriage was over and that when he returned home that fateful night Ethel told him she was leaving.

13.13 The sentencing judge is reported as saying, 'The evidence shows your attack on your wife armed with a fearsome weapon was sustained and determined. It was an attack of barbaric savagery on a defenceless woman in what should have been the safety and sanctuary of her own home…these were the actions of someone with a clear intention to kill, rather than just cause serious harm…your actions were fuelled by alcohol and your rage inspired by jealousy and anger…every case of murder ends one life but also affects the lives of many others…Ethel was a caring and good person who touched the lives of others with her kindness. Socially she was fun and full of life. Her death can properly be described as a senseless act, which has taken from those closest to her and her community as a whole a much loved person'.

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14. CHRONOLOGY and OVERVIEW

14.1 Introduction

14.1.1 The chronology and overview sections of the Home Office domestic homicide review report template have been combined into one section in this report for two reasons: to avoid duplication and to reflect the very limited contact agencies had with Ethel and Roger.

14.2 Background to Ethel and Roger

Ethel

Ethel was brought up in Greater Manchester and was 39 years of age at the time of her death. She had one sibling, a sister. Ethel went to school locally and on leaving pursued her interest in childminding and worked as a nanny. While studying for her B-tec in child care she had jobs in: a bookmaker's office; a claims management company and an estate agent.

Prior to meeting Roger in about 2001, Ethel had a few short term relationships. She entered the caring profession and gravitated to working in a residential setting with children who had behavioural problems. This was a role she really enjoyed and was excellent at. She worked long hours often doubling up on her shifts.

Ethel's family want her remembering as a loving mother and auntie, a good friend who worked hard and cared about the people she looked after; she was a beautiful person.

In a statement after Roger's conviction Ethel's father said, '…he could not stop thinking about how terrified Ethel must have been, but what really preyed on his mind was that the person who did this should have been the person protecting her'.

Roger

Roger and his family have declined to take part in the domestic homicide review and despite the best efforts of the National Probation Service's Offender Manager and Offender Supervisor in prison, he refused to discuss his background in any detail. Consequently the information about him is limited and gleaned from third party sources.

Roger was born and brought up near Rochdale and had several siblings. Prior to meeting Ethel he was known to Greater Manchester Police for minor criminal damage and assaults dating back to 1998.

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It is believed his home life was turbulent with one episode of personal tragedy. Apart from the two weeks immediately prior to Ethel's homicide it is thought that Roger was never in paid employment.

His lifestyle revolved around binge drinking, watching television and playing on game consoles. There is also evidence that he gambled; playing poker on line.

There is evidence and accounts from his friends and Ethel's family that when in drink he would often pick fights. It was one such incident that led to what is believed to be a retaliatory assault on him by four men in 2014.

The Relationship

The following narrative has been sourced from interviews with family and friends and documents in the possession of the domestic homicide review panel.

Ethel and Roger met around 2001/2002 and began living together soon afterwards. Ethel pursued her career in caring and supported Roger financially. By 2015 they had three children together and were settled in Rochdale. Ben described how Ethel told him that from the beginning of the relationship with Roger she was never really convinced it was right. She seemed to tolerate it for the sake of the children. Later in the report there are examples of Roger's controlling behaviour, such as not allowing Ethel to shave her legs.

Soon after the birth of their first child Ethel bought a house in her name with financial support from her family. She told a friend it was in her sole name as Roger did not work.

Ethel's family worked hard to include Roger in family activities and while he attended events he isolated himself at them, preferring to watch television and play on a game console. When those events took place in the couple's home he would often stay upstairs.

If Ethel had alcohol in the house she would have to hide it from Roger to prevent him binge drinking. He would disappear without notice for several days and go on what the family describe as 'benders' and abuse alcohol. There were reports of him collapsed on the street during such excursions.

A colleague of Ethel's told the police after her death that, 'in the last two years Ethel commented more about difficulties in the relationship. For example if she went for a night out there would be arguments for weeks after. She described Roger as obsessive'.

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The colleague continued, 'On one occasion when Ethel was pregnant with … she seemed particularly upset when I saw her …Ethel was a private person when it came to discussing things about her marriage. Eventually she described how Roger had pinned her against the wall by her throat…it was difficult to talk in any detail … On occasions, I saw Ethel at work with bruising on her arms, it was like someone had grabbed her hard or pinned her down. When I asked Ethel about the bruising, she would say things like, it was the kids or she had fallen. At no time did she say that Roger was responsible. Ethel would tell me that she had slept on the settee for days after falling out with Roger'.

A friend said, 'Over the years Ethel … spoke to me about her marriage. At one time, Ethel would be able to come out with our group of girlfriends and Roger would be happy to stay with the kids. But then this stopped and if Ethel wanted to come out with us Roger also wanted to go out the same night and so Ethel had to try and arrange a babysitter. This made meeting more difficult. Ethel often spoke about her marriage and she was not happy … she also said that Roger was not happy either and had previously said he was leaving'.

In June 2017 Ethel began a relationship with Ben a work colleague. They had known each other for five years. Ben describes how the liaison developed. In late September 2017 Ethel told Ben that Roger knew everything. She explained that she had got a new telephone and left it charging. Roger had put her old Sim card in it which revealed her old messages and photographs.

From then on there is evidence of Roger's increasing threats against Ben and Ethel. He was reported as saying, '… if I can't have you no one can. I will stab you … I will kill you both … if I have not got you I have nothing to lose'.

Ethel told Roger she did not want to be with him anymore. It appears Roger became desperate not to lose Ethel. She told Fiona that she was not concerned for her own safety and was more concerned that he would take his own life.

When Roger found the text messages between Ethel and Ben he moved out of the home for two days and stayed with a friend. He returned to the house and, according to Ethel, he was obsessed with her relationship with Ben.

Roger checked Ethel's telephone, her mobile telephone bills and went on "WhatsApp" to see if Ethel's telephone and Ben's telephone were online at the same time. He checked her underwear drawer on the pretence he wanted to buy her underwear for her birthday and examined her overnight work bag.

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Fiona advised Ethel to get Roger out of the house, change the locks on the doors and go to the police about the threats and to consider a restraining order.

Ben told Ethel they needed to cool things down between them for their own safety as it had gone too far, although neither wanted to end the relationship.

Roger promised Ethel he would change and stop drinking. He secured a job in an abattoir. Because Roger did not have a bank account his wages were paid directly into Ethel's bank account. Roger wanted to gain online access to her bank account but Ethel would not allow it.

Ethel told Fiona that during the last few weeks she did not want to be intimate with Roger which annoyed him. Ethel also said that Roger had never hit her. She described his different moods: grumpy; quiet; crying and upset.

Ethel said Roger became possessive and would not let her leave the house. He did not forcibly stop her, but would leave her with the children in the house or would take the car to stop her going out. On one occasion Roger insisted that Ethel take one of the children with her when she visited a friend, thereby making it difficult to see Ben.

About a week before the homicide Ethel told Fiona that she was worried about Roger. Ethel said she was scared of being permanently stuck with Roger and always being unhappy. She said Roger would never let her live happily ever after. Her eldest son heard some of the arguments between his parents.

The day before the homicide Roger took Ethel and the children shopping which unusually he paid for. Afterwards he took the family out for tea to celebrate receiving his first pay from the abattoir.

Ethel told Fiona she was planning to leave Roger and was going to tell him so in about a week's time but did not know how to finish with him. She did not want to leave Roger without ensuring he had some money. Fiona got the impression that Ethel thought Roger would never harm her as he loved her.

Ethel was more worried for Ben. Ethel confided in Fiona that she had a telephone at work that contained the threats made by Roger and that Fiona should give it to the police if anything happened.

Ben and Ethel discussed how she could safely end the relationship and both felt that Roger would realise the marriage was over and go voluntarily. Nevertheless both were frightened of Roger and decided to

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'cool' their relationship to give Roger time to come to a decision and lessen the danger they faced.]

Ethel and Fiona exchanged supportive text messages in the hours leading up to Ethel's death.

14.3 Overview

14.3.1 Greater Manchester Police was the only agency that had any knowledge of potential domestic abuse between Ethel and Roger. That was the incident in 2010 when the police were called by Ethel's sister during his bizarre behaviour on a car journey. The details appear in paragraph 13.4.

14.3.2 After Ethel's death the police identified several friends and family members whose collective accounts of the couple's relationship showed its fragility and Roger's controlling nature.

14.3.3 The following agencies submitted material to the review.

- Greater Manchester Police
- Pennine Acute NHS Trust
- Pennine Care NHS Foundation Trust
- Heywood, Middleton and Rochdale Clinical commissioning Group
- Rochdale Children's Services [for events post the homicide]
- Salford Royal NHS Foundation Trust

14.3.4 All other agencies submitted nil returns including education.

14.3.5 Roger's volatile personality as evidenced by the family and Ethel's friends preceded the assault and injuries he received in 2014. A few years later he complained of dizziness and headaches and was given reassurance by a consultant neurologist that the cause was not connected to the assault.

14.3.6 Following Ethel's death the children were supported by family and social work professionals.

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15. ANALYSIS USING THE TERMS OF REFERENCE

15.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour[9], did your agency have that could have identified Ethel and/or the children as victims of domestic abuse and what was the response?

15.1.1 Roger's bizarre actions during the 2010 car journey predates the review period and is included to provide some context and illustrate the longevity of his unusual behaviour. If that incident happened in 2018 a domestic abuse risk assessment would be completed, Roger would be signed posted to mental health services and the implication for child safeguarding discussed with children's services and health visiting.

15.1.2 The start of the review period was selected to coincide with the alleged unprovoked assault on Roger by four males in 2014 because it was suggested it may have altered his personality. The family counters that view and say the attack was retaliatory following an altercation in a public house started by Roger and that it was always in his nature to be violent when in drink.

15.1.3 The panel looked carefully for evidence of personality change post the assault. There is no doubt that Roger sustained physical injuries to his arm and face; they were well documented and treated in real time by health professionals. There was no diagnosis that suggested his assault resulted in a personality change; a consultant neurologist accounted for his dizziness with a different diagnosis. Family and friends say his post assault behaviour in terms of binge drinking and fighting was no different.

15.1.4 Within the review period no agency or professional knew or suspected there was any domestic abuse between Ethel and Roger and therefore opportunities to identify indicators were not present, Family, friends and employer's knowledge is examined under term 3.

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[9] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

15.1.5 Health visiting policy requires all health visitors to look for safe opportunities to ask routine questions of new mothers about whether there is any domestic abuse in the household. Such an opportunity arose in 2015 during a new birth visit. The baby's record is silent on whether the routine enquiry was made. The health visitor involved was seen and provided assurance that this is part of her routine practice. The panel noted that reassurance and resorted to the maxim that if it was not recorded it did not happen.

15.1.6 There is evidence that routine enquiry in health care settings is of benefit. For example:

'Women had a positive view of antenatal enquiry for domestic abuse in healthcare settings and support its continuation. Women expect to be asked and that midwives can respond appropriately. Raising the issue creates a culture in which women are made aware of the impact of abuse and understand there are avenues of support even if she decides not to leave the relationship. Women may choose not to disclose about the abuse at the initial time of asking, for fear of their own safety but asking signifies that she can disclose about at a later contact'.[10]

15.1.7 Roger was a binge drinker. The misuse of alcohol is often seen in perpetrators of domestic abuse and repeatedly features in domestic homicide reviews.

15.1.8 The Home Office Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews December 2016 evidences this. The analysis identified that of the 33 intimate partner domestic homicide reviews in 2014/15, alcohol issues were present in 10 cases in either the victim or perpetrator. Ethel did not misuse alcohol, Roger did.

15.1.9 In April 2015 Roger consulted his doctor for headaches following the 2014 assault. The note from that consultation has the term, 'admits alcohol' in it; there is no other context. However, it is consistent with his known binge drinking. That exchange between Roger and his doctor would not in itself be a positive indicator of domestic abuse. It required further probing.

15.1.10 Like the adults, the children never featured as being exposed to, or caught up in domestic abuse. However, children living in homes where domestic abuse is present are known to witness it through visual or auditory senses.

15.2 Term 2

What services did your agency offer the victim and/or children and were they accessible, appropriate and sympathetic their needs and were there any barriers in your agency that might have stopped Ethel from seeking help for the domestic abuse?

[10] https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12060

15.2.1 Because Ethel, Roger and the children were never identified as being involved in domestic abuse no agency had the need to offer the family services. All agencies reporting to this review report stated their domestic abuse services are attuned the needs of victims.

15.2.2 The panel discussed the services available locally for victims and perpetrators of domestic abuse and concluded they were well established. Rochdale has a multi-agency Domestic Abuse Working Group which identifies demand for domestic abuse services and ensures that appropriate services are commissioned.

15.2.3 Roger's doctor recorded the undefined phrase, 'admits alcohol' which had the potential to attract a service. There is no record that the doctor offered or signposted Roger to locally available alcohol services. It may be Roger did not disclose the extent of his binge drinking to his doctor. Had he, the panel would have expected to see a referral

15.2.4 Ethel and Ben spoke about going to the police over Roger's threats and behaviour towards Ethel. Ethel felt that in the absence of physical injuries she would not be taken seriously.

15.2.5 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services [HMICFRS] published the following report in November 2017.[11]

'A progress report on the police response to domestic abuse'.

Chapter 2 [page 25] deals with the police response to domestic abuse and one of the findings is:

'The attitudes and behaviour of frontline staff are continuing to improve, as a result of investment in training on domestic abuse'.

This is balanced with the following points made on pages 25/26/27.

'The initial police response to a domestic abuse incident can be the first face-to-face contact the victim has had with the police. A negative experience can result in the victim losing trust in the police and failing to report future incidents, thereby potentially placing themselves and their children at further risk.'

'The victims that we spoke to described a mixed response from the police service. Some said it was clear that officers had recently received training and understood the dynamics of domestic abuse. There were some excellent examples of extremely caring and dedicated officers, but also examples of officers who seemed apprehensive about dealing with victims of domestic abuse:

'Of particular concern to HMICFRS, was the experience of some victims who reported that officers appeared to disbelieve them or downplayed the significance of the incident'.

[11] www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/progress-report-on-the-police-response-to-domestic-abuse.pdf

Ethel had dealings with Greater Manchester Police through her role as the deputy manager of supported accommodation for young people. It is not known what impression she formed of the police from these encounters. However, she expressed to Ben that she would not be taken seriously and that was a barrier to receiving support. Greater Manchester Police's web site has the following entry.[12]

'What happens if I report domestic abuse to police?

Police officers will come to wherever the incident has taken place and will take whatever action is needed to make you safe. Officers will separate the parties involved so that you will have an opportunity to speak to them in confidence about what has happened and any previous incidents, without the offender being around to intimidate or threaten you'.

15.2.6 The panel felt a subjective reading of the above entry was likely to be positive. Ethel had Ben to support her and together they were very likely to receive a positive and serious response from the police to her circumstances.

15.3 Term 3

What knowledge or concerns did the victim's family, friends and employers have about Ethel's victimisation and did they know what to do with it?

15.3.1 It is under this term that the true extent of Roger's abusive behaviour emerged and that did not happen until after Ethel's homicide.

15.3.2 Ethel's employer did not know of the domestic abuse in her life; a number of work colleagues did and the family knew a little.

15.3.3 At the beginning of the relationship Roger was always a binge drinker and fighter. During the middle years his controlling nature emerged and intensified during the last year of Ethel's life. In brief there was a pattern of escalating abuse. Set out below are the examples of Roger's abuse including controlling and coercive behaviour. These examples include a clear pattern of economic abuse.[13]

- Abusing alcohol by binge drinking and absenting himself from the home without notice or apparent concern for the consequence of leaving Ethel to cope alone.

- Declining to work or claim benefits thereby pressurising Ethel to support him financially.

- Taking money from Ethel's purse and bank account without asking.

[12] http://www.gmp.police.uk/live/Nhoodv3.nsf/section.html?readform&s=E8102F77AD08113B802580A7003D2EA6

[13] Financial abuse is an aspect of 'coercive control' – a pattern of controlling, threatening and degrading behaviour that restricts a victims' freedom. www.womensaid.org.uk

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- Taking money from the children's savings without permission.
- Coercing Ethel to sleep on the settee after domestic arguments.
- Using household income for on line gambling.
- Not allowing Ethel a choice in naming their children.
- Insisting the children wear branded clothes despite the tight finances.
- Spending lavish amounts of money on his own clothes.
- Grabbing Ethel by the throat and pinning her against the wall.
- Not allowing Ethel to shave her legs.
- Secreting a mobile telephone with a tracking device in her car.[14]
- Assaulting two males in a public house who he wrongly assumed were attracted to Ethel.
- Requiring her to use visual social media when she telephoned Roger so he could check the surrounding of where she was calling from.
- Making Ethel take one or more of the children with her when she went out.
- Threats to stab and kill Ethel.
- Threats to harm Ben.
- Constantly questioning where she had been and cross checking this with her mileage and spending on fuel.
- Searching her overnight sleeping case.

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[14] Online platforms are increasingly used to perpetrate domestic abuse. Online domestic abuse can include behaviours such as monitoring of social media profiles or emails, abuse over social media such as Facebook or Twitter, sharing intimate photos or videos without your consent, using GPs locators or spyware. Women's Aid research on online domestic abuse found that: Nearly a third of respondents (29%) experienced the use of spyware or GPS locators on their phone or computers by a partner or ex-partner. www.womensaid.org.uk/information-support/what-is-domestic-abuse/onlinesafety/

- Unauthorised access of Ethel's mobile telephone account.

- Bombarding her with text messages and telephone calls to check on her whereabouts and activities. This is also stalking.

- Making direct and indirect threats to cause harm to her and those she cared for. On one occasion he told Ethel he would, 'skull drag her' from the pub if she went out.

15.3.4 Women's aid reported this about economic abuse. 'The Domestic Abuse Report 2019: The Economics of Abuse, we surveyed 72 survivors and found that:

- Nearly a third (31.9%) of respondents said their access to money during the relationship was controlled by the perpetrator
- A quarter of respondents said that their partner did not let them have money for essentials during the relationship
- A third of respondents had to give up their home as a result of the abuse or leaving the relationship and nine found themselves homeless as a result of leaving
- 43.1% of respondents told us they were in debt as a result of the abuse and over a quarter regularly lost sleep through worrying about debt
- 56.1% of our sample who had left a relationship with an abuser felt that the abuse had impacted their ability to work and over two fifths of all respondents felt the abuse had negatively impacted their long-term employment prospects/earnings.'

15.3.5 Ben and Ethel spoke about going to the police over Roger's threats and abusive behaviour and a friend of Ethel's urged her to report Roger to the police. Ethel told Ben that she felt the police would not take her seriously as she had no injuries.

15.3.6 Ethel told two friends that Roger had threatened to stab and kill her. Roger's threats to kill and his controlling and coercive behaviour were very likely to be criminal offences. They were certainly capable of investigation and consideration of prosecution. The fact that Ethel felt the police would not treat her complaint seriously was a barrier to her reporting domestic abuse and is a learning point for the review.

15.3.7 The Greater Manchester Police representative on the panel told its members that the Force was committed to supporting the victims of domestic violence and had good policies and procedures in place to do so. Greater Manchester Police's web site[15] provides good information on non-violent domestic abuse, including controlling and coercive behaviour in a non-judgemental, factual and supportive way.

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15 http://www.gmp.police.uk/content/section.html?readform&s=27C23C960534C42D80257961004003D3

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15.3.8 Ben told the review author that Ethel felt trapped in the relationship with Roger and was frightened to leave him in case he harmed her or himself. Her strategy was to try and remain calm and patient, making it clear, by her words and deeds, that the marriage had no future, in the anticipation and hope that Roger would recognise and accept the inevitable and leave.

15.3.9 Nevertheless, Ethel also wanted to ensure that Roger was not left destitute, thereby removing one of the potential barriers to his leaving. She was delighted when he secured a job and independent income as it meant he could move to financial autonomy.

15.3.10 Ben describes Ethel's and his dilemma thus. They saw a future together based on love, mutual respect and support and did not know how to achieve it without aggravating Roger to the point of violence or other erratic action that could threaten their safety.

15.3.11 In the months before her death, Ethel told John, a senior manager in the company she worked for, that she no longer loved Roger and was going to leave him. Her plan for this was to wait for Roger to realise the marriage was over and for him to leave the matrimonial home. This is consistent with Ben's account.

15.3.12 John knew that the danger to people leaving abusive relationships increased at the point separation. However he did not know that Ethel's relationship was abusive. On one occasion Ethel told John that Roger would never lay a finger on her and John knew she told other colleagues the same thing. Nothing Ethel said caused John any concern; he never saw her with bruising or other marks, nor did she disclose any violence to him. John understood controlling and coercive behaviour and did not hear anything from Ethel to suggest she was experiencing it.

15.3.13 Had Ethel disclosed domestic abuse to John he would have considered what that meant for safeguarding children; her own and the client group she worked with. If John judged Ethel's children were at risk he would have referred them to children's services and signposted her to local domestic abuse services. He would have also sought advice in confidence through the company's human resources department.

15.3.14 John would like to think that any employee would feel able to disclose they were experiencing domestic abuse. The opportunities come with the regular supervision sessions the company's managers have with staff. The company has a written child safeguarding policy and separate 'well-being' policies that continue to be developed. The well-being policy encompass domestic abuse but does not specifically mention it. The well-being policy allows managers to support staff in a bespoke way.

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15.3.15 John said Ethel told him that she was pleased when Roger got a job as it would be easier for him to leave. John wondered if Roger might have seen employment as means to stabilise the marriage because he was earning.

15.3.16 The panel discussed what advice they would offer family and friends in these circumstances. The key to achieving Ethel's aim of safely leaving her marriage and starting a different life, to which she was fully entitled, was to receive impartial and factual information from a domestic abuse professional. There are many pathways to receiving such advice in Rochdale, for example: Rochdale Borough Council; Safenet; Victim Support; Citizens Advice; End the Fear; Greater Manchester Police and the National Domestic Violence Helpline. Any domestic abuse professional in those organisations would have been able to provide Ethel with a safety plan and if needed refer her to an Independent Domestic Abuse Advocate.

15.4 Term 4

What knowledge did your agency have that indicated Roger might be a perpetrator of domestic abuse and what was the response?

15.4.1 While family, friends and acquaintances knew that Roger fought when drunk, it was unknown to agencies. He was known by Greater Manchester Police, Pennine Acute NHS Trust and his doctor as a victim of, what he said was, an unprovoked attack.

15.4.2 Greater Manchester Police have policies and practices in place to arrest and prosecute perpetrators of domestic abuse. The National Probation Service have accredited domestic abuse programmes for offenders under its supervision. If Roger had voluntarily sought help for his behaviour he could have accessed Rochdale Connections Trust Male Freedom Programme.[16]

15.5 Term 5

Did your agency follow its child safeguarding policy in the 48 hours following Ethel's death?

15.5.1 Following the homicide children's services acted swiftly and appropriately to protect the children who are now safely placed within the maternal family.

15.6 Term 6

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

15.6.1 The agencies contributing to this review, and other main service delivery agencies in Rochdale have diversity policies in place. Ethel and Roger did not have any protective characteristics that brought them within the ambit of Section 4 of the Equality Act 2010 s [section 11 of this report refers.]

[16] http://www.r-c-t.co.uk/male-freedom.html

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15.6.2 Neither person presented to services as someone requiring a mental capacity assessment or in need of care and support. There is no evidence that the injuries sustained by Roger following an assault altered his behaviour.

15.7 Term 7

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Ethel and Roger or on your agency's ability to work effectively with other agencies?

15.7.1 The panel looked for, and did not find any, examples or suggestions that in the agencies very limited involvement with Ethel and Roger, that capacity or resources were a problem. The omission of written evidence within health visiting records on whether Ethel was asked a direct question about domestic abuse appears to be an oversight on the part of one person.

15.7.2 The non-referral by Greater Manchester Police to other agencies of the 2010 domestic incident involving Roger is outside the scope of this review and the panel members are confident the 2018 policies and practice would see appropriate referrals made in the same circumstances.

15.8 Term 8

What learning has emerged for your agency?

15.8.1 The agencies and panel learning appears in section 18 of the report.

15.9 Term 9

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

15.9.1 The panel did not identify any examples of outstanding or innovative practice. The protection of the children immediately following their mother's death and their father's arrest was done in accordance with well-established multi-agency child safeguarding arrangements within Rochdale.

15.9.2 Pennine Acute NHS Trust's Bereavement Team provides support for families affected by death in any sudden unexpected circumstances.

15.10 Term 10

Does the learning in this review appear in other domestic homicide reviews commissioned by Rochdale Safer Communities Partnership?

15.10.1 Recommendation 1 of this domestic homicide review, *'That Rochdale Safer Communities Partnership reviews its current plan to inform the public of what they can do if they know or suspect someone is the victim of domestic abuse'* was also found in two other Rochdale reviews; one in 2014 [Female A] and the other in 2016 'Delia'.

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16. CONCLUSIONS

16.1 Ethel and Roger formed a relationship in 2001 and married some years later. They had three children together. Ethel was forging a career in specialist child care, studying for additional qualifications and working hard. She had an excellent reputation with her colleagues and employers and was a valued member of staff.

16.2 Roger came to the relationship with a reputation as a binge drinker who picked fights when under the influence of intoxicating liquor. Save for two weeks before the homicide, Roger never worked [voluntarily or in paid employment] or drew benefits. The family lived on Ethel's salary.

16.3 Ethel was pregnant with their first child before she fully understood the true nature of Roger and thereafter felt somewhat trapped in the relationship, always hoping that Roger would alter his behaviour. The years passed and Roger's behaviour became entrenched and was a fact of the relationship.

16.4 The evidence for this is found in statements and interviews with Ethel's family and friends post her death. One of Ethel's friends said Roger would go out for a pint of milk and not return for several days having been binge drinking. His interest seem to have revolved around watching television and playing on a games console with episodes of on-line gambling. His practical support with running the home was very limited. This aspect of the family life was mainly left to Ethel, who had to cope with it in addition to her full time employment. There appears to have been little mutual support, the weight fell to Ethel.

16.5 Roger looked after the children when Ethel was rostered for overnight sleeping duties in the children's home and he was quick to remind her once she came home that they were her responsibility as he had done his bit. Their home was bought in Ethel's sole name and reflected the lack of contribution Roger made to the household finances and her concern that joint ownership would tie them together and would probably entitle him to a financial stake in the property.

16.6 There are many examples of Roger's domestic abuse, including controlling and coercive, behaviour in the report; many predate the beginning of her liaison with Ben. One of the predated incidents saw Roger put his hands around Ethel's throat and pin her against a wall. Strangulation is a significant risk factor in domestic abuse.[17] It is sometimes referred to as a Red Flag indicator of possible homicide.

16.7 The panel thought that Roger showed narcissistic tendencies. He was meeting his own needs without any concern for the impact on his wife or

[17] Attempted Strangulation/Strangulation, often referred to as choking, is one of the best predictors of a future homicide in domestic violence cases. Victims of prior attempted strangulation are seven times more likely to be killed by their intimate partner. Source: Glass, N.K. Laughon, J. C. Campbell, R. B. Block, Hanson, G., & P.S. Sharps, "Strangulation is an Important Risk Factor for Attempted and Completed Femicides." Journal of Emergency Medicine (35) (2008): 329-335.

children. It seemed that Ethel, and those around her, may not have fully realised or understood the depth of Roger's control and coercion and the hold it gave him over her, nor recognised the escalation in his behaviour in the last months of her life.

16.8 Ethel and Ben had known each other for about five years as colleagues. Their attraction and care for each other developed in the year before her death. At first they kept their relationship from Roger. His suspicions grew as did his abusive behaviour towards Ethel. He intensified his intrusive behaviour towards her to such an extent that it probably amounted to a crime of controlling or coercive behaviour as set out in Section 76 of The Serious Crime Act 2015.

16.9 Ethel's close family and friends describe Roger as possessive and jealous towards her. The majority did not think that he had been violent to her. That thinking is probably linked to a popular misconception that domestic abuse is predicated on physical violence. Roger's destructiveness was in his controlling and coercive behaviour reinforced through stalking and harassment.

16.10 His multiple text messages and telephone calls to Ethel, coupled with his covert placement and use of a tracking device in her car and monitoring her mileage and fuel spend, met the threshold for a criminal investigation into stalking and harassment as defined by statute.[18] Once Roger knew that Ethel was seeing Ben he resorted to straightforward direct and indirect threats to them; sometimes through third parties.

16.11 Ethel told several people she wanted to end the relationship and did not know how to do so safely. On one level she was concerned for her safety, fearing that Roger would harm or kill her and on another her concern was centred on Roger's safety as she thought he could self-harm. The panel felt these apparent conflicting views were reasonably typical of a person who was experiencing severe domestic abuse and whose thinking was affected by it. The panel also thought that victims of domestic abuse can sometimes underestimate the actual danger they face. This is seen in other reviews.

16.12 Ben said he and Ethel discussed how best she could leave the marriage without causing distress for herself and him while at the same time ensuring that Roger was not destitute. She felt his need for money could be solved by his recently acquired paid employment. The issue of her and Ben's safety was one they never had time to solve. Roger may have seen his new found income as a positive factor for maintaining the marriage.

16.13 The plan was for Ethel and Ben's relationship to cool while simultaneously allowing Ethel to continue with her clear signals to Roger that the marriage was over in the anticipation he would come to terms with it and leave of his own accord. Ethel said this to her manager, John.

[18] Protection from Harassment Act 1977; Protection of Freedoms Act 2012

16.14 Ethel and Ben spoke about her going to the police to report Roger's threats and controlling behaviour. Ethel believed the police would not take her seriously as she did not have physical injuries.

16.15 In the few days before the homicide there is evidence in the text and verbal messages from Roger to Ethel and Ben what he was thinking, for example:

- If I can't have you no one can
- I will stab you
- I will kill you both
- If I haven't got you, I have nothing to lose

16.16 Ethel's thinking at that time included the following texts or verbal messages she sent her friends:

- The whole situation is driving me mad, and making me ill.
- A sarcastic text in a reference to Roger read, 'We will live unhappily ever after'.
- Going to tell Roger this week that the relationship was over and did not know how to finish with him.

16.17 It is not known what happened when Roger returned home from a day's drinking. He was reported to be angry. It is known he stabbed Ethel multiple times in a sustained assault.

16.18 A family member thought that Ethel told him the marriage was over and, '…he killed her purely because he knew he was losing her. If he couldn't have her, he wasn't going to let anybody else. When she put her coat on that night, no way was he going to let her walk out of the house'.

16.19 The panel was clear that Ethel was entitled to choose a life for herself that did not include living with, or being in an intimate relationship with Roger. Thousands of couples separate and divorce each year without being involved in domestic homicides. However, this case reinforces the fact that the risk to victims increases at the time of, and for a few weeks after, separation.

16.20 Ethel needed good independent advice from a domestic abuse specialist who would have helped her develop a plan to leave the marriage with minimum risk. Greater Manchester Police would have provided that or referred her to other services for support.

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17. LEARNING IDENTIFIED

17.1 Agencies

17.1.1 Pennine Care NHS Foundation Trust was the only agency to identify learning.

'Although Ethel was seen both at home and in the clinic environment it is not evident within the health records whether she was seen alone or not, or whether domestic abuse routine enquiry was utilised. Although there was no evidence in the records on meeting with the Health Visitor as part of the review she stated that routinely asking about domestic abuse is part of her everyday practice at routine contacts'.

'Recording systems have changed within Pennine Care NHS Foundation Trust in the Rochdale Borough since Ethel and … were seen at home by the health visiting service. It is now expected that routine enquiry would be undertaken at each core contact and this is now included on standard paperwork which must be signed when domestic abuse enquiry is undertaken'.

17.1.2 Pennine Care NHS Foundation Trust does not make a recommendation on this point because policies and procedures are in place and better established. Instead the panel makes one on auditing health visiting records to check compliance with 'routine enquiry'.

17.1.3 The above learning features in The Home Office Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews December 2016, which reports:

'The most common theme occurring in intimate partner homicide domestic homicide reviews was record keeping. This was highlighted as an issue in 28 out of 33 (85%) intimate partner homicide domestic homicide reviews sampled'.

17.2 Domestic Homicide Review Panel

17.2.1 Each learning point is presented in two parts: The narrative followed by the learning.

Learning Point 1
Narrative
The Home Office Key Findings report 2016 contained a section titled: Public awareness of domestic abuse and avenues of support.

'In 14 of the 33 intimate partner reviews the full extent of violence only came to light during the police investigation into the homicide, revealing that friends, family and neighbours knew about the abuse but either did not know what to do about it or were asked by the victim to not report it and complied with this. Of these 14 cases there were: 7 cases where friends knew and 7 cases where family knew'.

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These findings match Ethel's case in parts. Some of her family, friends and Ben knew she was a victim of domestic abuse. One friend told Ethel to get Roger out of the house, change the locks on the doors and go to the police about the threats and get a restraining order. The panel thought, while the advice was generally sound, it should have been executed within the bounds of a safety plan.

Learning
Family and friends will often be the only people who know that someone is a victim of domestic abuse and the current investment by Rochdale Safer Communities Partnership in raising public awareness on what family members and friends should, and should not, do needs to continue in order to support victims.

Learning Point 2
Narrative
Ben and Ethel spoke about reporting Roger's threats and behaviour to the police. Ethel felt the police would not take the matter seriously as she had no physical injuries. Paragraphs 15.2.4 to 15.2.6 look at the reasons why victims may feel that way.

Learning
Victims' perceptions of the response they may receive from the police when they do not have current physical injuries can prevent them from reporting domestic abuse and receiving help.

Learning Point 3
Narrative
Ethel wanted to separate from Roger and end the marriage. The evidence for that is overwhelming and comes from family, friends and Ben. Roger knew of Ethel's intentions and responded by threatening her and Ben. Ethel simultaneously feared for her and Ben's safety and for Roger's well-being including his financial viability post separation. Ethel recognised the dangers in ending the marriage and did not know how to do so safely. In the absence of going to the police the plan was to wait for Roger to leave of his own accord in the realisation that the marriage was over.

Learning
Victims who are in controlling and abusive relationships where resistance by the perpetrator to ending it exist, need to have a professionally constructed safety plan in place before making the final break.

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Learning Point 4
Narrative
Paragraph 15.3.3 lists Roger's coercive and controlling behaviours, including substantial evidence of economic abuse. When viewed collectively they graphically illustrate Ethel's victimisation. Many of the behaviours were known to different people [her community] around Ethel, who probably did not know they constituted domestic abuse. That lack of awareness requires addressing.

Learning
Communities who do not know what coercive and controlling behaviour is are unable to support victims.

Learning Point 5
Narrative
The private sector company Ethel worked for did not have a separate domestic abuse policy for staff. This gap in the private sector has been identified in previous domestic homicide reviews nationally. Services for victims of domestic abuse are usually catered under a generic well-being policy and staff may not have the right level of knowledge.

Learning
Private sector companies may be better placed to support their employees who are experiencing domestic abuse through bespoke policies and a good knowledge of domestic abuse.

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18. RECOMMENDATIONS

18.1 Agency Recommendations

18.1.1 There are no recommendations from agencies.

18.2 Panel Recommendations

The panel recommends:

1. That Rochdale Safer Communities Partnership reviews its current plan to inform the public of what they can do if they know or suspect someone is the victim of domestic abuse.

2. That Greater Manchester Police should determine whether their current domestic abuse policies and practices are a barrier to victims reporting domestic abuse in cases where physical injuries are absent.

3. That Rochdale Safer Communities Partnership reviews the advice available for victims on the increased danger they face when leaving abusive relationships and whether that advice is well known and readily accessible.

4. That Rochdale Safer Communities Partnership reviews its current domestic abuse strategy to determine if it focusses sufficiently on coercive and controlling behaviour, including economic abuse, how communities can be informed of what it is and what to do when they recognise it.

5. That Pennine Care NHS Foundation Trust audits health visiting records for compliance with 'Routine Enquiry.'

6. That Rochdale Safer Communities Partnership considers how best it can engage the private sector to develop bespoke policies that support employees experiencing domestic abuse.

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Appendix A Action Plan

No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1	That Rochdale Safer Communities Partnership reviews its current plan to inform the public of what they can do if they know or suspect someone is the victim of domestic abuse.	Review and updating of promotional literature/messages/campaigns. Incorporate key messages into the proposed 2019-21 Domestic Abuse Communication Strategy. Ensure information about how to access services and support is readily available including hard to reach groups Ensure future campaigns have a focus on coercive and controlling behaviour Discuss at Domestic abuse Working Group ways to promote services – including what is already being done. This group is attended by leads from local partners.	Information more widely distributed/on display/easily accessed Content of future campaigns Minutes of Domestic Abuse Working Group	Victims, friend and family have a greater knowledge of services and support available An increase in enquiries/referrals from family and friends.	Rochdale Safer Communities Partnership Early Help Communications Domestic Abuse Working Group partners	Dec 2019

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No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
		Ensure wider promotion of services to family/friend/s community is within the new Domestic Abuse Strategy	Domestic Abuse Strategy			
2	That Greater Manchester Police should determine whether their current domestic abuse policies and practices are a barrier to victims reporting domestic abuse in cases where physical injuries are absent.	Force – GMP Review of current policies, procedures and training. Consider how the reporting of non-injury DA is currently being given to members of the public.	Force – GMP Monitored via: -DA Action Plan 2018. – National Vulnerability Action Plan 2017-2019 - HMIC DA Action Delivery Plan - GMP Domestic Abuse Policy (due to be reviewed in light of the recent programme of change)	Force – GMP The aim is to ensure that victims are aware that a physical injury does not need to be present for GMP to take positive action in relation to DA incidents. GMP's current Domestic Abuse procedures and practices promote and support victims reporting domestic abuse whether or	Detective Supt Denise Worth – GMP DA Lead	

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No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
				not physical injuries are present. The introduction of Coercion and Control legislation supports victims who do not always have physical injuries and GMP's training commitment and delivery to staff are ongoing. These practices are driven and monitored via GMP Domestic Abuse Policy and Procedure, DA Action Plan, the National Vulnerability Action Plan, the HMIC DA Action Delivery Plan and also The Crown		

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No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
				Prosecution Service Guidance in relation to charging decisions for DA cases. GMP is working in partnership with other agencies to improve and encourage the reporting of all Domestic Abuse.		
No	**Recommendation DHR Panel**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
3	That Rochdale Safer Communities Partnership reviews the advice available for victims on the increased danger they face when leaving abusive relationships and whether that advice is well known and readily accessible.	Training for frontline practitioners to include a focus on the increase in risk at separation. Safeguarding Board and other in-house training departments to review their domestic abuse and safeguarding training to ensure separation and risk is included.	Training packages amended and submitted to Rochdale Safer Communities Partnership Campaigns and literature include separation and risk.	Victims, friend and family have a greater knowledge of the heighted risk at separation and how to get support for safety planning so they can leave safely.	Rochdale Safer Communities Partnership Early Help Safeguarding Board Children's Portal (Training)	Dec 2019

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No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
		Separation and risk to be discussed at local Domestic Abuse Working Group to ensure partners are clear on the advice to be given. Ensure partners know of web-pages for safety planning on Rochdale Council web-site. Review and updating of promotional literature/messages/campaigns (Recommendation1) to include reference to risk increasing on separation	Minutes from the Domestic Abuse Working Group to include the discussion and any associated actions.	An increase in enquiries to agencies regarding safety planning and how to do it. An increase in visits to our safety planning pages on Rochdale Council domestic abuse web-pages.	Schools Safeguarding Lead Communications Department Domestic Abuse Working Group partners	
4	That Rochdale Safer Communities Partnership reviews its current domestic abuse strategy to determine if it focusses sufficiently on coercive and controlling behaviour, including economic	Rochdale Safer Communities Partnership to hold stakeholder events with partners to review Domestic Abuse Strategy. Stakeholder events to include learning from our domestic homicide reviews including the recommendation to raise	Minutes from stakeholder events. Reviewed Domestic Abuse Strategy to include coercion and control and how Rochdale intend to	Professionals and community members have a greater awareness of coercive controlling behaviour, including economic abuse.	Rochdale Safer Communities Partnership Domestic Abuse working Group partners Early Help	Sept 2019

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No	Recommendation DHR Panel	Key Actions	Evidence	Key Outcome	Lead Officer	Date
	abuse, how communities can be informed of what it is and what to do when they recognise it.	awareness of coercion and control. Rochdale Safer Communities Partnership and partners to consider ways of how we can increase awareness of coercion and control amongst professionals and the community, to include training, promotional literature, social media, local campaigns and schools.	raise awareness of it and what to do. Local domestic abuse literature, campaigns, social media, to include coercive controlling behaviour and what to do about it. In-house training packages to include coercive controlling behaviour – to be submitted to Rochdale Safer Communities Partnership. Relationship and Sexual Relationship information in schools to include	An increase in local reports to police of this crime. An increase in referrals to services in relation to this behaviour	Schools Safeguarding Relationship and Sexual Relationship Steering Group	

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			coercive controlling behaviour and what to do. RSE steering group to confirm this.			
5	That Pennine Care NHS Foundation Trust audits health visiting records for compliance with 'Routine Enquiry.'					
6	That Rochdale Safer Communities Partnership considers how best it can engage the private sector to develop bespoke policies that support employees experiencing domestic abuse.	To devise a Domestic Abuse Training Plan locally that fits needs and to include the private sector within that training plan. To build on existing relationships with the private sector and discuss training needs with them. To discuss with private sector the benefits of having a	Domestic Abuse Training Plan Bespoke training is offered to private sector Domestic Abuse policy template	Private sector will have a better understanding of domestic abuse and how to respond to concerns or disclosures amongst their staff teams. Employees are supported to access	Relationship and Sexual Relationship Rochdale Development Agency Link for Life	Dec 2019

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		bespoke Domestic Abuse Policy and provide a template they could use/amend. We have an existing project called "Cut It Out" in Rochdale. This is a training package for hair and beauty salons locally to raise awareness of domestic abuse and services available. We will evaluate this and consider roll out to other sectors	distributed with support – records kept of engaged employers.	specialist support for domestic abuse		

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