OLDHAM COMMUNITY SAFETY AND COHESION PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

July 2018

Catherine

Review Panel Chair: David Hunter

Report Author: Paul Cheeseman

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1. INTRODUCTION

1.1 The principal people and places referred to in this report are:

Catherine	Victim	White British
John	Offender and Husband of Catherine	White British
Bridget	Catherine's eldest sister	
Sarah	Catherine's second eldest sister	
Roger	Cousin of John	
Address One	Home of Catherine and John at time of homicide	
Address Two	Previous home of Catherine and John prior to Dec. 2014	

1.2 The key events described in this report begin in late 2006 although there is some background information that pre-dates this.

1.3 Through the Domestic Homicide Review (DHR) information has been provided from a number of sources which supports that Catherine was in a controlling and coercive relationship with John. This Domestic Homicide Review (DHR) obtained many examples of John's control over Catherine; belittling her; saying she was disgraceful and '*no one but me would want you'*, isolating her from family, friends and the Church. The Panel was provided with information that supported that Catherine suffered physical violence when John pushed and hit her. She told friends that on several occasions, he threatened to stab and kill her. The review found the core issue was John's coercive and controlling behaviour and the abusiveness towards Catherine that came with it. His abuse of alcohol also impacted on his behaviour but was not the cause.

1.4 In early 2015 John stabbed Catherine with a knife in the home they shared. Catherine survived the injury and was treated in hospital. John was arrested and initially charged with the attempted murder of Catherine. Tragically Catherine died in hospital one month after she was admitted. The cause of her death was pneumonia, with a stab wound to the chest and other significant contributory factors. There was a direct causal link between Catherine's death and the stab wound. The indictment of John was therefore changed to murder.

1.5 John was convicted of this offence at a Crown Court in late summer 2015 and given a life sentence with a minimum tariff of fifteen years. This means he will

not be eligible for parole until he has served that period in custody. The Judge's sentencing remarks included[1];

"This was a single, short-lived attack, triggered by loss of temper, I am not satisfied there was any degree of provocation. If your wife's words of criticism amounted to provocation, and I don't think they did, they were themselves provoked by your own behaviour. I do take into account your previous good character and I do take into account your age. You are now 56 and most of your remaining years will be spent in prison. It is right that you have expressed regret and remorse - your present remorse is however tempered by your own self-pity, which emerged tellingly in the course of your evidence, as you spoke of the distress you now suffer when you wake every day. The prospect of waking every day is precisely what you denied your wife"

1.6 Sarah said on behalf of the family;

'I've lost my younger sister, my children have lost their special auntie, and my mother has buried her loving daughter, something she never thought she would have to do. She cannot make sense of what has happened, none of us can. My husband is devastated also, she was like a younger sister to him and he always tried to look after her. Catherine was attacked by the person who should have been looking after her for life. It is hard enough to lose your younger sister/daughter, but the circumstances in which we have lost her are unbearable. We will never get over this'

1.7 The review panel wishes to record their deepest sympathies to all of Catherine's family and her friends on their tragic loss.

1.8 The chair of the panel understood that the remarks of the sentencing Judge were limited to the stabbing incident and need to be considered in the context that John exercised coercion and control over Catherine for many years.

[1] Source: thelawpages.com

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 Decision Making

2.1.1 The Oldham Community Safety and Cohesion Partnership decided on 15.02.2016 that the death of Catherine met the criteria for a Domestic Homicide Review as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states the review should be completed within six months of the decision to hold a review being made. In this case that date was 15.08.2016. The overview report was presented to the Community Safety and Cohesion Partnership on the 26th April 2017.

2.1.3 The DHR exceeded the 6-month time line. Initially this was due to the Local Greater Manchester DHR policy conflicting with National Guidance. The Local Community Safety Partnership considered a single agency review as being most appropriate and this was supported by the local policy. Consultation with the bereaved family and the Home Office initiated a review of this earlier decision and the outcome was that a DHR was commissioned in line with National Guidance issued by the Home Office. Discussions have taken place at a Greater Manchester level and the local policy has been withdrawn.

2.2 Domestic Homicide Review Panel

2.2.1 David Hunter was appointed as the Independent Chair by the Oldham Community Safety and Cohesion Partnership on 15.02.2016. He was responsible for managing and coordinating the review process. Paul Cheeseman wrote the report. Both are independent practitioners who between them have chaired and written previous DHRs, Child Serious Case Reviews and Multi-Agency Public Protection Reviews. Neither have been employed by any of the agencies involved with this DHR and were judged to have the experience and skills for the task.

2.2.2 A DHR panel was assembled (see table 1) which represented local agencies and included members with detailed knowledge of domestic abuse. Further independence was achieved with the appointment to the panel of the Citizens Advice Bureau, who provided expertise on debt, and the Independent Domestic Violence Advocate.

2.2.3 The Chair and Review Panel considered the scope of the review and drew up clear terms of reference which they felt were proportionate to the nature of the homicide. The first of four panel meetings were held on 14 April 2016. Attendance was good with all members freely contributing to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The panel held detailed discussions about the contents of the Individual Management Reviews (IMR) and ensured the Overview Report

brought these together. The panel then drew together conclusions, lessons and recommendations.

Table 1: Review Panel Membership

Name	Role	Organisation
Janine Campbell	Designated Nurse for Adult Safeguarding	Oldham Clinical Commissioning Group
Paul Cheeseman	Author	Independent
Ann Christopher	Named Nurse Safeguarding Adults	The Pennine Acute Hospitals NHS Trust
Janice France	Senior Probation Officer	National Probation Service
Nicola Green	IDVA	Independent Domestic Violence Advocacy Service, Oldham Metropolitan Borough Council
Julian Guerriero	Criminal Justice Lead (Substance Abuse) CSS	Community Safety Services, Oldham Metropolitan Borough Council
David Hunter	Independent Chair	Independent
Lorraine Kenny	Community Safety Manager	Community Safety Services-Oldham Metropolitan Borough Council
John Moran	Team Manager Adult Social Care	Oldham Metropolitan Borough Council
Claire Moss	Detective Inspector	Greater Manchester Police
Jayne Ratcliffe	Head of Adult Social Care and Principal Social Worker	Oldham Metropolitan Borough Council
Haydn Roberts	Head of Service Community Safety Services	Oldham Metropolitan Borough Council/Chief Inspector Greater Manchester Police

Bridget Thomas	Named Nurse Safeguarding	Central Manchester NHS Foundation Trust
Jonathan Yates	Chief Executive Officer	Citizens Advice Oldham

2.3 Agencies Submitting Individual Management Reviews

2.3.1 The following agencies submitted Individual Management Reviews:

- Greater Manchester Police
- Pennine Care NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust (CMFT)
- Independent Domestic Violence Advocate
- Oldham Council Adult Social Care

2.3.2 The following agencies provided information or support;

- The Pennine Acute Hospitals NHS Trust
- Housing and Care 21

Enquiries were made with alcohol and drug service providers (One Recovery Oldham) and there was no trace of Catherine or John having contact with them or with the previous provider, ADS Oldham. Pennine Care also confirmed there had been no previous contact with Pennine alcohol or drug services.

2.4 Notifications and Involvement of Families

2.4.1 Some of the agencies that provided IMRs or other information held little that was of direct relevance to the DHR. The panel recognised from the outset the importance of engaging with the family and friends of the victim. Given the limited scope of information from agencies they felt this was particularly important. David Hunter wrote to Catherine's family and enclosed a Home Office Review leaflet for families and a leaflet from Advocacy After Fatal Domestic Abuse[2]. The letter expressed the Review Panel's sincere condolences and explained that a review was underway and invited them to contribute.

2.4.2 Catherine's family met with David Hunter and Paul Cheeseman on 22.04.2016. A member of Advocacy After Fatal Domestic Abuse also attended the meeting. This meeting was extremely important to the panel in helping them discover information about Catherine's life and her relationship with John. The panel wish to record their thanks to Catherine's family for engaging with them and for the support provided by the representative from Advocacy After Fatal

[2] AAFDA is a charity that supports families involved in domestic homicide reviews.

Domestic Abuse. Where the family's views appear in the report they are attributed accordingly.

2.4.3 David Hunter wrote to John at the prison where he is serving his sentence. John agreed to take part in the review. He was seen on 26 July 2016 by David Hunter and Paul Cheeseman in prison in the presence of his Offender Manager and Offender Supervisor. The views he expressed have not been verified.

2.4.4 Catherine had several close friends and work colleagues that also held important information. David Hunter visited three of these and met with a Catholic Priest who knew Catherine and John personally. David Hunter also spoke with a Catholic Priest who provided chaplaincy support to Catherine while she was in hospital. Again, where their views and those of friends appear in the report, they are attributed accordingly.

2.5 Terms of Reference

2.5.1 The purpose of a Domestic Homicide Review is to:

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

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7]

2.5.2 Timeframe under Review

The DHR covers the period 07.11.2006 to 16.04.2015[3]

Specific Terms

1. What if any indicators of domestic abuse did your agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

[3] This represents the period between the first known recorded incident of domestic abuse by an agency and the date Catherine died in hospital.

2. How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

3. What knowledge did your agency have of the debt and alcohol misuse within the household?

4. What debt and alcohol services are available locally to help people in abusive relationships?

5. Were there any barriers in your agency that might have stopped the victim from coming forward to seek help for her domestic abuse victimisation and debt?

6. What knowledge did the family, friends and employers have of the adults' relationship, including the household debt that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

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

8. How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

9. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects

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

11. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

3. BACKGROUND: CATHERINE AND JOHN

Note: The information in this section is drawn from the documents seen by the Panel and contributions from family members and friends and an interview in prison with John.

3.1 Catherine

3.1.1 Catherine was born and raised in the Home Counties and has two older sisters, Bridget and Sarah. Her mother and late father were devout Roman Catholics and Catherine was raised in the faith. She is described as a happy and helpful child and was educated at Catholic primary and secondary schools near to her home. Bridget trained as a teacher and Sarah as a nurse.

3.1.2 Catherine left school at 16 years of age, attended college and then went on to study nursing. She qualified as an Enrolled Nurse in 1987 and studied hard to convert to a Registered Nurse in 1991. From there she qualified as a Specialist Ophthalmic Nurse. Catherine did not have any children of her own. She is described as very close to her nephews and niece whom she loved and frequently treated to gifts.

3.2 John

3.2.1 John was an only child and was raised in the Oldham area by his parents both of who are now deceased. He attended primary and secondary schools in the area. He gained eight GCSEs and one CSE. He studied for his 'A' levels for one year before leaving and joining the Merchant Navy.

3.2.2 He went to sea for one year and then attended the Merchant Naval College where he studied Engineering. In the early 1980's he went to South Africa and sailed with a company based there. He eventually settled in Reading where he gained employment at the hospital. This is where he first met Catherine, before he married his first wife. He then went back to sea.

3.2.3 His first marriage was not a success. He said that when he returned from sea his first wife *'did not want to know him'*. They divorced. His first wife had a daughter with a previous partner. John said he has no contact with either of them. He says he found out from his step daughter that his first wife had been married several times before and she had never disclosed this when she married John. He says this provided grounds for the annulment of the marriage. It was following his divorce and a return to Reading that he says he resumed contact with Catherine.

3.2.4 When he was seen in prison John did not accept that he misused alcohol although he did accept that on occasions he drank more than he should have done[4]. He said the only time he would drink was when he felt under stress

[4] Sarah commented that this was contrary to what John stated in court where he said he now realised he had had a drink problem from an early age and although numerous people had told him, he didn't believe it until now. Sarah wondered whether this was either an attempt by John to manipulate the court, or the DHR Chair and Author, or both.

which he now accepted was the wrong thing to do. His statement is contrary to all the evidence that the DHR panel has seen from family and friends and of recorded contacts between John and his GPs. John said that financial issues caused unhappiness in his relationship with Catherine. It will be seen later that he was sometimes financially dependent on Catherine.

3.2.5 During the interview John wanted to present himself as open and honest. However, he was evasive and tried to justify and minimise events and his relationship with alcohol was a prime example. Another example was when he was asked whether he had any children. He immediately said no. The interviewers thought there was a child in his first marriage and when they challenged him John said, '*oh that was my step-daughter'*. While his initial answer was factual it was also obfuscation.

3.3 Catherine and John's Relationship

Family Recollections

3.3.1 When Catherine met John she told the family he was divorced and at some point, his marriage was annulled. Catherine and John visited a priest in her parents' parish. He said everything was in order and the couple announced their engagement. Catherine's parents were not keen on the marriage because of the divorce, although they accepted Catherine's wishes. Catherine told Sarah that John was trying to cut contact with his daughter from his first marriage.

3.3.2 Following her engagement to John, Catherine moved to the Greater Manchester area where she worked for the rest of her life as a nurse. The couple married in 1997. At some point John converted to Roman Catholicism. He worked as a merchant seaman and was often away on trips. When he came home the couple travelled extensively. Sarah says John smoked heavily and smelt of alcohol.

3.3.3 She describes him being red and shaking and often feeling sick and clutching his stomach. Catherine told her sister this was because John was not sober while at sea and would go through withdrawal when he returned. Over the years the family said they only saw John drive a car on a couple of occasions. He said he didn't like driving. Later in their marriage Catherine told Sarah John had been disqualified from driving. Greater Manchester Police found no record that John had been disqualified from driving[5].

3.3.4 The family provided other examples of John's behaviour that supported their belief that he consumed excessive amounts of alcohol. They believe he had been sacked from two major shipping companies he worked for because of drink related behaviour. The second time he lost his job Sarah said a letter

[5] Catherine's family believe he was disqualified from driving by a court and say they saw papers to this effect when they cleared Catherine house. They also say it was accepted during the homicide trial that he had been disqualified and there had been an error in record keeping by the police. The panel believe the family version is the correct one and there has been an error in record keeping somewhere. However, a detailed investigation as to how this happened would add nothing to the DHR.

arrived from the company stating he had been fired because of the company's zero tolerance policy on alcohol. John apparently told Catherine that someone had spiked his drink. Sarah says Catherine was very gullible and believed this explanation.

3.3.5 At Christmas 2012 Catherine and John stayed with Sarah for a period. She recalls John being in high spirits and put this down to the fact he drank constantly over the holiday period. During his stay, he told Sarah that he would be living for the rest of his life off the NHS. Catherine was present when he made this remark. When she asked if he had an NHS pension he said he did not and that he would be living off Catherine's pension. The family were relieved when he left.

3.3.6 Sarah recalls that on 27 December 2012 John telephoned and was in a *'sinister and mocking'* mood. He put Catherine on the line and she said to her sister *'he's drunk-it's either you or the police'*. Catherine then disclosed to her sister that John was an alcoholic. Catherine said he was often trying to get her into trouble with the police. She told Sarah about an occasion when John was drunk, was shouting in her face and she pushed him while trying to get out of the bathroom. This had resulted in her being arrested and accepting a caution.

3.3.7 Sarah says that Catherine accepted the caution because she thought it was the easiest thing to do. It was only when she was told by the police that she must report the incident to her professional body - the Nursing and Midwifery Council - that the seriousness hit her. Catherine's sisters feel very strongly about this incident. When they met with David Hunter and Paul Cheeseman they said they felt the incident had not been investigated properly.

3.3.8 They felt Catherine did not realise the implications of a caution and accepted it because she was a timid person and frightened of the police. They say the incident had a dramatic impact on Catherine's life. The family believe that, because of the actions of the police, John was *'handed a* (metaphoric) *weapon to use'*. In other words, in the future, John would use this incident to control Catherine by threatening to report her to the police and portraying her as the perpetrator. While this incident is analysed in more detail at section 5 of the report it is appropriate at this juncture to state that is exactly what the DHR panel believe John did when he made a report to them of a domestic incident on 3 October 2011. It was a premeditated form of controlling and coercive behaviour.

3.3.9 This was the last occasion on which Sarah had any contact with John. Soon after Catherine returned to see her mother and Sarah. When her mother heard that John was an alcoholic she was said to be terrified and wanted Catherine to leave John. Her mother gave Catherine money to open a separate account and the family advised her to see a solicitor. Catherine said that John had told her that if she left he would leave her with nothing. She also said John and her had money troubles. All the money his deceased mother had left him had gone and money Catherine's mother had given her had been spent as well.

3.3.10 It appears Catherine did visit a solicitor and was advised that she was entitled to half of the property they lived in. Catherine told Sarah when John returned from sea she confronted him and told him she had seen a solicitor. Catherine said he was shocked and said he would go to the doctor and stop drinking. After this point Sarah says Catherine was reluctant to discuss her relationship with John, although she did say he was drinking less.

3.3.11 Just before Christmas 2014 Sarah says Catherine announced that she and John had sold their house (address two). She said they had been very silly with money and had been for debt counselling[6] and this was one of the options: to pay everything off. They then moved to a rented property (address one). Catherine said address two had been sold to someone they knew who gave them some extra money for not going through an estate agent. Catherine did not understand how this worked although she did say the arrangement gave them some extra cash. Sometime after this announcement Catherine told Sarah that John was going into business with someone repairing cookers and had put £1000 into the venture. Her sister was concerned that this meant using money from their savings.

3.3.12 Catherine visited her family in the Home Counties for the final time in February 2015. She was tired and down, although she was now almost back to full hours at work following her recent surgery. Catherine said she was taking anti-depressants. A few weeks later Sarah received a call from Greater Manchester Police informing her that Catherine was in hospital following the assault upon her by John.

3.3.13 Catherine's family travelled to Manchester to be with her in hospital. Her Sarah describes conversations they had in which Catherine outlined the way in which John behaved towards her. Catherine said she did not feel safe and was frightened of John and that he would come out (of custody) and get her. She said John was very controlling, always verbally abusive and stopped her from seeing her family. John told her that her family did not care about her and that once her mother died the family would lose touch with her. Sarah said Catherine was quite innocent and believed what people said to her.

3.3.14 Catherine told Sarah that John started drinking at their wedding and had never stopped. She said he drank every day. Catherine said John was always putting her down, calling her a *'useless piece of shit'* and telling her she was stupid and saying she *'smelled'*. Catherine said they argued about drink and money mainly. She said he told lies and blamed everything on her. Catherine said John would not look for work and had recently taken her £1,000 bingo winnings and put them in his account.

3.3.15 Catherine then told Sarah that on occasions John came at her with a knife and said he was going to stab her. Catherine said she told him to *'just do it'*, at which point he would turn away and say *'no'*. Catherine said John had done this about six times in the past. On the most recent occasion Catherine said

[6] A check was carried out by the panel member for Citizens Advice Oldham and there is no record the couple sought or received debt counselling.

she was sitting down and went to get up for her phone or keys and John made the same threat. Except on this occasion he stabbed Catherine with the knife. She said he remained seated in the house, watching, while she rang the emergency services.

3.3.16 While Catherine was in hospital she received visits from two Catholic priests. She received the sacraments and was reconciled with her faith. She had not been to mass for a while as John had apparently said he did not like her going. Catherine told Sarah that, while in hospital, she spoke to a priest and told him what happened. He said the first thing she had to do was get a divorce and an annulment of the marriage could be arranged later. Catherine was said to be very relieved that she had been given this advice.

Friend's and Colleague's Recollections

3.3.17 David Hunter met with three people who knew Catherine well. They gave similar and very revealing details. They said Catherine knew she was in a controlling and coercive relationship with John. They gave some examples of John's control over her. This included him saying, she was disgraceful and *'no one but me would want you',* isolating her from family, friends and the Church.

3.3.18 They describe Catherine as having been a different person when John was at sea. They slept in separate rooms. He pushed her and assaulted her while she was driving. On several occasions, he threatened to stab and kill her. The core issue was John's need to control Catherine. It appears that Catherine told John that she wanted the relationship to end and her friends believe he would have viewed this negatively because he was not working and relied on her income to buy alcohol. They all urged Catherine to leave John. However, Catherine told them she would never be forgiven by God if she did leave.

3.3.19 While she was in hospital Catherine told June that the priest who came to see her had reassured Catherine that she would be forgiven by God. June said she believed Catherine thought this was like a great weight that had been lifted from her. Sarah does not believe it was the major factor that could explain why Catherine did not leave John. She believes Catherine gave different reasons, at different times, to different people for not leaving.

3.3.20 Sarah says that, in her view, a major factor was Catherine's mother telling her to leave. Catherine found this very surprising at the time and would have respected her mother's knowledge and belief of the church's standing on these things more than anyone. Sarah believes that if her mother could not have persuaded Catherine to leave then no one - priest or otherwise - would have stood a lot of hope.

3.3.21 David Hunter spoke by telephone to the Catholic chaplain to the hospital in which Catherine was a patient. He recalled visiting Catherine in hospital although he did not specifically recall her talking about domestic abuse. However, he accepts Catherine did and his approach would have been as Catherine described to June; that in her circumstances it was entirely proper

for her to leave an abusive relationship and that in fact she had nothing to ask forgiveness for, but would go with his blessing.

3.3.22 David Hunter also met with the Parish Priest at the church in which Catherine worshipped before she moved from address one to address two. He knew Catherine and John as parishioners although he did not know of any domestic abuse or other problems between them. He received John into the church in 2001 as a convert. He said he did not know John had been married previously and the marriage had been annulled.

3.3.23 David Hunter and Paul Cheeseman met with Carol a good friend of Catherine. Carol described Catherine as someone who would *'give you the last pound out of her purse'*. She said Catherine just wanted to be a friend and to be liked by people. Catherine disclosed to Carol, that some years ago, John had threatened to stab her with a knife. Catherine said this happened again about two years before her death.

3.3.24 Carol said Catherine told her that John had hit her while she was driving the car. Carol also worked out that John was coercive towards Catherine and knew the couple had money problems. Carol did not believe Catherine spent money on herself as she never bought new clothes or furniture. However Carol said John very often spent what seemed like unnecessary amounts of money on food, for example joints of meat, which he would then give to neighbours. John was always insisting Carol share meals with him and Catherine. Carol tolerated these requests although she believed he was *'arrogant'* and frequently drunk.

3.3.25 Amanda and Catherine were colleagues. Amanda said if she had been very concerned about Catherine, she knew what to do because like Catherine she had received safeguarding training. Amanda said that, looking back, she would have told Catherine to get out of the marriage. However, this would have to be said in private because if information had been disclosed without Catherine's knowledge, she would have been horrified.

3.3.26 Carol said Catherine loved John to bits, adored and forgave him. Catherine told Carol , when she was in hospital for surgery, that she was almost in tears thinking that she would not see him again. Carol said she thought it was hard to say if John's actions could have been predicted.

John's Recollections

3.3.27 John was seen in prison by David Hunter and Paul Cheeseman. He gave a description of the relationship which saw him as the victim. This account was not recognised by Catherine's family or friends nor is there other independent evidence to support his version. He said he did not tell anyone about his alleged victimisation. More importantly, his version of events was played out in court and was discounted by the jury who found him guilty of murder. Therefore, at least twelve strangers who heard the evidence rejected his picture of the relationship at the time the homicide occurred and did so to a standard of beyond reasonable doubt.

3.3.28 Therefore the DHR Panel rejected John's interpretation of events.

4. THE FACTS BY AGENCY

4.1 Introduction

4.1.1 The agencies that submitted IMRs and chronologies are dealt with separately in the following non-judgemental narrative which identifies the important points relative to the terms of reference. The main analysis and judgements of events appears in Section 5. However, some early commentary is made in to avoid any misinterpretation or minimising of John's behaviour.

4.2 Greater Manchester Police

4.2.1 Greater Manchester Police hold several records in relation to Catherine and John. Some of these relate to occasions on which the couple have been victims of property crime. These were unconnected to this review and are therefore not examined.

4.2.2 The following records are of importance to this review. They are numbered separately so that the detail of each is not lost. However, they should not be viewed in isolation of each other. Collective, the reports of domestic abuse illustrate a continuous and unending pattern of abuse suffered by Catherine at the hands of John.

Domestic Incident One - 2 May 2000[7]

4.2.3 Only limited information is available on this incident due to its age. Greater Manchester Police records show that John called the police claiming Catherine was screaming at him and he was afraid to go downstairs as she may assault him. The only details known are that both Catherine and John were spoken to and given advice. They both refused their details.

Domestic Incident Two - 7 November 2006

4.2.4 At 18:05 hours John made a 999 call. The call was abandoned by John, however the call taker telephoned and spoke to John. He said he and Catherine had been arguing and it had now calmed down. The call taker asked to talk to Catherine who did not wish to speak. The call taker told John a police officer would visit them.

4.2.5 At 20.31 hours the same day a police officer attended the couple's home. The officer reported that the incident was a verbal argument only. The officer completed the 1-12 incident data on the FWIN[8]. At point 1 the officer recorded

[7] Although the start date for the DHR was set as 2006, because this was the first record of a domestic incident, it later emerged that Greater Manchester Police had recorded this incident in 2000.

[8] FWIN is an acronym for Force Wide Incident Number. This is a computerised system for recording and auditing all incidents reported to Greater Manchester Police requiring a police response. In 2006 GMP adopted a policy that placed a requirement for officers reporting domestic incidents to include on a FWIN a minimum and consistent data set known locally as the '1-12' SPECSSVO model, which included an initial brief risk assessment.

that John was the victim and at point 2 that Catherine was the perpetrator. The circumstances at point 5 were recorded as:

"male and female have a verbal altercation due to female having to attend hospital in a few days for a major operation but stating to male she wasn't going to go due to being frightened, male is drunk and feels if the police are involved they would be able to solve the problem, male phones police due to being drunk wanting verbal advice".

4.2.6 At point (8) the officer recorded that alcohol was a factor on the male's behalf. The FWIN was closed as a domestic incident between partners with an additional closing code that indicated that alcohol was a factor in the incident.

4.2.7 Because the code used to close the log indicated the incident was categorised as a domestic incident involving adults, it was automatically referred to the Public Protection Investigation Unit (PPIU). Here an officer that specialised in these incidents reviewed the log. A summary of the PPIU officer's findings was then placed on the log. In this case the following additional comments have been added *"no previous history, NFA (no further action) at this stage"*. It is noteworthy that on the PPIU log Catherine has been created as the primary victim with John as the alleged perpetrator. This is the opposite of what the police officer that attended the incident recorded. That officer has been spoken to by the IMR author and is unable to explain why victim and perpetrator details became interchanged.

4.2.8 The issue of who is the perpetrator and who is the victim will be analysed further at section 5 and research evidence used to help understanding. This was a key issue for the review panel to consider. The person making the first report of a domestic incident to a police force is sometimes presumed to be the victim. Without further investigation, this can lead to unhelpful assumptions or confusion as to who is the actual perpetrator or victim. The panel bore this in mind when considering the way Greater Manchester Police responded to reports of domestic violence between the couple and was an important conclusion.

Drinking and Driving Information - 21 February 2008

4.2.9 On this day Greater Manchester Police received an anonymous call reporting that John had driven whilst drunk in the past and in twenty minutes was going to drive to a local hospital. The caller knew John had been drinking that day and said he had a drink problem. The vehicle details given by the caller related to Catherine's car. Information was passed to police patrols and no sightings of the car were reported. The FWIN was then closed. This incident is relevant as it is consistent with views expressed by family and friends that John consumed excessive amounts of alcohol

Domestic Incident Three - 28 February 2010

4.2.10 At 16.25 hours Greater Manchester Police received a report from the ambulance service that John had been assaulted by Catherine and that she

had hit him over the head. A police officer visited the couple's address. Catherine told the police officer she and John had argued and that he was intoxicated. The police officer spoke to John who was in an ambulance and about to go to hospital. John had a cut to his head and reported this had been caused during a verbal argument between the couple. He said Catherine pushed him away and caused him to fall and bang his head on a door frame. The police officer arrested Catherine for the assault on John and she was taken to a police station custody office. Catherine was interviewed. She admitted the assault on John. Catherine was issued with a caution[9] for an offence of wounding contrary to S20 of the Offences Against the Person Act 1861. Catherine's family feel strongly that she should not have been issued with a caution for this offence. This incident and the appropriateness of the caution are considered in more detail later in the report.

4.2.11 Catherine was released from custody. The crime report that was completed in respect of this incident indicates that the argument was over debt and that alcohol was a factor. The police officer completing the 1-12 data on the FWIN, recorded that John was intoxicated and that Catherine was not. At point 12 of the risk assessment, the officer has written:

"Very decent pair, incidents have happened in the past with both parties being responsible; Catherine has a notifiable occupation and is likely to face work disciplinary actions as a result of the caution which will bring further tensions in the house – low/medium risk".

4.2.12 As part of their work the panel asked Greater Manchester Police to supply a copy of the witness statement John made following this incident and for a copy of the tape recording of the interview with Catherine. These were provided.

4.2.13 John made a statement of three pages in length to a police officer on the day of the incident. In analysing the statement, it is important to recognise that Catherine would ultimately become the victim of a homicide. Nothing of what John says in this witness statement should therefore ever be viewed as providing mitigation for his subsequent actions. The panel also recognised it was important to understand what John had to say to the police about the events that day and of his relationship with Catherine, as that played a part in the decisions made by the police. The copy of the witness statement therefore provided the best opportunity to see a contemporaneous record of what John had to say.

4.2.14 In the statement John says he and Catherine had been to a bingo hall that day. He says he consumed two small bottles of wine and two small bottles of beer. John said Catherine spent an awful lot of money on store cards and this led to rows. After returning home John took a bath. Catherine entered the bathroom and John decided to ask her how much she owed on a store card.

[9] A simple caution is a formal warning given by the police to an adult offender aged 18 years or over and who has admitted that they are guilty of an offence. It is commonly used to resolve cases where full prosecution is not seen as the most appropriate solution.

John says Catherine went 'ballistic', and struck him to the right side of the head. John says he took hold of Catherine by the shoulder to stop it. As he had hold of Catherine, John says she 'swiped' his legs from under him causing him to fall downstairs. During his fall John sustained the head injury.

4.2.15 In his statement John says Catherine had been violent in the past, he was 'sick and tired of it' and, although he loves her, feels this is too much. He said that if necessary he would attend court and that he is making a complaint of assault to the police.

4.2.16 The panel felt it was important to consider exactly what Catherine said when she was interviewed by the police concerning this incident. Greater Manchester Police located a copy of the tape-recorded interview and arranged for this to be transcribed. The interview with Catherine lasted 13 minutes. The interview complies with the Codes of Practice[10] in all respects. The police officer conducting the interview asked Catherine if she was willing to be interviewed without a solicitor and she confirmed she was. The officer then explained that access to a solicitor is free and that at any point in the interview Catherine may ask for a solicitor. She said she was 'fine'.

4.2.17 The police officer then took Catherine through the events of that day. Catherine said she and John had been to play bingo. She explained that John drinks when he is home from sea and that she suspected he drank before they went out. While they were at the bingo session, during one of the breaks, John went to a nearby pub. Catherine believed he consumed shorts or spirits. This belief was based on Catherine's view that John's behaviour was very argumentative when he consumed spirits. He also consumed wine while in the bingo hall. Catherine said she was tee total. John was slurring his words and when they returned home she told him to go to bed.

4.2.18 Catherine said John 'would not have it', he started going on about 'debt' and about Catherine spending money and about how 'awful' she was. Catherine said the arguing became violent. She said John was drunk and she was furious. Catherine said that she had a 'temper'. She said that while she was on the lavatory she pushed John and he 'went flying' falling onto an upright fan and then onto the bannister hitting his head against a door frame.

4.2.19 Catherine said there was a struggle between them. She said she might have punched John to the face. However, she denied John's claim that she kicked his legs from under him and pushed him down the stairs. The police officer specifically asked Catherine if John struck her or took hold of her to which she replied 'No it was my instigation'.

4.2.20 Catherine then said to the police officer 'He (John) actually several months ago we had an incident where punches were thrown and he busted my nose in the car there was blood everywhere and his comment to me was now you have busted my nose and we are done and that's where the blood was from'.

[10] The Police and Criminal Evidence Act 1984 (PACE) contain Codes of Practice. Code C sets out the guidance for the detention, treatment and questioning of persons by police officers.

From Catherine description, this seems to refer to the same incident she disclosed to Carol. The police officer did not explore that incident any further with Catherine and a short while later the interview was terminated.

Domestic Incident Four - 3 October 2011

4.2.21 At 18.28 hours John made a 999 call to Greater Manchester Police. He said he had just come home from being away at sea for three months and Catherine had made various threats to harm him. John said Catherine had a history of violence against him and had split his head open in the past.

4.2.22 The call taker also spoke to Catherine. She said John had been drinking and wanted to go for a meal with neighbours but was not happy when Catherine refused to go with him. Catherine said that she did not want to go as she was concerned that she may lose her job soon, after a previous domestic incident, because she was a nurse.

4.2.23 A police officer visited the couple at their home at 19.11 hours. The officer reported that the incident was a verbal altercation only with no assault and no threats. The officer said John had been drinking and wanted to go out; Catherine did not because her mother was very ill. Neither Catherine nor John wanted to leave the address.

4.2.24 The matter was recorded as a domestic incident between adults with alcohol a factor. A PPIU log was created. This showed John as the primary victim and Catherine as the alleged perpetrator. A DASH risk assessment was completed and the risk level was set to standard. Question 23 of the DASH concerns financial issues and whether there is any debt. The answer recorded was “no”.

4.2.25 The following day, a domestic abuse specialist officer reviewed the PPI and the DASH risk assessment. The officer contacted John who reported that everything was fine between him and Catherine. He told the officer that it had become heated the previous night as they were both stressed due to people in the family being ill.

4.2.26 An enhanced risk assessment was completed and the risk level was confirmed as standard. The domestic abuse officer recorded that there had been two previous domestic incidents, one in 2002 and one last year where Catherine had received a caution for assaulting John. The 2002 date is clearly an error and should have been 2006. The case was reviewed by a PPI specialist supervisor who noted the comments and filed it. No referrals were made or felt necessary.

Drinking and Driving Information - 10 September 2014

4.2.27 At 20.13 hours an intelligence report was submitted concerning John driving with no insurance and whilst under the influence of alcohol. The report recorded that John would be driving the car the following day between 12.00 hours and 15.00 hours to visit his wife in hospital. The information was passed to the road policing unit. The following morning an officer added an entry

stating the vehicle was insured. There are no other actions recorded on the log.

The Homicide of Catherine - Early 2015

4.2.28 On the 17th March 2015 at 18.26 hours a 999 call was made to the ambulance control which was also passed to Greater Manchester Police control room. The report was from Catherine. She said she had been stabbed by her partner at their home[11]. Catherine was conscious, breathing and talked to the call taker at ambulance control. She told the call taker the offender was still at the scene. Catherine said she had pulled the knife from her own chest and was seriously bleeding.

4.2.29 Within four minutes a police officer arrived at the couple's home. The officer attended to Catherine and then realised that John was standing in the corner of the room. John said to the officer *"you might as well arrest me I stabbed her"*. The police officer said John had been drinking. The officer arrested John on suspicion of attempted murder and passed him outside to another police office before returning to help Catherine. The police officer continued to give first aid to Catherine until an ambulance arrived and took her to hospital.

4.2.30 While waiting to be searched John said to a police officer;

"(Catherine)…threw me down the stairs and caused me this scar on the head and today she has wound me up, she spends money like it is going out of fashion. We are £27,000 in debt, she just started, she just wound me up so I stabbed her, she pushed me to it."

4.2.31 In the custody office John made the following admission;

"she said stab me, stab me, stab me so I did."

4.2.32 John also told a Doctor and a police officer that;

"….*Chopping some meat up and she was saying go on stick it in me stick it in me so I did. I can see I am going to be spending some time in her majesty's pleasure"*

4.2.33 Catherine spoke to a police officer while in hospital. Catherine said John had been drinking, they had an argument and he stabbed her whilst she was sitting down. The police officer completed a DASH risk assessment setting the risk to Catherine as high. The answers provided by Catherine suggest that there had been a long history of domestic abuse. She told the officer that John had been alcohol dependant since their marriage, he had previously threatened her with a knife and he had been very possessive and controlling throughout their marriage. Catherine's account put into perspective the reports made by John against her. The nature of the relationship is explored within the analysis.

[11] Catherine and John moved house from address two to address one in February 2015.

4.2.34 A nurse at the hospital where Catherine was detained referred her case to a MARAC[12]. A meeting was scheduled to take place a few days later. Catherine was seen again by the police while in hospital and by then was recovering well from surgery. She gave brief details of the domestic history between her and John. Catherine said their relationship was very strained because of John's drinking. She described him as an alcoholic. Catherine also explained that they had concerns over debt which added to the strain. A decision was then made to record Catherine's evidence for court on video[13] following her discharge.

4.2.35 The same police officer visited Catherine again a few days later. Catherine was now walking with the aid of a frame and could provide an account of her life with John. She explained that they had been married for 18 years and that six weeks after their wedding she had found out that John was an alcoholic. She blamed most their arguments on his drinking and said that they argued over money.

4.2.36 Catherine was then moved onto a ward and was expected to be discharged once a social care plan had been put in place. However, a few days later she developed respiratory difficulties and her condition deteriorated. Catherine was admitted to the intensive care unit where tragically she died.

4.3 NHS Oldham Clinical Commissioning

4.3.1 Catherine and John were registered at the same GP practice and had been patients there for many years. They each attended the practice on several occasions. Catherine usually saw the same GP. John saw several different GPs. During the period of the review the couple were known to six GPs at the practice. Only those attendances that are felt to be of relevance to the DHR are reviewed here.

Catherine

4.3.2 In May 2009 Catherine told a GP she was feeling low in mood: a bit emotional. She said her father had died one year previously and her mother was unwell. She was taking anti-depressants at that time and did not have any harmful thoughts. The GP records do not show whether any action was taken.

4.3.3 Catherine visited the surgery on four further occasions about her low mood and by August 2009 she told the GP she was feeling much better. However, in November 2009 she saw the same GP that had treated her previously and disclosed she was not feeling well and could not cope. She said John was away in the navy and had alcohol problems. Catherine also said she was having difficulty caring for her mother in law. The GP increased Catherine's

[12] A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

[13] Statutory Guidance known as 'Best Evidence' allows for the evidence of certain witnesses, including those who are vulnerable or intimidated to be recorded on video and played to the court as an alternative to a written witness statement and a personal appearance in court as a witness.

medication. When Catherine was reviewed in December 2009 she told the GP she was feeling much better and her employer had been supportive.

4.3.4 In October 2010 Catherine visited her GP and disclosed that she had been arrested for assaulting John Catherine told the GP that John drank a lot of alcohol and she said the nursing and midwifery council were aware of the investigation. The GP offered Catherine counselling which Catherine declined. The GP increased Catherine's medication.

4.3.5 Catherine was next seen in May 2012 when she saw her GP and disclosed she was struggling with her mood, her sleep and that work was stressful. The GP offered Catherine a referral to a counsellor or a psychiatrist. Catherine declined this offer. The GP continued to prescribe Catherine medication. Catherine saw the same GP on all the attendances outlined in paragraphs 4.3.3-4.3.5.

4.3.6 In November 2014 Catherine saw a nurse practitioner following surgery in a local hospital. She was accompanied by John. Nothing of relevance was disclosed and this was the last time that Catherine visited the surgery.

John

4.3.7 John first registered at the surgery in 1991 at which time he disclosed he consumed between 40 to 60 units of alcohol per week. The GP advised him to reduce his intake. In November 1992, a discharge summary was recoded from a hospital showing John had taken an overdose of proprietary medication because of the breakdown of his marriage. This pre-dated the start of his relationship with Catherine. Sarah said Catherine was only too aware of this. It was another of the reasons Catherine gave Sarah for not leaving John. Sarah said Catherine was worried John would try it again. It was also a big worry to her he would try it in prison. She felt he wouldn't cope with it.

4.3.8 There is nothing further recorded until January 2008 when John visited his GP and said he was suffering with anxiety and depression. The GP did not document any action. When John was reviewed by a different GP in April 2009 he said he consumed about 30 units of alcohol a week.

4.3.9 John was reviewed by three different GPs in November 2010, May 2011, March 2012 and October 2013. On the first occasion, he denied drinking excessive amounts of alcohol. On the second occasion, the GP noted that John smelt strongly of alcohol. He told the GP he consumed about 28 units each week and was advised to decrease this amount. On the third occasion, he was seen by the same GP that Catherine saw. The GP recorded that John was advised about his drinking. The same GP saw John on the fourth occasion and recorded that John disclosed he was drinking excessively. No actions were recorded in relation to any of these reviews other than the advice to John that he should reduce his intake.

4.3.10 In February 2014, John disclosed to a GP that he was suffering a great deal of stress. John said there were several factors. These included the loss of his

job, bereavement and Catherine's ill health. John was not offered any interventions.

4.4 Pennine Care NHS Foundation Trust

4.4.1 Pennine Care NHS Foundation Trust had many contacts with Catherine from September 2014 onwards. Catherine had been admitted to hospital for a surgical procedure and then to Pennine Care NHS Foundation Trust for wound management.

4.4.2 Between September and November 2014 the district nursing team had seventy-four contacts with Catherine; fifty-three of these were home visits, twelve were clinical visits and there were nine telephone contacts. The only issue of relevance to this DHR is that on three occasions Catherine was in a low mood. Records show that one of these occasions was explained as being due to the surgery having failed. On the other two occasions, there is no explanation for the low mood.

4.4.3 There are only two references to John being present during visits. On one of these occasions in September 2014 Catherine was not at home when the district nurse called. John was said to be very annoyed when the nurse suggested that Catherine would now need to attend clinic if she is now mobile. Catherine was discharged from the service in November 2014 and there were no further contacts with Pennine Care NHS Foundation Trust.

4.5 Central Manchester University Hospitals NHS Foundation Trust

4.5.1 Catherine's only contact with Central Manchester NHS Foundation Trust was after John stabbed her and she was admitted through the Emergency Department. Following surgery Catherine was transferred to the Cardiac Intensive Care Unit for a period and was then transferred to a ward. Catherine was said to be anxious and fearful of her husband and her own safety.

4.5.2 The Cardiac Intensive Care Unit completed Safeguarding Notifications and liaised with the police. Hospital staff completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment and made a referral to MARAC. Catherine told staff the stabbing incident was the first episode of physical domestic abuse from John. The panel discovered, through conversations with Catherine's friends, that she had been subjected to force from John on other occasions.

4.5.3 Catherine said she had been frightened at home for several months and that abuse from John had been happening more often. Catherine said this was when John drank alcohol and that the latest incident, in which he had stabbed her, was the sixth occasion John had threatened her with a knife. Catherine said they were in a lot of debt.

4.5.4 During her stay on the ward Catherine was reported to be scared and panicky. She had nightmares and flashbacks of the incident. Plans were put in place to address Catherine's physical and psychological needs and there was evidence

of good liaison between Greater Manchester Police, health agencies and domestic violence services in planning for Catherine's discharge. Sadly, this never took place as Catherine's health deteriorated rapidly and she died following admission to the Intensive Care Unit.

4.6 Independent Domestic Violence Advocate

4.6.1 There is no record of any contact between Catherine and the Independent Domestic Violence Advocate Service prior to the incident in which she was stabbed by John. Following this incident and the referral by the hospital, the Independent Domestic Violence Advocate contacted Catherine to offer safety planning and support for the time when she would be discharged. The service made a second visit to Catherine in hospital to talk about the support that could be provided. Catherine made it clear to the advocate that she wanted support from the service when she left hospital.

4.6.2 When Catherine was in hospital she answered questions so that a DASH risk assessment could be completed. Question 4 asks whether the victim feels isolated from family and friends and whether the abuser has stopped them trying to see their friends or family. Catherine gave the following answer to this question;

'Yes has always tried to stop me from seeing family'.

4.6.3 Question 15 on the risk assessment also asks whether the abuser tried to control everything the victim does and/or are they excessively jealous. Catherine gave the following answer;

'Very possessive - didn't want me visiting family - had to stop going to church.'

4.6.4 From the conversations with Catherine's family it is clear she was very close to them and that her religious beliefs and membership of the Catholic Church were important to her. Preventing her from seeing her family or going to church were cruel and oppressive acts and constitute behaviour that is coercive and controlling. The panel found no evidence that Catherine took a decision of her own free will to isolate herself from her family and the church. All the evidence points to Catherine having very close and strong links to them. John's behaviour towards Catherine was domestic abuse based on coercive and controlling behaviour.

4.7 Oldham Council Adult Social Care

4.7.1 Adult Social Care had little contact with Catherine prior to the incident in which she was stabbed by John. The agency had significant contact with Catherine following her admission to hospital after this incident. Only those matters most relevant are summarised below.

4.7.2 In September 2014 Catherine contacted Adult Social Care to request an assessment of need. She said John was unemployed and he had to help her wash and dress. She also said that she required an assessment for aids and adaptations. No further action was taken as John was providing support and

a referral had been made to the Community Occupational Therapy Team. Adult Social Care asked Catherine to make contact again if John was no longer able to provide the support she needed[14].

4.7.3 Following Catherine's admission to Central Manchester University Hospital after she was stabbed the hospital made a referral to Adult Social Care for an assessment of need. The referral stated that Catherine would require a package of care on discharge from hospital and that Safeguarding Services were involved in her case.

4.7.4 A social worker visited Catherine in hospital and maintained contact with her over the following month and arranged for a package of care. Catherine said she felt like she had been '*brainwashed'* for many years and was having nightmares following the assault on her by John. Catherine said she would return home, although only if John remained in custody. She said she had supportive friends and family and asked if she could get help to apply for a divorce. The social worker later provided Catherine with information from Citizen's Advice website that indicated that she could be eligible for legal aid to support her application for divorce.

4.7.5 The social worker who dealt with Catherine has now moved to another local authority. However, she agreed to contribute to the review and spoke to the report author by telephone. She said the thing she remembered the most was how, even though John had stabbed Catherine, Catherine said she still could not see herself divorcing him. The social worker was struck by what Catherine said about John simply standing by and doing nothing after she was gravely injured by him.

4.7.6 Requests for support were made to counselling, psychology and psychiatry and liaison was undertaken with the Independent Domestic Violence Advocate Service. Adult Social Care Safeguarding Team attended the MARAC which was held while Catherine was in hospital. The MARAC concluded there was no safeguarding role at that time as Catherine remained in hospital and John was in custody. Adult Social Care continued to work closely with Catherine and her family in respect of her discharge plan. Sadly, that was never implemented as Catherine died in hospital.

4.8 Other Agencies Providing Information

4.8.1 The following agencies held some information of value although they were not required to submit an IMR as their contact with Catherine and John was very limited.

[14] In 2014 when this assessment was completed, Oldham Adult Social Care Criteria was Fair Access To Services, which Councils defined locally. This was an unsatisfactory and unfair system. In April 2015, the Government introduced the Care Act. This laid down national eligibility criteria for Adult Social Care. In Oldham, at first Contact, an eligibility assessment is completed. This now includes questions about wellbeing, relationships, finances and alcohol use. This means there is now a consideration of the broader needs of people. This is a positive step and reduces the risk of significant issues being missed at first point of contact.

Housing & Care 21

4.8.2 Catherine and John said they had owned their own property since they married. In December 2014, they sold their house (address two) and approached Housing and Care 21 to rent a property. They said the reason for this was because they were having to sell their home to pay debts. They completed an application form that showed payments to various store cards and an outstanding debt of £6,269.

4.8.3 The housing officer that saw them said there were no indicators at the pre-tenancy interview or sign up stages of domestic abuse or alcohol misuse. On the housing application, they answered *'no'* to the questions, *'risk of domestic abuse'* and *'I am in fear of violence'*. At the pre-tenancy meeting the housing officer discussed with them their ability to pay the rent. Catherine and John told the officer they had a PPI claim awaiting payment for the sum of £16,000 and that Catherine was receiving sick pay from her employer. This was following recent surgery.

The Pennine Acute Hospitals NHS Trust

Catherine

4.8.4 Catherine had one attendance in the Emergency Department in respect of a swollen foot which was not inflicted. She also saw a surgeon and a nurse regularly in a surgical out-patient clinic and did not make any disclosures of domestic abuse.

4.8.5 On 15.12.2014 Catherine had a brief chat with a counsellor. The counsellor would have explained her role and given her the opportunity to make an appointment. This was set for 05.01.2015. Catherine did not attend the appointment.

4.8.6 Sarah does not know why Catherine did not attend counselling. Sarah says that whilst in hospital, following her injury, the issue of further counselling came up and Catherine said she would be happy to go back to the counsellor she had spoken to recently. Sarah provided a referral letter to the panel from Catherine's manager, stating Catherine had problems out of work. Sarah believes this confirms the fact Catherine had counselling in the past and was content to have more.

4.8.7 Catherine did make some disclosures to friends and work colleagues. One of those friends was Catherine's manager. However, these concerns were not transmitted through any channels within Pennine Acute Hospitals NHS Trust.

John

4.8.8 John attended with Pennine Acute Hospitals NHS Trust in February 2010 when he was taken to the Emergency Department by ambulance for a small graze

to his head[15]. There is no record that domestic abuse was considered and his injury was treated as a possible assault. John was said to be '*very difficult'* in the department. He refused to stay for a period of head injury observation and was felt to be quite abusive to staff.

4.8.9 On 12.03.2015 John was seen in a Pennine Acute clinic. A letter from the clinic to his GP states that as John disclosed he was smoking and drinking every day.

[15] At the time of this event the injury was photographed by Greater Manchester Police and a copy was provided to the panel. It is clear John's injury was a wound rather than a graze and such an injury would therefore constitute a wound within the terms of S20 of the Offences Against the Peron Act 1861. No explanation was found for the disparity in the recording of this injury.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

5.1 Introduction

5.1.1 Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the Individual Management Reviews and the Domestic Homicide Review Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken to avoid unnecessary duplication.

5.2 Term 1

What if any indicators of domestic abuse did your agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

5.2.1 NHS Oldham Clinical Commissioning Group (responsible for the GP service), Pennine Acute Hospitals NHS Trust and Greater Manchester Police are the three agencies that held information in relation to the indicators of domestic abuse.

5.2.2 Catherine and John were patients at the same GP practice for several years. Catherine usually saw the same GP and John saw several different GPs. On one occasion, he was treated by the same GP as Catherine.

5.2.3 Catherine made several visits to see her GP in 2009 with low mood for which she was prescribed anti-depressants. There does not appear to have been any discussions between Catherine and her GP about her marriage or any routine enquiry about domestic abuse. The IMR author says that the routine enquiry of domestic abuse is not mandatory outside the scope of maternity services. However, it is good practice to discuss any concerns with the patient and offer support and referral to domestic abuse services. Therefore, at this stage in 2009, there was no expectation domestic abuse should have been explored.

5.2.4 However, in October 2010 Catherine disclosed to her GP that she had been arrested for assaulting John. There is no evidence the GP considered the risks of abuse or made any referrals for support. John was a patient in the same practice as Catherine and, based upon what Catherine told her GP, on the face of it, he was at risk from her. It is now known that Catherine was in fact suffering domestic abuse from John, and had been for several years. The panel discussed whether a risk assessment should have been completed based upon what Catherine told her GP. The panel concluded that in 2010 there would have been no so such expectation. At that time, NICE guidance on GP risk assessment had not been issued[16].

[16] These standards are now incorporated into Domestic Violence and Abuse National Institute for Health and Care Excellence Quality Standard 2016. Quality Standard One requires health and social care practitioners to recognise indicators of possible domestic violence and abuse and respond appropriately. They should make

5.2.5 John was already known within that practice to have problems with alcohol consumption. Indeed, he had a long history of consultations with GPs at the practice at which his excessive alcohol consumption was the main discussion point. Catherine also told her GP that he *'drinks lots of alcohol'*.

5.2.6 His medical records could have been checked by that GP and that information discovered. That in turn could have opened opportunities for assessing the risks to Catherine and John from each other and for sensitive exploration of what was happening in their marriage.

5.2.7 However, at that time, revised procedures for dealing with domestic abuse were not in place; the Royal College of General Practitioners did not publish their toolkit for primary care until 2012. Procedures had not yet been revised to create an expectation that health care professionals would support and advise victims of domestic abuse. The panel avoided the temptation to apply hindsight and contemporary policy and practice to historic events and therefore make no criticism of the actions of the GP at that point in time.

5.2.8 Both Catherine and John continued to make presentations to their surgery after 2012 with indicators that could have triggered exploration of domestic abuse. When Catherine attended in May 2012 she was struggling to sleep and was suffering again with low mood. On this occasion, she received medication and the offer of a referral for counselling which she did not take. There does not appear to have been any exploration of domestic abuse nor of what had happened to her since Catherine disclosed she had assaulted John in 2010. There is a known connection between mental health and domestic abuse. Men and women with mental health problems are at an increased risk of being victims of domestic violence[17].

5.2.9 John was seen in the practice on several occasions between the disclosure by Catherine in 2010 and her death. He disclosed excessive alcohol consumption on many these occasions and once he was recorded as smelling strongly of alcohol when visiting the surgery (24.05.2011). There appears to have been no exploration of the reasons why he drank excessively, nor the impact it had upon Catherine. While John often saw different GPs, on 15.03.2012 and on 14.10.2013, he saw the same GP that treated Catherine and to whom she made the disclosure in 2010 that she had been arrested for assaulting John. No actions were taken, save on the first occasion John was advised about his drinking. While the panel recognises there are issues around patient confidentiality the panel believes this was a missed opportunity to make some connections and ask some sensitive questions particularly about the impact of John's alcohol consumption upon his relationship with Catherine. Excessive

sensitive enquiries of people presenting with indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe.

[17] Trevillion, K. et al. 'Experiences of domestic violence and mental disorders: a systematic review and meta-analysis' PLOS ONE http://dx.plos.org/10.1371/journal.pone.0051740

alcohol consumption is a well-known indicator of domestic abuse that should be recognised by health professionals[18].

5.2.10 The Oldham Clinical Commissioning Group IMR author has identified two practice improvements that have been made since Catherine was killed by John. The first change concerns how all healthcare practitioners are now expected to provide support to victims of abuse and make referrals to external agencies as required. There is now a need to increase the knowledge and confidence of practitioners to be able to fulfil this role in an effective manner and an agency recommendation has been made (see Oldham CCG recommendation 1).

5.2.11 The second improvement relates to the way in which services are provided to patients who misuse alcohol. This issue is explored further in section 5.5. The Oldham CCG panel member confirmed that none of the blood tests carried out on John by his GP revealed indicators of excessive alcohol consumption. However, evidence that John may have been misusing alcohol was available as recently as 12.03.2015 when John was seen in Pennine Acute Ophthalmology clinic. A letter from the clinic to his GP states that as John has disclosed smoking and drinking every day, the doctor was questioning whether John may have a condition affecting his sight called tobacco-alcohol amblyopia. Catherine's family believe that, only if specific tests had been requested would John's misuse of alcohol been detected. They believe the attendance at the ophthalmic clinic was an indicator of alcohol misuse.

5.2.12 Pennine Acute Hospitals NHS Trust also had an opportunity to identify indicators of domestic abuse when John was admitted to their Emergency Department on 28.02.2010. On that occasion, he was brought in by ambulance having told North West Ambulance Service control that he had been assaulted by Catherine. This led to a call being sent to Greater Manchester Police and Catherine being arrested.

5.2.13 Despite that information being known it appears no thought was given to domestic abuse and his injury was treated as a possible assault. One of the reasons for this was that John was said to be very difficult in the department refusing to stay for a period of head injury observation. While there should have been some exploration with John as to how he came by his injury the panel believe his behaviour may well have made this very difficult.

5.2.14 Greater Manchester Police hold records on four domestic incidents involving Catherine and John which occurred in 2000, 2006, 2010 and 2011. In the three most recent cases John is identified as the primary victim and Catherine as the perpetrator. Analysis of the incident in 2000 is not appropriate given the length of time since it happened and the paucity of information.

[18] There is a large body of research linking alcohol and domestic abuse. Alcohol is associated with incidents of physical and severe physical domestic violence. Institute of Alcohol Studies: Alcohol, domestic abuse and sexual assault September 2014

5.2.15 The incident in 2006 was of a verbal nature and the attending officer recorded John as the victim. The officer stated John was drunk and that, following an argument about Catherine being frightened to go to hospital for a major operation, he telephoned the police for advice. The officer did not complete a risk assessment on this occasion. The officer cannot recall very much about what happened. After ten years, it would not be reasonable to expect the officer to recall why they might not have recorded a risk assessment. Information has been migrated between different systems since this incident and is now difficult to audit. Much of Greater Manchester Police policy and practice has also changed. Consequently, in respect of analysing policy compliance, there is little learning to be drawn from this incident.

5.2.16 However, it is noteworthy that it was John that telephoned the police about Catherine being 'frightened'. John's actions in telephoning the police to intervene in an issue like this appeared unusual; dialogue with the GP would appear to be the more appropriate route that most members of the public would follow. One hypothesis might be that this was John attempting to use the police to frighten Catherine. This would constitute an example of coercive control and is discussed later in section 5.3. Another hypothesis could be he was genuinely concerned that she was frightened about going into hospital. The panel was careful not to dismiss the fact that males can be victims of domestic abuse without attributing that status to John.

5.2.17 When John was seen in prison he was asked about this incident. He said they had argued and he rang the police because he feared Catherine might be violent towards him. There is no independent evidence to support his statement. His call to the police specifically stated that it was Catherine that was in fear of going to hospital. Neither in the call to the police nor in the conversation with the police officer that attended did John ever mention that he was in fear of Catherine. What is clear is that, like almost every other contact he had with the police, he was either intoxicated or there was evidence he had consumed alcohol.

5.2.18 The attending police officer recorded John as the victim and Catherine as the perpetrator on this occasion. However, when the summary document held on the legacy Public Protection Investigation Unit system[19] was checked, their roles had been transposed with Catherine appearing as the victim. Neither the police officer attending nor the IMR author can explain why this happened.

5.2.19 The DHR panel believe this incident highlights the difficulty in some cases of correctly identifying who is the victim and who is the perpetrator and address this at the end of section 5.2 It is particularly difficult to identify the primary victim where there is no immediate evidence of injury, damage or force. In this case John seems to have been recorded as the victim solely on the basis that he made the 999-telephone call. That in turn has led to Catherine being

[19] This is a system used by Greater Manchester Police to hold relevant material on issues such as domestic abuse. It interfaces with their Operational Policing Unit System (OPUS) which is a computerised system used within the force to store intelligence/data.

recorded as the perpetrator. However, Catherine's actions appear to stem from her reaction to John's continuing coercion and control.

5.2.20 While the panel makes no criticism of the actions of the police on this occasion they believe it demonstrates the need to gain a good understanding of what is going on in relationships. Approved Professional Practice[20] from the College of Policing (that was not available in 2006) now includes this specific advice;

'In all cases officers must take the wider context of the relationship and any history of abuse into account, in addition to the nature of the specific incident'.

5.2.21 The incident in 2010 did contain very clear evidence that violence was involved. An ambulance had been called and John had a head injury. The police officer that attended appears to have identified this as such and taken positive action in line with contemporary policy. John made a specific allegation of assault against Catherine and told the police officer he wanted to make a complaint. As such the police officer had the necessary grounds to arrest Catherine and their initial actions appeared to the panel to have been both lawful[21] and in line with police and Home Office guidance on positive action. The panel will analyse at section 5.3 the way in which the matter was then dealt with when Catherine reached the police station.

5.2.22 The police officer that dealt with the case completed the 1-12 data that was required at that time on the FWIN. This included a risk assessment which contained the following words;

"Very decent pair, incidents have happened in the past with both parties being responsible; Catherine has a notifiable occupation and is likely to face work disciplinary actions as a result of the caution which will bring further tensions in the house – low/medium risk".

5.2.23 Once again the records held by the police show that John was intoxicated and that Catherine was not. Because an incorrect code was used to close the FWIN it was not identified as an incident for assessment by the Public Protection Investigation Unit and there was no follow up contact made. Consequently, no safeguarding action was undertaken and no referrals to support groups or agencies were made.

5.2.24 It is a matter for conjecture whether, had there been a follow up or referrals made, specialist scrutiny might have changed things and provided clearer insight into what was happening within the relationship between Catherine and John. John had indicated to the police officer that attended that he did not want any follow up contact from support agencies. Consequently, the failure to close the log correctly may have had no impact on whether there was a follow up. Policy and practice has changed significantly since then and

[20] www.app.college.police.uk/domestic-abuse-index

[21] Code G Police and Criminal Evidence Act 1984 sets out the grounds for a lawful arrest. In short there must be reasonable grounds to suspect someone is guilty of an offence and arrest must be necessary to achieve several specified criteria one of which is the investigation of the offence.

the panel have avoided the hindsight test. However, they are reassured by the Greater Manchester Police IMR author's conclusion that current procedures are now much more robust and that a similar incident now would result in a referral being made to the Public Protection Investigation Unit. However, the panel noted that to attract the attention of the Public Protection Investigation Unit, a correct coding would still be needed.

5.2.25 The call to the police in 2011 was again made on the 999 system by John. Both John and Catherine spoke to the call taker and gave their version of events. Again, it appears John had been drinking and he cited the previous incident when he sustained a head injury (incident three). Catherine was clearly concerned about this as she said she feared losing her job.

5.2.26 A log for the incident was created and John was recorded as the victim and Catherine as the perpetrator and a police officer attended their address. They concluded the incident did not involve an assault or threats and was a verbal altercation. Alcohol was cited as a factor. The police officer completed a risk assessment recording John as the victim and Catherine as the perpetrator and indicated in one of the questions that Catherine had previously been arrested for assault. The risk level was shown as 'standard'[22].

5.2.27 On this occasion the log was correctly closed which resulted in it then being reviewed by a specialist in the Public Protection Investigation Unit. That officer completed an enhanced risk assessment which included reference to the 2010 incident and one in 2006. The action taken showed John had been spoken to and all was fine between them, but they were both stressed due to people in the family being ill. John was advised to contact the police if he needed anything further. No referrals were made to support agencies and, because John was given victim status, he was not signposted to alcohol support groups (this issue of intoxication will be considered further at term 4).

5.2.28 The Greater Manchester Police IMR author believes that, because each case was taken in isolation with John as the victim, the severity of the impact on the relationship between him and Catherine was never fully realised. No one got beneath the surface of what was going on. The most recent incident in 2011 occurred when the DASH model was in place. Question 28 provides an opportunity to document other information relevant to the victim's vulnerability including alcohol abuse. The answer recorded here was that there was *'no other information to add'*. The IMR author believes this was a missed opportunity. However, none of the cases outlined above reached the numerical threshold for a referral to MARAC which, at that time, would have been the only real mechanism to ensure any intervention by appropriate agencies.

5.2.29 The DHR panel has carefully considered all the incidents the police have recorded. They concur that a wider look at the couple's relationship would

[22] By this date Greater Manchester Police had changed their system for assessing risk from the 1-12 model to the current DASH 1-28 model. Standard equates to 'low' risk of harm.

have been helpful in discovering what was going on and who was exercising the real power and control. However, the panel accept the four incidents in question were several years apart and that practice and policy locally and nationally has now changed significantly. This means that deeper exploration, even of those cases recorded as standard or medium, is now more likely to happen. For example, in the Greater Manchester area partners are piloting an initiative called STRIVE in which standard domestic incidents are re-visited to understand and address the underlying causes and triggers.

5.2.30 While welcoming these improvements, the panel returned to the issue that John was always recorded as the victim. Now that a wider view can be taken as to what was going on in their relationship it is by no means clear John was the victim, nor, that Catherine was the perpetrator. Apart from the third incident in 2010 there appears to be no evidence, other than John's account that Catherine was abusive or aggressive to him during these incidents. One hypothesis the panel has considered is that, by always making the first call, John has intentionally portrayed himself to the police in the role of victim. The panel recognise this is a tactic that is sometimes used by perpetrators to divert attention away from their own behaviour[23].

5.2.31 The panel concludes this section by reinforcing their earlier view: that great care needs to be applied when determining 'who is the victim?' and 'who is the perpetrator?' The panel accepts that agencies systems and processes mean that they need to make an early identification of these roles. While the panel does not suggest this happened in the case of Catherine or John, care needs to be taken to avoid reaching inaccurate or hasty judgments. Doing so may just allow manipulative and determined perpetrators to hijack the system with misleading information.

5.2.32 This can have both immediate and far reaching consequences. It can lead to victims losing trust in agencies and feeling they will never be believed. For example, as happened in this case, because Catherine was never identified as a victim she was never given the opportunity to receive support from a specialist agency. While we know, Catherine was a private person, and declined counselling, contact with a support agency such as an Independent Domestic Violence Advocate (IDVA) may just have provided the right circumstances for Catherine to open up and disclose what was going on in her relationship. She told trusted friends what was happening.

5.2.33 This is exactly what happened when Catherine was in hospital following the stabbing. It is clear she felt safe, and within the sanctuary of a hospital ward, could disclose an accurate picture of her relationship with John. This picture showed to the IDVA that she was the victim of domestic abuse and that John was the perpetrator. The police system for recording domestic incidents

[23] "Partner blaming is a very common strategy that is used by perpetrators of domestic violence to mitigate their responsibility. Sometimes perpetrators will carefully paint the picture that their partner is responsible" The Pennine Domestic Violence Group: http://www.pdvg.org/perpetrators-of-domestic-violence/harmful-strategies-of-avoiding-responsibility

demands that officers make a binary choice of who is the victim and perpetrator. As is known, that determination is not always obvious. The following sections show the complexities of identifying the real perpetrator.

5.2.34 Gadd et al [2002] identified 4 groups of men who present as domestic abuse and violence victims:

Non retaliatory - won't use/instigate abuse but will use force to restrain a partner who is attacking him

Retaliatory - Abuse in response to the partner's prolonged abuse and controlling behaviour

Equal combatant - instigates/abuses in proportion to his partner's abuse

Primary instigator - who is the instigator of abuse but whose partner will respond to this abuse with force on occasion

5.2.35 Gadd suggests the need to screen the person who states they are a victim as this will identify a primary aggressor and a primary victim. If the primary aggressor is stating they are a victim this needs to be managed in a way that doesn't elevate risk to the primary victim - including undertaking any activity with the victim that may be seen, by the primary aggressor, as collusive or supporting his version of events or his perception of the abuse dynamic. Where this has to happen (e.g. Arrest), then additional support needs to be offered to the primary victim in terms of signposting to support, risk assessment.

5.2.36 Johnson [2012], who argued for a bespoke response to domestic violence and abuse that was not always gendered also identified 4 typologies of domestic violence and abuse:

Situational couple violence - both parties are equally abusive as each other and do not appear to desire to control the other (usually younger couples or couples who have not developed healthy conflict resolution tactics)

Intimate partner terrorism - the typically gendered form of domestic violence and abuse with a male perpetrator and female victim and coercive and controlling behaviour a feature of the abuse dynamic

Co-responsive abuse - where an intimate terrorist is subjected to an assault from his victim, normally with the intention of stopping abuse from occurring or worsening

Mutual couples violence - where both parties are wishing to control each other and may extend this dynamic outside of their relationship to preserve their relationship (e.g. Rape/torture of victims to feed their dependency on each other)

5.2.37 Johnson also advocates for screening to determine the typology of abuse. Once this established, then the primary aggressor also needs to be assessed as the extent and nature of risk they pose to their victim, but also their motivation to change, or motivation to consider change. If this is assessed as genuine, then Johnson does promote the use of engagement to support their omission on the cycle of change lDicelmente 2009] in a non-collusive manner that appropriately challenges without escalating risk. In these cases, and potential trigger issues (e.g. drugs, alcohol, etc.) are addressed in addition to, and often alongside, the domestic violence and abuse. Such support challenges gender stereotypes, instrumental violence, non-healthy parenting, etc., and in some cases explores the perpetrator's background to ascertain links to childhood experiences of domestic violence and abuse.

5.2.38 The Chair and author of the domestic homicide review thought John was an intimate terrorist or primary instigator who did not appear to be motivated to change as nothing was his fault. He was sophisticated in his exertion of coercive and controlling behaviour and so is likely to fall within the category of Westmoreland 2017's research with little success to reform his behaviour. However, in 2006, the general level of awareness about coercion and control was far less than in 2017 and therefore while in principle it seems an opportunity was missed in 2006 to explore who the primary perpetrator was, it would be unfair to suggest the officers were lacking in their response. Nevertheless, the non-recognition of the complexities of perpetrator types is part of the learning from this review.

5.2.39 The current DASH risk assessment model is not designed to deal with this level of sophistication.

5.3 Term 2

How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

5.3.1 Catherine never spoke out to any agency about the domestic abuse she received until she was in hospital receiving treatment after John stabbed her. Consequently, no agency had the opportunity to provide her with services or support in respect of domestic abuse. Catherine appears to have received a good service from all agencies when she was in hospital. However, there is no learning to be gained from an analysis of those services as the crucial issues and learning in this case occurred in the years leading up to the attack upon her.

5.3.2 The only agency John made his views known to was Greater Manchester Police. This section will not rehearse each of these contacts that have already been covered earlier. However, Catherine's family feel strongly about incident three and the impact it had upon her life. The panel feels there is a key piece of learning to be found in respect of this incident.

5.3.3 The officer that attended was presented with evidence from which it was reasonable to suspect that an offence had been committed and that Catherine had committed it: John had a cut on his head and he said Catherine hit him in the face with her fist and he fell down the stairs. It seems the actions of the police officer that arrested Catherine were compliant with both Code G of the Police and Criminal Evidence Act 1984 and with that part of Home Office Circular[24] 16/2008 which encouraged an approach of *'positive action'*. Arresting a suspected offender is regarded as *'positive action'*. The panel believes the arresting officer's actions were reasonable at that point.

5.3.4 Catherine was taken into custody. She declined the services of a solicitor and was interviewed for thirteen minutes during which she fully admitted to the assault. To assist in determining what should then happen[25] the officer completed a gravity matrix. This gave a final score of two which, if taken in isolation, would have made Catherine suitable for a caution. That part of the Home Office Circular describing the use of cautions is set out, in part, below;

'Use of cautions is rarely appropriate in domestic abuse cases. This is because cases coming to police attention are not usually the first offence and the nature of such offences tends to constitute a breach of trust. For these reasons, it is always preferable for domestic abuse defendants to be charged and prosecuted where the case meets the evidential prosecution test and the public interest test. Supervisors should closely monitor the administering of cautions in domestic violence cases and should only be considered as an appropriate disposal only when:

- *There is some evidence that it is a first domestic abuse offence and there have been no other reports or intelligence of previous abuse to the victim or previous partners or family members;*
- *The defendant has no previous police record of violence;*
- *The case has been reviewed by the CPS and they have taken the decision not to progress a prosecution;*
- *The investigation has been reviewed and the officer in charge is satisfied that there is no potential for investigation development;*
- *Other possible criminal sanctions have been examined and progressed.*

[24] From time to time the Home Office issues Circulars are addressed to the Commissioners of the City of London and Metropolitan Police and Chief Officers of Police for other areas. They contain advice and guidance as to the way in which certain policing functions should be discharged. They are not statutory guidance although there is an expectation they will be followed. The policy on the issuing of cautions has changed since this event. The most recent guidance is now The Director's Guidance on Adult Conditional Cautions Guidance to Police Officers and Crown Prosecutors Issued by the Director of Public Prosecutions under Section 37A of the Police and Criminal Evidence Act 1984 7th Edition: April 2013.

[25] There is a spectrum of ways in which allegations of crime can be dealt with. They include no further action, bailing the suspect while further enquiries are made, issuing the suspect with a caution, summonsing or charging the offender so that they appear before a court to answer the allegation.

Where a positive action policy has been adhered to and officers still have difficulty in securing a charge/summons, forces need to have a system in place to ensure that simple cautions are considered in preference to an NFA decision'.

5.3.5 The Greater Manchester Police IMR author states that the circumstances of this case would not have met the above criteria for a caution to be administered. This is because; it was not the first reported domestic incident; the case was not reviewed by the CPS and the victim was supportive of a prosecution per his statement which meant that there was potential for the investigation to develop.[26] There is also no record John was consulted before the caution was issued and the officer in the case has no recollection of this. The Inspector who administered the caution cannot recollect the case specifically and says their decision would have been informed by the score on the gravity matrix. They cannot recall if consideration was given to the Home Office circular or if this case was ever presented as one of domestic abuse.

5.3.6 The IMR author states it will never be known whether a charge and prosecution through the court system, as opposed to a simple caution, would have made a difference in this case. The panel felt that there should have been an exploration by the interviewing police officer of the disclosure by Catherine that she had been punched in the face by John while they were in the car. The panel felt the officer should have asked Catherine whether she had reported the matter as she was in fact disclosing an assault.

5.3.7 Rather than issuing a caution for the assault on John, if Catherine had been bailed and a file referred to the CPS they may have advised that further enquiries were made and this might have impacted upon whether any action was taken against Catherine. In addition, the panel felt that John's behaviour towards Catherine (i.e. drunk, being abusive and invading her personal space while using the lavatory) was unreasonable. The CPS or a court may have taken a view that Catherine response to that (i.e. pushing John out of the way) was therefore reasonable.

5.3.8 While the above is conjecture, the DHR panel do believe that consideration of an alternative outcome might have opened an opportunity to explore in more depth what was happening in the relationship between Catherine and John. As it was, the whole incident was over, a caution issued and Catherine released from the police station within two hours. Because Catherine received a caution this placed John in a position in which he could exercise greater power and control over his wife. The panel do not suggest or infer that Greater Manchester Police had any reason to recognise this might happen. As noted

[26] When John was seen in prison by the DHR chair and author, he said he told the police officer to give Catherine a fright which is suggestive of informal action. That claim, made to the DHR chair and author, is not wholly compatible with making a written statement supporting a prosecution. This is yet another example of John's manipulative behaviour.

under the previous term of reference, it is not always readily apparent who the real victim is.

5.3.9 Catherine's family believe she was a nervous person who would have been frightened of police stations and would simply want to get out of custody as quickly as possible. It is therefore entirely possible that she accepted the offer of a caution without considering or understanding the wider consequences for her professionally or personally. She told Sarah she thought it was *'just a telling off'*. As a nurse, Catherine was then required to report what happened to her professional body, the Midwifery and Nursing Council, which placed her in some jeopardy. Of more concern is the fact that, in the words of Sarah, John was given a '*weapon'* to use against Catherine in the future. The Crown Prosecution Service list, 'Reputational Damage' as a potential indicator of coercive and controlling behaviour.[27]

5.3.10 When describing the incident, Catherine told her sister that she was now trapped. John threatened her with calling the police if they argued and of telling her family. Catherine said she was *'terrified'* of the police. It is known that John carried out his threat to tell the police when he rang them in relation to Incident four and told them that Catherine had assaulted him in the past. Telling the operator about this made Catherine concerned as she then told the operator herself about her worries.

5.3.11 The panel believe that John's behaviour towards Catherine, by threatening to ring the police and of threatening to disclose this to the family was probably an example of coercion and control. [28] This is evidence to support the hypothesis raised in paragraph 5.2.16. The Home Office DHR Guidance that defines coercion and control as (including);

'Threats to reveal or publish private information.'

5.3.12 The panel discussed that males were victims of domestic abuse and in this case felt that while on the face of it John claimed to be, and was recorded as, a victim of domestic abuse, the actual victim was Catherine as identified by the analysis.

5.4 Term 3

What knowledge did your agency have of the debt and alcohol misuse within the household?

5.4.1 There are references to John and Catherine, at one stage, having a joint debt of about £27,000. When John was seen in prison he said the couple at one-time owned address two outright. However, because of debt, they had taken a mortgage on that address of '*about £30,000'* which was used to redeem the debt. The next paragraph shows that the mortgage on the house was over

[27] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

[28] Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship.

£73,000, something that John must have known when he told the DHR chair and author that it was about £30,000. Again, this illustrates his mendacity, manipulation, minimisation and willingness to deceive with misinformation[29].

5.4.2 It appears that debt once again mounted as Catherine told Sarah at Christmas 2014 that address two had been sold and used to clear debt. Enquiries by Greater Manchester Police disclosed that in September 2014 Catherine had a credit card with an outstanding balance of £5,818. Enquiries by the panel member from Citizens Advice Oldham reveals this figure was included within £15,000 that Catherine owed to six different lenders. At the same time the couple had a joint mortgage on address two of £73,855.

5.4.3 In addition to this information there have been several references to a PPI claim of around £19,000 that may also have been used to clear debts. When seen in prison John said that Catherine could claim this amount back with the help of Roger.[30]

5.4.4 The DHR panel have not tried to unpick the complexity of the couple's debt issues over the years. However, they are satisfied that debt was an issue and that it caused tension in the relationship between Catherine and John, particularly so in the year leading up to Catherine's death when John was not working[31]. The debt was such that it required the house to be sold, resulting in a move to public sector accommodation as tenants. When seen in prison John said that he and Catherine kept their finances separate and acknowledged that he ran up debts on credit cards to fund holidays. The panel did not attribute the debt within the household as a causative factor of John's abuse of Catherine; it was a feature which caused tension.

5.4.5 The only agency (other than financial institutions) that had knowledge of this debt, and that it was an issue in the relationship, is Greater Manchester Police. There was only one reference to this in John's statement to the police following Incident three. John said they had argued over money and Catherine's spending on credit cards. The police officer that attended did not identify John's comments as being reflective of the couple having financial difficulties especially as he was aware that Catherine was employed in a local hospital. No referrals were made by the police to any agencies that could assist with debt.

5.4.6 Several agencies knew about the issue of alcohol misuse by John. The GP surgery was one of those. John was a patient there for twenty-four years and during that time discussed his alcohol intake with different GPs on six occasions. John always denied that he used alcohol excessively. He was advised to reduce his alcohol intake by a GP on three occasions. There is no

[29] Sarah says statements she has seen documentation which shows the mortgage to have been £110,000 at one stage.

[30] Sarah provided the panel with letters that confirmed a successful PPI claim had been made. As part of the probate arrangements the family say a substantial amount of this remains unspent.

[31] Sarah states that at one stage John was subject to a court order which threatened the sale of the house. This concerned the order of a boiler that was then cancelled.

evidence that John took steps to do that and neither is there evidence that John was offered a referral to the community alcohol team or advised that he could self-refer. However, these events pre-date the introduction of measures within GP surgeries to improve alcohol interventions.

5.4.7 Greater Manchester Police held information from several sources relating to alcohol misuse from John. It was recognised in incidents two, three and four. Alcohol misuse was always attributed to John and there is no evidence, or suggestion, that Catherine was ever intoxicated.

5.4.8 No referral was made by the police to alcohol services in respect of John's misuse. The IMR author for Greater Manchester Police spoke to the officers who attended the incidents in 2010 and 2011 and neither of them identified John's alcohol consumption as a problem. The IMR author believes it is possible that John was not referred into alcohol services because he was always considered to be the victim in this case. The panel discussed this point and believe it would be good practice to consider referring perpetrators and victims who have are believed to misuse alcohol towards an appropriate service.

5.4.9 There were two occasions when Greater Manchester Police received information John was driving while intoxicated. On the first occasion an unsuccessful search was undertaken for his car. On the second occasion a search was not made because some of the information was not accurate nor specific enough.

5.5 Term 4

What debt and alcohol services are available locally to help people in abusive relationships?

5.5.1 There are many services available to support persons with debt issues in the Oldham area. Oldham Council's web site provides residents with advice on debt and money. The site also contains links to the following services;

- Money Advice Service: An independent service set up by government, which helps people manage their money. The service offers free and impartial advice and works in partnership with other organisations to help people make the most of their money;

- The National Debt Helpline: An independent charity, dedicated to providing free debt advice by phone and online to people across the UK;

- Citizen's Advice: The organisation provides a wide range of debt and money management advice to the public, online, by telephone and in person at its local offices which include offices in Oldham, Rochdale, Tameside and Central Manchester;

- Age UK Oldham: Members of the public can complete an online referral form for the agency's Information and Advice Service for Welfare Benefits. People referring themselves are contacted by telephone within two working days and any subsequent appointments will be booked as necessary. Alternatively, people can call in at Age UK's Information Centre, in Oldham town centre 9.30am – 3.30pm each weekday for general advice and non-form filling appointments with advisors. Advisors can also be contacted for help or to make an appointment each weekday. They can order written guides or just speak with people to point them in the right direction for the help they need.

5.5.2 The panel member from Citizens Advice Oldham was asked to consider whether they could have provided help to Catherine and John if they had approached them. While the panel member said, it was very difficult to advise retrospectively he felt there were several options the couple could have been given advice about.

5.5.3 The panel considered the issue of whether the services outlined above were comprehensive enough for local users and whether they were sufficient to help residents in abusive relationships. The panel concluded they were in both instances. They received information from Citizens Advice in relation to a pilot delivery plan for the Greater Manchester Police and Crime Commissioner (GMPCC) that helps deliver legal and financial advice for vulnerable victims of crime including the victims of domestic abuse.

5.5.4 The Oldham Clinical Commissioning Group IMR author states that in 2016, in respect of alcohol services, primary care practitioners should discuss with the patient if they consent to a referral to the community alcohol team. An Early Help Team was commissioned in 2015. The early help assessment is designed to help people to develop self-help and self-management skills to meet their long-term needs.

5.5.5 The IMR author says the team consists of various professionals who can support victims of domestic abuse, including Independent Domestic Violence Advocates (IDVA) whose role it would be to support the victim on a wider scale, looking at their personal objectives and representing the victim at the Multi Agency Rick Assessment Conference (MARAC). Alcohol and mental health workers form part of this Early Help Team. These professionals can provide advice and support to empower individuals on a short-term basis.

5.5.6 There is no indication an AUDIT[32] assessment was ever carried out on John. The Criminal Justice Lead for Substance Abuse believes, had one been carried out, John would have scored 20+ and should have been referred on for

[32] The Alcohol Use Disorders Identification Test was introduced by the World Health Organisation. The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. A score of 20 would place a person in the highest zone of risk.

assessment & evaluation. They are of the view there is little to suggest that work was done to look at John's motivation to address his level of drinking or any harm minimisation approach taken. They state that every indication is that John would have been treatment resistant, reluctant to engage and opportunities were probably missed for this to be challenged. The only other possible option would have probably been a more coercive approach forcing John to be assessed and that may have been through the reports of his drink driving or the alcohol question in the DASH assessment that were never able to be taken further. Nevertheless, the Criminal Justice Lead states that, even if referred into treatment, none of this may have influenced John's abusive or violent behaviour, because the root cause of his behaviour was his need to control Catherine.

5.5.7 At the time of these events alcohol services locally were delivered through Oldham Addiction Dependency Solutions (ADS) and the Oldham Drug and Alcohol Services (ODAS). There is now a joint drugs and alcohol service commissioned by Oldham Council known as 'One Recovery'. Referrals into this service can be made in several ways. These include self-referral, by a GP or by a health or social care professional. Police officers can 'sign post' an individual to these services.

5.5.8 Oldham Council's IMR author states that the breadth of the recovery model is such that there are plenty of opportunities to support both men and women in abusive relationships. People identified as being in abusive relationships can be referred to and supported by Oldham Council's Early Help services and MASH and then referred to One Recovery, if required. Alcohol interventions are also provided at a local hospital and these also provide a route into alcohol treatment and other services. The Inspire Programme for Women, provided as part of the Council's Early Help Offer, would be relevant for women in abusive relationships.

5.5.9 In Oldham professionals from several agencies have also attended training sessions on the Blue Light Project. These aim to help professionals improve the response to family members and carers of problem drinkers. By attending these sessions professionals gain a better understanding of the local response to family members and carers of problem drinkers and identify gaps and barriers in the response pathway[33].

5.5.10 The panel concluded that there appeared to be a good understanding within the partnership that alcohol abuse was often present in domestic abuse. The services that are provided appear to be comprehensive and well publicised. The panel are satisfied the services are sufficient to help those in abusive

[33] The Blue Light Project was established following a domestic homicide review in Rochdale in 2011. It challenges the belief that if a problem drinker does not want to change then nothing can be done to help. The project challenges this approach. It shows that positive strategies and alternative approaches can be used with this client group. Blue Light Project: The Project Manual-Alcohol Concern 2014.

relationships and that professionals in agencies would be able to direct or refer people into these services.

5.6 Term 5

Were there any barriers in your agency that might have stopped the victim from coming forward to seek help for her domestic abuse victimisation and debt?

5.6.1 Catherine was never identified as a victim of domestic abuse and never disclosed to any agency that she or John had any debt problems. No agency has identified any obvious barriers that might have prevented Catherine seeking help. Catherine was an experienced local health professional who would have known something about domestic abuse and how to access services.

5.6.2 Sarah says there is evidence in a folder she has recovered that Catherine was trained in safeguarding and the various forms of abuse. Sarah believes this indicates that even someone who has attended training may not recognise their own situation as an abusive one.

5.6.3 Catherine told Sarah in December 2014 that she had received debt counselling. Local checks by the DHR panel have not identified that Catherine visited a debt counselling service in the Oldham area. However, it could be that Catherine was referring to the advice provided by Roger.

5.6.4 There are many reasons why victims of domestic abuse do not report it to agencies. An informative chart appears at Appendix B.

5.7 Term 6

What knowledge did the family, friends and employers have of the adults' relationship, including the household debt that could help the DHR Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

5.7.1 Family and friend's knowledge of the relationship between Catherine and John is outlined in some detail at section 3 and is therefore not repeated here. One of those friends was Catherine's work colleague who did not believe Catherine was in any danger of being seriously harmed by John and therefore respected Catherine's wishes to keep the details of the relationship confidential. The colleague told Catherine she would support her if she wanted to leave John.

5.7.2 The first knowledge the family had that there may be abuse in the relationship was in December 2012 when Catherine spoke to Sarah by telephone and told her that she had been arrested almost three years previously. Catherine visited the family soon after and said that John was an alcoholic. Her family appear to have encouraged Catherine to visit a solicitor and were keen that she ended the relationship with John. Catherine received financial support from her

mother. Catherine told them she had visited a solicitor, received advice and told John what she had done. It appears it may have been his promise to stop drinking that then made Catherine decide to remain.

5.7.3 Sarah said she had found a telephone number on Catherine's mobile telephone for a firm or solicitors she believed Catherine may have approached for advice. Sarah thought this might just have been an initial free consultation and did not think much would have been recorded and basic advice given. Enquiries were made by the panel with this company. They were not able to find any record of contact with Catherine.

5.7.4 Catherine also disclosed the debt issue to the family in December 2014 when she said that address two had been sold to clear debts. The family were disappointed the house had been sold as they felt they might have been able to help the couple keep it. It does not appear that Catherine disclosed to the family the full extent of the financial problems her and John had to deal with over several years.

5.7.5 Catherine is described as a private person. While she made limited disclosures to friends it appeared she did not want this information sharing more widely. This was certainly something that female three felt would have prevented her from approaching an agency, unless there was something very serious to disclose. Neither family, friends nor employers recognised/appreciated the seriousness of the problems nor had all the information to put the pieces together and recognise what was going on in the relationship between Catherine and John.

5.7.6 Catherine was a devout Catholic and one hypothesis the DHR panel have considered is the extent to which her faith may have prevented Catherine from taking steps to disclose John's abuse and to leave the relationship. Friends urged Catherine to leave John. However, Catherine told them she would never be forgiven by God if she did leave. That was a mistaken belief. David Hunter discussed the issue of the Catholic Church's position on this issue with Catherine's former parish priest. He confirmed that the Church's position is that, in such circumstances, there is no 'requirement' to remain in an abusive relationship, and that 'forgiveness' is not an issue as there is nothing to 'forgive'. Open source information available on the internet makes this position very clear.

5.7.7 One hypothesis the DHR panel considered is that Catherine was too embarrassed to raise the issue of forgiveness. They felt a good learning point arising from this review is that none of Catherine's friends who knew of her dilemma thought to seek independent advice on the Church's attitude to forgiveness in these circumstances. The panel wondered if Catherine kept much of what was happening in her relationship from her family, again because she did not want to embarrass herself and them. Additionally, John's controlling behaviour may have made Catherine too frightened to disclose the real issues for fear of retaliation, against her, should he find out she had told her family.

5.7.8 This hypothesis was shared with Sarah. She thought Catherine possibly gave different reasons for not leaving, at different times, to different people. Catherine's Sister felt Catherine would have been more upset about worrying the family than being ashamed to tell them. Sarah felt a major factor was their mother telling Catherine to leave.

5.7.9 Why Catherine did not take the advice of her friends, family and particularly her mother will never be known. However, the panel felt it was helpful to conclude this section with an important contribution from Sarah. She felt that Catherine was naïve and that she was susceptible to suggestions. She felt that John would have found her easy to control. That may explain why Catherine did not take some of the opportunities and advice given to her and why, if John had promised to stop drinking in December 2012, she believed him and did not divorce him then.

5.7.10 A hypothesis that has been raised is that John had threatened to involve the police and to use the caution Catherine was given as a 'weapon'. The panel reinforce their belief that, if this hypothesis is true, it indicates that John was someone who used coercion and control over Catherine. That may well be the major reason why Catherine did not leave John; because she was too frightened of what he might do to her, her career and her reputation. There is some evidence for this in that Catherine's family and friends report that she was very concerned that she would lose her job if the police became involved again.

5.7.11 Catherine did not discuss her relationship difficulties with her parish priest. Had she done so she would have received clear impartial advice on the Church's position of remaining in an abusive relationship. In some domestic homicide reviews undertaken by the chair and author, involving faith groups, such impartiality is not always present.

5.8 Term 7

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

5.8.1 The Greater Manchester Police IMR author has identified some shortcomings in respect of the procedures for finalising codes on police logs that meant the incident in 2010, when Catherine was arrested, was not brought to the attention of the Public Protection Investigation Unit. This has already been discussed at length under term two. As mentioned earlier, since these events, much of the policy and procedure used by Greater Manchester Police in relation to domestic abuse has been improved and changed because of national and local lessons. A key step was the change to the DASH model of risk assessment in 2011. While incident four in 2011 was compliant with that process the level of risk meant it did not reach the threshold for MARAC.

5.8.2 The CCG IMR author identifies that the care provided to John in respect of his alcohol misuse did not promote what is regarded as best practice. While the

single and multi-agency policies then in place in respect of the GP's involvement with Catherine and John were followed, these policies and procedures have now changed in line with legislation and recommendations.

5.8.3 Pennine Care identified that on two occasions district nurses noted that Catherine was low in mood but no explanation documented as to the reason. Had this been documented it would have provided evidence for the reason for low mood and subsequent actions. On the one occasion, it was documented, this was due to the failed surgery and Catherine being told there was nothing else that could be done for her. No other agencies identified any gaps in policies and procedures.

5.9 Term 8

How effective was inter-agency information sharing and cooperation in response to the subjects' needs and was information shared with those agencies who needed it?

5.9.1 There was no information shared between agencies in respect of Catherine or John's needs until Catherine was admitted to hospital after he stabbed her. No referrals were made by any agencies in respect of Catherine and John's needs until that time. The reasons why John's GP and Greater Manchester Police did not sign post or refer John are outlined above.

5.10 Term 9

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

5.10.1 Catherine and John were white British with English as their first language. Catherine had been a devout Roman Catholic since her very early years and John converted to Catholicism after he married Catherine. Neither the Panel nor the agencies contributing to this review, saw any evidence that the services provided to them were in any way biased because of their individual characteristics.

5.11 Term 10

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

5.11.1 None of the agencies contributing to this review identified that there was any ineffective management of practitioners by their respective agencies.

5.12 Term 11

Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

5.12.1 There were no issues in relation to capacity or resources identified by any of the agencies contributing to this review that affected the ability of agencies to provide services to the victim before she was stabbed by John.

6. LEARNING IDENTIFIED INCLUDING GOOD PRACTICE

6.1 GOOD PRACTICE

Greater Manchester Police

6.1.1 The IMR author believes that the force's roll out of the STRIVE[34] programme, since the events in this DHR, provides the platform of open communication and early intervention for both the victim and the perpetrator. STRIVE involves professionals from partner agencies and voluntary sectors who have the skills to provide the necessary wrap around care or to signpost the individual to the relevant support group. This means that relevant issue, like John's misuse of alcohol, are much more likely to be identified and appropriate support offered.

NHS Oldham Clinical Commissioning Group

6.1.2 Some shortcomings were identified in the way in which support could have been offered to John by his GP surgery in relation to his misuse of alcohol. NHS Oldham Clinical Commissioning Group believe the commissioning of the Early Help Team will have a positive impact on the support that is now available. They have also identified significant improvements with regards to the way in which domestic abuse is handled. There is now an expectation that health care practitioners will provide support to victims and make referrals were required. Discussions should take place with patients to explore concerns and the victim's wishes.

Central Manchester Foundation Trust

6.1.3 There were no specific actions or learning for this agency. Their only contact with Catherine was after she was admitted to hospital following the stabbing. The agency feels that health care staff responded appropriately and sensitively to concerns around domestic abuse. They believe the case tested their domestic abuse systems and processes and it was found that all procedures and guidance was followed and staff went the extra mile to ensure Catherine's safety and provide reassurance and a safe environment.

Oldham Council Adult Social Care

6.1.4 Oldham Adult Social Care identified several points of good practice in respect of the way they dealt with Catherine's needs when she was admitted to hospital after she had been stabbed. Her case was quickly allocated to a social worker who began collecting information the same day and acted promptly in contacting, and visiting, Catherine. The social worker worked very proactively with Catherine, her family and friends to ascertain her wishes, identify her support needs and to agree how those needs would be met when she left hospital. This extended to considering accommodation options and the case notes and associated documentation indicate that the social worker would have involved the Police in discharge planning to make sure that any risk of

[34] Funding for the STRIVE initiative is in place courtesy of the Mayor of Greater Manchester's Office until March 2020.

further domestic abuse was identified and minimised prior to Catherine leaving hospital. The social worker also maintained regular contact with other professionals involved in the case, coordinating plans and actions.

6.1.5 Oldham Council Adult Social Care identified some gaps in practice however these all relate to events after Catherine was admitted to hospital. These include that alcohol and debt were not clearly documented as contributory factors to the domestic abuse. The Council believe that, if a similar case arose now their approach would be different as the Adult Contact Team is now integrated into the Multi Agency Safeguarding Hub. Multi agency planning meetings would be held to ensure a more holistic approach to identifying and mitigating risk, and planning support and other interventions.

LEARNING IDENTIFIED

6.1.6

LEARNING ONE
Leearning GPs need to undertake more probing and consider wider family issues when they receive important information that might indicate domestic abuse is occurring in a relationship.
Narrative In October 2010 Catherine told her GP that she had been arrested for assaulting John and that John drank a lot of alcohol. While the GP offered counselling, which Catherine declined the GP did not appear to explore these issues any further with Catherine. John was a patient at the same surgery and disclosed on different occasions that he misused alcohol. The GPs that saw John and were aware of his misuse of alcohol do not appear to have probed as to what impact this was having on his relationships and family nor whether there were any indicators of domestic abuse.

LEARNINGTWO
Learning The current model for recording and classifying domestic abuse is binary and results in almost immediate classification of one party as either victim or perpetrator. When in fact domestic abuse can be much more complex. Such a binary classification can then be compounded when subsequent calls are made. This leads to an assumption or perception being reached that the same person who was in the role of the victim/perpetrator last time will be

in the same roll the next time. A deeper exploration is needed before classifying domestic abuse events and there should be a willingness to revisit earlier classification when further information is received that might cast doubt on the original classification. There needs to be an awareness across all agencies that perpetrators might manipulate the system for their own ends.

Narrative

On each of the four occasions that Greater Manchester police received calls about domestic incidents between John and Catherine all the telephone calls were made by John who always placed himself in the roll of victim. When the police attended these calls, they seemed to accept John's version of events and subsequently recorded them as domestic incidents with John as the victim and Catherine as the perpetrator. Deeper exploration of the relationship may have revealed that this was not necessarily the case. When John reported domestic incident four he claimed Catherine had a history of violence against him and appeared to use the previous incident (incident three-03.10.2011) as a means of reinforcing to the police that he was a victim. In fact, this was a verbal argument in which John had been drinking and Catherine had not wanted to go out for a meal because her mother was ill. She could not reasonably have been said to be a perpetrator of domestic violence; yet the model for classifying domestic abuse requires one party to be determined as the perpetrator and one as the victim.

LEARNING THREE

Learning

Although neither John or Catherine received a referral to an agency, had either of them being referred as victims, then the offer of a debt counselling service would have been important to resolving their relationship issues and reducing the likelihood of future occurrences of domestic abuse.

Narrative

Throughout the relationship between John and Catherine debt seems to have been an issue that raised tensions and led to arguments. Albeit only one agency knew about it before Catherine was stabbed. This was Greater Manchester Police who were aware of the issue of debt as John outlined the nature of the problem when he provided a witness statement about incident three when he said he had been assaulted by Catherine.

LEARNING FOUR
Learning All disclosures concerning incidents of domestic abuse should be explored. There may be evidence of a crime that requires investigation and they also provide important information about what is happening in a relationship.
Narrative During her interview under caution with a police officer on 28.10.2010, Catherine disclosed that John had struck her in the face while they were in their car. The police officer conducting the interview did not ask Catherine whether she had reported the matter nor did they ask any exploratory questions about the incident.

LEARNING FIVE
Learning Not recognising when coercive and controlling behaviour is present in relationships can lead to: risk being understated and victims having uncontrolled vulnerability.
Narrative John's domestic abuse was founded on his desire to coerce and control Catherine. While this type of abuse is not new, the attention it received, and professionals' understanding of it, pre 2015 was not as prominent as current knowledge. Coercive and controlling behaviour is emerging as a significant risk factor in domestic homicide reviews.

7. CONCLUSIONS

7.1 Catherine was described by her family as *'really kind, especially to children, a dedicated nurse, who loved people; she loved giving and there is nobody we can think of that she didn't like nor who didn't like her and she had a close circle of friends'.* The family miss her tremendously and feel angry that John took her life and then when he was tried for her murder never said sorry, never said he loved her and never showed remorse.

7.2 Catherine's kind and loving personality also contained an element of naivety which Sarah felt meant that she was very trusting and susceptible to suggestions. She loved and cared for John, was loyal to him and forgave him his shortcomings of which he had a number.

7.3 Despite John's denials he misused alcohol. This was obvious from an early stage to Catherine's family and eventually to friends and others that knew him. It was the most obvious issue the DHR panel identified in this review. He continued to deny it when he was seen in prison. It should also have been clear to health professionals who had contact with him over the years.

7.4 While GPs advised him to exercise restraint, there was no attempt by them to sign post or refer John for specialist help. Catherine disclosed to her GP that she had been arrested for assaulting John. Further exploration of the impact of John's misuse of alcohol and this disclosure by Catherine might have opened opportunities for assessing the risks both Catherine and John faced. Quite why that did not happen is not clear. However different policies are now in place now within GP surgeries to ensure that similar cases are identified and appropriate support offered.

7.5 There were several contacts between Catherine, John and Greater Manchester Police. These comprised four calls over a period of fifteen years to addresses the couple lived at. These calls related to domestic incidents and, except for incident one of which detail is missing, it was John that made the call. All the calls involved verbal disagreements between him and Catherine except for incident three when John was injured.

7.6 The common feature from all the calls was that John was either intoxicated or had consumed alcohol. On the third occasion John said he wanted action taking against Catherine for his injury, he said he was willing to attend court. Catherine was arrested, interviewed and cautioned for the offence. Another example of John's obfuscation was when he was seen in prison for this review he claimed he didn't want Catherine prosecuted and only wanted her to receive 'a fright'. The fact he wanted his wife to be frightened, rather than receive help, also provides some further insight into his personality.

7.7 John's misuse of alcohol and the tensions resulting from household debt were not the cause of his behaviour towards Catherine. John's need to coerce and control Catherine was the causative factor. This can be evidenced when he told police that he wanted to give his wife a fright. Furthermore his tactic in

calling the police and claiming to be a victim was probably done to reinforce his dominance over Catherine and manipulate professionals.

7.8 Catherine should not have received a caution. Her case was not dealt with in accordance with the Home Office Circular that provided contemporary advice as to the circumstances a caution should be given in a case of domestic abuse. Catherine also made a disclosure that she had been assaulted by John when he struck her in the face while they were in their car. Had a caution not been given, then the case may have been open to further scrutiny by specialists in the Public Protection Investigation Unit or the Crown Prosecution Service and that might have revealed important information as to what was happening in her relationship with John.

7.9 Catherine's timid and naive personality may be the reason that she willingly accepted a caution, perhaps to get out of police custody as quickly as she could. The caution had much more serious consequences than Catherine might have realised. It put her in jeopardy with her professional body and Catherine's family believe that giving her a caution simply handed John a 'weapon' that he could use against her.

7.10 Apart from the first case, all other reports to the police showed John as the victim and Catherine the perpetrator. Except for incident three, when John received an injury, there appears to be no evidence when the police attended the incident to substantiate that was the case. The panel accept that agencies such as the police need to make early initial judgments as to who is the victim and who is the perpetrator. In this case those initial judgments appeared to have been based purely upon the fact that John was the person who made the call to the police and not what emerged when the police attended the calls.

7.11 In none of the incidents was John ever offered advice or signposting from the police for alcohol. This maybe because he was always recorded as the victim or maybe because the police officers did not believe that alcohol misuse was a significant issue. He declined the offer of specialist support following incident three. Catherine was never offered support and perhaps this was due to the fact she was always recorded as the perpetrator and never the victim.

7.12 Except for the third incident in 2011 there appears to be no evidence, other than John's word, that any of the incidents involved Catherine being abusive or aggressive to John. One hypothesis the panel has considered is that, by always making the first call, John intentionally portrayed himself to the police in the role of victim. The panel recognise this is a tactic that is sometimes used by perpetrators to divert attention away from their own behaviour.

7.13 It is clear Catherine's family believe the caution she received handed John a 'weapon' to use. Catherine was frightened of the professional consequences that followed and told her family so. She also told them that John threatened to ring the police about her, which he did on one occasion following the caution. Catherine had told friends that John had assaulted and abused her verbally in the past. They describe her being a different person when he came

home and sometimes coming to work after obviously crying. Catherine's family believe her personality made her susceptible. The panel believe John behaved towards Catherine in a way which showed he was trying to exercise coercion and control over her.

7.14 A key issue in this case is why Catherine did not leave John and seek a divorce when she had the opportunity. Certainly, friends and family gave her this advice and were willing to support her. Many reasons have been explored in this report and the DHR panel believe all of them remain possibilities. Catherine may have feared the shame of separation; the impact upon her relationship with family and the Church; her deep faith may have led her to believe that God would not forgive her, despite the advice her mother gave; she loved John was willing to forgive him and perhaps believed he would keep his promise to address his misuse of alcohol and change his ways. These are possibilities and will always remain so.

8. PREDICTABILITY/PREVENTABILITY

8.1 The Panel looked carefully and objectively at these points and sought evidence for its determinations.

Predictability

8.2 Until the incident that resulted in the homicide of Catherine, John had no convictions and was of good character. John was known to misuse alcohol however that fact alone did not make him a risk to Catherine or anyone else. Greater Manchester Police attended four incidents involving the couple prior to the occasion John stabbed Catherine. Except for the disclosure by Catherine when she was interviewed under caution that John had assaulted her, no agency had a reason to suspect John presented a risk to Catherine.

8.3 Friends and family had different pieces of the jigsaw that represented Catherine and John's relationship. No one had the full picture of what was happening in their lives. Given the geographic distances between friends, family and work colleagues it is very unlikely they would ever have come together to share what they knew. Each of them had given advice and support to Catherine that they appear to have felt was proportionate to the risks Catherine faced.

8.4 Even if a full picture had been available of John's behaviour towards Catherine, it would not necessarily have led to an assessment that she was at high risk of serious harm from John. John's actions appear to have been, in the words of the trial judge, *'a single, short-lived attack, triggered by loss of temper'*.

8.5 On the collective information known to all agencies it cannot be said that the death of Catherine could have been predicted although it could be predicted that calls for service to the police about the couple would continue.

Preventability

8.6 The Panel conclude that no agency could have prevented John from killing Catherine.

9. RECOMMENDATIONS

9.1 Introduction

Agencies' Recommendations

9.1.1 The agencies' recommendations appear in an addendum document and are not detailed here.

9.1.2 The domestic homicide review panel recommends;

(i) The Oldham Community Safety and Cohesion Partnership monitor the implementation of the participating agencies recommendations to ensure they are delivered and that agencies report on the progress they have made towards delivery;

(ii) The Oldham Community Safety and Cohesion Partnership request agencies ensure their systems and processes for identifying and categorising victims are flexible and capable of dealing with cases in which it is not clear who is in which role;

(iii) That, if it comes to light a victim has been a perpetrator, or vice versa, there is a process for re-visiting and, if necessary, reclassifying the roles;

(iv) The Oldham Community Safety and Cohesion Partnership request Greater Manchester Police take steps to raise awareness of domestic abuse services to persons who are in custody as perpetrators of domestic abuse;

(v) The Oldham Community Safety and Cohesion Partnership contact financial service providers and debt advisors operating in their area to identify whether they understand the link between debt and domestic abuse and whether they screen for domestic abuse;

(vi) The Oldham Community Safety and Cohesion Partnership explore what messages faith organisations are providing on domestic abuse in their area.

(vii) Greater Manchester Police consider, when a caution is to be administered for domestic abuse, if practicable, the case is first discussed with a specialist domestic violence officer.

(viii) That the Oldham Community Safety and Cohesion Partnership establishes whether professionals dealing with domestic abuse in its partner agencies have a good understanding of coercive and controlling behaviour and how to support victims subject to it.

Appendix A

Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

   "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.03.2013 is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

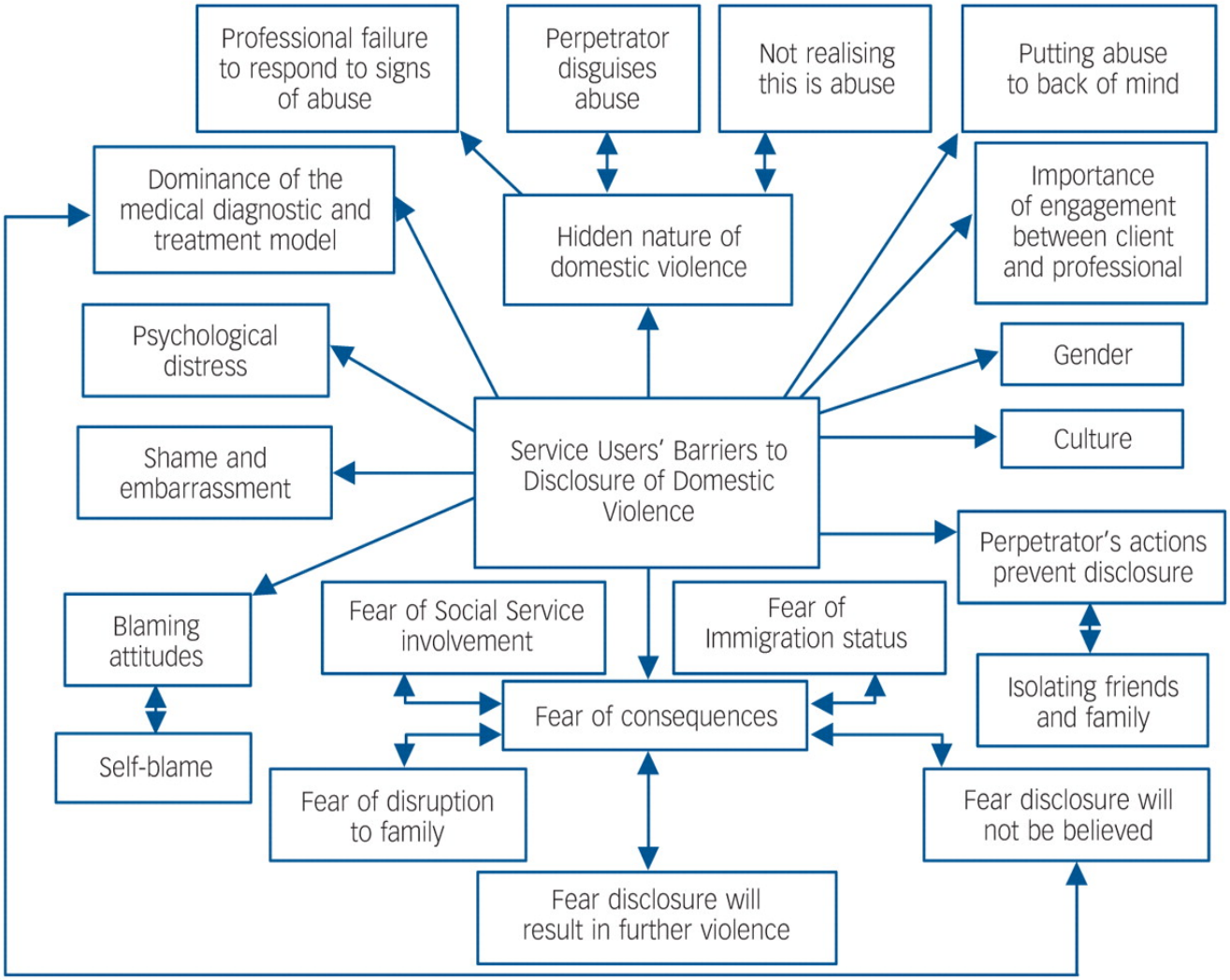
   - psychological
   - physical
   - sexual
   - financial
   - emotional

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

4. *Coercive behaviour is:* an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Appendix B

Barriers to Disclosure



Source: www.http://bjp.rcpsych.org/content/198/3/189.full

Appendix C

DHR Panel Recommendations

No	Scope of Recommendation	Action to Take	Lead Agency
1	The Oldham Community Safety and Cohesion Partnership monitor the implementation of the participating agencies recommendations to ensure they are delivered and that agencies report on the progress they have made towards delivery;	The implementation of the single agency and DHR Panel recommendations will be monitored through the Domestic Violence and Abuse Partnership and will be reported to the Community Safety and Cohesion Partnership	Oldham Council
2	The Oldham Community Safety and Cohesion Partnership Oldham request agencies ensure their systems and processes for identifying and categorising victims are flexible and capable of dealing with cases in which it is not clear who is in which role;	All agencies to be contacted and advised on the need for flexibility of service offer for individuals regardless of perceived status	Oldham Council
3	That, if it comes to light a victim has been a perpetrator, or vici versa, there is a process for re-visiting and, if necessary, reclassifying the roles;	Review within DVA Policy	Greater Manchester Police
4	The Oldham Community Safety and Cohesion Partnership request Greater Manchester Police take steps to raise awareness of domestic abuse services to persons who are in custody as perpetrators of domestic abuse;	GMP to ensure information (advice and support) is available to persons in custody through liaison and diversion processes.	Greater Manchester Police
5	The Oldham Community Safety and Cohesion Partnership contact financial service providers and debt advisors operating in their area to identify whether they understand the link between debt and domestic abuse and whether they screen for domestic abuse;	Letters to be issued to services and advisors through the CAB.	Oldham Council Citizens Advice Bureau

6	The Oldham Community Safety and Cohesion Partnership explore what messages faith organisations are providing on domestic abuse in their area.	Representative from Community Safety Services (CSS) to attend Inter-Faith Forum Meeting.	Oldham Council
7	Greater Manchester Police consider, when a caution is to be administered for domestic abuse, that if practicable, the case is first discussed with a specialist domestic violence officer.	Review within DVA Policy	Greater Manchester Police