

Manchester Community Safety Partnership



Domestic Homicide Review Report:

'Shawn'

Died: August 2017

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Domestic Homicide Review - Shawn

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1.0 Introduction

1.1 The victim Shawn died after sustaining multiple stab wounds on 24th August 2017. He was 47 years of age. His body was found at the address of his partner Lisa, aged 46, who was later arrested and charged with his murder. Lisa subsequently pleaded guilty to manslaughter and was sentenced to four years and six months imprisonment.

1.2 In September 2017 Manchester Community Safety Partnership (CSP) decided to conduct a Domestic Homicide Review. David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has over six years' experience as an independent author of DHRs and other statutory reviews. He has no connection to services in Manchester. Membership of the DHR Panel and a description of the methodology by which the DHR was conducted is set out in Appendix B. A statement of the independence of the author and chair of the DHR Panel can be found at Appendix C.

1.3 DHR Panel meetings were held in December 2017, March 2018 (this meeting had been scheduled to take place in February but had to be cancelled due to adverse weather conditions) and July 2018 and the final report was approved by Manchester Community Safety Partnership at the end of August 2018.

1.4 A Coroner has the discretion to resume an inquest (or not) following the conclusion of criminal proceedings, and in the case of Shawn decided not to hold an inquest following the conviction of Lisa.

1.5 Manchester Community Safety Partnership wishes to express condolences to the family and friends of Shawn.

2.0 Terms of Reference

2.1 It was decided that the period to be covered by this review should be from 1st January 2016 until the date of the victim's death on 24th August 2017. Also included will be the Sexual Assault Referral Centre (SARC) contact with the perpetrator Lisa following her arrest in connection with the death of Shawn.

2.2 It was also decided that full histories of both the victim and perpetrator would be considered to enable a full understanding of any mental health and substance misuse issues, vulnerabilities and risks.

2.3 The general terms of reference are as follows:

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

2.4 The case specific terms of reference are as follows:

- How partner agencies responded to indications of domestic abuse within the relationship between the perpetrator and the victim.
- How the risks presented by the perpetrator and the risks to which the perpetrator was exposed were responded to by partner agencies?
- How the risks presented by the victim and the risks to which the victim was exposed were responded to by partner agencies?
- How did the mental health issues experienced by the perpetrator, and the substance misuse issues experienced by both the victim and the perpetrator, affect the way in which partner agencies responded to indications of domestic abuse?
- How did difficulties in engaging with the victim and the perpetrator affect the way in which partner agencies responded to indications of domestic abuse?
- Consider whether the social care function has been adequately fulfilled by agencies with those responsibilities, in respect of the perpetrator and victim.

2.5 Equality and Diversity

The review considered equality and diversity in relation to the seven 'Protected Characteristics' set out in the Equality Act 2010 and found that there were no issues for further consideration in this case.¹

¹ <https://www.equalityhumanrights.com/en/equality-act>

3.0 Glossary

Domestic violence and abuse 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 psychological, physical, sexual, financial and emotional abuse.

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.

Coercive behaviour is a continuing 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.

Fair Access to Care Services (FACS) The eligibility criteria are set out in the 'Prioritising need' framework guidance. The aim is to ensure that there is fair access to services for individuals living in the same authority and, depending on the council's resources, for individuals with similar levels of social care needs in different parts of England. The criteria describe in an open and transparent way the evidence of levels of social care need that should be demonstrated during an assessment.

The Gateway Service is the single point of access for Manchester Mental Health and Social Care Trust's community services. Part of the Adult Community and Social Inclusion Division, it is staffed by dedicated administrators. It improves access to services by ensuring that service users are quickly placed and supported in the service most appropriate to their needs. The aim is to complete all routine referrals within 24 hours of receipt.

Mental Capacity Act: The Act is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 or over.

Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

Olanzapine belongs to a group of medicines called antipsychotics. Antipsychotics are psychiatric drugs which are available on prescription, and are licensed to treat types of mental health problems whose symptoms include psychotic experiences. It is administered orally. It is commonly used in the treatment of schizophrenia and acute manic episodes of bipolar disorder.

Self-Neglect: The statutory guidance which supports the Care Act 2014 defines self-neglect as covering “a wide range of behaviour including neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding”.

4.0 Synopsis

The victim Shawn – brief history prior to relationship with perpetrator Lisa

4.1 At the time of his death the victim Shawn was 47 years of age. He had a lengthy history of using alcohol and drugs. On several occasions he was referred to a local unit which specialised in treating alcohol dependency, but his sporadic attendance often led to his discharge from treatment. In general, his lack of engagement with primary and specialised care services adversely affected his overall physical and mental wellbeing and may have impacted on his ability to make fully informed decisions about his care and support needs. It is understood that Shawn was a father of adult children and also a grandfather. Because several of the agencies in contact with Shawn did not have records of the fact that he had children, it is not known whether, or to what extent, he had contact with his children. However, none of Shawn's children or grandchildren were known to MCC children's social care during the period covered by this review.

4.2 Shawn had been prescribed methadone as an opioid substitute since at least 1990. He was registered with GP practice 1 from 1993 until his death. He was referred to Drug Services in 2002 and a consultant letter written the following year noted that in addition to his daily methadone, he was using around three bags of heroin a day as well as crack cocaine. Shawn had been known to the police from 1989, primarily for offences involving dishonesty, many of which may have been committed to fund the purchase of illicit drugs.

4.3 He was also known to the police for incidents of domestic abuse involving partners, former partners and his father. He often appeared to become threatening and aggressive whilst intoxicated. The most serious of these incidents took place in 2003 when he used threats of violence to force a former partner to have sexual intercourse with him. Later the same year Shawn was convicted of raping his former partner, sentenced to three and a half years imprisonment and registered as a sex offender for life.

4.4 From the point at which he was released from prison until his death, Shawn was managed and supervised by GMP's sex offender management unit (SOMU).

4.5 In 2006 a partner of Shawn reported two incidents of assault which had resulted in a cut finger and bruised eye socket. Shawn was arrested and charged but his partner later withdrew her allegation and the prosecution was discontinued.

However, he was recalled to prison for breaching the terms of his licence relating to the prior rape conviction.

4.6 Shawn was referred to the community alcohol team on several occasions during the period 2008 to 2010.

4.7 The police had three contacts with Shawn and his then partner over the period 2010 to 2011. Each incident involved intoxicated altercations between Shawn and his partner in the street. No injuries were noted or complaints of assault received and the police took no further action.

4.8 In August 2012, Shawn contacted the police in a confused state claiming there were numerous people in his house 'flying across the room.' Upon police arrival there was no evidence of any other persons having been in Shawn's house which generated concern for his mental health. The police made no referral as Shawn did not consent to the sharing of his details.

4.9 On 19th September 2013, the ambulance service requested police assistance in returning Shawn to GP practice 1 which he had left after declining treatment for sepsis due to his ulcerated legs having become infected. Shawn was located and taken to hospital 1 where he eventually agreed to be admitted. He was noted to have been drinking and presented as argumentative.

4.10 The ambulance service referred Shawn to MCC adult social care because of concerns about his awareness of his own health and wellbeing. His ulcerated legs were considered to be associated with self-neglecting behaviours particularly his lack of personal hygiene. Additionally, Shawn had told GP practice staff that he didn't care whether he lived or died.

4.11 Whilst Shawn was in hospital, a contact officer from the Local Authority contact centre spoke to Shawn over the phone and concluded that he had 'substantial needs' in relation to fair access to care eligibility criteria 2003 (FACS). During the conversation Shawn said that he was 'sick of people's concerns' and the only help he needed was with housing. He was provided with the contact details of several social housing providers.

4.12 After being treated in hospital for four days, Shawn was considered to be medically stable and was discharged to the care of his GP. The hospital made no contact with adult social care prior to discharging Shawn and it would appear that a proposed community care assessment (under Section 47 of the NHS and Community Care Act 1990) to facilitate a planned and supported discharge from hospital was terminated as a result. Adult social care also concluded that there were no

safeguarding concerns in respect of Shawn. There was evidence of self-neglect by Shawn but at that point self-neglect had not yet been formally categorised as a potential adult safeguarding concern.

4.13 On 14th October 2013, the manager of a nursing home contacted the police to report that Shawn had entered by forcing his way through a rear door of the premises and appeared intoxicated, confused and disorientated. The police attended and concluded that Shawn could be experiencing mental health problems. He appeared confused and claimed to have walked out of hospital 2 earlier that day having been admitted following a head injury. No information about any such head injury has been shared with this review.

4.14 Shawn agreed to return to hospital where he was transported by ambulance. Staff in A&E noted Shawn's lower legs to be infected but he left the hospital before he could be examined by a doctor.

4.15 The police were notified but it is unclear if further attempts were made to return Shawn to hospital. However, the police referred Shawn to adult social care, who referred him to the Mental Health & Social Care Trust Gateway Service on the grounds that Shawn appeared to have a primary support need relating to mental health issues, secondary issues with drug and alcohol misuse and the appearance of unmet social care needs.

4.16 On 6th December 2013 it was decided not to accept the referral in respect of Shawn after mental health services made several unsuccessful attempts to contact him. When these failed, mental health services informed GP practice 1 that they had received a referral from GMP, they had been unable to make contact with Shawn and as a result had been unable to complete an assessment of his mental health needs and were discharging the referral. GP practice 1 was advised to refer back to mental health services should Shawn present to his GP and require support with his mental health needs.

4.17 Over the following years Shawn was periodically referred by GP practice 1 to secondary health services for gastric problems but he frequently did not attend appointments. The final such referral was to hospital 2 in June 2016, but after Shawn did not attend he was discharged back to his GP.

4.18 Shawn also contacted his GP for additional prescriptions often claiming that his medication had been lost or stolen. The response of GP practice 1 was to decline additional prescriptions and offer advice about the safe storage of drugs. The GP practice also implemented a system which limited Shawn's prescriptions to a weekly frequency. The final contact the practice had with Shawn was in February 2017

when he again stated that he had lost his medication. No replacement prescription was allowed.

4.19 On 16th August 2016 SOMU officers visited Shaun to complete an annual management plan. The outcome was that his risk was reduced from medium to low on the basis that he had been managed in the community for a number of years, was settled in address 1, benefitted from the support of his parents and there had been no intelligence to indicate any risk of sex offending. In reducing his overall assessed risk, the SOMU officers added the caveat that the adverse effects on Shawn's mental and physical health of his drug and alcohol misuse was an area in which he remained at medium risk.

4.20 Shawn was last seen at GP practice 1 in November 2016 when he cut his finger on a tin and had the wound dressed. He rejected advice to have an x-ray as the cut was near the joint.

The perpetrator Lisa– brief history prior to relationship with victim Shawn

4.21 At the time of the death of Shawn, Lisa was 46 years of age. She had been under the care of mental health services on several occasions since the age of twelve. She had a diagnosis of schizophrenia, suffered with panic attacks and had a history of alcohol dependence. She had been registered at GP practice 2 since July 1996. There is no record that Lisa had contact with MCC's community alcohol team in an effort to reduce drinking and/or work towards abstinence and recovery. Lisa has a teenage son who was looked after by her mother. There is evidence to suggest that Lisa's money management and budgeting skills were an issue which may have impacted on her ability to have use of a mobile telephone and access health appointments. This may have further limited her opportunities to have her mental state and medication compliance reviewed on a regular basis.

4.22 Between 1999 and 2005 Lisa was referred by her GP to mental health services on several occasions but frequently did not attend outpatient appointments. When this happened she was discharged back to the care of her GP.

4.23 Lisa was known to the police for one criminal offence (obtaining services by deception in 2000) and was also perceived by the police to be both a victim and perpetrator of domestic abuse.

4.24 In August 2007 Lisa's partner contacted the police to report that she had been assaulting him for some time and disclosed marks on his body. Her partner said that Lisa was schizophrenic but had not been taking her medication. Lisa was arrested but her partner later withdrew his complaint and asked the police to advise Lisa to desist

from assaulting him. The CPS declined to authorise a prosecution despite a police appeal.

4.25 During the same month the ambulance service was contacted by Lisa who was described as intoxicated and 'suicidal'. She said she had cut her own throat. Lisa was found in bed with a deep cut to her neck which she was unable to offer any explanation for. Nor was she able to account for a number of bruises noted on her body. Her partner (the same partner as in the previous paragraph) was arrested but denied responsibility. Lisa was treated at hospital 1. As Lisa stated she had no recollection of how she came by her injuries and both she and her partner had been found in a 'heavily intoxicated' state, no further action was taken. The A&E liaison practitioner at hospital 1 made a referral for community mental health team (CMHT) support and cognitive behavioural therapy (CBT). Risk of exploitation in relation to Lisa's partner was mentioned in the referral.

4.26 At the end of the same month there was a third incident involving Lisa and her partner. He contacted the police to say that Lisa was 'smashing the place up' and that as a result he had barricaded himself in the living room. The police attended and no sign of damage or disturbance was found. Lisa was noted to have several injuries, some of which appeared recent. She said she was unable to recall how the injuries had been sustained. Her partner was arrested but later released without charge after Lisa declined to assist the investigation. Both parties were noted to be 'highly intoxicated'.

4.27 In October 2007 Lisa's partner again contacted the police to allege that she had been threatening him with a knife. The police attended and established that a verbal argument had taken place and then subsided. Lisa's partner said that he had found a knife in Lisa's belongings and had 'panicked' as he alleged that she had previously held a knife to his throat. Both parties were noted to have been drinking heavily and the police decided to take no further action.

4.28 Lisa attended psychiatry outpatient appointments in September and October 2007 following the referral by the A&E practitioner (Paragraph 4.25). She reported better relationships with her mother and her partner, reduced alcohol consumption, that she was taking her medication and her mood had improved. However, Lisa did not attend the following three planned appointments and was discharged back to the care of her GP.

4.29 In March 2008 Lisa was treated for a graze to her right elbow in hospital 1 A&E after being found in the road smelling strongly of alcohol by a passer-by.

4.30 Later in March 2008 Lisa's partner contacted the police to say that she was drunk and refusing to leave his home. He added that she had mental health issues and needed to be 'sectioned.' Lisa had left the property prior to the arrival of police and they took no further action.

4.31 In July 2008 Lisa's GP referred her to psychiatry outpatients and the Community Mental Health Team, (CMHT) stating that Lisa had a history of not attending appointments with mental health services but was now willing to engage. The GP recorded that she was compliant with her medication, but was experiencing paranoid thoughts that people were against her and ruminating over trivial worries. Her mental state was identified in the referral as stable but with a risk of relapse. Lisa attended an outpatient appointment in September 2008 when she described experiencing paranoid thoughts but no thoughts of harm to others. Her prescription of Olanzapine was increased and she was offered an assessment which it did not prove possible to complete as Lisa was not at home on the four occasions when the CMHT called to conduct the assessment. She was subsequently discharged by the CMHT but remained under the care of psychiatry outpatients.

4.32 In October 2008 Lisa's partner contacted the police to allege that she had assaulted him by biting his finger. She was arrested and charged with common assault and received a conditional discharge for twelve months.

4.33 The following month Lisa complained to police that her partner had punched her in the face inflicting a cut and swollen eye. He was arrested and later cautioned for the offence.

4.34 In January 2009 Lisa was treated in A&E at hospital 1 for a fractured left forearm which she said had been caused by a fall three days previously.

4.35 In June 2009 Lisa's partner contacted police to complain that she had become verbally abusive and had punched him. When officers attended Lisa was asleep in bed. Her partner did not wish to make a formal complaint and the police took no further action.

4.36 In September 2009 Lisa's partner contacted police to say that Lisa, who he described as his 'ex-girlfriend' was drunk and throwing things around his home. No criminal allegations were made and the police transported Lisa to her own home.

4.37 The following month Lisa's now ex-partner contacted the police to say that she had burst into his home in a drunken condition and had punched and kicked out at him. When police arrived Lisa had already left and her ex-partner said she had not actually accessed his flat but had been trying to get in. Lisa's ex-partner contacted the

police on a further two occasions over the next few hours to complain that she had returned to his address and was trying to gain entry. On each occasion Lisa had left the premises prior to the arrival of the police and no action was deemed necessary.

4.38 During an outpatient appointment in October 2009 Lisa disclosed that sometimes she drank a lot of alcohol and when she did so, she became paranoid, thinking that she had killed someone. Her Olanzapine prescription was further increased.

4.39 From the end of 2008 until the end of 2009 Lisa's housing provider is said to have made several referrals to mental health services following anti-social behaviour complaints from Lisa's neighbours. Mental health services have a record of one referral from Willow Park Housing Trust in November 2009. She had disclosed that her brother had assaulted her and was noted by a housing officer to have a bruise under her eye and red marks around her neck. She apparently did not wish to report this matter to the police. Lisa disclosed domestic abuse she had experienced in previous intimate relationships but said that she was in a new relationship and 'now everything was fine.' Lisa said she was keen to re-establish contact with psychological services. The housing officer contacted the CMHT the following month requesting that Lisa be offered a support worker due to her vulnerability.

4.40 Lisa was seen in outpatients in early 2010 and the doctor explored the incident with her brother which resulted in her being assaulted. Lisa said that she could not fully recall it as she had been drinking heavily at the time. She said that as a result of the incident and complaints from her neighbours to her housing provider, she had stopped drinking. She added that she was keeping herself busy and had a male friend with whom she spent time. She was experiencing some paranoid thoughts and requested a support worker from the CMHT. The outcome of the appointment was a further increase in Olanzapine and a review in clinic in 6 week's time.

4.41 A community psychiatric nurse (CPN) from the CMHT completed an assessment of Lisa at her home address two weeks later. Lisa described recent events which had resulted in the noise nuisance complaint to the housing provider. She said she had reduced her alcohol consumption in recent weeks. She described thinking that people were out to get her but she said that she was able to use distraction techniques to manage these thoughts. She said that she sometimes missed a dose of Olanzapine because she felt that it made her feel drowsy in the morning. The assessment did not identify any social care needs with Lisa being able to maintain her home to a good standard, shop and cook for herself, reportedly exercising and socialising with a male friend. Following this assessment, it was agreed that Lisa did not meet the criteria for support from the CMHT and would be seen in outpatients.

4.42 Lisa was assessed as stable when seen at outpatient clinic in February 2010 but did not attend appointments over the following months and was discharged back to the care of her GP.

4.43 In July 2010 Lisa's ex-partner contacted the police to say that she had been pressing the buzzer at his flat and was refusing to leave. She had left the flat prior to police arrival and her ex-partner declined to support any further police action.

4.44 Later the same month Lisa attended A&E at hospital 1 having banged her shoulder getting into a taxi the previous evening. She had a history of spontaneous shoulder dislocation with the first instance having taken place approximately four years previously whilst she was cleaning windows. She was referred for physiotherapy. At this time, she was noted to suffer from depression and was said to live alone.

4.45 In August 2010 Lisa's GP referred her for a psychiatry appointment. The referral acknowledged that she had previously been discharged after not attending appointments but she was said to be feeling anxious and paranoid. She was seen in an outpatient clinic in November 2010 at which her frequent non-attendance at appointments was discussed with her. She acknowledged that if she wanted support from the CMHT she would need to engage with services.

4.46 It was decided that Lisa would receive a further CMHT assessment to establish if she met the criteria for support from the team. This assessment was completed in January 2011 by a social worker from the CMHT. However, it was not initially possible to complete the assessment because Lisa was intoxicated and unable to remain on topic. The social worker returned to complete the assessment later in the month. This assessment is holistic considering both health and social care needs.

4.47 The assessment found that Lisa was able to meet all of her daily living needs, although sometimes her thoughts prevented her from going out. She described no problems with her diet and was able to cook for herself. She also said she was able to look after her home. Lisa's main area of concern was her paranoid thoughts. When outside her home she believed that people were talking about her and that something was going to happen. This could lead to her isolating herself. Lisa was able to describe distraction techniques which she could use to help manage her symptoms. She again acknowledged that she occasionally missed taking a dose of Olanzapine as it sedated her.

4.48 She denied any current or past thoughts of harming others. She expressed occasional thoughts of self-harm but it had been two years since she had last experienced these thoughts. She said she was happy and settled in her current address. She said she was in receipt of benefits and managed her bills independently.

She raised no concerns about her relationships at that time saying she had a good relationship with her mother. She said she had never used illicit substances. She acknowledged that she used alcohol as a way of coping with paranoid thoughts. She did not perceive her drinking to be a problem and did not want any additional support with this.

4.49 The assessor concluded that Lisa did not require a care coordinator under the care programme approach (CPA) but may benefit from accessing a drop in service.

4.50 Lisa continued to be offered psychiatric outpatient appointments but was discharged back to the care of her GP in June 2011 as she appeared stable and there was no identified risk to herself or others. In August 2011 Lisa's GP again referred her to the CMHT on the grounds that she was omitting to take Olanzapine at times. It was decided to offer Lisa an outpatient's appointment but she did not attend and was discharged to her GP who subsequently referred her back again in November 2011. Another outpatient appointment was offered which Lisa did not attend and she was again discharged to her GP.

4.51 During 2011 surgical intervention was discussed for Lisa's spontaneous shoulder dislocations but by September of that year she had been discharged after disengaging.

4.52 In December 2012 Lisa's ex-partner contacted the police to report that she had just hit him in the chest and was refusing to leave the pub where he was living. Upon police arrival it was noted that both parties were extremely intoxicated. As neither party wished to make any allegation against the other, the police transported Lisa home. This was the final domestic abuse incident involving Lisa which was reported to the police prior to her relationship with Shawn beginning in May 2017. All of the prior reported incidents had involved the same partner.

4.53 In March 2013 Lisa's GP referred her back to mental health service outpatients reporting that she had become increasingly paranoid over the previous few weeks and as a consequence was spending most of her time at home. The GP reported that Lisa was cohabiting and did not require any support with activities of daily living. It was also reported that she was compliant with her medication.

4.54 Lisa was seen as an outpatient in August 2013. It was noted she was experiencing panic attacks when out alone and was anticipating them when she was at home prior to going out. She was also experiencing discreet periods of paranoia when she thought that people were against her. She said she was living alone but had a boyfriend she saw a few times a week. She was said to be drinking twice weekly. A treatment plan was agreed with Lisa and shared with her GP. This involved continuing

with Olanzapine at the current level whilst discontinuing Venlafaxine and introducing Citalopram. Her GP was advised to refer back if further support was required.

4.55 In January 2016 Lisa was admitted to hospital 1 A&E after being found collapsed in the street. She had been drinking. She was assessed by alcohol liaison services and noted to be drinking 40 units per week. She was provided with advice and said she planned to contact improving access to psychological therapies (IAPT) services to address her underlying anxieties.

4.56 On 20th February 2016 a friend of Lisa contacted the police to say that he had not seen her for three weeks and had become concerned. Three days later Lisa was traced when she contacted the ambulance service after falling in the street and injuring her head following what she described as a three day 'drinking binge'. She was taken to hospital 2 but left prior to undergoing a computerised tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body). The police were contacted and effected entry to her flat and returned her to hospital for treatment.

4.57 On 24th March 2016 a member of the public alerted police to Lisa who was found to be drunk and staggering in the street. She was noted to have what was described as an 'old' black eye and marks on her neck she attributed to falling over. She was transported to her then partner's (not Shawn) home.

4.58 On 7th June 2016 Lisa attended GP practice 2. During the medical review she said that she was under stress as an un-named drug addict was living in her home. She said that her family were changing the locks the following day.

4.59 On 26th August 2016 Lisa reported offensive graffiti written on the front door of her flat to the police. She suspected her neighbour to be responsible.

4.60 On 9th November 2016 Lisa visited GP practice 2 and reported that she was hearing voices and that people were speaking to her from the dead. She requested a referral back to the community mental health outpatient service. She appeared unkempt and smelled strongly of body odour. The GP made the referral to the integrated care gateway and stated that Lisa was reporting symptoms of psychosis and drinking alcohol to excess. The referral also indicated that in the past she had been vulnerable and exploited by others. (The GP did not request a social care assessment for Lisa or indicate in the referral that she had any social care needs.)

4.61 The response from the CMHT referral and allocation meeting where the referral was reviewed was for Lisa to be offered an outpatient appointment and advice was given to the GP to consider a referral to Drug and Alcohol Services. The

Dual Diagnosis Service was not offered as the service had been redesigned and no longer provided appointments for patients. It is now a consultancy service which provides advice and support to staff on the management of patients with alcohol and substance misuse issues. Lisa was offered a psychiatry outpatient appointment for 10th May 2017, which was six months after the GP referral and in line with the outpatient standard operating procedure (SOP).

4.62 On 5th January 2017 a gas operative carrying out an annual gas service at address 2 referred Lisa to the housing provider as he/she was concerned that Lisa was talking to herself and drinking alcohol in the afternoon. Tenancy support made two unsuccessful home visits before making contact with Gateway Mental Health. The latter advised that they were providing a service to Lisa and that she had an appointment with a psychiatrist in May 2017. (There is no record of this contact from the housing provider in Lisa's clinical notes).

4.63 On 11th January 2017 Lisa's GP wrote to her to advise her that psychiatry would send her an appointment to see a consultant in outpatients. The GP advised that community alcohol services were now provided on a self-referral basis and their contact details were provided.

4.64 The following day a DWP assessor for a personal independence payment (PIP) assessment expressed concern about Lisa's presentation, in that she appeared 'unwell'. Lisa's GP practice was made aware but took no further action. Usual practice would have been to inform the GP who knew the patient best and the GP safeguarding lead. The DWP concern about Lisa would then have been discussed at a weekly meeting to consider any patients the practice were concerned about. However, none of these actions appear to have taken place.

4.65 On 8th February 2017 the landlords property team made an in house safeguarding referral over concerns about offensive graffiti on Lisa's letter box. The housing providers anti-social behaviour team attempted to make contact to discuss the issue with Lisa but she did not respond and a new letter box was fitted.

4.66 On 27th April and 3rd May 2017 psychiatry outpatient reception staff left messages on the mobile phone number they had for Lisa to remind her of her forthcoming outpatient's appointment on 10th May 2017. Greater Manchester Mental Health NHS Trust (GMMH) has advised the review that it is not possible to establish when a letter notifying Lisa of the appointment was sent 'due to the way in which the letters are auto generated by the patient clinical record system, Amigos'.

4.67 Lisa did not attend her outpatient's appointment on 10th May 2017. Another appointment was booked for 11th November 2017 but the doctor responsible did not

make a record on Amigos or send an outcome letter to the GP as required by the Outpatient SOP. The doctor conducting the clinic was unfamiliar with the requirements of the Outpatient standard operating procedure (SOP).

The relationship between Lisa and Shawn

4.68 The relationship between Lisa and Shawn appears to have begun in late May 2017. On 12th June 2017 a neighbour of Lisa contacted the police to report her missing from her home at address 2, not having seen her for over two weeks. The police began missing person enquiries and on 18th June 2017 were notified by Lisa's father that he had found out that she was living in address 1 with Shawn. The police visited her there and found her to be 'safe and well'. The police noted Shawn to be Lisa's 'new boyfriend' and that she had been living with Shawn in address 1 for four weeks. Lisa agreed to return to address 2 the following day and make contact with her housing provider who had changed the locks on her property after the police had forced entry as part of their missing person enquiries.

4.69 Although the police had made no referrals after finding Lisa staying with Shawn at address 1, they did ask the MCC contact centre for any details of addresses for Lisa as part of their missing person enquiries. Lisa's vulnerability as a missing person did not prompt any further action on the part of the contact centre.

4.70 By this time, Shawn's housing provider, also appeared to have become aware of his new relationship with Lisa. On 12th June 2017 housing officer 1 visited address 1 after water leaked from Shawn's flat into an adjoining flat. The housing officer noticed that Shawn had been 'badly beaten'. Shawn confirmed that he had been assaulted but would not disclose who was responsible. Shawn denied the housing officer access to the flat saying that it was dirty and that his unnamed girlfriend was present. (It is assumed that his girlfriend was Lisa.)

4.71 The following day the housing officer texted Shawn to give him 24 hours' notice of entry after a further leakage of water from address 1. Shawn texted back to say that he was staying 'out of sight' at his parent's address after being beaten up. He later told her that the person who assaulted him was someone who until recently had lived in a nearby flat. From this information, the housing officer deduced the likely identity of the person who had assaulted Shawn. She also concluded that Shawn would benefit from tenancy support and made the relevant referral.

4.72 On 23rd June 2017 a housing team leader received a report from a neighbour of Shawn that there had been shouting, screaming and banging of doors from Shawn's flat 'every night of the week'. The neighbour added that Shawn's girlfriend

had mental health issues and he expressed concern about her. The neighbour was asked for the girlfriend's name and was able to recall Lisa's first name only. He added that the noise had started around 8pm the previous evening and he had left his flat to stay with his mother as a result. On returning today he had found blood 'all up the communal landing'. He was advised to ring Crime Stoppers in the event of further incidents. Shawn's housing provider tried and failed to make contact with Shawn by phone.

4.73 On 26th June 2017 a police community support officer (PCSO) spoke to Shawn and Lisa in the street near address 1 following reports of a drunken male in the area. Shawn said he was on his way home with Lisa who was staying with him whilst she sorted out some issues in respect of her own home. The PCSO submitted intelligence which was picked up by the SOMU which initiated a risk assessment of Shawn on 29th June 2017.

4.74 On 28th June 2017 a tenancy support referral was made to a housing tenancy support officer encompassing the recent concerns in respect of Shawn. The referral identified he had needs in respect of issues with drugs/alcohol, his physical health and 'offending anti-social behaviour (ASB)'. Shawn was to be visited on 3rd July 2017.

4.75 The following day Lisa called into the office of her housing provider to collect her new keys following the recent change of the locks. She said she had been staying with Shawn, and provided his telephone number for future contact as she said she did not have a phone. Lisa's housing provider decided to make a further referral for tenancy support for Lisa as she disclosed she was suffering from depression and anxiety. Tenancy support were to visit her on 12th July 2017.

4.76 On the same day (29th June 2017) SOMU officers visited Shawn to conduct the annual reassessment of the risk he presented to others. Shawn was alone and in an intoxicated and dishevelled state. It was noted that he had bruising to his eye which he attributed to an unnamed 'idiot weirdo' from a nearby block of flats. The SOMU officers discussed Shawn's relationship with Lisa whom Shawn claimed was aware of his status as a registered sex offender. He accepted that the officers needed to approach Lisa to confirm this, although he was unable to provide either a phone or any other contact details for her. Contact details for the SOMU case officer were left with Shawn with instructions for him to call when he was with Lisa in order to make arrangements for the SOMU case officer to meet her confirm her awareness of Shawn's history. There is no record of Shawn making that call. Shawn was again assessed as of low risk on the grounds that there had been no intelligence concerning sexual offending.

4.77 On 30th June 2017 Shawn's housing provider received further complaints from Shawn's neighbours in relation to 'nuisance' and domestic incidents with his girlfriend. A 'perpetrator letter' was then sent to Shawn advising of a forthcoming joint visit with the police on 3rd July 2017 to discuss complaints of 'noise nuisance' and an alleged assault by a former tenant.

4.78 On 3rd July 2017 Shawn contacted his housing provider to tell them he would not be at home for the above mentioned home visit as he had to take his mother to hospital. A fresh appointment was arranged for 10th July 2017 which Shawn did not keep.

4.79 On 6th July 2017 Shawn's provider received a complaint from a neighbour to the effect that Shawn had written graffiti on his door, poured red wine through his letter box and sent derogatory texts to his mother's phone. The neighbour also mentioned 'constant arguing' between Shawn and his girlfriend. The housing provider team leader again stressed the importance of ringing Crime Stoppers when domestic incidents were taking place between Shawn and his girlfriend.

4.80 On 6th July 2017 Lisa's mother visited GP practice 2 to request a letter confirming her daughter's schizophrenia diagnosis as Lisa was being threatened with eviction which the letter may help to prevent. Lisa's mother also mentioned that her daughter was 'staying with drug addicts' in address 1. Lisa's housing provider has confirmed that Lisa had begun accumulating rent arrears after her Housing Benefit payments had been reduced to reflect the Under Occupation Charge (Bedroom Tax). She had been issued with a Notice of Seeking Possession but would have been advised by rent officers that the Notice was the first step in a lengthy legal process and that providing she kept up with her rental payments and continued to engage with her housing provider, no further action would be taken.

4.81 The 10th July a Housing visit to Shawn's flat was rescheduled for 25th July and then 27th July 2017. Both changes were at Shawn's request.

4.82 On 12th July 2017 tenancy support visited Lisa who appeared intoxicated and said she had slept in the park. An 'early assessment' was partially completed.

4.83 On 17th July 2017 Lisa contacted a rent officer and disclosed that she had had a breakdown but 'now had the help she needed' and wanted to address her rent arrears.

4.84 Attempts by tenancy support to visit Lisa on 19th and 27th July and on 9th August 2017 were unsuccessful. Contact was made with Lisa's friend who said he was no longer in contact with her but believed she was using drugs and alcohol.

4.85 On 26th July 2017 the housing tenancy support officer wrote to Shawn offering tenancy support and requesting that he make contact within one week, otherwise it would be assumed that he did not require their service. Shawn made no contact

4.86 The following day housing staff managed to make a home visit to Shawn at address 1. They discussed the series of complaints from neighbours in relation to 'domestics and alleged assaults on his girlfriend'. Shawn denied the allegations and said he had 'got rid' of his girlfriend and that she would not be returning. Housing staff said that neighbours had taken footage of Shawn attempting to punch Lisa in the face, an incident he said he didn't recall. He went on to claim that Lisa was 'insane' and had been assaulting him. He was asked whether he wanted to contact the police about Lisa assaulting him and he said he did not. He said that it was she who had poured red wine through a neighbour's letterbox and not him. (Paragraph 4.79) Later in the conversation he said that he still loved Lisa and would visit her in her flat instead. He acknowledged excessive alcohol use. He also said he was taking Librium (prescribed to treat symptoms arising from withdrawal from drugs and/or alcohol). The flat was noted to be in a poor condition, in that it was unclean with mould growth in the kitchen and lounge.

4.87 An appointment was made to enable Housing to re-inspect the flat on 10th August 2017 which Shawn cancelled as he said he needed more time to decorate the property. A further appointment was arranged for 16th August 2017 but it was not possible to gain access on that date.

4.88 On 16th August 2017 Lisa's housing provider sent a letter to Lisa offering help and support and asking her to contact them. When no reply was received they wrote to Lisa again on 22nd August 2017 to advise that if they did not hear from her they would close her case.

4.89 Shortly after 6pm on Monday 21st August 2017 a friend of Lisa contacted the police to say that Lisa had arrived at his flat in a very intoxicated state and had claimed that she had been assaulted by an unnamed male friend the previous day. Lisa had left by the time the police attended and the friend was unable to provide any further details about the alleged assault. The friend was also unable to provide contact details for Lisa. The police then made unsuccessful attempts to contact her.

4.90 At 6.01am the following morning (Tuesday 22nd August 2017) the police received an abandoned 999 call in which a distressed female shouted 'he's beating me again.' The number was recalled and Lisa told the police that her location was address 2 and claimed she was being held captive by a male at that address. The police attended but were unable to obtain a response at the door. Enquiries with

neighbours did not indicate signs of a violent disturbance at the flat and it was concluded there was insufficient justification to force entry into the premises. The inquiry was delayed until later in the day for a welfare check on Lisa to ensure her safety. However, the welfare check was continually delayed due to other priorities and was still being delayed when Shawn's body was discovered at address 2 on Thursday 24th August 2017.

4.91 Shortly after 1pm on Thursday 24th August 2017 the ambulance service contacted the police to report that they had attended address 2 and discovered the body of Shawn on which marks of violence could be seen. Lisa was present at the address and was arrested on suspicion of the murder of Shawn.

4.92 Following her arrest, Lisa was treated at hospital for a head injury and bruising to her arms. She had initially told the ambulance crew that she had taken an overdose but later denied this.

4.93 After disclosing sexual abuse by Shawn, Lisa was examined at a sexual assault referral centre (SARC) on 26th August 2017. She remained in the custody of the police at this time. She disclosed that the most recent alleged sexual assault, involving digital vaginal penetration, had occurred in excess of 72 hours prior to the SARC medical. Prior to this the most recent penile vaginal rape had been more than seven days prior to the SARC medical although Lisa was uncertain over dates.

4.94 On 29th August 2017 the SARC referred Lisa to adult social care on the grounds that she suffered with mental health problems and that during her three month relationship with Shawn, she alleged that she had been raped on more than one occasion. There was reference to a mental health assessment which was to take place whilst she was in custody. The referral also indicated that should Lisa be granted bail, she would need support. Adult social care were also contacted by Lisa's appropriate adult who shared Lisa's account of events leading up to Shawn's death before adding that Lisa had been unable to take her medication for schizophrenia (olanzapine) because Shawn had been very controlling and had not allowed her out of the flat to collect her prescription. (However, the pharmacy from which Lisa collected her olanzapine prescription on a monthly basis has confirmed that it was collected on 4th August 2017.)

4.95 The referral referred to in the paragraph above was screened in the multi-agency safeguarding hub (MASH) and allocated to a MASH social worker who contacted GMMH who advised that they were in the process of undertaking a serious incident requiring investigation (SIRI) three day review. Lisa was now on remand and so would be able to access prison-in-reach mental health support. Should she be released it was envisaged that Lisa would be assessed by the CMHT.

5.0 Family and friends contribution

5.1 The parents of Shawn and the mother of Lisa were offered the opportunity to contribute to this review. An initial letter was sent to both the parents of Shawn and the mother of Lisa to advise them of the DHR, explain the purpose of a DHR and invite them to contribute to the review should they wish to do so. The family were provided with information regarding the support available from independent agencies for families and friends. When no reply was received from either party, a further letter was sent offering them an opportunity to contribute to the review. This was followed up by telephone contact from the independent author. However, the parents of Shawn did not respond to the letters or reply to the telephone call and it was decided that it would not be appropriate to take the matter further. Lisa's mother answered the telephone call from the independent author and initially indicated that she may wish to contribute to the review but said she wished to consult Lisa, who she visited weekly in prison, before she made her decision. Arrangements were made to contact Lisa's mother by telephone after she had visited her daughter, but several telephone calls were made without reply. Again, it was decided it would not be appropriate to take the matter any further.

5.2 The perpetrator Lisa was also offered the opportunity to contribute to this review. She was serving the sentence imposed for the manslaughter of Shawn and so contact was made via her offender manager. Care needed to be taken in the manner of approaching Lisa because of her mental health issues. However, after a conversation with her offender manager, Lisa declined to contribute to the review.

6.0 Analysis

6.1 The case specific terms of reference are as follows:

(i) How partner agencies responded to indications of domestic abuse within the relationship between the perpetrator and the victim.

(ii) How the risks presented by the perpetrator and the risks to which the perpetrator was exposed were responded to by partner agencies?

(iii) How the risks presented by the victim and the risks to which the victim was exposed were responded to by partner agencies?

(iv) How did the mental health issues experienced by the perpetrator, and the substance misuse issues experienced by both the victim and the perpetrator, affect the way in which partner agencies responded to indications of domestic abuse?

(v) How did difficulties in engaging with the victim and the perpetrator affect the way in which partner agencies responded to indications of domestic abuse?

(vi) Consider whether the social care function has been adequately fulfilled by agencies with those responsibilities, in respect of the perpetrator.

(i) How partner agencies responded to indications of domestic abuse within the relationship between the perpetrator and the victim.

6.2 A number of agencies became aware of the short relationship between the perpetrator Lisa and the victim Shawn which appears to have begun in late May 2017. From the information obtained by agencies it is possible to piece together an account of the relationship.

6.3 At the point at which the relationship began the perpetrator Lisa had been waiting for an outpatient's appointment with the community mental health service for six months having experienced a deterioration in her mental health. She had unassessed and possibly unmet social care needs in that there were indications of self-neglect when Lisa visited her GP in November 2016. However, the indications of self-neglect were not included in the GP referral to mental health services. Lisa was offered the opportunity to self-refer into community alcohol services by her GP but she does not appear to have done so.

6.4 At the point at which the relationship began the victim Shawn appeared to have been neglecting his health for a number of years which had exposed him to potentially life threatening infections. He was being prescribed methadone as an opiate substitute but may have been using illicit or prescription drugs as well. He was on the sex offender's register for life but the risk he presented to others had been reduced from 'medium' to 'low' in 2016. During the most recent SOMU risk assessment he was said to be well supported by his parents although there is conflicting evidence on this point.

6.5 The police became aware of the relationship when Lisa was traced to Shawn's address after being reported as a missing person. Given the concerns expressed about Lisa by a range of practitioners over the preceding months, it seems likely that Lisa would have presented as quite vulnerable when traced by the police. Therefore, one might have expected a referral to have been made to adult social care at this point, particularly as the police had already been in touch with adult social care whilst making enquiries to trace Lisa. The fact that Lisa was now living with a registered sex offender who presented a risk to female partners was not picked up on by the police at this time. This information would have been available to the

officer had Shawn been checked on the local intelligence or Police National Computer (PNC) systems. However, a PCSO remedied the situation by submitting intelligence when he subsequently found Shawn and Lisa together in the street. This intelligence was seen and acted upon by SOMU.

6.6 Both Shawn and Lisa experienced violence or the threat of violence whilst they were in their brief relationship with each other. Shawn was seen to have been 'badly beaten' although he declined to disclose the identity of his attacker. (Paragraphs 4.70 and 4.71) A neighbour of Shawn's reported 'blood all up the communal landing' after a disturbance between Shawn and Lisa. (Paragraph 4.72) Shawn was seen to have an injury to his eye when SOMU visited him. (Paragraph 4.76) Shawn's landlord were made aware of footage of Shawn attempting to punch Lisa in the face which had been taken by one of Shawn's neighbours. (Paragraph 4.86) A housing team leader saw Shawn pushing Lisa (undated). Shawn alleged that Lisa had been assaulting him but declined to report the matter to the police. (Paragraph 4.86) Lisa alleged that she had been assaulted by an unnamed male. (Paragraph 4.89) Lisa made a 999 call which she abandoned. When the police re-contacted her she alleged that Shawn was 'beating her again' and that he was 'holding her captive'. (Paragraph 4.90) Following her arrest for Shawn's murder she reiterated the latter assertion that Shawn had prevented her leaving the flat they were staying in which had stopped her obtaining the medication prescribed for her schizophrenia. She also alleged that Shawn had raped her twice.

6.7 Lisa appeared to largely move in with Shawn at the latter's flat (address 1) from an early stage in the relationship. After a number of complaints including one of 'shouting, screaming and banging of doors' were made by Shawn's neighbours, he appears to have gravitated towards Lisa's flat at address 2 in the latter stages of the relationship, which is where he died. As a result of Shawn and Lisa spending the majority of their time together in Shawn's flat, Shawn's landlord, became aware of escalating concerns about the relationship. The response of Shawn's Landlord to indications of domestic abuse raised questions about how familiar or confident they were in addressing this issue. They did not share the evidence of violence within the relationship - 'blood all up the communal landing' (Paragraph 4.72) and the footage of Shawn attempting to punch Lisa in the face (Paragraph 4.86) – with the police. They advised Shawn's neighbours to ring Crime Stoppers if they witnessed or were concerned about domestic abuse between Shawn and Lisa. This may be appropriate advice to give to tenants who do not wish to be seen as reporting issues directly to the police, but it is an insufficient response to escalating concerns of domestic abuse involving one of their tenants. And the housing provider sometimes avoided 'naming' what they were confronted with as domestic abuse, opting for 'offending ASB' (Paragraph 4.74) and 'noise nuisance' (Paragraph 4.77) instead.

6.8 After receiving an abandoned 999 call from address 2 on 22nd August 2017 (Paragraph 4.90) the police managed to re-contact Lisa who alleged that Shawn was 'beating her again' and 'holding her captive'. The police attended but were unable to obtain a response from address 2 and enquiries with neighbours did not indicate any signs of a violent disturbance at the address. The police concluded there was insufficient justification to force entry into the premises. In making this decision, it is not known whether the police took Shawn's status as a sex offender, albeit assessed as low risk, into account, or the concerns for Lisa's welfare which had arisen the previous evening when she alleged that she had been assaulted by an unnamed male who may, or may not, have been Shawn. (It is noted that the police had decided to force entry into address 2 after Lisa had been reported as a missing person in June 2017 (Paragraph 4.68) and may also have done so in February 2016 following concerns about a head injury to Lisa (Paragraph 4.56)). The incident was then repeatedly delayed until the discovery of Shawn's body at address 2 over two days later. It is clear from the GMP individual management report (IMR) submitted to this review that the force was facing multiple other demands over this period and it is of value to be reminded that this incident was one of many that the police had to assess and respond to.

6.9 This review has been advised that GMP professional standards branch conducted an internal investigation into the police response to contacts from Lisa during the period from 21st and 24th August 2017. The investigation highlighted the need to focus on the current police escalation policy and guidance in relation to 'threat, harm or risk'. This guidance should be used when resources are not available to attend an incident. Considering 'threat, harm or risk' helps police decision makers determine which incidents the *unavailability* of resources would have the most detrimental effect upon. Considering the police response from a multi-agency perspective, there appears to have been a missed opportunity for the police to make contact with Lisa's housing provider who may have been able to assist them in gaining access to address 2 and making contact with her.

How the risks presented by the perpetrator and the risks to which the perpetrator was exposed were responded to by partner agencies?

6.10 The perpetrator Lisa was a very vulnerable woman. After a period of relative stability, her mental health appeared to have deteriorated in the months prior to her relationship with Shawn beginning and there were also indications of self-neglect which did not appear to have been present in earlier assessments. She had been in an earlier volatile relationship with a former partner which led to numerous contacts with the police who perceived Lisa to be both a victim and perpetrator. From the information available Lisa appeared to suffer more serious injuries than her partner

and there is some evidence that he exaggerated his complaints about Lisa (Paragraphs 4.26 and 4.27).

6.11 Both parties are frequently described in the police reports as being 'intoxicated' which appeared to impede the efforts of the police to gain an accurate understanding of what took place. There is no indication of any follow up visits to interview either Lisa or her partner when sober. Cases of dual perpetrator domestic violence have been found to include the highest number where both partners were alcoholics or heavy drinkers, with alcohol present in 88% of such cases, significantly higher than sole domestic violence perpetrators (63%) (1). the same research also found that alcohol made it difficult to determine who the primary aggressor was (2).

6.12 DASH risk assessments were adopted by GMP in May 2011 and all but one domestic abuse incident involving Lisa and her former partner took place prior to this date. It is not known whether Lisa was referred to IDVA or any other source of support for domestic abuse as it has not been possible to access the pre-2011 database on which such referrals would have been recorded. There is no indication that a MARAC referral was made. There appeared to be strong grounds for considering a MARAC referral after three domestic abuse incidents within the month of August 2007 (Paragraphs 4.24 - 4.26). (The MARAC process had been introduced in Manchester in 2006).

6.13 Lisa disclosed domestic abuse in previous intimate relationships to her housing provider and mental health services in 2009 (Paragraph 4.39-4.40). She also disclosed domestic abuse by her brother at this time. No referral to domestic abuse services appears to have been considered.

6.14 When Lisa was examined within the SARC following the death of Shawn, a DASH risk assessment was carried out which indicated a score above the threshold for referring Lisa to MARAC had Shawn not already been deceased. Lisa also alleged that she had been raped by Shawn during their relationship. The SARC examination report has not been shared with this review as this would require the consent of Lisa, who did not wish to contribute to this review.

6.15 During her SARC examination Lisa also alleged that Shawn had been very controlling and had not allowed her to access her medication. However, GP practice 2 has confirmed that Lisa's monthly prescription of Olanzapine was dispensed by her pharmacy on 4th August 2017. Lisa's dosage of Olanzapine had gradually been increased over the years to the highest therapeutic dose allowed. Although the medication was dispensed it is not known if Shawn prevented Lisa from taking it. If she had been unable to take Olanzapine this would have led to the return of schizophrenia symptoms. Even whilst taking the medication Lisa had been

experiencing psychotic symptoms and her mental health may have also been adversely affected by living in an environment where there may have been domestic and sexual abuse. Her alcohol use could also have had an adverse effect on her mental health.

6.16 Edleson (1998) categorises women who use violence in intimate relationships into three groups: (a) those who use violence in self-defence to escape or protect themselves, (b) those with a long history of victimisation from previous partners and in childhood and who use violence in order to decrease their own chance of further victimisation, and (c) those who are the primary aggressors and use their greater physical power to control their partners. (3) Looking at what is known about the violence used by Lisa in her earlier relationship and in her relationship with Shawn, the evidence suggests that she may have fallen into either or both of groups (a) and (b).

6.17 As previously mentioned Lisa's mental health appeared to deteriorate in November 2016 which led to her being referred to mental health services. An appointment was arranged for May 2017. Lisa was also provided with the opportunity to self-refer for support in respect of her alcohol dependence which she seems to have declined. Concerns continued to be expressed about Lisa's mental health during this intervening period (Paragraphs 4.62 and 4.64). The concerns expressed by the DWP PIP assessor were shared with Lisa's GP but this failed to prompt the expected actions (Paragraph 4.64). The concerns were not brought to the attention of mental health services. The DWP has advised this review that PIP assessors are recruited from occupational therapists, nurses, physiotherapists, paramedics or doctors. The DWP has also advised that PIP assessors very rarely identify that the claimant appears to have a significant undiagnosed medical condition. In such circumstances they have a responsibility to notify a suitable person involved in the claimant's care, usually the GP. Notification to the GP is generally dependent on the consent of the claimant.

6.18 There does not appear to be any consideration by her GP of how Lisa might be supported during the six month period prior to her outpatient appointment with mental health services. GMMH has advised this review that there is a leaflet which provides details of *Sanctuary*, which provides support to adults who are experiencing anxiety, panic attacks, depression, suicidal thoughts or are in crisis and *Crisis Point*, which is an open-access mental health crisis centre that offers bespoke crisis management support, which can be handed to patients whilst they're waiting for a psychiatry outpatient appointment. It is not known whether Lisa's GP provided her with this information. It is understood that the six month waiting period for a non-urgent outpatient appointment with mental health services is in accordance with GMMH standards. However, Lisa appeared to have been able to access mental

health services more quickly in the past when referred by her GP. DHR Panel members felt that demand on mental health services had increased in recent years.

6.19 At the time Lisa was referred by her GP to mental health services in November 2016 there appeared to be insufficient consideration by her GP of her social care needs. There were indications of self-neglect which should have merited a referral to adult social care. Since the implementation of the Care Act in April 2015 self-neglect has been categorised as a potential adult safeguarding concern. Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Although self-neglect may not always prompt a safeguarding enquiry, a referral should have been considered. No indications of self-neglect had previously been identified in assessments carried out by CMHT in 2010 and 2011.

6.20 Prior to presenting to her GP in November 2016, Lisa appeared to have experienced a period of stable mental health since 2013 as previously stated. She had been known to secondary care mental health services since 1999. During this period Lisa did not consistently engage with the outpatient appointments offered to her and as a result was discharged back to the care of her GP on several occasions for none attendance.

6.21 Lisa had a long history of alcohol dependence. She appears to have had only limited engagement with alcohol services. On one occasion she said that she did not see her drinking to be a problem (Paragraph 4.48) although she appeared to come to harm from time to time as a result of drinking alcohol to excess (Paragraphs 4.29 and 4.55). Her drinking was said on one occasion to lead to paranoid thoughts (Paragraph 4.38) and on another occasion she was said to have used alcohol as a way of coping with paranoid thoughts (Paragraph 4.48).

6.22 It is also possible that Lisa used alcohol as a maladaptive coping strategy to deal with trauma possibly including the trauma of domestic abuse. Alcohol has been found to be associated with victimisation, with research finding victims of domestic assault to have higher alcohol consumption than non-victims, and that the risk of violence increased with levels of consumption (4). Whilst there are many reasons why victims of domestic abuse may drink, amongst those caught up in long-term domestic abuse, there is evidence that they may use alcohol to cope with the effects of domestic abuse. One study found that women who suffered domestic abuse from their partners were twice as likely to drink after the abuse as their violent partner (5). In Lisa's case there appeared to be a lack of practitioner awareness of the increased risks arising from the combination of substance misuse (alcohol), mental illness and domestic abuse.

6.23 In general, agencies only infrequently perceived Lisa as a victim of domestic abuse or sought to understand her presentation as a victim of domestic abuse over many years which involved interpersonal violence, violation and threats which may have resulted in complex trauma and impacted on her well-being.

6.24 When her GP referred Lisa to mental health services in November 2016, the GP does not appear to have enquired about domestic abuse. The GP did not receive Identification and Referral to Improve Safety (IRIS) training until early the following year. IRIS is a general practice based domestic violence and abuse training support and referral programme. This contact would likely have triggered the HARK template reminder to the GP to ask about domestic abuse. HARK is an acronym for four direct questions – Humiliate, Afraid, Rape, Kick (or other form of physical violence) – which can help identify people who have suffered domestic abuse. When a GP practice is IRIS trained the HARK template is placed on the practice's computer system.

6.25 Overall, there was an absence of sharing of risk information about Lisa after her mental health appeared to deteriorate in late 2016. Her GP was probably in the strongest position to notice her deteriorating circumstances. Although her GP did not see her again after November 2016 the GP practice was notified of the PIP assessor's concerns about Lisa (Paragraph 4.64) and Lisa's mother visited the practice on behalf of her daughter and shared her concerns that Lisa was 'staying with drug addicts' in address 1 (Paragraph 4.80). Additionally, Shawn's housing provider became aware of some of the risks he presented to Lisa, but their focus was primarily on the impact that Shawn's relationship with Lisa was having on other tenants.

How the risks presented by the victim and the risks to which the victim was exposed were responded to by partner agencies?

6.26 Shawn was a perpetrator of domestic abuse who was imprisoned after being convicted of raping a former partner in 2003. Following his release from prison he assaulted another partner which led to a recall to prison. There had been no further complaints of domestic abuse against Shawn for a number of years although he came to the notice of the police on three occasions during the period 2010 to 2011 after intoxicated altercations with his then partner in the street.

6.27 Following his rape conviction Shawn was placed on the sex offenders register for life and was monitored thereafter by GMP's sex offender management unit (SOMU). The risk he presented to others had been reduced from 'medium' to 'low' in August 2016.

6.28 GMP's SOMU promptly considered the risks which the victim Shawn could present to the perpetrator Lisa once they became aware of the relationship. SOMU decided to disclose Shawn's status as a sex offender to Lisa and requested Shawn ring SOMU when Lisa was with him to facilitate a further opportunity to make this disclosure. Shawn advised SOMU that he had made Lisa aware that he was a registered sex offender. There is no evidence that Shawn rang SOMU when he was with Lisa as requested. SOMU has advised this review that whilst his new relationship with Lisa had been added to Shawn's risk management plan, the annual assessment of the risks he presented had not been completed by the time of his death. It had been intended to locate and interview Lisa as part of this risk assessment. (The police have confirmed that during interviews conducted with her following her arrest, she said she knew that Shawn had been convicted of rape and served a custodial sentence as a result).

6.29 When assessing the risk presented by sex offenders, both static and dynamic risk factors are considered (6). Static factors include previous sexual assaults and domestic abuse by the offender. Dynamic risk factors are considered to be changeable and relate to the offender's personal circumstances and behaviour. These include sexual interests, management of relationships, management of self, substance misuse, mental ill health, grooming behaviour patterns and access and proximity to victims.

6.30 The vulnerability of Lisa does not appear to be a dynamic factor considered by the risk assessment. In entering into a relationship with Shawn, Lisa was clearly vulnerable but there is no documentation to indicate that SOMU took steps to find out about her vulnerability by contacting partner agencies. SOMU has advised this review that it was their intention to locate and interview Lisa as part of the annual assessment of the risks presented by Shawn but this had not been accomplished prior to the homicide. The police held information about Lisa's recent missing person episode and the historic information about domestic abuse with an earlier partner in which she was perceived to be both a victim and a perpetrator. It is not known whether SOMU considered this information held by the police. A question which arises is the extent to which a duty of care is owed to the person the sex offender has begun a relationship with. In this case it is unclear whether SOMU considered a duty of care to extend beyond taking steps to ensure that Lisa was aware that Shawn was a registered sex offender. SOMU has advised this review if they became aware that issues of mental health or coercive or controlling behaviour had affected a person's ability to make a competent decision regarding the risk posed by their partner, then the officer would be expected to take 'whatever appropriate steps were necessary to safeguard that person'. Since SOMU had not made contact with Lisa prior to the death of Shawn, it is not known what 'appropriate steps' may have been considered in her case.

6.31 The police officer who traced Lisa to Shawn's flat in June 2017 after becoming aware of his relationship with Lisa could have considered making an adult safeguarding referral.

6.32 Shawn's social landlord was unaware of his status as a sex offender, having relied upon self-reported information from Shawn in which he did not declare his conviction for rape or his registration for life as a sex offender. The landlord could have been a valuable source of information to inform the SOMU risk assessment, particularly in respect of 'access and proximity to victims', as there would likely be vulnerable females amongst the providers other tenants. It is possible that the landlord may have reacted differently to the accumulating evidence of an abusive relationships between Shawn and Lisa had they been aware that Shawn was a registered sex offender.

6.33 Shawn was also vulnerable. He was frequently discharged from specialist alcohol services after failing to attend appointments. His misuse of drugs led to substitute prescribing over many years and contributed to him committing acquisitive crime which brought him into conflict with the criminal justice system. He came to the attention of a range of agencies in 2013 when self-neglect appeared to impact on his mental and physical health but no holistic assessment of his needs took place despite the recognition that he had 'substantial' needs under the FACS criteria (Paragraph 4.11). The indications of self-neglect emerged prior to the implementation of the Care Act 2014 which categorised self-neglect as a potential adult safeguarding concern.

6.34 It seems likely that Shawn's history of offending, including his conviction for rape and registration for life as a sex offender, his role as a perpetrator of domestic abuse and his tendency to present as aggressive when under the influence of drink masked the potential for him to be a victim of crime. The injuries he began presenting with in the weeks prior to his death may have been perceived as a consequence of his lifestyle rather than a possible indication that he could be in an abusive relationship. The Respect Charity's Toolkit for work with male victims of domestic violence (7) highlights the risks to the victim of incorrectly perceiving them to be the perpetrator or to be part of a mutually violent couple.

How did the mental health issues experienced by the perpetrator, and the substance misuse issues experienced by both the victim and the perpetrator, affect the way in which partner agencies responded to indications of domestic abuse?

6.35 It is arguable that neither Lisa or Shawn's individual needs were looked at in totality, nor were the combined effects or risk factors such as mental illness, substance misuse, and domestic violence considered when they became a couple. There were missed opportunities to conduct holistic assessments of Shawn's needs in 2013 and Lisa's needs in November 2016.

6.36 It is also arguable that the way services eligibility criteria are determined sometimes assumes that service users just have one primary need or 'problem' as opposed to the reality that service user's lives are often complicated and risks can be fluid depending on protective factors, resilience and presenting social stressors such as debt, housing issues, relationship issues etc. Additionally, research suggests that many drug workers do not feel confident in addressing the needs of such clients (8).

6.37 The question arises of whether Lisa had the mental capacity to weigh up the information that Shawn was a registered sex offender having served a prison sentence for rape and then make an informed decision over whether to remain in the relationship or leave him. A fundamental principle of the Mental Capacity Act (MCA) and English law generally is that adults have the right to make decisions on their own behalf and are assumed to have the capacity to do so unless it is proven otherwise. The responsibility for proving that an adult lacks capacity falls upon the person who challenges it. Had an MCA assessment of Lisa been carried out, she would have been found to have an 'impairment or a disturbance of the mind or brain' which affected her ability to make the particular decision because of her diagnosis of schizophrenia. The MCA assessment would then have gone on to consider whether Lisa was able to make a decision for herself. A person is regarded as being unable to make a decision if, at the time the decision needs to be made, she is unable:

- to understand the information relevant to the decision
- to retain the information relevant to the decision
- to use or weigh the information, or
- to communicate the decision (by any means)

6.38 Lisa's capacity to make decisions does not previously appear to have been questioned. Mental capacity is time and decision specific. Lisa's capacity when mentally stable and/or sober may have differed to times when she was mentally unwell and/or under the influence and so her ability to understand, retain, use or weigh information could have been affected. Being in a relationship in which coercion and control are present can also affect a person's capacity to make a decision for themselves. Research also suggests that the substance misuse of victims of domestic abuse may make it difficult for them to accurately assess risk posed to them in that their perception may be 'dulled' (9). Shawn's capacity also

appears not to have been questioned. This may have been an issue to consider when he declined support (Paragraph 4.11)

How did difficulties in engaging with the victim and the perpetrator affect the way in which partner agencies responded to indications of domestic abuse?

6.39 Both Shawn and Lisa engaged only sporadically with services and were often discharged back to the care of their GP when they did not attend appointments. Shawn appears to have strongly resisted support from services when his physical and mental health appeared to be adversely affected by his self-neglect in 2013. He said he was 'sick of people's concerns' (Paragraph 4.11)

6.40 Lisa appears to have been prepared to sustain engagement with agencies for periods and experienced some improvements such as self-reported reductions in alcohol consumption for example. However, she appeared reluctant to engage with specialist alcohol services.

6.41 Lisa's apparent lack of access to a mobile phone was a factor which isolated her from support and made engagement with her more challenging for several agencies including her housing provider and mental health services.

6.42 It is of interest that neither Shawn nor Lisa's GP practices, with whom they had both been registered for many years, appear to have been aware that they each had children. Without this knowledge the GP practices were not in a position to consider how any health and wellbeing issues with which they presented could impact on their children. Some agencies became aware of Shawn and Lisa's intimate relationships but the question of whether domestic abuse might be present in any of these relationships appears to have been considered only when it was obvious.

6.43 Many local safeguarding children boards have adopted multi-agency policies which set out processes to follow when children and families disengage. It may be appropriate for community safety partnerships to consider whether processes need to be put in place for engaging with 'difficult to engage' individuals who may be at risk of domestic abuse.

6.44 In Manchester there is some very good practice to draw upon. For example, one GP practice which has over 800 registered homeless patients, of whom 22% are women, has developed a drop-in based approach for these patients given the difficulty in locating or contacting them for formal appointments. Multi-agency work with other agencies, including drug and alcohol services, who are in contact with patients has helped to improve attendance at formal appointments. An IRIS worker

attends the drop in every other week and the homeless team are comfortable with raising the issue of domestic abuse and making appropriate referrals. In Lisa's case it may have been helpful for health services to interact with her social landlord, to improve the chances of her attending an appointment made nearly six months before. Lisa's provider has advised this review that improving contact with their tenant's GPs is a priority.

Consider whether the social care function has been adequately fulfilled by agencies with those responsibilities, in respect of the perpetrator and victim.

6.45 Lisa had a functional mental illness (schizophrenia) and appeared to have unassessed care and support needs which fall within the agreement under Section 75 of the National Health Service Act 2006 between a local authority and an NHS body. As part of the Section 75 agreement in Manchester there are two separate contracts; one for Adults of Working Age who meet the criteria for secondary mental health services due to a functional mental illness and a Later Life Contract for Adults over 65 years with an organics mental illness.

6.46 She also appeared to have unassessed care and support needs under the Care Act 2014 National Eligibility Criteria in that she had a mental impairment and appeared to be unable to meet two or more of the eligibility outcomes for adults with care and support needs which are set out below:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the adult's home safely
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationships
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child.

And there was an impact upon Lisa's wellbeing which the Care Act describes as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect

- control by the individual over their day-to-day life (including over care and support provided and the way they are provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal domains
- suitability of the individual's living accommodation
- the individual's contribution to society.

6.47 However, Lisa was subject to a holistic assessment (looking at both health and social care) by GMMH which is known as the Manchester Care Assessment Schedule (MANCAS). This MANCAS review was completed in 2011 and identified no social care or mental health needs that met the threshold for providing care coordination under the care programme approach (CPA).

6.48 In Shawn's case a proposed community care assessment (under Section 47 of the NHS and Community Care Act 1990) to facilitate a planned and supported discharge from hospital did not take place (Paragraph 4.12).

Good practice

6.49 On 5th January 2017 a gas operative carrying out an annual gas service at address 2 referred Lisa to her landlord as he/she was concerned that she was talking to herself and drinking alcohol in the afternoon. (Paragraph 4.49)

6.49 On 26th June 2017 a police community support officer (PCSO) spoke to Shawn and Lisa in the street near address 1 following reports of a drunken male in the area. The PCSO submitted intelligence which was picked up by the SOMU which initiated a risk assessment of Shawn on 29th June 2017. (Paragraph 4.60)

7.0 Findings and Recommendations

Social housing provider awareness of domestic violence and abuse

7.1 If one considers multi-agency efforts to prevent domestic abuse in Manchester as a 'whole system', then this DHR indicates that some of the 'components' of that whole system and the links between them may be in need of strengthening.

7.2 The relationship between the victim and the perpetrator appears to have been quite volatile and escalated to fatal violence within three months of Lisa and Shawn becoming a couple. Despite the brevity of the relationship, several agencies – or 'components of the whole system' - became aware of concerns, although it was the

perpetrator Lisa who appeared to agencies as being more vulnerable than the ultimate victim Shawn.

7.3 One agency which became aware of quite significant concerns about the relationship was the social housing provider for the victim Shawn. Their staff responded diligently to the growing concerns by persistently seeking to engage with Shawn and offer him tenancy support, but their focus was primarily on their tenant and the impact his and Lisa's behaviour was having on other tenants, rather than on taking action to intervene in a relationship in which there was strong evidence of domestic violence and abuse.

7.4 This review has been advised that the key role that social landlords can play in responding to domestic violence and abuse is recognised in Manchester and that the Manchester Housing Providers Partnership (MHPP) is the vehicle which brings together social landlords and MCC to address issues of mutual concern. The partnership consists of lead partners (Lisa's social landlord) and support partners (Shawn's social landlord). The partnership has a community safety workstream which includes domestic violence and abuse.

7.5 The strong impression gained from this case is that social housing providers have an important role to play in responding to and preventing domestic violence and abuse, but may not currently be sufficiently well equipped to do so. Additionally, agencies with a 'core' role in addressing domestic abuse may not fully appreciate the potential usefulness of social housing providers which is evidenced by the police not seeking the assistance of Lisa's social landlord, to check on the welfare of herself and Shawn during the two day period following Lisa's abandoned 999 call and the discovery of Shawn's body.

7.6 It is understood that there are close links between Manchester Community Safety Partnership and the Manchester Housing Providers Partnership. It is therefore recommended that the former Partnership seeks assurance from the latter Partnership that social housing providers have the policies in place, supported by training, which equip their staff to respond with confidence to domestic violence and abuse.

Recommendation 1

That Manchester Community Safety Partnership shares this DHR overview report with the Manchester Housing Providers Partnership and seeks assurance from the latter partnership that social housing providers have the policies in place, supported by training, which equip their staff to respond with confidence to domestic violence and abuse.

The police response to the abandoned 999 call on 22nd August 2017

7.7 After receiving an abandoned 999 call from address 2 on 22nd August 2017 (Paragraph 4.90) the police re-contacted Lisa who alleged that Shawn was 'beating her again' and 'holding her captive'. The police attended but were unable to obtain a response from address 2 and enquiries with neighbours did not indicate any signs of a violent disturbance at the address. The incident was delayed until later that day for a welfare check on Lisa to ensure her safety. However, the welfare check was continually delayed due to other priorities and was still being delayed when Shawn's body was discovered at address 2 over two days later. When the police originally attended the incident on 22nd August 2017 they decided that there were insufficient grounds to force entry into address 2. No contact was made with Lisa's housing provider to seek their assistance in gaining entry to the address.

7.8 GMP professional standards branch conducted an internal investigation into the police response to contacts from Lisa during the period from 21st and 24th August 2017. It is understood that the investigation found that the level of 'threat, harm and risk' present in the incident should have informed the decisions to delay the welfare check in accordance with GMP's escalation policy. However, the review has been advised that the radio operators involved did not escalate the incident to supervision which prevented 'threat, harm and risk' considerations being applied in accordance with policy.

7.9 GMP has advised the review that they do not consider it necessary to make a single agency recommendation in respect of their response to the abandoned 999 call or the subsequent decisions to repeatedly delay the welfare check in respect of Lisa. Their rationale for this decision is the force's escalation policy has been amended, tested and found to ensure the application of suitable resources when a call is escalated. The Community Safety Partnership may wish to seek assurance from GMP that the policy of escalating incidents where the unavailability of resources would have the most detrimental effect is now fully embedded in practice.

Recommendation 2 (single agency)

That Manchester Community Safety Partnership seek assurance from GMP that the policy of escalating incidents where the unavailability of resources would have the most detrimental effect is now fully embedded in practice.

Sex offender management and domestic violence and abuse

7.10 This review also raises questions about how well the process of managing the risk registered sex offenders may present to intimate partners is integrated with multi-agency efforts to prevent domestic abuse and safeguard adults. In this case Shawn was being managed as a sex offender for life. Having been convicted of raping a former partner he presented a potential risk to future partners. GMP's SOMU became aware of his relationship with Lisa and promptly updated his risk management plan to take account of the new relationship with Lisa. The necessary further assessment of the risk Shawn presented had not been completed prior to the homicide taking place.

7.11 It would appear that the static and dynamic risk factors SOMU consider (in accordance with national guidance) do not specifically include the vulnerability of the person the sex offender has entered into a relationship with. (Paragraphs 6.29 and 6.30 refer).

7.12 Where appropriate, an offender is permitted the opportunity to self-disclose their conviction history. However, this will always be followed up by SOMU to ensure the information is correct and has not been minimised to ensure that the risk is fully understood. In this case, SOMU's involvement with Lisa was incomplete at the time of Shawn's death. Had SOMU made contact with Lisa and had they become aware that Lisa lacked the capacity to make an informed decision, this review has been advised that steps would have been taken to safeguard her. In this case Lisa's mental capacity may have been affected by her deteriorating mental health, alcohol misuse and her freedom to make a decision to end the relationship may have been compromised by issues of coercion and control in the relationship.

7.13 The guidance on the management of sex offenders is national guidance overseen by the National Police Chiefs' Council. It is understood that the guidance is also subject to periodic academic review. This case raises some questions of interest in respect of how well sex offender management is integrated with the prevention of domestic violence and abuse and with the safeguarding adults' agenda. Since SOMU had not been able to make contact with Lisa to advise her of Shawn's sex offender status prior to the homicide taking place, it is not known whether SOMU would have considered it necessary to take any action to safeguard her. It is not known how frequently action such as adult safeguarding referrals or mental capacity assessments result from SOMU contact with individuals such as Lisa.

7.14 It is therefore recommended that this DHR overview report is shared with the Multi-Agency Public Protection Arrangements (MAPPA) Strategic Management Board (SMB), which is the body which fulfils the duties of relevant authorities under Section 326 (1) of the Criminal Justice Act 2003 to 'keep the arrangements (including MAPPA and sex offender management) under review with a view to

monitoring their effectiveness and making any changes to them that appear necessary or expedient.' The MAPPA SMB could then consider whether any changes may be necessary to the way in which risks presented by registered sex offenders to intimate partners are assessed and managed and refer the report to the National Police Chiefs' Council if considered appropriate.

Recommendation 3

That Manchester Community Safety Partnership shares this DHR overview report with the Greater Manchester MAPPA Strategic Management Board so that the latter partnership may consider whether any changes are necessary to the way that the risks presented by registered sex offenders to intimate partners are assessed and managed and refer the case to the National Police Chiefs' Council if appropriate.

The mental health and social care needs of the perpetrator

7.15 When Lisa presented to GP practice 2 in November 2016 she was referred to mental health services as her mental health appeared to have deteriorated and she was also offered the opportunity to self-refer to specialist alcohol services which she appears to have declined. There were also indications of self-neglect which were not included in the referral to mental health services. Lisa was offered a mental health outpatients' appointment for May 2017 but there appeared to be no consideration of any support Lisa might need during the period prior to her appointment. Concerns continued to be expressed about Lisa but these did not lead to any additional support being provided.

7.16 Lisa did not attend her May 2017 outpatient appointment with mental health services. Two calls were made to a mobile phone number for Lisa but by this time it appears that she did not have access to a mobile phone. When Lisa did not attend her May 2017 appointment it was planned to offer her a further appointment in November 2017 but lack of staff familiarity with internal GMMH systems resulted in this appointment not being entered onto the system.

7.17 The response of primary and secondary health services to Lisa's deteriorating mental health from the point at which Lisa presented to her GP in November 2016 discloses a number of learning opportunities. Firstly, the focus of the GP practice was primarily on her mental health and substance misuse needs and a referral (to mental health services) and signposting (to specialist alcohol services) flowed from this. However, evidence that Lisa was self-neglecting suggested potential social care needs which would have benefitted from a more holistic assessment of Lisa's needs. An adult safeguarding referral could also have been considered as self-neglect has been categorised as a potential adult safeguarding issues since April 2015. Secondly,

once Lisa's GP was made aware of the date of Lisa's outpatient appointment with mental health services, consideration could have been given to the support she could need during the intervening period. In their contribution to this DHR review, GMMH has drawn attention to a leaflet which should be handed out to patients in those circumstances advising them of services to which they could self-refer. It is not known if this leaflet was offered to Lisa, nor is it known how effective the services to which Lisa could have self-referred are in supporting people waiting for mental health service outpatient appointments. Thirdly, the concerns which continued to be expressed about Lisa's mental health whilst she awaited her outpatient appointment did not lead to any escalation of action including the possibility of bringing forward Lisa's outpatient appointment. Fourthly, more could have been done to ensure that Lisa attended her outpatient appointment in May 2017. Lisa had a history of failing to attend appointments. Telephone reminders to back up the appointment offer letter was practice likely to be sufficient for most patients but it is questionable whether it was sufficient for a patient such as Lisa. She was supported by her mother and by her social housing provider. It may have been possible for Lisa's GP to link with her social housing provider to support her to attend the outpatient appointment. It is of interest that when her landlord became aware of Lisa's deteriorating mental health after a referral by a concerned gas operative, they did not make contact with her GP, preferring to refer directly to secondary mental health services.

7.18 GMMH plan to review the caseloads of the outpatient consultants in order to reduce the waiting time for initial non urgent outpatient appointments. This is welcome. However, action is required by primary care to ensure that all the presenting needs of patients are addressed, that all presenting needs are shared as part of any referral to mental health services, that the needs of a patient whilst awaiting an appointment with mental health services are considered and that when further concerns about that patient's mental health are shared with primary health services there is a review of that patient's care. It is therefore recommended that Manchester Health and Care Commissioning takes the action necessary to address the issues emerging from this DHR and share the outcome with Manchester Community Safety Partnership in due course.

Recommendation 4 (Single Agency)

That Manchester Community Safety Partnership request Manchester Health and Care Commissioning to address the issues emerging from this DHR, in particular:

- *The findings from the review are shared with Primary Care with the expectation that all presenting needs of patients are considered and that professional curiosity is exercised to contribute to risk assessment.*

- *Ensure that GPs inform patients of services they can access during the period they are waiting for a mental health outpatient appointment.*
- *Review how GP practices can engage with those patients that are traditionally difficult to engage including review areas of best practice and consider how an outreach approach may be implemented.*
- *Primary Care to be updated on self-neglect as a safeguarding issue and equipped to make a social care referral for self-neglect/vulnerability rather than only considering a mental health referral.*

Manchester Health and Care Commissioning should share the outcome of this recommendation Manchester Community Safety Partnership in due course.

7.19 This case also suggests that awareness of self-neglect as an adult safeguarding issue across a range of agencies including primary care, the police and social housing providers may be an issue. It is therefore recommended that this DHR overview report is shared with Manchester Safeguarding Adults Board so that they can consider what action to take to enhance the multi-agency approach to self-neglect in Manchester.

Recommendation 5

That Manchester Community Safety Partnership shares this DHR overview report with Manchester Safeguarding Adults Board so that the latter Board can consider what action to take to enhance the multi-agency approach to self-neglect in Manchester.

7.20 This case also indicates that police awareness of the circumstances when adult safeguarding concerns could justify a referral may need attention (Paragraph 4.68). It is therefore recommended that GMP consider developing a single agency action plan to address this.

7.21 The case also indicates that efforts to engage with 'difficult to engage' service users such as Lisa and Shawn could be enhanced. Improved engagement with 'difficult to engage' service users could have a direct impact on the prevention and detection of domestic violence and abuse. For example, in this case Lisa began her brief relationship with Shawn during the same month in which she did not attend her outpatient appointment with mental health services. Had primary and secondary health services managed to remain engaged with her, it may have been possible to obtain some insight into her relationship with Shawn and offer support.

7.22 The independent author has now carried out a number of domestic homicide reviews in which agencies experienced difficulties in engaging with the victim and/or perpetrator. Frequently these were cases in which the victim and/or perpetrator were abusing alcohol, drugs or experiencing mental health issues, or a combination of these conditions. In each case disengagement, or intermittent engagement presented a barrier to appreciating the risk of domestic abuse.

7.23 This review has made reference to multi-agency engagement policies adopted elsewhere and the good practice being developed in a Manchester GP practice with a high caseload of homeless patients. Additionally, Recommendation 3 envisages primary care taking steps to improve arrangements for engaging with service users regarded as 'difficult to engage'. However, it is recommended that Manchester Community Safety Partnership seeks assurance that *all* relevant partner agencies have policies in place to engage with 'difficult to engage' service users who may be at risk of domestic abuse.

Recommendation 6

That Manchester Community Safety Partnership seeks assurance that partner agencies have policies in place to engage with 'difficult to engage' service users, particularly those abusing alcohol and/or drugs and/or experiencing mental health issues, who may be at risk of domestic abuse.

7.24 It is also recommended that Manchester Community Safety Partnership widely disseminate the learning from this case. There are a number of aspects of this case which will be of value for practitioners from a range of agencies to consider including the important role that social housing providers can play in addressing domestic violence and abuse and the links between domestic violence and abuse and mental health and substance misuse.

Recommendation 7

That Manchester Community Safety Partnership widely disseminate the learning from this DHR.

7.23 GMMH also plan to make their specialist consultant aware of the requirements of the Adults of Working Age standard operating procedures which will presumably prevent the circumstances arising which prevented the planned November 2017 outpatient appointment for Lisa being entered onto the system.

References

(1) Hester, M. (2009), 'Who Does What to Whom? Gender and Domestic Violence Perpetrators', p. 15

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Edleson, J. L. (1998). Violent women: Fact and fantasy—social service agencies have a responsibility to know the difference. Domestic Abuse Project Training and Research Update, p. 3.

(4) Galvani, S. (June 2010), 'Grasping the Nettle: alcohol and domestic violence', p. 2

(5) *ibid*

(6) Retrieved from <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/identifying-assessing-and-managing-risk/>

(7) Retrieved from <http://www.mensadviceline.org.uk/help-and-information/frontline-workers-and-male-domestic-violence-victims/toolkit-for-work-with-male-victims-of-domestic-violence/>

(8) Harvey, S. and Rowland, J. (2011) Supporting the development of safe and affective responses within drug and alcohol agencies, retrieved from www.avaproject.org.uk/media/64002/mara%20engagement%20project%20stage%201%20exec%20summary%20may%202011.pdf

(9) Retrieved from <https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf>

Appendix A

Single Agency Actions

Adult Social Care

No single agency recommendations. The following multi-agency recommendations are made:

- Adult Safeguarding should have been triggered for Lisa during the timescale set up within the DHR
- One recording system recording systems that communicate to each other
- Expanding the use of the High Risk Protocol
- Legal Literacy and Signs of Safety Training & Well-being due to the Care Act 2014 is a relatively new piece of legislation that self-neglect falls under as a safeguarding concern

Manchester Health and Care Commissioning

See Recommendation 4 in the DHR Overview Report.

CCG (GP Practice 1)

Ensure that patients with a drug dependency have a medication review at least annually.

CCG (GP Practice 2)

No recommendations

Equity Housing

- Using this case to issue a reminder to colleagues about the importance of maintaining detailed and accurate records
- Give consideration to providing potential witnesses with written information about domestic abuse and advice about timely contact with appropriate agencies such as Domestic Abuse helplines, the Police, Crime Stoppers etc.

- Review the Domestic Abuse policy and procedure in the light of any recommendations and actions flowing from this case review.

GMMH

- Review the caseloads of the outpatient Consultants in order to reduce the waiting time for initial none urgent outpatient appointments
- Specialist Consultant to be made aware of the requirements of the Adults of Working Age SOP

GMP

No recommendations

NWAS

No recommendations

MFT

No single agency recommendations.

Wythenshawe Community Housing Group (WCHG)

- Ensure further referrals are made into MASH and/or Mental Health services where there have been numerous failed attempts to engage and where there are multiple risk factors.
- Case closure will also be subject to a management case review and where appropriate the number of contact attempts will increase from 3 to 6 visits.
- Seek to improve links between WCHG and GP practices via the Local Care Organisations and other partnership working, with the aim of agreeing a process for information sharing between housing provider and GP where appropriate.

Appendix B

Methodology by which DHR completed and membership of DHR Panel

The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

Individual Management Reviews (IMR) were completed by

- Equity Housing Group
- North West Ambulance Service
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester Health and Social Care Commissioning
- Greater Manchester Police
- Manchester City Council Adult Social Care
- Wythenshawe Community Housing Group (WCHG)

The authors of the IMRs had had no prior involvement in the case.

As previously stated the parents of the victim and the mother of the perpetrator were offered the opportunity to contribute to this review but declined. The perpetrator was also offered the opportunity to contribute to the review but also declined.

The DHR was overseen by an independently chaired Panel which ultimately approved the DHR overview report and submitted it to Manchester Community Safety Partnership.

Membership of the DHR panel

The Domestic Homicide Review Panel consisted of:

- Head of Investigations, Greater Manchester Mental Health
- Operations and Performance Manager, Adult Social Care

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- Designated Nurse, Adult Safeguarding, Manchester Health and Social Care commissioning
- Detective Sergeant, Greater Manchester Police
- Specialist LGTB Independent Domestic Violence Advisor, Independent Choices
- Regional Relationship Manager, Equity Housing Group
- Anti-Social Behaviour Manager, Wythenshawe Community Housing Group
- Policy Specialist, Manchester City Council
- Independent Chair and Author
- Administrative support was provided by Manchester City Council

It is intended that a copy of the DHR overview report will be shared with the following:

Equity Housing Group

North West Ambulance Service

Manchester University NHS Foundation Trust

Greater Manchester Mental Health NHS Foundation Trust

Greater Manchester Health and Social Care Commissioning

Greater Manchester Police

Manchester City Council Adult Social Care

Wythenshawe Community Housing Group

Community Safety Partnership

Manchester Safeguarding Boards

The victim's family

The perpetrator's family

Appendix C

Statement of independence

The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005.

Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015).

Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

He has no current or previous connection to any agency in Manchester