ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Mary

OVERVIEW REPORT FOR PUBLICATION

June 2020

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CONTENTS

1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to, and supported, Mary a resident of Rochdale.

1.2 Mary had been in a relationship with Ray for about two years. Mary's marriage ended some years ago. In three subsequent relationships she was the victim of domestic abuse perpetrated by other partners. Ray was also known to Greater Manchester Police (GMP) as a perpetrator of domestic abuse.

1.3 Mary's children had grown up and had left home when she met Ray. She asked him to leave her home after he abused her. Mary sought advice from Victim Support and had the locks changed at her home. On the day she was killed she returned home and found Ray had unlawfully entered the house. She telephoned a relative to alert them, however Ray killed her in the short time before anyone could get to Mary and help her.

1.4 Mary's eldest daughter said;

> The loss of our mum has shattered our lives as well as those of her sisters and the rest of our family. Nana took the news very hard and this led to her becoming ill two weeks later. Within a week her condition deteriorated, and she sadly passed away…we feel that we have not had enough time to let what has happened sink in, we are still in shock and overwhelmed by what has happened to our mum.

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

1.6 The key purpose for undertaking domestic homicide reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future[1].

[1] Home Office Guidance Domestic Homicide Reviews December 2016

2. TIMESCALES

2.1 Rochdale Safer Communities Partnership held a DHR Screening meeting and recognised Mary's death met the criteria for a DHR.

2.2 The first domestic homicide review panel meeting was held on 23 January 2018. At this meeting a time table was set to deliver the review by 6 August 2018. The panel recognised this date fell outside the recommendations within the Guidance[2] for completing DHRs. However, the non-availability of some panel members because of other commitments meant it was not possible to complete the review within a six-month time scale.

2.3 The domestic homicide review was presented to Rochdale Safer Communities Partnership on 22 January 2019 and then sent to the Home Office.

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016].

3. CONFIDENTIALITY

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

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

3.3 This table shows the age and ethnicity of the victim and offender at the time of the homicide.

Name	Who	Age	Ethnicity
Mary	Victim	52	White British
Ray	Offender	51	White British
Peter	Mary's son	n/a	n/a

3.4 This table shows details of addresses referred to in this report.

Address	Details
Address one	Mary's home and the scene of her homicide.
Address two	Previous address given by Ray to Rochdale Council
Address three	Current address given by Ray to Rochdale Council

3.5 Mary was responsible for Council Tax at address one from 27 June 2015 to her death. The property was owned by The Guinness Partnership. She was receiving benefits. Ray was not declared on the claim. Ray was responsible for Council Tax at address two from 8 December 2016 until 13 April 2017. He then left and provided Rochdale Council with a care of address at address three which is also in Rochdale.

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 23 January 2018. They were shared with Mary's family who were invited to comment on them.

4.2 The DHR panel set the period of the review from 1 September 2015 through to the date of Mary's death in autumn 2017. They chose this date as Mary and Ray had been in a relationship for about two years.

The purpose of a DHR is to:[3]

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

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

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

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

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

f] Highlight good practice.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Mary as a victim of domestic abuse and what was the response?

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

2. Were the decisions made by the police Public Protection Investigation Unit to revise the July and September 2017 DASH risk assessments from medium to standard appropriate?

3. What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Mary from seeking help for the domestic abuse?

4. What consideration did your agency give to the domestic violence disclosure scheme?[4] Did it bring the scheme to Mary's attention under the 'right to ask' criterion or suggest to Greater Manchester Police that they should consider informing Mary under the 'right to know' criterion?

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

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

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

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

9. What learning has emerged for your agency?

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

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

[4] Clare's Law, or the Domestic Violence Disclosure Scheme (DVDS), is designed to provide victims with information that may protect themselves for an abusive situation. (See Appendix C)

5. METHOD

5.1 The DHR review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff to understand what happened.

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

5.3 Thereafter a draft DHR overview report was produced which was discussed and refined at panel meetings before being agreed. The DHR overview report has been shared with Mary's family.

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

6.1 The Panel chair wrote to one of Mary's sisters and Mary's eldest daughter. The police Family Liaison Officer delivered the letters and the Home Office Domestic Homicide Review leaflet for Families and the Advocacy After Fatal Domestic Abuse[5] leaflet. Additionally, the terms of reference for the review were included.

6.2 Mary's eldest daughter replied to the Panel Chair though the Family Liaison Officer saying that she and the family were struggling to come to terms with Mary's death and did not wish to take part in the review at this time. She said that might change and that she would like to be kept updated on the progress of the review.

6.3 The Family Liaison Officer was approached again and negotiated with Mary's family. Peter, Mary's eldest child, agreed to contribute to the review and the chair spoke with him during a booked telephone conversation on 7 July 2018. His attributed contribution appears as appropriate. The family were provided with a copy of the report in August 2018 before it was submitted to the Home Office Quality Assurance Panel.

6.4 Contact was made with Ray's Offender Manger from the National Probation Service. Ray has decided not to take part in the review.

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

7. CONTRIBUTORS TO THE REVIEW.

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

Agency	IMR[6]	Chronology	Report
Greater Manchester Police (GMP)	X	X	
Heywood, Middleton & Rochdale Clinical Commissioning Group (CCG)		X	X
Victim Support	X	X	
The Guinness Partnership	X	X	

7.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with Mary or Ray.

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

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Sarah Butler	Tenancy Enforcement Manager	The Guinness Partnership
Paul Cheeseman	Author of the DHR report	Independent person
Janet Emsley	Cabinet Member for Neighbourhoods, Community & Culture at Rochdale Borough Council	Rochdale Borough Council
Janice France	Senior Probation Officer	National Probation Service
David Hunter	Chair of the DHR panel	Independent person
Chris Highton	Principal Community Safety Officer	Rochdale Borough Council
Alison Kelly	Lead Designated Nurse	Heywood, Middleton & Rochdale Clinical Commissioning Group
Hazel Lord	Business Support Officer	Rochdale Borough Council
Andrya Prescott	Business Development Manager	Safenet Domestic Abuse & Support Services
Suzanne Fawcett	Detective Constable	Greater Manchester Police
Hamaira Younus[7]	Manager	Victim Support
Chantelle Thompson	Operations Manager	Victim Support

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

8.3 The Panel met four times and the circumstances of Mary's homicide were considered in detail to ensure all possible learning could be obtained from

[7] Hamaira attended the first panel meeting and her place was taken by Chantelle who attended the remaining meetings.

her death. Outside of the meetings the Chair's queries were answered promptly and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

9.2 The chair completed forty-one years in public service retiring from full time work in 2007. The author completed thirty-five years in public service retiring from full time work in 2014. Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews and domestic homicide reviews.

9.3 The chair and author undertook domestic homicide reviews in Rochdale in 2014, 2015 and 2016. Otherwise neither the chair nor author has ever worked in Rochdale or for any agency providing information to the review.

10. PARALLEL REVIEWS

10.1 HM Coroner for Rochdale opened and adjourned an inquest pending receipt of this report. One of Mary's children was the spokesperson for the family and saw, and commented on, the report before it was submitted to the Home Office. The same child has been provided with a copy of the finalised report prior to publication.

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

10.3 Every time someone has direct or indirect contact with the police when, or shortly before, they are seriously injured or died the police force involved must refer the matter to the Independent Office for Police Conduct (IOPC). In this case Greater Manchester Police (GMP) made a referral about Mary's death as police officers had contact with her when they attended address one on 17 September 2017.

11. EQUALITY AND DIVERSITY

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

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

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

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

11.3 The DHR panel heard that on some occasions Ray and Mary had consumed alcohol and may have exceeded safe recommended levels. The misuse of alcohol is statutorily excluded from the definition of disability under the Act.

11.4 Neither Mary nor Ray had any known protective characteristics that would have fallen within S4 of the Equality Act 2010. Professionals applied the first principle of Section 1 Care Act 2005:

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

11.5 There is no evidence that either Mary or Ray lacked capacity within the meaning of the Care Act 2005.

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

12. DISSEMINATION

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

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

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Mary lived at address one with Ray. They met in September 2015 and he moved into the address in February 2017. GMP received two calls concerning domestic abuse in which Ray was the perpetrator and Mary was the victim. The first of these was on 9 July 2017 when a disturbance was reported in the street with a female being chased by a man. Police officers attended. Mary was not injured although she told the police she wanted Ray to stay away from her house until the next morning.

13.2 The second call was on 17 September 2017. Mary was at her mother's house and reported that Ray had assaulted her: he had put his hands around her neck after they had argued when leaving a public house. Mary chose not to give a statement to the police although it appears it was this incident that was the catalyst for her deciding to leave Ray.

13.3 Mary sought advice from Victim Support. They provided her with a safety plan in the recognition that the danger to victims of domestic abuse increases at the time of separation and for several weeks thereafter. This included having her locks changed as she was afraid Ray had keys to the property and would return. The Guinness Partnership, from which Mary rented her house, carried out this work within two days.

13.4 Although it only emerged during the homicide investigation, it is now clear that Mary was very frightened of Ray. His behaviour towards her was controlling and coercive[9]. He would not let her wear boots she liked, he did not like her contacting friends and demanded she returned home within a certain time. Mary disclosed to family that he had assaulted her, and she told them she feared Ray would kill her. After they separated, Ray's controlling behaviour continued. He sent many text messages to Mary, watched her house and turned up at a private appointment she had with the Job Centre. These activities were acts of stalking and harassment.

13.5 On the day she was killed, Mary returned to her address alone (she had often asked family to accompany her because she was frightened of Ray). She had just been to an interview at the Job Club where Ray had turned up and was waiting for her. Staff noticed she seemed frightened and telephoned for a taxi to take her home. Unbeknown to Mary, Ray had entered her house unlawfully. She telephoned a relative and they heard Mary say that Ray was in the house and he had a knife. She pleaded with him to put the knife down and she would talk to him.

[9] See Appendix A and B

13.6 The relative called the police to get Mary help before calling another family member. By the time the family member got to address one a short time later, the police had already reached the house and found Mary deceased.

13.7 A Post Mortem Examination found that Mary died because of knife wounds. Ray was arrested two days after Mary died and was charged with her murder. Enquiries by the police found that Ray had entered address one through an insecure window shortly after buying a knife from a nearby shop.

13.8 Ray appeared before a Crown Court where he pleaded guilty to murdering Mary. He was sentenced to Life Imprisonment with a minimum tariff of 22 years. That means he must serve that period before he can be considered for release. When sentencing him His Honour the Judge said to Ray;

> They (Mary's family) feel guilt that they were not there to save their mother – but they have no reason to feel guilty – the guilt is yours, and it is a guilt which you must carry for the rest of your life…it is clear that you were not willing to let Mary go[10].

[10] Manchester Evening News 7 February 2018

14. CHRONOLOGY

14.1 Background to Mary and Ray

Mary
Mary was born in the Blackley area of Manchester. She was one of four children, all girls, and was the second eldest. She was raised in Langley, Middleton where she attended primary school and high schools. Mary was a popular person and there were no significant issues in her childhood. Peter described his mother as: a very selfless person who cared deeply about her four children and sisters and all family members. She never had much money and would still go without and put other people's needs before her own. Mary was shy, probably timid which enabled people to take advantage of her. In this respect she was vulnerable Mary met her first and long-term partner when she was 18 years of age. The couple had four children: two boys and two girls. Mary did not work and devoted her time to her children and home. As they grew up Mary had occasional work as a school dinner lady. Mary spent a great deal of time caring for an aunt over a ten-year period and then, after she passed away, she cared for her aunt's neighbour. Mary was a caring person: she was not paid for this work and did it because she enjoyed helping. Mary and her partner separated after 22 years. Peter described his father as quite possessive and a bit restrictive of Mary's movements; for example he queried where she had been if she spent an extra 10 minutes at the shops. In real time Peter recognised his father's behaviour as emotional abuse. They remained on good terms and Mary then moved to address one. Mary started to make new friends and became more independent. She was described as confident and someone who looked after her appearance. Her children knew that she had a couple of partners after Mary separated from their father. She then met Ray and they were in a relationship for two years (see below).

Ray

As he did not wish to engage, the panel learned little about Ray's background, save for very brief details provided by his family in two witness statements provided to GMP. Ray's mother said he was one of four children from her first marriage; three boys and a girl. Before living with Mary, Ray was resident with his mother and his step-father. She said the relationship with her son was very much 'up and down'. One minute they would be 'brilliant together' and the next they would be fighting. It would always be because they had been drinking.

Ray had a son and daughter. In a statement to the police his daughter said her father separated from her mother in September 2015. Ray told his daughter in January 2016 that he had a new girlfriend, called Mary, and he had been going out with her since November 2015.

The Relationship

Mary met Ray when they went on a night out. Her family said that after about ten months of the relationship, things began to change. They didn't know much about him, as Mary kept him away from the family. Ray moved into address one with Mary in February 2017. Mary said she didn't want him to move in however, she felt forced to because she could not leave her dog on its own for long periods of time. Ray would not allow her to stay at home on her own, so she felt she had to let him move in.
Once Ray had moved in, Mary's behaviour is said to have changed. She was less outgoing and became more introverted. When family members called her, Ray would answer her telephone, or she would answer and put the loudspeaker on so Ray could hear the other half of the conversation. Mary would make excuses to get out of seeing people or for having to leave early. She would never blame Ray, although she would say he was timing her and she had to rush back. The family realise that it was due to him that she was never relaxed and always anxious to leave and return home.

The family believe Ray was a very controlling person and prevented Mary from doing a lot of things. They knew of many instances that characterised his controlling behaviour. For example:

- Ray would call Mary at 0600 hours and demand that she moved the camera telephone around the room so he could check her location.

- Ray did not like Mary having her hair done, and he would not allow her to wear the boots she liked.
- She was made to feel uncomfortable to the point that it was easier to agree with Ray than cause an issue about something she did not necessarily agree with.
- Peter took his mum to see her eldest daughter. They stayed overnight and all the time Mary was anxious and wanted to get back to Ray. On the four-hour drive home Ray telephoned every 10/15 minutes wanting to know where she was on the journey; it was as if he was plotting their course.
- On another occasion Mary send Peter a picture of what looked like bruising to her face.
- Ray made Mary wear a wedding ring and to refer to him as her husband even though they were not married. Peter said his mum was embarrassed as this was bizarre behaviour by Ray. Peter said he knew his mum would not have wanted to do this and felt she would have done so out of fear of Ray.

Peter knew the relationship was a controlling one and advised Mary to leave. Mary said she could manage things and did not want to leave Ray. The family say the relationship between the couple was volatile. On several occasions Mary left Ray because he was violent and aggressive. Mary said she would not go back to Ray and yet the following week she forgave him, and they were back together. He always apologised to her saying how sorry he was, and the family said she would fall for it. Mary would telephone her children and talk to them about what had happened.

Peter feared that Mary might hold back telling her family about instances of abuse and Ray's behaviour. Peter felt Mary needed an outlet and her family would be able to keep an eye on her. Peter felt that, if they went to the police, they did not believe there would be any outcome. Peter said his mum would probably downplay matters and then she may no longer tell the family about anything again.

After a few times, when they broke up, Mary started to say she feared Ray and that she 'valued her life'. She said if she got back with him 'he would kill her' and that she was not going back to him.

The last occasion this happened, the family say Ray assaulted her at a pub when they had gone out for a social drink in the afternoon with their Nana. Because of this event, Mary decided to leave Ray. This occasion was

said to be different and Mary was adamant she was not going to take Ray back. The family knew that Mary had contacted Victim Support and had the locks changed at address one. Mary ignored Ray's text messages, started to wear the boots she liked and visited family again which Ray would never let her do.

Mary had a second mobile telephone which she used for contacting people Ray did not approve of; particularly male friends. Although Mary had separated from Ray she was said to seem very frightened and said things were getting much worse and that he would end up killing her. She spoke of how Ray would 'drag her around the room like a rag doll'. She said, 'I value my life, so I'm not getting back with him'.

Mary was encouraged to stay with a family member in another part of the country. However, she would not go and was worried in case Ray did anything to harm her dog. He was continually trying to get hold of her directly, or through family or friends after they separated. She asked family members to talk to him so that she knew what Ray's plans were and what was in his head. He told a family member that he was watching Mary's house.

Mary wanted to do something positive and made an appointment at the Job Club, to see if she could find work. She was said to be concerned about Ray going to the appointment. On the morning of the appointment she telephoned each her children asking what to do if he turned up. In fact, that is what happened, and Mary told them that he had been waiting for her to arrive at the Job Club. She told family members that she intended to call the police and get a restraining order.

Peter said that Mary found the strength and courage to leave the relationship and looked forward to a better life. She had been separated from Ray for nine days. On the day of her death Ray saw Mary who firmly declined his offer of reconciliation. Peter believes that what Ray did next was premeditated, although Ray claimed, "he lost it". Peter believes there to be no truth in that. He says Ray harassed his mum in the morning to the point that she asked a member of the public to intervene and she walked her to her appointment. She was then so shaken that she couldn't attend the appointment and a member of staff put her into a taxi to her mother's. Peter says he (Ray) realised at this moment that she was not going to take him back and he had lost control of her. He then walked to the bus stop (10+ mins), got a bus to the town centre near her house (nowhere near his), bought a knife, walked 20 minutes to her house,

broke in through the back and lay in wait for her to return home. Peter says this isn't a man who wanted a chat and lost control, he knew exactly what he was going to do and he carried it out.

Peter said the he felt the fact his mum did not work made her especially vulnerable. Her time became more dominated by Ray and her only regular contact would have been with her mum and sisters - though this would have been restricted by Ray. In addition, once Peter's younger sister left home there was no-one in the house with Mary every day and Peter felt Ray was able to move in. Peter said his mum stated she didn't want Ray to move in but she did so for an easy life.

Finally, Peter said he felt there should have been a helpline or other services where he and/or his mum could have sought support and a long-term solution.

14.2 Events Table

14.2.1 The following table contains important events which help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review, from witnesses that were seen during the homicide review and from the memories and recollections of Mary's family and friends.

Date	Event
2002 to 2005	GMP attend ten domestic incidents involving Mary as a victim of abuse by Male One.
2006 to 2007	GMP attend two incidents involving Mary as a victim of abuse by Male Two.
2006 to 2009	GMP attend three incidents in which Ray is the perpetrator of verbal domestic abuse upon a former partner.
2010	Ray is arrested to prevent a breach of the peace following a disturbance at a family event.
2012	GMP attend an incident involving Mary as a victim of abuse by Male Three.
2013	Ray is assaulted by unknown persons and suffers a facial injury and a fractured foot.
Sept 2015	Mary meets Ray while on a night out.
10 December 2016	An operative from The Guinness Partnership attends address one to make a repair. A male opens the door

	and says he will 'get his sister'. The male shuts the door and does not return.
9 July 2017	GMP attend near to address one following reports of a man chasing a woman. They speak to Mary and Ray. The matter is recorded as 'domestic abuse'. Mary is not injured and chooses not to provide a statement. She is given advice. The risk to her is recorded as 'medium'. This is later reviewed and re-assessed as 'standard'.
17 September 2017	GMP attend and speak to Mary who reports that Ray placed his hands around her throat following a visit to a public house. She chose not to provide a statement. GMP record the matter as a crime and as a case of domestic abuse. The risk to Mary is recorded as 'medium'. This is later re-assessed as 'standard'. Mary decides to separate from Ray.
19 September 2017	Mary makes a telephone call to Victim Support asking for help and discloses domestic abuse.
21 September 2017	An Independent Victim Advocate from Victim Support speaks to Mary. They give Mary advice and a safety plan that includes changing the locks at address one.
22 and 23 September 2017	Mary had telephone conversations with staff from The Guinness Partnership. She discloses domestic abuse and requests her locks are changed and a kitchen window lock repaired.
24 September	The Guinness Partnership change the locks at address one. The work to complete the repair to the window is scheduled for another date which is after Mary is killed by Ray
A date in Autumn 2017	Mary attends an appointment at the Job Club. Ray is waiting for her. She is said to be frightened and leaves by taxi. When she returns to address one he has entered the property unlawfully through an insecure window. He kills her with a knife he bought from a nearby shop.

15. OVERVIEW

15.1 Introduction

15.1.1 This section of the report summarises what information was known to the agencies and professionals involved with Mary and Ray. Section 15.1 of the report looks at information held by agencies before the start date of the review that the panel felt might illuminate their understanding of events. The panel decided on this approach because they heard that Mary and Ray had been in a relationship for about two years before her homicide.

15.1.2 Section 15.2 of the report examines events as known by each agency between 1 September 2015 and the homicide of Mary.

Information held by agencies prior to 1 September 2015

15.1.3 Mary was known to GMP as a victim of domestic abuse when she was in a relationship with her first partner Male One. Between 2002 and 2005 GMP were called to ten domestic incidents. Although none of these incidents was recorded as crime, they were all correctly recorded as Public Protection Investigation (PPI) matters[11]. Alcohol was deemed to be a factor by one or both parties in all calls. On the tenth occasion, Mary was recorded as a repeat victim of domestic abuse.

15.1.4 GMP were called to two incidents involving Mary and her then partner Male Two in the period between 2006 and 2007. In the first incident Mary's daughter reported an assault. When the police spoke to Mary she said that she had not been assaulted and chose not to give any further details regarding the incident. Both incidents were correctly recorded as PPI matters.

15.1.5 In 2012 GMP were called to an incident involving Mary and Male three. Mary reported that he had assaulted her by punching her in the face during an argument. A crime of S.39 assault[12] was recorded. Mary chose not to provide a statement. Male three made a full admission when he was interviewed by the police and the matter was dealt with by means of Restorative Justice[13].

15.1.6 Ray was known to GMP prior to his relationship with Mary. He was involved in three calls relating to domestic abuse in 2006 and 2009 involving his ex-

[11] Public Protection Investigation Unit (PPI) is a specialised unit within Greater Manchester Police that handle domestic abuse cases and other case involving vulnerable victims. When police officers attend reports of domestic abuse they are required to submit a PPI report.
[12] S39 of the Offences Against the Person Act 1861-often referred to as a 'Common Assault'
[13] Restorative Justice is a sanction that can be imposed on an offender as an alternative to attending court.

partner. All were recorded as arguments between them and there was no record that violence had been used.

15.1.7 In 2010 Ray was arrested for a breach of the peace and then de-arrested. This incident was not a domestic matter and was recorded as an argument between adults at a family/friend gathering. It involved Ray, his niece and her boyfriend.

15.1.8 On 15 March 2013, Ray attended an Urgent Care Centre following an alleged assault upon him. He had an injury to the left side of his face and a fracture in his foot. There is no information available to indicate who might have been involved in the incident that led to these injuries.

15.2 Information held by agencies between 1 September 2015 and the date of Mary's homicide.

Greater Manchester Police (GMP)

15.2.1 During the period under review and before Ray killed her, he was involved in two domestic incidents in which Mary was the victim. The first occurred during the early hours of 9 July 2017 close to address one. An anonymous caller contacted GMP and reported a disturbance. They said a female ran past them in the street being chased by a male and shouted, 'Call the Police'.

15.2.2 The anonymous caller spoke to the police officer who attended. The male and female appeared to be arguing, then kissing in a bush. They came out of the bush and the male led the female back into the house by the hand. The officer spoke with the couple and they were identified as Mary and Ray.

15.2.3 Neither of them made any allegations. Ray was removed from the address and the police officer attending completed a DASH[14] risk assessment and created a PPI report. This recorded that Mary and Ray had been in a relationship for two years. They both drank alcohol, but neither took drugs or had any mental health issues. The officer spoke to each of them separately.

15.2.4 Mary told the police officer that she wanted to stay at address one and that Ray could return in the morning. The police officer asked Mary some questions for the DASH report. However, Mary chose not to provide any

[14] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009.

answers. Before leaving, the police officer gave Mary an End the Fear (ETF)[15] leaflet and told her about Clare's Law[16].

15.2.5 The police officer recorded on the PPI report that this was the first reported incident between the couple. The officer said that, because of Mary's mannerisms and body language, they felt she feared Ray and may be struggling to get out of the relationship. Because of this, the officer felt there was potential for further risk to Mary from Ray. The officer felt it might be prudent for a follow up call to be made to Mary from the PPIU. The police officer graded the incident as 'medium'[17] risk.

15.2.6 On the 12th July 2017, an officer from the PPIU reviewed the report that the attending officer had completed and re-assessed the risk as 'standard'. The report was closed, and a letter was sent to Mary offering her support.

15.2.7 On 17 September 2017 in the early hours of the morning Ray telephoned GMP. He said he wanted the police to remove him from the address (address one) as his girlfriend didn't want him there and wanted him to leave. He then said `right I`m going' and cleared the line.

15.2.8 About thirty minutes later, GMP managed to contact Ray by telephone. He told them he was going to stay at his mother's house and that Mary was going to stop with her mother. Because there were no police patrols available there was a delay in attending.

15.2.9 At 08:14 hours on the 17th September 2017 police officers attended and spoke in person with Ray and then with Mary who was at her mother's address. The police officer attending submitted a DASH, a PPI report and a crime report for common assault with Mary as the victim and Ray as the perpetrator.

15.2.10 The following information was recorded on the crime report;

CIRCUMSTANCES OF INCIDENT

Both parties who are in a relationship went to a public house in (redacted) town centre. The victim went outside the pub. The offender followed the

[15] 'End the Fear' is a Greater Manchester wide programme for anybody who is experiencing domestic or sexual violence. Here they can find help, support and advice. The programme also provides support to people who know someone who may be being abused. The programme aims to encourage victims of domestic and sexual violence in Greater Manchester to find the courage to come forward and seek support and help.

[16] See Appendix C

[17] Domestic abuse incidents in the GMP area receive one of three risk gradings depending upon the judgment of the police officer attending and the answers victims provide to the DASH questionnaire or a combination of the two. The gradings are 'standard', 'medium' or 'high'.

victim outside and because there were other males outside that the offender presumed the victim was talking to, the offender became upset. After a short time, an argument ensued between these parties which led the offender to place his hands around the victim's neck although not tightly. The victim batted the offender away and left the pub.

VICTIM

The victim was spoken to who did not wish to give a statement against the offender signing my PNB [pocket note book] stating that she would not attend court and that she did not wish for any further Police assistance. The victim did not suffer any injuries.

OFFENDER

The offender has been identified and was spoken to prior speaking to the victim as he opened the door at the address and the victim was at a relative's address. The offender who was the informant to the Police just stated that he was intoxicated on the evening this incident is alleged to have happened.

LOCATION

The location is the (redacted) public house in (redacted) town centre. H2H[18] not applicable due to location. CCTV hasn't been checked at this time due to the victim's unwillingness to support a prosecution and that the victim didn't suffer any injury.

WHAT NEEDS TO HAPPEN

This incident will be forwarded to an Inspector with view to filing. The victim does not support a prosecution. There are no independent witnesses that have come forward. The victim did not suffer any injury. There is 1 previous PPI between these parties.

15.2.11 The investigating officer asked Mary all the 28 questions on the DASH report. Mary answered "no" to all questions except the following, the answers for which are repeated in full;

Question 2: Is the victim very frightened?

[18] Short hand for House to House enquiries.

Answer: YES - Mary is apprehensive because when Ray has a drink he can be unpredictable and very verbal.

Question 3: What is the victim frightened of? Further injury or violence?

Answer: Mary just wanted Ray not to return to the address.

Question 6: Has the victim separated or tried to separate from the abuser in the last year?

Answer: YES - They have tried to separate over the past year but Mary has always gone back to Ray.

Question 18: Has the Abuser ever attempted to strangle/choke/suffocate/drown the victim?

Answer: YES - With regards this incident, Ray placed his hands around Mary's throat although it wasn't tight.

Question 25: Has the Abuser ever threatened/attempted to commit suicide?

Answer: YES- Mary stated that Ray has attempted suicide previously but Mary stated that she thought it was attention seeking.

Question 27: Do you know if the abuser has ever been in trouble with the police or has a criminal history?

Answer: YES- Mary stated that Ray is known to the Police but it was a long time ago.

15.2.12 The investigating officer updated the PPI report with a risk assessment of 'medium'. In summary the assessment recorded that the relationship was good for the most part, except when Ray drank alcohol which caused him to become aggressive.[19] The risk assessment repeated the circumstances of the offence: that Mary had chosen not to pursue a prosecution against Ray and that she wanted him to leave and not to return to address one. The police officer advised Ray not to return and advised Mary to contact the police should he return and cause any problems.

15.2.13 The PPI report was submitted to the Public Protection Investigation Unit where it was triaged by an officer from that unit. The officer re-assessed the risk as 'standard'. No referrals were made.

[19] The panel was careful not to suggest that Ray perpetrated domestic abuse just because he drank. He was a violent man and his desire to control Mary was the reason he used physical violence against her. His consumption of alcohol was ancillary to his violence and did not initiate it.

15.2.14 An action was created for an Inspector to review the crime report. However, the date for this review fell after the date of Mary's homicide.

Heywood Middleton and Rochdale Clinical Commissioning Group

15.2.15 Mary and her children attended the GP surgery on several occasions. There was nothing documented in either Mary or the children's medical record to indicate there were any issues regarding domestic abuse or relationship difficulties.

15.2.16 Ray attended his GP surgery on several occasions with a long-standing unconnected condition. There was no evidence that any of these attendances were connected to domestic abuse nor that he was in a relationship or had any anger issues. He attended Accident and Emergency department on four occasions during the review period. None of these attendances were connected to violent events and were for routine mattes unrelated to any relationship issues.

Victim Support

15.2.17 On 19 September 2017 Mary self-referred by telephone to an Independent Victim Advocate (IVA) at the Victim Support central office in Bolton. Mary said she would like some practical and safety advice. She did not feel secure as her boyfriend had the keys to her door and was making comments on Facebook. Mary said she was staying at her sister's address sometimes. The information Mary provided was then passed to the Rochdale Office to offer her local support.

15.2.18 On 21 September 2017 another IVA, this time from the Rochdale Office, contacted Mary by telephone in relation to her request. Mary said she had on going issues with her ex-partner, they had been in a relationship for two years and recently he had become abusive. Because of this she had ended the relationship. Mary said he had been sending her text messages and calling her. She said the police would be attending to discuss this further.

15.2.19 Mary said her ex-partner had a key for her house and she was scared he was going to get in when she was out. She said that, when she was in and the door was locked properly and bolted, she felt safe in the house. Mary said it was when she went out and came back in that she was worried. She said she just wanted him to leave her alone.

15.2.20 The IVA spoke to Mary and completed a needs assessment. During this conversation, Mary was given some practical information and support and

advised to contact her landlord to change the locks. The IVA discussed completing a DASH risk assessment with Mary. She chose not to do this as she said she was due to see the police the following Saturday and wanted to see what occurred during this visit. That was the last contact Victim Support had with Mary. A follow up telephone call had been arranged although sadly, by that time, Mary had already been killed by Ray.

The Guinness Partnership

15.2.21 The Guinness Partnership is a national social housing provider. Mary was resident in a property that was managed by The Guinness Partnership. During the period of the review there were many contacts between Mary and The Guinness Partnership. Most of these were unrelated to relationship issues and therefore only those issues the DHR panel assessed as of some relevance are considered here.

15.2.22 During the review period Mary had several contacts with The Guinness Partnership that related to financial matters. Mary engaged regularly with The Guinness Partnership and generally returned their calls. However, between early April and late August 2017 there was a period of non-engagement from Mary to The Guinness Partnership. This was when the agency wanted to know from Mary why there were some underpayments on her rent account. While during this period Mary was in a relationship with Ray, the DHR panel believe there is insufficient evidence or information to indicate a connection between Mary's lack of engagement and her relationship issues.

15.2.23 Mary had several contacts with The Guinness Partnership that related to the maintenance of her property. On 9 and 25 November 2016 a Maintenance Operative had face to face contact with Mary at address one in connection with a boiler repair. This was a routine matter, and there was no record of anyone else being involved.

15.2.24 On 10 December 2016 an Out of Hours Operative visited address one in response to a request to attend a leak from the bathroom into the kitchen. The door to address one was answered by a man who said he would 'get his sister'. The man shut the door and did not return despite the Operative knocking on the door. The Operative therefore left after twenty minutes.

15.2.25 On 22 September 2017 Mary contacted The Guinness Partnership by telephone. She told The Guinness Partnership that she was the victim of domestic abuse. She said that she wanted to secure her home. Arrangements were made to change the locks at address one and to repair a broken window lock.

15.2.26 Mary spoke to The Guinness Partnership again on 23 September 2017 in connection with the arrangements for this work. During the telephone conversation she disclosed that she did not feel safe. The work to change the door locks was completed the following day. Work on the broken window lock was scheduled although did not take place before Mary was killed. A cross reference is included within the Guinness Partnership records to the GMP crime number relating to the assault upon Mary by Ray (see paragraph 15.1.11).

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Mary as a victim of domestic abuse and what was the response?

16.1.1 GMP held information that Mary was a victim of domestic abuse. The earliest record dates from 2002 at which time Mary was in a long-term relationship with Male One (see paragraph 15.1.3). None of these incidents were recorded as crimes although all of them were recorded on PPIU reports. On reviewing the reports, the GMP IMR author identified that one of the reports should have been recorded as a crime. This was in October 2003 when it was reported Mary slapped her partner (male one).

16.1.2 In three of these reports Mary was listed as the perpetrator and in the remainder Male One was recorded as the perpetrator. The panel believe that no inferences should be drawn from that. Given the passage of time, it is not practical to research all these events to establish a sequence of events. The panel recognise that perpetrators will sometimes make the first telephone call to the police to report an incident[20].

16.1.3 The panel believes great care needs to be applied when determining 'who is the victim?' and 'who is the perpetrator?' The panel accepts that agencies systems and processes mean that they need to make an early identification of these roles. There is insufficient information to reach a judgement as to whether this happened here. The panel therefore goes no further than to say that Mary was very clearly a victim in most of these calls and could also have been one in the other three. The point needs to be made that manipulative and determined perpetrators may seek to hijack agencies systems with misleading information to paint themselves as the aggrieved party.

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

16.1.4 Following the submission of the tenth PPIU report Mary was designated in that report as a 'repeat victim'[21]. While Mary was killed by Ray and not Male One, the DHR panel believe her designation as a repeat victim has implications. That is, as a repeat victim of domestic abuse, Mary had additional vulnerabilities stemming from not being protected or supported during previous episodes of domestic abuse. This experience may have influenced how she dealt with subsequent abuse and exploitation.

16.1.5 Indeed, that is what happened as in 2006 and 2007 Mary was the victim of domestic abuse at the hands of a new partner, Male Two, on two occasions (see paragraph 15.1.4). This abuse continued when Mary was the victim of domestic abuse on one occasion at the hands of Male Three in 2012 (see paragraph 15.1.5).

16.1.6 Ray was known to have been involved in three incidents of domestic abuse with an ex-partner (see paragraph 15.1.6). He had also been arrested for a breach of the peace. This was not recorded as domestic abuse and there was no necessity to do so. Ray would not have fallen into the category of being a serial or serious offender for domestic abuse[22].

16.1.7 The first incident recorded between Mary and Ray occurred in July 2017 (see paragraph 15.2.1). While the circumstances of this incident were a little unclear, the DHR panel believe the actions of the attending officer deserve comment. While Mary chose not to provide responses to the DASH questionnaire, the officer believed that, due to her mannerisms and body language, she feared Ray and may have been struggling to get out of the relationship. The officer therefore flagged up the need for a follow up call.

16.1.8 The DHR panel felt this was an example of how police officers and other professionals can exercise their judgment to make sure victims can receive an offer of support even when the DASH assessment is not completed. Recognising subtle signs and indicators like this can have very real value in

[21] The police Domestic Abuse Policy 2015 states that in relation to repeat victims. "If a victim reports an incident of domestic abuse to the police on more than one occasion they will be considered a repeat victim. This is regardless of whether the incidents reported involve the same or different perpetrators. Officers need to review previous safeguarding measures and utilise the RARA model to consider increasing or adapting existing safeguarding measures and referral or signposting to partner agencies for intervention to prevent the victim suffering further abuse.";

[22]Someone who has committed domestic abuse against three or more different partners, or an offender who has committed five or more domestic abuse offences against one partner.

helping identify domestic abuse. Unfortunately, because the PPIU officer who triaged the report downgraded it to standard, this meant that no further contact with Mary was required. Only a standard letter was sent by the PPIU to Mary.

16.1.9 The second incident between Mary and Ray occurred on 17 September 2017 (see paragraph 15.2.7). This incident represented an escalation in the risk that Ray presented to Mary as he had placed his hands around her throat. Although Mary answered 'No' to twenty-two of the twenty-eight questions on the DASH form, the answers that she gave to six indicated she was frightened of Ray. This was because he was unpredictable when he drank alcohol and could be verbally abusive.

16.1.10 While a crime report was submitted, because Mary chose not to make a statement and she did not have any physical signs of injury, this was not investigated further. The DHR panel discussed with their panel colleague from GMP whether this matter could have been investigated. The panel considered that, even though Mary had chosen not to provide a statement, the matter could still have been investigated. They contrasted this with the way the assault upon Mary by Male Three was dealt with (see paragraph 15.1.5). Although on that occasion Mary also chose not to provide a statement that did not prevent the police from arresting and interviewing Male Three. He admitted the offence and a sanction was imposed.

16.1.11 The panel felt that there can be value in such a course of action even when a victim chooses not to provide a statement. It sends a powerful message to perpetrators that their actions will have consequences and that they will receive a sanction, albeit not necessarily before a court. Because the outcome is a sanction the police force involved will record this information on their local crime systems and on the Police National Computer. Hence information about a perpetrator is more readily available both locally and nationally should the police or another agency conduct a search of their systems in the future. It provides another potential layer of protection should the perpetrator abuse another victim.

16.1.12 Victim Support held information that Mary was a victim of domestic abuse because of her contacting them for advice on 19 September 2017 (see paragraph 15.2.17). Mary told the IVA that spoke to her by telephone on 21 September that she did not wish to provide information for a DASH risk assessment as she was due to see the police.

16.1.13 The panel noted the IVA involved appeared not to press Mary further for this information and accepted that it was her choice. Although Mary spoke about waiting to see a police officer, a check on the GMP records indicated that there were in fact no arrangements by the police to see Mary again. The DHR panel do not know why Mary told the IVA the police were due to see her. There may be several reasons. Mary could have been mistaken, or, for her own reasons, she may not have wished to share any more information with the IVA. Whatever Mary's reasons for not providing information for the DASH, the DHR panel felt the advice and support, including a safety plan, provided to Mary by Victim Support was appropriate and reasonable.

16.1.14 Mary contacted The Guinness Partnership on 22 September 2017 (see paragraph 15.2.25). She disclosed domestic abuse and said she wanted to secure her home because her ex-partner had keys and her kitchen window lock was broken and hanging down. The lock change was completed on 24 September 2017. The kitchen window lock was due to be changed a few days later, however Mary was killed before that work was carried out. The point of entry that Ray used the day he killed Mary was through the window with the broken lock.

16.1.15 The Guinness Partnership identified some shortcomings in their compliance with their internal domestic violence service principles and these are considered within section 16.3 of this report.

16.1.16 The DHR panel considered whether the visit the Guinness Partnership Operative made on 10 December 2016 might have been connected to the abuse of Mary (see paragraph 15.2.24). While it was unusual behaviour, the panel did not feel there was enough information to draw any inferences. Probably, the male could have been Ray. If it was, it is not clear why he referred to Mary as his 'sister'. It may have been because he was concerned that his presence at the house might have had consequences in relation to housing benefit.

16.2 Term 2

Were the decisions made by the police Public Protection Investigation Unit to revise the July and September 2017 DASH risk assessments from medium to standard appropriate?

16.2.1 The DHR panel concluded that the actions of the police officer who attended the call on 9 July 2017 (see paragraph 15.2.1) were reasonable

and proportionate in relation to the information they gathered. Mary did not disclose that she had been assaulted by Ray or had been a victim of abuse. Even though Mary chose not to provide information for the DASH report, the police officer still completed a risk assessment. They used their judgment, submitted a PPI report and assessed that Mary feared Ray because of his mannerisms.

16.2.2 It is the policy of GMP that when a PPI report is submitted, a 'triage' is conducted. The reason for the process is considered further within section 16.8 of this report. The PPI report, the DASH questionnaire and the history of Ray and Mary was considered by a reviewing officer. One of the issues that was considered was that Mary was a repeat victim of domestic abuse, albeit not with Ray. The most recent occasion when she had been a victim was at the hands of Male Three in 2012 (see paragraph 15.1.5). Taking this information into account the reviewing officer who 'triaged' the report from 9 July 2017 made the decision that the appropriate grading to apply was 'standard' rather than 'medium'.

16.2.3 The IMR author for GMP has discussed that decision with the Detective Inspector and Detective Sergeant responsible for the Public Protection Investigation Unit. They both concluded that the grading of 'standard' was appropriate in the circumstances. This is based upon there having been no previous incidents between Ray and Mary and she did not disclose any injuries or any offences. While Mary was a repeat victim of domestic abuse, that was over five years previously and with different partners.

16.2.4 The police officer who spoke to Mary on 9 July 2017 had already given her a leaflet about domestic abuse and had also told her about 'Clare's Law'. When a 'standard' grading is applied to a case, then no follow up call is made. Instead the report was closed, and Mary was sent a letter offering her support.

16.2.5 The DHR panel recognise that GMP need to ensure that the most appropriate grading is applied to domestic abuse reports. This ensures that a proportionate response is provided, and limited resources are applied to the most appropriate cases. The DHR panel accept that the judgment made by the reviewing officer in this case was proportionate and reasonable.

16.2.6 None the less, like the IMR author, the DHR panel would have expected that a follow up call could have been made to Mary as the attending officer requested. They recognise that, sometimes, while victims may initially

choose not to provide information, when they are contacted again later they choose to provide a different response. The DHR panel are not able to judge how Mary might have responded to a follow up call. The fact it was not made, meant an opportunity to maintain engagement with Mary was missed and to give her the choice to provide information about the abuse she was suffering from Ray.

16.2.7 In contrast to the first report of domestic abuse the DHR panel believe the second report on 17 September 2017 should have remained graded as 'medium' risk when 'triaged' (see paragraph 15.2.13). On this occasion Mary answered positively to some of the questions including the question as to whether Ray had ever attempted to strangle her. Such behaviour is indicative that the victim is at greater risk and is a factor that has been seen in other domestic homicides.

16.2.8 The officer that attended the incident that day applied their judgment and considered all the information they had available and believed risk faced by Mary was 'medium'. The DHR panel believe that was an appropriate response. The DHR panel believe it was inappropriate that the report was later re-assessed and a 'standard' risk applied. Mary had answered six questions positively, four of which are high risk factors. The DHR panel believe it would have been more appropriate to have maintained the risk as 'medium'.

16.2.9 Had the risk remained as 'medium' then further contact by telephone would have been made with Mary. It is also possible that Mary might have been offered to the Drugs and Alcohol Service because consumption of alcohol was a factor. Given she was now choosing to provide information for the DASH report, in contrast to the previous report, might have been an indicator that she wanted to engage. However, as discussed earlier in paragraph 16.2.6, it is simply not possible to say how Mary would have responded to such contact. The point the DHR panel wish to make is that by re-grading the risk, Mary was not given that further opportunity.

16.3 Term 3

What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to her needs and were there any barriers in your agency that might have stopped Mary from seeking help for the domestic abuse?

16.3.1 The police officer who attended the incident on 9 July 2017 followed GMP policy and procedures. They spoke to Mary and Ray separately, conducted a DASH assessment, gave Mary an "End the Fear" leaflet and information about "Clare's Law". The DHR panel were satisfied that the approach was sympathetic. They felt the officer displayed good judgment in recognising that Mary might have been in fear of Ray based upon her mannerisms.

16.3.2 Similarly, when the police officer attended the report on 17 September 2017, they also appeared to follow the correct policy in relation to the way that GMP expect domestic abuse to be responded to. A crime report was submitted, and a DASH risk assessment completed.

16.3.3 As discussed earlier in paragraph 16.1.11, both the police IMR author and the DHR panel believe the offence of common assault committed by Ray upon Mary could have been investigated. Enquiries could have been conducted to ascertain if CCTV was available at the scene, witnesses could have been sought and Ray could have been arrested and interviewed. The police IMR author states this is not an unusual response to a common assault when the victim chooses not to support a prosecution.

16.3.4 The DHR panel has already outlined in section 16.2 post, the way in which the grading of risk was applied to the reports that were made concerning Ray's abuse of Mary. The DHR panel believe both the police officers that dealt with Mary treated her sympathetically and took account of her choices. Although the DHR panel believe there was an argument for retaining the 'medium' risk grading following the second report of domestic abuse, they did not identify any organisational barriers that would have prevented Mary from accessing help and support regarding domestic abuse from specialist GMP officers. GMP contact details and contact details for other agencies were given on both occasions to Mary.

16.3.5 The DHR panel feel the approach of Victim Support was appropriate and sympathetic to Mary's needs. They provided a safety plan which Mary followed by arranging for her locks to be changed. Victim Support have identified that the recording of information from Mary was not as detailed as might be expected. They have initiated corrective action for the future. The DHR panel does not believe that presented any barriers to Mary accessing their service and disclosing abuse.

16.3.6 The Guinness Partnership have identified some short-falls in the standard of service they provided to Mary when she called to report domestic abuse. On both 22 and 23 September 2017 in telephone calls she made to The

Guinness Partnership, Mary disclosed she was a victim. It is the policy of The Guinness Partnership that in such cases an urgent anti-social behaviour log under the category of domestic abuse is recorded. On both occasions Mary telephoned that did not happen.

16.3.7 The Guinness Partnership IMR author believes this created a barrier to their agency assessing the risk involved. Had policy been followed this might have involved The Guinness Partnership contacting statutory agency partners and reducing Mary's risk by considering measures such as an exit strategy, target hardening, a safe room and possibly a housing transfer. The DHR panel concur with the Guinness Partnership assessment that Mary's case appeared to be seen from the perspective of simply being a lock change request. There were wider issues that could have been considered.

16.3.8 The DHR panel considered the issue that Ray gained entry to address one through the window with the broken lock. The panel felt that, even if that lock had been repaired, it probably would not have prevented someone as determined as Ray from finding another way into the property so that he could lay in wait for Mary and carry out his attack. While the window lock should have been repaired earlier, the panel agreed with The Guinness Partnership that the learning here was around the wider issues identified in paragraph 16.3.7.

16.4 Term 4

What consideration did your agency give to the domestic violence disclosure scheme? Did it bring the scheme to Mary's attention under the 'right to ask' criterion or suggest to Greater Manchester Police that they should consider informing Mary under the 'right to know' criterion?

16.4.1 The only agency that considered the domestic violence disclosure scheme was GMP. The police officer who spoke to Mary on 9 July 2017 referred to it as 'Clare's Law'. While the advice was well intentioned and was a good example of how the police and other agencies can promote knowledge of the scheme, the officer may not have been aware that there was nothing in Ray's history that meant Clare's Law could be used.

16.4.2 Ray was known to GMP and was recorded as having been involved in two incidents of domestic abuse in 2006 and 2009 (see paragraph 15.1.6). These were both incidents involving verbal abuse. Had Mary chosen to

request information on Ray, the decision would have been made by a Detective Inspector within the PPIU. However, given Ray's history, there was nothing relevant to disclose under either the 'right to know' or 'right to ask' part of the scheme (see Appendix C).

16.4.3 The Guinness Partnership have a domestic abuse guidance note. This contains reference to the 'right to ask' under the Domestic Violence Disclosure Scheme. Because Mary's case was not logged as anti-social behaviour/domestic abuse an opportunity to have a focused discussion with Mary about the risks and the 'right to ask' was lost. However, even if that had taken place, for the reasons set out in paragraph 16.4.2 there was nothing that GMP to disclose even if had Mary asked the question.

16.5 Term 5

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

16.5.1 No agency held any information from Mary's family or friends about any concerns they had for Mary before she was killed by Ray. Following her homicide GMP conducted a detailed investigation. This included taking statements from members of both Mary and Ray's family.

16.5.2 Mary was very close to her family, she had a good relationship with them. She saw them frequently and it seems they knew some of what was happening in her life. This is set out in section 14 of the report and not repeated in whole here. Her family knew that Mary and Ray argued frequently and then got back together. Mary's family say Ray was jealous and controlling and would not let her go anywhere without him.

16.5.3 The family had knowledge of the argument in July 2017 (see paragraph 15.1.3) and the incident on 17 September 2017 (see paragraph 15.1.9). Members of Mary's family say Ray was texting them and Mary trying to resume their relationship. Mary would not have him back. She stayed with her mother for most of the week whilst waiting for the locks to be changed at address one. The family knew Mary was scared to go back there and one of them would usually go back with her to check everything was alright.

16.5.4 Shortly before Ray killed Mary she told family members of an incident in the town centre. Mary had an interview at the Job-Centre and Ray was

waiting for her at the bus station when she arrived. The family was unaware that they could have approached agencies for help and advice with Mary's victimisation. Learning point 1 deals with this issue.

16.6 Term 6

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

16.6.1 Only GMP held information about Ray's history of domestic abuse. There were seven PPI reports in which he is recorded as a perpetrator of domestic abuse. Three of these relate to incidents involving Mary, including her homicide.

16.6.2 There are two PPI reports in 2006 and one in 2009 involving Ray and his ex-partner. These were recorded as domestic arguments between ex-partners in which no violence and no offences were reported. There is one PPIU report relating to an incident in 2010 in which Ray was arrested to prevent a breach of the peace. This was not an incident of domestic abuse and involved an argument between adults at a family and friends gathering. Ray was not recorded on either the Police National Computer or the Police National Database[23] as a perpetrator of domestic abuse.

16.7 Term 7

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

16.7.1 All of the agencies involved in this review have policies in place in relation to diversity issues. Mary and Ray did not have any protected characteristics that brought them within the ambit of Section 4 of the Equality Act 2010 (see section 11 of this report).

16.8 Term 8

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Mary and

[23] The Police National Database (PND) is a system that allows police forces to share information about individuals who may have committed serious crime including being a repeat offender in cases of domestic abuse.

Ray, or on your agency's ability to work effectively with other agencies?

16.8.1 GMP commented upon resources in relation to their 'triage' process for reports of domestic abuse. Shortly before the incident involving Ray and Mary in July 2017, all front-line officers attending domestic incidents were given training to assist them in making their own risk assessments regarding domestic abuse. Prior to this, it was the responsibility of PPIU officers to conduct the risk assessment for all domestic incidents.

16.8.2 If officers risk assessed an incident as 'medium' or 'high' then safeguarding would be the responsibility of the PPIU. If the incident was risk assessed as 'standard' then the safeguarding responsibility remained with the investigating officer. While the front-line officers were becoming accustomed to the new risk assessment procedures, the number of reports initially assessed as 'medium' risk increased.

16.8.3 On the 3 September 2017, Rochdale became an early adopter site for the new model of safeguarding and investigation under the GMP Investigation and Safeguarding Review (ISR). The Public Protection Investigation Unit was closed and the detectives working there became part of the Local Policing detective's team. This meant that the existing processes for 'triaging' reports of domestic abuse and the safeguarding of victims changed.

16.8.4 For the first few months of the change, the queue of domestic abuse reports that required 'triaging' increased. The ISR introduced a Daily Risk Management meeting in the MASS (Multi-Agency Screening Service) in which all 'high' risk cases and 'medium' cases involving children were discussed. Therefore, the incident on the 17 September 2017 between Mary and Ray was not discussed and would not have been discussed even if it had remained as a 'medium' risk.

16.8.5 Victim Support commented that, following the start of a new contract they initiated in July 2017, they received a lot more referrals than was anticipated. This meant that the case load for team members was higher and led to less time being available for each case. In this case the time available to support Mary was not compromised. Although the level of detail in the information recorded from her could have been greater.

16.9 Term 9

What learning has emerged for your agency?

16.9.1 The learning identified by each agency and by the DHR panel is considered separately within section 18 of this report.

16.10 Term 10

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

16.10.1 The DHR panel did not identify any examples of outstanding or innovative practice.

16.11 Term 11

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

16.11.1 Previous published and ongoing reviews within the area of Rochdale Safer Communities Partnership has identified the issue of controlling and coercive behaviour by perpetrators towards their victims. This behaviour is also seen in many other national reviews. Controlling and coercive behaviour is seen across all spectrums of relations and in both intimate and familial settings.

17. CONCLUSIONS

17.1 Mary was a kind woman who liked to care for people. She had suffered as a victim of domestic abuse at the hands of other partners before she met Ray. This history of abuse increased the vulnerability of Mary. While their relationship at first appeared to be normal, Mary's family soon saw signs that, they later recalled to the homicide enquiry, signified a change.

17.2 There were several examples of Ray's behaviour which, taken in isolation, may not have appeared significant. However, when considered together and in the broader context of the relationship the DHR panel believe these were clear indicators of coercive and controlling behaviour by Ray.

17.3 For example, not allowing Mary to wear the clothes she liked, making her come home for a set time, insisting her telephone calls were listened to over the loud speaker. The panel also believe that Ray used this behaviour to take up residence in Mary's house leaving her no option other than to have him there.

17.4 During the period the couple lived together only Greater Manchester Police (GMP) held any information that was of relevance to this domestic homicide. GMP attended two reports of domestic abuse when Mary was the victim and Ray the perpetrator. The first of these involved verbal abuses. The DHR panel felt the decision to recategorize this as 'standard' rather than 'medium' risk was appropriate.

17.5 However they felt that a follow up call should have been made to Mary by the PPIU as the reporting officer had used his professional judgment and felt she wanted to leave the relationship. Had the call been made it might have presented Mary with an opportunity to be given advice. Whether Mary would have taken that advice is a matter of speculation and the DHR panel feel there are simply too many variables to reach a conclusion that there is any connection between that decision and Mary's homicide.

17.6 The second call to GMP was the catalyst for Mary to leave Ray. Again, Mary chose not to take any action against Ray when he assaulted her by putting his hands around her throat. Although that was her wish, the DHR panel feel that the assault should have been investigated and the benefits for that are set out in paragraph 16.1.11. Further the panel believe the decision to re-classify the risk to Mary on this occasion from 'medium' to 'standard' was not appropriate.

17.7 Again, the DHR panel believe there are simply too many variables to suggest there might be a connection between that decision and Mary's homicide. However, the DHR panel feel the escalation in Ray's behaviour meant that the risk was increased. A 'medium' grading may have provided

a further opportunity to speak to Mary and give her advice. The DHR panel considered 'Clare's Law' and whether this might have applied to Mary. While Ray was known for previous abusive behaviour in an earlier relationship, his acts within that relationship were not physically abusive and involved words rather than force; albeit the panel recognised that words alone can be destructive and along with threats, form the basis of coercive and controlling behaviour. Consequently, there was no information that could have been shared.

17.8 As it turned out, Mary had made her own decision to separate from Ray. What Mary might not have known was that the point of separation increases the risk to victims. The panel felt the advice given by Victim Support was appropriate. The Guinness Partnership identified some shortfalls in their service as they did not implement their domestic abuse policy, they acted promptly to change Mary's locks.

17.9 The lock change seemed to make Mary feel safer and she went back to address one from her mother's. However, Ray's controlling behaviour continued, as evidenced by incidents such as: multiple text messages, watching Mary's house and, on the day he killed her, waiting for her when the bus pulled up on her way to the Job Club.

17.10 Mary's family knew a lot about Ray's behaviour and Mary's fear of him, particularly after they separated. Mary's son Peter has told the DHR he felt that, if they went to the police that might not result in an outcome. If that happened Peter feared his mum would probably downplay matters and then she may no longer tell the family about anything again. This is an important learning point and reinforces the need to continue to publicise ways in which victim's families can seek support and advice about domestic abuse.

17.11 On the day Ray killed Mary he broke into address one and laid in wait for her. Had she known he was in the house, the DHR panel are certain she would not have gone into the property. Unfortunately, Mary did not realise how much danger she was in. Ray had armed himself before he broke in. His intention appeared clear. His act, in stabbing Mary in her own home, was the final and ultimate piece of domestic abuse by a desperate, jealous and controlling man. He did it so quickly that, despite Mary's call for help, it was not possible for either her family or the police to save her.

18. LEARNING IDENTIFIED

18.1 Agencies Learning

Heywood, Middleton and Rochdale CCG	
1	The learning for the GPs is awareness of the importance of timely referral to alcohol specialist services. To demonstrate and document professional curiosity.
The Guinness Partnership	
1	Customer Contact - TGP had regular contact with Mary. That contacted ended and was a change that should have been explored as an opportunity to implement additional customer support.
2	Processes - TGP received a request for an emergency lock change. We focused on the process of changing the lock rather than understanding the reasons behind Mary's request to secure her home: that she was a victim of domestic violence. An ASB case should have been logged for Domestic Abuse
3	TGP attended an emergency repair for a leak, which was reported by Mary. When we attended, the operative did not see or interact with Mary. An unknown male answered the door, and then left the operative on the doorstep for twenty minutes and denied access. We did not follow up this emergency repair.
4	Overall learning - Isolated interactions did not enable TGP to identify the significant risks posed to Mary. If the above points had been implemented Mary could have accessed specialist support services within TGP. The risks to Mary could have been identified and reduced.
Greater Manchester Police	
1	The first is with regards to the triage process of the PPIs after submission by the attending officer. On full review of the second PPI (in Sept 2017), the IMR author deems that the risk assessment grading of Medium by the initial officer was correct and due to the nature of the assault – strangulation (a high-risk indicator), the risk assessment should have remained as Medium. This would have meant that a follow up call to Mary would have been made.
2	The other area of learning is in respect of the criminal investigation into the assault by Ray on the 16th September. When Mary was spoken to by the attending officer she confirmed that she had been assaulted by Ray and did not want Ray prosecuting[24], the officer did

[24] There are many reasons why victims may not want to report their abuse and/or have action taken against the perpetrator. Research conducted by Her Majesty's Inspector of Constabulary [HMIC] found the reasons for not reporting domestic abuse to the police included; Fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent).

	not conduct any further enquiries or make attempts to secure possible evidence.
Victim Support	
1	Victim Support completed an internal investigation following the notification of the DHR and following this investigation identified areas of improvement, including better recording of communications on our case management system by the IVA involved. A CAADA DASH risk assessment was offered during phone contact however this was declined[25] by Mary and this was not recorded correctly. As a result, we have worked with the IVA involved with the case, including undertaking a performance related review in order to improve working practices.

18.2 The Domestic Homicide Review Panel's Learning

(N.B the DHR panel has not repeated the learning identified by individual agencies which are set out at paragraph 18.1 above. Where a lesson links to a recommendation a cross reference is included)

Learning 1 (Panel Recommendation One)
Narrative
Ray subjected Mary to domestic abuse that comprised physical assault and controlling and coercive behaviour. Mary told her family about some of Ray's behaviour. She may not have told her family about all her experiences of victimisation at his hands. For reasons the panel have not established, Mary's family did not disclose what they knew to any agencies.
Learning
Family and friends will often be the only people who know that someone is a victim of domestic abuse and the current investment by Rochdale Community Safety Partnership in raising publicity on what they should, and should not do, needs to continue to support victims safely.

Learning 2 (Panel Recommendation One) (Agency Recommendation 8, 9 and 10)

Everyone's business: Improving the police response to domestic abuse; March 2014 HMIC [now Her Majesty's Inspector of Constabulary and Fire and Rescue Services [HMICFRS]]

[25] See footnote 23 above.

Narrative
Mary eventually decided to leave Ray. After she left, he subjected Mary to further controlling and coercive behaviour by repeatedly sending her text messages. After a period, Mary may have felt that she was safe from Ray and therefore she returned to address one.
Learning
This review, and others, has identified that the risk to victims significantly escalates at the point of separation. Victims who are in controlling and abusive relationships where resistance by the perpetrator to ending it exist, need to have a professionally constructed safety plan in place before making the final break.

Learning 3 (Panel Recommendation Two) (Agency Recommendation 6)
Narrative
Mary was identified as the victim of domestic abuse at the hands of Ray and other partners. Appropriate assessments had been conducted by GMP to identify the risk that Mary faced from all her perpetrators. The risk that Mary faced was assessed as either medium or standard. One police officer used their judgment and identified that they felt from Mary's mannerism that she wanted to leave Ray.
Learning
This, and other DHR's, has identified that the victims of fatal abuse at the hands of perpetrators have not always been classed as being in the high-risk group. The lesson is that agencies need to judge risk on a broad range of information which includes, and is not restricted solely to, DASH risk assessments.

Learning 4 (Agency Recommendation 2, 3, 4, 5)
Narrative
Mary had been a tenant of The Guinness Partnership for thirty years. They had extensive records relating to Mary's tenancy. The Guinness Partnership felt they knew Mary very well. However, none of these records contained any information to indicate that she was the victim of domestic abuse until the final entries when she contacted The Guinness Partnership requesting her locks should be changed.
Learning

Landlords may not have insight into all aspects of a tenant's life. The absence of information about domestic abuse provides no certainty that they are not being abused and that it is going unseen and unrecorded.

19. RECOMMENDATIONS

19.1 Agencies Recommendations

The single agency recommendations appear in tables within Appendix D. The review panel has avoided repeating recommendations that are already embedded in the single agency plans.

19.2 The Panel's Recommendations

Number	Recommendation
1	The learning from this DHR repeats the learning identified in other recent DHRs in the Rochdale area. Rochdale Community Safety Partnership should recognise this and identify if the learning in this review can be used as evidence to support recommendations made in those other reviews particularly around raising the knowledge of family and friends, what to do when leaving an abusive relationship and raising awareness about controlling and coercive behaviour.
2	That Rochdale Community Safety Partnership recommend to the Home Office that there is a need to conduct national research that looks at the story of perpetrators of abuse and why they behaved in the way they did.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

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

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[26]

- The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;

[26] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information (e.g. threatening to 'out' someone).
- assault;
- criminal damage (such as destruction of household goods);
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

Domestic Violence Disclosure Scheme ('Clare's Law')

What is this Scheme?

The aim of this scheme is to give members of the public a formal mechanism to make enquires about an individual who they are in a relationship with or who is in a relationship with someone they know, and there is a concern that the individual may be abusive towards their partner. If police checks show that the individual has a record of abusive offences, or there is other information to indicate the person you know is at risk, the police will consider sharing this information with the person(s) best placed to protect the potential victim. Your local police force will discuss your concerns with you and decide whether it is appropriate for you to be given more information to help protect the person who is in the relationship with the individual you are concerned about. The scheme aims to enable potential victims to make an informed choice on whether to continue the relationship and provides help and support to assist the potential victim when making that informed choice.

Who can ask for a disclosure?

A disclosure under this Scheme is the sharing of specific information about an individual with the person making the application or a third person for the purposes of protecting a potential victim from domestic violence.

- anyone can make an application about an individual who is in an intimate relationship with another person and where there is a concern that the individual may harm the other person;
- any concerned third party, such as a parent, neighbour or friend can make an application not just the potential victim;
- however, a third party making an application would not necessarily receive the information about the individual concerned. It may be more appropriate for someone else to receive the information such as the victim or another person who is best placed to protect the potential victim

Appendix D Action Plans

Panel Action Plan

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1.	The learning from this DHR repeats the learning identified in other recent DHRs in the Rochdale area. Rochdale Community Safety Partnership should recognise this and identify if the learning in this review can be used as evidence to support recommendations made in those other reviews particularly around raising the knowledge of family and friends, what to do when	Review and updating of promotional literature/messages/campaigns. Include within the proposed Domestic Abuse Communications Strategy. Ensure information about how to access services and support is readily available including hard to reach groups Ensure future campaigns have a focus on coercive and controlling behaviour and the increased risk when planning to leave. Discuss at Domestic Abuse Working Group ways to promote services – including what is already being done. Ensure wider promotion of services to family/friend/s	• Information more widely distributed/on display/easily accessed • Content of future campaigns • Minutes of Domestic Abuse Working Group • Domestic Abuse strategy • Victims, friends and family have greater knowledge of services and support available • Review of recommendations	• Victims, friend and family have a greater knowledge of services and support available • An increase in enquiries/referrals from family and friends. • Public and professionals have a greater understanding of coercive controlling behaviour and the heightened risk when leaving a relationship	RSCP	July 2019

	leaving an abusive relationship and raising awareness about controlling and coercive behaviour.	community is within the new Domestic Abuse strategy	and action plans from existing DHRs. • Awareness campaigns implemented using range of media, including posters, leaflets and social media campaigns.			
2	That Rochdale Community Safety Partnership recommend to the Home Office that there is a need to conduct national research that looks at the story of perpetrators of abuse and why	Local - RSCP	Update provided to the Rochdale Safer Communities Partnership Board meeting.	A better understanding of why domestic abuse perpetrators behave in the way they do.	Rochdale Safer Communities Partnership Chairs	Recommendation to be made by July 2019.

	they behaved in the way they did.					

Single Agency Plans

Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG)						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1.	Ensure GP awareness of the importance of referrals to alcohol services	Local	Share the learning from the Domestic Homicide review with the GP practice	HMR CCG safeguarding team	Training date to be arranged	June 2018

The Guinness Partnership						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
2	Review the drafted amendments to the Responsive Repairs Policy version 0.9 and seek to understand if this can be implemented. This policy states in section 5 "*…..Where*	National	Present within internal service standards	Customer Service Directorate	Service standards rolled out to all staff	By December 2018

	exceptional circumstances occur which pose an immediate health and safety risk we will aim to attend within four hours…"					
3	Identify requirements, using the learning from this review, as part of the build for the new CRM case management system tool.	National	Learning present within the needs assessment and CRM design	Customer Service Directorate	An update will be provided when the design has been established.	By March 2019
4	Construct a 7-minute brief on the lessons learnt from this review and include why. To be briefed to all relevant staff within 3 months of circulation.	National	Issue the 7-minute brief to all staff	Customer Service Directorate	Domestic Violence Training	By December 2018
5	Immediately update Domestic Violence Guidance to include Domestic Violence Disclosure Scheme	National	TGP to review its guidance and share with all staff	Policy Team	Specialist Officer to review guidance and	By December 2018

	(Clare's Law); the 'right to know'.				share with staff	

Additional Action Undertaken by The Guinness Partnership
Since this report was written in early 2019 the Guinness Partnership have undertaken the following work in relation to improving their response to domestic abuse.
✓ Completion of a DASH Risk Assessment with all customers who have a domestic abuse case logged with the partnership. This is a screening tool to identify customers who require MARAC intervention. Property survey forms and safety plans are routinely used too. ✓ A new HARM model was launched in April 2019 which is completed with the customer who reports anti-social behaviour to the partnership. This assesses the impact of HARM and enables the provision of a more personal response. ✓ A new Customer Domestic Abuse Policy was launched in October 2019. ✓ In July 2018 the Executive Team agreed that Guinness sign the "Make a Stand" pledge, this has been achieved. ✓ Since July 2018 the partnership have been working towards the Domestic Abuse Housing Alliance [DAHA] accreditation. The commitments are: 1. Review your existing "Domestic Abuse and Safeguarding" policies and procedures 2. Create and implement a stand-alone Domestic Abuse policy 3. Ensure your policy includes the Government definition of domestic abuse 4. Create and implement a procedure for customers suffering from domestic abuse 5. Create and implement a stand-alone Domestic Abuse policy and procedure for staff experiencing domestic abuse or ensure domestic abuse is incorporated in to your HR policies 6. Ensure you support staff who deal with domestic abuse 7. Create and implement a Safeguarding Children and Adults policy 8. Ensure all your policies and procedures are reviewed every 3 years

The Partnership are committed to achieving this accreditation by end March 2020.

- ✓ New Safeguarding Children and Adults policy launched December 2019.
- ✓ The partnership have reviewed their toolbox talk Safeguarding training for operatives (tradespeople) and created a new toolbox talk programme starting January 2020.

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
6.	Rochdale Division to provide guidance to officers who triage PPIs to ensure that a full review of history is conducted and that a structured rationale for the risk assessment is placed on to the PPI. Consideration to be given with regards to role our across GMP.	Local – GMP Rochdale	Issue comprehensive guidance/training to triage officers.	GMP Rochdale	An update will be provided to the panel when training has been implemented on the Rochdale Division.	6 months from notice of requirement for action.
7.	GMP to review its guidance given to investigating officers	GMP	GMP review its policy and guidance and disseminate to all front-line staff.	GMP	A specialist officer will review the	6 months from notice of

	in respect of Domestic Assaults where victims do not support a prosecution. This is with a view to prescribing what is expected from the investigating officer.				current policy and guidance to ensure it is fit for purpose and determine the best option for dissemination. An update will be provided to the panel.	requirement for action.

Victim Support						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
8.	Better communications to be completed on VS case management system.	Local	Direct Training with staff	Victim Support	Case management training	By end of November 2017
9	Improved knowledge on Domestic abuse	Local	Direct Training with staff	Victim Support	Further Domestic abuse training which was rolled out to the wider team.	By the end of November 2017

10	Shorter times frames to be put into place regarding contact with DV victims	Local	Direct training with staff	Victim Support	One to one training on CAADA DASH risk assessment and dip samples of 36 out of 84	By end of November 2017