ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Olivia

OVERVIEW REPORT

For Publication

December 2019

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CONTENTS

1. INTRODUCTION

1.1 This report is about Olivia who was killed by her boyfriend Mario on a day in late 2016. He was convicted of her manslaughter and is now detained in a secure hospital.

1.2 Olivia had cerebral palsy. While this affected her in different ways, it never stopped her making friends and leading an active and purposeful life. Olivia was a bright and capable person who was studying hard at university so that she could follow her wish to work with children with learning difficulties. She is missed by her family, her friends and her colleagues at the school she worked in. The Domestic Homicide Review (DHR) review panel extend their deepest sympathy to them all on their sad loss.

1.3 Mario had suffered from mental health problems for a long time. At the time of these events he was diagnosed with paranoid schizophrenia. Mario had a pattern of refusing to take anti-psychotic medication and heavy consumption of alcohol. While they only lived together for a short period of time, it is clear Olivia was concerned for Mario and extended to him the care and support that she showed to other people throughout her life.

1.4 Mario was a jealous man and this review uncovered examples of the way in which he behaved badly towards other people. He tried to control[1] Olivia and subjected her to domestic abuse[2]. During the autumn of 2016 a series of events occurred during which Mario's behaviour became more irrational and he disengaged completely from mental health agencies before killing Olivia.

1.5 This report tries to look at those events through Olivia's prism. Sometimes Olivia preferred to communicate through written medium rather than speech. This report considers whether agencies responded to Olivia's preferences and understood her needs. It focuses upon whether there were opportunities by agencies to understand the risks that Olivia faced from Mario and whether those risks were responded to. This report is not about blame: it is about learning. It is about illuminating the past to make the future a safer place for people like Olivia.

1.6 Olivia's mother said Olivia was;

[1] S76 of the Serious Crime Act 2015 created an offence of controlling or coercive behaviour in intimate or familial relationships. This is discussed further within this report.
[2] 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, and emotional.

'A loving daughter who brought light and happiness into all our lives. She was a kind and caring person who had much to give and much to live for. All that has been taken away from us. The family will never forget the beautiful person she was and still is'.

2. TIMESCALES

2.1 On 11 January 2017 Rochdale Safer Communities Partnership held a DHR Screening meeting and recognised Olivia's death met the criteria for a DHR.

2.2 The first domestic homicide review panel meeting was held on 1 February 2017. At this meeting a time table was set to deliver the review by 11 July 2017.

2.3 At the second DHR Panel meeting on 19 April 2017 it became apparent that it was not practicable to deliver a meaningful DHR by 11 July 2017. This was because of delays in the criminal investigation caused by Mario's detention under mental health legislation. In addition, investigations were also being undertaken by the Independent Police Complaints Commission (IPCC[3]) into Olivia's contact with Greater Manchester Police (GMP) and by NHS England into the mental health services provided to Mario (see section 10).

2.4 The Chair of the Rochdale Safer Communities Partnership approved a new date for the completion of the DHR of 31 October 2017 and the Home Office were informed. A further two meetings of the DHR review panel took place.

2.5 At their fourth meeting in September 2017 the DHR panel felt it was essential to have sight of both the IPCC and NHS England reports before they could complete their work as they contained important information that informed the learning within the DHR review. Further extensions were sought and approved by the Chair of the Rochdale Safer Communities Partnership and the Home Office was informed.

2.6 Following receipt of the IPCC and NHS England Independent Investigation report further meetings of the panel were needed. To allow time for these meetings and for the panel's report to be shared with the families a revised completion date of 15 October 2018 was approved by the Chair of the Rochdale Safer Communities Partnership and the Home Office informed.

2.7 The domestic homicide review was presented to Rochdale Safer Communities Partnership on 23 January 2019 and sent to the Home Office on 23 May 2019.

[3] The IPCC became the Independent Office for Police Conduct (IOPC) on 1 January 2018

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 Olivia and Mario's family of the review. Pseudonyms are used in the report to protect the identity of the victim and perpetrator[4]. Professionals are referred to by an appropriate designation.

3.3 The Panel was grateful to Greater Manchester Police for the assistance it provided the review with meeting the families.

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

Name	Who	Age	Ethnicity
Olivia	Victim	23	White British
Mario	Offender	31	White British

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

Address	Details
Address one	Mario and Olivia's shared address and the scene of her homicide.
Address two	Mario's parents address
Address three	Olivia's mother's address

[4] Olivia's mother requested that her daughter's real name be used in the report. Legal advice sought by the Chair recommended that a pseudonym should be used. The Chair wrote to Olivia's mother informing her of this advice. When he did not receive a response he wrote again asking if she had any objection to the use of the pseudonym Olivia. No objection was received and therefore Olivia has been used in the report. Mario's parents selected his pseudonym.

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 1 February 2017. They were shared with Olivia's family who were invited to comment on them.

4.2 The DHR panel set the period of the review from January 2014 through to the date of Olivia's death in late 2016. They chose January 2014 as this represented the point at which Olivia began a relationship with Mario.

The purpose of a DHR is to:[5]

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 did your agency have that could have identified Olivia as a victim of domestic abuse and what was the response?
2. What knowledge did your agency have that indicated Mario might be a perpetrator of domestic abuse and what was the response?

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

3. What account did your agency take of any mental health problems[6] of Olivia and/or Mario when responding to domestic abuse?

4. What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to her needs?

5. Were there any barriers in your agency that might have stopped Olivia from seeking help for the domestic abuse?

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

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

8. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Olivia or Mario?

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

10. Were single and multi-agency policies and procedures followed and were any gaps identified?

11. What managerial support did your agency provide to front line practitioners dealing with the domestic abuse involving Olivia and Mario and was it effective?

12. What lessons has your agency learned?

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

14. What services are available to perpetrators of domestic violence in Rochdale?

[6] Mental Health Problems is the term used on the MIND website

[7] See Home Office DHR Guidance 2016 Page 36: EQUALITY AND DIVERSITY Address the nine protected characteristics under the Equality Act 2010 if relevant to the review.

5. METHOD

5.1 NHS England consulted Rochdale Safer Communities Partnership and discussions took place concerning how the NHS England Independent Review and the DHR review would interface (see paragraph 10.3).

5.2 Based upon previous experience (gleaned from a DHR that involved an NHS England Independent Review), the DHR Chair agreed to work together with the independent author commissioned to deliver the mental health review. This included holding joint meetings of the panel with the independent reviewer and, when possible, with the families and professionals. It was felt this would help prevent duplication and, most importantly, ensure Olivia's family were kept informed and able to contribute to the reviews in a way that minimised the intrusion in their lives.

5.3 It was decided that separate reports would be produced. This was because the NHS England independent report contained a significant amount of information that, while of important clinical value, was not directly relevant to the DHR. Where necessary and relevant the DHR review panel report draws upon the findings of the NHS England independent report.

5.4 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.

5.5 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.

5.6 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 Olivia and Mario's family.

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

6.1 The Panel chair wrote to Olivia's mother. 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[8] leaflet. Additionally, the terms of reference for the review were included. The panel chair and an advocate from Hundred Families[9] met with Olivia's mother. She was able to provide important information about Olivia and her relationship with Mario. Her contribution is included within section 14 of the report.

6.2 The Panel Chair wrote to Sarah who was one of Olivia's close friends. Sarah responded and indicated she would like to contribute to the DHR process. The chair and the DHR report author met with Sarah and she provided her recollections of her friendship with Olivia and important information about her relationship with Mario.

6.3 The Panel Chair also wrote to Mario's parents. They said they would like to contribute to the review and the Chair and the independent mental health reviewer met with them. Again, they were able to provide relevant information about their son and his relationship with Olivia.

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

[9] Hundred Families help with support, information and advocacy after killings by people with mental health problems. http://www.hundredfamilies.org

7. CONTRIBUTORS TO THE REVIEW.

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

Agency	IMR[10]	Chronology	Report
Greater Manchester Police (GMP)	X	X	
Heywood, Middleton & Rochdale Clinical Commissioning Group (CCG)			X
Pennine Acute NHS Trust			X
Rochdale Borough Adult Social Care (ASC) also incorporating Emergency Duty Team (EDT)	X	X	
Pennine Care NHS Trust also incorporating Early Intervention Team, Community Mental Health and RAID (Rapid Assessment Interface and Discharge)	X	X	
National Probation Service/Community Rehabilitation Company			X
Victim Support			X
North West Ambulance Service	X	X	
Independent Police Complaints Commission			X
NHS England Independent Mental Health Review			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 Olivia or Mario.

[10] 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**
Janet Emsley[11]	Councillor-Portfolio Member for Community Safety	Rochdale Borough Council
Janette Birch	Administrator	Rochdale Borough Council
Paul Cheeseman	Author of the DHR report	Independent person
Maria Dineen	Approved Independent Contractor (Mental Health Review)	Consequences UK
Andrea Edmonson	Safeguarding Practitioner	North West Ambulance Service
Janice France	Senior Probation Officer	National Probation Service
Louise Hamer[12]	Acting Named Nurse for Safeguarding (HMR)	Pennine Care NHS Foundation Trust
David Hunter	Chair of the DHR panel	Independent person
Chris Highton	Principal Community Safety Officer	Rochdale Borough Council
Karen McCormick[13]	Designated Nurse Safeguarding Adults	Heywood, Middleton & Rochdale Clinical Commissioning Group
Rebecca McGeown	Named Nurse for Safeguarding (HMR)	Pennine Care NHS Foundation Trust

[11] Janet Emsley replaced Daalat Ali who attended the first panel meeting.
[12] Louise Hamer replaced Rebecca McGeown from the eighth panel meeting
[13] Karen McCormick was replaced by Jen Yousuf at the seventh panel meeting.

Hayley McLellan	Interim Service Lead Community Mental Health Services	Pennine Care NHS Foundation Trust
Rebecca Moss	Temp. Head of Service Mental Health	Rochdale Borough Council
Glen Parkes[14]	Senior Probation Officer	National Probation Service
Alison Troisi	Detective Sergeant	Greater Manchester Police
Julie Wan Sai Cheong	Named Nurse Adult Safeguarding	Pennine Acute Hospitals NHS Trust
Ruth Wilson	Manager	Victim Support
Jen Yousuf	Head of Quality	Heywood, Middleton & Rochdale Clinical Commissioning Group

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 eight times and the circumstances of Olivia's homicide were considered in detail to ensure all possible learning could be obtained from her death. Outside of the meetings the Chair's queries were answered promptly and in full.

[14] Glen Parkes was replaced by Janet France from the seventh panel meeting.

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.

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

10.3 An NHS Independent Investigation should be undertaken when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. These investigations are conducted under the Serious Incident Framework for England (2015) issued by NHS England on 27 March 2015. They normally do not commence until after the criminal case has been concluded. However, in this case, it was determined the NHS Independent Investigation would be conducted in parallel with the Domestic Homicide Review. Maria Dineen, an approved independent contractor for NHS England, was commissioned to attend panel meetings and to ensure the mental health components of the Domestic Homicide Review met the standard required by NHS England.

10.4 Every time someone has direct or indirect contact with the police when, or shortly before, they are seriously injured or die the police force involved must refer the matter to the Independent Office for Police Conduct[15] (IOPC). In this case Greater Manchester Police (GMP) made a referral about Olivia's death as police officers had contact with Olivia when they attended address one on 18 November 2016. IPCC completed a report which they shared with the DHR panel under the terms of an information sharing protocol established between them and the DHR chair.

[15] At the time Olivia died this was known as the Independent Police Complaints Commission (IPCC)

11. EQUALITY AND DIVERSITY

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

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

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

[1] A person [P] has a disability if—
[a] P has a physical or mental impairment, and
[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[16]

11.3 Olivia had cerebral palsy which is a group of permanent movement disorders that appear in early childhood. Signs and symptoms vary among people. Often, symptoms include poor coordination, stiff muscles, weak muscles, and tremors. Olivia sometimes found it difficult to communicate through speech and on occasions used written media such as a computer tablet. The DHR panel are satisfied that Olivia's condition met the criteria for a disability set out above.

11.4 Mario suffered mental health problems for several years. At the time he killed Olivia he was diagnosed with paranoid schizophrenia. The DHR panel are satisfied his condition met the criteria for a disability set out above.

11.5 Section 16 of this report assesses whether Olivia and Mario were able to access local services because of their disabilities and whether they were appropriate to their needs.

11.6 Mario is reported to have had episodes of excessive consumption of alcohol. The misuse of alcohol is statutorily excluded from the definition of disability under the Act.

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

11.7 Cerebral Palsy is a physical rather than a mental health condition and there is no suggestion that Olivia lacked capacity [17] and 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'.

11.8 'If a child has Cerebral Palsy, it doesn't mean that he or she has impaired cognitive functioning. Sometimes, a child's Cerebral Palsy will only affect his or her physical functioning. However, about 30 to 50 percent of children with Cerebral Palsy have some level of cognitive impairment. Children with severe Cerebral Palsy have a greater likelihood of having cognitive impairments.'[18]

11.9 There is evidence that on some occasions Mario lacked capacity. Where relevant and appropriate commentary appears within section 16 concerning the approach that professionals took to assessing his capacity.

[17] Mental Capacity Act 2005
[18] http://www.cerebralpalsy.org/information/cognition

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.

- Olivia's mother and family;
- Mario's parents;
- Greater Manchester Mental Health NHS Foundation Trust [They are currently caring for Mario]
- National Probation Service
- Other agencies who form Rochdale Safer Communities Partnership

13. BACKGROUND INFORMATION [THE FACTS]

13.1 Mario suffered mental health problems for many years. He was compulsorily detained in hospital under the Mental Health Act for a period during 2012. From 2013 onwards, Mario was under the care of the Pennine Care NHS Foundation Trust-Heywood, Middleton and Rochdale Early Intervention Team (EIT).

13.2 On 15 March 2013 Mario had a diagnosis of paranoid schizophrenia[19]. He lived at address two with his parents and received care in the community from care coordinators based in the EIT. They would visit Mario at home and treat him with anti-psychotic medication. When necessary Mario would attend outpatient appointments. Mario was under the care of four different care coordinators during the events described in this report (referred to as care coordinators one to four).

13.3 Mario and Olivia formed a relationship in 2014 (the exact date is not known). During 2015 and 2016 his parents refer to several episodes during which Mario drank excessive amounts of alcohol and had delusional thoughts and behaviour. He threatened his father on one occasion which resulted in the police attending, although Mario's father did not wish to see his son prosecuted and said he needed treatment.

13.4 Although there were episodes when Mario was compliant with his treatment plan, there were many other occasions when he refused to take his medication and was awkward and uncooperative with health professionals and his parents.

13.5 In July 2016 Olivia's mother disclosed to a care coordinator that Olivia was pregnant. This coincided with a visit they made to see Mario at address one. At this time, he was drinking alcohol excessively and had threatened a neighbour. Olivia was warned by the care coordinator not to be near Mario when he was intoxicated.

13.6 During the summer of 2016 various attempts were made by the EIT to try and persuade Mario to comply with a treatment plan. Mario made it clear

[19] Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms. Doctors often describe schizophrenia as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality. Symptoms of schizophrenia include hallucinations, delusions, muddled thoughts based on hallucinations or delusions and changes in behaviour. Some people think schizophrenia causes a "split personality" or violent behaviour. This is not true. The cause of any violent behaviour is usually drug or alcohol misuse. Source: www.nhs.uk/conditions/schizophrenia

that he did not want to engage with the EIT nor allow a mental health assessment to be carried out. He was eventually discharged from treatment with the EIT back to the care of his GP.

13.7 In August 2016 police officers attended a disturbance at address one. Olivia was there, and Mario was taken to hospital with facial injuries. He had head butted a wall. This was recorded by GMP as a domestic abuse incident.

13.8 On 18 November 2016 Mario's mother contacted Rochdale ASC and spoke to a social worker and told them of concerns she had for her son. He was not taking his medication and Mario's mother said he needed 'sectioning'[20]. A complex series of events then occurred which are described in detail within section 15 of the report. These events reached a climax later that night when police officers and ambulance staff attended address one.

13.9 Olivia spoke to police officers and showed one of them a document on her computer tablet. The document contained Olivia's description of what it was like to live with Mario. It contained references to events that comprised serious assaults and domestic abuse perpetrated by Mario on Olivia.

13.10 The police officers that saw Olivia that night felt she was vulnerable, persuaded her to leave address one and took her home to address three. The police officer that read the document did not take any action in relation to the references to domestic abuse. The actions of the police officers that attended on the evening of 18 November 2016 have been the subject of an IPCC investigation and report[21].

13.11 Police officers and ambulance staff that attended address one that night spoke to Mario. An ambulance technician recalled that Mario's demeanour did not cause her any undue concern and there was nothing out of the ordinary or unusual about him. The RAID team[22] had been contacted by the police and they said Mario could attend at accident and emergency voluntarily.

13.12 No specialist mental health services attended address one that night to assess Mario's mental health. The NHS independent review felt that a social

[20] Sectioning is often used as short hand for the compulsory detention of a person under the provisions of the Mental Health Act 1983.
[21] https://policeconduct.gov.uk/research-and-learning/learning-and-recommendations
[22] RAID (rapid assessment interface and discharge) aims to provide timely mental health assessments to patients in A&E, reduce A&E attendances/re-attendances, provide effective interventions to people with alcohol misuse problems and provide expert clinical support and education to acute staff on caring for people with dementia. www.penninecare.nhs.uk/your-services/mental-health-services/raid-liaison-psychiatry-services/

worker on duty that night in EDT (who had the qualification to do so[23]) should have visited the address and assessed Mario. Consequently, Mario remained at address one and the police and ambulance staff left the scene. NWAS and GMP made separate safeguarding referrals to Rochdale ASC. In response to those referrals a social worker from ASC spoke to Olivia and her mother a few days later by telephone. The social worker advised Olivia to call ASC if she needed support.

13.13 On an evening in late 2016 Mario stabbed Olivia. Police officers and ambulance personnel attended. Attempts were made to resuscitate her although she sadly died in hospital in the early hours of the following day. Mario was arrested. A post mortem found Olivia died from a single stab wound to the neck.

13.14 Mario was detained in a hospital where he underwent several psychiatric assessments. He was eventually interviewed and charged with Olivia's murder. In summer 2017 he was found guilty of the manslaughter of Olivia on the grounds of diminished responsibility. He was sentenced to a Section 37 Hospital Order and Sec 41 Restriction Order[24].

13.15 The IPCC completed an investigation into the contact between Olivia and GMP officers on 18 November 2016. The performance of a police officer that attended that night was found to be unsatisfactory for failing to recognise potential domestic abuse connected to mental health. They will receive further training on dealing with mental health and domestic abuse.

[23] Some social workers are designated as approved mental health professionals (AMHP) under the Mental Health Act 1983. The role of the AMHP is to avoid excessive medicalisation of the assessment and treatment of mental health conditions by deciding whether a person should be detained under the Mental Health Act.

[24] S37 Mental Health Act 1983. This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. S41 Mental Health Act 1983. This order is imposed to protect the public from serious harm. It places restrictions on leave of absence, transfer between hospitals, and discharge. These require the Ministry of Justice to grant permission.

14. CHRONOLOGY

14.1 Background to Olivia and Mario

Olivia
Olivia was raised and educated in Rochdale. Olivia's parents are divorced and her mother lives with her partner and Olivia's two sisters in the Rochdale area. Olivia lived in the same house until she moved out to live with Mario. Olivia had a brother who is deceased. Olivia worked as a Lunchtime Organiser at the same school in Rochdale that she attended as a child. She was studying for a degree in education with special educational needs: a field she hoped to work in when she completed her studies. Olivia suffered with cerebral palsy which, throughout the course of her life, affected her differently at different times. At the time of her death the effects of the illness were relatively mild. Olivia had a speech impediment. This meant she often preferred to write things down rather than speak. In her victim impact statement, read to the court when Mario was convicted, Olivia's mother said she did not accept the diagnosis of Mario or the recommended order the court made. She said Olivia was vulnerable and in a very complex relationship with Mario but was making her way for herself studying at university and had everything to live for.

Mario
Mario and his two sisters were raised in the Rochdale area where his parents and younger sister still live. Mario was bullied as a child, causing him to be removed from school in the Rochdale area and re-enrolled in another school in Lancashire. After leaving school he went to college in the Greater Manchester area before enrolling at university to study forensic science. Mario's father said Mario had always been an odd or awkward child. Mario started to suffer mental health problems around the age of 20. He became fixated with local criminal gangs and told people he had been

kidnapped and tortured. Mario told his mother that his teeth had been drilled. She was so concerned that she took him to a dentist for re-assurance. The dentist confirmed this was not the case although Mario refused to believe this. He was later diagnosed with paranoid schizophrenia.

Mario had debts of about £4k while at university as result of which his father controlled his personal finances. This lead to the pair being in dispute. Mario's father said his son always wanted 'easy money' without being prepared to work for it. Because of this dispute Mario moved to Sussex to be independent from his parents in 2012.

On returning from Sussex Mario did not go back to his parents address and instead moved into a property in Rochdale (address one). Mario had care coordinators who administered his medication at home. His father says he often refused to take this.

Mario's father does not feel his son accepted responsibility for his actions, always feeling he was hard-done by, unlucky, why does it always happen to me? Mario believed that people were conspiring against him and when reasonable explanations were offered for matters in Mario's life, they too became part of the conspiracy.

His father said Mario drank too much alcohol and after his fourth can a 'switch' seemed to click in his brain and his behaviour became erratic. Mario accepted he had a drink problem, but his father did not know if Mario was referred to alcohol services. His father never had any evidence or suspicions that Mario used illegal drugs.

When Mario moved in with Olivia his father noticed a significant change in Mario's attitude towards him. He said Mario seemed to take on the role of 'I'm a big man now'. However, his father said Mario simply could not manage his money and had his head in the sand over bills.

His father felt Mario was using Olivia for emotional support and wanted to control her. Mario became extremely jealous of Olivia according to his father.

When Mario's father met with the DHR Chair and the independent mental health reviewer he expressed several concerns about the way agencies had dealt with his son.

He felt the police should have got a grip of Mario as he had two or three 'run ins' with them. He wondered why Mario could refuse to see his psychiatrist. Mario's father said he told several people in authority about his son's behaviour and no one helped. He questioned why it took ten hours for an ambulance to come for Mario on the evening of 18 November 2016. Mario's father questioned how many more warnings professionals needed and said he wondered why anyone was surprised about what his son did.

Mario's father said he would like to express his condolences to Olivia's mother for the loss of her daughter although he does not know how to do this or whether it would be appropriate.

The Relationship

Mario's younger sister was a friend of Olivia and introduced them in 2014 (although Olivia's mother believed they had known each other much longer). The pair engaged in an on-off relationship for some time before eventually moving in together at address one in Rochdale in September 2016.

Olivia was the victim of domestic abuse at the hands of Mario and her experiences of Mario's abusive behaviour towards her is described in more detail within section 15 of this report. The families of both Olivia and Mario had knowledge of some events and, on some occasions, were directly involved.

As well as family, Olivia had some close friends with whom she shared her experiences of being in an abusive relationship with Mario.

Recalling their relationship, Olivia's mother said that her daughter was pregnant with Mario's child and had a termination[25]. She said Mario did not know about this and Olivia did not tell him because she said:

'Oh Mario would kill me'

[25] The review panel recognised that Olivia may have believed she was pregnant. Although Olivia attended for tests and told health professionals she was pregnant there is no evidence she carried a child for the full term. There is no record she sought a termination.

Olivia's mother thought at the time this was a passing comment. She said their relationship was terrible. One day Mario would be fine and would seem sweet. Olivia's mother thought he was nice although she then noticed some strange behaviour. She warned Olivia to keep him at arms-length and to be friends instead.

Olivia's mother said she knew of Mario's mental health issues and that he was not taking his medication when he should have been. Olivia told her mother that Mario was really hard work, it was very stressful and that she was trying to get him to take his medication. Olivia's mother said she noticed Olivia had lost a lot of weight and wasn't eating properly. She looked pale and withdrawn. Olivia's mother said her daughter was not her daughter anymore.

Olivia's mother recalled seeing her daughter at Mario's mother's house. She had a mark on her torso and her mother was horrified. Mario's mother told Olivia's mother she wanted her son sectioning. Olivia's mother agreed. She says Olivia was worried that, if she went home that evening and he was sectioned, he would blame her. The last time her mother saw Olivia was the day before her death when she came around for her lunch and she seemed happy and chatty.

Sarah was a close friend who says she knew Olivia since they were eight years of age. She said Olivia was always very self-conscious because of her speech. Olivia spoke to Sarah a lot about her relationship with Mario. Sarah took a dislike to Mario from the first time she met him; she said she only tolerated him because of her friendship with Olivia. Sarah described examples of Mario's controlling and coercive behaviour. When Mario was drinking he would not allow Olivia to eat. He made her feel bad about herself. Sarah noticed a decline in Olivia's personal care. Mario would not let her take a shower and she started to present with unkempt hair when she normally kept it nice. Sarah recalled that Mario told Olivia;

'If you don't have me you will never have anyone else'

Sarah said that Mario was Olivia's first real boyfriend however she felt that Olivia only stayed with him out of pity. Sarah says that Olivia came to her house lots of times crying and did not know what to do about Mario's abusive behaviour. Sarah says she advised Olivia to go home to her mum. Both Sarah and Olivia's mother recall that Olivia showed them an entry she had made on her electronic diary about her relationship with Mario.

Sarah says that shortly before Olivia was killed she sent her, through Facebook messenger, a long list called 'What Living with Mario Is Like.' Sarah says she was horrified by what Olivia had written[26]. She says she had never seen anything like it before. There were references to Mario having slightly slit Olivia's chest with a knife and to other injuries she suffered at Mario's hands.

Sarah said as soon as she possibly could she got Olivia to come around to her house. She told Sarah she had sent the entry because she was worried that Mario would find it and delete it and she didn't want that to happen. Sarah asked Olivia what Mario had done with the knife and she showed her a 4 or 5-inch vertical slice above her left breast, going from near her collar bone to about an inch above her nipple. Sarah asked what had happened and Olivia said she was arguing with Mario and he had picked her up and thrown her on the floor four times, causing horrible carpet burns on her knees and hurting her back. Olivia said the knife wound was caused when Mario had been messing with a knife and had sliced her on her chest. Sarah says she begged and begged Olivia not to go back to Mario and instead to come home or stay at Sarah's, so she could have a break.

Sarah says that she discussed going to the police with Olivia. However, Olivia would not do that as she did not want to get Mario into trouble. Sarah says she told Olivia time and time again that Mario would severely hurt her.

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 Olivia and Mario's family.

Date	Event
May 2010	Mario is convicted of assault against a disc jockey.
Sept 2012	Mario is reported missing form a hospital in Rochdale after attending voluntarily with mental health problems.

[26] GMP shared the contents of the diary entry with the DHR panel. The panel did not feel it was appropriate to reproduce the diary in full within this report. Where appropriate, the panel refers to individual events that Olivia described which help understand the suffering she endured.

	He was assessed by GMP as presenting a medium risk to himself.
Nov 2012	Mario is traced by police and found to be living in Eastbourne. He does not want his parents telling where he is.
Dec 2012	Mario is found collapsed at Gatwick Airport. He is detained by the police as he is mentally unwell. He is later released.
Dec 2012	Mario is found in a hotel in Derbyshire behaving in an unusual way. He is eventually detained in a hospital under the Mental Health Act. He absconds on two occasions and is found by the police.
2013	Mario's contact commences with Pennine Care NHS Foundation Trust Early Intervention Team (EIT)[27]. He receives regular contact from care coordinator 1.
2014	Attempts are made to treat Mario with depot[28] anti-psychotic medication. He has small doses and then refuses to accept anymore.
Dec 2014	Mario visits his GP and challenges the depot medication. He is told he will be sectioned if he does not comply. This is his last visit to his GP.
Jan 2015	First reference to Olivia as Mario's girlfriend. His parents tell care coordinator 1 he is drinking heavily and is in debt.
April 2015	Mario discloses he has broken up with Olivia. At various times after this he is reported as drinking heavily. He also threatened his father.
May 2015	Olivia starts visiting her GP with low mood and says she is struggling following the break up with her boyfriend. She is given medication and referred for counselling.

[27] The Early Intervention Team is a specialist team who work with young people aged 14 – 35 who describe having psychosis episodes or similar experiences. They look at the experiences they are having and how it affects them. They look at how to help patients recover from these experiences, by giving them good information so patients can decide what will help them.

[28] Depot antipsychotic medication is a special preparation of medication which is given by injection. The medication is slowly released into the body over several weeks: Source: Royal College of Psychiatrists

July 2015	Officers from GMP attend a report of a fight between Mario and his father. Mario is arrested although his father does not want a criminal prosecution and says Mario needs medical help. A DASH[29] risk assessment is completed and graded as 'standard'.
Aug 2015	Attempts are made to re-start the depot medication. Mario accepts it once, then refuses further doses. Care coordinator 2 takes over. Mario continues to express delusional thinking and is binge drinking.
12 Aug 2015	Mario visits A&E after behaving strangely and banging his head against a wall.
Nov 2015	The EIT informed Mario's GP that he had stopped taking his medication and a mental health management plan was shared with the GP.
Jan 2016	Mario tells care coordinator 2 that he is having traumatic thoughts even though he was taking medication. Later that month he tells a psychiatrist he has stopped drinking and his paranoia has decreased.
March 2016	Care coordinator 2 is replaced by care coordinator 3. Mario is reported as being delusional and his father is finding his behaviour difficult to live with.
April 2016	Mario is reported to be back in a relationship with Olivia.
1 July 2016	Olivia visits her GP for a pregnancy consultation. She discloses her boyfriend is bipolar.
13 July 2016	Care coordinator 3 and Mario's mother visit him at home. Mario is in bed with a hangover. Rubbish and vomit are on the floor. Mario's mother tells care coordinator 3 that Olivia is pregnant, and the news had hit Mario hard. He threatens to kill his neighbours. Care coordinator 3 advises Olivia not to be near Mario when he is intoxicated.
26 July 2016	Care coordinator 3 visits Mario. He sends a text asking the coordinator to leave. Two days later Mario disengages from the EIT. A psychiatrist notes he will require follow up by the community mental health team.
4 Aug 2016	Olivia completes three sessions of Cognitive Behavioural Therapy (CBT) and does not attend a fourth. She is discharged from the service. During the last session she

[29] (Domestic Abuse Stalking and Harassment). GMP policy on domestic abuse requires that on each occasion an incident is identified a risk assessment is completed. Based upon answers the victim provides and other information the risk is assessed as 'standard', 'medium' or 'high'.

	disclosed to her practitioner from the service that she was upset by a relationship breakdown.	
11 Aug 2016	Mario failed to attend an appointment with the EIT. A discharge crisis plan is formulated.	
11 Aug 2016	22.14	Neighbours report Mario shouting and screaming. Police attend, and Mario is taken to hospital with facial injuries. Olivia is present. A DASH is completed, and the risk to Olivia is recorded as 'standard'. Mario leaves hospital before being seen
30 Aug 2016	Maternity services share information with Olivia's GP that she has disclosed the father of the baby is a Paranoid Schizophrenic	
18 Sept 2016	Olivia visits A&E. A blood test indicates she may not be pregnant.	
26 Sept 2016	Olivia informs a member of midwifery staff that she had suffered a miscarriage.	
29 Sept 2016	Mario fails to attend an outpatient appointment to consider his mental health.	
30 Sept 2016	Mario fails to attend a care programme approach appointment.	
27 Oct 2016	Care coordinator 4 records that Mario did not want to engage with services. A consultant considers Mario needs a 'face to face' assessment of his mental state.	
8 Nov 2016	Care coordinator 4 visits Mario who does not wish to engage and wants no further visits. He only wants contact with his GP. A plan is sent to Mario's GP[30].	
18 Nov 2016	Last GP entry about Mario is a letter from Mental Health Teams stating he is being discharged back to the care of the GP. It outlines a proposed plan of early intervention by the mental health teams.	
18 Nov 2016	16.48	Rochdale ASC receive a referral from Mario's mother. She says he has attacked Olivia, is not taking medication and 'needs sectioning'.
18 Nov 2016	17.10	A social worker from ASC makes a telephone call to Mario's mother. She says he has calmed down. The social worker advised her to call for an ambulance.
18 Nov 2016	17.36	Mario's mother calls 999 for an ambulance.

[30] A redacted copy of the plan appears at Appendix B

18 Nov 2016	17.44	NWAS do not have an ambulance available & call GMP requesting assistance. A GMP sergeant decides not to send a police patrol as it was a medical request.
18 Nov 2016	18.23	NWAS are unable to allocate an ambulance because of the volume of calls.
18 Nov 2016	19.20	The social worker makes a telephone call to Mario's mother who says she is at address one waiting for an ambulance.
18 Nov 2016	21.24	NWAS call GMP saying there is a disturbance at Mario's home. A police patrol is sent.
18 Nov 2016	21.58	Police officers attend. Olivia shows a police officer her computer tablet and the document 'What living with Mario is like'. Olivia and Mario's mother are taken home. Mario remains at address 1. The police log is updated as 'male is calm' and there is nothing for the police.
18 Nov 2016	21.59	GMP contact NWAS and advise them of the outcome and suggest they re-contact police if required.
18 Nov 2016	22.00	NWAS contact Rochdale Council and make a safeguarding referral about Mario.
18 Nov 2016	22.30	The social worker on duty in EDT makes a third call to Mario's mother to update her. She says police have taken her and Olivia home. The social worker advises Mario's mother to call EDT with any further concerns.
18 Nov 2016	22.50	The social worker in EDT contacts NWAS regarding their referral. NWAS tell the social worker that the call for an ambulance is still in the queue.
18 Nov 2016	22.58	NWAS call GMP requesting assistance at Mario's address.
19 Nov 2016	00.03	Police officers attend address one.
19 Nov 2016	00.44	Police Officer updates the log and it is graded Medium Risk. The log is closed generating a PPIU[31] record.

[31] Public Protection Investigation Unit (PPIU) is a specialist unit within GMP. One of the responsibilities of the unit is to review cases of domestic abuse.

21 Nov 2016	Rochdale ASC team receive a fax from NWAS with details of the incident on 18 November. A social worker responds to the fax, calls police PPIU and Olivia's telephone which is unobtainable.	
23 Nov 2016	11.54	A social worker speaks to Olivia and her mother by telephone and discusses Olivia's safety. Olivia is advised to call ASC if she needs support.
A day in late 2016	23.27	NWAS call GMP stating that Olivia has been stabbed in her home. NWAS had been contacted by Mario. Police officers, paramedics and fire service officers attempt to resuscitate Olivia.
The following day	01.28	Olivia is pronounced dead after being taken to hospital.

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 Olivia and Mario. 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 Mario's behaviour before he met Olivia. Section 15.2 of the report looks at each agency and the information they held between the start of the couple's relationship and August 2016.

15.1.2 Section 15.3 of the report adopts a chronological approach and a detailed examination of events between 11 August 2016 and the homicide of Olivia. The panel decided on this approach because 11 August 2016 was the first occasion on which a call was recorded of an incident of domestic abuse to the police, or any other agency, involving Mario and Olivia. The panel felt that dealing with the events during this period chronologically, rather than agency by agency, made it easier to examine the complexity of multi-agency working and the opportunities that were presented for agencies to act.

15.1.3 In adopting this approach the review panel feel it is important to stress, that does not mean incidents should be viewed in isolation of each other. As well as the information supplied by the agencies the panel also reviewed the document that Olivia prepared ('What Living With Mario Is Like'). The information from that document is considered in detail within Section 16. That document and relevant information from agencies contained in this section of the report illustrate that, collectively, the domestic abuse Olivia suffered at the hands of Mario followed a continuous and unending pattern and was not confined to the events that occurred post 11 August 2016.

Information held by agencies prior to January 2014

15.1.4 Although the DHR panel set the start date in relation to the review as January 2014 they felt there was some important information held by agencies prior to then which helped illuminate Mario's past.

15.1.5 In May 2010 Mario punched a night club disc jockey in the mouth. This led to his only criminal conviction when he was charged with assault. He appeared before Manchester Magistrates' Court and received a sentence of a 12-month community order and 250 hours unpaid community work. There is no reference on the crime report to any mental health problems. Mario was heavily intoxicated at the time of the offence.

15.1.6 In September 2012 Mario was reported missing from a hospital in Rochdale after he attended voluntarily because he was mentally unwell. Mario failed to take his prescribed anti-psychotic drugs. GMP completed a missing person report. This included information from staff who said Mario claimed he was scared as he believed someone was trying to kill him. He was also depressed. A note in the GMP missing person file records that Mario was 'capable of harming others if he becomes desperate'. The report records that he had recently been diagnosed as potentially schizophrenic although this was not confirmed. GMP assessed Mario as presenting a medium risk to himself.

15.1.7 During the time he was missing Mario sent text messages to his elder sister (who lived abroad) in which he made death threats towards his parents. In late November 2012 Mario was traced to an address in Eastbourne. He was seen by a police officer and he asked the police to keep his whereabouts secret from his parents. Sussex Police made an assessment and reached the decision that, because he was living independently as an adult, they would not reveal his whereabouts. They only told his parents Mario was 'safe and well'.

15.1.8 In early December 2012 Mario was found collapsed at Gatwick Airport following reports to the police of a man behaving unusually. Police officers who attended found Mario mentally unwell and took him to a police station for him to be assessed. It has not been possible to establish what then happened to Mario other than he must have been released as three days later he came to the attention of Derbyshire Police.

15.1.9 Mario was found in a hotel in Derbyshire after his behaviour raised concerns with staff. Police officers attended and detained Mario under Section 136 of the Mental Health Act 1983[32]. He was assessed and then detained in a Rochdale hospital under S2 of the Mental Health Act 1983[33]. He absconded from there on two occasions during late December 2012. On the first occasion Mario returned the same day. On the second occasion he was found by a police officer in Manchester city centre the following day.

15.2 Information held by agencies between January 2014 and July 2016

[32] The act gives a police constable the power to remove someone to a place of safety (which is defined in the act) if it appears the person is suffering from mental disorder and to be in immediate need of care or control if it is necessary to do so in the interests of that person or for the protection of other persons. Effectively the power can only be used in a public place. It cannot be used if the person is in a house or flat.

[33] This provides for the detention of people at a place of safety for a specified period to allow them to be examined or interviewed and of planning for their treatment or care.

Pennine Care NHS Foundation Trust-Heywood, Middleton and Rochdale Early Intervention Team (EIT)

15.2.1 Mario had been under the care of EIT since 2013. Between January 2014 and July 2016 Mario had a significant number of contacts with the EIT. These are summarised below and only those felt to be of relevance to the terms of reference of the DHR are included within the narrative.

15.2.2 Mario was dealt with under the Care Plan Approach (CPA)[34]. He received regular home visits from a care coordinator (care coordinator 1) up to August 2015. Mario also attended outpatient appointments, mostly with his mother and care coordinator 1. Attempts were made in 2014 to treat Mario with Depot anti-psychotic medication. Mario only received a small number of doses then refused to accept anymore as he did not believe it assisted him.

15.2.3 The first reference to Olivia as Mario's girlfriend was in January 2015 when Mario's parents told care coordinator 1 about her. They said Mario had also been drinking heavily over the Christmas period and that he was in debt. Mario's father also repeated these concerns later the same month.

15.2.4 In February 2015 when visited by care coordinator 1, Mario was assessed as 'upbeat'. This was mostly because of his girlfriend who was trying to help him control his drinking. However, in late April 2015, Mario disclosed that he and Olivia had broken up. While Mario said he was 'Ok' with this, soon after, his mother told care coordinator 1 Mario now had less social contacts and was having persecutory thoughts about his sister. He believed she was in contact with the EIT (which was untrue).

15.2.5 There then followed several routine appointments and visits between Mario and care coordinator 1. Mario also saw a psychiatrist. At various times during this period it was reported that Mario was drinking heavily and having delusional thoughts. Although none of this involved harm to himself or others. Mario's mother also contacted care coordinator 1 and told them about threatening behaviour from Mario towards his father and the involvement of the police (see paragraph 15.2.31).

[34] The Care Programme Approach (CPA) is a package of care for people with mental health problems. They are entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that is regularly reviewed. The plan is written down and sets out what support they will get and who will give it. The plan might cover medicines, help with money problems, help with housing, support at home or help to get out and about outside the home. The care plan also outlines any risks, including details of what should happen in an emergency or crisis. Each person with a CPA also has care co-ordinator (usually a nurse, social worker or occupational therapist) to manage their care plan and review it at least once a year. Source https://www.nhs.uk/conditions/social-care-and-support/care-programme-approach

15.2.6 Changes were made to Mario's medication including trying to restart his depot medication. He only accepted this once before refusing a further dose in August 2015. He claimed it caused a side-effect. At this time Mario's care moved from care coordinator 1 to care coordinator 2 who continued the same pattern of home visiting.

15.2.7 These visits continued with, at various times, Mario expressing delusional thinking and reports from his parents that he continued to drink alcohol excessively. In January 2016 care coordinator 2 visited Mario. He told the care coordinator he was still troubled by traumatic thoughts, even though (as far as could be ascertained) Mario was taking his anti-psychotic medication. His thoughts included;

- Being kidnapped;
- That the mafia were after him;
- Stabbing someone in the eye;
- Murdering someone.

It would appear from the notes held by Pennine Care NHS Foundation Trust that the only action taken was to ask for an urgent consultant review. He was reviewed by the consultant's junior doctor on the 28 January 2016, however these issues were not directly addressed or acted upon.

15.2.8 Ten days after that visit Mario was seen by the EIT consultant psychiatrist. He said he was taking his medication, had stopped drinking alcohol, was playing golf and visiting his parents regularly. He also said his paranoia had decreased. In March 2016 care coordinator 2 was replaced by care coordinator 3.

15.2.9 Care coordinator 3 followed the same pattern as their predecessor: engaging with Mario's parents and attempting to engage with Mario which at times proved difficult. His behaviour remained delusional and his father at one point reported that he was finding his son difficult to live with. During April 2016 it appears from what his mother said that Mario was now in a relationship with Olivia. During a visit in June he told care coordinator 3 he was 'back together' with Olivia and they were getting on well.

15.2.10 During this period there are references by his parents to Mario drinking heavily and admissions from him that he had either reduced and/or had changed his medication levels. This was contrary to the advice he was given and caused care coordinator 3 some concerns. Mario was also unreliable in maintaining appointments with health professionals.

15.2.11 On 13 July 2016 care coordinator 3 was due to meet with Mario and his parents at their home. Mario was not there, and his mother said she and her husband had had a bad night with Mario. He had kicked the door in. The care coordinator and Mario's mother went to address one. Mario refused to answer the door and Olivia, who was in the house, let them in. They found rubbish, including beer cans and vomit on the floor. Mario was in bed with a hangover and refused to come down.

15.2.12 During that visit Mario's mother told care coordinator 3 that Olivia was five weeks pregnant and had cerebral palsy. His mother thought the news of the pregnancy had hit Mario hard and that he needed to face up to his responsibilities. Mario's mother said he had threated to kill his neighbours[35]. Mario's mother said she and Olivia's mother would meet up and provide support to the couple. Olivia said she would not be living with Mario and intended to get her own accommodation.

15.2.13 During the visit care coordinator 3 said they would make a safeguarding children referral. At the same time, they also advised Olivia not to be near Mario when he was intoxicated. Subsequently, the care coordinator did not make the safeguarding referral as they felt Mario did not appear aggressive towards Olivia. The following day the care coordinator telephoned Mario's mother and provided contact details for the Drug and Alcohol Service.

15.2.14 Four days after that conversation, care coordinator 3 again spoke to Mario's mother. She told the care coordinator her son had improved, and Mario and Olivia were planning to move in together. His mother said she would support the couple to find accommodation and that Mario would not be allowed around the child if he was drinking.

15.2.15 On 26 July 2016 care coordinator 3 visited Mario's home. Mario sent a text message to the coordinator and asked them to leave. Two days later the EIT consultant psychiatrist recorded that Mario had disengaged from the team, his girlfriend was pregnant, and he was due to be evicted from his accommodation. The psychiatrist noted that Mario would require follow up by the community mental health team.

GP Services-Olivia

15.2.16 Olivia and Mario attended different GP surgeries in the Heywood, Middleton and Rochdale CCG area. Olivia was registered at her GP surgery from birth. She suffered from Cerebral Palsy which left her with weakness on her left

[35] There is no reference within the GMP records of any reports having been received of Mario making a threat to kill a neighbour.

side of her body and she struggled with her speech control. Olivia suffered from problems with low mood connected to her weakness and tremors.

15.2.17 Olivia visited her GP several times in connection with these issues. Her GP managed her condition by prescribing medication and making referrals to an appropriate service. Olivia was also seen within the Neuro Rehabilitation Outpatients clinic and by the out of hours GP service. None of these presentations appear connected to her relationship with Mario.

15.2.18 Between May 2015 and March 2016 Olivia visited her GP on several occasions with low mood. On two of these visits she told her GP that she was struggling following the break up from her boyfriend. There is no indication within the notes as to the identity of the boyfriend. However, based upon the recollections of her family and friends, it is highly likely she would have been in a relationship with Mario during this period. Olivia was prescribed medication and referred into mental health services for counselling.

15.2.19 On 1 July 2016 Olivia visited her GP for a consultation regarding a pregnancy. During this visit she disclosed her boyfriend was bipolar and unsupportive. The GP notes record that options were discussed with Olivia and her mother and her medication was reviewed. The notes do not record what the options were. On 27 July 2016 Olivia told her GP she had decided to continue with the pregnancy. There is no record of who the father was. No discussion appears to have taken place concerning the question of whether Olivia suffered or was at risk of domestic abuse. Olivia was referred to midwifery services.

15.2.20 On 4 August 2016 Olivia's GP received a letter from the Healthy Minds service to inform them she had attended three sessions of Cognitive Behavioural Therapy (CBT) (see paragraph 15.2.27 et al). She did not attend a fourth session and was discharged from the service.

GP Services-Mario

15.2.21 Mario had been registered at the same GP surgery in Rochdale since he was an infant. He had suffered from mental health problems over the years. An entry on the GP record in March 2014 from the EIT stated Mario had accepted a Depot injection and was responding well.

15.2.22 In December 2014 the GP recorded that Mario wished to challenge having these injections as he was having side effects from them. Mario was told that, if he did not comply, he would be sectioned under the Mental Health Act.

15.2.23 Between that visit and the homicide of Olivia, Mario's GP received several letters from Mental Health Services concerning contacts they had with Mario. The last face to face contact Mario had with his GP was on 18 February 2015 when Mario attended the surgery to review his anxiety states. The entry in the GP records does not state what the outcome of that visit was.

15.2.24 Mario's GP continued to receive notifications about Mario from other clinical services. In late June 2015, in a letter from mental health, there was reference to Mario not taking his anti-psychotic medication. The letter referred to Mario's small degree of insight into his illness. It also referred to Mario disclosing that 'others control his thoughts'. The letter stated that, as in the past, there was no identified risk in any domain[36] which would mean an assessment was necessary under the Mental Health Act. Mario's GP received a notification concerning a visit Mario had made on 12 August 2015 to Accident and Emergency when he behaved very strangely and had banged his head. He left before being seen.

15.2.25 A letter in October 2015 from a Consultant Psychiatrist referred to Mario having a history of binge drinking, taking shots and becoming aggressive. In November 2015 the EIT informed the GP that Mario had stopped taking his medication for seven days. His care co-ordinator felt he was not fully compliant and presented with delusional ideas. A mental Health Management plan was shared with the GP.

15.2.26 On 13 July 2016 Mario's care coordinator wrote to the GP[37]. The letter set out details of the visit care coordinator 3 had made to Mario's house with his mother on 13 July. The letter referred to Olivia being 5 weeks pregnant and contained other details already set out at paragraph 15.2.11.

Healthy Minds

15.2.27 Pennine Care NHS Foundation Trust are responsible for this service. It provides a range of treatment and support options for people struggling to cope with low mood, stress, anxiety, depression, or any of the common mental health problems. The service can also support patients with a long-term physical health condition.

15.2.28 Olivia attended this service following a referral by her GP. Here she worked with a Psychological Wellbeing Practitioner between March and July 2016. The focus of the support sessions was to help Olivia cope with symptoms

[36] Domains are used during a mental health assessment as a structured way of observing and describing a patient's psychological functioning at a given point in time. The domains include appearance, attitude, behaviour, mood, and affect, speech, thought process, thought content, perception, cognition, insight, and judgment.
[37] This letter was received and scanned into the GP system on 29 September 2016.

of anxiety and depression. Olivia was assessed as having moderately severe depression. This was assessed as being manageable through cognitive interventions.

15.2.29 The Practitioner who saw her could not recall the precise detail of the work she did with Olivia. However, she remembered that Olivia reported having an active life previously, and that she was no longer pursuing her activities. The practitioner recalled that during the short time she supported Olivia, she did 'come out of herself' more.

15.2.30 During the third visit to the service at the end of June 2016 Olivia was not able to engage with the agenda for the session as she was upset by a relationship breakup. While Olivia never talked about Mario during her sessions with the practitioner, it is most likely it was him she was referring to when she spoke of a relationship. The dominant content during the sessions was about her family. The practitioner says that Olivia did not share anything that gave them concern about her safety. This was the last contact Healthy Minds had with Olivia as she cancelled further appointments.

Greater Manchester Police

15.2.31 In July 2015 officers from GMP attended address two following a report of a fight. Mario had argued with his father over money, pushed him into a wall causing grazing to his father's hand before running away. Mario was arrested nearby. His father did not feel he wanted to support a criminal prosecution against his son.

15.2.32 He told the police that Mario needed medical help. He also told them he was frightened of Mario and this was making him depressed; he said he believed Mario could hurt somebody; that he had previously assaulted a man in a nightclub; that Mario was in debt and owed £4k to the bank; that Mario was a binge drinker; was refusing to take his medication at home and would not engage with doctors.

15.2.33 The police officer who dealt with Mario correctly submitted a DASH risk assessment report. This contained information about Mario's schizophrenia and the fact that he was heavily intoxicated at the time of this incident. The officer who submitted the report recorded that Mario posed a 'medium' risk of causing harm to others.

15.2.34 The report was referred to a specialist officer within the Public Protection Department (PPIU) at Rochdale for re-assessment. The PPIU officer downgraded the risk assessment to 'standard'. The rationale for this decision was that; it was an incident between father and son over money; the parties did not live together; Mario's father would not support a

criminal prosecution; this was the first reported incident; there was nothing on the DASH risk assessment to indicate an enhanced level of risk to Mario or third parties.

15.2.35 A letter was sent to Mario's parents offering advice. Because the risk was reassessed as 'standard' no referrals were made to local mental health agencies.

Rochdale Borough Council Adult Care

15.2.36 Rochdale Borough Council Adult Care (henceforth referred to as Adult Care) held no information concerning Olivia or Mario during this period.

North West Ambulance Service

15.2.37 North West Ambulance Service (NWAS) held no information concerning Olivia or Mario during this period.

15.3 Information held by agencies between 11 August 2016 and the date of the homicide of Olivia

15.3.1 On 11 August 2016 Mario did not attend an outpatient appointment with EIT. It was planned to discharge Mario from the EIT and transfer his care to the community mental health team. A discharge crisis plan was formulated and, to complete the transfer, a meeting with Mario was needed.

15.3.2 At 22.14 hrs on 11th August 2016 neighbours contacted police because Mario was outside address one in Rochdale shouting and screaming. The information indicated Mario appeared to be under the influence of drugs and was shouting "get out." A neighbour believed Olivia was inside the house. A second neighbour reported seeing Mario go in and reported groaning from inside the house. The callers believed the incident was escalating.

15.3.3 Staff within GMP control room noted on the log (henceforth known as a FWIN[38]) that Mario was the only occupant of the address. They included details about the incident in July 2015 and about his mental health. Officers reached the scene at 22.36 hrs.

15.3.4 Police officers who attended reported back that Mario was refusing to engage with them. They could see through a window that he had blood on his face. An ambulance was requested and at 23.24hrs the police officers at the scene told the control room Mario had been taken to hospital for treatment to a self-inflicted gash to the face caused by him head butting a

[38] FWIN is an acronym for 'Force Wide Incident Number' and refers to the GMP computer-based system for logging calls and incidents. Each incident recorded generates a unique reference number.

window. Mario left the Accident and Emergency Department before being seen. A notification form was sent to Mario's GP.

15.3.5 The following information was recorded on the FWIN;

"Verbal domestic only, no offences, alcohol a factor, no children involved, close for DASH report".

15.3.6 A DASH risk assessment was submitted in which it was recorded that the officer attending had spoken to both Mario and Olivia at the house. They said they had argued after drinking. Mario told the police officer he had head-butted a window resulting in his injury and had agreed to go to hospital for treatment. Olivia was uninjured and had voluntarily gone back to address three.

15.3.7 A 'standard' risk of harm was recorded on the DASH form. The rationale for this was given as: there was no reported previous domestic history between the parties; this was a verbal argument only; Olivia returned to her mother's home voluntarily; Olivia stated that she wished to remain in a relationship with Mario; the officer believed this to be a caring relationship and did not believe the likelihood of a repeat incident was high.

15.3.8 The DASH risk assessment recorded that Olivia was pregnant although this was not expanded upon. Neither the report, nor the risk assessment, addressed Mario's known mental health issues, the reference to drugs made by the initial caller, Olivia's disability or her future welfare in the light of the pregnancy disclosure. The DASH and accompanying PPIU report were not reviewed by specialist PPIU officer[39]. No referrals were made to partner agencies about this incident.

15.3.9 During an appointment at maternity services on 25 August 2016 Olivia disclosed to staff that the father of the baby was a Paranoid Schizophrenic and was on medication. Olivia said he was currently stable but did have violent outbursts, the last one being 2 months ago. She said he was never aggressive towards her and tended to punch a door or bang his head on a wall. Olivia said she was hoping to live with him. The name of the father was not recorded. This information was shared with Olivia's GP by Maternity Services who submitted a 'special circumstances form'.

15.3.10 Information supplied by Accident and Emergency at The Royal Oldham Hospital (Pennine Acute) show Olivia attended there on 18 September 2016 with vaginal bleeding. Blood samples were taken for a BHCG test[40].

[39] GMP policy at the time of these events was that only those domestic abuse incidents in which the risk to the victim was recorded as 'medium or 'high' would be passed to the PPIU.
[40] Quantitative human chorionic gonadotropin (hCG) blood test

This test measures the level of HCG hormone present in a sample of blood. HCG is a hormone that is produced during pregnancy.

15.3.11 The levels were less than one, which was the same as the level found when the test was conducted on 1 July 2016. This would indicate that Olivia was not pregnant. She was discharged and referred to the antenatal clinic and a notification was sent to her GP. On 26 September 2016, a member of midwifery staff from Pennine Acute contacted Olivia by telephone and she informed them that she had suffered a miscarriage.

15.3.12 On 29 September 2016 Mario did not attend an outpatient appointment to consider his mental health. In his absence, care coordinator 3 completed the mental health review documents. The community mental health team consultant psychiatrist agreed that Mario could be invited to a further care programme approach (CPA) meeting. If he did not attend, he would be discharged from the EIT back to his GP.

15.3.13 On 30 September 2016 Mario missed his CPA appointment, and a further date was sent to him. This was for 25 October and was subsequently cancelled by the outpatient department. This appointment was to be attended by his new care coordinator (care coordinator 4).

15.3.14 On 27 October 2016 care coordinator 4 recorded that Mario did not want to engage with services, that he had declined further input from mental health services and he would rather see his GP. This was discussed with the consultant for the community mental health team who considered that it was necessary for a face to face assessment of Mario's mental state.

15.3.15 On 8 November 2016 care coordinator 4 visited Mario at address one to undertake an assessment. Mario said he did not wish to engage and said he wanted no further visits: only contact with his GP. As far as care coordinator 4 could determine, Mario seemed stable and his communications were clear. Care coordinator 4 wrote to Mario's GP with a copy of the care plan.

15.3.16 The last entry on the GP record for Mario is on 18 November 2016. It relates to a letter received from a psychiatrist in Mental Health. It outlined a proposed plan of early intervention to the Mental Health Teams. It stated Mario was reluctant to engage and had not attended his appointment. Mario was therefore being discharged from the service back to GP care. Mario did not have any further contact with his GP following this letter: the last face to face consultation with his GP had already taken place on 18 February 2015. The discharge plan contained emergency telephone numbers a section headed 'Triggers, Crisis and Risk and Risk Management

Plans' and a section headed 'contingency plans' (see Appendix C). One of the telephone numbers was for the Emergency Duty Team (EDT).

15.3.17 At 16.48 hours on 18 November 2016 EDT at Rochdale Council Adult Care received a referral via the Council's out of hour's customer service line. The caller was Mario's mother. She said Mario was a Paranoid Schizophrenic, had ripped up the carpet in the bathroom, said there was a dead body underneath the floor boards and had torn out smoke alarms believing cameras were inside them.

15.3.18 Mario's mother said he was not taking his medication and had attacked his girlfriend Olivia who had turned up at the address. Mario's mother was extremely upset and frightened and said he needed "sectioning" as soon as possible and he needed to start taking his medication. She asked the EDT Social Worker to call her back.

15.3.19 At 17.10hrs that day a social worker made a telephone call to Mario's mother. She told the social worker that Mario had calmed down and was relatively settled. However, she felt he needed to be in hospital and to recommence his medication. The social worker advised her to call an ambulance or to take Mario to hospital and to update EDT later.

15.3.20 At 17.36hrs Mario's mother made a 999 call for an ambulance. Because NWAS was very busy that night, the case was passed to the urgent care desk team[41]. A paramedic from that team contacted Mario. The team considered that Olivia was vulnerable and at immediate risk of harm.

15.3.21 NWAS graded the call as Green 2: this required a twenty-minute response time[42]. The evening of 18 November 2016 was extremely busy and, in the Manchester area between 17.00hrs and 23.00hrs, NWAS dealt with 416 calls that were Cat A and Red 1 and 2.

15.3.22 At 17.44 hrs on 18th November 2016 GMP received a telephone call from NWAS requesting police assistance. The call log stated:

"Assistance required (Mario) 31 years, at the address, male is paranoid schizophrenic. His parents have called ambulance to tell them that he is having an adverse mental health episode".

[41] Urgent Care Desk Paramedics contact patients who are waiting for a response if there is a delay. This allows for additional information to be given which can be used to escalate or de-escalate the emergency response. It is supportive to patients and their families and keeps them updated.
[42] NWAS grade calls depending on need. In order of urgency the codes are: Cat A, Red 1 and 2, Amber, Green 1,2,3 and 4. Cat A and Red 1 and 2 are all life threatening and therefore take precedence over calls. NWAS policy is that all red calls must be cleared first before they can respond to any others.

GMP control room created a FWIN (Serial No 1647) which was graded for a 'priority response[43]'.

15.3.23 NWAS received their information from Mario's parents, who had advised sending 'strong men' because Mario was likely to be violent. Amongst other information NWAS passed to the police was that Mario had recently attacked his girlfriend, was known to be violent, suffered from paranoid schizophrenia and was not taking his medication. NWAS did not have an ambulance available to send immediately.

15.3.24 The exact wording used by the NWAS operator to the police operator, taken from a recording is:

"They [Mario's parents] have just heard from his girlfriend who is saying he attacked her a few days ago."

15.3.25 NWAS did not tell the police that Olivia was at the address that evening. However, the implication is that Olivia must have witnessed Mario's behaviour which had prompted her to call to his parents. If she was at the address, then she was potentially at risk.

15.3.26 A police sergeant on duty at Rochdale became aware of the FWIN. The Sergeant intervened in the sending of a police patrol on the basis that NWAS did not have an ambulance available immediately to send to the address. The sergeant was not prepared to commit a police patrol to attend in isolation to what they saw as a medical request rather than a need for immediate police attendance.

15.3.27 At 18.23hrs NWAS had not been able to allocate a vehicle to attend at Mario's home. At this time the ambulance service had 105 calls requiring allocation. These were to be allocated in order of priority. It was anticipated there would be a further delay of 45 minutes.

15.3.28 At 19.20hrs the social worker from EDT made a second telephone call to Mario's mother. She said she was at address one, had called for an ambulance and was waiting for it to arrive. She said Mario was calm and he was not aware an ambulance was on its way.

15.3.29 At 21.24 hrs the same evening NWAS called GMP again. A new FWIN was created (Serial number 2182). The following is an extract from that FWIN;

"Disturbance ongoing [at address one], Mario suffers from schizophrenia and paranoia. The male is suffering from mental health problems and has previously been violent towards his partner, threatening her with a knife. Male is on the line to ambulance now and female can be heard screaming

[43] GMP policy is that a priority response should be attended within one hour.

in the background. Mario 31 years. Male has also assaulted his father this week [sic] and is known to be violent, male's partner suffers with cerebral palsy. No mention of any weapons this evening. No details of any partner known."

The FWIN was graded for immediate (emergency) response.

15.3.30 At 21.30 hrs the first police officers reported they had arrived at address one. Some of the officers had body worn cameras which enabled the detail of the events to be captured. A series of interactions then took place between the police officers, Mario and his mother. The essence of these was that Mario refused to leave address one despite assurances from the police officers that they were not there to harm him or take him away; they wanted to help him.

15.3.31 Eventually Olivia left address one and went to a police van with one of the officers. Olivia had her computer tablet with her and showed a police officer a document on it with the title 'What living with Mario is like'. A police officer can be seen on the video footage from the body worn camera scrolling through the document. The officer asked Olivia if she had kept the document for the police and she replied that she did it for Mario's mother.

15.3.32 During a conversation with the police officers, Mario's mother told them that she had been told by Olivia that Mario had pushed her and had 'come at her with a knife'. Mario's mother said she did not report that to the police. She also told the officers about Mario's bizarre behaviour.

15.3.33 Mario's mother says she told the police officers that night that Mario 'would become aggressive and a danger to himself or others if not treated'. She says the police officers told her that he 'was not presenting himself to be a threat to himself or others therefore it would be against his human rights to just take him'.

15.3.34 Mario's mother says she insisted that Mario needed to be sectioned and she was concerned for his welfare. She said the officers told her Mario did not appear to be dangerous to anyone or himself, so he could not be sectioned. The police officers then took Mario's mother and Olivia to their respective homes. During the journey Mario's mother says she told the officers that Olivia would go back to address one and that Olivia agreed this when asked.

15.3.35 At 21.58 hrs the same night, one of the police officers that had attended address one provided the following update to the GMP control room:

"Male calm on arrival, standing down, nothing apparent for police at this time."

15.3.36 At 21.59 hrs GMP contacted NWAS to advise them of this outcome and to re-contact the police should they require assistance if/when an ambulance arrived at address one. The FWIN was then closed and endorsed to the effect that the incident had been passed to another agency. No follow up reports were submitted.

15.3.37 At 22.58 hrs NWAS made a further call to GMP. A third FWIN (Serial number 2419) was created. The essence of the call was that NWAS had received information from social services that they should not attend address one without police assistance. This was because Mario suffered with paranoid schizophrenia and was armed with a knife. Arrangements were made for an ambulance and a police patrol to meet at a rendezvous point and then go to address one.

15.3.38 At 00.03 hrs on 19 November 2016 two of the police officers who had attended the earlier call returned to address one. An ambulance also attended. An emergency medical technician (EMT) who was with the ambulance says a male (they assumed this to be Mario) answered the door. He acted normally and answered questions. The EMT said Mario's responses were rational and there were no behavioural concerns. The ambulance and its staff together with the police officers therefore left the scene and Mario remained at address one.

15.3.39 Enquiries undertaken later by NWAS disclosed that no patient contact record was completed by the ambulance crew that evening. One of the ambulance crew recalled that they did not;

'remember anything being out of the ordinary or unusual about him, if there was I would have certainly taken further action' and;

'due to the short time on scene I can only presume that he didn't want an ambulance, if anything untoward was present I wouldn't have walked away'

15.3.40 One of the police officers that attended both incidents spoke to their Inspector for advice in relation to their powers. The Inspector's assessment was that, based upon what the officer reported, there were no grounds for arresting or detaining Mario. The same police officer submitted a report to the PPIU specialist team at Rochdale. This was graded as 'medium'. The content of the report is reproduced below;

'The circumstances of this incident are as follows: the mother of Mario has been on holiday for two weeks and returned today. Mario and Olivia live at the same address, Olivia had contacted Mario's mother stating his mental health had deteriorated whilst she has been away; he has not been taking his medication in two months. This has made him paranoid and has made

him think she is cheating on him. A few months ago, Olivia faked a pregnancy and miscarriage, and this appears to be the route of the problem. This deeply hurt him and makes him question his relationship. Mother had contacted the ambulance from her home address at 6pm regarding concerns about her son; she had attended their address to speak to Olivia and Mario. Olivia and Mario have had issues throughout their relationship the most recent being the fake pregnancy and miscarriage. The pair appear to be together as they fear they could not get anyone else due to Mario's mental health problems and Olivia has cerebral palsy. The ambulance contacted police stating that Mario had been having a schizophrenic episode. Myself and (another PC) attended the address, Mario came to the door however would not let us enter. We had no power of entry as there were no offences disclosed. All parties present were at the door and appeared safe and well. Olivia stated over the past few weeks Mario's behaviour had become nastier towards her due to his deteriorating mental health. In our opinion Olivia appeared vulnerable and wouldn't be capable defending herself if he became violent. For this reason, she was returned to her mother's address at (redacted). Mario appeared calm & compliant and made no threats to harm himself or others. His appearance was smart, and he was responding to our questions without issue. Mario stated his mother was over protective of him since he has been sectioned and he is upset he cannot take over his own finances as a man his age should be able to do so, and he would like some independence. The only issue he seemed to have was with his girlfriend and their relationship. RAID team were spoken to and stated that if he was happy to attend voluntarily at Bury A & E they would speak with him however stressed no urgency for him to attend. We spoke with mum regarding medical history and how he has been coping on his own she stated up until recently she thought everything was fine. She stated there was no history of self-harm or suicide. Mario had not expressed any thoughts of suicide or self-harm. Mario told us to not enter his house as there were no issues; all parties seen and spoken to. [We] stressed that he needed to take his medication. Due to the above we took Olivia and mother back home. Mother was happy to leave address and stated she would liaise with crisis team. Mario was left at the address. A short time later we returned with the ambulance. He answered the door his mannerisms were the same he stated he was fine and did not need to speak to them or require an ambulance. No powers as no offences reported or apparent. Medium risk, both require support from adult social services and mental health team. No consent given to share [information]'.

15.3.41 As a result of the referral made to Adult Care by NWAS a social worker made a telephone call to Olivia on 23 November 2016. They explained the

purpose of the call, asked how things were with her boyfriend and whether Olivia felt she needed any support. Olivia explained that she was ok, but Mario needed help, because he was a paranoid schizophrenic, was not taking medication and could be verbally abusive.

15.3.42 The social worker asked Olivia what the paramedics and police had done. She said they hadn't taken it any further. Olivia said the paramedics didn't feel Mario needed 'sectioning'. Olivia told the social worker she did not feel she was at risk and was staying at her mother's, until Mario received support as he would not take his medication. When asked whether she felt she needed any help, Olivia said she was fine.

15.3.43 The social worker then spoke to Olivia's mother on the telephone and she confirmed Olivia was staying with her until Mario received support. Olivia's mother said she had discussed it with her daughter and she did not feel she needed any support. Olivia's mother explained that Mario could be verbally abusive more than anything. The social worker asked her if she felt Olivia was at risk. Her mother said she did not feel Olivia was. Her mother said it was more around verbal abuse than anything else.

15.3.44 Olivia's mother told the social worker she felt Mario needed support to ensure he took his medication. He was refusing to have this put into place and had also refused the involvement of a Community Psychiatric Nurse. The social worker explained to Olivia and her mother the support that could be put into place through Victim Support[44] to help Olivia cope with the verbal aggression. The social worker explained that, if Olivia felt she needed support, she should contact adult social care.

15.3.45 Following this conversation the social worker discussed the matter with their duty manager. A decision was made to close the case. That afternoon, a police PPIU referral was received by adult care concerning the same incident (this contained the information that the officer had recorded in the report to PPIU (see paragraph 15.3.40). The referral was marked;

'Adult Care for intervention with Olivia, Mental Health service for intervention with Mario'

15.3.46 Following the submission of the PPIU report (paragraph 15.3.40) the GMP triage officer made a referral to adult care and mental health. As contact had already been made with Olivia (following the NWAS referral), adult care decided to close the PPIU referral with no further action.

[44] The DHR panel made enquiries with Victim Support and found there had been no contact by Olivia or her mother with their service.

15.3.47 Olivia's final visit to her GP was in late 2016, four days prior to her homicide, and was for a routine matter unconnected to the DHR. An alert was attached to Olivia's GP record the following day which stated she had a 'stalker'. The note stated that no information was to be shared. There was no reference as to whether this was Mario.

16. ANALYSIS USING THE TERMS OF REFERENCE

16.1 Term 1

What indicators of domestic abuse did your agency have that could have identified Olivia as a victim of domestic abuse and what was the response?

16.1.1 Olivia made several visits to her GP between May 2015 and March 2016 and on two occasions said she was struggling following a break up from her boyfriend. Olivia was referred for counselling. On 1 July 2016 Olivia consulted her GP regarding a pregnancy. On that occasion she disclosed her boyfriend was bipolar.

16.1.2 While Olivia did not make any direct disclosure of domestic abuse, there is known to be an increased risk of domestic abuse, particularly around the time of separation[45]. On this occasion there is no indication the GP asked Olivia a direct question about domestic abuse. Neither does it appear the GP asked Olivia any wider questions about her family life nor the impact that bipolar disorder may been having on her relationship with her boyfriend or his behaviour towards her.

16.1.3 Pregnancy has been shown in several studies to be an independent risk factor for domestic abuse and pregnancy within the previous 12 months was found to double the risk of physical violence[46]. Both pregnancy and mental health presentations are two of the situations in which NICE guideline 50 recommends routine inquiry about domestic abuse even where there are no indicators of abuse. The DHR panel felt it would have been good practice if the GP had asked these questions.

16.1.4 On 11 August 2016 neighbours contacted the police about a disturbance involving Mario outside address one (see paragraph 15.3.2). The incident was recorded as domestic abuse and a DASH risk assessment completed with the risk recorded as 'standard'.

16.1.5 The answer to question nine on the DASH risk assessment stated that Olivia was pregnant although this was not expanded upon in the PPIU report. Neither did the report nor the risk assessment address Mario's known mental health issues, the reference to drugs made by the initial caller, Olivia's disability or her future welfare in the light of the pregnancy disclosure. There did not appear to have been any exploration of the root

[45] Richards L (2004) Getting away with it: a strategic overview of domestic violence, sexual assault and serious incident analysis. London: Metropolitan Police Service

[46] Richardson, J; Coid, J; Petruckevitch, A; Chung, W S; Moorey, S. & Feder, G. (2002) Identifying domestic violence: cross sectional study in primary care. British Medical Journal. 324. 274-277

cause of the argument between Mario and Olivia which may have been around her pregnancy.

16.1.6 The GMP IMR author believes this was a missed opportunity to seek help for both Mario and Olivia in terms of making partner agency referrals. The DHR panel agree. It appears to the DHR panel that the police officer who attended simply did not recognise the importance of several factors that are relevant in assessing the risk of domestic abuse.

16.1.7 On 25 August 2016 Olivia made a disclosure about Mario's mental health and behaviour while visiting maternity services (see paragraph 15.3.9). Maternity services appear to have recognised the connection between pregnancy and domestic abuse as they completed a 'special circumstances form' which was sent to Olivia's GP. The DHR panel feel it is disappointing that nothing appeared to happen to this alert. It was not placed on the GP system and never discussed with Olivia by her GP. The fact that Mario had a mental disorder, was punching doors and banging his head on a wall were all potential indicators of domestic abuse albeit Olivia said he was not aggressive towards her.

16.1.8 NICE guideline 50 recommends routine inquiry about domestic abuse even where there are no indicators of abuse. The DHR panel believe this was a missed opportunity by the GP to explore with Olivia the impact that Mario's behaviour was having upon her. The DHR panel recognise the time constraints that are placed upon GP's during consultations. However, the GP could have sign posted Olivia to support services that might have had the time needed to engage with Olivia, secure her confidence in them and potentially have received a direct disclosure of domestic abuse.

16.1.9 While there were opportunities on the above occasions to explore indicators of abuse, it is not possible to say whether Olivia would have made a direct disclosure of domestic abuse. Consequently, it is not possible to say how significant those missed opportunities might have been.

16.1.10 The DHR panel believe there were significant opportunities on 18 November 2016 to identify direct evidence that Olivia was a victim of domestic abuse at the hands of Mario. The first of these came when Mario's mother contacted EDT at Rochdale Council and told a social worker that Mario had attacked his girlfriend.

16.1.11 It does not appear the social worker explored that comment any further with Mario's mother, for example to establish the nature of the attack, when and where it happened or whether it had been reported to the police. While the social worker missed an opportunity here, the information about Mario attacking Olivia eventually reached the police as NWAS

contacted them requesting assistance (see paragraph 15.3.23). The call from NWAS included reference to the attack on Mario's girlfriend and his violent behaviour.

16.1.12 The DHR panel believe the receipt of that information should have triggered consideration of the risk of harm that Olivia faced from Mario. The sergeant who intervened in the matter did not commit a police patrol because they considered this was a medical matter (paragraph 15.3.26). While the DHR panel recognise the sergeant acted professionally in relation to the availability of limited resources, in doing so they seem to have either been unaware of or completely overlooked the risks Olivia faced from Mario.

16.1.13 The police response was different when NWAS contacted GMP at 21.24hrs and reported a disturbance at address one (paragraph 15.3.29). That call contained additional information as to the use of a knife and led to police officers attending address one.

16.1.14 The body worn camera footage recovered from police officers who attended that night shows Mario's mother told them Mario attacked Olivia with a knife. The footage shows they did not ask any further questions about the incident. When the police officers that attended were first dispatched, the GMP radio operator told them that Olivia had been threatened with a knife earlier that week.

16.1.15 One of the police officers later said they believed this incident had been dealt with already as the control room gave the officer the information. A body worn video recording showed Mario's mother telling two of the police officers that Olivia had not reported the matter to the police.

16.1.16 The DHR panel believe the references to the use of a knife were significant and a clear indication that Olivia was at risk from Mario. The presence of a weapon is something that increases the risk of harm to victims of domestic abuse and there is specific reference to weapons such as knives within the DASH risk assessment.

16.1.17 The video shows one of the police officers scrolling through the document that Olivia had written on her lap top computer. The document of just over four pages refers to issues such as Mario hiding Olivia's telephone and includes derogatory comments he made to her and things he accused her of.

16.1.18 Of significance, the document includes the following text;

'He said he would never hurt me, yet, he has slightly slit my chest with a knife, and picked me up 4 times and threw me across the room; giving me a severe carpet burn on my knee, scar on my chest and backache'

There is also a comment that refers to Mario 'having to kill' Olivia. The panel believe these, and other comments, could amount to criminal offences and are also evidence that Olivia has been subjected to domestic abuse by Mario.

16.1.19 The police officer who read the document that night says that there was too much going on and so they skim read it. It is not the role of the DHR panel to comment on the veracity of the police officer's explanation. The DHR panel have restricted their consideration to whether there was evidence on 18 November 2016 that Olivia was a victim of domestic abuse. The DHR panel conclude there was such evidence. That evidence was available from several sources. It included the information Mario's mother had provided about the use of a knife. It was also available within the document Olivia showed one of the police officers.

16.1.20 Neither the comments about the use of the knife nor the content of the document shown by Olivia to one of the police officers was explored sufficiently, if they were ever explored at all. The DHR panel believe there was sufficient information available, based upon the comments made by Mario's mother and from the contents of the document, to have considered arresting Mario for criminal offences of assault and wounding, or at least to have recorded a crime and commenced an investigation. The DHR panel conclude that the actions of the police on the night of 18 November 2016, to what were clear indicators of domestic abuse, was inappropriate.

16.1.21 Section 16.3 below deals with the response of agencies to the mental health issues in this case.

16.2 Term 2

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

16.2.1 Mario had suffered with mental health issues which were known for several years to both his GP and to Pennine Care EIT. Mental health problems have been cited in several studies as a risk factor for perpetrating domestic abuse. Mental health problems were present in 25 of 33 intimate partner homicide DHRs examined in research commissioned by the Home Office[47]. Twenty-one cases involved perpetrators with mental health problems. In

[47] Domestic homicide reviews key findings from analysis of domestic homicide reviews. Home Office December 2016.

the DHRs involving perpetrators with mental health problems, the majority (16) were known to health professionals.

16.2.2 The same study also identified that among perpetrators and victims the presence of both substance use and mental health were common issues in Domestic Homicide Reviews. Twelve of the DHRs examined involved perpetrators with both mental health problems and substance use issues. The report notes that both substance use and mental health problems, individually or together amongst perpetrators and victims, are aggravating factors that escalate violence in relationships that are already abusive.

16.2.3 Pennine Care EIT knew in January 2015 that Mario's girlfriend was Olivia and that he was drinking heavily (see paragraph 15.2.3). There was further reference the following month to Olivia being a factor in the control of Mario's drinking (see paragraph 15.2.4). In late April 2015 there was reference to the couple having broken up. Separation is a key factor that can increase the risk of domestic abuse. It does not appear to the DHR panel that this information prompted any health professionals to consider whether Mario might present a risk to Olivia. The panel believe there was a missed opportunity here to ask some routine questions. The panel accept that the care coordinator might not have been in dialogue with Olivia, however, Mario's parents did converse regularly with professionals from the EIT. The panel feel they could have been asked for their views on the impact Mario's behaviour was having on Olivia and whether there were any other indicators that she may have been at risk.

16.2.4 The events in 13 July 2016 should have prompted further enquiry by care coordinator 3 (see paragraph 15.2.12). There were several clues here that should have been followed. Mario's behaviour had escalated from drinking alcohol heavily; he had now made threats to kill a neighbour and had used physical violence kicking in a door.

16.2.5 Care coordinator 3 appeared to recognise that there was some risk to Olivia as they advised her not to be near Mario when he was intoxicated. They also recognised there was a potential child safeguarding issue, in respect of her unborn child, as they spoke of submitting a safeguarding referral. That did not happen as the care coordinator felt that Mario did not appear aggressive towards Olivia.

16.2.6 The DHR panel believe the response of the care coordinator, which was to provide contact details for the Drug and Alcohol Service, was insufficient. The care coordinator seemed to recognise Olivia was at risk from abuse and this should have alerted them to the need to complete a risk assessment. If the care coordinator was not trained in the use of DASH, the panel felt they should have sought advice from their safeguarding

named professional as to what steps to take. As well as assessing and responding to the risk Olivia faced she could also have been signposted to specialist support services for domestic abuse.

16.2.7 The DHR panel have already considered at paragraph 16.1.8 the opportunities that were presented to the GP to consider the risks that Olivia might have faced from Mario following the receipt of the 'special circumstances form' from maternity services. The panel consider later in this report (at paragraph 16.9.7 et al) the quality of the information that was contained within the Discharge Crisis Plan (Appendix C) a copy of which was sent to Mario's GP (see paragraph 15.3.16).

16.2.8 GMP knew in July 2015 that Mario was a perpetrator of domestic abuse following the altercation with his father. The police officer that attended that incident correctly identified this and completed and submitted a DASH risk assessment of 'medium' (see paragraph 15.2.33). The police IMR author believes the decision to downgrade this to 'standard' when it was reviewed by the PPIU was flawed because it did not take full account of Mario's mental health problems. As set out earlier, mental health issues may increase the risk of domestic abuse. In the opinion of the author this incident represented a missed opportunity on the part of the police to notify partner agencies about an escalating situation and to seek assistance for Mario and his parents.

16.2.9 Another opportunity for GMP to consider the risks that Mario posed was presented when neighbours called the police because of his behaviour outside address one (see paragraph 15.3.2). While the police officer attending correctly identified and recorded this as a domestic abuse incident, the assessment missed some important factors which had a bearing upon risk. These included Mario's mental wellbeing, the reference by the caller to drugs and Olivia's disability.

16.2.10 Pregnancy is another factor that can increase the risk of domestic abuse[48]. The midwife that saw Olivia appeared to correctly identify this and the mental health issues relating to Mario when they saw her on 25 August 2016. This resulted in a 'special circumstances' form being completed. The DHR panel has commented earlier in this analysis about the fact the form did not appear to have then been considered further by Olivia's GP.

[48] Statistics collected in the United Kingdom show that around one in three domestic violence cases start or get noticeably worse when a woman is pregnant. At least 20% of all midwives in the United Kingdom know that at least one of the expectant women in their care is experiencing domestic violence. Another 1 in five midwives suspect that a woman in their care is being subject to domestic abuse, however they do not have conclusive proof. Source: WomeninLondon.org.uk

16.2.11 There were several opportunities during the events of 18 and 19 November 2016 for agencies to identify that Mario might be a perpetrator of domestic abuse. These have already been analysed within section 16.1 of this report and are therefore not repeated here.

16.3 Term 3

What account did your agency take of any mental health problems[49] of Olivia and/or Mario when responding to domestic abuse?

16.3.1 As set out in section 2, NHS England commissioned an independent report into the mental health services provided to Mario. The person appointed to lead this review worked closely with the DHR panel and they shared relevant information. The lead for the NHS England review attended several meetings of the DHR panel and in turn the panel Chair and the DHR report author attended a round table event of agencies facilitated by the independent person.

16.3.2 The NHS England review is now complete, and its findings have been accepted by NHS England. A full copy of the report is available to view at https://www.england.nhs.uk/north/our-work/publications/ind-invest-reports/. The DHR panel have also considered and agree with the findings of the independent report. The DHR panel recognised that the identification and response to mental health problems is a complex issue. Rather than trying to condense or interpret the conclusions of the independent report themselves, the DHR panel felt it was appropriate to replicate the findings of the independent report within Appendix B of this report. The DHR panel felt that adopting this approach will ensure there are no mixed or missed communications in relation to the issue of mental health.

16.4 Term 4

What services did your agency offer to the victim and were they accessible, appropriate and sympathetic to her needs?

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[49] Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as 'neuroses' are now more frequently called 'common mental health problems.' Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no one else can. Mental health problems affect the way you think, feel and behave. They are problems that can be diagnosed by a doctor, not personal weaknesses. Mental Health Foundation https://www.mentalhealth.org.uk

16.4.1 Olivia accessed several services delivered by agencies within the Rochdale area. All of these (except for two contacts with GMP in August and November 2016) related to her physical and mental health. Olivia did not access, nor seek access, to any specialist domestic abuse services. The DHR panel concluded that the medical services Olivia received were accessible, appropriate and sympathetic to her presenting needs. Term 1 considers the issue of whether any of those agencies identified indicators of domestic abuse and, if they did, how they responded.

16.4.2 Olivia had contact with GMP on 11th August 2016 following a call by neighbours concerning shouting and screaming at address one. The issue of whether there were indicators of domestic abuse have already been dealt with in section 16.1 of this report. Notwithstanding the issue of indicators of abuse, there were other factors present that day that should have been explored and documented in more detail and could have led to an opportunity for referrals to other agencies. For example, Olivia's statement she was pregnant and the impact of Mario's mental health particularly against the background of Olivia's disability.

16.4.3 The reason why referrals were not considered on that occasion may be connected to the attending officer assessing the risk as 'standard'. This meant the incident was not re-assessed by PPIU who might have realised the value of a referral.

16.4.4 The appropriateness of the services that Olivia received from GMP, NWAS and Adult Social Care on 18 November 2016 have been already been considered in detail at section 16.1 and 16.2 of this report and are therefore not repeated here.

16.5 Term 5

Were there any barriers in your agency that might have stopped Olivia from seeking help for the domestic abuse?

16.5.1 The DHR panel has not been able to identify any discreet agency barriers that might have prevented Olivia seeking help for domestic abuse. All the agencies that were involved in providing services to Olivia had policies and practices in place that provided a response to either direct disclosure of domestic abuse or the presence of indicators of domestic abuse. Terms one and two (section 16.1 and 16.2) considered how agencies responded to any of these.

16.5.2 The DHR panel recognise that there may have been reasons, other than agency barriers, that prevented Olivia seeking help. Set out below is one research finding which illustrates the barriers victims of domestic abuse face when considering disclosure.

'Many victims do not report their abuse. It is vitally important that police officers understand why this might be the case. Of those that responded to HMIC's open on-line survey, 46 percent had never reported domestic abuse to the police. The Crime Survey for England and Wales reported that while most victims [79 percent] told someone about the abuse, for both women and men this was most likely to be someone they know personally [76 percent for women and 61 percent for men]. Only 27 percent of women and 10 percent of men said they would tell the police.

The reasons the victims we surveyed gave for not reporting the domestic abuse to the police were: 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]'.[50]

16.5.3 As set out in section 14.1 and considered further at 16.1, Olivia either directly told or indicated to friends and family that she was frightened of Mario. For example, she told her mother that she had a termination and that if Mario knew he 'would kill me'. When her friend Sarah talked to Olivia about going to the police, Olivia said she did not want to get Mario into trouble. Fear of what Mario might do to her, or fear about what might happen to him, are therefore both possibilities that could have acted as barriers to Olivia accessing help for the domestic abuse she suffered.

16.5.4 The only agency that appears to have directly discussed with Olivia whether she needed help and support was Rochdale Council Adult Care. This happened on 21 November 2016 following the receipt of the referral from NWAS concerning the events of 18 and 19 November. In response to this, a social worker spoke by telephone to Olivia and her mother, discussed the issue of risk, asked whether Olivia needed help and suggested Victim Support or support from Adult Care if required.

16.5.5 Both Olivia and her mother appeared to consider there was little risk from Mario. Their concerns seemed to have been around Mario and the fact he was not taking his medication. Until that happened, Olivia was going to stay at address three. The DHR panel feel that the way in which Olivia was primarily concerned about Mario's mental health needs, before her own, reflected her kind and considerate personality.

16.5.6 The DHR panel believe the actions of the social worker who spoke by telephone to Olivia and her mother, and the advice they gave, were reasonable under the circumstances. Both Olivia and her mother had indicated they did not feel there was a risk and did not need support at

[50] Everyone's business: Improving the police response to domestic abuse 27 March 2014 ISBN: 978-1-78246-381-8 www.hmic.gov.uk

that time. Olivia said the police and paramedics had not taken the events of 18 and 19 November 2016 any further. That might have mistakenly reinforced for all concerned that the issue was one of mental health and not domestic abuse. Unlike the police officer who had read the entry written by Olivia on her lap-top computer ('What living with Mario is like'), the social worker had not seen the details of the abuse Olivia had suffered.

16.5.7 The DHR panel also believe the responses that Olivia and her mother gave to the social worker raise important issues as to whether victims can accurately assess the risk they face. Views on this vary. Dr Amanda Robinson[51] in a paper considers both sides of the argument. She concludes that

"It continues to be apparent that risk assessment and classification is dependent on the good judgment and experience of trained advocates, rather than a simple matrix that can be completed by anyone with access to victims of domestic abuse".

16.5.8 The DHR panel believe that, while the social worker acted with integrity and their advice was limited, they acted upon the intuition of Olivia and her mother without the support of a risk assessment tool such as DASH. The social worker that spoke to Olivia did not have access to DASH. The DHR panel heard from Rochdale Adult Care that they now intended to incorporate DASH into their training and practice.

16.5.9 Despite all of the above, the DHR panel concludes by reinforcing its view (see section 16.1 and 16.2) that the greatest barrier to Olivia receiving help for domestic abuse was that professionals simply did not recognise the risk of harm that she faced from Mario and therefore did not understand the way in which it was rapidly escalating on the night of 18 and 19 November 2016.

16.6 Term 6

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

16.6.1 The DHR panel spoke to friends, family and work colleagues of Olivia to try and establish what they knew about her relationship with Mario. On behalf of the panel the head teacher of the school where Olivia worked spoke to her colleagues. They had discussed healthy relationships with Olivia and she had always told them that she wasn't interested in finding a boyfriend. Her studies were more important to her.

[51] Risk assessment and the importance of victim intuition. The Domestic Abuse Quarterly Spring 2007.

16.6.2 Work colleagues were surprised to find, on returning from the summer holiday, that Olivia had met Mario and was going to move in with him. Sadly, there was only a short period of time between this and her death and Olivia had not shared much with them about the relationship. There had been a rumour at the school that she had told a colleague Mario had once pulled her hair. The headteacher has been unable to corroborate that remark and the member of staff has left the school. However, the headteacher is certain that nothing else was shared by Olivia of concern to anyone within school about the relationship.

16.6.3 The headteacher has reviewed the school induction arrangements. He has identified that the Staff Induction Statement is clearly weighted towards teaching staff and believes there is an opportunity to more clearly reference associate staff (such as Olivia) within it. He is attending to this.

16.6.4 The headteacher has also identified that within the local authority's Health, Well Being, Work Life Balance and Stress Management Guidance the onus is on work-life balance and work-related stress. There is little reference to the kinds of wider support which might be afforded to colleagues suffering difficulty outside the workplace. He has suggested to the DHR panel that the guidance could be amended to include a short section on the wider support which might be available for employees and then this section referenced within all school's new staff induction processes. The DHR panel are grateful for the headteacher's contribution and will ensure this is incorporated within the learning and recommendations from this review.

16.6.5 From conversations the DHR chair held with Olivia's mother and Mario's parents, it appears they all had pieces of information that might have helped agencies put together a picture of Mario's abusive behaviour and these are set out in detail at section 14.1 of the report. Mario's father says he told several people in authority about his son's behaviour and no one helped. He feels the police should have got a grip of Mario following the 'run ins' he had with GMP. He questioned how many more warnings professionals needed and said he wondered why anyone was surprised about what his son did.

16.6.6 Olivia's mother received a disclosure from her daughter that she had a termination when carrying Mario's child. Olivia told her mother he did not know and said; 'Mario would kill me'. Her mother warned Olivia to keep at arms-length from him. Olivia's mother also noticed changes in her daughter's physical state that correlated with the relationship. Both Mario's mother and Olivia's mother saw the scar that Olivia had on her chest caused by Mario wounding her with a knife.

16.6.7 The DHR panel gave careful consideration as to why this information had not been passed to the police and other agencies. The panel recognised there are many reasons why victims do not always choose to report domestic abuse. However, in this case, the panel believe there were several opportunities when things were said by Mario's parents that could have led professionals to ask more direct questions of them.

16.6.8 Examples have already been provided earlier in this analysis when care coordinators from the EIT were given information about Mario, his relationship with Olivia and risk factors such as excessive consumption of alcohol, separation from Olivia and her pregnancy (see paragraphs 16.2.3 et al). The panel believe these, and other issues, should have been more fully explored by professionals. The onus should not have been upon Mario's parents to explicitly illuminate the risks their son presented. The concern they expressed about his behaviour should have been sufficient to trigger professionals to search further.

16.6.9 Similarly, on the night of 18 November 2016, Mario's mother provided direct evidence that Mario had perpetrated abuse against Olivia. She told this to the social worker in EDT at Rochdale Adult Care. She also told police officers from GMP that Mario had pushed Olivia and 'come at her with a knife'.

16.6.10 The panel have already set out their conclusions as to the way in which this disclosure was dealt with (see paragraph 16.1.20). They repeat their belief: that the way the information was handled was inappropriate. More questions should have been asked of Mario's mother to establish the detail of her disclosure. She could not have been more explicit in what she was trying to tell agencies that night.

16.6.11 Olivia's friend Sarah also held important information. For example, the comment that Olivia said Mario made;

'If you don't have me you will never have anyone else'

The DHR panel recognise that, and similar phrases, have been used in other DHRs that members have reviewed. It is a danger sign and indicates an increased level of risk, albeit, as someone who was not professionally involved in the case Sarah may not have recognised it as such. The DHR discussed the words that Mario used and felt that, if this information had reached an Independent Domestic Violence Advocate (IDVA)[52] they would

[52] An IDVA is a person who is trained to respond to victims of domestic abuse, assess the risk they face and provide them with support and advice about their safety. An IDVA would have been deployed to support Olivia if the risk she faced been graded as 'high' or if a multi-agency risk management conference (MARAC) had considered her case.

have recognised the significance of those words and the risk that Olivia faced.

16.6.12 Sarah had also seen the document on her friend's computer 'What living with Mario is like'. As well as showing Sarah the content, Olivia also described in some detail the way in which Mario wounded her with a knife and threw her on the floor. Sarah pleaded with Olivia not to go back to Mario. She discussed going to the police and says Olivia told her she did not want to get Mario into trouble.

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 the subjects?

16.7.1 Both Olivia and Mario were white and British. Their first language, both spoken and written, was English. The DHR panel did not see any evidence that either of them belonged to a faith group nor subscribed to a specific religion. All the services they accessed were delivered in a way which took account of these factors.

16.7.2 Section 11 of this report has already set out the definition of protective characteristics within the terms of the Equality Act 2010. Both Olivia, in respect of Cerebral Palsy and Mario in respect of his mental health problems fell within the definition of having a disability.

16.7.3 The DHR panel are satisfied the services Olivia received appeared, with one exception, to take account of her disability. The DHR panel are satisfied that the services Mario received all took appropriate account of his mental health problems. The way these services were delivered formed part of the NHS Independent Review referred to within section 16.3 of this report.

16.7.4 The exception in Olivia's case was that the police officers who dealt with her did not appear to recognise the impact of Cerebral Palsy upon her.

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 Olivia or Mario?

16.8.1 Some issues were identified by agencies within their IMRs relating to capacity and resources. The panel are clear that the key issue in this case is not about resources; rather it is about recognising the signs of domestic abuse, correctly assessing risk and taking appropriate actions in response to those risks. Capacity and resources may have been a reason that

influenced some of the judgments made by professionals in this case: they were not the reason that Mario killed Olivia.

16.8.2 There were issues within EIT concerning the movement of staff in and out of the service that led to a change of care coordinators on four occasions. Those changes may have impacted upon the rapport and communication with Mario and with his parents. At the same time the standards of service within EIT changed and there was a significant increase in referral rates. They did not impact upon the ability of EIT to recognise and assess the risk that Mario presented to Olivia.

16.8.3 On 18 November 2016 NWAS faced significant demand pressures. This meant there was a delay in responding to the call made by Mario's mother. The DHR panel recognise that emergency services operate with finite resources and when demand exceeds those resources, judgments need to be made on what is a priority. When the ambulance attended at address the decision the crew made, that Mario did not need to be detained, was not influenced by resources or capacity, rather it was Mario's presentation that was the key issue.

16.8.4 The DHR panel also recognise the demands faced by GMP. On 18 November 2016 they were also under pressure. That resulted in a supervising sergeant deciding not to send a police patrol to address one until an ambulance was available. The panel concur with the author of the police IMR that the decision was made in good faith by an experienced officer who had many other competing demands. However, the panel also concur with the author's view that it was not the appropriate decision because it did not take account of all the relevant factors, particularly mental health and safeguarding issues.

16.8.5 GMP deal with around 67,000 domestic abuse incidents every year. Consequently, their policy is that only medium and high-risk DASH assessments qualify for re-assessment by specialist domestic abuse officers within PPIU. Standard DASH risk assessments are submitted and managed by response officers. This creates practical difficulties as response officers are expected to accurately assess risk in complex domestic abuse cases.

16.8.6 The DHR panel recognise that assessing risk is a complex issue and have already commented upon that in section 16.1 and section 16.2. In this case they do not believe the issue of resources, nor the GMP police on domestic abuse, were factors in the way in which the risk Olivia faced from Mario was assessed on 18 and 19 November 2016.

16.8.7 Rochdale Council Adult Care commented within their IMR that the nature of the Emergency Duty Team Service means that immediate crises are dealt

with as they present. Demand from other referrals has a potential impact, as do limited staff/resources and lone working. The independent mental health review report has considered the approach of the EDT social worker and the decision not to arrange for an assessment of Mario during the night of 18 November 2016 (Appendix B section 6.2.1.5).

16.9 Term 9

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

16.9.1 On 25 August 2016 a midwife submitted a Special Circumstances Form in which information was shared with her GP following the disclosure Olivia made concerning Mario. The DHR panel felt that was an appropriate decision. The DHR panel has commented later at paragraph 16.10.3 about how Olivia's GP dealt with that information.

16.9.2 There are some aspects of information sharing by Adult Care EDT which were poor. On 18 November 2016, information they received from Mario's mother, that her son was a paranoid schizophrenic, was not passed by EDT to NWAS. Neither did the social worker on night duty pass on details of the incident that night to their colleagues in Adult Care to follow up. Adult Care only became aware of what had happened a few days later because they received a safeguarding alert submitted by NWAS.

16.9.3 The DHR panel felt the way in which NWAS shared information was appropriate and in accordance with multi-agency expectations. On the contrary, the DHR panel feel it is disappointing that information was not shared more easily and quickly intra-service between EDT and Adult Care. The DHR panel considers later at paragraph 16.11.5 the way in which Adult Care went on to deal with the NWAS disclosure.

16.9.4 On 13 July 2016, care coordinator 3 visited address one with Mario's mother. During that visit information was disclosed that Olivia was pregnant. Given what care coordinator 3 knew about Mario and his diagnosis, his threat to kill a neighbour and generally chaotic lifestyle there were grounds for making a referral.

16.9.5 The DHR panel heard from the Pennine Care representative that, when being notified of Olivia's pregnancy, the expectation would be for the care co-ordinator to have recognised the risk Mario potentially posed to his unborn child. Liaison would have been expected between the care co-ordinator and universal children's services such as the community midwife and the health visitor at this point to inform a multi-agency risk assessment. It would be discussed whether the initiation of an early help

assessment (EHA) would be helpful in assessing the risk to Olivia and her unborn baby.

16.9.6 The Pennine Care representative believes Olivia could have been supported within that framework to increase her awareness of domestic abuse and the risk she and her baby faced from Mario. If services felt that Olivia failed to recognise the risk of domestic abuse or was not able to take appropriate actions to effectively safeguard herself and her unborn baby, then a referral to children's social care would have been warranted once the pregnancy was viable. This is in line with Greater Manchester Safeguarding Partnership Procedures[53].

16.9.7 While care coordinator 3 planned to make a referral, they did not follow this through because they did not believe that Mario had presented as aggressive to Olivia. It appears to the panel that, in doing so, assumptions were made with no reference to Mario's previous risk history.

16.9.8 The DHR panel believe it was inappropriate for the care coordinator not to have acted in the manner that was expected by Pennine Care (see paragraphs 16.9.5-6). Had the care coordinator followed the safeguarding partnership procedures there might have been an opportunity for a multi-agency discussion to determine how to respond to the needs, wellbeing and safety of Olivia and the unborn child. Had this happened then information from other agencies, such as the police, might have enabled a DASH to have been completed. That might have led to the risk Mario posed to Olivia being appropriately assessed and responded to much earlier. When Rochdale Community Safety Partnership received this report on 22 January 2019, they felt an additional lesson regarding the safeguarding of unborn children was needed. This lesson together with an appropriate recommendation has therefore been included (see lesson 9 and panel recommendation 6).

16.9.9 Discussions should have been held to consider Mario's Care Programme Approach Plus status (CPA plus). This issue is discussed in some detail within the extract from the report of the independent assessment of the care and treatment of Mario (see Appendix B Section 6.2.1.2) and is therefore not repeated here.

[53] Sections: 3.2 Making a Referral to Children's Social Care, 13. Pre-Birth Assessments which indicates a referral would be required where there is risk of significant harm in a pregnancy that has progressed beyond 16+ weeks gestation.

16.9.10 The DHR panel carefully considered the discharge crisis plan (see Appendix C) that was prepared by Care Coordinator 4. A copy of the form was given to Mario and his GP. The panel felt that, overall, the discharge plan was poor and failed to recognise the risks that Mario presented. Page two of the plan contains a section headed 'Triggers/Crisis and Risk Management Plans'.

16.9.11 While the heading refers to risk management, the content of that page contains no reference whatsoever to the issue of risk. The panel felt the plan failed to recognise how unwell Mario was and seemed to be more reflective of someone who suffered from mild anxiety. That was not the case with Mario. He had a tendency to be violent, and this was not recognised anywhere within the discharge crisis plan. The plan failed to identify anywhere that Mario presented a risk to other people. The panel felt that the inclusion of emergency contact numbers was reflective of the fact that the focus of the form appeared to be upon managing Mario and not the risks that he presented to others.

16.9.12 The discharge plan was shared with Mario's GP. However, the panel felt the poor quality of the information contained within the document meant that Mario's GP would not have been alerted to the real nature and severity of the risks that Mario posed to others. Notwithstanding that, the DHR panel felt that the receipt of the discharge plan should have prompted Mario's GP to seek further and better information from Pennine Care about the nature of Mario's illness.

16.9.13 The DHR panel recognised that, since these events, the sharing of information between agencies within the Rochdale area has improved with the introduction of the MASH (see glossary). However, the DHR panel had concerns as to whether the MASH, MARAC and associated processes had access to mental health information or that mental health professionals were invited or represented on these groups. The panel have made a recommendation about this issue (see recommendation 3 section 19.2)

16.10 Term 10

Were single and multi-agency policies and procedures followed and were any gaps identified?

16.10.1 The DHR panel found that all agencies had policies and procedures in place for dealing with domestic abuse. There were some examples when these were not followed, and some gaps have been identified as set out below.

16.10.2 On 25 August 2016 Olivia disclosed information about Mario's mental health to a midwife during an Ante Natal Clinic (see paragraph 15.3.9). The

midwife correctly completed and submitted a Special Circumstances Form. This form was received by Olivia's GP.

16.10.3 It does not appear the GP then considered what was on the form or whether they had any discussions with Olivia to see if she was accessing support or needed signposting to other services. The author for the GP IMR feels it would have been good practice to do this. The DHR panel concurs. They feel that, when inter-agency referrals like this are made, there needs to be clarity as to what the expectations and actions of agencies involved in the exchange of information should be.

16.10.4 Referrals should add value to the safeguarding process and there needs to be a record as to what an agency receiving a referral has done with it and why; even if they have decided not to take any action. The DHR panel makes further comment about referrals in paragraph 16.11.9.

16.10.5 The extract from independent assessment of the care and treatment of Mario (see Appendix B) considers in some detail the way in which policies and procedures were followed in respect of the response to Mario's mental health problems. Gaps were found in the way in which Zoning[54] was applied (section 6.2.1.2 Appendix B) and requirements to carry out a Mental Health Act assessment. There were also gaps in the approach to Mental Health Act Assessment and Adult Care policy and procedures. The analysis of these gaps is not repeated here.

16.10.6 GMP did not identify any significant failures to comply with their policies and procedures other than a failure to comply with their graded response procedure on 18 November 2016. The DHR panel accept the assessment by GMP and feel that the important learning in this case for the police is not about the adherence to policy and procedures: rather, it is about the way in which police officers recognise the indicators of domestic abuse and assess and respond to the risks victims face.

16.11 Term 11

What managerial support did your agency provide to front line practitioners dealing with domestic abuse involving Olivia and Mario and was it effective?

16.11.1 All the agencies involved in this case have arrangements and policies in place in respect of the supervision of front line practitioners. There is evidence that, when dealing with domestic abuse, some practitioners sought advice from their line managers.

[54] Zoning is a term used in the treatment of mental illness. It provides a framework for managing risk, targeting resources, and promoting continuity of care.

16.11.2 For example, supervisors within GMP were involved in reviewing and countersigning risk assessments submitted by police officers in relation to calls concerning domestic abuse. The first of these was on 19 July 2015 when Mario assaulted his father. The second occasion was on 19 November 2016 following the events the previous evening when an ambulance was called to address one by Mario's mother.

16.11.3 On that occasion, having attended at address one, the police officers involved approached their Inspector and sought advice as to their powers. The Inspector felt that, in view of what had been reported and the officer's interactions with Mario, there were no grounds for arresting or detaining him. The Inspector said that, due to the circumstances, it was more a matter for a mental health practitioner to make a more informed approach.

16.11.4 It does not appear that the Inspector was aware of the document that Olivia had shown one of the police officers that night ('What living with Mario is like'). The DHR panel feel the advice the Inspector gave was reasonable, based upon what they had been told. However, the panel believe the fact the conversation was limited to mental health issues illustrates a need to ensure that practitioners and supervisors recognise the links that may exist between mental health problems and domestic abuse. When supervisors are approached for advice by practitioners it should be best practice to ensure they ask appropriate questions about the risks that person presents to others around them and not just the risk the person with the mental health problems presents to themselves.

16.11.5 Another example of the involvement of supervisors in relation to the domestic abuse that Olivia suffered was on 21 November 2016. On this occasion a social worker spoke by telephone to Olivia and her mother following the receipt of the safeguarding alert from NWAS. The conversations concerned the risk that Olivia faced from Mario and whether she needed support. The social worker was told by Olivia that she did not feel she was at risk and that she did not feel she needed any support. In turn the social worker consulted their manager and a decision was made to close the case to Adult Care.

16.11.6 The DHR panel believe the social worker involved took the correct action in seeking views from both Olivia and her mother about the risks Olivia faced and the need for support. While it was important to consult them, the DHR panel do not feel it was appropriate to close the case immediately when they said they did not need support.

16.11.7 Both Olivia and her mother expressed concerns that Mario needed support for his mental health problems. It was clear from the conversation the social worker had with them, that the police and paramedics had not taken

matters any further on 18 and 19 November 2016. It was therefore unclear how Mario was going to receive the support Olivia and her mother felt he needed.

16.11.8 The DHR panel believe that Adult Care should have made further enquiries with mental health services to understand what steps were being taken to assess Mario's mental health and provide support to him and those around him. The receipt of the referral from the police later that day should have been a further trigger that meant contact was made with mental health services and questions were asked as to what action they were taking.

16.11.9 The DHR panel believe it is important that, when agencies make and receive referrals from each other, there should be clarity as to what is being asked or expected. Referrals need to add value to the understanding and response to domestic abuse. If referrals simply become a routine 'tick the box' exercise, opportunities will be missed to assess the risk victims face and to identify gaps in the services they need.

16.11.10 Finally, the DHR panel did not find any examples when practitioners were not able to access support from their supervisors when they needed it.

16.12 Term 12

What lessons has your agency learned?

16.12.1 The lessons learned in this review are set out within section 18 post.

16.13 Term 13

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

16.13.1 The DHR review panel did not feel there were any examples of outstanding or innovative practice in this case.

16.14 Term 14

What services are available to perpetrators of domestic violence in Rochdale?

16.14.1 Rochdale Safer Communities Partnership launched a revised domestic abuse strategy in November 2016. "Sitting Right with You"[55]. The strategy is designed to tackle domestic abuse in Rochdale and features services to support people affected by abuse, as well as offering more help for perpetrators to stop.

[55] https://www.rochdaleonline.co.uk/news-features/2/news-headlines/106489/rochdale-safer-communities-partnership-launches-transformed-domestic-abuse-strategy

16.14.2 Rochdale is one of ten local authority areas within the Greater Manchester area. The primary source of information for domestic abuse services within Greater Manchester is through a web site called "End the Fear"[56]. The web site lists a range of services available to victims, families and perpetrators of domestic abuse. By clicking on a link, users are taken to a separate page which lists services for that user.

16.14.3 The link for perpetrators is titled "Help if you are hurting someone". Following this link takes the user to a page that describes how a perpetrator may feel about their abusive behaviour and encourages them to seek help. Embedded within the page is a link to "Respect", a national help line for those who might be concerned about their own violence or abuse towards a partner. A separate link "Getting Help" takes the user, via one of the ten geographic areas, to a page listing local services.

16.14.3 The DHR panel are satisfied that both the local strategy and the pan Greater Manchester web-site appear to recognise the importance of engaging perpetrators and signposting them to services. In addition, Greater Manchester Police introduced Project Strive in 2016 which is intended to empower police officers to assist victims and perpetrators of domestic abuse[57].

16.14.4 In Olivia's case, the DHR panel did not feel the abuse she suffered would have been stopped nor the risks she faced from Mario reduced, by improvements to the perpetrator programme.

16.14.5 The DHR panel recognised the STRIVE programme contains important elements that will help tackle domestic abuse including, under 'Intervention', specific reference to obtaining support for perpetrators. The DHR panel has already comprehensively analysed the way in which police officers from GMP dealt with Olivia and Mario. They repeat here their belief that, when police officers visited address one on 18 and 19 November 2016, there was a failure to recognise that Olivia was a victim of domestic abuse and that Mario was the perpetrator.

16.14.6 All the signs were there for professionals, particularly the police, to recognise that Olivia was the victim of abuse. Instead much of the focus

[56] http://www.endthefear.co.uk/directory/rochdale/

[57]STRIVE stands for Safeguard - Identify the needs of the victim and flag to the appropriate team/agency; Threat Assessment - What capability does the offender have? What measures are in place to manage threat, e.g. Arrest, civil injunctions, threats to life process?; Re-visit - Revisiting victims to understand underlying issues and triggers; Intervention - Provide early intervention so that victims and perpetrators gain access to support services; Volunteers - Empowering community volunteers to support victims; Engagement - What support has been offered to the victim? Could additional support and engagement with other support agencies keep the person safe? e.g. health / drugs / alcohol etc.

seemed to be upon the mental health needs of Mario. Reference to the presence of a knife, which is a significant factor that increases risk, should have sent a clear signal to all professionals about the need to increase their professional scrutiny of what they saw and heard. The DHR panel believe that, while the presence of the STRIVE programme is to be welcomed, it will only be effective if professionals recognise the factors that should trigger increased professional scrutiny.

17. CONCLUSIONS

17.1 Mario had a history of complex mental health problems. He was known to services for many years. The panel recognise that some of Mario's behaviour, such as his irrational thinking, may have been caused by his schizophrenia.

17.2 The panel do not believe that his schizophrenia was the cause of his pattern of abusive behaviour towards Olivia and his father. The panel take cognisance of the advice from the NHS (see footnote 18 page 21) that there is an incorrect assumption that the condition may be responsible for violent behaviour.

17.3 The panel recognised that Mario misused alcohol. The panel recognised that may have been a factor in relation to some of his behaviour. They do not believe it was the cause of his abusive behaviour. The panel believe the core issue was that Mario wanted to control Olivia.

17.4 In contrast to Mario's abusive behaviour and his desire to control her, Olivia was a kind and considerate person who led a purposeful life. Despite the way Mario behaved towards her, Olivia cared for him and wanted him to receive help. She seemed to put this before everything else.

17.5 Olivia shared the document that she wrote ('What living with Mario is like') with her close friend Sarah. She recognised that Mario was trying to exercise control over Olivia. She also saw the reference within it, to Mario having wounded Olivia with a knife. The panel do not know why Olivia did not take Sarah's advice to come home. There may be many possibilities (see paragraph 16.5.2).

17.6 One is that Mario was controlling Olivia in such a way that she was extremely frightened of him. The fact that he had used a knife on her and inflicted a wound must have been terrifying. She told her mother that Mario would kill her if he found out that she had a termination. The document that she showed Sarah, and later the police, contained a reference to Mario having to kill her. Olivia was also frightened that, if there was any attempt to 'section' Mario, he would blame her.

17.7 July 2016 appears to have marked a significant change in the relationship between Mario and Olivia. It was a point from which there were events that might have allowed agencies to identify domestic abuse.

17.8 One of these was when Olivia visited her GP for a pregnancy consultation. She told the GP her boyfriend was bipolar. The GP did not appear to recognise the need to make any enquiries into the impact that might have

had on their relationship. Mental health problems and pregnancy are two factors that can increase the risk of domestic abuse.

17.9 About two weeks later a care coordinator and Mario's mother visited address two to in an attempt to engage with him. He had been drinking, he had kicked a door in and had threatened neighbours. Those events represented an escalation in Mario's abusive behaviour.

17.10 The care coordinator appears to have recognised there was a risk to Olivia because they advised her to stay away from Mario when he was intoxicated. While they considered submitting a child protection referral that did not happen because the care coordinator did not believe the behaviour was directed at Olivia. Without having completed a thorough risk assessment, such as completing a DASH, it is unlikely the care coordinator or any other agency could have reached a defensible conclusion as to risk.

17.11 The DHR panel believe this was a missed opportunity to assess and respond to the risk that Mario posed to Olivia. The response of the care coordinator, which was to provide Mario's mother with contact details for the alcohol and drugs service was inadequate. It also appears to the panel that a pattern had started to emerge from this point onwards in relation to the response of agencies. That is, the focus was very much upon the needs and care of Mario particularly in relation to his mental health and not upon Olivia and the risks he presented to her.

17.12 From July 2016, there were clear signs that Mario's mental health was deteriorating. The NHS independent review has looked in depth at what should have happened and the issue of zoning (see appendix B section 6.2.1.2). Mario's behaviours were visibly deteriorating yet his risks were not reviewed by the EIT as they should have been and he was not escalated to the Red Zone.

17.13 Instead, Mario was discharged from the care of EIT to his own GP when there was sufficient information available to suggest he should have been retained by them for an assessment of his mental state. Had Mario remained under the care of EIT there would have been continued surveillance of his mental health presentation. Instead it appears to the panel that the agencies that should have been responsible for Mario's mental health simply lost sight of him.

17.14 Despite his abusive behaviour towards them, Mario's parents remained in contact with him and appeared to keep a watchful and caring eye over their son and Olivia. Unfortunately, his parents were not given sufficient information about what the plan was to deal with Mario's mental health needs. The DHR panel also believe that the discharge plan that was

prepared when Mario refused any further engagement with EIT and which was supplied to Mario's GP (see appendix C) was of poor quality and failed to identify the risks that Mario presented to others. While the discharge plan was of poor quality the panel feel it should still have prompted Mario's GP to seek further information about his illness from EIT.

17.15 The first indication GMP had of the relationship between Mario and Olivia was on 11 August 2016 when neighbours alerted them to a disturbance at address one. The incident was correctly recorded as domestic abuse. Olivia was assessed as at 'standard' risk from Mario. The police officer attending did not appear to recognise that the root cause of the argument between the couple may have been around Olivia's pregnancy. The review panel believe this, and the failure to identify other factors such as Mario's mental health, meant an opportunity was missed for the police to seek support from other agencies.

17.16 Maternity Services acted correctly in recognising there were risk factors of domestic abuse when Olivia attended their service on 25 August 2016. She told them about Mario's mental health problems and about him punching doors and banging his head on walls. Sending the 'Special Circumstances' form to the GP was in line with policy.

17.17 It does not appear there was any response in the GP practice when that form was received there. The DHR panel believe this represented a missed opportunity by the GP to explore the impact of Mario's behaviour with Olivia.

17.18 The events of 18 November 2016 presented very real opportunities for agencies to act. On this occasion Mario suffered a mental health crisis. His mother recognised the significance of what was happening and contacted a social worker in EDT at adult care. The NHS England independent advisor concluded the overwhelming professional opinion is that the duty social worker could have done more than he did that night to achieve a specialist assessment of Mario; either that night, or in the days subsequent to this. (Appendix B Section 6.1.4).

17.19 Instead, the onus was then placed upon GMP and NWAS to respond. Through a series of telephone calls and conversations between Mario's mother, a social worker and the police it emerged that Mario had attacked Olivia. From the outset the police appeared to regard this as a medical issue relating to Mario, rather than the core issue of the risks he presented to Olivia. That led to the initial delay in the police responding.

17.20 Following further calls from NWAS, which included reference to the use of a knife, police officers attended. The information given earlier was further

reinforced when police officers arrived and were told in person by Mario's mother that he had assaulted his father and come at Olivia with a knife. Olivia showed one of the police officers the document she had written on her computer tablet. This contained references to events that could amount to criminal offences such as Mario cutting Olivia with a knife and threatening to kill her as well as evidence of domestic abuse and controlling behaviour such as hiding Olivia's telephone.

17.21 The police officers who attended that evening have given explanations as to their response to this information. The officers recognised that Olivia had difficulties with her speech and should therefore have known writing was her preferred method of communication. Despite this, the officer who was shown the computer tablet said there was too much going on and so they skim read the document. Police officers also appeared to mistakenly believe that the information concerning the attack on Olivia with a knife related to an incident that had already been dealt with.

17.22 Instead of looking at the risk to Olivia, the police officers appear to have concentrated upon the mental health problems relating to Mario. It does not appear they recognised the signs of domestic abuse. Because Mario's behaviour did not cause either the police officers or the NWAS staff concern they did not detain him under the Mental Health Act. The fact the police officers focus was upon mental health, rather than domestic abuse, is reinforced for the panel by their actions in seeking advice from their Inspector about powers of detention.

17.23 In relation to mental health, the DHR panel recognise the difficulties faced by the police on the three occasions they dealt with Mario (11 August and 18 and 19 November 2016). Paranoid schizophrenia is a complex illness. Mario could switch between very irrational behaviour and periods when he appeared to be very lucid.

17.24 That may be why, on the first occasion, the police officer involved did not record the fact that Mario had mental health problems. On the second two occasions it also helps to explain why the police officers and the NWAS staff believed that Mario's behaviour did not appear to present a danger to himself or others.

17.25 The DHR panel conclude that, while mental health problems were a significant issue, this case is fundamentally about the failure to recognise and respond to the indicators of domestic abuse that were present on 18 November 2016. The criminal justice system was the appropriate response to these indicators. Not mental health legislation.

17.26 Although Mario was not seen that night by any mental health professionals, an assessment of him should have been highlighted as required within the next few days, and under the Mental Health Act if necessary. The independent mental health review concluded that no mechanism was put in place to ensure further attempts were made to assess and clarify Mario's mental state. This represented a serious breach in safe practice procedure (Appendix B Section 6.2.1.5).

17.27 When adult care spoke to Olivia and her mother on 23 November they asked direct questions about whether Olivia felt at risk. She said she did not feel she was, and that she was staying at her mother's address until Mario received support. Adult care did not make any enquiries to establish whether that was the case. In fact, as set out about above, there were no arrangements in place for Mario to receive support.

17.28 Because there was no approach to Mario by any mental health professionals after 18 November 2016, her mother says Olivia assumed that everything was okay, and it was safe for her to return to Mario at address one. The DHR panel cannot reach any conclusions as to whether the presence of optimal social care and mental health might have had an impact upon Mario's subsequent behaviour towards Olivia. Neither can they reach a conclusion as to what caused Mario to attack and kill Olivia.

17.29 In the final analysis, the DHR panel believe that, while there are issues in relation to the way in which agencies dealt with Mario's mental health, the overwhelming learning from this DHR concerns the failure to recognise domestic abuse and to use the criminal justice system in response.

18. LEARNING IDENTIFIED

18.1 Agencies Learning

18.1.1 Greater Manchester Police

- Recognition of disability and mental health problems;
- Inter-agency communication and information sharing;
- Resources.

18.1.2 Heywood, Middleton and Rochdale CCG

There was no disclosure by Olivia that she was at risk of Domestic Abuse however all staff should consider the needs of all household members, along the "Think Family" ethos and ensure that appropriate signposting takes place for other household members.

a. The wider workforce needs to learn from this review and lessons learnt to be disseminated to the wider workforce.

18.1.3 Pennine Care NHS Foundation Trust Early Intervention Team

1. a) To ensure staff are able to competently recognise and identify domestic abuse and act appropriately to address in line with a multi-agency approach and Trust policy.

   b) To ensure the staff supervision process is robust and prompts/challenges and supports staff in the course of their work.

   c) To ensure Zoning is an integral function embedded within the teams supporting individual staff though a whole team approach to identify and manage those individuals with the most complex and high-risk behaviours.

   d) Training to include;

   Risk management—longitudinal risk history to inform current risk formulation. Trust already provide Enhanced Risk Formulation training which will be reviewed to establish if this needs to be adapted to address issues re domestic abuse and longitudinal risk.

   Enhanced Dual Diagnosis training is already commissioned by the Trust To ensure all relevant staff grades attend.

   Domestic Abuse within the context of the toxic trio.

   Clinical Skills –to equip staff with the necessary skills to manage risk within complexity and aid clinical decision making—this has already been discussed and identified as a training need within the Trust

learning needs analysis. To enhance clinical judgement and reduce reliance on subjective information.

e) To ensure CPA policy is followed;

- Family/ significant others are involved particularly in the discharge process to enable their view to be considered and taken into account.
- Standards re frequency of contact to be reviewed in line with Non-Engagement policy.

f) To ensure transition policies are reviewed to ensure that transfers between teams are safe and patient focused rather than process driven.

Work is currently underway to develop a transfer policy between EIT and CMHT.

g) To establish community managers meetings between CMHT and EIT to enable discussion re complex casework, joint working for safe and planned transfers and skill sharing for the benefit of the patient.

Dates for these meetings have now been arranged.

18.1.4 **Rochdale Borough Council Adult Care**

1. a. All duty staff should consider the needs of all household members, along the "Think Family" ethos and ensure that appropriate signposting takes place for other household members.

   b. Staff should not make presumptions that other teams are involved without checking.

   c. There is a need to review management oversight of EDT in relation to quality of practice, training needs and supervision.

   d. The wider workforce needs to learn from this review and lessons learnt to be disseminate to the wider workforce

   e. Standard operating procedures for duty need reviewing.

18.1.5 **North West Ambulance Service (NWAS)**

NWAS have identified some learning from the safeguarding concern that was raised and are holding an internal learning review.

18.2 The Domestic Homicide Review Panel's Learning

18.2.1 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 in bold in the header. Each piece of learning includes a narrative that provides the context for that learning. The DHR panel has not repeated the learning nor recommendations from the NHS independent mental health review which is being dealt with through their processes.

Panel Learning One (Agency recommendations 1-4)
Learning
GPs need to undertake more probing and consider wider issues when they receive important information that might indicate that a patient is at increased risk of domestic abuse.
Narrative
During a visit to see her GP, Olivia disclosed that she was pregnant and that her boyfriend was bipolar. Pregnancy and mental health problems are two factors that can increase the risk of domestic abuse.

Panel Learning Two (Agency recommendations 6 & 7)
Learning
Professionals needs to recognise the factors that may increase the risk of harm from domestic abuse. They need to be able to assess that risk using a recognised model (or be able to identify someone in their organisation who can) and provide appropriate referrals to agencies that can help respond to that risk.
Narrative
A care coordinator visited Mario with his mother. The coordinator received information that Mario had misused alcohol, had kicked a door in and had threatened to kill a neighbour and that Olivia was pregnant. The care coordinator advised Olivia they should stay away from Mario when he was intoxicated, and they gave his mother details of the drug and alcohol service. They did not conduct a risk assessment on Olivia nor offer to provide any referrals to other agencies that might be able to support her.

Panel Learning Three (Agency recommendations 1-4)
Learning

When agencies receive information from another agency which might identify a person is at increased risk of domestic abuse they should have a plan to deal with that information which includes recognising and responding to any risk. It is not satisfactory simply to leave it on a file.
Narrative
Maternity services received a disclosure from Olivia that Mario had mental health problems, was punching doors and banging his head on walls. That information was sent to Olivia's GP. The GP had already received a disclosure from Olivia that her boyfriend was bipolar. This new information indicated that his behaviour had escalated and hence the risk to Olivia from domestic abuse had also increased. The GP did not appear to do anything in response to this information.

Panel Learning Four (Agency recommendation 15 & 16)
Learning
Professionals need to 'think family' and recognise all the factors that are present that may impact upon the levels of risk of domestic abuse including mental health and pregnancy.
Narrative
GMP were called to a domestic incident at address involving an argument between Mario and Olivia. The incident was recorded as domestic abuse and a DASH completed. However there appeared to be no cognisance of the fact that Mario suffered from mental health problems or that the cause of the argument might have been Olivia's pregnancy.

Panel Learning Five (Agency recommendation 18)
Learning
Professionals need to recognise when there may be a risk to life and ensure that an appropriate response is provided.
Narrative
When GMP received the initial call from NWAS they delayed the response on the basis that there were insufficient police resources and that the matter was a medical issue rather than one that involved a risk to Olivia.

Panel Learning Six (Agency recommendation 17)

Learning
All disclosures concerning incidents of domestic abuse should be explored. There may be evidence of a crime that requires recording and investigation. Professionals need to ask questions, establish all the facts, establish the risks that are present and recognise the appropriate response to take when they receive such information.
Narrative
When police officers attended address one on 18 November 2016 they were told that Mario had attacked Olivia and had used a knife. Olivia showed a police officer a computer tablet with a document she had written that contained information that she had been subjected to domestic abuse, this included controlling behaviour. There was also information that Mario had wounded her with a knife, that he had assaulted her by throwing her to the floor and that he had tried to exercise control over her. The police officers who received the information about the use of the knife erroneously believed the matter had already been dealt with. The officer who read the document stated they only skim read it.

Panel Learning Seven (Agency recommendations 6-10)
Learning
When reviewing and assessing the mental health of patients, professionals need to ensure that they do not just concentrate upon the needs of the patient and the risks they present to themselves. They should also give consideration to the risks the patient presents to others.
Narrative
The Discharge Crisis Plan prepared for Mario contained no reference to the issue of risk. The plan failed to recognise how unwell Mario was and seemed to be more reflective of someone who suffered from mild anxiety. The plan to be about managing Mario and not the risks that he presented to others.

Panel Learning Eight (Panel recommendation four and five)
Learning
Victims of domestic abuse may choose to hide their abuse from work colleagues. It is important that employers create a culture, and have processes in place, that encourage and facilitate victims to come forward and make disclosures. These processes should also provide guidance to

colleagues who receive disclosures so that they know what to do with that information.
Narrative
The headteacher from the school where Olivia worked identified a need to ensure the Staff Induction Statement is also weighted towards associate staff and that the local authority's Health, Well Being, Work Life Balance and Stress Management Guidance includes information about support which might be afforded to those staff suffering difficulty outside the workplace.

Panel Learning Nine (Panel recommendation Six)
Learning
On 13 July 2016 information was disclosed to a care coordinator that Olivia was pregnant. The care coordinator did not appear to recognise the threat that Mario may have posed to the unborn child and did not make a referral to universal children's services.
Narrative
It is important that professionals recognise when a person poses a risk to an unborn child and when this happens they should always make a safeguarding referral is submitted.

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	Rochdale Community Safety Partnership monitor the implementation of the participating agencies recommendations to ensure they are delivered and that agencies report on the progress they have made towards delivery.
2	Rochdale Community Safety Partnership develop a 'seven-minute briefing' that incorporates the learning from this review which should be shared with professionals from all partner agencies and incorporated within their training plans and processes.
3	Rochdale Community Safety Partnership seeks assurances that the MASH, MARAC and associated processes have access to mental health information and/or mental health professionals are represented at these meetings.
4	Rochdale Borough Council ensures that guidance to teachers and associate staff in school Staff Induction Statements includes reference to domestic abuse.
5	Rochdale Borough Council reviews its Health, Well Being, Work Life Balance and Stress Management Guidance to ensure it includes information about support which might be afforded to those staff suffering difficulty outside the workplace specifically domestic abuse.
6	That Rochdale Community Safety Partnership emphasises to all its constituent agencies that unborn children should be considered from a safeguarding perspective and seeks assurances that the issue is covered in their safeguarding training.
7	That Rochdale Community Safety Partnership considers running an awareness campaign to educate the public, particularly friends and families of victims, so they understand how to respond to domestic abuse.

Appendix A

Glossary

Advocacy After Fatal Domestic Abuse (AAFDA)- www.aafda.org.uk A centre of excellence for reviews into domestic homicides and for specialist peer support.

Anti-psychotic medication-They are a range of medications that are used for some types of mental distress or disorder - mainly schizophrenia and manic depression (bipolar disorder). They can also be used to help severe anxiety or depression.

Body Warn Camera (BWC)-A recording device carried by some police officers that they can activate to record interactions and incidents. The product may then be used in evidence.

Care Plan Approach-The Care Programme Approach (CPA) is a package of care for people with mental health problems. They are entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that is regularly reviewed. The plan is written down and sets out what support they will get and who will give it.

Cerebral Palsy-is a group of permanent movement disorders that appear in early childhood. Signs and symptoms vary among people. Often, symptoms include poor coordination, stiff muscles, weak muscles and tremors.

Clinical Commissioning Group (CCG)- were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Community Mental Health Team (CMHT)- CMHTs support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

Cognitive Behavioural Therapy (CBT)- Cognitive behavioural therapy (CBT) is a talking therapy that can help patients manage their problems by changing the way they think and behave. It is most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.

Crown Prosecution Service (CPS)-Prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales. The CPS is independent, and we make our decisions independently of the police and government.

Domestic Abuse Stalking and Harassment (DASH)- 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. It helps keep victims safe, by adopting a proactive 'you must ask' questions approach. It provides the police and partner agencies with a common checklist for identifying, assessing and managing risk.

Early Intervention Team (EIT)- A specialist team who work with individuals aged 14 – 65 who describe having psychosis episodes or similar experiences. EIT look at the experiences they are having and how it affects them.

Emergency Medical Technician (EMT)-Is a role within ambulance services. Their purpose is to assist in the delivery of high quality and effective pre-hospital clinical care and patient transportation.

Force Wide Incident Number (FWIN)- is an acronym for 'Force Wide Incident Number' and refers to the GMP computer-based system for logging calls and incidents. Each incident recorded generates a unique reference number.

Hundred Families- help with support, information and advocacy after killings by people with mental health problems. http://www.hundredfamilies.org

Independent Domestic Violence Advocate-Is a person who is trained to respond to victims of domestic abuse, assess the risk they face and provide them with support and advice about their safety.

Multi-agency risk assessment conference (MARAC)-Is a regular local meeting to discuss how to help victims at high risk of murder or serious harm.

National Probation Service (NPS)-Is a statutory criminal justice service that supervises high-risk offenders released into the community.

NHS England-Is an executive non-departmental public body of the Department of Health and Social Care. It leads the National Health Service (NHS) in England and has five regional teams that support the commissioning of healthcare services for different parts of the country.

North West Ambulance Service (NWAS)- Provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport.

National Institute for Care and Health Excellence (NICE)-Provide guidance, advice, quality standards and information services for health, public health and social care.

Independent Police Complaints Commission (IPCC)-(Now the Independent Office for Police Conduct (IOPC))- Oversee the police complaints system and investigate the most serious incidents and complaints involving the police.

Paranoid Schizophrenia- Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms. This means the

person may not always be able to distinguish their own thoughts and ideas from reality. Symptoms of schizophrenia include hallucinations, delusions, muddled thoughts based on hallucinations or delusions and changes in behaviour.

Pennine Acute Hospitals Trust (PAHT)-Serves the communities of North Manchester, Bury, Rochdale and Oldham, along with the surrounding towns and villages. This area is collectively known as the North-East sector of Greater Manchester and has a population of around 820,000. The Trust provides a range of elective emergency, district general services, some specialist services and operates from four main hospital sites and community clinics.

Pennine Care NHS Foundation Trust (PCFT)- Pennine Care NHS Foundation Trust was formed in 2002. It provides mental health and community care to people across Greater Manchester. It employs 5,500 staff who provide care to 1.3 million people across six boroughs of Greater Manchester.

Public Protection Investigation Unit (PPIU)- Public Protection Investigation Unit (PPIU) is a specialist unit within GMP. One of the responsibilities of the unit is to review cases of domestic abuse.

Sectioning- is often used as short hand for the compulsory detention of a person under the provisions of the Mental Health Act 1983.

Victim Support- Is an independent charity supporting people who have been victims of crime.

Zoning-Provides a framework for managing risk, targeting resources, and promoting continuity of care, it is a visual system that allows the Multi-Disciplinary Team to quickly identify individual service users across the team's entire caseload who present with increased levels of risk and require additional levels of support; ideally to halt the relapse and prevent admission. The zoning process achieves this through care coordinators talking through their cases and using the risk assessment and formulation to inform and drive the interventions. There are four zones normally, the red, amber, green and black zone. **RED ZONE** represents service users who are considered to be currently at risk or in crisis and whose care requires daily review. **AMBER ZONE** represents service users whose mental health is becoming unstable and who are experiencing a decrease in their level of functioning and maintenance of coping strategies. They may also be presenting with an increased risk of harm to self or others. **GREEN ZONE** represents service users who are stable, are engaging with the services and their planned interventions and are able to utilise effective strategies to remain well. **BLACK ZONE** represents service users who reside somewhere other than their own home e.g. hospital, prison or residential care.

Appendix B

Extract from a Report of the Independent Assessment of the Care and Treatment of Mario
A patient of NHS mental health services

July 2018

Section 6. Findings of the investigation

This section of the report sets out the assessment of the care and management of Mario by the various NHS providers involved. It also comments globally on the events of 18 November which is the area of greatest concern to the families of Mario and Olivia.

The perspectives and opinions presented have been formulated via the following activities:

- assessment of Mario's early intervention records by an independent experienced early intervention nurse, who currently manages an early intervention team in London
- a range of individual and group interviews with members of the early intervention team who knew Mario and provided care to him
- an interview with the team member at who provided a counselling service to Olivia, who was in receipt of primary care mental health support
- an interview with the emergency duty team social worker, who was on duty the night of 18 November
- multi-agency round the table reflective learning event, at which there was representation of all agencies involved in the events of 18 November, including frontline practitioners, team leaders, as well as safeguarding leads, and senior managers. The advocate for Olivia's mother was present at this meeting, alongside the chair of the domestic homicide review.

Additionally, professionals' perspectives have been provided by service managers in each of the relevant agencies which has assisted the overall formulation of the authors understanding of this case.

6.1 What aspects of the care and management of Mario and Olivia was managed well

6.1.1 The NHS mental health trust

Between 2013 and July 2016 Mario's care was reasonable. There were aspects that could and should have been better, including CPA, and the zoning (addressed in the following section). However, there is evidence that care coordinator 1 had a good relationship with Mario's parents, and they report having had faith in her. It seems she managed to engage with Mario, in spite of his reticence regarding mental health services per se.

Care coordinators 2 and 3 also demonstrate their commitment to working constructively with Mario and his parents. Care coordinator 2 was more successful in this, even though she left the early intervention team shortly after becoming Mario's care coordinator.

When Mario's care coordinator was changed, the clinical records show that the required standard of handover was delivered, with the outgoing care coordinator and the incoming care coordinator both meeting with Mario and his mother at her home, which was the usual meeting venue for the service with Mario. This standard was not repeated in relation to the handover between care coordinators 2 and 3, or 3 and 4. The reason for this was that the outgoing care coordinator had left the service before the replacement care coordinator had been appointed.

Medication management:

It is difficult to see what more the early intervention team could have done with regards to achieving a consistency of medication with Mario. They tried him on depot medication, but Mario always drew back from this. Without the necessary factors being present to enable an assessment under the Mental Health Act (1983 updated 2007), and the threshold for a community treatment order not being met, the only lever for the team was one of continual persuasion. The clinical records demonstrate that the team continually made attempts to get Mario to take his medication

6.1.2 The primary care counselling service

In 2016, the Psychological Wellbeing Practitioner worked with Olivia from March 2016 to July 2016, when Olivia disengaged from their service. The focus of the support sessions was to help Olivia cope with symptoms of anxiety and depression, triggered by ill health in a family member and her frustrations in not being heard by close family regarding her suggestions of support for the family member. Olivia did disclose some suicide ideation in this early contact, but also that she had no intent to act on these thoughts. Protective mechanisms were discussed, including:

- presenting at A&E
- using the Samaritans helpline
- attending at her GP practice.

Because of this first assessment, Olivia was placed on the waiting list for ongoing 'face to face' support from the counselling team. Owing to the demands on community based psychological support services, this did not happen until 26 May 2016.

The notes made by the Psychological Wellbeing Practitioner, and her conversation with the independent review team, indicated that Olivia engaged well and was open with the practitioner assigned to support her; revealing that she had stopped her anti-depressant medication because it made her feel tired, and that her anxieties had remained unchanged since March.

The Practitioner undertook to complete the Patient Health Questionnaire[58] with Olivia, a recognised tool for assessing the severity of depression in an individual. Olivia scored 18 on this tool, indicating that she had moderately severe depression at that time. However, the underlying features of this were considered to be manageable via a range of cognitive interventions, with which Olivia was willing to engage.

[58] https://patient.info/doctor/patient-health-questionnaire-phq-9

The Practitioner encouraged Olivia to continue using the gym, as this would help her endorphin levels, and also provided her with a sleep CD to aid with this. Olivia's, aims for herself were to:

- feel happier
- to 'go out' more
- to feel confident about herself,

The Practitioner could not recall the precise detail of the work she did with Olivia, given the passage of time, but she could recall that Olivia reported having an active life previously and that she was no longer pursuing her activities. What the Practitioner was clear about was the use of behavioural activation therapy[59]. One of the activities Olivia would have done is to maintain a behavioural diary, in which she maintained a log of her activities, then, during the session with her therapist, this would form the focal point for discussion.

Her Practitioner recalled that, during the short time she supported Olivia, she did 'come out of herself' more, whereas during the first contacts eye contact was limited. The Practitioner recalls that Olivia also smiled more.

During the third session (30 June 2016), the Practitioner noted that Olivia had not completed her 'home tasks' (this is work such as mindfulness that an individual will be asked to do in between sessions). Olivia was also unable to engage with the agenda for that session as she was upset by a relationship breakup. Although the Practitioner dedicated their session to giving Olivia time to talk about this, Mario's name was not mentioned, though she and the independent reviewers have presumed that it was Mario, based on triangulation evidence from the mental health record.

Olivia's Psychological Wellbeing Practitioner stated with clarity that Olivia never talked about Mario in their sessions. The dominant content was about her family. There was nothing shared by Olivia that gave the Psychological Wellbeing Practitioner any concerns about Olivia's safety.

The meeting on 30 June was the last contact the counselling service had with Olivia. She cancelled further appointments, which coincided with the discovery of her pregnancy in July.

6.1.3 The Ambulance Service

The Ambulance service were only involved in the antecedent chronology leading to Olivia's death on 18 November 2016. From the point at which a call was first placed to them, to the point at which one of their crews attended at Mario's house to make a determination regarding Mario's presentation and the need, or not, for a more specialist mental health assessment, the service acted appropriately and in line with their policies and procedures.

It was a period of many hours from the first call to attendance at Mario's home that night. This was because of the high volume of calls experienced. Rightly, the service responded to the life-threatening cases first, which was why the green rated call relating to Mario took so long to be responded to.

[59] It is one of many functional analytic psychotherapies which are based on a Skinnerian psychological model of behavior change, generally referred to as applied behavior analysis. This area is also a part of what is called clinical behavior analysis and makes up one of the most effective practices in the professional practice of behavior analysis. For more information: http://www.talkingsense.org/how-we-can-help/our-therapy/individual-therapy/behavioural-activation/

The chronology shows that the ambulance service remained engaged in the scenario. At just after 9pm, when the ambulance service spoke again with Mario's mother, they contacted the police directly because of what they heard in the background; including a woman screaming, a man, presumed to be Mario, sounding very paranoid to the extent that his mother had to leave the building to complete her call to the ambulance service. It was because of the ambulance service's due diligence that the police attended at the home of Mario, and the safe escort of his mother and Olivia was achieved that evening.

These features meant that the ambulance service was not prepared to close the case until a crew had attended in a clinical capacity, to assess whether it was safe for Mario to remain at home without any mental health intervention that night.

Although the paramedics and Emergency Technicians are not psychiatrically trained, they are trained in the basics of assessing mental state and they attend significant numbers of call outs that have a mental health component. They are, therefore, able to judge if a patient needs to be transported to hospital for a more detailed mental health assessment.

It was not until midnight that an ambulance crew was able to attend at Mario's home, with police in attendance to support them, in view of Mario's history and the recent events of the evening.

It was at this stage that the management team for the ambulance service consider their service could have performed better, the detail of this is set out in the next section of the report.

6.1.4 The emergency duty team

The customer services team and the social worker, on 'emergency duty' the night of 18 November 2016, were the only representatives of adult services that had contact with Mario's family. No contact with Mario occurred.

The social worker on duty spoke with Mario's mother on three occasions during the night of the 18 November, but did not himself attend at Mario's house, or arrange for a specialist mental health assessment of Mario. The social worker involved considers that he acted correctly in the context of his work that evening and the situation described to him by Mario's mother. However, the overwhelming professional opinion is that the duty social worker could have done more than he did that night to achieve a specialist assessment of Mario; either that night, or in the days subsequent to this. This will be discussed in the next section of the report.

With regards to the subsequent contact between adult social care and Olivia, this was reasonable. It was established that Olivia was at her mother's house and that she had no intention of going back to live with Mario until he was receiving professional help from mental health services. It was also established that she did not require further support at that time, and was advised what to do if she changed her mind.

Given that she was saying 'all the right things', coming across as sensible, and that this was the first contact she had with adult social care in the context of possible domestic abuse, it is difficult to see what other concrete actions the adult social care service could have carried out for Olivia at this time.

Concerning the issue of Mario, there is an improvement opportunity for the way the service responds to domestic abuse concerns, with specific regard to:

- the issue of the steps taken to assess mental health
- re-engagement with services cases where both individuals are involved or have recent engagement with specialist health and/or social care services.

6.2 The aspects of the care and management of Mario and Olivia that should have been better

There are no aspects of the care and management of Olivia, by the counselling service, that the independent process has identified as requiring improvement. The professionals who met with Olivia delivered a good service within the time constraints imposed.

There were however, several aspects of Mario's management that could, and should, have been better than they were.

6.2.1 The NHS mental health service

The core aspects of care and management that fell below the expected standards required were:

- the lack of effective handover of care coordination responsibility between care coordinator 2 and care coordinator 3, and care coordination 3 and care coordinator 4
- the assessment of Mario's risks and the ineffective utilisation of what is called 'zoning',
- a missed opportunity for raising a safeguarding alert in July 2015
- the discharge of Mario from the early intervention team, with specific reference to the:
    - discharge itself
    - non-engagement with Mario's parents as active partners in the discharge
    - crisis management plan.

6.2.1.1 The ineffective handover between care coordinators 2 and 3, and 3 and 4.

It is a core part of the care programme approach that at the points of discharging a person from a service, or handing over care coordination responsibility, the handover process must be underpinned by comprehensive sharing of information; including background details, relapse signatures, risks, key interventions, medication, and aims and objectives of care.

This did not occur between care coordinator 2 and care coordinator 3. It also did not occur between care coordinator 3 and care coordinator 4. The main reason practice standards lapsed appears to have been as a result of care coordinators 2 and 3 having left the early intervention team prior to the reallocation of care coordination responsibility. This meant they were no longer working for the team when the new care coordinators were appointed. Normally, in such circumstances, the team leader would absorb this responsibility. However, at the time it seems that the early intervention team were in flux, with a lack of clear leadership owing to ill health.

Prior to the commencement of this independent process, the team had been allocated an interim part-time team leader to provide it with the stability the team required. Although this individual's assessment of the team was one with close working relationships, that was

supportive of each other, with generally good standards of record keeping and practice, she also identified "that the principles and application of CPA and section 117 responsibilities were not comprehensively understood by the team and were not embedded in practice. Discharges and reviews were generally conducted with the client, care co-ordinator and consultant with limited consideration given to inviting the family, GP and other carers and agencies involved in the client's care. Discharges were not planned appropriately and did not consistently follow the principles and guidance of CPA."

This observation of the interim-team leader, coupled with what the early intervention team told the independent investigation team at interview, enables an understanding of how Mario's parents were excluded from the discharge planning process. The care coordinator responsible at this stage (4) also advised the independent team that he had newly joined the team from the forensic service, where they were precise about confidentiality. In his experience, a service user would normally give their express consent for sharing information with other family members or significant others. When he took over as care coordinator in the weeks leading to Mario's discharge from the early intervention service, he had read Mario's records to inform himself of the history, risks, and current situation etc, and nowhere did he see any formalised consent provided by Mario allowing him to divulge information to his parents; therefore, he did not share any. Had there been anything in the records that indicated that Mario had given his express consent for information sharing then he would have done so. Had he been able to have a constructive conversation with Mario himself, it is more than likely that his approach to the discharge planning would have naturally involved his parents, as he now appreciates, because most meetings with Mario occurred at his parents' home. However, Mario was clear in his wish for no communication with the early intervention team and did not engage in constructive conversation.

6.2.1.2 The assessment of Mario's risks and the ineffective utilisation of 'zoning',

Overall, Mario presented with low level risks associated with his alcohol intake. There were, however, two incidents in 2016 which ought to have prompted a more careful assessment of him in respect of the risks he posed to himself or others. There was one incident in 2015 which indicated a transitory rise in Mario's risks, which related to an altercation he had with his parents over money; during which he assaulted his father and was arrested by the police (no charges were pursued).

The next significant behavioural incident was on 13 July 2016. Mario was disengaging from the early intervention team and did not attend at his mother's house to meet with care coordinator 3. She and Mario's mother went to his home to see if he was there. On arrival, the scene they encountered was one indicative of deteriorating mental health and excessive alcohol intake. Olivia was present and pregnant.

Care coordinator 3 managed the situation on the ground well. This was her first community based post. When Mario was refusing to speak with anyone, or get out of bed, she went to his room to speak with him about his current situation. The records also show that she spoke frankly with Olivia, advising her that when Mario was drinking alcohol in excess that she ought not to be around him. The records show that Olivia told care coordinator 3 that she would not be living with Mario. The records also show that care coordinator 3 told Mario the risks to fatherhood and his contact with his child if he continued to drink harmfully. Care coordinator 3, on this day, noted that she would progress a safeguarding referral.

It is also noteworthy that care coordinator 3 had increased Mario's risk categorisation from the green, low risk, zone to the amber, medium risk, zone because of his erratic approach with his medications and his low engagement with the service. The independent team were somewhat surprised that, following the events of 13 July, he was not escalated to the red zone. His behaviours were visibly deteriorating, and his desire to have no contact with mental health services was more strongly stated. Furthermore, he was in a relationship with a young woman who herself was vulnerable.

Care coordinator 3 told the independent team that she had considered raising Mario's profile at the zoning meeting. She had previously tried to do this and had been advised that they only discussed service users ranked as high risk. She felt this had been communicated in a way that deterred her from speaking further at the meeting. One of the Band 6 registered mental health nurses has confirmed that it is possible care coordinator 3 found staff a bit gruff with her. At the time, care coordinator 3 had some memory retention and concentration issues that were not known about or understood by the wider team. Consequently, they developed a low tolerance level for what appeared to be repetitive questions asked by her. This coupled with a misunderstanding of how zoning was effectively used led to Mario's risks not being reviewed by the team as they should have been.

The interim team manager had identified issues relating to practice around zoning and risk management. The independent team asked this individual to set down her observations and reflections, and what actions were being taken to improve practice. Her narrative revealed: "Zoning was undertaken every morning, however, only clients who were placed in the Red zone were discussed. The meeting took place in the largest of the staff offices at desks with other staff stood around, and there was noticeably no zoning board. At that time, there was limited discussion about the clients placed in Red zone, and often it was identified that there was "no change". The team did not discuss clients placed in any other zones and risks were not discussed in any detail. There was no discussion around risk formulation, nor was there any discussion about any changes required to care plans to manage the identified risks and to enable positive change to occur".

A significant influencing factor to zoning not being applied as it ought to have been by the team was a lack of:

- standard operating policy for this process across the Trust
- trust wide training and ongoing assessment of practice.

The lack of accurate application of zoning principles and practice was not because of a lack of commitment in the early intervention team. The senior nursing staff who led this process believed that they were doing it correctly.

6.2.1.3 A missed opportunity for raising a safeguarding alert in July 2015

Linked with the above was a missed opportunity for making an early safeguarding referral for Olivia in respect of her pregnancy and the safety of the unborn child, considering Mario's deteriorating mental health.

At interview, care coordinator 3 was consistent in her assertion that it was her intent to do this. On discussion with more experienced and senior colleagues she was advised that this

was not necessary, as Mario was making no threats towards Olivia. The independent team asked a band 6 nurse, who gave advice to care coordinator 3, about this and she was equally clear that her advice was to proceed with the referral. It is inconceivable to her that she would have advised differently; she knew Mario, as she had been his initial care coordinator (care coordinator 1) and the behaviours displayed on 13 July demonstrated a significant deterioration, in her experience of him. The fact that Olivia was in the first trimester of her pregnancy underlined the need for a safeguarding referral.

How the miscommunication occurred between care coordinator 3 and her colleagues is not fully understood. Some factors are thought to have been:

- personality issues among some team members at the time
- a lack of team tolerance for the concentration and memory issues being experienced by Care coordinator 3 over this time
- the concentration and memory issues being experienced by care coordinator 3, resulting in a sometimes-muddled recall of information or advice she had been given.

The interim team manager reported that her initial impressions about the team's approach to safeguarding were that they generally made appropriate referrals around safeguarding, both for adults and children. However, they were not always fully aware of the risks, especially around the impact of mental health on safeguarding children.

Note: there have been a range of stories about Olivia's pregnancy since the commencement of the domestic homicide review process. It seems that Olivia may not have been pregnant in July 2016. There is clinical information available that indicates a positive pregnancy test, and then subsequent tests indicating that she had miscarried at an early stage in her first trimester. The facts of what happened cannot be determined as Olivia is no longer able to share these. Whether she was, or was not, pregnant does not materially affect the required consideration of the safeguarding actions. At the time staff believed Olivia to be pregnant, and that was sufficient.

In the context of losing the unborn child, and at such an early stage in pregnancy, it is very unlikely that any safeguarding actions would have been taken even had a referral been made.

6.2.1.4 The discharge of Mario from the early intervention team

There are two aspects to this, the discharge itself, and the non-engagement with Mario's parents as active partners in this and the crisis management plan.

At the time, the early intervention team considered there was no option but to discharge Mario. Reasonable effort had been made to try and conduct a CPA handover with the relevant community mental health team, but Mario did not attend those meetings. It would not be customary anywhere for a community mental health team to accept a new patient without being able to assess them. Furthermore, Mario himself made clear his wish to be discharged from the early intervention service, back to his GP.

The issue regarding the lack of engagement with Mario's parents has been attended to in section 6.2.1.1 of this report. There is however, another issue to consider. That is whether Mario ought to have been discharged from the team at all.

The independent team, the service manager for the early intervention service, and the Trust's patient safety lead consider that had the local and corporate approach to zoning been working as it should, Mario would not have been discharged as he was. There was sufficient information available to suggest he ought to have been retained by the team and an assessment of his mental health state achieved, via the Mental Health Act if necessary.

This consideration is important, as it presents a realistic opportunity for a different chronology to have emerged over the months of October and November. That is not to say that the incident with Olivia could have been avoided, but it does mean there would have been a continuing surveillance of Mario's mental health presentation, leading to enhanced clarity regarding his mental health state. It also means it is more likely than not, that a robust response would have been made in the days following the events of 18 November 2016. This, on the balance of probabilities, would have included an assessment of Mario under the Mental Health Act (1983 updated 2007) if he remained unwilling to allow mental health professionals to assess him.

Significant contributors to Mario not being retained by the team are:

- standardised practice in early intervention services, to discharge to a community mental health team or GP at the end of the three-year contact period
- the incomplete application of zoning and risk management practices within the Trust and early intervention team at the time.

Of these, the most significant was the lack of effective utilisation of zoning principles and practice.

6.2.1.5 The decision not to arrange for an assessment of Mario at his home during the night of 18 November 2016

On the night in question, the duty social worker was working in what is termed a 'lone working' capacity. He was the only social worker on duty for the borough covering adults and, thus, was taking receipt of all emergency calls pertaining to adult social care. There was another social worker on duty acting similarly for children's social care.

During the night of 18 November, there were 10 referrals to adult social care, of which three were classified as high risk.

Time referred	Referral type	Time spent (mins)	Rated
16:45	Request to progress Sec 5:2 to Sec 2	20	Low
16:45	Request for Sect 2 on the ward – passed to AMHP Sat 19th	10	Low
16.48	Call centre referred concerns raised by Mario's mother and call made to her by social worker		High

17:00	Welfare visit request over weekend – elderly female	10	Low
17:51	Homeless referral from Crisis team	25	Medium
18:32	Homeless referral (service user self-referral)	20	Medium
19;20	Follow up call to Mario's mother		High
21:24	Homeless referral from police female fleeing DV	40	High
22:00	The ambulance service contacted EDT re. escalation of concern regarding Mario		High
22:30	Follow up call to Mario's Mother		High
22:59	Self-referral – suicidal male	45 mins	High
02:15	Referral for 136	30 mins	Low
05:20	Update on 136	10 mins	Low

The total time spent attending to the calls relating to Mario was two-and-a-half hours.

The line manager for the duty social worker was asked whether it was possible for the duty social worker to have attended at Mario's home that evening. Her response was: "It's difficult to judge as an outsider what one would have done on the evening without being in the throes of other work coming through whilst also taking into account the conversation with police that Mario's presentation had calmed down. However, I think on the face of it when this was first referred at 16.45 knowing the police were attempting to visit the property at some point that evening, given the presenting situation I would have attempted to try and co-ordinate an assessment with them and establish [doctor's] availability. The other work could have been picked up on return to office, although we can't predict what other emergencies may have filtered through. Also, [we need] to consider the amount of time the [Mario's] assessment may have taken/bed issues etc. that could have delayed other work being completed to time scales i.e. homeless pregnant female at 21:24 and suicidal male referred at 22.59. Had he gone out these may not have been dealt with in timely fashion.

I also think had it not been possible to arrange an assessment that evening I would have most definitely passed this on to the next AMHP on Saturday morning to pick up, if only to speak with the [mother] and obtain her views of [her son's] presentation the day after and whether she was likely to see him over the weekend, establish when he was last seen by GP or any other professional, I wouldn't have closed it down completely."

The perspective of the social worker's line manager is echoed by all professional groups involved in this case, as well as by the independent mental health advisor to the author of this report.

Looking at how the situation unfolded over the night of 18 November, it seems that Mario calmed quickly after the first referral was received. There was a concerning telephone call at 21:00, which was recorded by the ambulance service. On arrival, the police assessed both the situation and Mario as calm. It is unlikely, therefore, that a Mental Health Act assessment would have been pursued that night, but onwards referral and follow up was required.

The question, then, is why the duty social worker did not read the situation similarly on the night. At interview, the information he provided makes clear that he was concerned about the case and, therefore, advised Mario's mother to call an ambulance. He was, he asserted, aware that the ambulance service would seek the support of the police.

Other factors influencing the duty social workers perspectives and actions on 18 November were:

- Mario was at home, safe, and not posing a present threat, as he was on his own; there were no concerns about his immediate personal safety
- if police and ambulance arrived at Mario's home and he refused transportation to hospital, and appeared mentally unwell, this would have triggered communication either with the control centre at the ambulance service and further communication with the emergency duty team, and/or a call to the rapid assessment team in the emergency suite at the local accident and emergency, who would have provided advice
- without the police in attendance, based on the history he had obtained from Mario's mother, the social worker would not have been able to do anything and, as he was working in a lone-worker capacity that night. it made more sense for him to wait to see how the situation unfolded
- the social worker checked the adult social care system, ALLIS, for information about Mario; there was none. The next steps are to check the mental health system. PARIS. However, the social worker had no access to PARIS that night. This was because either i) he had not had to access the mental health system in four weeks and/or ii) he had not updated his password. If one does not access PARIS every 30 days, then one is automatically locked out of the system. Normally, in this circumstance, the social worker would seek information from the crisis team who are located next door to the emergency duty team. However, on that night there was no-one available, so this was not possible. On discussion, the social worker agreed that he could, with the benefit of hindsight have contacted the rapid assessment team, however, in his experience, to do so would be unusual.

Part of the investigation process was a multi-agency round-table event which included representation from:

- the local county council
- the local mental health NHS Trust
- the regional ambulance Service
- the advocate for Olivia's family
- the local police service
- the local clinical commissioning group.

This event raised a number of issues:

- why Mario's mum was recommended to call an ambulance – for what purpose?
- why the request of the nearest relative (Mario's mother) for a Mental Health Act assessment of her son was not recognised by the emergency duty social worker.

The recommendation to call an ambulance was made during the first telephone call the emergency duty social worker had with Mario's mother, at 17:10 on 18 November, which was 20 minutes after the customer services call centre referred the call to him. In this 20-minute period Mario had calmed; Mario's mother advised the duty social worker of this. At

this point Mario's mother continued to assert that her son required hospitalisation, for treatment and to be recommenced on his medication.

Although the duty social worker believes his decision to advise her to call an ambulance at this stage was reasonable, he is the only professional involved in this case who has this perspective.

A range of professionals, including the independent advisor to the author of this report, consider better approaches would have been to:

- arrange an assessment of Mario by the emergency duty team social worker, with the support of the police and possibly the duty GP; there were sufficient features of concern to have justified this
- request the out of hours doctor to attend at Mario's home with police support
- once the police had attended because of a concern about risk escalation at 21:00, due to potential risk to Olivia and Mario's mother, and on the police's decision to leave Mario at home because he seemed calm and no action was required by them, to have suggested that Mario's mother encourage Mario to go to A&E for an assessment either via taxi or home transport (low probability of success)
- with Mario's consent, an access and crisis assessment could have been initiated (low probability of success)
- across the multi-agency community there is a general sense that it was not appropriate for the ambulance service to have been 'left holding the fort' regarding trying to gain a clinical insight to Mario's mental health state, given the complexity of the situation.

Regarding the non-action in response to a request from the nearest relative, a key concern for a range of professionals from these agencies was why the duty social worker had not recognised the request by Mario's mother as a nearest relative request for assessment, that her son be detained in hospital.

The emergency duty team professional was unable to interpret the request in this way, and unable to appreciate what seemed plain to other professionals in the room, that Mario's mother wanted her son assessed.

This gap in professional opinion remains at the time of writing. Despite this difference of opinion, the realistic timing of such an assessment is less clear. Reviewing the chronology as it unfolded that evening, there was no urgency to conduct a specialist assessment of Mario that night, and it is unlikely that he would have allowed a Mental Health Act team into his home. His presentation, whilst paranoid, was calm, and it is unlikely that an application for a warrant to enter his home would have been made that night.

What is more likely, and represents what should have occurred, is:

- mechanisms ought to have been put in place to ensure the follow up of Mario the following day, to try and gain a better insight as to his mental state
- based on the reported history, if he continued to refuse access to enable this to happen, then serious consideration should have been given to achieving this via the conduct of a Mental Health Act assessment (1983 updated 2007), under warrant and with police support.

That no mechanism was put in place to ensure that further attempts were made to assess and clarify Mario's mental state, represents a serious breach in safe practice procedure.

The team manager for the emergency duty team was asked about the options for onwards referral, specifically when an individual requires assessment but it is not achieved within the span of duty for the emergency duty professional. The author of this report was also interested in referral routes for emergency duty staff.

The following information was received from the team manager for the emergency duty team, and is relevant to the understanding of what was, and was not, possible on the night of 18 November, and in the days after. The emergency duty team do not have a direct referral pathway to GP surgeries. Ordinarily, emergency duty team staff would signpost a service user to make an appointment to see their GP if the initial referral to emergency duty team was considered not to be an emergency.

In this case, although recommending self-referral to the GP was unlikely to be effective for Mario, it was possible for the emergency duty team social worker to have made a record on ALLIS, that primary care follow up was required, but that adult care needed to initiate contact with the GP surgery, owing to the high risk of Mario not doing so. The Adult Care duty worker would then read this at the start of normal business hours and follow up actions as requested by the emergency duty worker.

The emergency duty worker also has the option to discuss cases with the rapid assessment team, where people present as requiring a mental health assessment (not Mental Health Act Assessment). However, there are no direct referral pathways to the rapid assessment team, other than advising a patient to present at A & E for assessment. The rapid assessment team will see a person after they have been triaged by A & E staff, should this be necessary.

The emergency duty team are aware of the street triage function, however, there are no current pathways for the emergency duty worker to refer to this service, other than directing people/patients to A & E, where they will be triaged first via A & E liaison and referred to rapid assessment/Street Triage if appropriate. It is the understanding of the independent author that the police have strong links with street triage; where police become involved in incidents in the community, or in a public place, where people are found to be mentally unwell/high risk to self and others, police can consider contacting street triage (attached to rapid assessment team) to discuss their views and arrange an assessment. This meets the guiding principles of the Mental Health Act 1983 (as revised 2007) use of least restrictive options and intercepting the use of police powers under Section 136. Although it is not established practice for emergency duty team (EDT) professionals to contact the rapid assessment team, had there been a consideration of this, to access relevant information about Mario, then the EDT practitioner would have been able to access his PARIS records. This would have revealed Mario's past history, and most recent history, and may have influenced a different level of response to that which occurred on 18 November 2016.

Technically, there was the option of assessment by the crisis team. However, this would have had to have been achieved by 21:00, and Mario was unlikely to have provided his consent for this given his refusal to engage with the police or the ambulance service that night. Furthermore, because the referral met the grounds for a Mental Health Act assessment, this would have exceeded the remit of the access and crisis team.

The manager agrees that considering the information communicated by Mario's mother, and her son's apparent calmness, as considered by the police, an emergency Mental Health Act

assessment may not have been necessary on the night of 18 November. However, a range of actions should have been taken including:

- setting down in writing for Mario's mother, as nearest relative, the reasons why a Mental Health Act assessment was not conducted on the night she requested it, and why no recommendation was being made for it
- keeping the referral open on the emergency duty system and signposted to the Approved Mental Health professional, who would have picked it up the following day, on a handover, at 08:00 on 19 November
- emailing the referral to the emergency duty community teams centralised address, for the attention of the duty Approved Mental Health Professional on Monday 21 November
- the emergency duty social worker could have assigned the notification to the adult duty tray for Monday 21 November. Although this social worker did add a case note it was not assigned to the tray. This meant it was not read by the adult care duty worker.

Even if a decision was made that a Mental Health Act assessment was not required, there would have been the opportunity for a referral to be made to Mario's GP or to the community mental health team or early intervention team.

6.2.1.6 The attendance of the regional ambulance service at Mario's home at approximately 2am on 19 November 2016

The ambulance service was only involved with Olivia's and Mario's pre-incident chronology on 18 November 2016. The actions of this service were mostly reasonable and in keeping with their policies and procedures, including how calls are prioritised and responded to. In many respects, one can consider that a good level of service was provided to Mario by this service. All other involved agencies had stood down once Olivia was away from Mario's home and safely transported to her mother's home. However, because of the history initially provided to the ambulance service, the call was maintained as requiring a response, until someone had been able to determine whether a specialist mental health assessment was required that shift, the night of 18 – 19 November.

The ambulance service managed to dispatch a vehicle to attend at Mario's home at 22:51, with it being at the rendezvous point at 00:02. The crew were being accompanied by police colleagues.

The statement obtained from one of the attending ambulance technicians advises that when the ambulance crew and police attended, Mario came to the door. Because of the passage of time, the ambulance technician was only able to recall that:

- Mario's demeanour did not cause her any undue concern
- there was nothing 'out of the ordinary or unusual about him'.

The technician reported that she was certain that she would have acted if there had been anything untoward or concerning. The technician is also clear that neither she, nor her colleague, would have left the scene if they had any concerns about Mario; that would be her usual practice. Unfortunately, no patient report form is available to set out the precise details of this crew's attendance at Mario's home. The technician is adamant that she would have completed this as it is part of a crews' normal practice following each attendance. An

audit of the crew's patient report forms for the shift in question was requested by the author of this report, and showed that the report form relating to Mario was the only one missing from the patient contacts on that shift. It seems more likely than not that, owing to the non-contact with Mario other than brief words on his door step, no form was completed, or it was mislaid prior to being submitted with all the other forms.

The professional advisor to the domestic homicide review panel considers that there was a lapse in standards by the crew, as they ought to have contacted the control room to seek advice when it was clear that they could not achieve a meaningful assessment of Mario. The history provided by his mother was significant; a recording of contact with Mario's mother at 21:00 on 18 November demonstrated that Mario could be heard in the background and was clearly paranoid to the extent that his mother had to leave the house to complete her call to the service.

The duty social worker considers that, had he been aware that the ambulance service had not been able to gain sufficient access to Mario to form an informed opinion regarding his presentation, he would have organised an assessment under the Mental Health Act, with police assistance.

Appendix C

Pennine Care NHS
NHS Foundation Trust

DISCHARGE CRISIS PLAN

Full Name:	Mario	**Date of Birth:**	Redacted	**NHS Number:**	Redacted
Address:	Redacted			**Post Code:**	Redacted

Other Useful Numbers:	**Name:**	**Contact Number:**
GP	Dr Redacted	Redacted
Emergency contacts:	**Name:**	**Contact Number:**
Out of hours Advice and Support	RAID Team	Redacted
Out of Hours Mental Health Worker	Ask for Duty Social Worker	Redacted
The Samaritans	www.samaritans.org	Redacted
Emergency Duty Team		Redacted

Discharge Plan Completed on:	09.11.16

TRIGGERS/ CRISIS AND RISK MANAGEMENT PLANS

Please ensure any additional support with regards to Children & Adults is included in this plan

A crisis and risk management plan may be useful when things become too much. Sometimes when people reach crisis they forget that other's can help them. Spending time now with your Care Coordinator / Key Worker to look at what might help if things become really difficult may be useful**.**

How I Know When Things Aren't Going Well	**How Other's Might Know**	**What I Can Do**	**What Other's Can Do**
Feelings of acute anxiety. Fearfulness and feelings of paranoia – being watched.	Phone calls to family in the late and or early hours. Needing to be with others and unable to relax when alone. Restlessness. Being overly suspicious of others. Changes in appetite.	Practice stopping automatic negative thoughts. Think of more rationale explanations for what might be happening. Find useful activity. Use the gym to tire self out and improve mood. Contact available services for support.	Reassure me and acknowledge feelings and voiced fear as anxiety and unmanageable distress. Spend time with me but also reassure me that I may manage alone. Practise positive thinking with me and help me engage with activities to divert thoughts – for example, getting me out of the house. Contact available services for support.

CONTINGENCY PLANS

Contingency planning may help you to know what to do if your usual Carer / Services are not available

In the event of :	Contingency:
In the event that you feel you need additional support outside of normal working hours.	Utilise listed numbers for services on front of care plan, if appropriate. Go to your nearest Accident and Emergency department who are open 24 hours a day, 365 days of the year. Contact your GP for further advice once the surgery has reopened.

~~Copies of My Discharge Plan have been given to~~

Name and Address:	Role	Date:
Dr (Redacted), (Redacted) Road Surgery	GP	09.11.16

Care Coordinators / Key Workers Signature :	**Redacted**

Appendix D Action Plans

DHR Panel Recommendations						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Rochdale Community Safety Partnership monitor the implementation of the participating agencies recommendations to ensure they are delivered and that agencies report on the progress they have made towards delivery.	Domestic Homicide Review Governance Group to review agency recommendations and confirm with agencies when actions have been completed. Domestic Homicide Review Governance Group to conduct deep dive exercise – random selections.	Minutes from Domestic Homicide Review Governance Group, agency audits, training registers, updated policies.	Improved identification, recording and response to domestic abuse. Improved awareness and support for cases involving the toxic trio. Enhanced joint working between teams in relation to domestic abuse and risk. Improved recording and investigation of domestic abuse related crimes	Rochdale Safer Communities Partnership	Sept 2019

2	Rochdale Community Safety Partnership develop a 'seven minute briefing' that incorporates the learning from this review which should be shared with professionals from all partner agencies and incorporated within their training plans and processes.	Domestic Homicide Review Governance Group to agree and produce a 7 minute briefing for this DHR 7 minute briefing to be shared at the Domestic Abuse Strategy Group and all partner agencies. 7 minute briefing to be published on the Rochdale Borough Council intranet for staff to access Domestic Homicide Review Governance Group to liaise with Safeguarding Board and ensure Rochdale Borough Council incorporates this into their training.	Copy of the 7 minute briefing Updated versions of agencies training and processes to be submitted to DHR Governance Group	To circulate learning from this domestic homicide review to wider workforce. Improved practice across partners resulting from updated training processes.	Domestic Abuse Coordinator	Aug 2019
3	Rochdale Community Safety Partnership seeks assurances that the MASH, MARAC and associated processes have access to mental health information and/or mental health professionals are	Rochdale Community Safety Partnership to confirm with chair and managers of these meetings/processes that mental health professionals are represented and/or have access to information is available. If it isn't Rochdale Safer	Process change where necessary. Minutes of meetings reflect attendance of mental health professionals and/or access to information.	Improved inter-agency communication and information sharing. Increased awareness of mental health and high risk behaviour in relation to domestic abuse.	Rochdale Safer Community Partnership	Sept 2019

	represented at these meetings.	Communities Partnership to agree access and/or attendance with mental health partners				
4	Rochdale Borough Council ensures that guidance to teachers and associate staff in school Staff Induction Statements includes reference to domestic abuse.	Rochdale Safer Communities Partnership to liaise with Education Safeguarding Officer and Healthy Schools Teaching and Learning Advisor to check domestic abuse is covered in induction statements and training.	Content of induction training for schools to be submitted. Content of induction statements for schools to be submitted	All school staff to have increased awareness of the impact of domestic abuse on children, how to recognise signs and access support. Induction training: Completed. Further plans for Early Help to roll out 2 hour domestic abuse training specifically for school staff.	Rochdale Safer Communities Partnership Rochdale Borough Council Education Safeguarding Officer Rochdale Borough Council Healthy Schools Teaching and Learning Advisor	Sept 2019
5	Rochdale Borough Council reviews its Health, Well Being, Work Life Balance and	Rochdale Borough Council has a Domestic Violence Policy for employees, this gives guidance to managers about how they can offer support for	Employee Health and Well-being Strategy includes domestic abuse once reviewed.	Employees are more aware of support available to them from work regarding	Rochdale Safety Communities Partnership	Sept 2019

	Stress Management Guidance to ensure it includes information about support which might be afforded to those staff suffering difficulty outside the workplace specifically domestic abuse.	employees affected by domestic abuse. Rochdale Safety Communities Partnership to liaise with Rochdale Health and Work Steering Group to ensure the current Employee Health and Well-being Strategy includes domestic abuse Rochdale Borough Council Human Resources to recirculate guidance to all managers and staff via corporate bulletin.		personal matter in particular domestic abuse. Managers have more awareness of the impact of domestic abuse and what support they can offer employees	Rochdale Health and Work Steering Group Domestic Abuse Coordinator	
6	That Rochdale Community Safety Partnership emphasises to all its constituent agencies that unborn children should be considered from a safeguarding perspective and seek assurances that the issue is covered in their safeguarding training.	Rochdale Safety Communities Partnership to liaise with Rochdale Children's Safeguarding Board to ensure the Domestic Abuse training and Safeguarding Children training make reference to unborn children and give clear guidance for practitioners.	Updated training slides are submitted from Children's Safeguarding Board	Practitioners are clear of action to take in cases of domestic abuse and unborn children Unborn children are protected due to increase in awareness amongst practitioners Increase in safeguarding referrals for unborn children	Rochdale Safety Communities Partnership Rochdale Safeguarding Children's Board	Sept 2019

7	That Rochdale Community Safety Partnership considers running an awareness campaign to educate the public, particularly friends and families of victims, so they understand how to respond to domestic abuse.					

Single Agency Plans

Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG)						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	When a disclosure or threat of violence is identified this must be recorded immediately.	A flag or notification must be displayed on the patient records to prompt staff.	A flag or message is displayed when EMIS record is opened. This will alert practice staff not to disclose details as the individual faces risk from a third party.	Early indicator of domestic abuse will prompt and provide the opportunity to ask for further information and refer to appropriate services.	Alison Kelly Lead designated nurse HMR CCG	31/8/2017

2	GP's will consistently record, flag and chronologies on EMIS (Electronic Patient Record system) disclosures of domestic abuse. Records will clearly evidence discussions held including patient's capacity, risk assessments undertaken and resulting referrals.	Email communication with all GP Practices detailing key learning from this Domestic Homicide Review and record keeping requirements. This will be presented in the form of briefing bubbles Lessons learned, and refection session will be facilitated at the victim's GP Practice to ensure key messages are shared	Audit of GP recording of known cases of Domestic abuse	Improved recording and flagging of known domestic abuse cases.	Alison Kelly Lead Designated Nurse HMR CCG	31.08.2017
3	Bespoke GP training made available for GPs and Practice Staff	All GP practices to be offered bite size bespoke Domestic Abuse training to include Definition of Domestic Abuse Introduction to DASH risk assessment and MARAC GPs responsibilities for recording and sharing information.	Training registers Feedback and evaluation documents	GP's and Practice staff will be alert to indicators of Domestic Abuse & high-risk indicators, responding appropriately to disclosures	Alison Kelly, Lead Designated Nurse HMR CCG	31/8/2017
4	GP's and GP Practice staff will have an increased knowledge	All GP's and Practice staff to receive 'Think Family' Safeguarding training	Audit of Safeguarding knowledge following	GP's and Practice staff will be alert to indicators of Domestic Abuse &	Alison Kelly, Lead Designated	30.04.2017

	base of domestic abuse, risk factors, risk assessment, local support services available and responsibilities for sharing information	(compliant with Level 3 of the Intercollegiate document – Royal College of Paediatrics and Child Health, 2014). This is inclusive of • definition of domestic abuse • introduction to the DASH risk assessment & MARAC • GP's responsibilities for recording, sharing information and referral • Further enquiry and investigation when patient is presenting with injuries which could be indicative of being a victim of Domestic Abuse	delivery of 'Think Family' Training Completed GP Safeguarding Assurance Tool evidencing date of training Training registers	high-risk indicators, responding appropriately to disclosures As above	nurse HMR CCG Alison Kelly, Lead	2016-17 completed 26.02.2017
		GP Safeguarding Contact Pack (which includes referral pathways for Domestic Abuse victims, perpetrators and children affected by domestic abuse)	Safeguarding Assurance Tool is completed in all GP Practices on an annual basis (from 2016) and requires Practices to evidence use of the Safeguarding Contact		Designated Nurse HMR CCG	Ongoing and monitored via

		will be consistently used in all GP practices	Pack and compliance with mandatory training GP's are required to provide evidence that identified actions have been completed	As above Each GP Practice will have a point of contact with enhanced knowledge	Alison Kelly Lead Designated Nurse Safeguarding HMR CCG	Assurance visits/ contact
		Each GP Practice will identify a Domestic Abuse Champion. Champions will receive additional training which will be inclusive of: - • Toxic Trio • Response to Domestic Abuse disclosures and notifications • DASH Risk Assessment Tool and high-risk indicators • MARAC referral process, inclusive of the use of professional judgement to make referrals • Domestic Violence Disclosure Scheme	HMR CCG Safeguarding Team will maintain a directory of Domestic Abuse Champions within each GP Practice			31.03.2018

		• Learning exercise from this Domestic Homicide Review				

North West Ambulance Service						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
5	Hold a learning review with the Support Centre Managers.	Discuss and review the relevance of the language used when taking safeguarding concerns and the way that questions are asked. The Author feels that this is a positive exercise and will enhance future practice in relation to information sharing. The review is taking place in June,	Minutes from the review will be submitted, along with agreed actions.	Better communication between frontline staff and Support Centre staff.	Safeguarding and MH Strategic Advisor and Support Centre Manager	31/08/2017

Pennine Care NHS Foundation Trust Early Intervention Team						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
6	• To ensure robust assessment of domestic situations within	A. Review of current cases matching this patient profile and identify vulnerable significant others,	Evidence of caseload review with agreed actions.	Increased awareness within services of this patient group and vulnerability of others	Donna Edgley	Completed 04.01.2018.

	the patient profile of mental illness, alcohol use and aggressive behaviour.	particularly expectant partners. B. Evidence in supervision of the needs of expectant parents to be risk assessed and managed enabling access to appropriate services. C. Above to be clearly documented on Trust electronic patient record. D. Risk assessment involving domestic abuse / alcohol misuse and mental ill health to be clearly documented	 Evidence of 1-1 supervision with practitioners around complex cases discussion uploaded on to PARIS system. Also discussed in zoning and inputted onto PARIS. New supervision tool presented to the PCFT tier 4 meeting 04.01.18 and is now live and uploaded onto the patient's case notes on PARIS. The discharge crisis plan documentation to be reviewed and updated to include a holistic assessment of risk i.e. safeguarding risk to self and others in the context of mental illness.	due to high risk behaviour.		

		in discharge crisis plans.	 Mental health wellbring and recover			
7	• To consider current training needs of mental health practitioners working for PCFT.	A) Toxic Trio training to be delivered as a bespoke session to the E.I.T team to reflect on this case and enable staff to identify, risk assess and manage effectively. B) Mental health practitioners across PCFT to be signposted to Toxic Trio and / or Domestic Abuse multi-agency training facilitated by their local LSCB / LSAB.	Bespoke training delivered by Specialist Safeguarding Children Nurse to E.I.T 30.07.17.  Toxic Trio EIT.pptx  Toxic Trio Multi-Agency Training Enhanced Risk Formulation training	Increased awareness of staff to be able to competently and effectively manage this client group. 7 minute briefings developed by the RBSCB / RBSAB around toxic trio and information sharing sent out to PCFT mental health practitioners via email to raise awareness of complex safeguarding issues.  7MB Toxic Trio.pdf  7 minute Informaiton sharing.pdf Multi-disciplinary group safeguarding supervision sessions delivered across HMR by	Donna Edgley/ Hayley McGowan	Completed 30.07.2017.

		C) Review existing Enhanced Risk Formulation training to ensure this includes consideration of longitudinal risk.	reviewed 08.06.18 and confirmed that longitudinal risk is included.	the PCFT safeguarding team. This is co-facilitated by Specialist Safeguarding Nurses from mental health and children's community services. The aim is to improve awareness of each other's roles and responsibilities and work together more effectively as per the think family approach.  2017-18 Safeguarding Session		
8	• Establish closer links between EIT and CMHT services.	A) Regular community managers meetings to enhance joint working. B) Development of transition protocol to ensure safe and planned transfer of care between services.	A draft transition protocol has been developed to support joint working between CMHT and E.I.T and is out for consultation.	Enhanced joint working between teams.	Donna Edgley CMHT and EIT managers.	Completed 01.06.2017.
9.	• Review of PCFT policies and procedures	A) Zoning-to ensure consistent approach across Trust	Zoning and CPA plus has been reviewed to include minimum standards and	There will be consistency of	Donna Edgley/ Hayley Mcgowan	

	relating to complex case management.	including recording, frequency etc. B) CPA —to ensure staff are adhering to policy and including carers etc in discussions. Ensure CPA plus is embedded into practice with multi-agency input as required. C) Safeguarding—to ensure all staff adhere to policy, can make effective clinical judgements and work collaboratively with agencies to safeguard those at risk.	expectations of the various professionals involved. Safeguarding cases are regularly discussed in staff supervision and zoning to check and agree appropriate actions to support clinical decision making	application and practice across PCFT. All staff will be aware of policies and procedures, PCFT and multiagency in line with the Greater Manchester Safeguarding Partnership that guide complex case management in relation to safeguarding. There will be increased awareness of different roles and responsibilities for PCFT practitioners working across a range of services to improve collaborative working and improve multi-agency risk assessment.		
10.	• Review of multi-agency processes in place within Rochdale that facilitates joint assessments	A) HMR Mental Health Clinical Risk Lead to consider how PCFT could work more collaboratively with GMP and Adult Social Care to discuss PPI's in the	MAST (Multi-Agency Adult Safeguarding) meetings established from April 2018 at Rochdale police station. PPI referrals are now screened by GMP and any cases where there are identified	The number of inappropriate PPI's being shared with mental health services will reduce. There will be increase awareness of mental health difficulties and the	Debra Sudbury.	Completed April 18.

	and effective care planning.	Early help and Safeguarding Hub (EHASH).	mental health concerns or adult safeguarding issues are discussed at the twice weekly MAST meetings. The MAST meeting is now attended by a mental health practitioner from the Criminal Justice Team.	impact on offending behaviour, including domestic abuse. There will be more effective sharing of information across PCFT, adult social care and the police.		

Rochdale Borough Council Adult Care						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
11	All duty staff should consider the needs of all household members, along the "Think Family" ethos and ensure that appropriate signposting takes place for other household members.	Review Standard Operating procedures for Adult Care duty and EDT to ensure "Think Family" approach is embedded in the expectations for staff. Ensure that this is communicated to staff in team meetings and in 1:1 supervisions	Updated Standard Operating procedures are in place.	Improved outcomes for the individual and all family members and improve risk management.	For Adult Care Duty-Andy Jones with support from Victoria Buckle. For EDT - Jude Brown and Rebecca Moss with support from Julie Urmson.	Mar-16

12	Staff should not make presumptions that other teams are involved without checking.	1. Review systems in place for EDT regarding information sharing, including examination of how EDT integrates with day services. 2. Where MH has been a feature Adult care duty staff must contact MH services to identify which MH team is involved and pass information on. Where no MH team is involved, Staff should make a referral to Access and Crisis Team, SPOE for MH to ensure MH Services have ownership of the case.	1. Improved systems in place that evidence better information sharing and integration that enables more robust risk management. 2. Adult Care to alter SOP and brief staff to ensure that any identified need within the wrap around family is referred to the appropriate referral made where no services identified.	More timely response, with right teams involved to manage risk.	For Adult Care Duty-Jane Myers with support from Andy Jones. For EDT - Jude Brown with support from Julie Urmson.	28-Feb-17
13	To review management oversight of EDT in relation to quality of practice, training needs and supervision.	Review the shared services arrangement of EDT	New model and agreements in place	Functional 24/7 safe service	Rebecca Moss and Jude Brown	Apr-17
14	Learning from this review and lessons learnt to be disseminate to the wider workforce	Briefing to be created on this review and disseminated to staff.	Evidence of training	Improved knowledge and understanding about the importance of "Think Family"	Jane Timson	Apr-17

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
15.	The issues revealed by this IMR in relation to the recognition of Disability and Mental health problems; Inter-agency communication and information sharing and Resources are to be reported to GMP's Organisational Learning Board for assessment. Relevant learning from that assessment to be disseminated across GMP	1. IMR author to submit a report to the GMP Organisational Learning Board. 2. The Organisational Learning Board will assess the issues raised by this IMR and will disseminate relevant learning across GMP.	1. Submission of a report to the GMP OLB 2. Evidence of assessment and dissemination of learning across relevant departments and divisions in GMP	Raised awareness in GMP in relation to: • Recognition of disability and mental health problems • Inter-agency communication and information sharing. • Resources		

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
16.	Professionals need to recognise all the factors that are present that may impact upon the levels of risk of domestic abuse including mental health and pregnancy. Narrative: GMP were called to a domestic incident at address involving an argument between Mario and Olivia. The incident was recorded as domestic abuse and a DASH completed. However there appeared to be no cognisance of the fact that Mario suffered from	Greater Manchester Police to reassure the Rochdale CSP that the current training programme in relation to DA encompasses the factors present that increase risk, namely Mental Health and Pregnancy.	All response staff receive training in relation to Domestic Abuse. This currently includes the requirement to update a DA incident with The Toxic Trio: **Mental Illness, Substance Misuse and Domestic Abuse.** Along with R.A.R.A : REMOVE AVOID REDUCE ACCEPT which is used by officers to document their actions/ safety plan. The GMP DASH Risk assessment training includes the following High Risk indicators which are highlighted on the OPUS IT system to ensure that officers are aware of them when completing a DASH risk assessment: **Victim's perception of risk** **Isolation by perpetrator** **Recent Separation** **Conflict around child contact** **Constant calls/texts/contacts/follow/stalk** **Pregnancy/baby in last 18 months** **Child abuse**	The aim is to ensure that at the point of attending a DA incident all practitioners and supervisors are giving full consideration to the factors that increase the risk to victims.	GMP DA Lead.	

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
	mental health problems or that the cause of the argument might have been Olivia's pregnancy.		**Escalation of abuse in frequency/severity** **Controlling and/or excessively jealous behaviour** **Use of weapons/objects *** **Threats to kill** **Strangulation/choking/drowning/suffocation** **Sexual abuse** **Fear of anybody else i.e. family/3rd party** **Abuse of animals and/or pets** **Alcohol/Drugs/Mental Health** **Suicide/attempts or threats** The GMP DA Policy was published in May 2015 and is currently under review in relation to GMP Investigation and Safeguarding Review (ISR) Programme which is currently being rolled out across GMP. With the launch of the policy in 2015 all response staff received further training in relation to DA incidents as they became accredited to file Standard Risk Incidents.			

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
17	All disclosures concerning incidents of domestic abuse should be explored. There may be evidence of a crime that requires investigation. Professionals need to ask questions, establish all the facts and recognise the appropriate response to take when they receive such information. Narrative: When police officers attended address one on 18 November 2016 they were told that Mario had attacked Olivia and had used a knife. Olivia	Greater Manchester Police to reassure the Rochdale CSP that National Crime Recording Standards are being adhered to in relation to historic DA crimes.	In 2016 National Crime Recording Standards training was completed and officers reminded that historic crimes revealed during completion of the DASH if not previously reported at the time, must be recorded. This can be evidenced by the 45% increase in DA crime recorded in the last 12mths.	GMP will continue to ensure that crimes reported during attendance at DA related incidents will be recorded and investigated appropriately.	ACC Potts	Complete

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
	showed a police officer a computer tablet with a document she had written that contained information that she had been subjected to domestic abuse, this included controlling behaviour. There was also information that Mario had wounded her with a knife, that he had assaulted her by throwing her to the floor and that he had tried to exercise control over her. The police officers who received the information about the use of the knife erroneously believed					

Greater Manchester Police						
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	the matter had already been dealt with. The officer who read the document stated they only skim read it.					

Greater Manchester Police						
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
18	Professionals need to recognise when there may be a risk to life and ensure that an appropriate response is provided. Narrative: When GMP received the initial call from NWAS they delayed the response on the basis that there were insufficient police resources and that the matter was a medical issue rather than one that involved a risk to Olivia.	Greater Manchester Police to reassure the Rochdale CSP that the escalation policy in relation to Threat Harm Risk and resource allocation is being adhered to.	In 2015 the GMP Escalation Policy was launched. This was reviewed in 2017 and an interim guidance document disseminated. In 2017 a pilot scheme was undertaken in relation to assessment of Threat Harm Risk. The OCB are currently in the process of adopting the protocol across the whole of GMP. The OCB are also supported by the VSU, Vulnerability support unit who are able to complete research on both the address and persons present, to assist in the determination of risk.	GMP OCB staff are able to recognising risk amongst the volume and ensuring that certain calls remain a priority for the next available resource.	ACC Potts	Complete