Strictly Confidential

# Manchester Community Safety Partnership

**Domestic Homicide Review** 

Storm apparently took her own life in June 2020.

**Independent Author – David Mellor BA QPM** 

**Report completed on 1<sup>st</sup> October 2021** – (amended on 21<sup>st</sup> February 2022 to include family comments on the final DHR Overview report)

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### **1.0 Introduction**

**1.1** This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Storm (not her real name), a resident of Manchester prior her death which took place in June 2020.

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

**1.3** Storm died in hospital in June 2020 after a serious attempt to hang herself from the gate to an alley in a Manchester street three days earlier. She was 29 years of age. Storm and her four young children had relocated to Manchester from the London Borough of Islington in November 2019 to be near members of her maternal family who resided in Manchester but also to physically distance herself from her expartner Kevin who was the father of the children. Storm had disclosed coercive and controlling behaviour by Kevin which appeared to be a factor in prior attempts to take her own life in Islington. She continued to experience mental health problems in Manchester and made further attempts on her own life which led to intervention by Children's Social Care and restrictions on her contact with her children. At the time of her death, the children were in the care of her ex-partner Kevin who by this time had also relocated from Islington to Manchester.

**1.4** On 21<sup>st</sup> July 2020 Manchester Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) because the circumstances which led to the death of Storm gave rise to concern that she may have been suffering domestic abuse including coercive and controlling behaviour.

**1.5** The review will consider agency contact/involvement with Storm and her expartner Kevin which occurred between 1<sup>st</sup> January 2019 and Storm's death in June 2020. As Storm and her family were known to a range of agencies in the London Borough of Islington prior to their relocation to Manchester in November 2019, agencies in Islington have provided summaries of relevant contact prior to 2019.

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

#### **DHR Timescales**

**1.7** This review began on 29<sup>th</sup> July 2020 and was concluded on 1<sup>st</sup> October 2021. DHRs should be completed, where possible, within six months of their commencement. This review was initially placed on hold until a Serious Incident Review was completed by Greater Manchester Mental Health NHS Foundation Trust (GMMH). This decision was confirmed by Manchester Community Safety Partnership and the Home Office advised. When it became clear that the GMMH Serious Incident Review would be delayed, it was decided to begin the DHR from October 2021. Additionally, the review has been complex, involving a number of agencies from both the London Borough of Islington and Manchester City Council. A further complication was that at the time Storm's family were invited to contribute to the review, her children were being cared for by her ex-partner Kevin but were removed from his care soon after. This delayed family contact. The Home Office were informed of, and agreed to, all the extensions.

#### Confidentiality

**1.8** The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms were agreed with Storm's family and used in the report to protect the identity of the individuals involved. At the time of her death, both Storm and her ex-partner Kevin were 29. Both were/are White British.

**1.9** All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case there are four bereaved children. Manchester Community Safety Partnership therefore wishes to express sincere condolences to the family and friends of Storm.

#### 2.0 Terms of Reference

- **2.1** The general terms of reference are as follows:
  - 1. Establish what lessons are to be learned from Storm's death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
  - 2. 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;
  - 3. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
  - Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
  - 5. Contribute to a better understanding of the nature of domestic violence and abuse;
  - 6. Highlight good practice.
- **2.2** The case specific terms of reference are as follows:
  - How effectively were any disclosures by, or indications of domestic violence and abuse to, Storm addressed by the agencies in contact with her?
  - How effectively were the risks to Storm presented by her partner Kevin assessed and managed?
  - When Storm was referred to MARAC whilst resident in the London Borough of Islington, how effective was the response? What action was taken to address the risk of domestic abuse she faced at that time?
  - How effective was action to safeguard Storm's children from the impact of domestic abuse.

- Did agencies gain an understanding of the lived experience of Storm's children?
- How effective was the support offered or provided to Storm in respect of her mental health issues?
- How effectively did agencies respond to Storm's suicidal ideation and attempts to take her own life?
- Was her capacity to parent her children assessed and appropriate steps taken to safeguard her children from harm when they were in her care?
- What support was offered or provided to Storm to help her address her use of drugs and alcohol?
- How effectively did agencies respond to the relocation of Storm and her children from the London Borough of Islington to Manchester? Were Storm and her children able to access services and appropriate support?
- How effectively did agencies respond to the subsequent relocation of Storm's former partner Kevin from the London Borough of Islington to Manchester?
- How effective was multi-agency working in this case?
- Did the agencies Storm sought support from communicate and share information effectively with each other?
- Were there any specific considerations around equality and diversity issues in respect of Storm such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?
- Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect Storm or impact upon the support provided or offered to her by agencies?

### 3.0 Methodology

**3.1** On 17<sup>th</sup> June 2020 Greater Manchester Police referred the case to Manchester Community Safety Partnership for consideration of holding a DHR. On 21<sup>st</sup> July 2020 representatives of the Manchester Community Safety Partnership met to consider the referral and it was agreed that the circumstances of the death met the criteria for a Domestic Homicide Review.

**3.2** The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with Storm, her family and her ex-partner. Several agencies also provided summary IMRs. The authors of the IMRs had the discretion to interview members of staff if this was required.

**3.3** The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

#### **Contributors to the DHR**

**3.4** The following agencies provided Individual Management Reviews to inform the review:

- Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester Police
- London Borough of Islington, Children's Services
- London Borough of Islington, Clinical Commissioning Group
- London Borough of Islington, Crisis Team
- Manchester City Council, Children's Services
- Manchester City Council, Homeless Service
- Manchester Foundation Trust
- Manchester Health and Care Commissioning Primary Care
- Metropolitan Police Service
- Manchester City Council, Homeless Service

The following agencies provided summary Individual Management Reviews to inform the review:

- London Borough of Islington Primary Care
- Manchester City Council Education Service
- Manchester City Council, IDVA Service
- North West Ambulance Service

**3.5** The authors of each IMR were independent in that they had had no prior involvement in the case.

### The DHR Panel Members

#### **3.6** The DHR Panel consisted of:

David Mellor	Independent Chair and Author
Leanne Conroy	Policy Specialist, Manchester City Council
Ian Halliday	Community Safety Policy and Performance Manager, Manchester City Council
Zylla Graham	Detective Inspector Serious Case Review Team, Greater Manchester Police
Delia Edwards	Domestic Abuse Reduction Manager, Manchester City Council
Louise Honour	Adults Safeguarding Nurse, Manchester Health and Care Commissioning
Catherine McGarrity	Specialist Nurse Safeguarding Children Manchester Health and Care Commissioning
Lauren O'Hanlon	Team Manager, Children's Services, Manchester City Council.
Paul Allen	Service Manager, Children's Services, Manchester City Council.
Sharon Boardman	Deputy Adult Safeguarding lead, Greater Manchester Mental Health
Karolina Bober	Violence Against Women and Girls (VAWG) Strategy and Commissioning Manager, Islington Borough Council
Katy Endean	Specialist Safeguarding Nurse, Manchester Health and Care Commissioning
Deborah Idris	Head of Safeguarding and Quality Assurance, Islington Borough Council

Matt Beavis	Detective Sergeant Specialist Crime Review Group. Metropolitan Police
Marie Fitzpatrick	Designated Nurse Safeguarding Children and LAC (Islington Directorate)
Debbie Butcher	Named Nurse Safeguarding Children, Central Manchester University Hospitals NHS Foundation Trust
David Pennington	Designated Professional Safeguarding Adults North Central London CCG (Islington)
Adele Owen	Greater Manchester Suicide Prevention & Bereavement Support Programme Manager
Paula Jackson	Child Protection Coordinator, Islington Borough Council
Joan Todd	Team Manager Homeless Floating Support Service Manchester City Council.

**3.7** DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions; 4<sup>th</sup> November 2020, 20<sup>th</sup> January 2021, 20<sup>th</sup> April 2021, 17 March 2021 and 27th May 2021.

**3.8** Storm's mother and her two sisters contributed to the DHR through telephone conversations with the independent author. Covid-19 restrictions precluded inperson contact with Storm's family at that time. Storm's ex-partner Kevin also contributed to the DHR through a telephone conversation with the independent author. When Storm's family were advised of the intention to undertake a DHR they were provided with information about Advocacy After Fatal Domestic Abuse (AAFDA) but did not access advice or support from this service or any specialist advocacy service. Storm's family were informed about the Home Office DHR guidance including their right to meet the DHR Panel if they wished. Storm's mother and her two sisters were provided with copies of the final draft DHR Overview report to read and her mother and one of her sisters met the independent author in-person to comment on the report.

#### Author of the overview report

**3.9** David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has nine years' experience as an independent author of DHRs and other statutory reviews.

#### Statement of independence

**3.10** Since 2006 he has been an independent consultant. He was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

**3.11** Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

**3.12** As stated he was a police officer in Greater Manchester Police from 1990 until 1999. He has no current connection to services in Greater Manchester. He has no current connection to services in Manchester.

#### **Parallel reviews**

**3.13** An inquest into the death of Storm will be held in due course.

#### **Equality and diversity**

The protected characteristics relevant to Storm are addressed in Paragraphs 7.99 to 7.104.

#### Dissemination

The following will receive copies of the DHR overview report:

The Greater Manchester Deputy Mayor for Policing, Crime, Criminal Justice and Fire North West Ambulance Service Manchester University NHS Foundation Trust Greater Manchester Mental Health NHS Foundation Trust Greater Manchester Health and Social Care Commissioning Greater Manchester Police Metropolitan Police - London Manchester City Council Adult Social Care Manchester City Council Children's Social Care Manchester Community Safety Partnership London Borough of Islington Community Safety Partnership North Central London CCG University College London Hospital NHS FT Greater Manchester Health and Social Care Partnership Manchester Safeguarding Boards Storm's family Storm's ex-partner

#### 4.0 Involvement of the family and ex-partner of Storm

**4.1** Storm's sister spoke to the independent author by phone and her mother later joined the conversation.

**4.2** Storm's sister described her as a great mother who really loved being pregnant, loved babies and loved being a mother. However, all her time was consumed by the children and life became pressurised for her. Storm's sister went on to say that Storm was a loving, passionate person who was really kind to others.

**4.3** Turning to Storm's relationship with Kevin, she said that they had split up around the end of 2018/beginning of 2019 but Kevin wouldn't accept that it was over. It had become a really 'toxic' relationship in that there was constant arguing, but when Storm tried to end the relationship, he would talk her into staying with him. The sister felt that the relationship was not healthy for Storm or the children. She said that Kevin was guite controlling and would take her phone away for example. On one occasion she said that storm had been without a phone for a year. Storm's sister said that Kevin would ring Storm all the time and the sister felt that he was very clever in how he spoke to Storm and made her feel that she was never good enough and that no-one cared for her except him. The sister said he made Storm feel like he was all she had. The sister said that he began 'watching' Storm's flat after they split up. She said that Kevin was also a very big man and an intimidating physical presence. The sister went on to say that Storm told her that Kevin had raped her several times but that if she reported anything she would never be believed and he would never admit it. The sister felt that being in this position – of feeling that she would not be believed - 'drove her mad'. The sister was using the 'drove her mad' phrase in the colloquial sense.

**4.4** The sister said that the move to Manchester was motivated in the main by a wish for Storm to be away from Kevin's 'grasp' and be nearer to the sister and their mother. The sister said that it was not really practical for Storm and her four children to stay with her mother and her sisters and so Storm sought housing support. The sister said that the Sandown Hotel was not a nice place for Storm and the children to stay together in what the sister described as a tiny little room and that Storm became really low whilst she was there following the family's arrival in Manchester.

**4.5** The sister said that Kevin began coming up to Manchester for the day to see the children and the sister would meet him and manage his contact with the children and then he would return to London. She said that the children liked that. But he began to stay overnight in Manchester hotels but when the Covid-19 restrictions were introduced, there were no hotels open. She felt that he used the Covid-19

restrictions as an excuse to stay at Storm's house in Gorton. She felt that the family had been trying to facilitate Kevin's contact with the children but that he always tried to take things 'a step too far'. She added that when he visited the children in April 2020 he never went home.

**4.6** The sister said that Storm wasn't allowed to stay with the children on her own and Kevin had nowhere to stay. She said that he had never had his own place and had been staying with his girlfriend in London. Storm's sister implied that Kevin moving in with Storm enabled her to live with the children in the Gorton property. The sister said that she didn't agree to Kevin staying with Storm and the children at all but felt that Storm 'was a little bit weak when it came to Kevin'.

**4.7** The sister said that after Storm allowed Kevin to stay he began trying to resume their relationship. The sister felt that Kevin just wouldn't let Storm move on.

**4.8** The sister felt that Storm struggled with her mental health because she never felt she was good enough for the children or for Kevin. She couldn't find peace because she felt she was failing the children. She also felt a failure because she had been unable to keep her family together so that the children had a father living with them. The sister said that Storm's parents split up when she was young and she didn't want that for her children. Storm's mother felt that her daughter was not the same person after the birth of child 4 which she said had been very traumatic.

**4.9** The sister felt that although Storm appeared outwardly confident and was always well-presented because she always 'looked after herself', she really lacked self-esteem.

**4.10** Neither Storm's sister or her mother felt that Kevin had been supportive to Storm when she was struggling with her mental health. Storm's mother said that Kevin's sister told her that they had heard Kevin having a phone conversation with Storm in which he had encouraged her to take her own life, making remarks such as 'the kids would be better off without you'.

**4.11** The sister felt that by June 2020, Storm had nothing left to live for. She had lost the children, had no house, no money and Kevin had a house in Harpurhey – near Storm's family which is what she had wanted - and the children.

**4.12** The sister said that it had been difficult to maintain contact with Storm when she was staying in the guest house in the period before her death, as she had lost her phone. Additionally, Storm appeared to feel like she couldn't trust her family and that, towards the end, that no-one loved her. Tension had developed between

Storm and her family. For example, her sister said she found cocaine in the Gorton house which raised concerns about how safe it was for Storm to stay with them.

**4.13** The sister and mother both felt that Storm should have been 'sectioned' under the Mental health Act and they said that they had begged the police to take her to hospital for a MHA assessment. But she was taken to the Guest House instead. Whilst Storm was with the police on this occasion, the sister and mother said that they had rung a mental health nurse who was supporting Storm and told her that Storm was not safe and could take her own life and that the nurse had said that she would ring the police and tell them to bring her to hospital. The family said they were unhappy that the nurse did not apparently do this.

**4.14** Storm's second (Manchester based) sister contributed to this review separately. She largely confirmed the accounts provided by Storm's mother and other sister. She emphasised the significance of Storm's relationship with her father, saying that for much of her life, Storm did not have a relationship with her father and, as a result, she really wanted her children to have a relationship with their father Kevin. She implied that Storm felt a degree of failure when her relationship with their father.

**4.15** The second sister felt the difficulties in her relationship with Kevin played a large part in Storm's mood deteriorating. She said that both Kevin and Storm said nasty things to each other and stated that Kevin taunted Storm about her suicidal ideation, telling her that she 'should kill herself'.

**4.16** The second sister said that she had visited Storm in Islington 'all the time' until things got 'really bad' between Storm and Kevin and she had stopped visiting for a while.

**4.17** The second sister said Storm decided to move to Manchester because her relationship with Kevin had 'hit a dead end', she had been trying to stay with him for the sake of the children, she needed to make a fresh start, be with her family and get the help she needed.

**4.18** The second sister spoke to the independent author after Kevin had contributed to this review, which provided an opportunity to ask the sister about Kevin's assertion that the main reason why Storm moved to Manchester was because she had been disowned by her family for cheating on Kevin. The second sister said that this was definitely not the case, that Kevin constantly accused Storm of cheating on him and this was the kind of manipulative thing that Kevin would say.

**4.19** She said that after staying in Manchester after visiting for either child 1 or child 2's birthday, Kevin and Storm resumed their relationship 'in secret'.

**4.20** The second sister commented on the support Storm received from services in Manchester. She felt that it was right for Children's Social Care to 'see things from the children's point of view' but the sister didn't feel that Storm's mental health and attempts to take her own life seriously enough. She felt that losing the care of the children to Kevin – who got them 'overnight' – was a factor in her taking her own life. Also the sister felt that Kevin getting the house in Harpurhey 'so easily', which was something Storm had 'fought so hard for', was also a factor.

**4.21** Storm's mother and sisters met with the independent author in-person and read the final DHR overview report and made a number of comments which were then incorporated into the report. They said they were very satisfied with the DHR report and fully supported the findings and recommendations. They said they felt that they had been listened to throughout the DHR process. They also felt that the DHR overview report had understood the impact of Kevin's abuse on Storm which they felt that many of the professionals who came into contact with Kevin did not fully appreciate.

#### Views of Storm's ex-partner Kevin

**4.22** Kevin spoke to the independent author by telephone. He expressed concern about the decision to undertake a DHR and felt that 'people were trying to point the finger' at him.

**4.23** He said there were no incidents of domestic abuse in his nine year relationship with Storm but acknowledged that they had arguments, which had sometimes become heated, adding that Storm was not an easy person to live with. He added that whenever he and Storm got into an argument, she would 'spiral out of control'. He said that he 'never laid a finger on her' although she had 'put her hands on him' a few times. He said that every time the police came they told him to 'take a walk' in order to get some space from each other. He said he was never arrested by the police. He indicated that he was aware that the term 'domestic abuse' included more than violence.

**4.24** Kevin said that Storm only started talking about the domestic abuse 'stuff' to her family after he told them (her family) about her relationship with a male he repeatedly referred to as the 'paedophile'. He said that after Storm 'got caught out' 'cheating' on him, she began telling lies to her family about domestic abuse. He went on to say that Storm's family were Travellers and that, because of this, they strongly disapproved of women 'cheating' on their husbands/partners. Storm's family say that

they are not Travellers, although their ancestors were and that it is therefore untrue for Kevin to claim that Storm's family approved or disapproved of anything based on Traveller culture or customs.

**4.25** Kevin reflected on his life together with Storm. He said that she was mentally unwell but this was not because of any domestic abuse by him. He said the cause of her mental health difficulties was the way she had been brought up. He said she didn't get on with her mother who he described as an alcoholic and after not seeing her father for many years, he said that Storm reconciled with him, only for him to die a few months later. He said that during this short period, Storm had become really close to her father and his death had had a big impact on her.

**4.26** Kevin said that Storm had tried to take her own life many times, including when their children were present. He said that on one occasion she threw the cat off the second floor balcony of her flat after it urinated in the flat. He said that the cat was lucky to survive. He said that he had been on the phone to the crisis team in Islington 'every other week'. He felt that she should have been sectioned years ago. He said he had lost jobs because of having to run home when Storm was unable to cope.

**4.27** When asked why he thought Storm had left Islington, Kevin initially said that he thought she wanted a fresh start or a new life given that her relationship with him was over. He said that by this time he was 'done' with their relationship, 'wasn't going to put up with it anymore' and wasn't going to go back to Storm. He said that he was with someone else and Storm 'couldn't take it'. He added that Storm had been calling him every night, trying to persuade him to resume their relationship. Then he said that Storm texted him to say that she was moving to Manchester. He said he thought she was joking at first. When he realised she was serious, he said he thought that there was nothing he could do about it but was concerned about being able to see his children. He felt that he would need to move himself or he wouldn't see much of the children. He went on to allege that Storm had 'made the domestic stuff up' to try and get a flat in Manchester.

**4.28** Later in the conversation, Kevin said that Storm's move to Manchester was 'one million percent' because her family in London had disowned her because she had cheated on Kevin with a 'paedophile'. Still later in the conversation, he stated that another reason why Storm went to Manchester was because the 'paedophile's' partner was 'after her'.

**4.29** After Storm and the children moved to Manchester, he said he said he would travel up every couple of weeks, stay for two or three nights and take the children to a hotel. He said he was angry with Storm because she had 'cheated' on him and

then taken his children away from him. He said when they were together, he and Storm argued a lot and he didn't want their children to see that, which was why he took the children to a hotel.

**4.30** He said that over time he began to stay at Storm's house in Gorton, rather than in a hotel. He said that by this time they had stopped arguing so much and began to reflect on their relationship and how it had all gone wrong. He said he would stay in her house and he would look after the children whilst she went to stay with her boyfriend. He said that he moved into Storm's house permanently around May 2020. He was aware she had attempted to take her own life and just wanted to help her. He said he was concerned that her family wouldn't do enough to help her so he needed to be there.

**4.31** He recounted Storm's attempt to take her own life later in May 2020. He said that he needed to collect child 3 from Storm's mother's address and took child 1 and child 2 with him in a taxi to pick the child up. He recalled Storm asking him not to leave child 4 with her because she said she felt 'funny'. He said he thought she meant she felt physically poorly rather than mentally unwell. Around 15 or 20 minutes later, he said that Storm rang him to say that she was finding it hard to breathe and so he passed his phone to Storm's mother who spoke to Storm for a short while before beginning to cry, which was when he realised that something was seriously wrong.

**4.32** Kevin went on to say that it was after this incident that Storm 'lost custody of the children' and he stayed in the Gorton house and looked after the children.

**4.33** He said that he and the children were subsequently moved to an address in Harpurhey because Storm kept coming to the Gorton house late at night, in a drunken state and having also used cocaine. He said that he had to call the police out most nights and they took Storm away two or three times. He said that on one occasion she 'smashed the door up'. Kevin said that Storm was struggling to cope with not living with her children and only being able to see them for supervised contact for an hour.

**4.34** He said that after he and the children were moved to Harpurhey, Storm wasn't allowed to know their address. He said that this was on the instructions of Children's Social Care who also told them to 'block' each other on their phones.

**4.35** He felt sure that Storm would have wanted to phone him before she hanged herself but because they had been told to block each other, she would have been unable to do so. He went on to say that every time she tried to take her own life she would phone him.

**4.36** When it was put to Kevin that Storm often disclosed to professionals that difficulties in her relationship with Kevin was a trigger for her attempts to take her own life, he said that this was laughable and that they were all 'pointing the finger' at him. He added that if anyone was there for Storm, it was him.

**4.37** Kevin concluded by saying that if he was so bad, he would have been arrested and asked why would Storm would have wanted to give him another try? He answered his own question by saying that he felt that Storm loved him because he was a good man who worked hard, paid the bills and looked after their children.

**4.38** When contact with Kevin was initially made, he indicated that he didn't feel in the right frame of mind to contribute to the review and asked a friend from Islington to speak to the independent author on his behalf. Kevin's friend provided the following information:

**4.39** Kevin's friend said he and his ex-partner had known Kevin and Storm since the birth of child 1 in 2012, although he said that he had not been as close to Kevin over the past eighteen months. He said that Kevin, Storm and their children would visit his and his ex-partner's home and they would visit theirs. After he and his ex-partner split up, he continued the friendship, but mainly with Kevin.

**4.40** He said he was aware that Storm was bi-polar and that her mental health was 'up and down'. He was also aware that she had tried to take her own life and that Kevin had had drag her off the balcony of their flat when she tried to jump from it and also prevent her from jumping in a canal on another occasion. He said that he was aware that Kevin had tried to get Storm 'sectioned' a few times. The friend said that Storm had hit herself in front of her children a couple of times. However, the friend said he had never seen Storm when she was mentally unwell.

**4.41** The friend said that Kevin didn't know what to do about the situation. He said that Kevin was working nights on security at a casino and he would go home in the morning, find that storm was unable to get up, take the children to school and then go to bed until it was time to collect the children from school. The friend said that he was getting no help from Storm.

**4.42** The friend recalled that Storm's sister began coming down to London from Manchester to help out from time to time but that she and Storm would have a 'little party together'.

**4.43** The friend said that Storm and Kevin eventually separated. Kevin had nowhere to live and would sleep in the park or sometimes at the friend's house. He said that

Storm 'got together' with someone who did a 'minor thing' with under age children. He said that both he and Kevin knew this person and both were aware of what he had done, but Kevin kept going round saying that he was a 'paedophile'. The friend said that Kevin felt that Storm had entered into this relationship 'just to spite him'. (Storm's family have advised this review that once she became aware of the previous conduct of the man with whom she began a brief relationship, she quickly ended the relationship).

**4.44** The friend said then, on the spur of the moment, Storm said she was going to Manchester and told Kevin that if he wanted to see the children before she went, he had better come round quickly. He said that by this time Kevin was living with another woman.

**4.45** The friend said that he later heard that storm wasn't doing too well up in Manchester and had her children taken from her. He said that it was at this point that Kevin said that he needed to move up to Manchester.

**4.46** The friend said that Kevin would never hit Storm, adding that he was 'not that person'. The friend said that Storm would 'go for' Kevin and he said he had seen Kevin with a swollen face where Storm had hit him. The friend said that Storm would hit herself and call the police and try and blame Kevin. He said that this happened many times but then changed this to a couple of times.

**4.47** When asked what he thought had prompted Storm's move to Manchester, the friend said that it was because of bitterness towards Kevin because he'd started a new relationship.

#### 5.0 Chronology/Overview

#### Background information (Paragraphs 5.1-5.3)

**5.1** Storm was born in 1990. Her parents separated when she was a small child and after living in her mother's care for several years, Storm moved to live with her father during her mid teenage years. Her father died when she was 16 years of age and from records shared with this review, this was a particularly difficult time for her both in terms of bereavement and because she was at risk of homelessness. Her mother had moved from London to Manchester and was unable to offer Storm a home at that time. Storm's mother has advised this review that Storm did not want to live in Manchester at that time. Storm's sister described her as a great mother who really loved being pregnant, loved babies and loved being a mother. However, all her time was consumed by the children and life became pressurised for her. Storm's sister went on to say that Storm was a loving, passionate person who was really kind to others. Another sister emphasised the significance of Storm's relationship with her father, saying that for much of her life, Storm did not have a relationship with her father and, as a result, she really wanted her children to have a relationship with their father Kevin. She implied that Storm felt a degree of failure when her relationship with Kevin broke down, thus putting at risk her children's relationship with their father.

**5.2** Storm appears to have had a diagnosis of bipolar disorder. This diagnosis was questioned by mental health services in Manchester although Storm had been treated with medication for bipolar disorder for several years in Islington. Manchester mental health services felt that Storm's presentation suggested a personality disorder whilst her Manchester GP documented a diagnosis of long term generalised anxiety disorder.

**5.3** Storm experienced domestic abuse in a prior intimate relationship between March 2008 - when she was 17 - and April 2011 – when she was 20 - during which time the Metropolitan (Met) Police attended six incidents. All were treated as verbal disputes with the exception of the final incident following which her partner was cautioned for a common assault on Storm. The final incident also included evidence of controlling behaviour although the offence of controlling or coercive behaviour had not been enacted at that time. No incident was assessed as being higher than 'standard' risk.

**5.4** It is assumed that Storm began her relationship with Kevin during 2011. Their first child, child 1 was born the following year. Midwifery raised concerns about both parent's use of cannabis during the pregnancy and both of them having histories of

depression. Children's Social Care carried out an initial assessment. Child 2 was born in 2015.

#### 2016

**5.5** On 19<sup>th</sup> February 2016 Storm's mother contacted Greater Manchester Police (GMP) to request a welfare check on her daughter who had told her that she intended to jump off the third floor balcony of her flat in Islington. Storm's mother said that her daughter suffered with bi-polar disorder and was four months pregnant with child 3. The Met Police attended and spoke to Storm who said that she had stopped taking her medication because she couldn't stop vomiting. Child 1 and 2 were asleep. Storm declined an ambulance, but her sister, who was visiting from Manchester, said she would take her to hospital. Following a referral from the police the family were supported by a children's centre family support Worker from February until October 2016.

**5.6** On 24<sup>th</sup> September 2016 Storm called the police after Kevin – who was documented to be her 'on/off partner' - had smashed a plate following a verbal argument and was refusing to leave. Child 3 had been born one month earlier. All three children were described as 'happy and content'. Kevin left the address and the police assessed the incident as 'standard'. A letter was later sent to Storm providing contact details for Solace Women's Aid. Solace provides support to women and girls at risk of male violence in London. Islington 'Social Services' were notified.

#### 2017

**5.7** On 18<sup>th</sup> April 2017 the police were called by a third party who reported that Storm and Kevin were arguing in the street. The police attended and established that an argument had taken place after Kevin had taken their son to play football. Kevin said that this had been arranged in advance whereas Storm said that Kevin's actions were unexpected. Storm admitted slapping Kevin but he did not wish to make any complaint. However, the incident was classed as a domestic common assault and Storm was asked to attend a police station for interview under caution which she declined to do. There being no grounds for arrest, the crime report was closed. Storm told the police that Kevin 'used' the children to upset her. It was documented that Storm and Kevin were not living together at that time. The incident was assessed as 'standard' and the details were sent to 'Social Services'.

**5.8** On 18<sup>th</sup> July 2017 the police were contacted by the London Ambulance Service (LAS) after they received a call from a distressed female. When the number was called back, a male answered who said that LAS were not required. The police established that the telephone number was linked to Storm and attended her home

where they found her in the company of her aunt. Storm said that Kevin had visited her, they had had a verbal argument and he had left. Officers noted a bruise to the right side of Storm's face which she said she had caused to herself whilst 'in a temper'. This version of events was supported by her aunt. Storm declined to provide further information and the matter was closed. LAS made a referral to Children's Social Care as a result of Storm's 'deteriorating mental health' and 'selfharm' and the latter service completed a child and family (C&F) assessment in August 2017.

**5.9** On 31<sup>st</sup> August 2017 Storm called the police after Kevin arrived at her flat earlier than planned and took their 3 children to the park. The police attended and Storm was described as 'hysterical'. Her belief that Kevin's child contact arrangements had not been agreed were contradicted by messages sent from Kevin's phone. She went on to say that Kevin's early arrival had not given her enough time to get the children ready, that she felt intimidated by him, that he had called her a 'whore' in front of the children and accused her of 'cheating'. She said that Kevin had left her 3 weeks previously although she had tried to separate from him six months earlier. She added that he texted her 'constantly', 'questioned everything' and 'wouldn't take no for an answer'. The police documented that Storm and Kevin had recently separated after the former 'cheated' on the latter.

**5.10** A DASH and a RARA (remove, avoid, reduce or accept) risk management model were completed and the details shared with Islington Children's Social Care over concerns that arguments between the parents over child contact could affect the emotional development of their children. Assessed as 'green' (defined as 'low risk to vulnerable. Child's needs are not clear, not known or not being met'). Storm was referred to the National Centre for Domestic Violence (NCDV) – which is a community interest company that primarily provides legal support to victims of domestic abuse.

**5.11** On 7<sup>th</sup> September 2017 the police were called after a verbal argument between Storm and Kevin. Kevin had collected the children from school and after returning them to Storm, an argument arose over the lack of financial support he provided. Storm told officers that she was not in fear of Kevin but that arguments over childcare and his turning up unannounced had been escalating. She also said that he was not taking his medication. Storm was again referred to the NCDV. The incident was assessed as 'green' and Children's Social Care notified.

**5.12** However, the case was reviewed by the Islington Borough Police Community Safety Unit (CSU) who deemed Storm to be 'high' risk of domestic abuse and 'put forward' her case for discussion at a MARAC meeting, apparently on the grounds of the number of repeat incidents. In October 2017 the referral was reviewed by the

Islington MARAC chair who made the decision that the case did not meet the criteria for a 'MARAC repeat' and was therefore not allocated for the November 2017 Islington MARAC case list.

# 2018

**5.13** From January to August 2018 a family support Worker supported the family following a referral from midwifery whilst Storm was pregnant with child 4. Storm had requested this support.

**5.14** On 11<sup>th</sup> March 2018 Storm called the police as Kevin was drunk in her home and refusing to leave. On their arrival, the officers found Kevin to be intoxicated, argumentative and refusing to leave, which he eventually did, but only after he had been told that he was at risk of being arrested to prevent a breach of the peace and additional officers summoned. Prior to leaving he gave officers his key to Storm's address. Storm told the officers that Kevin would arrive at the flat and refuse to leave and had previously begged the children to let him in. To avoid an argument, Storm said that she would let him in and allow him to stay the night on some occasions. She added that sometimes he would insist on sleeping in her bed which made her feel uncomfortable. She said that Kevin continued to pay her phone bill but kept 'cutting it off'. She went on to say that when he drank, Kevin would not take his medication. Storm declined a referral for support. The police assessed the incident as 'green' and notified Children's Social Care. The police also added comments to their CAD (Computer-Aided Despatch) system to alert relevant personnel to the history of domestic abuse at Storm's address.

**5.15** The following day (12<sup>th</sup> March 2018) the police were called to Storm's address by neighbours who could hear shouting within. The police attended and spoke with Storm and Kevin who said that they had been having a verbal argument. Storm was noted to be calm whilst Kevin was documented to be very angry and agitated when spoken to by the officers. No offences having been disclosed, Kevin was allowed to leave. Storm, who was noted to be pregnant (with child 4) said that Kevin was experiencing mental health problems for which he was seeking medical advice. She said that her children had let him into the address. The incident was assessed as 'medium' risk and a supervisor advised the attending officer to submit a referral to Solace although it is unclear whether this was done.

**5.16** In May 2018 Kevin told his GP that he was sleeping on the balcony outside Storm's flat.

**5.17** Child 4 was born in June 2018. Storm had been offered support by perinatal service in January 2018 but did not attend appointments in January and February 2018

## 2019

**5.18** On 12<sup>th</sup> March 2019 Storm was discussed at a GP liaison meeting. She was receiving repeat prescriptions of Fluoxetine and Quetiapine. She had last been seen by the GP in August 2018.

5.19 On 19th July 2019 Kevin was seen by GP practice 2. He said that his partner had 'cheated' on him and he wanted to kill himself. Kevin was seen by the Camden and Islington Crisis Team later the same day. The team documented that Kevin presented with low mood, suicidal ideation, poor sleep and deliberate self-harm by cutting his shoulder. Stressors include housing issues - currently no fixed abode and had been 'sofa surfing' since he broke up with his partner (presumably Storm); work stress (employed as a bouncer) and uncertainty over the paternity of child 4. He reported that he attempted to jump off a friend's third floor balcony a few days earlier but had been prevented from doing so by friends who had intervened. He now regretted the incident and saw his children as a 'protective factor'. He declined to engage with ICOPE – an Improving Access to Psychological Therapies (IAPT) service - but was referred to the stress project, which provided therapeutic and Social support to people with mental health problems and stress related illness. He also declined the Everyman Project for anger management. He was admitted to Islington Crisis House who were supporting him to contact the local authority for housing. He was given two extensions to his stay to assist him with finding accommodation. He then self-discharged from Crisis House and declined to engage with the Crisis Team or attend further reviews. He had been diagnosed with recurrent depressive disorder (current episode moderate) and post-traumatic stress disorder (PTSD). The crisis trigger was documented to be homelessness. The episode had ended by 17<sup>th</sup> August 2019 and Kevin was not seen by his GP thereafter.

**5.20** on 24<sup>th</sup> September 2019 Storm was seen in urgent care walk in clinic for depression and the feeling that things were getting out of control. An appointment was made for review by her GP, but Storm did not attend.

**5.21** On 8<sup>th</sup> October 2019 Storm's sister contacted the Met Police from her home in Manchester to report a verbal argument between Storm and Kevin who had visited her home to collect the children. Whilst there, Storm said that he had looked through her phone and told her that she shouldn't message anyone he knows and had 'screamed' at her. The sister said that the message Kevin had taken exception

to was to the caretaker of the building to ask if he could get her some milk. She said he refused to leave the address but eventually did so due to the threat of police attendance but then sat outside the flat for 20 minutes. No risk assessment was completed by the police on this occasion. Storm's family read the final DHR overview report and expressed disappointment that no risk assessment was completed despite the information on the CAD which would have alerted officers to the previous domestic abuse history (see Paragraph 5.14).

**5.22** The following day (9<sup>th</sup> October 2019) Storm's sister again contacted the police to reiterate her concerns for her sister's welfare. She said that she had been sent voicemails that Kevin had left on Storm's phone which she felt were derogatory, in that they said that Storm was 'useless' and had no friends. The sister went on to say that Kevin was constantly sending text messages to Storm, putting her down and calling her names. She added that Kevin knew who Storm talked to and followed her. The sister also said that Storm was too scared to report this, adding that it was not possible for her sister to avoid contact with Kevin because of his involvement with their children.

**5.23** On 14<sup>th</sup> October 2019 a DASH risk assessment was completed because a supervisor had decided that the 9<sup>th</sup> October 2019 incident was a third party allegation of coercion and control. During the assessment, Storm said that she had separated from Kevin three months earlier and felt isolated, harassed, and watched. She said that she was looking for full custody of their children. She added that Kevin had previously threatened to take his own life.

**5.24** The police decided that a secondary investigation was necessary and the investigator to whom the case was allocated contacted Storm on 11<sup>th</sup> November 2019. Storm told the officer that Kevin was an intimidating presence because of his physical size and that he 'brought her down' by constantly calling and texting. She said that he made no effort with the children and provided her with no financial support but wanted contact with them at very short notice. She said he paid the contract on her phone, would check through it and would cancel the contract if they fell out. She added that he told his friends to drive past her home to check on her movements and had a friend who lived in the same block who monitored visitors to her home. On one occasion her sister was staying with her which prompted Kevin to ring her to ask who was in her home. She said Kevin still retained a key to her flat which he refused to return. She went on to say that she hadn't had friends for eight years, adding that he wouldn't allow people to talk to her and had frightened the caretaker through intimidation and threats of violence. She said that she was worried and did not feel safe. The investigator noted the presence of stalking as well as coercion and control and planned to obtain statements.

**5.25** On 12<sup>th</sup> November 2019 Kevin called the London Ambulance Service (LAS) from his place of work, stating that Storm had texted him to say that she was going to end her life by taking an overdose. Storm was at home with child 4 -then 17 months old – as her sister had collected her three older children and taken them to a café. Kevin was updated by the police and advised that the children were being cared for by Storm's sister. The police documented that Kevin continued to call Storm and they decided not to disclose the hospital to which she had been taken to him. Later in the day, the police were called back to Storm's home as Kevin arrived there and demanded the children be released into his care from Storm's sister. He was abusive to the police who advised him to leave which he did. The police notified Children's Social Care.

**5.26** Storm had been conveyed by LAS to University College London Hospital (UCLH) where she disclosed that she had taken an overdose of Cocodamol and Quetiapine tablets. She was noted to be tearful and appeared low in mood. She said that she had been trying to be strong but was living alone with her 4 children without financial help. Storm was documented to be manic depressive. She said that she had been feeling low for six weeks and the trigger for the overdose had been guilt because of her children not having a father. She said that she had been giving thought to how she could take her life and said she planned to attempt suicide again in the next few days or weeks. Storm was provided with 1:1 registered mental nurse (RMN) support. She was referred to the hospital mental health liaison team for assessment once 'medically optimised'.

**5.27** The following day (13<sup>th</sup> November 2019) Storm was seen by the hospital mental health liaison team and discussed her 'worsening mood' since her long term partner Kevin had left her and the children in July 2019. She said that he had stopped paying child support since moving in with another woman and her children and frequently phoned her to 'accuse her' and guestion her ability as a mother. She disclosed that she had felt 'overwhelmed' the day before and formed the view that her children would be better off without her. The clinical specialist nurse from the hospital mental health team concluded that there was evidence of emotional dysregulation and increased impulsivity exacerbated by mood, ability to cope alone with children and current 'separation/conflict' from Kevin. Storm was noted to wish to return home to care for her children. Although she now denied any immediate thoughts of ending her life her mental state was considered to be fragile and the stressors which led to her overdose remained and so there was a risk of further impulsive acts of self-harm or suicide. She consented to a referral to the crisis resolution team (CRT) for ongoing support. A Crisis House was identified to which it was planned to discharge Storm. The 1:1 support was ceased at Storm's request as she was finding the constant presence of the RMN to be intrusive.

**5.28** Also on 13<sup>th</sup> November 2019 Children's Social Care received referrals from the police and UCLH and were also contacted by Kevin who reported that Storm had taken 40 co-codamol tablets whilst child 4 was in her care. He said he was also concerned that Storm had had a relationship with 'a paedophile' and was communicating with a 'convicted rapist'.

**5.29** Later the same day, Social Worker 1 visited Storm in hospital. Storm said that she and Kevin had separated 5 or 6 months previously and since getting a new partner he had twice not turned up for contact with the children. She said she had intended to end her life and had been planning to do this for 2 or 3 weeks and saw the opportunity to do so whilst the three older children were with her sister and child 4 was sleeping. She said that she loved the children 'so much' but the thought that she couldn't give them what they needed kept 'popping into her head'. A child and family (C&F) assessment was to be completed.

**5.30** On 14<sup>th</sup> November 2019 Storm was again seen by the clinical nurse specialist from the hospital mental health liaison team who documented that she remained low in mood and visibly anxious and disclosed further suicidal thoughts and said she had thought about jumping from a tall building. She was documented to be 'consumed with guilt' about her ability to care for her children.

**5.31** On the same date Kevin, Kevin's sister and Storm's sister gave conflicting accounts to Social Worker 1 of domestic abuse within Storm and Kevin's relationship. Kevin's sister said that Storm had texted Kevin to say he would arrive at her home to find that she had killed herself and the children. Kevin reiterated what his sister had said but was unable to find the relevant text when requested to do so. He added that Storm had been harassing him and using access to the children to control him after he entered into his current relationship and 'poisoning the minds' of the children against him. Storm's sister said that Kevin refused to communicate with members of her family and would only communicate directly with Storm, which she ascribed to his controlling behaviour. She said he would message Storm 20-30 times a day. Storm's sister said that she regularly travelled to London to support Storm, staying for two weeks at a time.

**5.32** During the evening of the same day (14<sup>th</sup> November 2019) Storm left the hospital ward, purchased a bottle of vodka and walked to scaffolding in Euston intending to jump off. A passer-by persuaded her not to do this and she returned to the ward. Storm disclosed that she decided to take her own life after 'flipping' following a telephone call from Kevin in which she felt he blamed her for not being able to see the children. After being allowed to leave the ward for a cigarette she reported having an impulse to 'end it all' and then walked to Euston. Storm was assessed on her return to UCLH and 1:1 nursing assistant support was put in place.

**5.33** On 15<sup>th</sup> November 2019 Storm was discharged from UCLH and admitted to North Camden Crisis House where she was to be offered an informal setting to monitor her mental state and support her recovery. During the admission process, Storm disclosed that her 'ex-partner' had been violent towards her in the past by restraining her but she had not pursued any action against him. She was reported to no longer feel suicidal and was willing to seek support from staff when needed.

**5.34** On the same date a multi-agency strategy discussion took place at which it was decided that children's Social Care would initiate a single agency Section 47 investigation in respect of concerns about the impact of Storm's mental health issues on her parenting capacity, the allegations of domestic abuse levelled by 'either parent against the other' and the impact on the children's wellbeing of their parents talking negatively about each other.

**5.35** Whilst staying in the Crisis House, Storm often spent time with her sister and her children during the day. On 16<sup>th</sup> November 2019 she returned to the Crisis House in distress arising from a conversation with her daughter who had told her that Kevin planned to take the children to his new partner's house.

**5.36** On 19<sup>th</sup> November 2019 the Social Worker visited the Crisis House for a joint review at which a referral to Solace Women's Aid was discussed. It appears that any referral was to be deferred until after Storm was seen by the psychologist – which was scheduled for 26<sup>th</sup> November 2019 (28<sup>th</sup> November 2019 in Crisis House chronology).

**5.37** On 20<sup>th</sup> November 2019 the police completed a DASH risk assessment via a phone call to Storm. She said there were issues with child contact and controlling behaviour and went on to disclose that Kevin had sexual intercourse with her on a number of occasions whilst she was asleep after taking her 'bi-polar' medication (It has been confirmed that the medication prescribed to Storm could indeed have caused deeper sleep). Storm said that she did not wish to pursue the disclosures of rape further.

**5.38** On the same date Storm disclosed plans to move to Manchester 'to be closer to her family' to a Crisis House support Worker and a referral was made to the Manchester Home Treatment Team (HTT) who were to contact Islington Children's Social Care as part of the handover of care (Greater Manchester Mental Health NHS Foundation Trust (GMMH), which is the provider of the Manchester HTT, has no record of receiving this referral).

**5.39** On 22<sup>nd</sup> November 2019 a Crisis House support Worker provided Storm with information about Solace and Storm said that she would think about a possible referral.

**5.40** On 23<sup>rd</sup> November 2019 Storm was granted overnight leave from the Crisis House to celebrate her birthday and during the early hours of the following morning (24<sup>th</sup> November 2019) LAS called the police to assist them with Storm who was intoxicated in the street. The police escorted her back to the Crisis House and notified both Adult and Children's Social Services.

**5.41** During the evening of 24<sup>th</sup> November 2019 Storm self-discharged from the Crisis House, explaining that her mother and sister were returning to Manchester and so she needed to resume the care of her children. The Crisis House referred Storm to Islington Crisis team due to the unplanned discharge and her need for continued support.

**5.42** On 25<sup>th</sup> November 2019 Children's Social Care phoned Storm and she said she had returned home and that her sister was staying with her until the Crisis team visited to agree a treatment plan and schedule of visits.

**5.43** On 26<sup>th</sup> November 2019 Storm was assessed by the home treatment team who accepted her for treatment. She was seen again by the home treatment team on 28<sup>th</sup> November 2019.

**5.44** On the same date Social Worker 1 visited Storm in the family home. Her sister had returned to Manchester. Later the same day the Social Worker phoned Kevin to advise him that the original plan to convene an Initial Child Protection Conference (ICPC) had changed as the case was now to be transferred to Manchester for assessment. Kevin expressed his annoyance that Storm had told him of the plan to relocate to Manchester in a 'petty and spiteful' way. The Social Worker urged Kevin to think of ways in which he and Storm could communicate with each other without being 'petty'.

**5.45** Shortly after midnight on Friday 29<sup>th</sup> November 2019 LAS called the police after Storm cut her neck and wrist at her home address. Storm left her address before the arrival of the police but was located a short time later and treated for superficial cuts which she said she had caused with a broken mirror. She said 'I know this isn't going to kill me unfortunately'. She told the police that she had recently left an abusive nine year relationship during which time she had lost all her friends in London. She added that she planned to relocate to Manchester with her children and stay with her mother there. She said she had booked train tickets to Manchester for later that day. The police notified adult and Children's Social Care.

**5.46** Storm declined transport to hospital by LAS and was assessed as having capacity to make that decision. Storm's locally based aunt arrived to stay with Storm until her sister arrived from Manchester the following morning. LAS advised Islington Council's Emergency Duty Team (EDT) of the incident and said that the children were asleep in bed when LAS attended and had not witnessed the incident. The EDT noted the trigger for Storm's self-harming to be 'difficulties with her ex-partner'. LAS had spoken to the Crisis Team who were to visit Storm in the morning. The EDT attempted to contact Storm's aunt without success but were able to confirm the planned Crisis Team visit.

**5.47** During the morning of 29<sup>th</sup> November 2019 the Social Worker visited Storm at home when she told him that she had self-harmed the night before because of 'distress and guilt' after an argument with Kevin about moving their children to Manchester. The Social Worker phoned Storm's sister to confirm that she expected to arrive in London at 1.30pm and then return to Manchester with Storm and the children the same evening. The Social Worker asked Storm to contact the duty team on Monday 2<sup>nd</sup> December 2019 to update them.

**5.48** The Health Visitor became aware of Storm's intention to travel to Manchester and challenged the Social Worker about the need for Storm to be seen by a psychiatrist rather than allow her to travel to Manchester. The Health Visitor contacted Storm's GP to request an urgent mental health review by a psychiatrist. This was documented by the GP as a call from the Health Visitor in respect of a 'failed encounter' with Storm.

**5.49** The Crisis Team spoke to Storm's sister by phone. She advised that Storm was going to Manchester for the weekend and possibly staying there indefinitely with the children.

**5.50** Later the same afternoon, the police were called to Storm's address by Kevin's sister who said that she had spoken to Storm by phone earlier in the afternoon when Storm told her that she intended to travel to Manchester, where she planned to leave the children in the care of her mother and sister and then take her own life. Kevin's sister passed the same information to the Social Worker who was able to make contact with Storm's sister by text who said that the information shared by Kevin's sister was 'false' and that the family 'would not let Storm out of their sight'. The Social Worker advised Storm's sister to take her to A&E when they arrived in Manchester. Storm then rang the Social Worker to say that she had no intention of taking her own life. She also said that she planned to return to Islington on 2<sup>nd</sup> December 2019.

**5.51** The Met Police had been unable to contact Storm by phone and so they asked GMP to conduct a welfare check at the Manchester address to which Storm was believed to be travelling. GMP visited Storm's mother's address in Manchester in the late evening and established that she and the children were safe and well. The Met Police were notified of the outcome.

**5.52** Also on Friday 29<sup>th</sup> November 2019 the Section 47 enquiries were concluded. The outcome was that the children were not considered to be at risk of ongoing significant harm as a result of Storm's decision to move to Manchester with them, where she would be away from Kevin and have the support of her mother and sisters. It was noted that child 1 (aged 7) and child 2 (aged 5) had 100% school attendance. The school noted that child 2 had recently begun to show signs of anger and had become physical with peers and hurt them. Speech delay had been noted in Child 3 (aged 3).

**5.53** On Saturday 30<sup>th</sup> November 2019 the Islington Crisis Team phoned Storm who advised that she was in Manchester, had an adequate supply of medication and planned to apply for housing and stay in Manchester permanently. A referral was made to Manchester Home-Based Treatment Team (HBTT), which the latter service confirmed they had accepted the following day. The Manchester HBTT were advised that Storm had come to Manchester for two weeks to visit family and friends and needed a lot of support. She had a history of depression and anxiety and a long history of deliberate self-harm and suicidal thoughts. Manchester HBTT arranged to drop off current medications.

**5.54** A Met Police investigator had been tasked with obtaining more information from Storm about her disclosures of rape and spoke to her on Sunday 1<sup>st</sup> December 2019 at which time she confirmed that she did not wish to proceed and said that she was residing in Manchester. It was planned to obtain a withdrawal statement from her but no further action was taken prior to the closure of the case on 15<sup>th</sup> December 2019. No crime report was submitted in respect of the rape disclosure which meant that there was no specialist input from a specialist sexual offences investigation trained officer.

**5.55** On Monday 2<sup>nd</sup> December 2019 Storm presented as homeless at Manchester Town Hall and was documented to have fled from her ex-partner and that the police were involved due to domestic abuse. She and the children were provided with temporary accommodation in a hotel located in North Manchester, close to the address where her mother and sisters lived. It was documented that Storm could not be transferred to Universal Credit due to 'severe mental health issues' which made her eligible for a personal independence payment (PIP), and that MIND were completing the application for this. Recent attempts at suicide were noted. The

Homeless Health Visitor was informed. When new families are placed in temporary accommodation, they are able to refer them to other health services.

**5.56** Also on Monday 2<sup>nd</sup> December 2019 Islington Crisis Team documented a phone call to their counterparts in Manchester to inform them about Storm's self-harming incident on 29<sup>th</sup> November 2019. The Manchester service agreed to contact Manchester Children's Social Care. (Manchester HBTT has no record of the contact from Islington Crisis Team).

**5.57** On the same date Storm rang North Manchester HBTT requesting a higher dose of Diazepam. Storm was later seen, when she was said to have recognised that her 'volatile' and abusive controlling relationship with her ex-partner had had a negative impact on her mental health. A reduced supply of medication was provided due to concerns about her overdosing. Islington Children's Social Care were noted to be involved with Storm and her family.

**5.58** On 3<sup>rd</sup> December 2019 Storm was discussed at a Manchester HBTT MDT at which her 12<sup>th</sup> November 2019 overdose was noted to be 'due to the breakdown' of her long-term relationship with the father of children. Previous suicide attempts two years earlier and 5 or 6 prior overdoses were noted. (There was no mention of her preparations for suicide after leaving her hospital ward – Paragraph 5.32) Storm was zoned 'red', which entitled her to 3 phone contacts and at least 1 face to face contact each week.

**5.59** On 3<sup>rd</sup> December 2019 the Islington Health Visitor phoned the Islington Children's Social Care Deputy Team Manager to express concern that Storm had travelled to Manchester without psychiatric assessment. Children's Social Care confirmed Storm's temporary address in Manchester, 'safety planning' and the link to the Manchester 'Crisis Team' for Storm. (On 6<sup>th</sup> December 2019 the Islington Health Visitor team were contacted by Health Visiting in Manchester for a handover and the case was transferred on 9<sup>th</sup> December 2019.

**5.60** On 4<sup>th</sup> December 2019 the Islington Social Worker's team manager phoned Kevin who was angry that Storm had relocated to Manchester with the children, with whom he said he wanted to maintain contact. Manchester Children's Social Care were to be advised of Kevin's wish to be kept updated.

**5.61** On 5<sup>th</sup> December 2019 North Manchester HBTT visited Storm at the hotel, where she and the 4 children were sharing a room. Storm was noted to be struggling to cope with the Diazepam reduction regime, saying that the evenings were the worst time as her ex-partner was 'causing issues for her'. She said that she had now deleted his contact details from her phone.

**5.62** On 6<sup>th</sup> December 2020 Manchester HBTT liaised with the Manchester City Council (MCC) Contact Centre and it was agreed that there were no immediate risks to the children.

**5.63** On 8<sup>th</sup> December 2019 Manchester HBTT documented safeguarding concerns after Storm disclosed that Kevin was volatile, physically, and verbally aggressive and that two of the children had sustained bruising by him when he had gripped one of their faces too hard whilst washing their hair and hit another of child's legs with a TV remote control. Manchester HBTT planned to chase up Islington Children's Social Care to arrange transfer of the case to their Manchester counterparts. Storm said that her mood had improved following the move to Manchester.

**5.64** On 9<sup>th</sup> December 2019 a Manchester CMHT MDT reduced Storm to 'amber' zoning which means that she would receive at least one face to face contact each week. Zoning is a fluid process and a patient's zone can change if risks increase or decrease.

**5.65** On Tuesday 10<sup>th</sup> December 2019 Storm phoned her Islington Social Worker to advise that she and the children had been provided with temporary accommodation in Manchester 'at the end of her mother's road'. She went on to say that her mother and sister had been visiting her every day and that she was also being seen by the 'Crisis Team' three or four times each week. The Social Worker said that he would be referring Storm to Manchester Children's Social Care.

**5.66** On the same date (10<sup>th</sup> December 2019) a telephone conversation took place between the Islington Social Worker and Manchester HBTT and the latter advised that they planned to discharge Storm, adding that they thought the diagnosis of bipolar disorder was incorrect as her self-harm incidents had all been in response to 'arguments and issues' with Kevin (Islington CSC chronology). Manchester HBTT said that they could see no acute mental health issues but there could be some Personality Disorder issues (Manchester HBTT chronology). Storm was to be signposted to advice and support around 'appropriate' services. The Islington Social Worker said that they had been concerned about Storm's mental health as 'every time she had contact with her ex-partner she self-harmed' and had parasuicidal behaviour (includes suicidal gestures and attempts, and non-suicidal self- injury). The Social Worker felt that Storm was very unwell. He said he was 'not concerned' about the father of the children (Manchester HBTT chronology). Manchester HBTT stated that they had referred Storm to Manchester Children's Social Care adding that the latter service would like a referral from Islington. The Islington Social Worker made telephone contact with Manchester Children's Social Care later the same day.

**5.67** On Friday 13<sup>th</sup> December 2019 the Islington Social Worker sent an email to Manchester Children's Social Care to follow up on the phone call he had made three days earlier. In the email he documented three attempts at suicide/self-harm by Storm during his involvement with her, that the paternal family had alleged that Storm had threatened to kill the children before her initial suicide attempt (see Paragraph 5.31) and that it had been intended to convene an ICPC following the recent Section 47 enquiries.

**5.68** On 16<sup>th</sup> December 2019 Storm was reduced to 'green' zoning and it was decided to discharge her from the Manchester HBTT. The HBTT checked that Manchester Children's Social Care had accepted the transfer of care of Storm and her children from Islington and they asked them to chase this up with Islington Children's Social Care.

**5.69** On 16<sup>th</sup> December 2019 the Met Police investigator dealing with the coercive control investigation spoke with Storm by phone and established that she had relocated to Manchester, which Storm said she had done to avoid Kevin, who she said was unaware of her whereabouts. Storm agreed to provide a statement when she returned to London to collect the last of her belongings.

**5.70** On 18<sup>th</sup> December 2019 Storm's sister rang Manchester HBTT to say her sister was 'manic', struggling to cope and had issues with her accommodation. She was advised to contact 'housing'. The following day Storm was reviewed by an HBTT Doctor who prescribed Promethazine 25mg for two weeks to help her sleep and address her anxiety. Storm was seen and advised to register with a GP. After a final home visit, during which Storm said her sleep had improved, Storm was discharged from the service.

**5.71** On 23<sup>rd</sup> December 2019 Manchester Children's Social Care received a referral from Islington Children's Social care which stated that Storm and her children had moved to Manchester, that Storm was fleeing domestic abuse perpetrated by her expartner who was the father of the children and that Storm had made a number of attempts to take her own life, some of which had been witnessed by the children. The referral was allocated to Manchester Social Worker 1 to conduct a child and family (C&F) assessment.

**5.72** On 24<sup>th</sup> December 2019 Storm registered herself and the children with a GP practice in Higher Blackley (North Manchester) and was prescribed Fluoxetine 20mg and Quetiapine 100 mg for ongoing mental health problems.

**5.73** On Thursday 2<sup>nd</sup> January 2020 Storm disclosed to a pharmacist that she had been raped by an unknown male in the Hulme area of Manchester on New Year's

Eve. The pharmacist reported the matter to the police who contacted Storm. She said that after drinking with a friend in Manchester City Centre, they had taken a taxi with an unknown male to a party where Storm had been left alone with another male who had raped her, stopping only when she hit him with a bottle. Storm did not wish to make a formal complaint nor was she able to assist any investigation in relation to CCTV as she had been drinking and was unable to provide details of her movements. She declined attendance at the Sexual Assault Referral Centre (SARC) but contact details were provided in case she changed her mind. Contact details for Women's Aid and Victim Support were also provided.

**5.74** Also on Thursday 2<sup>nd</sup> January 2020 Kevin contacted the Islington Social Worker's Team Manager for advice as he said he was concerned for his children's safety but didn't know what to do. He added that he had hoped that the children would be removed from the care of Storm as a result of Islington children's Social Care's recent intervention. He said that he had received several texts from Storm saying that she could not cope and asking him to take the children. He also said that Storm had repeatedly asked him to resume their relationship which he said he did not wish to do. He said he had visited the children in Manchester on 21<sup>st</sup> December 2019 – which had been facilitated by Storm's family - and given the elder two children phones but had not been able to contact them since then. Social Worker 1's manager advised Kevin to seek legal advice.

**5.75** On Friday 3<sup>rd</sup> January 2020 Kevin contacted GMP to 'report a concern for Storm's welfare'. He said she had contacted him to say that she had been 'gang raped' and that one of the males involved had died. He said that he understood Storm to be in hospital and the children to be in the care of their maternal grandmother. The police cross referenced this call with Storm's disclosure of rape and carried out a welfare check of Storm and the children. Storm informed the police that the children had been left asleep with her friend's father when she and her friend went out on New Year's Eve. A Sergeant instructed that a care plan\* be created and a referral made to Children's Social Care. This was not done until a subsequent review highlighted the omission on 1<sup>st</sup> April 2020.

\*Care Plans have replaced Public Protection/Safeguarding Investigations and must be raised in response to any incident relating to a vulnerable adult, child or mental health and allocated to the local MASH.

**5.76** Also on Friday 3<sup>rd</sup> January 2020 the C&F assessment was completed by the Islington Social Worker and it recommended that the case be closed and referred to Manchester Children's Social Care. The assessment stated that it had not been possible to confidently state what impact Storm's 'emotional wellbeing' had had on the children, with whom no detailed direct work had been done, although they

appeared to be happy in their mother and aunt's care. Child 1 and child 2 said their mother had been 'sick' and 'sad'. The risks documented in the assessment focussed on Storm's mental health, suicide attempts and her 'poor relationship' with Kevin and 'historical concerns surrounding domestic violence/emotional abuse between the parents'. The assessment considered parenting capacity solely in respect of Storm and referred to a text she allegedly sent to Kevin threatening to harm the children. The concerns from the maternal family about Kevin's controlling behaviour and harassment of Storm were not referred to. Social Worker 1's team manager directed that a copy of the completed C&F assessment should be forwarded to Manchester Children's Social Care but it is not clear whether this happened.

**5.77** On 6<sup>th</sup> January 2020 Storm saw her GP who documented a diagnosis of long term generalised anxiety disorder, that she had moved from London due to an abusive relationship, was overwhelmed looking after four children and 'Social Services' were involved. The GP incorrectly documented that Storm was being supported by the HBTT (However, the GP did not receive a discharge summary from the HBTT until 28<sup>th</sup> January 2020. GMMH has advised this review that the delay in sending the discharge summary arose because Storm had not registered with a GP earlier). Storm presented as tearful but not suicidal and said that her accommodation had been broken into over the New Year, adding to her stress (the review has received no indication that this was the case) and requested 'more' Diazepam, sparing use of which was agreed.

**5.78** On 8<sup>th</sup> January 2020 Storm was seen by the MCC Homeless Service Hotel Support Worker after saying that she was struggling in the hotel. Storm was said to be suffering from anxiety, experiencing self-doubt and had been prescribed Diazepam by her GP. The Worker discussed the effects of leaving an abusive relationship and provided her with details of the Women's Aid drop-in sessions. Storm told the worker that child 2 was autistic (no previous reference to this) which was making life in the hotel more difficult. She said that she would like to live as close to her mother as possible.

**5.79** On 14<sup>th</sup> January 2020 the Hotel Support Worker visited Storm and advised her that she and the children would be moving to a temporary property in Gorton, where they would stay until all checks had been completed and a permanent home found, if eligible. Storm was said to be 'thrilled' to be finally moving.

**5.80** On 20<sup>th</sup> January 2020 a Child in Need (CiN) meeting was convened to support the ongoing C & F assessment at which information was shared by the Homeless Health Visitor, the Hotel Support Worker, Education and the Social Worker. Actions were agreed to support the family's transition to Manchester, including meeting with a Sure Start Worker to help Storm apply for school places and advise of bus routes
from Gorton to North Manchester – where her mother and sisters lived - and register with a new GP. Storm and the children were to be referred to Early Help although the Social Worker would retain the case until a worker was allocated.

**5.81** The Hotel Support Worker would continue to support Storm and the children until a Floating Support Worker was allocated. She later contacted the landlord for dispersed properties – HSL - to order a new cooker and washing machine as the existing ones were not working. She had difficulty in arranging for repairs to heating and lighting as Storm was visiting her mother on each occasion the electrician called.

**5.82** On 23<sup>rd</sup> January 2020 Storm saw her GP who she told she was moving to Gorton. The GP documented no change in mood but no suicidal thoughts. Storm did not change her GP as a result of her move to Gorton.

**5.83** On 28<sup>th</sup> January 2020 North West Ambulance Service (NWAS) transported child 4 to hospital A&E after the child knocked a kettle over, scalding the legs and hand from hot water. The skin was reddened but had been cooled under cold water for 10 minutes. Pain relief was given. No follow up was considered to be required.

**5.84** On 14<sup>th</sup> February 2020 Manchester Social Worker 1 contacted Islington Children's Social Care to request a chronology to help her complete the assessment of Storm and the family. In response C&F assessments completed in August 2017 and January 2020 and a chronology were sent from Islington.

**5.85** On 17<sup>th</sup> February 2020 a second CiN meeting was held as the C&F assessment was in the final stages of completion. The meeting highlighted the need for on-going support in respect of transition to a new area and 'safety plans' as part of a CiN plan.

**5.86** On 20<sup>th</sup> February 2020 a MCC Homeless Service Floating Support Welfare Officer emailed Storm to advise that he would be a point of contact until a Support Worker was allocated.

**5.87** On 24<sup>th</sup> February 2020 the C&F assessment was completed which confirmed the need for a CiN plan.

**5.88** During the morning of 26<sup>th</sup> February 2020 Storm was found unconscious and unresponsive by her children who contacted Storm's sister who then called NWAS who conveyed Storm to the Manchester Royal Infirmary (MRI). Around 1am child 3 had gone to ask Storm to change a nappy. Child 1 had also awoken and seen mother, saw she was cold and so the child had fetched her a blanket and put the heating on. Child 1 later followed the safety plan discussed with Social Worker 1 and

rang maternal aunt. Storm was admitted to the MRI who documented that she had taken an intentional overdose of approximately 48 Quetiapine and 'a sleeve' of Diazepam. Storm does not appear to have made any disclosures to hospital staff although the documentation on the Acute Ward to which Storm was transferred states that 'Partner Kevin not to visit patient'.

**5.89** NWAS raised a safeguarding concern to adult and Children's Social Care, having obtained information from Storm's mother who attended the address and told them that Storm had moved from London in December 2019 due to 'relationship issues' and had been the victim of a rape later in December 2019.

**5.90** On 27<sup>th</sup> February 2020 a strategy meeting was held involving Children's Social Care, the Police, the Homeless Health Visitor and the Hotel Support Worker at which it was decided that due to the escalating concerns Section 47 enquiries were required. It was established that Storm had been out for drinks with a person she knew from staying in Manchester previously on 24<sup>th</sup> February and had not returned home until 25<sup>th</sup> February 2019. At that time the children had been staying with their maternal grandmother. The apparent trigger for the intentional overdose was contact from Kevin who had called her 'toxic' and falling out with her sister about going out on the 'date'. It was agreed that more information was required from Islington. Concern was expressed that the children, who were staying with Storm's mother and sisters at Higher Blackley were not attending school as the two schools offered to the elder two children were some distance from each other.

**5.91** Following the meeting the Hotel Support Worker advised management that case required the urgent allocation of a Floating Support Worker.

**5.92** Also on 27<sup>th</sup> February 2020 Storm was seen by a mental health liaison practitioner in hospital. Storm said that she had met a male and not returned home leaving her family angry as they were looking after the children. Storm said she had been unable to obtain a reply when she texted her mother and sister and then rang Kevin who she said told her she was 'disgusting' and 'toxic' and so she thought that she may as well not be there and that everyone would be better off without her. She said that she put the children to bed and took an overdose and could not remember anything from that point. Storm said that she had lost 2 stones in weight since 2019 due to stress. The mental health liaison practitioner spoke with the Social Worker who was said to have described Storm's relationship with Kevin as 'toxic' in that Storm 'goaded' him and he was abusive to her. The mental health practitioner carried out a DASH risk assessment (score 17) and referred Storm to MARAC.

**5.93** On 2<sup>nd</sup> March 2020 Social Worker 1 asked the Hotel Support Worker if temporary accommodation could be found for Storm near her mother in Blackley.

The Social Worker was advised that MCC Homeless Team had a 'one offer' policy of a property anywhere within Greater Manchester although an individual's situation could be reviewed. However, the MCC Homeless Team management took the view that if the children were to continue to live with Storm, supported accommodation would be required, for which there could be a wait. A referral was made to Willow Bank – which was to the south of Manchester - which provided supported accommodation with 24/7 duty staffing but the Social Worker was concerned that this was some distance from Storm's family, the elder children were still out of education and it was difficult to make schools applications when it was unclear where they would be living. If her children were not living with Storm she would be treated as a single person and the Gorton property would need to be emptied and handed back.

**5.94** On 28<sup>th</sup> February 2020 Storm was reviewed by the hospital mental health liaison team and it was decided that an informal admission to an inpatient psychiatric bed was the most appropriate decision due to the impulsive and unpredictable nature of the overdose, and the fact that the previously identified 'protective factor' of Storm's children had not prevented her from taking the overdose whilst they were present in the house. However, Storm was not admitted to the inpatient psychiatric bed due to a shortage of female beds. On 2<sup>nd</sup> March 2020 Storm was seen in hospital by the mental health liaison nurse to whom Storm disclosed that she felt herself to be a burden on her family and was unsure if she could keep herself safe. She said she did not feel joy in anything she did in life.

**5.95** On 3<sup>rd</sup> March 2020 the Social Worker told the Hotel Support Worker that Kevin was travelling to Manchester the following day and she planned to meet him to obtain his views. (Outcome not known).

**5.96** On 6<sup>th</sup> March 2020 Section 47 enquiries were completed. It was noted that the children were staying in the care of their maternal grandmother and aunts whilst further support was sought for Storm in respect of her mental health. An ICPC was to be convened to consider the need for a Child Protection Plan (CPP).

**5.97** Storm was discharged from hospital on 7<sup>th</sup> March 2020 and went to stay and with her mother with the children. She was referred to North Manchester HBTT who planned to make telephone contact the following day. Storm was said to be remorseful about her overdose and wanted to return to her family and was said to be hopeful that Social Worker 1 would be able to support her to obtain a new property.

**5.98** On 9<sup>th</sup> March 2020 Storm's GP arranged a follow up appointment at which she reported feeling better and was living with her mother who was managing her

medication. The GP documented that Storm looked anxious but had no suicidal intent. This was the GP practice's last in-person contact with Storm.

**5.99** On the same date the Hotel Support Worker spoke with Storm, who was said to be confident that her children would be allowed to live with her again. Storm was advised that she would be expected to move into supported housing before being given a dispersed property due to the severity of the recent incident. Storm didn't accept this option as she wished to be near her mother. The Hotel Support Worker suggested that Storm's mother contact her landlord (Northwards) to ascertain if they would be able to offer a larger property than the 3 bed property they currently occupied which was overcrowded whilst Storm and her 4 children were staying with her mother and her two sisters. Storm was reluctant to hand back the keys to the Gorton property.

**5.100** The Hotel Support Worker later spoke to Social Worker 1 and advised that Storm had rejected the Willow Bank supported accommodation option as she was looking for schools in North Manchester. The Hotel Support Worker suggested Storm might wish to try the private rented sector in North Manchester. When the Hotel Support Worker explored this option, she established that the Private Rented Sector Team only worked with families in B&B and so she was directed to the Move On Team who said that a referral was needed from the Floating Support Worker once they had been working with the family and completed an assessment. The Hotel Support Worker advised Moving On that a Floating Support Worker had not yet been allocated and so was advised that the only option was for Storm to look for a private rented property and Move On would support her with accessing a deposit and the first month's rent.

**5.101** On 10<sup>th</sup> March 2020 an HBTT Doctor reviewed Storm's case and did not feel there was a role for HBTT, as her mental state was considered to be stable and there was no acute crisis and so she would be referred back to her GP who would be asked to reduce her Diazepam further. The doctor discussed a self-referral to improving access to psychological therapies (IAPT) with Storm, who indicated that she would do this.

**5.102** Also on 10<sup>th</sup> March 2020 Storm told the Hotel Support Worker that she wanted to retain her Gorton property until after the forthcoming ICPC and that all the worry about losing the property was increasing her stress levels. The Hotel Support Worker and Social Worker 1 discussed Storm and the children returning to the Gorton property with Storm's mother staying with them. If this option was approved there would need to be a working agreement in place. Later in the day Storm left the Hotel Support Worker a voicemail saying that she had been discharged from the HBTT as she was 'perfectly fit mentally'.

**5.103** During the late evening of 10<sup>th</sup> March 2020 her sister reported Storm missing from home after she said that she felt suicidal. Storm was located shortly after midnight at the Gorton address with a 'friend' whose name was not recorded. Storm told the police that she had been feeling claustrophobic and 'suffocated' living with her mother, sisters and her four children. Additionally, she said that her mother had been trying to prevent her leaving the house because of her (Storm's) mental health history. Storm went on to say that this had all got 'too much' for her. She said she was now feeling 'fine' and her presentation did not cause the officers any concern. Storm's family were advised of her whereabouts and that she was safe and well. The officers did not create a Care Plan or consider a referral. NWAS had received a report of Storm displaying 'manic' behaviour but had been cancelled by the police who had found Storm safe and well.

**5.104** On 12<sup>th</sup> March 2020 Social Worker 1 phoned the HBTT to express concern that Storm had no mental health support and was given advice about how to refer her to the CMHT via the Manchester Gateway – the single point of access for services provided by GMMH. Social Worker 1 was documented to have accepted the HBTT rationale for discharging Storm, whilst expressing concern regarding her impulsive behaviour in the context of stressful life events.

**5.105** Having received the MARAC referral from the hospital mental health liaison practitioner, Manchester IDVA attempted to contact Storm without success and contacted Social Worker 1 to ask her to advise Storm that the IDVA service were trying to contact her.

**5.106** On 23<sup>rd</sup> March 2020 the ICPC was held at which it was decided that all four children should be made subject of a CPP under the category of emotional abuse. Actions to ensure the family were appropriately supported included those relating to Storm's mental health, concerns in respect of domestic abuse and support in transitioning to a new area including access to education.

**5.107** On 25<sup>th</sup> March 2020 the IDVA spoke to Storm by phone. She reported that she didn't feel at risk now she was staying in temporary accommodation provided by the Manchester Homelessness Team the address of which was unknown to Kevin. She did not feel she needed a non-molestation order and declined IDVA support. Initial safety planning was discussed. She also reported that she had not been heard at MARAC in London but was known to agencies there. Storm added that she felt her mental health was more settled. The IDVA incorrectly assumed that Storm was open to mental health services as they were the referrer.

**5.108** Also on 25<sup>th</sup> March 2020 NWAS conveyed child 4 to hospital as she had a high temperature and there was concern that she might have contracted Covid-19. After examination in A&E the child was 'cleared' and returned home. It is unclear where the children were living at this time. This incident is also in the GMP chronology but dated 26<sup>th</sup> March 2020 as NWAS were initially unable to obtain a reply at the address and sought police assistance.

**5.109** Storm and the children were discussed at a Domestic Abuse Child Concern (DACC) meeting on 30<sup>th</sup> March 2020. The DACC is a daily meeting between the Police and Children's Social Care at which information is shared about domestic abuse cases in which children are affected. At this meeting it was noted that Storm had fled domestic abuse in Islington and that her current address in Gorton was not known to the perpetrator.

**5.110** On 1<sup>st</sup> April 2020 a virtual MARAC meeting took place using the 'exceptional delivery model' under which agencies were required to send updates to the Case Management Team prior to the meeting and offer any actions they felt were appropriate. The 'exceptional delivery model' had been introduced as a result of the Covid-19 restrictions. The case was then discussed between only the IDVA Team Leader and Case Management Team. Information shared at MARAC were domestic abuse incidents recorded in Islington in which it was stated that both parties were listed as victims and perpetrators. Storm was said to be willing to engage with mental health services and was said to be 'waiting for admission to a psychiatric unit'. The children were noted to be subject to a child protection plan and in the care of maternal grandmother. A referral had been made to Early Help. Storm had declined supported accommodation at Willow Bank and had been provided with contact details for Manchester Women's Aid in December 2019 but not made contact with the service. The actions arising from the MARAC meeting were for the Health Visitor and School Nurse to link in with other agencies to offer support, MCC Floating Support to offer ongoing support in respect of tenancy management, Children's Social Care to check 'significant others' as part of the child protection process and the IDVA and the MCC Homelessness Team were to merge their records on the MCC Adult Directorate information system.

**5.111** IDVA subsequently closed Storm's case after providing her with contact details for the service and a workers mobile number should she need the service in the future.

**5.112** On 2<sup>nd</sup> April 2020 the first Core Group meeting too place to oversee the child protection plan. As a result of Covid-19 restrictions the meeting took the form of a series of discussions with involved professionals and both Storm and Kevin. It was identified that referrals had been made for therapeutic support for Storm to support

the development of the plan which included returning the children to her full time care. It was agreed that Kevin's contact with the 'family' would be made through a 'third party family member'.

**5.113** On the same date Manchester Gateway received a referral in respect of Storm from Social Worker 1 and transmitted it to the North East Manchester CMHT, where it was triaged by the duty practitioner. After requesting further information from primary care, the duty practitioner decided that Storm did not meet the criteria for secondary mental health services and required support form psychological therapy, drug and alcohol services and specialist domestic abuse services. Storm's GP was notified and advised that Storm had been provided with improving access to psychological therapies (IAPT) self-referral information.

**5.114** On 5<sup>th</sup> April 2020 the MCC Homelessness team allocated a floating support Worker to Storm who subsequently made telephone contact with her to advise that she would not be able to visit her due to Covid-19 restrictions but would phone her every two weeks.

**5.115** On 6<sup>th</sup> April 2020 the Met Police noted that Kevin had been wanted as a suspect for coercive control since 8<sup>th</sup> October 2019 (Paragraph 5.23) but no statement had been obtained from Storm. A new investigator then contacted Storm who declined to make a statement, saying that, to do so, would not help her in her current situation. It was later decided to arrange an interview under caution with Kevin and also to contact Storm's sister to ask her to provide a statement which could enable an evidence-led prosecution to take place (Storm's sister declined to make a statement).

**5.116** On 14<sup>th</sup> April 2020 Social Worker 1 contacted the CMHT which confirmed that her referral in respect of Storm had not been accepted. There appears to have been a further discussion about Storm self-referring to IAPT and it appears that it was agreed that such a referral would be made, but there is no record of any referral being made or received by the IAPT.

**5.117** On 21<sup>st</sup> April 2020 Storm's case was transferred to Social Worker 2 in the Court and Locality team.

**5.118** A Core Group meeting took place on  $1^{st}$  May 2020. It is not known what was discussed.

**5.119** On 18<sup>th</sup> May 2020 Social Worker 2 contacted partner agencies to arrange a Core Group meeting and said that she had seen the family on Wednesday (presume this was 13<sup>th</sup> May 2020) and that Kevin was visiting the family and Storm was being

supervised by her mother and her sister and the family reported everything to be going very well and that Storm felt that she was in a much better place now, although she was concerned about rats and mice inside the property. The landlord HSL were contacted in respect of this and advised that they were only doing urgent visits as a result of Covid-19 restrictions but that they would call MCC who were doing free pest control visits.

**5.120** During the evening of 18<sup>th</sup> May 2020 the police and NWAS attended Storm's address (the Gorton property) after receiving a call from a relative of Storm who Storm had contacted. Storm had attempted to hang herself by wrapping speaker cable around her neck and throwing herself from the loft. She was found lying in the loft crying and expressed a desire to end her life as she was unable to cope with the responsibility of the children. She was documented to be under the influence of alcohol, cocaine and cannabis. Child 4 was in the house at the time. Storm was transported to hospital.

**5.121** Social Worker 2 established that Kevin may have been residing at the Gorton address with Storm for around three weeks after travelling from London for one of the children's birthdays. Storm had gone to a neighbour's house and they were drinking, using cannabis and cocaine. Kevin then attempted to bring Storm home and left the four children unattended to speak with the neighbour, during which words were exchanged and a threat was made to 'put windows in'. Storm returned home around 5pm the following day (18<sup>th</sup> May 2020), Kevin went to pick up one of the children from Storm's mother's address, put two of the children in his car, leaving child 4 with Storm who said she did not feel safe looking after the child and asked Kevin to stay which he refused to do. Storm then put child 4 in the living room and tied the door shut but child 4 managed to escape, went upstairs where Storm was attempting to take her own life. A safety plan had been in place involving the family and Kevin supervising Storm but she said she felt 'spied upon'. The plan now was to keep both parents apart and have a 'rota' of family support for the children.

**5.122** NWAS raised safeguarding concerns to Adults and Children's Social Care over concerns that Storm may take her life in front of the children as she had a 'clear intention to harm herself'.

**5.123** On 19<sup>th</sup> May 2020 Storm was seen in hospital by mental health liaison to whom she disclosed that she felt she was a burden to her family. She added that she had been experiencing auditory and visual hallucinations of her late father laughing and Kevin mocking her. She said that she had not had these hallucinations for around two years. She was considered to be at risk of emotional abuse by her partner and was diagnosed with emotional dysregulation accompanied by maladaptive coping mechanisms. The plan was to discharge Storm from hospital to

the care of her mother, refer her to the Central Manchester HBTT, inform her GP of her presentation and request the GP chase up the psychological therapy referral. However, the plan to discharge Storm to the care of her mother was in contravention of the plan from Children's Social Care that Storm would not be permitted any unsupervised contact with her children.

**5.124** Later the same day the HBTT saw Storm at her mother's address. She disclosed that both parents were alcoholics and she had grown up in pubs. She alluded to some abuse by a maternal uncle which was not further explored. Storm was documented to be staying with her mother for a short period before moving back to Gorton. The HBTT liaised with Social Worker 2 who advised that Storm must be supervised by her mother or sister when in contact with the children in accordance with the child protection plan.

**5.125** Also on 19th May 2020 a strategy meeting was held which was attended by Children's Social Care, the Police, the Homeless Families Team and Education. It was agreed that it was necessary to obtain updated information in respect of Storm's mental health. A family safety plan was to be developed which entailed the children staying in the care of Kevin, whilst Storm sought support with her mental health whilst staying with her mother. The safety plan in respect of contact between Storm and Kevin was revisited to ensure that when Storm saw the children, this was facilitated by the maternal family, in order to reduce the risk of domestic abuse incidents occurring.

**5.126** On 20<sup>th</sup> May 2020 senior managers from Children's Social Care reviewed the case given the escalating concerns and it was recommended that legal proceedings be issued.

**5.127** On 21<sup>st</sup> May 2020 NWAS and the police were contacted by Storm's mother after Storm locked herself in the bathroom. Her mother was concerned she may harm herself. Ambulance attendance was later cancelled after Storm became calmer and then went to bed.

**5.128** On the same date Storm's sister phoned HBTT to enquire about 'sectioning' Storm or at least having her assessed under the Mental Health Act. This was not recognised as a formal 'Nearest Relative' request and was not actioned although the HBTT practitioner responded by proposing the least restrictive option to which Storm agreed. Storm's family was advised that it was better for her to remain at home with support, although a medical review and a psychological assessment to support Storm to 'deal with past abuse' was arranged. The plan at this stage was to refer Storm again to CMHT for support from a care co-ordinator and progress the psychology referral when Storm was under the CMHT.

**5.129** Kevin was interviewed under caution by the Met Police on 22<sup>nd</sup> May 2020, having travelled to London from Manchester for that purpose. The Met Police had established that Kevin was caring for his children in Manchester after Storm had attempted to take her own life. He denied all disclosures made by Storm, specifically denying that he had controlled her lifestyle or threatened the caretaker of her then block of flats or had her followed. He said that his only contact was to collect the children twice weekly. The investigation was later reviewed and on 3<sup>rd</sup> June 2020 it was decided to take no further action and Storm was advised via her sister. Storm was documented to have declined support at that time. There is no indication that GMP were notified of the outcome.

**5.130** On 23<sup>rd</sup> May 2020 the Police were contacted by Storm's mother who said that Kevin had contacted her to say that Storm had turned up at the Gorton address and was not supposed to be there. Storm had been staying with her mother but had been out 'all day' and was assumed to have been drinking with a friend. Storm's mother said that she feared that Storm may have 'something with her' with which she might harm herself. Kevin told the police that Storm was 'manic, unpredictable and dangerous'. Storm was located at a friend's address on the same street as her mother's home. The police documented that Storm presented as 'fine', had no suicidal thoughts at that time and did not wish to return to her mother's address as they 'clashed' which affected her mood. The police facilitated contact between Storm and the HBTT who agreed to follow up with Storm at her friend's house the next day.

**5.131** On 24<sup>th</sup> May 2020 Kevin contacted the police to say that Storm had attended the address in an intoxicated state and one of the children had allowed her into the house. The police attended and removed Storm from the address and took her to her mother's address but her mother refused to allow her to stay with her. The police liaised with the MRI and the HBTT and a room was secured at a Guest House. Storm's sister contacted an HBTT nurse on the same date to say that her sister was vulnerable in that she was not taking her medication, was using alcohol and cocaine, and had been staying in Levenshulme (in Central Manchester) with a friend she had known for only two weeks.

**5.132** On 26<sup>th</sup> May 2020 a DACC meeting was held to discuss the need for Storm to stay somewhere safe as she was unable to stay within the care of her mother as originally planned.

**5.133** On the same day a conversation took place between the MCC Homelessness Team and Social Worker 3 – to whom the case had been transferred. Storm had been advised to recontact the Homelessness Team and temporary accommodation

for her as a single homeless person had been approved (B&B in the Guest House in which she was staying before moving to a single dwelling) but her children remained in the temporary property in Gorton with Kevin. The Social Worker said that she had advised Kevin to make a homelessness application in his own right.

**5.134** Also on 26<sup>th</sup> May 2020 Storm's case was discussed at an HBTT MDT meeting where it was agreed that she would benefit from support and a period of stability, particularly in relation to her 'domestic situation' before commencing any specific psychological input. The longer-term plan was to refer her to the CMHT and that the most appropriate referral route to psychological therapy would be through the CMHT psychologist. A medical review also took place the same day during which Storm's current stressors, medication and history were considered and the plan was to contact Storm's former Islington GP for medical records, to confirm her housing arrangements with Children's Social Care and to refer her to local drug and alcohol services. However, the request for medical records was not actioned at that time (In their contribution to this review Manchester Health and Care Commissioning point out that Storm's Islington medical records could have been obtained from her Manchester GP).

**5.135** On 27<sup>th</sup> May 2020 a further Core Group meeting was held, again in the form of a series of discussions with professionals from Children's Social Care, Education and Health and family members. It was noted that Storm was engaging with the HBTT and that the wider family were working with agreed safety plans to support the children and the family.

**5.136** From 27<sup>th</sup> May 2020 onwards a new Hotel Support Worker began trying to make contact with Storm to help in making an application for Housing Benefit but was unable to make contact. On 2<sup>nd</sup> June 2020 she established that Storm had lost her phone.

**5.137** Storm's move to the Guest House necessitated the transfer of her case from Central HBTT to North Manchester HBTT on 27<sup>th</sup> May 2020.

**5.138** On 28<sup>th</sup> May 2020 two weeks of medication – which was not in dosette form - was taken to Storm at the Guest House. She was noted to be binge drinking and taking cocaine. On the same date Storm's sister rang the HBTT to say that Storm had phoned her to say that she was going to kill herself. In response North HBTT were able to contact Storm at the Guest House and confirm her safety.

**5.139** On Saturday 29<sup>th</sup> May 2020 Storm cancelled an appointment with the HBTT due to feeling unwell. The appointment was rearranged for the following day. During the day Storm's sister rang the HBTT to say that she was concerned as Storm had

not arrived for an agreed visit with her children. Her sister was advised that Storm was unwell and so the HBTT made an unannounced visit to the Guest House but Storm was not seen, although staff confirmed that they had seen her that day. This information was passed onto Storm's sister (The HBTT had previously documented that Storm had given limited consent to information being shared with her family to confirm her safety). The HBTT continued to try and contact Storm by phone and text and made a further unannounced visit to the Guest House where the staff advised that she had been out all day. Whilst at the hotel a resident advised the HBTT Worker that Storm had allegedly been involved in an incident earlier in the day in which she had assaulted a member of the public (no further details were recorded). During the evening Storm contacted the HBTT to apologise for missing calls and said that she had lost her phone. Storm's sister contacted the HBTT a little later in the evening to report that Storm was intoxicated and didn't recognise her. The HBTT then phoned the Guest House to make a further check of Storm's welfare. The staff declined to check on Storm as 'they were a guest house and not supported accommodation'. When they read the final DHR report, Storm's family questioned why Storm had not been reported to the police as a missing person when the HBTT were unable to locate her.

**5.140** Also on Saturday 29<sup>th</sup> May 2020 Kevin contacted the Homelessness service to apply for accommodation near Storm's mother and sisters in North Manchester so that they were able to support him. Concern was expressed that Kevin may lack a local connection to Manchester and may be asked to return to London, raising the possibility that the children would need to be accommodated by the local authority.

**5.141** On Sunday 30<sup>th</sup> May 2020 the HBTT made an unannounced visit to the Guest House after Storm failed to attend an appointment but were unable to conduct a full Mental State Examination (MSE) due to Storm's intoxication. The staff had told the HBTT Workers that Storm had returned to the Guest House at 6am that morning in a 'very intoxicated' state and said that she was at risk of losing her placement with them. The HBTT were able to hold a conversation with Storm, during which she reported struggling with being separated from her children but denied any suicidal ideation or thoughts of harming herself. She also recognised that her risks increased when she used alcohol. A further appointment was arranged for Tuesday 1<sup>st</sup> June 2020 (Monday 31<sup>st</sup> May 2020 was a public holiday).

**5.142** On 31<sup>st</sup> May 2020 Storm's sister contacted HBTT to discuss concerns about her sister's behaviour and added that Storm had been advised that she could no longer remain at the Guest House. The HBTT documented that the latter issue would be discussed with Storm at the appointment the following day.

**5.143** On Tuesday 1<sup>st</sup> June 2020 Storm attended her appointment with the HBTT and presented as pleasant, well kempt and engaged with the assessment. She said she had not used alcohol for three days (inconsistent with HBTT observations on 30<sup>th</sup> May 2020) and planned to refrain from alcohol use as she was worried she could lose her accommodation. She described her mood as 'fine', whilst acknowledging her recent low mood, particularly around access to her children and recognised the negative impact that alcohol could have on her mood. She denied current suicidal thoughts. She indicated a desire to engage with psychological therapy as a long-term treatment and consented to a referral to IAPT which was made the following day. She declined a referral to Change, Grow, Live (CGL), the Manchester drug and alcohol service but was made aware of the self-referral pathway. It was mutually agreed that there was no current role for HBTT in Storm's care and she was discharged from the North HBTT and Children's Social Care were advised. The decision to discharge Storm was confirmed in a HBTT MDT the same day where issues with alcohol were identified as her primary difficulty.

**5.144** On 3<sup>rd</sup> June 2020 Kevin and the four children moved from the Gorton property to a property in North Manchester.

**5.145** On 5<sup>th</sup> June 2020 MCC Homelessness Team offered Storm a place at Women's Direct Access Centre (WDAC) in South Manchester where she would be able to access 24 hour support. If she was willing to accept, she could move in the next day.

**5.146** On Saturday 6<sup>th</sup> June 2020 Storm refused the place at the WDAC as she wanted to stay in the North Manchester area. It was explained to her that if she refused to accept this place she would be considered to be making herself intentionally homeless. Late in the day Storm phoned the Homelessness Team to say that it would be 'sending her over the edge' if she had to move to WDAC and that they 'didn't know what she was capable of'. After consulting the duty manager Storm was booked into the Guest House until Monday 8<sup>th</sup> June 2020 and was advised to call the assessment team that day. WDAC would hold a room for her until Monday.

**5.147** At 9.59am on Monday 8<sup>th</sup> June 2020 the manager of the Guest House phoned the Homelessness Service to say that Storm had stayed out last night and had still not returned. The manager did not want her back at the hotel as she was putting others at risk. Her room was cancelled.

**5.148** At 11.22am on Monday 8<sup>th</sup> June 2020 a member of the public contacted the police via the 999 system to report that a woman was hanging herself from a gate in

the street (which was near the Guest House). The police and NWAS attended and provided advanced life support and conveyed Storm to hospital where she later died.

#### 6.0 Analysis

**6.1** In this section of the report each of the terms of reference questions will be considered in turn.

# How effectively were any disclosures by, or indications of domestic violence and abuse to, Storm addressed by the agencies in contact with her?

**6.2** Storm and Kevin began a relationship in 2011 and had four children together. Agencies became aware of conflict within the relationship from September 2016 when Storm called the Met Police after Kevin smashed a plate and refused to leave the Islington flat in which they lived with the children. Kevin was documented to be Storm's 'on/off' partner at that time. During 2017 the Met Police were called to a number of domestic abuse incidents in which conflict arose over Kevin's contact with the children which suggests that they were not living together for much of this period. During 2018 the Met Police attended further domestic abuse incidents during which Storm disclosed controlling behaviour by Kevin – insisting on sleeping in her bed when she allowed him to stay the night and cancelling her phone contact – but this was not acted upon by the Police at that time. This pattern was later repeated in Manchester when he appears to have put pressure on Storm to let him stay with her in the Gorton property as hotels were closed due to Covid-19 restrictions.

**6.3** The pressure Kevin put on Storm to let him stay in the Islington flat with her and the children may also have been a feature of the lack of affordable alternative housing options when couples separate. Kevin, who was noted to sometimes sleep on Storm's balcony, may have struggled to find somewhere else to live when his relationship with Storm began to break down. Kevin presented to mental health services in July 2019 when the underlying issue was identified to be homelessness. The independent author has conducted other reviews when inability to afford alternative accommodation has been a factor in victim and perpetrator remaining together and the domestic abuse continuing.

**6.4** Coercive and controlling behaviour was recognised by the Met Police in October 2019 (Paragraph 5.23) and Storm then provided a very detailed account to the investigator (Paragraph 5.24) which also indicated evidence of stalking and harassment which may not have been recognised. The presence of stalking and harassment is regarded as an indicator of increased risk to the victim. Storm had also been trying to leave her relationship with Kevin for some time, which is also recognised as an indicator of increased risk.

**6.5** When Islington children's services initiated Section 47 enquiries in November 2019 the domestic abuse was perceived to be 'tit for tat', i.e. allegations levelled by 'either parent against the other' (Paragraph 5.34). In particular the Islington Social Worker appeared to perceive the domestic abuse as an issue which could be resolved if Kevin and Storm could communicate with each other in a less 'petty' way (Paragraph 5.44) which minimised the issue, attributed equal responsibility to each party and overlooked the evidence of coercion and control.

**6.6** Kevin was described by Storm and her family as physically intimidating big man who was employed in security. However, physical violence was rarely reported, Storm disclosing 'physical restraint' on one occasion (Paragraph 5.33), although this sounds like the way a professional, rather than a victim, might describe an act of violence. Storm disclosed rape by Kevin to the Met Police in November 2019 (Paragraph 5.37) but did not wish to pursue the matter further at that time, although she did not benefit from the expected input of a specialist sexual offences investigation trained officer (Paragraph 5.54) nor was she apparently offered specialist support. Specialist sexual offences investigation appeared to be triggered by the submission of a crime report which the Met Police investigator did not complete.

**6.7** Storm also disclosed derogatory name calling – 'whore', 'useless', 'no friends'; his questioning of her ability as a mother – which was corroborated to the Met Police by Storm's sister after listening to voicemails on Storm's phone (Paragraph 5.22). Given Storm's increasingly fragile mental health, this type of conduct by Kevin appears to have been particularly harmful. Storm's sister said that she tried to encourage Kevin to communicate with Storm's family rather than directly with Storm but he refused to do so (Paragraph 5.31).

**6.8** The police decided not to disclose which hospital Storm had been taken to following her overdose on 12<sup>th</sup> November 2019 because of concerns about his behaviour including continuing to phone her after an ambulance had attended (Paragraph 5.25).

**6.9** Storm's sister felt that she was too scared to report incidents, including rapes because she feared she would not be believed and convinced that Kevin would never admit anything. Her sister described the apparent powerlessness of this position as something which 'drove storm mad' (Paragraph 5.3).

**6.10** There was evidence that Kevin attempted to manipulate agencies into taking an adverse view of Storm, in particular a negative view of her parenting. He told Islington Children's Social Care that she had had a relationship with a 'paedophile' and was communicating with a 'convicted rapist' (Paragraph 5.28). Storm had had

an apparently brief relationship with a male who was a sex offender, albeit one was assessed as low risk. Both Kevin and his sister told the Islington Social Worker that Storm had threatened to kill the children and herself but when asked to share the text from Storm in which he said she had made this threat, he was unable to do so (Paragraph 5.31).

**6.11** Kevin made counter allegations against Storm, stating that she had harassed him, using access to the children to control him and 'poisoning the minds' of the children against him (Paragraph 5.31) and Storm physically assaulted Kevin on one occasion by slapping his face (Paragraph 5.7).

**6.12** Kevin has contributed to this review. He was aware that domestic abuse encompasses more than acts of violence and wished to make it clear that he did not perceive himself to be a domestic abuser. He was very preoccupied with Storm's relationship with the male he habitually referred to as the 'paedophile' and said that Storm began telling lies about the 'domestic abuse stuff' only after her relationship with this male came to light. He implied that in making allegations of domestic abuse against Kevin, Storm intended to distract attention from her infidelity, which he said was something which was strongly disapproved of in the Traveller community, to which he said Storm's family belonged. He went on to state that Storm then continued to falsely claim that he had domestically abused her in order to obtain accommodation in Manchester. As previously stated, Storm's family have advised this review that they are not Travellers.

**6.13** This does not appear to be a credible account. Concerns that Storm may be a victim of domestic abuse from Kevin began to arise in September 2016 (Paragraph 5.6) which pre-dated her relationship with the male Kevin described as the 'paedophile' by two years and ten months (Paragraph 5.19). If Storm's family were so disapproving of her infidelity, then this does not seem consistent with the support they continued to provide to her and the steps they took to help her move to Manchester. When challenged on this point, Kevin attempted to distinguish between Storm's family in Manchester and her family based in Islington. However, Storm's Islington based aunt supported her when she self-harmed just prior to her move to Manchester (Paragraph 5.46). The independent author gained the impression that Kevin's preoccupation with Storm's infidelity - if her relationship with the other male could indeed be reasonably construed as infidelity given the 'on/off' status of her relationship with Kevin – reflected Kevin's inability to cope with the loss of control over Storm which her relationship with another male represented to him.

**6.14** There were other elements of Kevin's account which strained credibility such as the account of his frequent attempts to obtain help for Storm from mental health services (Paragraph 5.26) and his account of Storm's behaviour when she visited the

Gorton house after her May 2020 attempt to take her own life which appeared exaggerated (Paragraph 5.33) and is not consistent with agency records (Paragraphs 5.130 and 5.131).

**6.15** Storm's sister has advised this review how she felt Kevin manipulated Storm into feeling that no-one cared for her except him and that he was all she had (Paragraph 5.3). There were strong echoes of this in Kevin's contribution to this review, when he said, for example, 'that if anyone was there for Storm it was him' (Paragraph 5.36) and said that he needed to be there for Storm because her family wouldn't do enough to help her (Paragraph 5.30).

**6.16** It is the view of the independent author that the contribution of Kevin's friend can largely be discounted as his account appears to be derived wholly from what Kevin told him and contains material which is clearly false such as his allegation that Storm would hit herself and call the police to try and blame Kevin. There was one incident in which Storm acknowledged that she had hit herself in the face (Paragraph 5.8) but there is no indication that she sought to blame Kevin for causing her visible injury.

# How effectively were the risks to Storm presented by her partner Kevin assessed and managed?

**6.17** The Met Police usually assessed the risk arising from domestic abuse incidents involving Storm and Kevin as 'standard' or 'medium'. No risk assessment was completed by the Met Police on one occasion (Paragraph 5.21).

**6.18** Following her relocation to Manchester, agencies generally seemed to assume that geographic distance from Kevin would protect Storm from domestic abuse. This may have been a factor in the absence of referral to domestic abuse services when Storm first arrived in Manchester. The Homelessness Team could have considered a referral to MARAC given that Storm was presenting as fleeing domestic abuse (Paragraph 5.55) and Manchester HBTT could have considered a referral for domestic abuse support after Storm disclosed that she was struggling during the evenings when Kevin was 'causing issues for her' (Paragraph 5.60). Manchester HBTT appeared to focus largely on the impact of the domestic abuse on the children – which was appropriate – but gave less attention to the impact on Storm (Paragraph 5.62).

**6.19** When it was discovered that Kevin had been staying for three weeks with Storm and the children in the Gorton property in May 2020, no DASH risk assessment was carried out. This may have been because Storm had just attempted to take her own life and the resultant safety plan entailed Storm residing with her

mother whilst the children were cared for by Kevin and Storm's contact with the children was to be managed by her mother or sisters. However, given the history of domestic abuse and the fact that Storm had relocated to Manchester in part to flee domestic abuse from Kevin, a DASH risk assessment should have been completed given the difficulty of ensuring that Kevin did not have further contact with Storm and, on the evidence of his previous conduct towards her, he could present a threat to her mental health.

**6.20** This attempt to take her own life in May 2020 also represented an additional opportunity to refer Storm for support from domestic abuse services as the conduct of Kevin was assessed as having been instrumental in her attempt to take her own life.

**6.21** Storm was never referred to Solace Women's Aid in London. Such a referral was considered on several occasions by the Met Police and mental health services but not made. However, the Met Police twice referred Storm to the National Centre for Domestic Violence (NCDV) (5.10 and 5.11), which is not a recommended course of action in Islington (or Manchester) because of the limited scope of the service provided by the NCDV and concerns about the extent to which the NCDV links in with local agencies working with the victim.

**6.22** Storm's Hotel Support Worker, who worked very diligently to support her during her stay in the Hotel and afterwards, provided Storm with details of the Manchester Women's Aid drop-in sessions (Paragraph 5.77).

#### When Storm was referred to MARAC whilst resident in the London Borough of Islington, how effective was the response? What action was taken to address the risk of domestic abuse she faced at that time?

**6.23** The Met Police made one referral to MARAC in September 2017 when the Islington Borough Police Community Safety Unit (CSU) deemed Storm to be 'high' risk of domestic abuse and 'put forward' her case for discussion at a MARAC meeting. However, in October 2017 the referral was reviewed by the Islington MARAC chair who made the decision that the case did not meet the criteria for a 'MARAC repeat' (Paragraph 5.12) and the case was not allocated to the November MARAC meeting. No further information about the criteria by which the MARAC chair made this decision has been recorded. In their contribution to this review, Islington Borough Council take the view that the 'high risk' referral in respect of Storm should have been considered and have advised this review of the approach which would be taken now.

**6.24** Storm was referred to Manchester MARAC by the hospital liaison mental health practitioner following her 26<sup>th</sup> February 2020 overdose (Paragraph 5.91) This was good practice. Manchester MARAC had very recently implemented a 'exceptional delivery model' to address the impact of Covid-19 restrictions on in-person meetings. This was the second MARAC meeting held via teleconference and at that time the only participants were IDVA and GMP, who reviewed information sent in by partner agencies. The resulting actions were then published on the Sharepoint systems which all agencies were expected to review and then implement their allocated actions. This process had some challenges and relied on agencies sending in information and uploading it to Sharepoint for review. The process has since changed and all agencies are expected to attend virtual MARAC meetings and present their information.

**6.25** There was a degree of information sharing at the MARAC although the meeting did not appear to gain a complete understanding of the risk of domestic abuse to Storm, in particular the suspected presence of coercive control (the investigation of which had not been shared with GMP by the Met Police) or the negative impact of Kevin's conduct on Storm's mental health. MARAC also appear to have been misinformed about the extent to which mental health services were engaging with Storm, documenting that she was 'waiting for admission to a psychiatric unit' which was incorrect. Overall, MARAC did not gain sufficient insight into Storm's vulnerability.

**6.26** The summary contained in the MARAC action plan is contradictory as is states Storm was not at immediate risk as she had moved despite the fact that separation is known to be a time of high risk for victims, even when they have moved areas. The action plan went on to state that Storm was at high risk of Kevin finding her. The IDVA then attempted contact within the expected time. Although Storm declined support as she said she felt safe, from the case notes it is not evident that safety planning was completed, as this is recorded as MARAC feedback, or that there were any discussions with the mental health service which made the referral, which one would have expected given her recent attempt to take her own life, the known risk of separation and conflict over child contact.

**6.27** This review has been advised that the IDVA service had been under significant pressures due to the volume of cases referred into MARAC, which exceeds the SafeLives recommended capacity for IDVA intervention. The IDVA service has recently gained an additional temporary Team Leader post which will enhance case supervision. In addition, two further temporary IDVA posts have been created in attempt to manage the demand on the service.

**6.28** The DHR Panel questioned whether MARAC outcomes were routinely notified to primary care. The IDVA service confirmed that letters are normally sent to GP's if IDVA have been unable to make a successful contact with a client and there are no other agencies involved. There are also occasions when GP's are contacted if contact has been lost with clients and the IDVA feels that the client may seek support from their GP practice. The Panel was also advised that in Islington, GP practice are routinely contacted in all MARAC cases and the standard letter used for this purpose has been shared with the review. In their contribution to this review, Manchester Health and Care commissioning advise that getting MARAC outcomes back to GPs was a significant gap.

**6.29** GMMH has advised this review that at the time of the MARAC meeting held on 1<sup>st</sup> April 2020 there was no agreed rota in place for attendance at MARAC meetings in Central Manchester. GMMH advise that ensuring MARAC attendance for mental health services has been challenging due to a lack of professionals agreeing to take on the role which carries a significant workload and responsibility in addition to a professional's core role. The professional is required to commit to one day of preparation (reviewing the input of GMMH for all parties to be discussed including the victim, alleged perpetrator and associated people), one day to attend the meeting and discuss concerns and actions with MARAC and further time to document outcomes and cascade any actions to the appropriate professionals within GMMH. GMMH recognises that this is a considerable undertaking for any professional involved and requires dedicated time and support to be able to effectively contribute to an essential process.

# How effective was action to safeguard Storm's children from the impact of domestic abuse?

**6.30** The impact of domestic abuse (and Storm's mental health) on the children was sometimes underplayed (Paragraph 5.6), although referrals to Children's Social Care were invariably made. In Islington many of the domestic abuse incidents arose over disputes over child contact arrangements (Paragraph 5.7). It is unclear if the impact of these disputes on the emotional wellbeing on the children was sufficiently explored in the assessments carried out by Islington Children's Social Care. Additionally, it is known that perpetrators can use child contact arrangements as an opportunity to inflict further emotional and physical abuse on the victim.

**6.31** The children were documented to be perceived by Storm as a 'protective factor' by the Manchester HBTT on several occasions and were listed as 'protective factors' by HBTT practitioners following Storm's attempts to take her own life in February 2020 and May 2020. It should have become increasingly clear that the children were not a 'protective factor' for Storm who began making determined

efforts to take her own life whilst caring for one or more of the children. Previous Serious Case Reviews (now referred to as Child Safeguarding Practice Reviews) have found that whenever practitioners perceive children as 'protective factors' in respect of parental mental health, the unintended outcome is invariably to increase risks for the children who in this case were all very young (1).

**6.32** Mental health services in Manchester did not appear to be formally involved in planning to safeguard Storm's children. They were not involved with Storm for periods but following the suicide attempt on 18<sup>th</sup> May 2020 the HBTT could have been invited to the strategy meeting the following day (Paragraph 5.123). Although Storm wasn't re-referred to the HBTT until discharge from hospital the day after the strategy meeting they had been involved with Storm for two recent prior episodes and would have valuable information to share. Nor was the HBTT invited to the Core Group meeting on 27<sup>th</sup> May 2020 (Paragraph 5.135). In their contribution to this review Manchester Children's Social Care have stated that they would have struggled to involve the HBTT in the strategy meeting as the HBTT were not working with Storm on the date of the meeting. This is true but the HBTT had worked with Storm previously and therefore held substantial information about her and it was very likely that Storm would be allocated to the HBTT case load on her discharge from hospital, which she was.

# Did agencies gain an understanding of the lived experience of Storm's children?

**6.33** The 'lived experience' is what a child sees, hears, thinks and experiences on a daily basis which impacts on their development and welfare. Practitioners need to actively hear what the child has to communicate, observe what they do in different contexts, hear what family members, significant adults/carers and professionals have said about the child, and think about history and context. Ultimately practitioners need to put themselves in that child's shoes and think 'what is life like for this child right now?'

**6.34** In this case the children experienced considerable upheaval which they may have struggled to understand. It is not known how well prepared they were for the relocation to Manchester. The elder two children were attending school full time in Islington and had an excellent attendance record. These two children did not attend school from the end of November 2019 until September 2020 and so for the first ten months of their time in Manchester were not able to access the support a school would provide and they were not observed by teachers and non-teaching staff.

**6.35** Some or all of the children were present on occasions when Storm attempted to take her own life. She took an overdose of Co-codamol and Quetiapine whilst

caring for child 4 – then aged 17 months old (Paragraph 5.25). All the children were present when mother inflicted superficial cuts to her neck and wrist just before the move to Manchester took place (Paragraph 5.45). All the children were present and in the sole care of mother when she took an overdose which rendered her unconscious in February 2020 and the eldest child – then 7 years old – did remarkably well to provide mother with a blanket, switch on the heating, look after the younger siblings and raise the alarm with maternal aunt (Paragraph 5.88). The youngest child was present when mother attempted suicide by hanging in May 2020 (Paragraph 5.120).

**6.36** The children spent several weeks staying in a single hotel room with their mother following their arrival in Manchester and were cared for by their mother, supported by their maternal grandmother and aunts and later cared for by their father with whom their contact had been intermittent since their departure from Islington.

**6.37** They lived in households in which there was domestic abuse involving their parents and conflict between their mother and maternal grandmother.

**6.38** The children have also had to cope with their mother's sudden death and after living with their father from May 2020, they were later removed from his care. Clearly the children have suffered greatly. Looking back, there may have been an opportunity for Islington Children's Social Care to have intervened when they became aware of Storm's plan to move to Manchester. Whilst the tragic events which were to follow could not have been predicted at that point, Children's Social Care were formally assessing the children, the assessment process was incomplete and the proposed relocation was completely unplanned.

# How effective was the support offered or provided to Storm in respect of her mental health issues?

**6.39** Storm was offered perinatal mental health support when pregnant with child 4 but did not attend appointments (Paragraph 5.17). Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. It is unclear what action agencies took in response to Storm's lack of engagement and whether the reasons for lack of engagement, such as the demands of caring for three young children, were explored. It seems that Storm's mental health was monitored by the Health Visitor and her GP (Paragraph 5.18).

**6.40** In 2017 the London Ambulance Service (LAS) was concerned about Storm's 'deteriorating mental health' and 'self-harm' and referred her to the Islington Crisis Team which promptly followed up with a home visit.

**6.41** From September 2019 Storm's mental health appeared to decline quite markedly. She was seen in an urgent care walk in clinic that month for depression and the feeling that 'things were getting out of control' (Paragraph 5.20).

**6.42** On 12<sup>th</sup> November 2019 Storm took an overdose of Co-codamol and Quetiapine (Paragraph 5.25) whilst the older three children were in the care of her sister. The triggers appeared to be feeling 'overwhelmed' by coping with her four children without financial support from Kevin, guilt over the children not having a father (Paragraph 5.26) and frequently being undermined by Kevin (Paragraph 5.27).

**6.43** Storm was discharged from UCLH to Camden Crisis House which helped to stabilise her mental health. Her family cared for the children which, for a time, reduced one of the stressors affecting her, although she later self-discharged because she needed to resume her childcare responsibilities (Paragraph 5.41). Whilst she was in the Crisis House the impact of her mental ill health and the risk she presented to herself began to generate concern about her capacity to care for the children.

**6.44** Having relocated to Manchester, Storm was supported by the North Manchester HBTT from 1<sup>st</sup> to 20<sup>th</sup> December 2019 before being discharged on the grounds that no acute mental health issues were apparent but there could be some personality disorder issues (Paragraph 5.65). The diagnosis of bi-polar appeared to be guestioned at this time. Whilst it is accepted that the HBTT provides short-term intensive community support, it seemed premature to completely discharge Storm from mental health services given her recent suicide attempts (although Manchester HBTT may not have been aware of the second attempt whilst an inpatient in UCLH at that time) and the fact that staying in B&B with her four children could exacerbate the stressor of struggling to cope with parenting the children. At the point of discharge Storm had not yet registered with a Manchester GP and the HBTT discharge letter did not reach her new GP until 28<sup>th</sup> January 2020 (Paragraph 5.76), although as previously stated GMMH delayed sending the discharge letter because Storm had not initially registered with a Manchester GP. Prior to 28<sup>th</sup> January 2020 the GP appeared to be under the mistaken impression that Storm was still being supported by the HBTT. At the point of discharge by the HBTT, Storm's sister contacted them to say that her sister was 'manic' and 'struggling to cope' (Paragraph 5.70).

**6.45** In the Serious Incident Review GMMH conducted following the death of Storm, they observed that a Mental State Examination was completed just prior to discharge which did not indicate any current risks. However, the GMMH Review

found that on each allocation to the North Manchester HBTT, including in December 2019, she was not allocated a named Worker which directly contributed to a lack of professional ownership of the responsibility to complete documentation, including an initial assessment, a risk assessment/safety plan and an initial 72 hour care plan. The GMMH Review went on to attribute the lack of a named Worker to the lack of a 'present acute crisis'.

**6.46** Storm came into contact with Manchester mental health services again during the hospital admission following her overdose of 26<sup>th</sup> February 2020. The hospital mental health liaison team decided that an informal admission to an inpatient psychiatric bed was the most appropriate course of action but Storm was not admitted due to a shortage of female beds. The GMMH Review report noted that the GMMH Patient Flow service is responsible for identifying beds for admission across the whole of the GMMH footprint (Bolton, Salford, Trafford and North and South Manchester) as well as potentially accessing out of area beds. Those who are assessed as requiring admission through hospital ED or under the Mental Health Act must be prioritised and so Storm was not identified as an urgent admission (despite initially being admitted through the MRI ED). The GMMH Review report found that had Storm been admitted to an inpatient psychiatric bed it is possible that a more thorough assessment of her risks and treatment may have been possible.

**6.47** Storm was referred to North Manchester HBTT following her discharge from hospital but within 3 days was discharged after an HBTT doctor reviewed her case and considered her to be stable (Paragraph 5.100). The GMMH Review report felt that this discharge from HBTT was supported by a clear clinical rationale, in that there was no current acute crisis, she was demonstrating good insight into both her needs and her crisis planning, had independently contacted her GP regarding a repeat prescription of her prescribed medication and denied any current thoughts or urges to harm herself or end her life. As in December 2019, Storm had never been admitted to the HBTT case load and therefore no risk assessment or care plan was required.

**6.48** Storm's Social Worker quickly contacted the HBTT to express concern about the lack of mental health support for Storm (Paragraph 5.103), a viewpoint this DHR is in agreement with. The Social Worker then referred Storm to the CMHT which resulted in a decision that she did not meet the criterial for secondary mental health services and required support from psychological therapy, drug and alcohol services and domestic abuse support (Paragraph 5.111). At this point the expectation of primary and secondary care was that Storm would self-refer to IAPT but there is no indication that she did so.

**6.49** The next time Storm came into contact with mental health services was after a further attempt to take her own life by hanging on 18<sup>th</sup> May 2020. She was seen by hospital mental health liaison the following day and discharged from hospital into the care of her mother the same day. The safety of this discharge plan was compromised in that, at that stage, it was envisaged that Storm's mother would be caring for the children and Storm's contact with them was to be tightly supervised (Paragraph 5.121). No specialist in-patient admission appeared to be considered on this occasion and Storm spent only one night in hospital prior to her discharge. (GMMH has advised this DHR that admission to an inpatient psychiatrist bed would have been considered and a decision to refer her to the HBTT for support in the community as the least restrictive option). Storm was referred to the HBTT, although on this occasion she was referred to the Central Manchester HBTT. The IAPT referral was to be chased up but it is unclear if that happened.

**6.50** Storm was supported by Central Manchester HBTT from 19<sup>th</sup> May until 27<sup>th</sup> May 2020 when she was transferred to the North Manchester HBTT after she moved to single homeless accommodation in the Guest House. Whilst being supported by the Central Manchester HBTT, Storm's case was discussed at an HBTT MDT meeting (Paragraph 5.134) from which the plan was to contact Storm's former Islington GP for medical records (not actioned), confirm her housing arrangements and refer her to local drug and alcohol services. The longer-term plan was to refer her to the CMHT.

**6.51** The Central and North Manchester HBTTs worked fairly intensively with Storm over the last two weeks of her life. Her frequent binge drinking and use of cocaine during this period affected the ability of the HBTT to engage with her effectively. Despite this frequent intoxication and indications that Storm was struggling, such as her family reporting that Storm said that she was going to kill herself, involvement on an assault of a member of the public, the Guest House clearly stating that her placement with them was at risk. However, an overly optimistic view arising from her positive presentation on 1<sup>st</sup> June 2020 led to Storm again being discharged from the HBTT (Paragraph 5.143). It is difficult to understand the decision to discharge her and why the original plan to refer her to the CMHT had been changed. Also, during this period of HBTT care, medication was provided to Storm in unsafe quantity and form (Paragraph 5.138). (The HBTT had been giving three or four days' supply of medication due to Storm's risk of overdose but on 28<sup>th</sup> May 2020 gave her two weeks supply of medication). The GMMH Review report found that Storm should have been allocated a named Worker when her case was transferred to the North Manchester HBTT on 27<sup>th</sup> May 2020 and that no risk assessment documentation had been completed at the point of discharge on 1<sup>st</sup> June 2020. The GMMH review report did not question the decision to discharge Storm but, as

previously stated, this DHR takes the view that the discharge was overly optimistic and was not fully informed by the risks apparent at that time.

**6.52** There is no indication that the IAPT received or actioned any referral for Storm. It is not completely clear why the intention to refer Storm to IAPT, for which this review has been advised there is no wait time, was not accomplished. At the 26<sup>th</sup> May 2020 Central Manchester HBTT MDT meeting it was agreed that Storm would benefit from support and a period of stability, particularly in relation to her 'domestic situation' before commencing any specific psychological input. The longer-term plan was to refer her to the CMHT and it was envisaged that she would access psychological therapy through the CMHT psychologist. However, by the time she was subsequently discharged from the North Manchester HBTT a week later, there was no mention of the plan to refer Storm to the CMHT in the 'Plan' section of the HBTT assessment (In their contribution to this review GMMH has stated that there is no documentation to indicate that the CMHT was no longer being considered as an option).

**6.53** It is also unclear why GMMH rejected or questioned Storm's apparently longstanding diagnosis of bi-polar which may have prevented an earlier referral to the CMHT and the benefit she could have obtained from care co-ordinator support.

**6.54** The GMMH Review report concluded that Storm had a history of para-suicidal and risky behaviour, characterised by impulsive acts of self-harm in the context of distress and emotional crisis. Once her immediate distress reduced she presented as insightful, engaging and motivated to address her own needs. This impulsivity during crisis and stable and insightfulness outside of crisis period made providing adequate support for her mental health and appropriate management of risk particularly challenging, in the view of the GMMH Review. The possibility that Storm may try and present as less mentally unwell than she was in order to maintain or regain the care of her children or to be allowed to continue to stay in the Gorton property provided by the Manchester Homeless service does not appear to have been considered. (After her March 10<sup>th</sup> 2020 discharge from the HBTT, Storm left the Hotel Support Worker a voicemail saying that she had been discharged from the HBTT as she was 'perfectly fit mentally' (Paragraph 5.102) which was not a description of her mental health which accorded with professional views at that time).

**6.55** The GMMH IMR author concluded that there were opportunities for each of the mental health services which Storm came into contact with to have considered the following referrals:

• Care Act Section 9 Assessment as there had been a clear change in Storm's care and support needs following her permanent move from London to

Manchester, which ranged from mental health, drugs and alcohol, domestic abuse, etc.

• Care Act Section 42 Enquiry as arguably the safeguarding adults duty was triggered on each occasion Storm was considered to be a risk to herself. She could have been considered to be self-neglecting through her inability to avoid self-harm or a failure to seek help or access services to meet her health and social care needs.

**6.56** GMMH's Manchester Division has a Section 75 agreement in place with Manchester City Council, which means had the above referrals been made, they would have been triaged by Adult MASH. Information would have been gathered by Adult MASH from partner agencies, including Islington Services and dependent on what was identified as Storm's primary need i.e. mental health or drugs and alcohol, under the Section 75 agreement, Adult MASH would have sent the referrals to the appropriate service provider.

# How effectively did agencies respond to Storm's suicidal ideation and attempts to take her own life?

**6.57** Storm's reasons for saying she intended to jump off her third floor balcony went unexplored by any health professionals. The Met police appeared to accept Storm's explanation that she had stopped taking medication because of constant vomiting in pregnancy (Paragraph 5.5)

**6.58** The triggers for Storm's overdose on 12<sup>th</sup> November 2019 appeared to be fully explored by the UCLH mental health liaison team, i.e. living alone with four children without financial help and guilt because of the children not having a father. Storm disclosed that she planned to attempt to attempt suicide again in the next few days or weeks and it was noted that the stressors which led to her overdose remained, as did increased impulsivity. Two days into her hospital admission Storm left the hospital ward, purchased alcohol and found a 'tall building' from which she planned to jump – which was a scenario she had told the clinical nurse specialist she had been contemplating - until a passer-by dissuaded her and she returned to the ward. When initially admitted, 1:1 support had been put in place but later withdrawn at Storm's request.

**6.59** Storm disclosed that the trigger for the interrupted 'tall building' suicide plan was 'flipping' following a telephone call from Kevin in which she felt he blamed her for him not being able to see the children (Para 5.32).

**6.60** The trigger for the superficial injuries Storm said she had caused with a broken mirror (Para 5.45) was not explored at the time as she declined hospital attendance but she later told the police that she had recently left an abusive nine year relationship during which time she had lost all her friends in London. The EDT subsequently noted that the trigger for Storm's self-harming were 'difficulties with her ex-partner' (Para 5.46), whilst the Islington Social Worker who later visited Storm at home was told that she had self-harmed because of 'distress and guilt' after an argument with Kevin about moving their children to Manchester (5.47).

**6.61** The triggers for Storm's first overdose in Manchester – on 26<sup>th</sup> February 2020 – were thought to be contact from Kevin in which he had called her 'disgusting' and 'toxic' and conflict with her family over going out on a date (Paragraph 5.89). Storm said that after speaking to Kevin she felt that she may as well not be there and that everyone would be better off without her (Paragraph 5.89).

**6.62** Turning to Storm's attempt to hang herself on 18<sup>th</sup> May 2020, she told the mental health liaison practitioner that she felt that she was a burden to her family. She also recounted auditory and visual hallucinations of her father laughing at her and Kevin mocking her. She was considered to be at risk of emotional abuse from Kevin and was diagnosed with emotional dysregulation and considered to have maladaptive coping mechanisms (Paragraph 5.121).

**6.63** With the benefit of hindsight, several antecedents of suicide were present in Storm's life. In the University of Manchester's 2017 report *Suicide by Children and Young People* (2), a random sample of deaths by suicide of people aged 20-24 in England and Wales were analysed. (At 28/29 Storm was a little older than the cohort in this study) The following antecedents of suicide highlighted by the report, were present in Storm's case: (The percentage figure in brackets relates to the percentage of deaths by suicide found in the sample of 20-24 year olds in which that antecedent was found)

- Family (parent, carer, sibling) history of mental illness (11%) and substance misuse (8%)
- Abuse (emotional, physical or sexual) (8%)
- Bullying (any) (8%)
- Social isolation (i.e. few or no friends) (11%)
- Excessive alcohol use (42%)
- Illicit drug use (51%)
- Suicidal ideas (55%)
- Financial problems (20%)
- Housing instability (25%)

**6.64** It is important to note that several of the above antecedents are common in young adults and cannot be used to predict suicide risk.

**6.65** The University of Manchester report concluded that the circumstances that lead to suicide in young adults often appear to follow a pattern of cumulative risk, with traumatic experiences in early life, a build-up of adversity and high risk behaviours in adolescence and early adulthood, and a "final straw" event, usually occurring in the three months prior to death (3). This event may not seem severe to others, making it hard for professionals and families to recognise suicide risk unless the combination of past and present problems is taken into account. The 'final straw' event may relate to relationship breakup, workplace problems, academic problems, family problems and housing instability.

**6.66** In Storm's case the 'final straw' event may have been the loss of the care of her children following the May 2020 attempt on her own life, the loss of property in Gorton in which she had lived with her children, the arrangements made to place her in single homeless accommodation and the concurrent allocation of temporary housing for Kevin and the children in North Manchester, which is what she had wanted but been unable to achieve.

**6.67** The justification for commissioning this DHR was the concern that Storm's apparent suicide may have been linked to the domestic abuse she had been suffering from Kevin, including the indications of coercive control. The strategy for preventing suicide in England recognises that 'there is evidence of a strong association between domestic violence and self-harm (4) and one of the action areas of the strategy is to tailor approaches to improve mental health in nine specific groups with particular vulnerabilities or problems with access to services including survivors of abuse or violence including sexual abuse (5). Storm made disclosures of both domestic abuse and rape against Kevin. (It is worthy of note that of the other eight vulnerable groups highlighted by the strategy for preventing suicide in England, Storm could have been included in three of them, namely people with untreated depression, people especially vulnerable due to social and economic circumstances and people who misuse drugs and alcohol).

**6.68** More recently (2018), Refuge (the national domestic violence charity) and the University of Warwick published research which explored the link between domestic abuse and suicide (6). They found that suicidality (suicidal thoughts, plans and attempts) is more prevalent amongst domestically abused women than their non-abused counterparts. They also found that depression, post-traumatic stress, anxiety and their behavioural consequences, such as social isolation, substance misuse and self-harm are common outcomes of domestic abuse, noting that these negative consequences are recognised risks for suicide.

**6.69** Additionally, the study draws attention to the theory that suicidal acts (completed or not) are understood as a 'cry of pain', rather than a 'cry for help', with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible (7). This theory goes on to suggest that regarding suicidality as a 'cry for help' rather than a 'cry of pain' risks obscuring the needs of those who may be in the greatest psychological pain and more likely to take their own lives in the future.

**6.70** In Storm's case, there seemed to be a strong connection between Storm's stated triggers for self-harm/attempts to take her own life and the derogatory things which Kevin said to her. For example, after the 12<sup>th</sup> November 2019 overdose, Storm told the Social Worker that the thoughts that she couldn't give the children what they needed kept 'popping into her head' (Paragraph 5.29). She told the UCLH mental liaison team nurse that she was 'consumed with guilt' about her ability to care for the children (Paragraph 5.30). Storm's sister told the police that she had listened to voicemails left on Storm's phone by Kevin in which he had described her as 'useless' (Paragraph 5.22).

**6.71** On other occasions impulsive suicide attempts may have been triggered by conversations with Kevin. For example Storm said that she 'flipped' after a telephone call from Kevin in which she felt he blamed her for his not being able to see the children, and left the UCLH ward looking for a tall building from which to jump (Paragraph 5.32).

**6.72** Overall, contact with Kevin when Storm was feeling particularly vulnerable appeared to increase her risk of suicide or self-harm. Additionally, she appeared to be at much greater risk from self-harm as a result of controlling behaviour and derogatory comments compared to physical harm from Kevin.

**6.73** The GMMH Review report found that there was an inconsistent record of escalating risk from when Storm moved to Manchester in December 2019 and her death in June 2020 and the lack of a review of existing risks assessments.

**6.74** Medication appears to have been prescribed to Storm in amounts which were incompatible with her history of suicidal ideation and attempts to take her own life. For example Storm took an overdose of approximately 48 prescribed Quetiapine (Paragraph 5.88) tablets and was given two weeks of medication – which was not in dosette form - by the North Manchester HBTT (Paragraph 5.138).

#### Was Storm's capacity to parent her children assessed and appropriate steps taken to safeguard her children from harm when they were in her care? Was Kevin's capacity to parent the children assessed?

**6.75** Storm self-discharged from Camden Crisis House and returned home to care for her children (Paragraph 5.41) which may not have been in the best interests of the children. However. The Crisis House referred Storm to the home crisis team and when Islington Children's Social Care contacted Storm the following day they were reassured to find that Storm's sister was staying with her, although this doesn't seem to have been physically verified and when they made a home visit found that the sister had in fact returned to Manchester (Paragraph 5.44).

**6.76** The children were allowed to remain in the care of Storm after she self-harmed by cutting her neck and wrist with a piece of broken mirror, albeit superficially (Paragraph 5.45 and 5.46). Agencies took comfort from the fact that a locally based aunt was able to stay with Storm and appear to have largely accepted the plan for Storm and the children to be taken to Manchester later that same day by Storm's sister.

**6.77** Although Storm's sister from Manchester was seen as a protective factor, could agencies have questioned whether it was in the best interests of the children to be taken from their home in Islington to a very uncertain future in Manchester at a time when their mother was mentally unwell and had recently made two serious attempts to take her own life and self-harmed just hours earlier. Could/should an urgent strategy discussion have been convened?

**6.78** In Manchester, appropriate steps were put in place to safeguard the children when in Storm's care but these gradually appeared to be relaxed and by the end of April 2020 the children appeared to be largely in the care of Storm and Kevin in the temporary accommodation in Gorton, although this was unknown to agencies for a time. The first Manchester Social Worker appeared to work very diligently to support Storm and her family and engage Storm's family in supporting them but a change of Social Worker, followed by another change of Social Worker at a time when Covid-19 restrictions would have been impacting on services, may have affected the focus of Children's Social Care for a time.

**6.79** It is unclear to what extent Kevin's capacity to parent the children was assessed after Storm's attempt to take her own life in May 2018 and whether the previous concerns about him as a perpetrator of domestic abuse were fully considered. This was a difficult situation for Children's Social Care to address. Storm's second attempt to take her own life (in Manchester) whilst caring for one or more of her children increased the risks to the children arising from being in her

care. Storm's mother and sisters had cared for the children after the first attempt Storm made to take her own life but there were reservations about Storm's mother's capacity to care for the children and Storm's mother and sisters would also be playing a key role in supporting Storm in her efforts to achieve a degree of stability in her life. In these circumstances, it is possible to understand why Kevin was considered a viable option to care for the children. He appeared to have been living with Storm and the children for several weeks and fulfilling his parenting responsibilities apparently adequately.

**6.80** However, Children's Social Care were aware that Storm had moved to Manchester with her children in order to distance herself from domestic abuse including coercive and controlling behaviour. His subsequent move from Islington to Manchester and the fact that he had been staying with Storm and the children in the Gorton property could have given rise to fears that this was a further example of coercive and controlling behaviour. Kevin's role in Storm's attempts to take her own life in Manchester and Islington could have raised further questions about the suitability of Kevin to care for children who had already experienced considerable trauma in their short lives. In their contribution to this DHR, Manchester Children's Social Care has advised that a family safety plan was agreed whilst (unspecified) further work was done with Kevin.

# What support was offered or provided to Storm to help her address her use of drugs and alcohol?

**6.81** Storm's relationship with alcohol only became apparent to agencies from November 2019. Being the primary and later the sole carer for four young children may have reduced her opportunity and her desire to drink alcohol but she became intoxicated when celebrating her birthday with family members whilst resident in Camden Crisis House (Paragraph 5.40).

**6.82** In Manchester, Storm frequently became intoxicated through alcohol and also began using cocaine. This seemed to be a significant change in her behaviour and over time began to appear self-destructive. The Manchester HBTT identified that Storm's impulsivity and risks to herself significantly increased under the influence of alcohol and illicit substances. Referral to drugs and alcohol services was contemplated when the CMHT rejected the referral from Storm's Social Worker (Paragraph 5.111) but does not appear to have been progressed. Storm declined a referral to Change, Grow, Live (CGL), but was made aware of the self-referral pathway (Paragraph 5.143) but she did not self-refer to CGL.

#### How effectively did agencies respond to the relocation of Storm and her children from the London Borough of Islington to Manchester? Were Storm and her children able to access services and appropriate support?

**6.83** This was a challenging relocation to support. Storm was mentally unwell. She had recently made a serious attempt to take her own life and during the resultant hospital admission had left the ward and taken steps to end her life once more. Shortly before the relocation she had again self-harmed. As stated earlier, partner agencies could have considered convening an urgent strategy discussion or at least held an ad hoc multi-agency meeting to plan how the relocation could best be supported. Only the health visitor appeared to challenge the planned relocation, proposing that Storm undergo an urgent mental health review by a psychiatrist (Paragraph 5.48) and escalated her concerns to Islington Children's Social Care management a few days later (Paragraph 5.59). The plans which emerged to check on mother and the children's welfare on arrival in Manchester could have been more effective. The Social Worker advised Storm's sister to take her to A&E on arrival in Manchester (Paragraph 5.50) which does not appear to have happened and appeared unrealistic given the fact that the sister had made the return journey from Manchester to London in a single day and there would be a need to get Storm and the children settled in on arrival in Manchester. The Met Police asked GMP to conduct a welfare check (Paragraph 5.51). GMP visited Storm's mother's address in Manchester and concluded that storm and the children were safe and well and notified the Met Police of the outcome. However, the Met Police had provided GMP with a fairly detailed account of recent events which could have raised concerns about Storm's mental health and justified a police care plan being completed.

**6.84** However, Islington Crisis Team made prompt contact with Storm following her arrival in Manchester and quickly referred her to the Manchester HBTT (Paragraph 5.53).

**6.85** Islington Children's Social Care had initiated Section 47 enquiries three weeks prior to Storm's move to Manchester and these were completed on the same day that the move took place (Friday 29<sup>th</sup> November 2019). The outcome of the Section 47 enquiries was that the children were not considered to be at risk of ongoing significant harm as a result of Storm's decision to move to Manchester which would physically distance her from Kevin and allow Storm to avail herself of the support of her family. This was a curious conclusion to reach as domestic abuse does not depend on geographic proximity, and the children would continue to be at risk from mother's mental health issues whilst having to cope with a challenging move. However, they did not make contact with Manchester Children's Social Care until 10<sup>th</sup> December 2019 (Paragraph 5.65) and do not appear to have shared their concerns about the children with their counterparts in Manchester until 13<sup>th</sup> December 2019

(Paragraph 5.66) which was a fortnight after Storm and the children travelled to Manchester. However, Islington Children's Social Care did not formally close Storm and the children's case until 3<sup>rd</sup> January 2020, when the C&F assessment was completed. It was intended that this assessment should be forwarded to Manchester Children's Social Care but it is not clear whether this was actioned (Paragraph 5.75). Islington Children's Social Care sent a chronology and copies of their August 2017 and January 2020 assessments to Manchester Children's Social Care on 14<sup>th</sup> February 2020, at the request of the latter service (Paragraph 5.83).

**6.86** Storm's relationship with Kevin had broken down and there were clear indications that, over time, it had become an abusive relationship. However, given Kevin's right to maintain contact with the children, geographic distance seemed unlikely to eliminate the possibility of abuse continuing.

**6.87** Although Storm would benefit from being closer to many members of her maternal family, it seemed unlikely that they would be able to offer Storm and her 4 children other than short term accommodation and Storm presented as homeless on the first working day after her arrival in Manchester. She and the children were provided with a room in a Hotel where they stayed until moving to temporary accommodation in Gorton in mid-January 2020. Given the 'severe mental health issues' the Manchester Homelessness Team documented (Paragraph 5.55), the seven plus weeks she spent with the children in one room in the hotel during the winter months when the opportunities for the children to play outside would be limited, seemed likely to adversely affect Storm's mental health.

**6.88** Over time, the application of Manchester City Council's Homelessness policy appeared to inadvertently have an adverse effect on Storm's mental health. Quite understandably the Homelessness Team were concerned about mother's ability to care for herself and her children in the temporary accommodation in Gorton following her February 2020 overdose and pushed for her and the children to move into supported accommodation. However, this was not located near her mother and sisters. Getting accommodation near her mother and sisters was a critical issue for Storm but the policy of 'one offer' of temporary accommodation was in tension with this. The need to move into single homeless accommodation when the children were no longer in her care following her May 2020 hanging attempt generated further stress for Storm.

**6.89** Two of the children had been attending school in Islington and all were being uprooted from everything which was familiar to them at short notice and being taken to a place where they were likely to face a degree of instability until housing and schooling could be arranged.

**6.90** This was not a well-planned relocation. This is not a criticism of Storm or her family. A crisis situation had developed. It was not unreasonable for Storm and her family to conclude that she and the children would be better off in Manchester. However, this would have been a challenging move to make even at a time when the lives of Storm and her children were stable.

**6.91** The risk from a perpetrator of domestic abuse to a victim often increases when the victim is attempting to leave the relationship. Therefore Storm's fairly abrupt departure from Islington could have been perceived to be a time of increased risk to Storm, despite the geographic distance her relocation initially put between her and Kevin. Was this risk fully appreciate by the agencies in Islington and Manchester?

#### How effectively did agencies respond to the subsequent relocation of Storm's former partner Kevin from the London Borough of Islington to Manchester?

**6.92** Agencies in Manchester understood that Storm's move from Islington to Manchester had been motivated in part by her desire to distance herself from Kevin. Storm had made a number of disclosures of domestic abuse against Kevin including controlling and coercive behaviour. Children's Social Care became aware that Kevin was travelling from Islington to Manchester to see the children in March 2020 (Paragraph 5.95) and at the Core Group meeting held on 2<sup>nd</sup> April 2020 it was agreed that Kevin's contact with the 'family' would be made through a 'third party family member' (Paragraph 5.112).

**6.93** Children's Social Care do not appear to have become aware that Kevin had been staying with Storm and the children in the Gorton property for a number of weeks until after Storm's second attempt to take her own life on 18<sup>th</sup> May 2020 (Paragraph 5.121) although there is some suggestion that Kevin may have become involved in the safety plan for the children prior to this incident (Paragraph 5.121). Following this second attempt on her life, the safety plan entailed the children staying in the care of Kevin, whilst Storm sought support with her mental health whilst staying with her mother. The safety plan acknowledged the risk of domestic abuse from Kevin, stating that Storm's contact with the children was to be facilitated by the maternal family.

**6.94** In the space of a very short period of time, Kevin went from being the perpetrator in a high risk case of domestic abuse – discussed at the Manchester MARAC on 1<sup>st</sup> April 2020 – to caring for the children in the home previously occupied by Storm – from 19<sup>th</sup> May 2020. It is unclear to what extent Children's Social Care were aware of all reported concerns about Kevin at that time, including Storm's
disclosure to the Manchester HBTT that he had physically abused two of the children (Paragraph 5.63).

**6.95** GMMH's Review report found that little consideration was given to the impact of Kevin on Storm's mental state and that there is no indication that the risk he presented to her was re-evaluated when he began visiting Manchester for contact with the children or when he permanently moved to Manchester and assumed responsibility for the care of the children and living in Storm's home with them. GMMH's findings could equally apply to Children's Social Care.

## How effective was multi-agency working in this case? Did the agencies Storm sought support from communicate and share information effectively with each other?

**6.96** The challenge of ensuring continuity of support for Storm and her children when they moved from the London Borough of Islington to Manchester presented a range of communication and information sharing difficulties. The learning arising from the manner in which agencies addressed these difficulties in documented in paragraphs 6.82 to 6.90.

**6.97** There was much good multi-agency working following Storm and the children's arrival in Manchester involving the Manchester Homeless Team, the Specialist Homeless health visitor, Education and Children's Social Care although this increasingly became crisis-led.

**6.98** The Manchester HBTT's made appropriate contact with Storm's GP. However, the GP practice did not appear to follow up on concerns about her mental health after March 2020.

Were there any specific considerations around equality and diversity issues in respect of Storm such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

**6.99** Storm's parents separated early in her childhood and after living in her mother's care for several years, Storm moved to live with her father during her mid teenage years. Her father died when she was 16 years of age and from records shared with this review, this was a particularly difficult time for her both in terms of bereavement and because she was at risk of homelessness. Her mother had moved from London to Manchester and was unable to offer Storm a home at that time. Storm's mother has advised this review that Storm did not want to live in

Manchester at that time. Storm later disclosed being abused by a maternal uncle which was not further explored by professionals.

6.100 It is unclear to what extent Storm may have suffered Adverse Childhood Experiences (ACEs) which are defined as 'stressful events occurring in childhood including domestic violence, parental abandonment through separation or divorce, a parent with a mental health condition, being the victim of abuse (physical, sexual and/or emotional), being the victim of neglect (physical and emotional), a member of the household being in prison and/or growing up in a household in which there are adults experiencing alcohol and drug use problems' (8). When children are exposed to adverse and stressful experiences, it can have a long-lasting impact on their ability to think, interact with others and on their learning (9). Storm disclosed a history of self-harming behaviour from the age of around 15 years when she began cutting herself superficially as a means of coping with emotional difficulties. She reported several overdoses and suicidal ideation. It was documented that she would often form what were described as 'unhealthy' relationships and describe people as 'friends' after knowing them for only a short period and became 'overwhelmingly distressed' when she was 'taken advantage of' due to her vulnerability. She had historical issues with alcohol and poly-substance misuse although she remained abstinent from 2012 – when her pregnancies began - until the final year of her life when she resumed alcohol consumption and began using cocaine. Storm's childhood experiences may have had a 'long reach' (10) into her adulthood. She experienced domestic abuse, including coercive and controlling behaviour, in both her intimate relationships, the first of which began months after her father's death.

**6.101** Storm may have had a disability in terms of a diagnosis of bipolar disorder. This diagnosis was questioned by mental health services in Manchester although Storm had been treated with medication for bipolar disorder for several years in Islington. People with bipolar disorder have episodes of depression when they may feel low and lethargic and mania when they may feel very high and overactive. Extreme episodes of bipolar disorder may last for several weeks or longer. Manchester mental health services felt that Storm's presentation suggested a personality disorder whilst her Manchester GP documented a diagnosis of long term generalised anxiety disorder.

**6.102** In terms of pregnancy and maternity, Storm gave birth to four children between 2012 and 2018. Concerns arose about her mental health and wellbeing at times and Storm was referred to perinatal services on one occasion.

**6.103** In terms of the protected characteristic of sex, there is a well-documented gap in employment rates for women and men with dependent children. Storm assumed full time responsibility for caring for her children in the family home and so

her opportunity to earn from employment was reduced leaving her financially dependent on Kevin's earnings to an extent.

**6.104** In his contribution to the review, Kevin stated that Storm was from a Traveller background. Storm's family state that they are not Travellers although their ancestors were Travellers. Some Gypsies and Travellers are protected against discrimination on the basis of their ethnic origin (Romany Gypsy or Irish Traveller) – even if they have moved into settled accommodation. Storm's family had moved into settled accommodation. Storm's family had moved into settled accommodation to suggest that she may have been discriminated against on the basis of the Traveller ethnic origin stated by Kevin.

# Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect Storm or impact upon the support provided or offered to her by agencies?

**6.105** Covid-19 restrictions were introduced in late March 2020 and presented a major challenge for all of the agencies in contact with Storm and her children. There seemed to be a reduced focus on her case from the Core Group meeting on 2<sup>nd</sup> April 2020 until mid-May 2020 during which time Storm may have assumed greater responsibility for caring for her children in the Gorton property and Kevin effectively moved in with her without the knowledge or approval of relevant agencies.

**6.106** The Covid-19 restrictions appear to have been a factor in Kevin's journeys from London to Manchester to visit his children evolving into a prolonged stay with Storm and the children in her temporary housing in Gorton. Covid-19 restrictions may have been used as a pretext for this by Kevin as Storm's sister and mother suggest in their contribution to this review.

## **Mental capacity**

**6.107** The GMMH Review report found that there were clear indications that Storm was able to retain information, independently crisis plan and had some insight into her care and treatment needs. Nor were any deficits in her capacity identified within the Mental State Examinations carried out in December 2019, May and June 2020.

**6.108** However, the GMMH Review recognised the contrast between Storm's impulsive behaviour in crisis and her stability and insight at other times. The GMMH Review report did not consider whether Storm had the capacity to make decisions when behaving impulsively. However, these impulsive decision making episodes were unplanned to an extent, making application of the Mental Capacity Act in these circumstances very challenging.

**6.109** The question of whether or not Storm was making decisions of her own free will was not considered as a discrete question by professionals. The possibility that her decision making could have been affected by the indications of coercive and controlling behaviour by Kevin could have been explored as could the impact on her capacity of the trauma of her children being removed from her care and being cared for by her abuser.

## Mental Health Act (Family Question)

**6.110** Storm's family enquired about her being assessed under the Mental Health Act at a time when she appeared to be in crisis and were advised that it would be better for Storm to remain at home with support (Paragraph 5.126). However, the viability of Storm being supported by family members at home had become fairly tenuous by that time (21<sup>st</sup> May 2020), and in their contribution to this review, her sister and mother question whether a Mental Health Act assessment should have been more actively considered. When Storm's family read the DHR overview report, they said that they had made several requests for Storm to be assessed under the Mental Health Act.

**6.111** The GMMH Review report found that whilst it was documented that Storm's family attempted to have her assessed under the Mental Health Act, this was not identified as a 'Nearest Relative' request and therefore was not communicated to the approved mental health professional (AMHP) hub in the appropriate manner. (Under Section 13(4) of the Mental Health Act (MHA) the 'Nearest Relative' has the right to request an assessment under the MHA and the AMHP service has a duty to consider such requests and if it is decided not to carry out an assessment, the reasons in writing must be communicated to the 'Nearest Relative'). The GMMH Review found that a lack of clear guidance on the receiving and processing 'Nearest Relatives' requests was the root cause of this omission.

**6.112** Storm's family were unaware of the rights of her 'Nearest Relative' (Storm's mother) under the MHA.

## **Good practice**

**6.113** There were many examples of good practice in this case including:

• A Met Police supervisor decided that Storm's sister's report to the police in October 2019 was a third party allegation of coercion and control which led to the completion of a DASAH risk assessment and a secondary investigation (Paragraph 5.23).

- The Met Police decided not to disclose to Kevin the details of the hospital Storm had been taken to after her overdose because they were concerned about his constant attempts to contact her by telephone (Paragraph 5.25).
- When Storm's Islington health visitor became aware of her intention to travel to Manchester, she challenged Children's Social Care over the need for Storm to be seen by a psychiatrist and contacted Storm's GP to request an urgent mental health review (Paragraph 5.48).
- The Manchester Homeless Service Hotel Support Worker remained involved in supporting Storm and the children for a substantial period after they moved out of hotel accommodation to the Gorton property, providing valuable continuity of support.
- Social Worker 1 provided very effective support to Storm and the children, including discussing a safety plan with child 1 which helped the child summon assistance following Storm's first attempt to take her own life in Manchester in February 2020.
- Following Storm's first attempt to take her own life in Manchester, the hospital mental health liaison team practitioner carried out a DASH risk assessment and referred her to Manchester MARAC.
- Social Worker 1 contacted North Manchester HBTT in March 2020 to express concern about Storm's lack of support in respect of her mental health and referred her to the CMHT.
- Storm's family expressed their appreciation of the support provided to them by the hospital in which Storm died.

# 7.0 Conclusion

**7.1** Storm died in hospital in June 2020 following a serious attempt to hang herself several days earlier. Storm and her four young children had relocated to Manchester from the London Borough of Islington in November 2019 to be near members of the maternal family who resided in Manchester but also to physically distance herself from her ex-partner Kevin who was the father of the children. Storm had disclosed coercive and controlling behaviour by Kevin which appeared to be a factor in prior attempts to take her own life in Islington. She continued to experience mental health problems in Manchester and made further attempts on her own life which led to intervention by Children's Social Care and restrictions on her contact with her children. At the time of her death, the children were in the care of her ex-partner Kevin who by this time had also relocated from Islington to Manchester.

**7.2** Storm's relocation from Islington to Manchester with her children proved extremely challenging for agencies in both locations to support and substantial learning has been identified as a result. In particular this review sheds light on the challenges faced by homelessness services in supporting people who present as homeless after fleeing domestic abuse.

## 8.0 Lessons to be learnt and recommendations

#### Awareness of coercion and control.

**8.1** Increasing professional awareness of the types of behaviour which indicate coercive and controlling behaviour in intimate relationships is indicated in this case by the fact that Kevin's controlling behaviour went unrecognised by the Met Police in 2018 but was subject to investigation the following year.

**8.2** However, the presence of controlling behaviour was overlooked in the Islington Children's Social Care's assessment completed in late 2019 and the possibility that Kevin was demonstrating controlling behaviour when he moved into the Gorton property with Storm and the children in late April or early May 2020 did not appear to be considered. Kevin's conduct at that time was similar to his behaviour in Islington when Storm said that, in order to avoid an argument, she had reluctantly allowed him to stay in the flat and he had insisted on sleeping in her bed which had made her feel uncomfortable.

# Impact of controlling behaviour and the undermining of self-esteem on a victim's mental health.

**8.3** A key feature of this case is the impact of Kevin's name calling and derogatory comments which appeared to chip away at Storm's self-esteem, adversely affect her increasingly fragile mental health and appears to have contributed to her attempts to take her own life and her eventual apparent suicide. This was apparent to an extent to many of the professionals who worked with Storm but was not fully explored or the impact on her mental health fully understood.

**8.4** It is therefore recommended that Manchester Community Safety Partnership that Manchester Community Safety Partnership ensures that all domestic abuse training focusses on coercive and controlling behaviour as a form of domestic abuse and that the learning from this case is utilised to inform domestic abuse training in respect of the impact of controlling behaviour in undermining the self-esteem of the victim and potentially affecting their mental health.

## **Recommendation 1**

That Manchester Community Safety Partnership ensures that all domestic abuse training focusses on coercive and controlling behaviour as a form of domestic abuse and that the learning from this case is utilised to inform domestic abuse training in respect of the impact of controlling behaviour in undermining the self-esteem of the victim and potentially affecting their mental health.

#### Support for victims who flee domestic abuse

**8.5** Storm presented to the MCC Homelessness service as relocating from Islington to Manchester in order to flee domestic abuse. As such a DASH risk assessment should have been completed and a referral for specialist domestic abuse support made. On this and other occasions, too much comfort was taken from the fact that Storm was in Manchester and Kevin was in Islington. Lack of geographical proximity does not prevent domestic abuse.

**8.6** It is therefore recommended that when the learning from this review is disseminated the message that lack of geographical proximity does not prevent all forms of domestic abuse is highlighted.

#### **Recommendation 2**

When the learning from this case is disseminated Manchester Community Safety Partnership highlights the fact that absence of geographical proximity does not prevent all forms of domestic abuse.

#### Meeting the needs of people with complex needs who present as homeless

**8.7** Storm had complex needs. The impacts of trauma in early life, the death of her father, the coercive and controlling behaviour of Kevin, the stresses of parenting four young children, the challenges of managing her family's transition from Islington to Manchester, her fragile self-esteem, her diagnosis of bipolar disorder, her escalating attempts to take her own life and her unhealthy relationship with alcohol meant that supporting Storm effectively would be challenging.

**8.8** The review has heard about the substantial challenges facing the MCC Homelessness service in meeting the demands placed upon them by the numbers of victims of domestic abuse presenting as homeless. However, there were many aspects of Storm's interaction with the Homelessness Service which were not ideal including the seven weeks she spent sharing a hotel room with her four children, the delayed allocation of a floating support Worker when she was placed in a family home in Gorton, the distance between the property in Gorton and the support Storm needed from her mother and sisters in North Manchester. These factors were amongst those which adversely affected her mental health.

**8.9** It is therefore recommended that Manchester Community Safety Partnership requests the MCC Homelessness Service to review the support they provide to the victims of domestic abuse who present as homeless, including the support they provided to victims of domestic abuse with complex needs and any adjustments they make to policy to accommodate complex needs.

#### **Recommendation 3**

That Manchester Community Safety Partnership requests the MCC Homelessness Service to review the support they provide to the victims of domestic abuse who present as homeless, including the support they provided to victims of domestic abuse with complex needs and any adjustments they make to policy to accommodate complex needs.

**8.10** The Domestic Abuse Act 2021 requires local authority's to appoint a Domestic Abuse Partnership Board for the purpose of providing advice to the authority on the exercise of certain functions under the Act including the Safe Accommodation Duty – a statutory duty relating to the provision of support to victims of domestic abuse and their children residing within refuges and other safe accommodation, including those who come from outside the area.

**8.11** It is therefore recommended that Manchester Community Safety Partnership seeks assurance from the Domestic Abuse Partnership Board that new services commissioned to meet the Safe Accommodation Duty include support provided to

victims of domestic abuse with complex needs and are reflected in adjustments made to policy to accommodate complex needs.

### **Recommendation 4**

That Manchester Community Safety Partnership seeks assurance from the Domestic Abuse Partnership Board that new services commissioned to meet the Safe Accommodation Duty include support provided to victims of domestic abuse with complex needs and are reflected in adjustments made to policy to accommodate complex needs.

## **Relocation from Islington to Manchester**

**8.12** The London Borough of Islington has fully contributed to this review. Agencies in Islington have identified single agency learning which is included in Appendix A. It is recommended that Manchester Community Safety Partnership shares this report with the Safer Islington Partnership so that the latter partnership may seek assurance in respect of local single agency action plans.

#### **Recommendation 5**

That Manchester Community Safety Partnership shares this report with the Safer Islington Partnership so that the latter partnership may seek assurance in respect of local single agency action plans.

**8.13** Storm and her children's relocation from Islington to Manchester was extremely challenging for agencies in Islington and Manchester to support, given the needs of Storm and the children and the concerns about Storm's mental health and attempts to take her own life, the concerns about domestic abuse and the very short notice that agencies received that the relocation was taking place. The response of agencies to the relocation is analysed in the report and it is recommended that all agencies involved reflect on their learning from how they supported Storm and her family manage this complex transition in order that they are better placed to respond to similar events in the future.

## **Recommendation 6**

That Manchester Community Safety Partnership and the Safer Islington Partnership requests all agencies involved to reflect on their learning from how they supported Storm and her family manage their relocation from Islington to Manchester in order that they are better placed to respond to similar events in the future.

# Secondary Mental Health Support for Storm following her move to Manchester

**8.14** Storm was supported by the North Manchester HBTT during three periods following her move to Manchester – on her arrival in Manchester in December 2019 and in response to her attempts to take her own life in February and May 2020. During the third of these periods, Storm was initially supported by the Central Manchester HBTT before her case was transferred to the North Manchester HBTT.

**8.15** GMMH shared the Serious Incident Review they completed following the death of Storm with this DHR. The GMMH Review, which was very thorough, found that the North Manchester HBTT never allocated a named Worker to her case and did not complete expected documentation including a risk assessment and a care plan.

**8.16** Following the first attempt on her life in Manchester, the GMMH provided hospital mental health liaison team decided that Storm should be admitted to a inpatient psychiatric bed but attempts to admit her over several days failed because of a shortage of female beds. Had the intended admission taken place a more thorough assessment of her risks and treatment may have taken place. Following her discharge from a general hospital bed, Storm was quickly discharged by the HBTT which led to concerns from Children's Social Care that she lacked mental health support, which this DHR shares.

**8.17** Storm was supported by the HBTT after her second attempt to take her own life in Manchester in May 2020. Storm appeared to be in crisis during this period and her family twice requested that she be assessed under the Mental Health Act. No such assessment took place and the process which should have been followed a request for a MHA assessment by the person's Nearest Relative was not followed. The decision making around Storm's final discharge by the HBTT was overly optimistic and not fully informed by the risks she presented.

**8.18** The GMMH Review identify the following areas of learning:

- That staff within GMMH are unaware of the process and procedure relating to a Nearest Relative's right to request assessment as part of their rights under the Mental Health Act 1983
- There are variations in expected documentation for HBTT's needs review to develop a single process for recording risk assessment and care planning.

- That systems in place to monitor named Worker allocation and responsibilities in North HBTT were not sufficient to ensure compliance with the HBTT Standard Operating Procedure.
- That the process of GMMH representation at MARAC in Central Manchester at the time of Storm's death was not sufficiently robust to ensure consistent attendance at these meetings.
- There appears to be a lack of training in relation to professional curiosity and protective factors for GMMH clinical staff.
- That there was no Operational or Service Manager level contact with Storm's family following her death.

**8.19** It is recommended the Greater Manchester Mental Health NHS Foundation Trust ensures that all areas of learning from their Serious Incident Review and any additional learning arising from this DHR, including the shortage of female inpatient psychiatric beds and a tendency for each care episode to be seen in isolation are fully addressed. (It is understood that a current Manchester Safeguarding Adults Review is considering similar issues).

# (Single Agency) Recommendation 7

That the Greater Manchester Mental Health NHS Foundation Trust ensures that all areas of learning from their Serious Incident Review and any additional learning arising from this DHR are fully addressed.

# Children described as 'protective factors' in respect of parental mental health

**8.20** Storm's children were consistently identified as the primary 'protective factor' against risk to herself, despite the fact that Storm began making determined efforts to take her own life whilst caring for one or more of the children (Paragraph 6.31). As previously stated, Serious Case Reviews have found that whenever practitioners perceive children as 'protective factors' in respect of parental mental health, the unintended outcome is invariably to increase risks for the children who in this case were all very young.

**8.21** The term 'protective factor' should not be used to refer to the children of an adult with mental health issues. The child or children should always be the central consideration in the management of risk by all services, whether child or adult facing.

**8.22** It is therefore recommended that Manchester Community Safety Partnership shares this report with Manchester Safeguarding Partnership so that the latter partnership can consider further action to discourage the use of the term 'protective factor' to refer to the children of an adult with mental health issues.

#### **Recommendation 8**

That Manchester Community Safety Partnership shares this report with Manchester Safeguarding Partnership so that the latter partnership can consider further action to discourage the use of the term 'protective factor' to refer to the children of an adult with mental health issues.

#### Apparent suicide of victims of domestic abuse.

**8.23** There appear to have been a number of factors involved in Storm's apparent suicide but it seems clear that the impact of Kevin's controlling behaviour, his undermining of her self-esteem and his contact with her immediately prior to some of her attempts to take her own life significantly increased the risk that she may self-harm or take her own life.

**8.24** The Manchester Suicide Prevention Plan 2020-2024 identifies 'those who have experienced domestic abuse including sexual abuse' as a group at risk of suicide. The Greater Manchester Suicide Prevention Strategy 2017-2022 doesn't include victims of domestic abuse in their eight priority areas. However the multi-agency partnership which oversees this strategy has recognised over the past 12-18 months the impact that domestic violence can have on self-harm and/or suicide ideation/suicides. The partnership plan to address the need to reflect victims of domestic violence as a 'high risk group' in the revised Greater Manchester strategy. Suicide prevention strategy priorities are informed by analysis of data about deaths from suicide. Given the fact that it has only been possible to conduct DHRs involving apparent suicide since the current Home Office guidance was last updated in December 2016, it may be that there has not been sufficient time for concerns about links between domestic abuse and suicide to fully inform suicide prevention strategies. It is understood that there are currently 4 DHRs which involve apparent suicide by the victim in progress, or recently completed across Greater Manchester.

**8.25** It is therefore recommended that this DHR report is shared with those responsible for the Manchester and Greater Manchester Suicide Prevention Strategies so that increasing awareness of the links between domestic abuse and suicide can inform the future development of prevention and safeguarding strategies. The Suicide Prevention Strategies may also wish to note the quantity of

medication prescribed to Storm which appears to have been incompatible with her history of suicidal ideation and attempts to take her own life (Paragraph 6.74).

## **Recommendation 9**

That Manchester Community Safety Partnership shares this DHR report with those responsible for the Manchester and Greater Manchester Suicide Prevention Strategies so that increasing awareness of the links between domestic abuse and suicide can inform the future development of prevention and safeguarding strategies.

## Involvement of Adult Mental Health services in child protection planning

**8.26** Following Storm's attempt to take her own life on 18<sup>th</sup> May 2020 Manchester HBTT could have been invited to the strategy meeting the following day. Although Storm wasn't re-referred to the HBTT until discharge from hospital the day after the strategy meeting they had been involved with Storm for two recent prior episodes and would have valuable information to share. Nor was the HBTT invited to the Core group meeting held on 27<sup>th</sup> May 2020 after Storm's second attempt to take her own life in Manchester (Paragraph 6.32).

**8.27** It is therefore recommended that Manchester Community Safety Partnership share this report with Manchester Safeguarding Partnership so that the latter partnership can consider how involvement of adult mental health services in child protection planning could be enhanced.

#### **Recommendation 10**

That Manchester Community Safety Partnership shares this report with Manchester Safeguarding Partnership so that the latter partnership can consider how involvement of adult mental health services in child protection planning could be enhanced.

## Support for parents from whom children are no longer in their care

**8.28** Storm's contact with her children was managed through a family safety plan following her first attempt to take her own life in Manchester in February 2020 and the children were cared for by Kevin following the second attempt to take her own life in May 2020. The loss of her children appeared to adversely affect Storm's mental health and may well have been a contributory factor in her apparent suicide less than a month later.

**8.29** This is the second DHR completed by this independent author in which the victim of domestic abuse has apparently taken her own life where issues of separation and loss from her children appear to have been a significant factor in her death. Mothers who are victims of domestic abuse not infrequently find themselves facing the dilemma of needing to leave the abusive relationship in order to demonstrate that they are capable of prioritising the needs of the children over their own needs, or risk losing their children. In Storm's case she had left Kevin and relocated to Manchester with the children which suggested an ability to protect the children from the impact of domestic abuse. The circumstances under which Kevin was able to locate Storm's address in Gorton and then move into the property are not completely clear but this exposed Storm and the children to the risk of domestic abuse and presented a serious risk to her mental health. This case and others demonstrate the support needs of mothers when their children are no longer in their care. It is surely in the interests of both the mother and their children for the mother to benefit from an offer of support which could reduce their risk of suicide or selfharm.

**8.30** The independent author is aware that Manchester Safeguarding Partnership and another local authority in the Greater Manchester area have commissioned a thematic review of the impact of loss of the care of their children on the mental health of the mother following three apparent suicides. It may be that a pan Greater Manchester approach to this issue needs to be considered in due course. It may also be an issue deserving of further research, perhaps by analysing the apparent suicide DHRs completed since the change in Home Office guidance in 2016.

**8.31** However, in the first instance it is recommended that Manchester Community Safety Partnership requests Manchester Children's Services to review the offer of family support when a parent no longer has the care of their child or children and disseminate guidance about best practice.

## **Recommendation 11**

That Manchester Community Safety Partnership requests Manchester Children's Services to review the offer of family support when a parent no longer has the care of their child or children and disseminate guidance about best practice.

## **Demands on Manchester IDVA Service**

**8.32** Storm declined support from the Manchester IDVA. However, it is not evident that safety planning was completed or that there were any discussions with the mental health service which referred her to MARAC, which one would have expected given her recent attempt to take her own life, the known risk of separation and

conflict over child contact. It is not known whether the pressures on the Manchester IDVA service at that time were a factor in this. Since that time additional resources have been allocated but the Community Safety Partnership may wish to obtain assurance that workload is now manageable and the quality of support provided is consistently meeting expected standards.

#### **Recommendation 12**

Manchester Community Safety Partnership may wish to obtain assurance that the workload of the IDVA service is now manageable and the quality of support provided is consistently meeting expected standards.

#### Lack of referral to Solace Women's Aid

**8.33** Agencies in the London Borough of Islington considered referring Storm to Solace Women's Aid on several occasions but never did so despite the number of domestic abuse incidents reported to the police, the evidence of coercion and control and stalking and a referral to MARAC.

**8.34** The Safer Islington Partnership may wish to seek assurance that victims of domestic abuse are referred to Solace when appropriate and that professionals from any agency which may come into contact with victims of domestic abuse are aware of the criteria for making such referrals.

#### **Recommendation 13**

The Safer Islington Partnership seeks assurance that victims of domestic abuse are referred to Solace when appropriate and that professionals from any agency which may come into contact with victims of domestic abuse are aware of the criteria for making such referrals.

#### Access of children to education

**8.35** Storm's elder two children were attending school full time in Islington and had an excellent attendance record. These two children did not attend school from the end of November 2019 until September 2020 and so for the first ten months of their time in Manchester their education was seriously disrupted and they were not able to access the support a school would provide and they were not observed by teachers and non-teaching staff.

**8.36** It is recommended that Manchester Community Safety Partnership seeks assurance that Manchester Education Service works with schools to ensure that

children whose family presents as homeless are found school places with the minimum of delay.

### **Recommendation 14**

That Manchester Community Safety Partnership seeks assurance that Manchester Education Service works with schools to ensure that children whose family present as homeless are found school places with the minimum of delay.

## **Adult Safeguarding**

**8.37** The Panel which oversaw this DHR highlighted the value of adopting a 'whole family' approach which could have led to the consideration of an Adult Safeguarding referral in respect of Storm. A 'whole family' approach could also have further clarified Storm's support needs following the removal of her children from her care. It is therefore recommended that when the learning is disseminated from this review, the opportunity is taken to highlight the value of a whole family approach.

#### **Recommendation 15**

When Manchester Community Safety Partnership disseminates the learning from this review, that the opportunity is taken to highlight the value of a whole family approach.

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(9) ibid

(10) ibid

## Appendix A

#### Single Agency Recommendations

#### Camden and Islington NHS Foundation Trust (Islington Crisis Team)

- Ensure patients risk assessment and care plans are reviewed following self harm incidents
- Provide specialist Domestic abuse support sessions to crisis, substance misuse and in patient services in the Trust
- To develop mandatory combined adult and child safeguarding training for staff to promote a think family approach

#### London Borough of Islington Children's Services

- Ensure all Social Workers and managers are aware that the minimum standard when transferring children to another authority includes:
  - Providing an up-to-date assessment
  - Chronology
  - Recommendation for safeguarding and support
  - Ensuring we have written confirmation of the new local authority's decision about allocation before ending our involvement.
- Where relationships are considered as "toxic", consideration must be given as to whether domestic and violence and abuse is a factor in the relationship.

#### London Borough of Islington GP practice

• Issue smaller quantities of medication to patients with suicidal ideation.

#### **Greater Manchester Mental Health NHS Foundation Trust**

Ensure GMMH policies are aligned with regional and national policies:

- Safeguarding Adults at Risk Policies & Procedures
- Domestic Violence & Abuse Policy

Provide assurance to CSP & MSP re: effectiveness of GMMH policies:

- Safeguarding Adults at Risk Policies & Procedures
- Domestic Violence & Abuse Policy

Learning from both reviews to be disseminated across the Trust:

- GMMH's RCA
- CSP's DHR

Ensure all Social Workers and managers are aware that the minimum standard when transferring children to another authority includes:

- Providing an up-to-date assessment
- Chronology
- Recommendation for safeguarding and support

#### **Greater Manchester Police**

- Police Staff representing GMP at multi agency meetings should have some training to understand National Crime Recording standards enabling them to bring disclosures of crime to the attention of a Police Officer at the earliest opportunity (this relates to the disclosures of coercive and controlling behaviour within the referral to the Manchester MARAC).
- Supervisory reviews of DABs (Domestic Abuse Event) relating to external MARAC referrals should give assurance that a 'gatekeeping facility' to recognise National Crime Recording Standards (NCRS) requirements is effective. (The context for this single agency recommendation is that when the DAB was reviewed by a supervisor, they agreed that no crime report was to be submitted, despite the DASH disclosing rape, assault and animal cruelty offences).

#### **Manchester Children's Services**

• No single agency recommendations

Manchester Children's Services have been requested to consider single agency recommendations in the following two areas:

 The decision that Kevin was a suitable person to care for the children following Storm's second attempt to take her own life in Manchester in May 2020 is challenged by the findings in this DHR. Storm's relocation to Manchester with her children appeared to have been motivated in part by Storm's wish to distance herself from his coercive and controlling behaviour. Kevin's subsequent relocation to Manchester could have been perceived as further evidence of controlling behaviour on his part. The indications of controlling and coercive behaviour by Kevin do not appear to have been given sufficient weight in the decision to place the children in his care.

The DHR concludes that the loss of her children appeared to adversely affect Storm's mental health and may well have been a contributory factor in her apparent suicide less than a month later. Additionally, Storm's family feel that losing the care of the children to Kevin – and Kevin being provided with a house near Storm's family, which was something Storm had been unable to achieve - may also have been a factor in her apparent suicide (It is appreciated that the offer of a property in North Manchester to Kevin and the children was a decision taken by Manchester Homeless Service). It would therefore be helpful if Manchester Children's Service could commit to supporting Recommendation 8 – 'to review the offer of family support when children are removed from parental care and disseminate guidance about best practice'.

## **Manchester Education**

• There should be a tighter mechanism for schools to report when a school place has not been taken up. If the child is known to Children's Services, they should also be informed of the school offer.

#### **Manchester Health and Care Commissioning**

- Review training records to ensure that all GP's undertake IRIS clinical 1 and Clinical 2 training.
- Arrange IRIS refresher training to include identification of risks when partners separate.
- Review coding mechanisms to ensure that significant events and specifically drug and alcohol issues are appropriately recorded.

## Potential additional single agency for Manchester H&CC

The DHR Panel questioned whether MARAC outcomes were routinely notified to primary care. The IDVA service confirmed that letters are normally sent to GP's if IDVA have been unable to make a successful contact with a client and there are no other agencies involved. There are also occasions when GP's are contacted if contact has been lost with clients and the IDVA feels that the client may seek support from their GP practice. The Panel was also advised that in Islington, GP practice are routinely contacted in all MARAC cases and the standard letter used for this purpose has been shared with the review (Paragraph 6.28)

#### **Manchester Homeless Service**

- Improve case notes and information created across the service
- Increased knowledge of the MARAC process and completing RICS
- Review of a customer's journey through the service

#### **Manchester IDVA Service**

- IDVA to request a change to the paperwork for the IDVA's to be explicit in contacting the referring agency and also ask for feedback call after MARAC, this needs to be clear.
- IDVA to raise at the next MARAC steering group the change in referral form and also raise the issue of out of area information sharing.
- IDVA to routinely ask about substance use on the initial triage call.
- IDVA to change the wording on the MARAC feedback form so it is explicit that this is initial Safety Planning.

#### **Manchester University NHS Foundation Trust**

The expertise of the MFT Mental Health Team is a resource that should be promoted within MFT as a source of advice particularly with very complex scenarios (advice could have been sought from the MFT Mental Health Team by the Specialist Homeless Families Health Visitor).

#### **Metropolitan Police**

 Recommendation 1 – Local Level- Central North Basic Command Unit Senior Leadership Team (CN BCU SLT) It is recommended that the Officers and Supervisors concerned in CRI CRIS (2729341/19) where a serious sexual assault was alleged are reminded of their responsibilities under the crime recording standards  Recommendation 2 – Local Level- Central North Basic Command Unit (CN BCU SLT)

It is recommended that a dip sample of current coercive control investigations is undertaken to provide assurance that such cases are progressing in an effective and timely manner on a consistent basis.

• Recommendation 3

It is recommended that victims of domestic abuse are referred to local Islington domestic abuse support services in the first instance. <u>https://www.islington.gov.uk/community-safety/violence-against-woman-and-girls</u> is updated regularly and always include list of local support organisations.

## North West Ambulance Service

• No recommendations.

## **University College London Hospitals NHS Foundation Trust**

- Review referral process for Mental Health patients e.g. RMN specials
- Review referrals to the UCLH Drug & Alcohol CNS

# Whittington Health Universal Children's Services (Health Visiting Islington)

• No recommendations

# Glossary

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

**Independent Domestic Violence Advisor (IDVA)** Their main purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

**Independent Sexual Violence Advisers (ISVA)** provide specialist tailored support to victims and survivors of sexual violence, which will vary from case to case and depend on the needs of the individual and their particular circumstances. The ISVA provides information, emotional and practical support including support before, during and after criminal and civil proceedings.

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

A **Non-Molestation Order** is aimed at preventing a person from using or threatening violence against their partner or ex-partner or their children, or intimidating, harassing or pestering them, in order to ensure the health, safety and well-being of the person and their children.

**SafeLives DASH** (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.

**Section 47 Enquiry** is required when Children's Social Care have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child.

A **Strategy Discussion** must be held whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. The purpose of the Strategy Discussion is to decide whether a Section 47 Enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry.

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