Rochdale Borough Safeguarding Adults Board
Rochdale Safer Communities Partnership

Combined Safeguarding Adults Review and Domestic Homicide Review in respect of Amira

Victim - Amira who died in December 2019

Independent Author – David Mellor BA QPM

Report completed on 17th November 2021

1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) and a Safeguarding Adults review (SAR) examines agency responses and support given to Amira (not her real name), a resident of Rochdale prior to her suicide which took place in December 2019.

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

1.3 Amira died after hanging herself in the bedroom of the home she had shared with her father and brother for most of her life. She was twenty four years of age at the time of her death. There was considerable conflict in the relationship between Amira and her father and brother which led to numerous police attendances at the address they shared. Amira made several disclosures of domestic abuse against her brother and her father although no successful prosecutions resulted. During the final months of her life, Amira sought assistance from a wide range of agencies which gave rise to concerns that she may be subject to coercion and control, that she may be at risk of forced marriage and that she was experiencing adverse physical and mental health including suicidal ideation.

1.4 On 9th January 2020 Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership jointly considered the circumstances of this case and concluded that the criteria for conducting both a SAR and a DHR had been met. A SAR was considered to be justified because abuse was suspected to have contributed to Amira's death and there was concern that partner agencies could have worked more effectively to safeguard her. A DHR was considered to be justified because the circumstances of Amira's death gave rise to concern that she may have been suffering domestic abuse including coercive controlling behaviour. The Board and the Partnership decided to commission a joint SAR/DHR. There was a slight delay in notification of the DHR to the Home Office as a result of the need to consider whether the case met the criteria for a DHR and a SAR.

1.5 The review will consider agencies contact/involvement with Amira and her family from 2013, when the police began to receive calls to Amira's home address relating to domestic abuse incidents until her death in December 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 death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

SAR/DHR Timescales

1.7 Rochdale Borough Safeguarding Adults Board received a SAR referral from Pennine Care NHS Foundation Trust on 5th December 2019 and a DHR referral was received from Greater Manchester Police on 13th December 2019. The decision to commission a joint SAR/DHR was taken at a joint screening meeting on 9th January 2020 and the Home office was notified on 28th January 2020. Amira's mother, father and brother were notified that the review was taking place on 2nd July 2020. The delay in notifying family members was initially as a result of the police investigation of Amira's apparent suicide which involved interviews with her father and brother in respect of whom Amira had made prior disclosures of domestic abuse. The first SAR/DHR Panel meeting took place one week prior to the first Covid-19 lockdown which halted much non-essential work for a time, including this review. The SAR/DHR report was completed on 5th November 2020. The report was signed off at a joint meeting of Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership on 19th November 2020. The report was submitted to the Home Office on 4th February 2021. Several factors contributed to the slight delay in completing the SAR/DHR, including the decision to hold a very valuable practitioner learning event – which is not normally a feature of the DHR process, the complexity of the joint review and the impact of Covid-19 restrictions.

Confidentiality

1.8 The findings of each SAR/DHR are confidential. Information is available only to participating officers/professionals and their line managers. A pseudonym (Adult F) was agreed with Amira's family and used in the report to protect the identity of the individual involved. The Home Office requested a different pseudonym to be used. Attempts to contact Amira's mother and father to discuss a changed pseudonym were unsuccessful and so the independent author chose the pseudonym 'Amira'. At the time of her suicide, Amira was 24 years old. She was of Asian British (Pakistani) ethnicity.

1.9 Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership wish to express their sincere condolences to the family and friends of Amira.

2.0 Terms of Reference

2.1 The following generic terms of reference questions were agreed:

- Establish what lessons are to be learned from Amira's death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

- Contribute to a better understanding of the nature of domestic violence and abuse.

- Highlight good practice.

2.3 The following case specific terms of reference questions were agreed:

- How effectively were any disclosures of domestic violence and abuse by Amira addressed by the agencies in contact with her?

- When the police were called out to a series of domestic abuse incidents in Amira's household, could a referral to the Multi-Agency Risk Assessment Conference (MARAC) have been made or considered?

- When Amira made disclosures of domestic violence and abuse to professionals other than the police, could DASH risk assessments have been completed?

- How effectively were the risks to Amira presented by her brother and father assessed and managed?

- Did professionals to whom Amira made disclosures of abuse consider whether she may be the victim of coercive control, so-called honour-based violence or forced marriage?

- How effectively did agencies respond to safeguarding concerns in respect of Amira?

- How effectively did agencies respond to suicidal ideation and indications that Amira may be mentally unwell?

- Were agencies with which Amira came into contact aware of relevant pathways of support to which she could be referred or directed?

- Did the agencies Amira sought help from communicate and share information effectively with each other?

- When Amira decided that she did not wish to engage with, or access services, did professionals consider whether she was making such decisions of her own free will?

- When deciding to take no further action when Amira did not engage with services, did agencies assess any risks involved in taking no further action or contact other agencies which were in touch which Amira?

- Were there any specific considerations around equality and diversity issues in respect of Amira 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?

3.0 Methodology

3.1 The SAR/ 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 the Amira and her father and brother. The authors of the IMRs had the discretion to interview members of staff if this was required. No interviews were conducted outside of the IMR process.

3.2 The IMRs were scrutinised by the SAR/ DHR Panel and further information was requested where necessary.

Contributors to the SAR/DHR

3.3 Individual Management Reviews (IMR) were completed by

- BARDOC Out of Hours GP service (chronology only)
- Department for Work and Pensions (chronology only)
- Greater Manchester Police
- NHS Heywood, Middleton and Rochdale Clinical Commissioning Group
- Northern Care Alliance (provider of hospital 1)
- North West Ambulance Service (Ambulance services and Regional 111 Service)
- Pennine Care NHS Foundation Trust
- Rochdale Borough Council Adult Care

3.4 The IMR authors had not been directly involved with Amira or her family and were not the immediate line manager of any staff involved in the case. The IMR reports were quality assured by a senior manager in the relevant organisation.

3.5 SAR/DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions (16th March 2020, 15th May 2020, 31st July 2020 and 10th September 2020. A practitioner learning event took place on 24th June 2020).

The SAR/DHR Panel Members

Role	Organisation
Jane Timson, Head of Safeguarding & Practice Assurance	Rochdale Borough Council

Andy Jones, Health & Social Care Neighbourhood Lead	Rochdale Borough Council
Kate Hilt, Social Care & AMHP Manager	Rochdale Borough Council
Suzanne Fawcett, Detective Constable	Greater Manchester Police
Suzanne Turner, Service Manager – Enhanced Access HMR & Trust wide CMHT	Pennine Care NHS Foundation Trust
Nick Gainsborough, Specialist Safeguarding Families Practitioner	Pennine Care NHS Foundation Trust
Susan Calvert, Adult Quality, Safety and Safeguarding Lead	NHS Heywood, Middleton & Rochdale Clinical Commissioning Group
Georgina Cartridge, Named Nurse Adult Safeguarding	Northern Care Alliance
Jane Whittaker, Safeguarding Practitioner.	North West Ambulance Service
Molly Brown Partnership Manager	Department of Work and Pension
Wendy Stringer, Domestic Abuse Co-ordinator	Rochdale Borough Council
Helen Heaton, Business Manager	Rochdale Borough Safeguarding Adults Board
Megan Kelsey, Development Officer	Rochdale Borough Safeguarding Adults Board
Helen Payton, Senior Administration Officer	Rochdale Borough Safeguarding Adults Board
David Mellor	Independent Chair of SAR/DHR Panel and Independent Author.

3.6 The Panel also received invaluable advice from Rochdale Women's Welfare Association.

3.7 Amira's father, mother and brother were invited by letter to contribute to the SAR/DHR. All attempts to engage with Amira's brother were unsuccessful. The independent author spoke separately to Amira's mother and father by telephone. Contact was made during the initial phase of the Covid-19 pandemic and so telephone contact was considered the safest method of contact at that time. Specialist support was offered to both Amira's mother and father but declined. The independent author enquired whether they had been able to access bereavement support. Amira's father said that he had not sought any support following the loss of his daughter. He said he had received a great deal of support, including much practical help from his wider family. Amira's mother said that she had been unable to access bereavement support. Since October 2018, the Rochdale Coroners Service has had a Coronial Bereavement nurse who is available to provide immediate bereavement support to families or other individuals who are suffering as a result of a death. The Coronial Bereavement nurse has advised this review that she provided Amira's mother with substantial bereavement support in the months following her

daughter's death. It is assumed that Amira's mother was unable to recall the support she received when she spoke to the independent author some months later. As stated, the SAR/DHR has been unable to engage with Amira's brother and therefore unable to ascertain whether he has been able to access support. Amira's parents were provided with the opportunity to meet the SAR/DHR Panel but declined. The independent author subsequently attempted to contact Amira's parents to offer them the opportunity to read and comment on the SAR/DHR report. Amira's mother said that she would like to speak to the independent author and discuss the findings of the report. This was arranged. Amira's mother had no comments to make in respect of the SAR/DHR report or the findings. The independent author made several unsuccessful attempts to contact Amira's father. He established that her father had travelled to Pakistan for an extended period. The independent author attempted to contact Amira's father following his likely return to the UK without success. The independent author attended the inquest into Amira's death and hoped to make contact with her father at that stage. However, Amira's father did not attend the inquest.

Author of the overview report

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

Independence statement

3.9 David has no connection to Rochdale Borough Safeguarding Adults Board or Rochdale Safer Communities Partnership or services in Rochdale.

3.10 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. He served in Greater Manchester Police – which is the police service for the Rochdale area - from 1990-1999.

3.11 Since 2006 he has been an independent safeguarding 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).

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

Parallel reviews

3.13 An inquest into the death of Amira has taken place and a verdict of suicide was reached. There were no other parallel processes.

Equality and diversity

3.14 The protected characteristics relevant to this review are addressed in Paragraphs 6.74 to 6.78.

Dissemination of the SAR/DHR report

3.15 The following people have received copies of the SAR/DHR overview report:

The Greater Manchester Deputy Mayor for Policing, Crime, Criminal Justice and Fire
Chair and members of Rochdale Borough Safeguarding Adults Board
Chair and members of Rochdale Safer Communities Partnership
Rochdale Suicide and Self-Harm Prevention Group
Rochdale Safeguarding Children Partnership
BARDOC Out of Hours GP service (chronology only)
Department for Work and Pensions (chronology only)
Greater Manchester Police
NHS Heywood, Middleton and Rochdale Clinical Commissioning Group
Northern Care Alliance (provider of hospital 1)
North West Ambulance Service (Ambulance services and Regional 111 Service)
Pennine Care NHS Foundation Trust
Rochdale Borough Council Adult Care

4.0 Involvement of Amira's family

4.1 Amira's father agreed to contribute to this review. Meeting face to face was not possible because of Covid-19 restrictions and so her father contributed through a telephone conversation with the independent author.

4.2 Amira's father expressed bewilderment at his daughter's death and appeared unable to accept or process the fact that she may have taken her own life. He repeatedly referred to how happy his daughter had appeared just a few days before her death. However, he added that Amira had been very annoyed with her brother when he resigned from his job with an electrical retailer shortly before her death.

4.3 He said he had a very close relationship with his daughter who he said he had brought up largely as a single parent since she was two years old. He added that whatever his daughter needed he would provide it. He frequently described his daughter as 'clingy' which appeared to imply a degree of dependence on her father.

4.4 Turning to Amira's relationship with her brother, he said that tension arose because Amira's brother was always jealous of his sister and resented the fact that he (father) gave Amira more money than him, which their father explained was because she needed more money when she was a student at university. Later in the conversation he said that Amira's brother would also become angry with his sister if she happened to touch his possessions such as his clothes. It was at this point in the conversation that Amira's father disclosed that his son displayed obsessive compulsive disorder behaviours. Amira's father later added that his daughter was always pushing her brother to get a job, which he resented.

4.5 Amira's father said that he was aware that his son assaulted his daughter from time to time. He recalled Amira telling him that she had been assaulted by her brother but that she could not show her father her injuries out of modesty. Amira's father went on to say that his son could also be violent towards him when angry. He said that he felt vulnerable when his son threatened him because his son was a large man and he (father) was much older and had a physical disability as a result of a work related accident which took place some years earlier. He added that his age and disability also prevented him from intervening when Amira was being assaulted or threatened by her brother. Several times, Amira's father said that he told his daughter that it was 'no good to keep ringing the police' but didn't elaborate on this comment.

4.6 Amira's father said that his daughter attended university in Manchester. He couldn't recall which university or which course she studied but he remembered that it was always her ambition to become a solicitor. He recalled her working at a

solicitor's office in Manchester for two or three months. It was unclear whether this was after Amira graduated or whilst she was undertaking her studies.

4.7 He said that his daughter was not working at the time of her death and had not been in employment for the two previous years. At the time of her death, he said she was waiting to hear whether her application to work for a major car retailer had been successful. When asked if she had ever worked for the sports retailer where Amira told the police she met a person called Nadia, who she informed the police was at risk of forced marriage, Amira's father said that his daughter had worked there for two or three weeks but he couldn't remember when this was. He felt that the reason why his daughter had struggled to gain longer term employment was because she had graduated from university and felt that she merited a better paid job as a result.

4.8 He said that Amira was not in a relationship at the time of her death. He said her attitude was that she wanted to look for a 'good job' first of all. He went on to imply that he would not have stood in the way of any relationship she formed, saying that he told her 'if you like somebody, you tell me, it's completely up to you'.

4.9 He denied that he had abandoned his daughter in Pakistan in December 2017. He acknowledged that she had travelled to Pakistan at that time for a family wedding and she had decided to extend her stay by around two months. He said that she had stayed in Pakistan for no more than three or four months overall. He added that he had sent her a flight ticket to return home. Amira's father later said that his daughter had her mobile phone stolen whilst staying in Pakistan which he said he replaced after she returned to the UK, although it appears that he didn't purchase a replacement phone for his daughter until a few months before her death.

4.10 Amira's father said that he was completely unaware of the health concerns which led his daughter to frequently contact NHS 111, the ambulance service and, on one occasion, attend hospital in the final months of her life.

4.11 When asked about his daughter's financial affairs, her father said that she was in receipt of Universal Credit. Initially he said that Amira had two bank accounts but later acknowledged that she had had bank accounts whilst a student at university. He said that she was always losing her bank card and so it had been arranged that her Universal Credit would be paid into his bank account. He said that if his daughter needed money, she asked him for it, adding that 'whatever she needed she got from me'. He said he became aware that her Universal Credit was no longer being paid into his bank account in the months before she died and when he asked her why this was the case, he said that she replied that she was angry with the Job Centre for asking her if she was actively seeking work and she wasn't going to keep going

to the Job Centre for £30 or £40 per week. He said he asked her how she would survive without her benefits and she replied that she would ask him (father) for money.

4.12 He said that his daughter had got into the habit of taking her food into her bedroom and rarely coming out. He said that she would listen to music or watch programmes on the mobile phone he bought her in the months prior to her death. He said he was not aware that she had any friends and could not remember her mentioning anyone called Nadia as a friend.

4.13 He said that he had not sought any support following the loss of his daughter. He said he had received a great deal of support, including much practical help from his wider family. He said he was worried about the impact of Amira's death on his son whose mental health appeared to have been adversely affected. He was unaware of any support his son might have sought or been offered.

4.14 Amira's mother also agreed to contribute to this review. She said that she had completely lost contact with Amira and her brother after her (mother's) relationship with Amira's father came to an end when Amira and her brother were young children. She explained that Amira's father was granted custody of their two children by the Courts and she was allowed 'supervised visits'. She added that when these decisions were made she had difficulty in 'staying well' and Amira's father had a great deal of support from family members who lived locally whilst she lacked any local family support.

4.15 She went on to say that Amira's father brought the children to see her twice and refused to bring them after that, saying that seeing their mother was 'affecting the kid's heads'. After that Amira's mother said that she had no contact with her children for many years until Amira contacted her around a year or so before she died. She said that Amira told her that she wanted to get to know her. They spoke over the telephone 'now and then' and met 'a few times'.

4.16 She said she had worried about what Amira's father had told the children about her and when she reconnected with Amira, she asked her about this and her daughter told her that her father had told the children that their mother had tried to 'put them up for adoption'.

4.17 Amira's mother was unable to shed much light on what was going on in her daughter's life during the period after they reconnected. She was unaware of anything that happened in Amira's family home, adding that she had had no contact with Amira's father for many years and Amira's brother had not wished to reconnect with her. She said that Amira didn't tell her much about what was going on in her

life. She became aware that her daughter 'wasn't happy' and that this may have been connected to what was going on in the family home, but she was unaware of any more detail. She didn't know whether Amira had any friends but was aware that she did not have a partner. She was unaware of any visit or visits her daughter may have made to Pakistan and was unaware of any marriage arrangements which may have been made. She was aware that her daughter had attended University but was unaware of any details of her degree of place of study. She said that her daughter wasn't in employment but she didn't know whether she had ever worked for the sports shop where Amira said she had met the friend who was at risk of forced marriage. When asked to describe her daughter as a person, her mother said that she was 'bright' and 'could talk'.

4.18 Amira's mother said that she was shocked by her daughter's death which she had found inexplicable. She added that she had been unable to access bereavement support as yet. She had contacted her GP for support who had referred her to what she described as a 'wellbeing' service which offered 'therapy'. She said that she had been on a waiting list for this service for 'quite a bit' and didn't know how long she would have to wait. She advised the independent author that she had significant health problems and lacked support apart from a friend who helped her.

4.19 Providing better information and support for families bereaved by suicide is a key objective of the England strategy for suicide prevention (1), as family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves. Since October 2018, the Rochdale Coroners Service has had a Coronial Bereavement nurse who is available to provide immediate bereavement support to families or other individuals who are suffering as a result of a death. The Coronial Bereavement nurse has advised this review that she provided Amira's mother with substantial bereavement support in the months following her daughter's death. It is assumed that Amira's mother was unable to recall the support she received when she spoke to the independent author some months later.

4.20 Amira's brother was invited to contribute to this review but did not respond to efforts to communicate with him.

5.0 Chronology/Overview

5.1 Amira was born in 1994 and had been living in the family home in Rochdale with her father and younger adult brother for approximately 20 years prior to her death in December 2019. Amira had no contact with her birth mother for many years although they resumed contact in recent years. Members of Amira's wider family lived nearby including her paternal grandparents and a paternal aunt. Amira was a British citizen of Pakistani descent. Amira followed the Islamic faith.

2013

5.2 On 19th July 2013 the police were called to an incident of domestic abuse involving Amira's father and step mother which resulted in Amira's father and paternal aunt being arrested for assault. Amira's step mother also disclosed that her husband had sexually assaulted her and she was later supported to stay in a refuge before subsequently returning to live with Amira's father. The case was referred to Rochdale MARAC. It is not known whether Amira, who was 18 years of age at the time, was present during the domestic abuse incident.

5.3 On 9th December 2013 Amira's paternal aunt requested police assistance to remove Amira's step mother from the family home. Amira's father was documented to be 'fearful of false allegations' and also expressed concern that the step mother had been encouraging Amira to marry her (step mother's) brother which Amira had not agreed to. Amira's step mother agreed to leave the address of her own accord.

2014

5.4 On 28th July 2014 the police were called to a verbal argument between Amira's father and her brother after the father's returned from Pakistan with his 'new wife'. Amira's brother was angry because his father had been 'selling assets' in Pakistan. The incident was assessed as a 'standard' risk.

5.5 On 12th August 2014 the police were called to the family home to which Amira's father had returned after living in Blackburn with his wife for six months. Following his return, a verbal argument had taken place between Amira and her brother. The police assessed the incident as a 'standard' risk.

2015

5.6 On 20th September 2015 Amira's father contacted the police to report an argument with his son. The father had recently returned to the UK after spending six months in Pakistan, to which he intended to return and planned to pass the tenancy

of Address 1 to Amira's brother. The landlord has no record of any such transfer of tenancy.

5.7 On 12th October 2015 Amira was referred to mental health services by her GP as she was experiencing low mood because of her acne. She did not attend the appointment with mental health services.

5.8 On 15th October 2015 Amira contacted the police to report that her brother had grabbed her by the throat during a verbal argument. She was uninjured. Her brother was removed from the property. Amira decided not to support any prosecution of her brother for assaulting her.

5.9 On 22nd December 2015 Amira contacted the police to report a cut to her nose which had been caused by flying glass after her brother banged on the door at the family home and smashed a glass panel. Amira said she had been told by her father not to let her brother into the address. The incident was recorded as accidental damage and the risk was assessed as 'standard'.

2016

5.10 On 6th February 2016 Amira's father made a 999 call to NWAS to report that his daughter had cut her hand as a result of an assault by her brother. Paramedic control contacted Amira and it was documented that she said she 'had had a row' with her brother but had no injuries. She said she was safe and did not require an ambulance or any other agencies. The ambulance was cancelled and no further action taken.

5.11 Amira last attended her GP practice in March 2016. In August of that year she did not attend a planned appointment at the GP practice, no reason was given for non-attendance and there is no indication of follow up within the GP records.

5.12 On 18th July 2016 Amira's father commenced a new tenancy in respect of the family home. His original tenancy had begun in 1998 but his landlord evicted him from the address in July 2016 after considerable rent arrears had built up over a lengthy period of time. Following eviction, Amira's father cleared the outstanding rent arrears and was allowed to take out a new tenancy on the same property.

5.13 On 6th December 2016 the police attended a report of fighting between Amira and her brother and found the latter to have left the address. The police documented that the family 'would not engage' to confirm what had taken place. The incident was assessed as a 'standard' risk.

2017

5.14 On 17th January 2017 Amira contacted the police to report that her brother had assaulted her following a verbal argument. He was arrested but Amira declined to provide a statement or support a prosecution. The CPS considered the case but decided not to proceed with an evidence-led prosecution due to a lack of victim support. A DASH risk assessment was conducted which disclosed a 'medium' risk. Amira declined the offer of support to obtain alternative accommodation.

5.15 On 1st March 2017 Amira was reported as missing from home and was later located in Blackburn staying with her step mother. She requested the police not to inform her family of her whereabouts.

5.16 On 13th March 2017 Amira's brother contacted the police to report that his sister had assaulted and racially abused him. The police attended and spoke to family members who 'undermined the account' provided by her brother which led to the crimes recorded by the police being filed as 'no further action'. The incident was recorded as a 'standard' risk.

5.17 On 17th March 2017 Amira contacted the police to report that her brother had stolen £50 and her keys to the family home. The police attended and it appeared to them that Amira was not currently living in the property and her father had requested the return of her house keys. Amira had refused and gone to her bedroom. She told the police that her brother then 'barged' into the room and searched her property taking the keys and cash. Family members did not confirm this account, stating that Amira's brother had not gone upstairs adding that they knew Amira did not have any money. No crime was recorded and the incident was assessed as a 'standard' risk. This incident may have taken place at Amira's paternal grandparent's home where she stayed for a time during 2017. Her father was said to be planning to change the locks on the family home.

5.18 On 27th June 2017 Amira's paternal aunt contacted the police to report that her niece was at the family home (address 1) threatening to smash the windows and 'wanting to fight' with her brother (Amira's brother). Her brother stated that their father had left the U.K. and agreed that his son could assume responsibility for the tenancy. Amira was said to have been living with her paternal grandparents in Rochdale but had fallen out with them and decided to return to the family home. Amira and her brother were documented 'not to get along' and her brother had refused to admit her to the family home, causing an argument. The incident was recorded as a 'standard' risk.

5.19 On 26th November 2017 Amira's father called the police after he discovered his son had cut up his newly fitted carpets 'due to his obsessive compulsive disorder'. Amira's father did not support a prosecution and was said to understand that his son was 'not well' but said that whenever he tried to remove his son from the property he came under family pressure to allow him to return. The incident was assessed as a 'medium' risk and a 'vulnerable adult referral' was sent to Adult Care. The police also referred Amira's father to Victim Support. In Rochdale there are two distinct services provided by Victim Support. One is a Greater Manchester wide multi-crime service which provides support to victims of crime who consent to be contacted. The other service is a specialist domestic abuse service commissioned by Rochdale Borough Council which provides independent domestic violence advocate (IDVA) support to high risk victims of domestic abuse. This service also provides support to medium risk victims of domestic abuse. Both Amira and her father were referred to the multi-crime Victim Support services on a number of occasions. There were no referrals of Amira, her father or her brother to the Victim Support service which provided specialist support to the victims of domestic abuse.

5.20 On 27th November 2017 Amira's brother was referred to Rochdale Infirmary's mental health adult liaison team by the Urgent Care Centre after he expressed suicidal thoughts as a result of becoming homeless following an argument with his father. He denied suicidal intent and declined mental health services. He was advised to see his GP for support if necessary and was provided with information on how to access services should he feel he could not manage his own safety. He was discharged.

5.21 The following day (28th November 2017) Amira's brother went to a police station to report that he had been sleeping rough since the incident on 26th November 2017 (Paragraph 5.19), had not eaten and felt suicidal. He stated that he had spoken to 'Housing' and Adult Care but felt that 'no support had been offered', adding that he had declined accommodation from Petrus -which provides accommodation and support for people who are homeless - feeling that he needed supported accommodation. Adult Care has advised this review that Amira's brother was offered support, which he declined. An ambulance was called and he was conveyed to Fairfield General Hospital. He was also referred to mental health services and the incident was assessed as a 'medium' risk. Amira's brother was later seen by mental health adult liaison at Fairfield General Hospital and continued to express suicidal thoughts should his housing issues be unresolved. No evidence of mental illness was found and he was discharged to be followed up by his 'current social care team' and was advised to attend A&E if he felt risks to be unmanageable. Within two hours of discharge from Fairfield General Hospital, Amira's brother presented at Rochdale Infirmary Urgent Care Centre who referred him to Mental Health Adult Liaison who found no evidence of mental illness and identified

homelessness as his primary issue. He was discharged to be followed up his current social care team. Adult Care has advised this review that the two references to Amira's 'current social care team' were incorrect as he did not have an allocated social worker and his contact with Adult Care over this period had been managed by a duty social worker.

5.22 Victim Support contacted Amira's father on 13th December 2017 and he said that he had a broken arm which had been caused by a slip. He disclosed that his son had sold the TV, sofa and washing machine 'because of his OCD' and sometimes hit himself. The Victim Support worker completed a DASH risk assessment resulting in a score of 7. Amira's father said that he had seen his GP who had prescribed painkillers and antidepressants for his (Amira's father's) depression. He consented to a referral to Adult Care and Victim Support was advised that the Adult Care duty team would contact him in a few days.

5.23 In October 2019 Amira disclosed that she was taken to Pakistan by her father in December 2017 and 'abandoned' there for a year, returning to the UK in 2018. No agency involved in this review appears to have had any contact with Amira between 27th June 2017 and 13th September 2018.

2018

5.24 On 13th September 2018 Amira reported that she had been assaulted by her brother who pulled her arm. She said he had also hit her on the head a week earlier but she had not reported this. She told the police that she felt that her brother was suffering from depression and anxiety and became 'paranoid' when she talked to her father as he assumed they were talking about him. She said that this led to her brother becoming angry and aggressive. On interview, Amira's brother provided what was documented to be a 'plausible explanation'. The matter was referred to the CPS who decided to take no further action. A 'medium' risk domestic abuse referral was submitted by the police in respect of Amira which was screened by Rochdale Multi Agency Adult Safeguarding Team (MAAST). MAAST screens adult vulnerability referrals to Adult Care, local adult mental health services provided by Pennine Care NHS Foundation Trust and Drug and Alcohol Services. The objective of MAAST, which meets twice weekly, is to ensure that the most appropriate care and support is put in place for a vulnerable adult as soon as possible. On this occasion MAAST screened the referral in respect of Amira and decided to make no referral to any agency. The MAAST flowchart indicates that the meeting also receives medium and high risk domestic abuse referrals where vulnerabilities are identified which may require support or intervention from partner agencies.

5.25 The following day (14th September 2018) Amira contacted the police to report that her brother had caused damage at the family home. It was documented that there was 'no complaint', presumably from father as tenant, and no further action was taken. Unspecified support was offered and declined by father. The incident was assessed as a 'medium' risk using a DASH risk checklist.

5.26 On 16th September 2018 NWAS was called to the family home via a 999 call after Amira's father reported being assaulted by his son. The former was found to have minor injuries for which he declined treatment. Amira's brother was in his bedroom and declined to engage with NWAS. NWAS documented that the police were informed, although this incident does not appear in the police chronology.

5.27 On 20th November 2018 Amira contacted the police to report that she had been assaulted by her brother who had hit her on the head with a 'bin'. The police attended and were informed by Amira's father that his daughter and son had been arguing before his daughter had thrown the bin at her brother who had then slapped Amira and left. The police gave Amira advice about alternative accommodation but she declined consent for any referrals to be made. It is understood that there may also have been a discussion with Amira's brother about moving elsewhere. The police took no further action in respect of the assault documenting that Amira did not support a prosecution. The incident was assessed as a 'standard' risk.

5.28 On 15th December 2018 Amira contacted the police to report an assault by her brother and the police call taker noted that she sounded in fear, saying that her brother was outside her room. Amira disclosed that her brother had kicked her on the leg and he was arrested and charged with assault. He was transported to an address in Halifax. The incident was assessed as a 'medium' risk and Amira was said to have been referred to Victim Support although the latter service has no record of this.

5.29 On 19th December 2018 Amira called the police to report that her brother had assaulted her father. The police attended and their enquiries found that 'no assault was confirmed' although there was a report of damage. Amira's father said that he had previously been reluctant to take formal action against his son as he did not want to cause him problems but now intended to seek legal advice and some form of order to keep him away from the family home. The police assessed the incident as 'medium' risk and referred Amira's father to Victim Support.

5.30 On 23rd December 2018 Amira contacted the police after hearing her brother make what she perceived as a threat to her – to smash a door in and assault someone - whilst on the telephone to her paternal aunt, with whom Amira's brother

was staying. Amira's aunt's address was said to be 'around the corner' from the family home. The police attended and were told by Amira's aunt and brother that no threat had been directed at Amira. A MAAST referral was considered however this did not take place as the police documented that 'Adult Care haven't identified as vulnerable therefore does not meet the criteria for mental health support'. (It is believed that the referral considered related to Amira's brother)

5.31 On 25th December 2018 Amira contacted the police to report that her brother was at the family home and was not allowed to be there. It appears that Amira's father had allowed his son to visit the address to celebrate Christmas but had not informed his daughter. The police attended and arrested Amira's brother for an unrelated matter.

2019

5.32 On 20th February 2019 Amira's brother was due in Court in respect of the 15th December 2018 assault on his sister. One week before the hearing, Amira contacted the court to retract her statement 'due to being under pressure at the moment'. It is understood that Amira's family had earlier tried to resolve 'her issues with her brother' prior to him being charged with assaulting her. A retraction statement was obtained from Amira, no evidence was offered and the case was dismissed.

5.33 On 14th March 2019 Amira reported that her brother had returned to the family home 'shouting and screaming'. The police attended and arrested him on suspicion of criminal damage although no further action was taken due to what was documented to be 'lack of support from the victim'. The incident was assessed as a 'medium' risk using a DASH risk checklist. A referral was made to MAAST but was screened on the grounds that Amira's brother was 'known to mental health services' and that the case was proceeding through the criminal justice system. It is assumed that the latter grounds formed part of the decision to screen the referral out before the police decided to take no further action.

5.34 During the early hours of the following day (15th March 2019) Amira's father contacted the police to report that his son was at the address. The police attended and took Amira's brother to a local mosque. The police were unable to complete a DASH risk assessment as Amira's father declined to provide any information although the incident was assessed as a 'medium' risk.

5.35 During the early afternoon of the same day Amira contacted the police to report that her brother was at the address and had tried to force entry, threatening to damage the door. On police arrival her brother was noted to be 'calm' and no damage could be seen. Amira told the police that she had been worried her brother

might cause damage on the basis of his previous behaviour, adding that if he apologised he would be allowed to return home. Her brother voluntarily left the area. The incident was assessed as a 'medium' risk.

5.36 On 16th March 2019 Amira contacted the police to report that her brother was at the family home banging on the door and she was afraid he would assault her or her father. The police attended and Amira's brother left the area voluntarily. The police recorded a public order offence which resulted in no further action. The incident was assessed as a 'medium' risk.

5.37 Later the same day, Amira called the police after her brother broke a window in order to gain entry to the family home where he assaulted their father. It is assumed that Amira's father did not wish to make any complaint. The police provided advice about the National Centre for Domestic Violence service. A 'medium' risk domestic abuse referral was made to MAAST in respect of Amira on 19th March 2019. No outcome was recorded at MAAST. It is assumed that the referral was screened out. The police referred Amira's father to Victim Support who attempted to telephone him on 8th April 2019. Their call appeared to have been picked up but the person receiving the call made no response. No further attempts at contact were made by Victim Support in respect of this referral.

5.38 On the same date the police contacted Amira's father's landlord to request the boarding up of the broken window. This was the only non-routine contact the landlord had with Amira's father apart from rent arrears.

5.39 On 21st March 2019 Amira's brother attended the family home whilst their father was in hospital, claiming that their father had told him that he could visit to collect money. The police were called and recorded a crime in relation to a threat of assault by her brother in respect of which no further action was taken as Amira did not support a prosecution. No DASH risk assessment was completed as Amira declined to provide the necessary information, nor did she attend a subsequent appointment to complete the DASH. (At this and other times Amira's freedom to take decisions for herself may have been affected by coercion and control). The incident was assessed as a 'standard' risk and a referral was made to MAAST. The incident was also said to have been assessed by STRIVE but deemed not appropriate for that service 'due to the previous history'. STRIVE is a local multiagency approach to supporting 'standard' risk victims of domestic violence and abuse and their families, with the aim of reducing repeat incidents by signposting them to agencies who could help them address underlying issues. In deciding that this was not a suitable case to refer to STRIVE, it was noted that there was a lengthy history with three 'medium' risk already in 2019. Amira was referred to Victim Support who telephoned her on 26th March 2019. Amira answered the call

and replied and said that she was unable to take the call 'right now'. Victim Support do not appear to have made any further attempts to contact Amira on this occasion.

5.40 On 5th July 2019 Amira's father contacted the police to report that his son had caused damage at the family home which his son had visited to 'demand' money from his father to help him find his own place to live. When his father refused, his son damaged the fence. The police arrested him and charged him with criminal damage. The incident was assessed as a 'medium' risk. Amira's father was referred to Victim Support who contacted him by telephone on 10th July. Amira's father said that his son no longer lived at the property and had no keys to it. Amira's father said he felt safe and did not need any support other than a lock for the door to his room and was advised to contact his landlord. Safety planning was discussed with him.

5.41 On Saturday 10th August 2019 Amira phoned NHS 111 to say that she had been feeling faint, dizzy and breathless for a few weeks. She was advised to attend an emergency treatment centre within one hour but there is no indication that she did so.

5.42 The following morning (Sunday 11th August 2019) Amira contacted NHS 111 to say that she had been experiencing dizziness, nausea and upper back pain for 18 hours. She was advised to contact primary care within 24 hours. During the same afternoon Amira again contacted NHS 111 to say that she had missed two calls from Bardoc, the out of hours GP service. NHS 111 documented 'passed to GP'. There is no reference to this call in the Bardoc or the GP chronologies submitted to this review although the author of the latter acknowledges that Amira's GP practice was notified of several NHS 111 contacts which the GP practice did not follow up.

5.43 During the early evening of the same date NWAS responded to a 999 call from Amira who said that Bardoc had advised her to see her GP but she felt as though she had had a further episode of breathlessness and chest pain with numb legs. She said her GP had diagnosed anxiety. She added that she hadn't eaten that day as she felt unwell. She declined transport to hospital and said she would attend the nearby urgent care centre that night. She was documented to have capacity to refuse hospital attendance. NWAS raised a safeguarding concern as Amira told them she had been prescribed medication but had 'put it in the bin' as she didn't understand it. The crew were also concerned by Amira stating she did not have her own phone and said that she was alone in the family home which the crew felt was untrue. Amira presented as 'very nervous' and appeared fearful of the crew carrying out a physical assessment and ECG (electrocardiogram which records heart activity).

5.44 The following afternoon (Monday 12th August 2019) NWAS responded to Amira after she called NHS 111 again. She was vomiting and during an episode in which

she became distressed, her heart rate increased and the crew decided to transport her to hospital. She also reported a sharp pain in her upper back and not eating properly for 3 weeks. She said she had been unable to attend a GP appointment that day because she felt unwell (There is no record of any GP appointment around this time in the GP chronology). Amira was transported to hospital by the ambulance crew. There is no indication from NWAS or hospital records that she was accompanied by a family member.

5.45 Amira was seen in General Hospital 1 A&E where it was documented that she had been experiencing central chest pain for one month which had worsened that day. She said the pain was worse on breathing and movement and that she had vomited 4 times that day. She was admitted to the ambulatory care unit (ACU) for a few hours where various tests were carried out before she was discharged during the late evening after receiving pain relieving medication. No safeguarding concerns were noted although Amira was observed to be 'quite distressed' during examination. Two discharge summaries were generated as a result of Amira's attendance and admission to hospital. The first one was generated by A&E and stated Amira's diagnosis to be acute coronary syndrome was diagnosed but was otherwise very briefly completed. This discharge summary was sent to, and received by, Amira's GP. The second discharge summary was generated by the ACU and should have been uploaded onto the hospital information system (ALS) where it would be available for Amira's GP to view. However, this was not done, apparently because Amira left hospital without her copy. The ALS discharge summary states that Amira was 'treated as GORD' (Gastro-oesophageal reflux disease) but is otherwise very brief.

5.46 On Tuesday 13th August 2019 Adult Care received the safeguarding concern completed by NWAS two days earlier. The safeguarding concern stated that Amira had disposed of medication prescribed to her by Bardoc the previous day because she did not understand it, that Amira used her father's phone and was unable to offer an explanation of why this was the case, that she had declined a physical assessment by the female ambulance crew and would not allow the crew into other areas of the house, maintaining that it was empty although the crew could hear someone in the next room.

5.47 The following day (Wednesday 14th August 2019) an Adult Care social worker and an assessment and support planner made a 'cold-call' visit to Amira. When they arrived at the house Amira was well presented and wearing a coat as if she was intending to leave the address imminently. During a fairly brief conversation, Amira said that she had not had a panic attack on Sunday 11th August but had been feeling anxious. She said that she had some stresses in her life, on which it appears she did not elaborate, and that focussing on these stresses could bring on anxiety attacks.

She went on to say that she had attended hospital the following day and had been provided with an 'anti-sickness drip' following which she felt much improved. She said the hospital had carried out a number of tests which had disclosed no concerns. Amira said she would approach her GP if she needed further support. There were no concerns about Amira's capacity. The Adult Care duty manager was advised of the outcome of the visit and decided that no further action was required by Adult Care at that time.

5.48 On Wednesday 21st August 2019 Amira phoned the Department for Work and Pensions (DWP) to say that she was 'really struggling financially' as her benefits were paid into her father's bank account and 'he keeps taking all the money'. She said she had spoken to the bank which had advised her to visit to check whether they could open a 'basic account' for her.

5.49 The following day (Thursday 22nd August 2019) Amira again contacted the DWP to advise that the bank would not allow her to open another account and she had tried other banks who were unable to open an account for her as she was deemed to have one already. Amira reiterated that she was struggling because her benefits were paid into her father's bank account and she was advised to seek family support and to visit the 'Money Advice' website.

Thursday 3rd October 2019

5.50 At 12.28am on Thursday 3rd October 2019 Amira made a 999 call from the family home which she abandoned without speaking. The police call taker could hear a female crying although there was no sound of a disturbance. The call taker rang her back and Amira said she could not speak due to the presence of another person and the call was again disconnected. The police treated the call as requiring a grade 1 (immediate) response and an officer arrived at the address at 12.39am. The call taker advised the attending officer that there was a domestic abuse history linked to the address.

5.51 Amira disclosed that her father had stormed into her bedroom, grabbed her wrist and took her mobile phone from her. She had managed to retrieve her phone which she had used to contact the police. The police recorded a crime of common assault and Amira's father agreed to leave the address and stay somewhere else for the rest of the night, leaving Amira and her brother in the family home. The crime was later finalised as 'no further action' as Amira was documented to not support a prosecution. The police documented that it was for this reason the police did not arrest Amira's father at the time.

5.52 At 2.04am the same night Amira made a further call to the police, on this occasion via 101. She said that her brother was at her bedroom door shouting and threatening to hit her, adding that he had mental health issues. The police call taker recorded that Amira was sobbing and appeared terrified. The officer who had attended the initial incident returned to the address at 2.08am and documented that Amira's brother had been shouting at his sister and following police attendance left the family home to join his father at another address. Amira was left in the property alone with the doors locked and it was documented that neither her father nor brother had keys with which to regain access. The officer updated the domestic abuse record (DAB) with details of the second call, noting that Amira believed her brother to be using cannabis and cocaine. Amira was documented to be fearful of further violence, disclosed that she had been assaulted previously and that her father had taken money (£1000) from her in the past. The incident was assessed as a 'medium' risk and referrals were sent to MAAST and Victim Support. The 'medium' risk referral was sent to the multi-crime service provided by Victim Support rather than the specialist domestic abuse service also provided by Victim Support. The multi-crime Victim Support service subsequently made three unsuccessful attempts to ring Amira.

5.53 At 6.09am the same morning Amira contacted the police to say that her brother was at the family home wanting to gain access. He left whilst Amira was on the phone and the police advised her to re-contact them if he returned.

5.54 At 6.47am the same morning Amira's brother contacted the police to say that he was unable to access the family home as his sister had locked the doors, adding that he believed that Amira had been told to leave the address at 6am by the police when their father would be returning. Amira made a further call to the police to say that he was 'sick of waiting' for officers to attend and that he felt like smashing the windows, adding that if he did so, his father would not support any prosecution.

5.55 At 9.17am the same morning Amira's paternal aunt contacted the police to say that Amira was 'going mental' at the family home in that she wouldn't allow anyone entry and was 'smashing the house up'. The aunt added that Amira had mental health issues, was a danger to herself and had previously self-harmed. The police attended and found no sign of a disturbance. They had initially asked NWAS to attend but cancelled them at this point. Father, as the tenant of the property, wished to return to the family home and wanted Amira to leave 'due to her behaviour'. It was documented that Amira did not understand why she had to leave the address but agreed to do so. She said she planned to go to her step mother's address in Blackburn but had no money with which to make the journey and so she would visit the Job Centre to 'sort out her finances' first. A 'medium' risk domestic

incident report was completed. No referrals were made on this occasion as Amira did not consent to information being shared about her.

5.56 At 12.47pm the same day Job Centre Plus in Rochdale contacted the police to say that Amira was at that location and had told their staff that she had been removed from her home by the police that morning at the request of her father and that if she was not allowed to return home and be in her own bedroom she did not want to live, adding that 'her light was just going to go out'.

5.57 The police appear to have advised Job Centre Plus that this was a 'medical matter' and advised them to call an ambulance which they did. NWAS attended and spoke to Amira who declined hospital attendance. She was deemed to have capacity to make this decision. NWAS made a safeguarding concern to Adult Care in which they documented that Amira's brother often made threats to her and their father had threatened to murder them in their sleep; that her brother had damaged the TV and other items in the house and she felt she needed to live in her bedroom in order to avoid contact with her father and brother; that she had no money as her bank card was in the possession of her father and 'any money had to go through him;' that as she had no family close by she had visited the Job Centre for support as she knew someone there; that, despite everything which was going on, she wanted to return home, and if she could not do so she felt that she 'had no reason to be here anymore'. The ambulance crew added that Amira was in a place of safety at the Job Centre but expressed concern that she would be a high risk when it closed although she was said to have spoken to an 'auntie' who was 'hopefully' coming to collect her soon. The crew had provided her with details of a Women's Refuge in Rochdale. The safeguarding concern stated that Amira's father had told her that she would be allowed to return home on condition that she stop lying, apologise and stop staying in her room. Amira told NWAS she often smoked cannabis and had found white powder in the house which she said belonged to her father or her brother. Finally the safeguarding concern relayed the request that Adult Care phone her first rather than visiting the family home.

5.58 During the afternoon, Amira was transported to a paternal Aunt's address by the police after NWAS made a further call to the police to say that she was refusing to leave the Job Centre. Amira told the police that she intended to return to the family home later that evening and was advised to recontact the police if she required further assistance.

5.59 On receipt of the safeguarding concern from NWAS, an Adult Care social worker attempted to ring Amira on the mobile phone number provided by NWAS, which was also consistent with the number Adult Care held for Amira following their contact with her in August 2019. An unidentified male answered who said that this

was a wrong number. Adult Care decided to visit the Job Centre the following day to clarify Amira's contact details and whereabouts, as by this time the Job Centre had closed for the day.

5.60 At 7.09pm the same day Amira rang the police to say that she had returned to the family home. She did not request police attendance as she said she felt it would make matters worse and she would be asked to leave again. She said she just wanted to sleep but she couldn't because her brother was shouting and 'creating drama'. The call taker initially had some difficulty in understanding the purpose of the call during which Amira asked if the police would disclose information to someone if they rang in and reported her. The incident was reviewed by a Sergeant who decided that it was necessary to override Amira's wishes and attend the incident in view of the number of related calls received that day. However, attendance at the incident was delayed and when reviewed by an Inspector the following morning he decided, after speaking to Amira by telephone, who he said was reporting no new issues, to close the incident without police attendance.

5.61 During the same date (3rd October 2019) DWP cancelled a payment of £241.77 for Amira on the grounds that the payment was due to be sent to her father's bank account and this was not regarded as a viable option for ensuring that Amira received her benefit payment. It was planned to arrange for Amira to receive the payment via the DWP Payment by Exception Service (PES). The PES service is used to provide money vouchers to customers who cannot have benefit paid into a bank account and who have no other way to receive their benefit.

Friday 4th October 2019

5.62 Amira returned to the Job Centre to thank the worker who had supported her the previous day. She was seen by a community connector – who are employed by Adult Care to undertake signposting, financial aid and outreach to services - who was concerned about Amira's presentation. She reported suicidal thoughts and feeling at risk of acting on these thoughts, although she had no plans to harm herself. The community connector was also concerned about the absence of protective factors and further risks including recent domestic violence and not eating.

5.63 The community connector contacted the Pennine Care NHS Foundation Trust (PCFT) Open Door mental health nurse whom she knew due to that service running drop in sessions at the Job Centre. The PCFT Open Door service developed a series of drop-ins alongside community connectors which people can attend to seek support and advice, including meeting a mental health practitioner without the need for a GP referral. The Open Door mental health nurse had a number of pre-arranged

commitments that day and advised the community connector to arrange for Amira to be taken by ambulance to the Urgent Care Centre for assessment by the mental health liaison team which Amira declined. Amira declined to go anywhere other than back to her family home. It is understood that the possibility of a Mental Health Act assessment may have been discussed.

5.64 The Open Door mental health nurse advised that she would call into the Job Centre when she had completed her pre-arranged appointments and arranged for a colleague to offer any support the community connector might need prior to her arrival.

5.65 At around 2pm the Open Door mental health nurse attended the Job Centre and was advised that Amira was still there. The community connector updated the mental health nurse on what had taken place the previous day and said that Amira was a victim of domestic abuse from both her father and her brother, that the police had been involved but there had been no completed prosecutions, that she stayed in her room all the time because it is the only place she felt safe and had been abandoned by her father in Pakistan in December 2017 for a year before returning to the family home.

5.66 The Open Door mental health nurse and the community connector spoke with Amira. She presented as calm and appropriate in manner and behaviour, polite, casually dressed and well kempt. Amira reported her mood to be depressed and that she had experienced loss of interest in general since her return from Pakistan. The mental health nurse observed that Amira presented in low mood in relation to her family situation. Amira said she had visited the Job Centre that day to thank her worker and said she felt embarrassed about the incident the previous day. Amira denied feeling suicidal and wanting to end her life, adding that she chose the wrong words the previous day as she had felt angry, highly anxious and very emotional, and that she had vented her frustrations around how she was feeling. Amira went on to say that she would never kill herself as she believed in God and would cope on her own by sitting undisturbed in her bedroom where she felt safe as she had done for a year. Amira described 'not feeling hungry and taking a poor diet'. She said she had lost interest in most things and was sleeping a lot. She listened to music on her phone and used the internet which she said had been 'her life' for a long time. She became more animated when talking about her degree which could have enabled her to become a teacher or a police officer but felt she would never use it.

5.67 When the mental health nurse attempted to explore events from the previous day Amira disengaged. When asked if there was anywhere else she could stay, Amira said that she would be returning to the family home as she felt she had done nothing wrong and was 'used to it now'. She was given advice about services which

she could access to support her which she declined, saying she would continue to see the community connector. The mental health nurse advised Amira that if she needed mental health services she could refer her and advised her to seek a 'further review' from her GP. Amira was documented as demonstrating full mental capacity in that she was alert, orientated to time and place and person and able to recall and discuss the contents of the assessment. She was also documented to be aware that her presenting symptoms were probably caused by being a victim of domestic violence and depression related to family dynamics.

5.68 She declined to visit her GP for help or medication and expressed her wish to deal with issues herself. She also declined the offer of being seen again, although she accepted Community Connector's contact details.

5.69 In addition to the above record of the contact with Amira, Adult Care records document that Amira's brother had threatened to kill her the previous day.

5.70 The mental health nurse advised the community connector to action a safeguarding concern as Amira had made the initial disclosure to her and the nurse explained that she would also complete one in relation to the intervention she had with Amira. However, no safeguarding concern was submitted.

5.71 The Adult Care Emergency Duty Team (EDT) received a referral from the Job Centre requesting that contact be made with Amira that evening. The referral stated that she had disclosed she was experiencing domestic violence, financial and verbal abuse from her father and brother, had not eaten for two days and had expressed thoughts about dying. The referral also stated that Amira had spoken to the 'Domestic Violence Team', but she had declined to disclose who she had spoken to, thereby preventing follow up. (No Rochdale domestic violence service has any record of Amira contacting them at that time). The EDT noted the possibility that Amira may be a victim of coercion and control.

5.72 The Open Door mental health nurse also phoned the EDT and shared her concerns in respect of Amira. A discussion took place about the most appropriate method of approaching Amira. The EDT practitioner advised that he would put an alert on Amira's record to request a professional's meeting to support further planning and investigation.

5.73 The EDT then phoned Amira was said she was at home. She declined offers of support, stating this had upset her father and that she was avoiding her father and brother. She reported feeling unwell and stressed but declined to discuss this further. She said she would not be contacting the police or any other service over the weekend. Her refusal to accept support was documented along with EDT's

concerns for her welfare. EDT sent a communication to Adult Care daytime services requesting follow up.

5.74 Due to Amira declining a service from the Open Door mental health nurse there was no subsequent MDT discussion of her case, or any further contact with her, by PCFT.

Monday 7th October 2019

5.75 Adult Care decided that the duty team would follow up on the concerns raised in respect of Amira and during the morning a duty social worker left a voicemail message for her. Amira returned the call the same afternoon, speaking to a business support officer to request a return call from the social worker.

5.76 During the same day the duty social worker made contact with DWP in respect of Amira.

Wednesday 9th October 2019

5.77 Amira phoned the police to express concerns for a friend who had telephoned her from Pakistan asking for her help as she believed that she was to be subject of a forced marriage. Amira was only able to provide a first name for her friend, saying she had accidentally deleted her telephone number after the call. Amira said that she knew this friend from working together at JD Sports. Enquiries were conducted with JD Sports in an effort to identify the friend however they had no records of the female – or indeed Amira - from the limited details provided.

5.78 The incident was reviewed by a Sergeant who considered that, in light of the domestic abuse history of the family, it may be that Amira herself was in fear of forced marriage and was seeking information for herself. The Sergeant decided that the incident should not be finalised until Amira had been spoken to in a safe location, any safeguarding concerns had been considered and the Forced Marriage procedure applied. The incident log was later updated by CID who provided Amira with a list of questions to ask her friend in order to assist with establishing her identity and location. Amira did not re contact the CID and did not answer messages left for her and the CID subsequently reported that enquiries were complete and they had been unable to identify the female in Pakistan.

5.79 On the same date DWP placed a note on Amira's Universal Credit account to advise her to attend the Job Centre the following day in relation to the DWP Payment by Exception (PES) service.

Thursday 10th October 2019

5.80 Amira rang the DWP to say that she was unable to attend the Job Centre appointment and was advised that PES could be sent to a secure email or mobile phone, a course of action to which Amira agreed, providing a mobile phone number to which payment of £241.77 was sent via SMS. The DWP put the following note on her Universal Credit account – 'Please do not call via withheld number - vulnerable customer'.

5.81 Adult Care contacted Amira by telephone to offer support including the option of moving to a place of safety to reduce the risks to her. She declined support saying that she did not wish to leave her home, adding that things had 'calmed down a lot more since the incident'. Amira went on to say that she wasn't well at the moment and that Adult Care contacting her increased her stress, which she said she 'didn't need'. She also said that she was fully aware of all contact numbers should she require support. The matter was later discussed with the duty manager and it was decided to close the case as Amira was declining support at that time.

5.82 On the same day a MAAST meeting took place. It is documented that an overview of Amira's family's history and 'these incidents' were discussed. What was included in 'these incidents' was not recorded. It seems possible that the referral to Victim Support made by the police after the second domestic abuse incident reported by Amira on 3rd October 2019 (see Paragraph 5.52) may have been the document MAAST considered at their 10th October 2019 meeting. This referral contained a summary of the first two domestic abuse incidents Amira reported on 3rd October 2019 and a summary of what the referral described as an 'extensive history of public protection incidents (PPI) between all parties in Amira's home address, including 26 PPIs to which Amira was linked. The police, Adult Care, Turning Point and mental health services were represented. The meeting noted that the family were not open to services however due to the history of drug misuse by Amira's brother, an invitation to access Turning Point would be offered to him. However, this invitation was later closed due to lack of engagement. There is no record of any referral being made in respect of Amira.

Friday 11th October 2019

5.83 DWP noted that Amira had performed a factory reset on her mobile phone and lost her PES vouchers. The original PES payments were cancelled, reissued and re-sent to Amira's mobile phone.

Monday 14th October 2019

5.84 Amira phoned the DWP to close her account as she was 'not prepared to continue being messed around with her payments from PES vouchers' which she stated she was unable 'to cash to normal payments into her account'.

Friday 1st November 2019

5.85 Amira called NHS 111 to report that she was breathless and had been experiencing chest and abdominal pain for four days. She said she would make her own way to hospital although there is no record of her attending.

Monday 18th November 2019

5.86 Amira called NHS 111 reporting chest pains, breathlessness and intermittent nausea. She was advised to attend an emergency treatment centre within 1 hour.

5.87 NHS 111 also appear to have passed Amira's details to Bardoc for a 20 minutes advice call. The out of hours GP tried to ring Amira but it is documented that an incorrect telephone number had been recorded. A home visit was therefore arranged. On arrival at Amira's home, she informed the GP that she only requested advice from NHS 111 and was not expecting a visit and said she didn't want to be seen as she felt better.

Friday 22nd November 2019

5.88 Amira called NHS 111 reporting chest pains, breathlessness and nausea. An ambulance was despatched and the crew completed clinical observations and an ECG. Amira was documented to be having episodes of palpitations lasting for several minutes which were worse at night and when lying down. She was currently pain free with no palpitations. However, she subsequently disclosed that she had experienced two 'blackout episodes' that week. The crew contacted Bardoc who advised Amira to attend hospital A&E for further assessment in view of her recent collapses. Amira refused to attend hospital by ambulance saying that she would make her own arrangements to attend with a family member. The crew documented that Amira had capacity to make this decision. Amira was given call-back advice in case her symptoms worsened whilst she was making her own way to hospital. There is no indication that Amira attended hospital on this occasion.

Early December 2019

5.89 During the late afternoon the police attended Amira's family home after she had been discovered by her father in her bedroom having apparently taken her own life by hanging. After discovering his daughter's body, father had contacted Amira's

paternal aunt who had contacted the police and NWAS. The police investigation found no evidence of foul play. Very limited items were found in her wardrobe. Her death took place shortly before her 25th birthday.

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 of domestic violence and abuse by Amira addressed by the agencies in contact with her?
How effectively were the risks to Amira presented by her brother and father assessed and managed?

6.2 Between 19th July 2013 and 3rd October 2019 the police were called to thirty seven incidents at Amira's family home, most of which involved disclosures, or indications of, domestic abuse. One incident appears to have been assessed as 'high' risk, fourteen of the incidents were assessed as 'medium' risk whilst the remainder were assessed as 'standard' risk. The police sometimes experienced difficulty in completing, or fully completing, DASH risk assessments as the family member perceived to be the victim of abuse did not always wish to provide information with which to complete the risk assessment.

6.3 Looking back over the many incidents it is possible to identify some patterns. The first two incidents, which took place in 2013, involved disclosures (of sexual and physical assault) by Amira's step mother against Amira's father and paternal aunt (physical assault only). The first of these incidents was assessed as 'high' risk, the case was referred to Rochdale MARAC and Amira's step mother was supported to stay in a refuge for a time.

6.4 A recurring theme was conflict between Amira's father and her brother which escalated over time from verbal arguments to two assaults and damage to the family home. There were eight such incidents. Amira's brother's mental health issues frequently appeared to be a factor in the conflict between father and son. Amira's father was reluctant to support prosecutions against his son. Over time he appeared to wish his son to leave the family home but told the police that when he asked him to leave he came under pressure from the wider family to allow him to return.

6.5 The remaining twenty seven incidents involved Amira. The majority of the incidents involved Amira calling the police to report assaults by her brother including grabbing her by the throat, pulling her arm, twice hitting her on the head and also kicking her on the leg. She also reported three incidents in which her brother caused damage at the family home, on one occasion leading to a cut to her nose from flying glass after he smashed a door panel. She also disclosed threats to her person and threats to cause damage at the family home from her brother. There were times

when police call takers recorded that Amira sounded fearful, even 'terrified' (Paragraph 5.52) of her brother.

6.6 Amira did not report any violence or abuse by her father until 3rd October 2019 when she disclosed to the police that her father had stormed into her bedroom, grabbed her wrist and taken her mobile phone from her (Paragraph 5.51). Later the same day she disclosed to an ambulance crew that her father had threatened to kill both her and her brother in their sleep (Paragraph 5.57). By this time indications that her father was exerting coercive control over her began to emerge. On 11th August 2019 she had told ambulance crew that she did not have her own phone (Paragraph 5.43) and when Adult Care attempted to contact her by phone in response to the safeguarding concern raised by NWAS, an unidentified male answered and said it was a wrong number (Paragraph 5.59). On 3rd October 2019 Amira told ambulance crew that she had no money as her bank card was in the possession of her father and 'any money had to go through him' (Paragraph 5.57) and the ambulance crew also documented that her father had told Amira that she would be allowed to return home on condition that she stop lying, apologise and stop staying in her room (Paragraph 5.57). It was around this time that Amira began to seek support from DWP to gain control over her benefits which were being paid into her father's bank account.

6.7 There was one occasion when Amira's brother disclosed assault and racial abuse by his sister and two occasions when their paternal aunt made complaints about Amira.

6.8 Family members were often unwilling to support any prosecution, or having initially supported a prosecution, subsequently decided to withdraw their support for a prosecution. Amira's father was unwilling to support formal action against his son on the grounds of his son's mental ill health. Amira did not support the prosecution of her brother on four occasions. Following assaults on Amira by her brother, the CPS considered, but ultimately decided against an evidence-led prosecution on one occasion (Paragraph 5.14), took no further action in another case (Paragraph 5.24), pursued a prosecution until Amira retracted her statement a week prior to the hearing, 'due to being under pressure at the moment' (Paragraph 5.32). It seems likely that Amira may have come under pressure from family members to retract her statement, given father's earlier comment to the police that the wider family had persuaded him to take his son back after he had asked him to leave the family home. On one occasion the police were unable to proceed with one complaint by Amira against her brother (theft of £50 cash and her house keys) largely because other family members did not confirm her account (Paragraph 5.17)

6.9 The police made a number of referrals in respect of Amira. At the time of writing the following support was available to the victims of domestic abuse in Rochdale:

- STRIVE is a Greater Manchester wide service delivered by Talk Listen Change (TLC) which provides support to 'standard' risk domestic abuse referrals from the police.

- Safenet is a Rochdale Borough Council commissioned service which provides refuge and 'medium' risk outreach services. Referrals are accepted from anywhere and support includes safety planning, applications for civil orders, assistance with housing etc. The multi-crime Victim Support service has recently agreed to pass cases to Safenet which require more support that their independent victim advocates (IVA) can offer.

- Victim Support (multi-crime) is a Greater Manchester wide service for victims of crime who consent to be contacted. An IVA will provide short term support and signposting. This service receives 'standard' or 'medium' risk domestic abuse cases in which a crime has been recorded and the victim has consented to the referral. As stated above this service has recently begun to pass 'medium' risk domestic abuse cases to Safenet and to the Victim Support community based domestic abuse service where the person requires more support than can be offered by an IVA.

- Victim Support (community based domestic abuse service) commissioned by Rochdale Borough Council which primarily provides IDVA support to 'high risk' domestic abuse victims. Additionally, one staff member provides support to 'medium' risk domestic abuse victims. Referrals are accepted from anywhere. As stated above the multi-crime Victim Support service has recently agreed to pass on cases which require more support than IVAs can offer.

- Rochdale Women's Welfare Association offers specialist support for women experiencing so called 'honour'-based violence and abuse.

6.10 The police referred Amira and her father to the multi-crime Victim Support service on three occasions each, although Victim Support has records of only two referrals in respect of Amira. Amira was not referred to any of the other services which provide support to the victims of domestic abuse in Rochdale. The two referrals the multi-crime Victim Support service received in respect of Amira did not result in any support being provided to her (Paragraphs 5.39 and 5.52) due to

difficulties in making telephone contact. A referral to STRIVE was considered but ruled out on the grounds that there was already a substantial domestic abuse history which made the case unsuitable for STRIVE (Paragraph 5.39). NWAS provided Amira with details of a Women's Refuge in Rochdale on 3rd October 2019 (Paragraph 5.57). The Job Centre referral made to Adult Care on 4th October 2019 stated that Amira had spoken to the 'domestic violence team' (Paragraph 5.71) although there is no indication that she contacted any Rochdale domestic violence service at that time. Whilst the arrangements for providing support to the victims of domestic abuse in Rochdale are likely to have evolved and changed over the period on which this review focusses, it is surprising that Amira was not referred for any domestic abuse support other than the multi-crime Victim Support service which is not equipped to provide more than short term support.

6.11 Neither the police acting alone, or the series of referrals they made, appear to have had any discernible impact on the conflict within Amira's family. The author of the GMP IMR states that over the years there appeared to have been numerous opportunities to consider alternative approaches such as Domestic Violence Prevention Orders (DVPO) or a referral to the Neighbourhood Policing Team consider working with the family to address problems and reduce calls for service.

6.12 The police frequently took positive action, removing Amira's brother from the family home on three occasions and arresting him four times. However, they responded inconsistently to the six calls they received from, or in respect of Amira on 3rd October 2019. The first two calls were dealt with effectively in that first Amira's father and then her brother were asked to leave the family home after her father assaulted her and her brother threatened her (Paragraphs 5.50 to 5.52). However, when her brother insisted on being allowed back into the address the following morning, it was Amira who left the family home, apparently at the insistence of her father and brother and with the acquiescence of the police. When the Job Centre later rang the police to say that Amira had turned up there in a distressed state, they advised the Job Centre that this was now a 'medical matter' which led to the involvement of NWAS. The police later transported Amira from the Job Centre to the address of an aunt. She told the police that she intended to return to the family home later that evening and was advised to recontact the police if she needed further assistance. When she returned home that evening, Amira contacted the police again. The police initially decided to visit the family home but after the incident was deferred, it was reviewed by an inspector the following morning, who decided after speaking with Amira, to close the incident without further police attendance. The content of the Inspector's call to Amira was not recorded.

6.13 The author of the GMP IMR states that the series of incidents were not finalised as a domestic incident which meant that the requirement to create a

Domestic Abuse Record (DAB) or Care Plan was not generated. The author of the GMP IMR expressed the view that the calls the police received from, or in respect of Amira, on 3rd October 2019 could have been indicative of a person in crisis and officers dealt with incidents discretely rather than considering the events of the entire day holistically. It is not possible to disagree with this view.

6.14 There were further indications that Amira was a person in crisis when she returned to the Job Centre on the following day (4th October 2019) but at no time were all the concerns which arose in respect of Amira over the course of those two days brought together. The MAAST meeting held on 10th October 2019 (Paragraph 5.82) provided an opportunity to consider referring Amira for support but the meeting seems unlikely to have had a full picture of the concerns for Amira's safety and wellbeing. The police had referred Amira to the multi-crime Victim Support service following first two incidents to which they responded on 3rd October 2019. As stated in Paragraph 5.82, it seems possible that MAAST considered this referral which contained a summary of the first two domestic abuse incidents Amira reported on 3rd October 2019 and a summary of what the referral described as an 'extensive history of public protection incidents (PPI) between all parties in Amira's home address, including 26 PPIs to which Amira was linked. It seems very unlikely that the further events of 3rd and 4th October 2019 were considered by MAAST. Although Adult Care was represented at the MAAST meeting it is understood that details of the safeguarding referral made by NWAS on 3rd October 2019, which was being dealt with by Adult Care at that time, were not shared with the MAAST meeting. The MAAST meeting would also have been unaware of the further indications that Amira may be at risk of forced marriage which had been reported to the police the day before the MAST meeting. The MAAST meeting made no referral in respect of Amira.

6.15 However, it is important to understand the role of MAAST and the limitations on what it can achieve. MAAST screens adult vulnerability referrals to Adult Care, local adult mental health services provided by Pennine Care NHS Foundation Trust and Drug and Alcohol Services. The MAAST flowchart shared with this review also indicates that the meeting receives medium and high risk domestic abuse referrals where vulnerabilities are identified which may require support or intervention from partner agencies. The objective of MAAST, which meets twice weekly, is to ensure that the most appropriate care and support is put in place for a vulnerable adult as soon as possible.

6.16 MAAST screens a high number of cases at each meeting and is regarded as being an effective mechanism for ensuring that the large number of police referrals in respect of vulnerable adults are assessed and directed to the most appropriate service. Inevitably, many referrals are screened out by MAAST on a range of grounds. Amira and her brother were considered by MAAST on a number of

occasions and so it is possible to make observations about the MAAST process which may be of value to partner agencies as MAAST continues to evolve. Firstly written records of MAAST decisions are very brief. Secondly, the MAAST process may reinforce the tendency to consider incidents in isolation which is very apparent in this case. If MAAST is not fully aware of earlier referrals in respect of the same person, they may make decisions to screen out a case despite accumulating concerns. The stated objectives of MAAST include 'multi-agency recognition and recording of patterns in behaviour of repeat victims..'. It is unclear whether MAAST has the resources necessary to achieve this aim. Thirdly, it seems possible that a referral to MAAST may be considered by the referring officer to be a route into services which may preclude further consideration of alternative sources of support the person may benefit from. This is one possible explanation for the surprising lack of referrals of Amira to specialist domestic abuse services. Finally, the documents shared with this review which set out the method of operating of the MAAST are not very specific.

6.17 NWAS responded to a range of concerns about Amira's presentation on 11th August 2019, including her not having access to her own phone and saying she was alone in the family home which the crew did not believe to be true by raising a safeguarding concern (Paragraph 5.43). They also raised a safeguarding concern on 3rd October 2019 when Amira made a number of disclosures to their crew at the Job Centre, including receiving threats from her brother - and her father who had threatened to kill her and her brother, and her father's control over her access to money.

6.18 Adult Care responded to the first safeguarding concern from NWAS by making a 'cold-call' visit to Amira but took no further action after a conversation with her which appeared to focus largely on the medical issues in the NWAS safeguarding concern rather than indications of coercive control. No referral for support in respect of domestic abuse appeared to have considered, although Amira may not have consented given her guarded responses to the Adult Care workers on this occasion (Paragraph 5.47). No DASH risk assessment was conducted.

6.19 Adult Care responded to the second safeguarding concern from NWAS by initially attempting to phone Amira, a call which was answered by an unidentified male who said that this was a wrong number, which could have escalated concerns about coercive control (Paragraph 5.59). Again the case was closed after Amira declined support including the option of moving to a place of safety. By this time Adult Care had also received further information from the community connector and the Open Door mental health nurse which should have heightened concerns about Amira's exposure to domestic abuse including coercive control. The decision to close Amira's case appeared to be taken without consulting partner agencies including the

police who Adult Care were aware had had previous involvement with Amira as a victim of domestic abuse. No DASH risk assessment was conducted.

6.20 Amira also made disclosures of domestic abuse to the community connector and the open door mental health nurse at the Job Centre on 4th October 2019 which both practitioners promptly and separately shared with the Adult Care EDT. No DASH risk assessment was conducted or safeguarding concern raised.

Did professionals to whom Amira made disclosures of abuse consider whether she may be the victim of coercive control, so-called honour-based violence or forced marriage?

6.21 Indications that Amira may be the victim of coercive control had begun to accumulate by 3rd and 4th October 2019. Coercive control consists of behaviours perpetrated by one person against another with whom they have an intimate or family relationship and is exercised in situations where the behaviour of an individual is shaped into conformity to the wishes of another person (2). Professional awareness of coercive control has probably been most prominent in domestic abuse involving intimate partners but the applicability of coercive control to familial relationships is made clear by the offence of coercive and controlling behaviour introduced by the Serious Crime Act 2015 which relates to both intimate and familial relationships.

6.22 Examples of coercive control behaviours which may be applicable to Amira's case include (3):

- isolating a person from their friends and family – Amira appeared to have no contact with family members other than members of father's family. In her contribution to this review, Amira's mother said that Amira's father denied her contact with Amira and her brother for many years. Amira's father does not accept this characterisation of events and has told this review that he took on the responsibility of bringing up Amira and her brother from a very young age after being awarded custody of the children by a Court. The impression gained is that when Amira sought support from father's wider family, there was often a tendency for the family member's from whom she sought support to reinforce her father's control over her.

- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep – Amira's reluctance to go to hospital may have been because she was unwilling to go without a chaperone, although she attended hospital once unaccompanied. In

his contribution to this review, Amira's father denied controlling who his daughter could see or form relationships with.

- depriving them of access to support services, such as specialist support or medical services – Amira disclosed that her father was unhappy about the involvement of services in her life. In his contribution to this review, Amira's father stated that he was completely unaware of his daughter's frequent contact with health and other services in the final months of her life. Amira was noted to lack access to her own mobile phone at times. In his contribution to this review, her father stated that his daughter had her mobile phone stolen whilst visiting Pakistan from December 2017 onwards. He added that he later purchased a replacement phone for his daughter but there appears to have been quite long interval between her return from Pakistan without a phone, and its subsequent replacement.

- economic abuse including control of finances, such as only allowing a person a punitive allowance – at the age of 24, Amira did not have her own bank account and her state benefits were paid into her father's bank account. When the police attended the family home following Amira's death, they noted 'very limited items' in her wardrobe. In his contribution to this review, Amira's father stated that his daughter had had bank accounts whilst a student at university but that it had been arranged for her Universal Credit to be paid into his bank account because his daughter 'was always losing her bank card'. Additionally, Amira disclosures that she had not eaten may have been an indicator of economic abuse as may the period when she lacked a mobile phone and was dependent on her father to provide one.

- enforcing rules and activity which humiliate, degrade or dehumanise the victim – Amira's father imposed several conditions on her returning to the family home on 3rd October 2019 including to 'stop lying'

- threats to hurt or kill – Amira disclosed many threats from her brother over the years and on 3rd October 2019 disclosed threats to kill by her father

6.23 The possibility that Amira may be the victim of coercion and control was recognised by the Adult Care EDT following contact from the community connector and the Open Door mental health nurse on 4th October 2019 (Paragraph 5.71) but does not otherwise appear to have been prominent in single or multi-agency discussions.

6.24 There were also indications that Amira may be at risk of forced marriage. Forced marriage is when a person faces physical pressure to marry (for example,

threats, physical violence or sexual violence) or emotional and psychological pressure (e.g. if the person is made to feel like they are bringing shame on their family) (4). Forced marriage is illegal in England and Wales and includes taking someone overseas to force them to marry (whether or not the forced marriage takes place) and marrying someone who lacks the mental capacity to consent to marriage (whether they are pressured or not).

6.25 At the age of 19, Amira appeared to be encouraged to marry her step mother's brother, although Amira was said to have disagreed with this course of action and the matter appeared to be taken no further at that time (Paragraph 5.3). The fact that Amira's father and step mother's relationship appeared to be breaking down at that time may have strengthened Amira's position in resisting the marriage.

6.26 On 4th October 2019 Amira disclosed that she had been abandoned by her father in Pakistan in December 2017 to the community connector and the Open Door mental health nurse (Paragraphs 5.65 and 5.66). Amira did not explain why she had been abandoned in Pakistan, nor was this apparently explored further. She alluded to the impact of this experience by disclosing that she had experienced a loss of interest in general since her return from Pakistan (Paragraph 5.66). Rochdale Women's Welfare Association – which offers specialist support for women experiencing honour-based violence and abuse - has contributed to this review and have advised that Amira's abandonment in Pakistan could be a very strong indicator of forced marriage, observing that the length of time she disclosed spending there could have been an indication of her family leaving her there, possibly destitute and unable to access help until she agreed to the marriage. The Association acknowledged that Amira had experienced a university education which appeared to represent a lower degree of family control at that time. There is no indication that the possibility that Amira may be at risk of forced marriage was considered by the community connector or the Open Door mental health nurse or by Adult Care when contacted by the above practitioners.

6.27 This raises questions about the level of professional awareness of what action to take in response to indications of forced marriage amongst partner agencies in Rochdale. Rochdale Borough Safeguarding Adults Board website provides valuable guidance on forced marriage. The guidance on signs of forced marriage relates primarily to young people although they include 'strict controls over the movements' of victims, domestic abuse and depression. The age of victims is helpfully broken down which demonstrates that forced marriage is a risk to adult women with 14% of victims stated to be 22-25 year olds, 8% are 26-30 year olds, 5% are 31-40 and 2% are over 41 years old. Forced Marriage is also referenced in the RBSAB Policy and Procedures as an example of abuse (Paragraph 3.2.14) and rejecting a forced

marriage is listed as an 'infringement' of 'honour' based rules which could be 'punished' (Paragraph 3.2.15).

6.28 The Safeguarding Adult Board website also contains a link to Government Multi-agency practice guidelines on *Handling cases of Forced Marriage* (5) which sets out detailed step-by-step guidance for practitioners. The guidance emphasises that there will be occasions when a woman does not mention forced marriage but 'presents with signs or symptoms' which, if recognised, may indicate to practitioners that she is within a forced marriage or under threat of one.

6.29 Forced marriage is also referenced in the Rochdale Borough Domestic Violence and Abuse Strategy 2014-17 (which is currently being updated). It is listed as a type of domestic violence and abuse and some data on prevalence is included. The strategy states that a number of specialist agencies provide services for those who may become victims of particular abuses such as forced marriage and honour based violence but does not describe or identify such services further. However, specific details of sources of support can be found within the domestic violence and abuse section of the relevant website.

6.30 There is no reference to forced marriage or so called honour based violence in the local Safer Communities Plan 2019-2020 although this is quite a high level strategy document which focusses on priorities and themes. Rochdale's local safeguarding children partnership subscribes to Greater Manchester safeguarding children procedures which provides substantial guidance on actions to consider when a child is at risk of forced marriage.

6.31 Further concerns that Amira may be at risk of forced marriage arose when she phoned the police on 9th October 2019 to purportedly express concerns for a friend who had telephoned her from Pakistan asking for her help as she believed that she was to be subject of a forced marriage (Paragraph 5.77). The incident was reviewed by a Sergeant who considered that, in light of the domestic abuse history of the family, it may be that Amira herself was in fear of forced marriage and was seeking information for herself (Paragraph 5.78). The Sergeant decided that the incident should not be finalised until Amira had been spoken to in a safe location, any safeguarding concerns had been considered and the Forced Marriage procedure applied. This was very good practice by the Sergeant. Unfortunately, although the incident was followed up by the CID, they appear to have accepted Amira's initial contact at face value and focussed on identifying her 'friend'. The author of the GMP IMR regards this as a missed opportunity to gain a fuller understanding of the risks that Amira may have been facing at that time. As a result, the incident was not finalised as a domestic or honour based violence incident which would have required

the officers to create a DAB/safeguarding report which in turn would have generated a review by specialist officers.

6.32 It has not been possible for this review to establish whether or not Amira was at risk of forced marriage. However, her disclosure that she had been abandoned in Pakistan for a year from December 2017 is supported by the absence of agency contact with her between 27th June 2017 and 13th September 2018. In his contribution to this review, Amira's father denied that he abandoned his daughter in Pakistan in December 2017. He acknowledged that she had travelled to Pakistan at that time for a family wedding and said that she had decided to extend her stay by around two months. He said that she had stayed in Pakistan for no more than three or four months overall (Paragraph 5.9). However, the account he provided to the review did suggest a degree of control over his daughter's stay in Pakistan. He sent Amira a flight ticket to return home. This may have been the benevolent act of a caring parent but Amira's financial dependence on her father had the potential to enable him to determine the length of her stay in Pakistan. Additionally, Amira's father advised this review that his daughter had her mobile phone stolen during her stay in Pakistan. This would have left her without any independent means of communicating with others and may have had the effect of isolating her from help if she was at risk of forced marriage at that time. Amira's mother has contributed to this review and said she had no knowledge of any marriage for her daughter, forced, arranged or otherwise.

6.33 However, the purpose of this review is not to investigate whether Amira was at risk of forced marriage but to identify learning from how agencies responded to what was known about Amira at the time, and what, with appropriate professional curiosity was 'knowable' about her circumstances.

When the police were called out to a series of domestic abuse incidents in Amira's household, could a referral to the Multi-Agency Risk Assessment Conference (MARAC) have been made or considered?

6.34 There was one referral to MARAC in 2013 in respect of disclosures of sexual and physical assault made by Amira's stepmother (Paragraph 5.2).

6.35 This review has been advised that if an incident is assessed as medium or high risk by the police there is an additional level of screening, with specialist officers considering the responding officer's report and reviewing the history for the people involved, previous interventions and what additional referrals could be made to support those involved. It is not easy to detect the impact of this additional level of screening in respect of the incidents assessed as medium risk in this case.

6.36 Further MARAC referrals could have been considered given the large number of incidents of domestic abuse reported to the police which at times, appeared to be escalating such as during the period of November and December 2018, when five incidents were reported (Paragraphs 5.27 – 5.31) and during March 2019 when six incidents were reported (Paragraphs 5.33 – 5.39). GMP's MARAC policy suggests a MARAC referral may be appropriate where the number of potential call outs indicate an escalation of concerns (Paragraph 5.6.4 of the GMP policy). Three or more incidents in a twelve month period is regarded as a guide for considering a MARAC referral, although several police forces regard this figure as an unrealistic threshold given the volume of domestic abuse reports received. GMP's MARAC policy regards repeat victimisation as a concern. As previously stated Amira appeared to be the victim of domestic abuse in twenty seven of the incidents reported to the police.

6.37 As previously stated it would have been helpful if a 'problem solving' approach had been applied to the large number of domestic abuse call outs from Amira's family home. This would have helped the police and partner agencies understand the patterns of the calls and highlighted the frequency of Amira being a victim.

6.38 However, lack of awareness of the risks associated with familial domestic abuse compared with intimate partner domestic abuse may have obscured the risks faced by Amira. National and local guidance tends to focus on domestic abuse in intimate relationships because it is the most prevalent form of domestic abuse. However, the Home Office provides guidance on abuse between family members (6), but the focus of this very helpful guidance, and the University of Oxford research on which it draws (7) is on adolescent to parent violence and abuse. Both the University of Oxford research and international research has found that adolescent to parent violence is predominantly a son-mother phenomenon. Given that guidance and research of familial domestic abuse focusses primarily on violence by teenage boys against their parents – primarily mothers – it is perhaps unsurprising that practitioners may not have fully appreciated the risks to Amira, a woman in her twenties, from her younger brother and her father. Indeed on one occasion Amira and her brother were documented 'not to get along' (Paragraph 5.17) which suggests that a subtly different approach was being taken to assessing risks arising from conflict between two young adult siblings than would have been the case had they been intimate partners.

6.39 MARAC referrals could also have been considered on the grounds of 'professional judgement', where there are serious concerns about a victim's situation. Had Amira been considered to be at risk of forced marriage, a MARAC referral would have been considered as the GMP MARAC policy states that forced marriage or so-called honour based violence should always be considered as high risk. A MARAC referral could have been considered in respect of Amira on 3rd or 4th

October 2019. Her contact with a range of agencies over the course of those two days suggested that she may have been 'in crisis' and that domestic violence and abuse, particularly coercion and control was a significant factor.

6.40 During the course of this review the author of the CCG IMR observed that the CCG had recently identified a gap in respect of the sharing of information between GPs and the MARAC process, noting that although there is a pathway for GPs to share information with MARAC in cases in which children are involved, this is not the case when the case involves only adults. This could have been a relevant issue in this case had Amira been referred to MARAC following the events of 3rd and 4th October 2019 as the GP practice was aware of her contacts with NHS 111, BARDOC and NWAS. Successful recruitment has since taken place to a post of Specialist Safeguarding Nurse within the CCG Safeguarding Team. A key element of this role will be to ensure that safeguarding pathways are developed and maintained.

When Amira made disclosures of domestic violence and abuse to professionals other than the police, could DASH risk assessments have been completed?

6.41 When Amira made such disclosures to agencies other than the police, DASH risk assessments were not completed. There were opportunities for DASH risk assessments to be completed by NWAS when they saw Amira at the Job Centre on 3rd October 2019 (Paragraph 5.57), by the community connector or the Open door mental health nurse when they saw Amira at the Job Centre the following day (Paragraphs 5.65 and 5.66) and by Adult Care on 10th October 2019 (Paragraph 5.81).

6.42 Victim Support conducted a DASH risk assessment in respect of Amira's father in December 2017 (Paragraph 5.22).

6.43 Pennine Care NHS Foundation Trust has advised this review that their mandatory Level 3 Safeguarding training in support of the Trust's Safeguarding Families policy includes the DASH tool and MARAC referral process although the Open Door mental health nurse who saw Amira on 4th October 2019 had not completed the Level 3 training.

6.44 Adult Care has advised this review that their staff use the DASH risk assessment tool but acknowledge that improvement is required in relation to the knowledge and awareness of their staff in this regard.

6.45 NWAS has advised this review that their staff do not carry out DASH risk assessments due to the time that is required to complete them whilst fulfilling their

core functions of pre-hospital emergency medical care and pre-planned transportation to hospital for residents of the North West. However, they do have a robust safeguarding concern raising process, which is evident from this case. NWAS also advises that if their staff receive a disclosure or assess that the patient or another member of the household is at immediate risk of harm from domestic violence or abuse, they should inform the police in addition to raising a safeguarding concern. If NWAS staff have similar concerns about patients they transfer to hospital, these concerns should be shared at the hospital to prevent the patient being discharged into an unsafe environment.

How effectively did agencies respond to safeguarding concerns in respect of Amira?

6.46 Safeguarding concerns appropriately raised by NWAS on two occasions, both of which contained much valuable detail. The community connector and the Open Door mental health nurse missed an opportunity to raise safeguarding concerns on 4th October 2019 although both alerted Adult Care EDT to concerns about Amira. The police could have considered raising a safeguarding concern in respect of Amira had they analysed the repeated calls they received from her.

6.47 Each of Amira's contacts with Adult Care resulted in her declining offers of support. It does not appear that consideration was given to screening for a Section 42 Safeguarding Enquiry, completing a DASH or a MARAC referral. With the exception of EDT, there is no information to suggest that staff considered the possibility of coercive and controlling behaviour. Emphasis was placed upon Amira having the capacity to make decisions and so Adult Care's respected her wishes and feelings. Therefore her repeated refusal to engage with services was not escalated.

6.48 Following EDT's handover of Amira's case to Adult Care on 7th October 2019, there was an opportunity to escalate the case to consider allocation to a named worker with a view to considering the criteria for a Section 42 Enquiry, completion of the DASH tool and referral to MARAC.

6.49 The author of the Adult Care IMR concluded that the work in this case was inconsistent with agency and Safeguarding protocols. A Section 42 enquiry should be considered where there is reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of abuse or neglect and as a result of their needs is unable to protect themselves. On the basis of what was known about Amira at the time, she was experiencing and was at further risk of abuse. However, it seems likely that screening for a Section 42 enquiry did not take place because Amira was not perceived to have care and support needs. The question of whether she had care and support needs was discussed by the Panel which decided to

commission this joint SAR/DHR and it was concluded that Amira had unassessed care and support needs under the Care Act's Wellbeing principle. However, the Wellbeing principle is broadly defined in the Care Act guidance as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society (8)

6.50 Such a necessarily broadly defined concept may not be the most helpful guide to practitioners in determining whether a person experiencing or at risk of abuse or neglect has care and support needs. Indeed a July 2019 Association of Directors of Adult Social Services (ADASS) Advice Note which provides a *Framework for making Decisions on the Duty to carry out Safeguarding Adults Enquiries* acknowledges that there is clear indication of 'struggle', inconsistencies and ambiguities across local authority areas in making decisions about this duty (9). Rochdale Borough Safeguarding Adults Board's multi-agency policy on adults who may be at risk of abuse or neglect states that an adult's vulnerability should be determined by a range of interconnected factors including personal characteristics, factors associated with their situation or environment and social factors.

6.51 In Amira's case she was a well-educated young woman who appeared capable of making her own decisions. However, the disclosures she made to NWAS on 3rd October 2019 and to the Open Door mental health nurse and the community connector the following day indicated that she was living in an environment in which she was subject to coercion and control, was in fear of violence from her brother and father, lacked the means to extricate herself from the situation because her father controlled her finances, was presenting with low mood, was isolating herself within the family home, her diet was said to be poor and she was using language which indicated a sense of hopelessness. There appeared to be a number of interconnected factors which suggested she was in need of care and support in order to protect herself from continuing abuse.

6.52 Had a Section 42 Enquiry been considered in Amira's case and it had been decided that she did not meet all of the Section 42 criteria, Adult Care could have

considered an 'other' safeguarding enquiry if they considered it to be necessary and proportionate to use its powers to make enquiries.

How effectively did agencies respond to suicidal ideation and indications that Amira may be mentally unwell?

6.53 Amira was referred to mental health services on one occasion, at the age of twenty, when she was experiencing low mood because of her acne. She did not attend the appointment with mental health services (Paragraph 5.7).

6.54 An opportunistic mental state assessment of Amira was conducted by the Open Door mental health nurse on 4th October 2019. Although the assessment was thorough, it wasn't recorded on any PCFT approved documentation, it wasn't classified as a formal referral to service and Amira's GP was not notified. Following this assessment, Amira was offered further support from mental health services which she declined (Paragraph 5.65-5.68).

6.55 On 3rd and 4th October 2019 Amira reported suicidal thoughts to several practitioners. On 3rd October she told Job Centre staff that she did not want to live if she was not allowed to return home and spoke of 'her light' going out (Paragraph 5.56). She spoke in similar terms to the ambulance crew who saw her at the Job Centre later the same day (Paragraph 5.57). The following day she expressed suicidal thoughts to the community connector at the Job Centre, adding that she felt at risk of acting on these thoughts whilst having no plans to harm herself (Paragraph 5.62). However, when Amira spoke with the community connector and the Open Door mental health nurse later the same day, she denied feeling suicidal and wanting to end her own life, adding that she had chosen the wrong words the previous day (Paragraph 5.66). She went on to say that she would never kill herself as she believed in God. Amira followed the Islamic faith.

6.56 Amira's death two months later, apparently by suicide, was not anticipated by any agency in contact with her in the final months of her life. Having said that no agency formally assessed her risk of self-harm or suicide.

6.57 However, with the benefit of hindsight, several antecedents of suicide were present in Amira's life. In the University of Manchester's 2017 report *Suicide by Children and Young People* (10), a random sample of deaths by suicide of people aged 20-24 in England and Wales were analysed. The following antecedents of suicide highlighted by the report, were present in Amira'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%)
- Physical health condition (23%)
- Illicit drug use (51%)
- Suicidal ideas (55%)
- Unemployment (30%)
- Financial problems (20%)
- Housing instability (25%)

6.58 It is not known if Amira had previously self-harmed or attempted suicide which are strong antecedents of suicide. It is important to note that several of the above antecedents are common in young adults and cannot be used to predict suicide risk.

6.59 The University of Manchester report concluded that the circumstances that lead to suicide in young people 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 (11). 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.

6.60 At the time of writing little is known about Amira's childhood except that she experienced a complete and lengthy break in contact with her mother, the impact of which is unknown. Nor is it known whether the indications of mental health in her brother were present during their childhoods. However, by 3rd October 2019 Amira seemed to be facing a personal crisis, the causes of which appear to have been her strained relationships with her father, brother and other family members, her fear of violence from her brother and her father, her father's restriction of her access to benefits, a sense that ambitions she may have entertained whilst studying for her degree were likely to be unfulfilled and indications that she may have been at risk of forced marriage. It is not known whether there was a 'final straw' event which may have triggered Amira's apparent suicide. It is noted that her death occurred shortly before her twenty fifth birthday.

6.61 The justification for commissioning the DHR element of this review was the concern that Amira's apparent suicide may have been linked to the domestic abuse she had been suffering from her father and brother, 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 (12) 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 (13). (It is worthy of note that of the other eight vulnerable groups highlighted by the strategy for preventing suicide in England, Amira could have been included in four or them, namely people with untreated depression, people especially vulnerable due to social and economic circumstances, people who misuse drugs and alcohol and Black, Asian and minority ethnic groups and asylum seekers.

6.62 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 (14). 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. An analysis of 93 DHRs published since the revised 2016 Home Office DHR Guidance stipulated that reviews should be carried out where the victim takes their own life, found that in 10 DHR's the victim took their own life (15).

6.63 It should be noted that both the international and UK research in this area focus primarily on the victims of intimate as opposed to the familial domestic abuse present in Amira's case. However, some of the research reviewed by the Refuge/University of Warwick study suggests that suicide risk is greater for abused women from ethnic minorities, or amongst abused immigrants and/or refugees, largely as a consequence of cultural practices, concepts of so-called 'honour' and 'shame', and language or community barriers that act to frustrate help seeking behaviours.

6.64 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 (16). This theory goes on to suggest that regarding suicidality as a 'cry for help' 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.

6.65 It is not known whether Amira had self-harmed or attempted suicide prior to her death but it seems likely that practitioners with whom she was in contact whilst

apparently 'in crisis' on 3rd and 4th October 2019 are more likely to have seen her expression of suicidal thoughts as a 'cry for help'.

When Amira decided that she did not wish to engage with, or access services, did professionals consider whether she was making such decisions of her own free will?

6.66 When Amira was seen by practitioners in the final few months of her life, the question of whether or not she was making decisions of her own free will was not considered as a discrete question. Practitioners took the view that there was no reason to doubt Amira's mental capacity for making decisions and did not appear to consider whether her capacity could be affected by the indications of coercive control in her life.

6.67 This is a particularly complex issue for practitioners to consider and has been the subject of case law. For example, a 2010 Court of Protection judgement found that the elderly parents of a 50 year old man were constrained from exercising their decision making capacity due to their son's coercive and controlling behaviour towards them (17). The Local Government Association (LGA) guide to support practitioners and managers - *Domestic Abuse and Adult Safeguarding* - draws attention to fact that being at risk of harm can limit an individual's capacity to safeguard themselves due to the psychological process that focusses an individual on acting within the immediate context of the threats that they face, in order to limit the abuse and its impact. This can lead victims to identify with the perpetrator and can prevent them from acknowledging the level of risk they face (18). It commonly prevents people leaving or ending a relationship. In Amira's case, domestic abuse was not being perpetrated by an intimate partner but she appeared to be unable to countenance living anywhere else than the family home, despite the continued risk of abuse from her father – who exercised control over her by restricting her access to her benefits and her brother – who presented a threat of physical and emotional abuse to her.

6.68 During the final few months of her life Amira made several decisions against professional advice, which could have been construed as unwise decisions. She twice declined hospital attendance (Paragraphs 5.57 and 5.88), declined assessment by the Urgent Care Centre mental health liaison team (Paragraph 5.63), declined a referral to mental health services (Paragraph 5.67), declined the option of moving to a place of safety (Paragraph 5.81), she declined the payment of her benefits via PES vouchers directly to her mobile phone (Paragraph 5.84), she did not attend hospital after telling NHS 111 she intended to do so (Paragraph 5.85) and she did not attend an emergency treatment centre as advised by NHS 111 (Paragraph 5.86). Unfortunately no single agency became aware of the full extent of these unwise

decisions because no agency initiated an information sharing exercise and the MAAST meeting does not appear to have been fully aware of the range and nature of contacts agencies had had with Amira prior to the meeting (Paragraph 5.82). Amira's GP practice could have become aware of Amira's decisions to decline hospital and emergency treatment centre attendance had their process for escalating concerns arising from NHS 111 notifications been more robust.

6.69 Had any agency become aware of Amira's unwise decisions, this would have been an issue of concern which should have been enquired into. The Mental Capacity Act (MCA) sets out five statutory principles which underpin the legal requirements of the Act, one of which is that a person is not to be treated as unable to make a decision merely because they make an unwise decision. However, the MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices'. The Code of Practice suggests issues worthy of further investigation might include whether the person is 'easily influenced by undue pressure' (19).

6.70 As previously stated, the question of whether Amira was 'influenced by undue pressure' from her father and possibly other family members received insufficient professional attention at that time.

When deciding to take no further action when Amira did not engage with services, did agencies assess any risks involved in taking no further action or contact other agencies which were in touch which Amira?

6.71 Adult Care decided to take no further action in response to the first NWAS safeguarding referral (Paragraph 5.47) after a fairly brief conversation in which the concerns included in the safeguarding referral were not fully explored. Adult Care also closed her case after the second NWAS referral (Paragraph 5.81) after she declined support during a telephone conversation. On neither occasion were there any doubts about her mental capacity and she appeared to be aware of sources of support. On both occasions she articulated distress but appeared reticent about discussing the causes of her distress with Adult Care. On neither occasion, did Adult Care contact other agencies who could have provided them with more information on which to make a better informed decision in respect of Amira.

6.72 This review has been advised of the Rochdale Borough Safeguarding Adults Board Multi Agency Risk Management Protocol which is a process to discuss, identify

and document serious current risks for high risk cases and formulate an action plan. However, it is clearly intended to apply only when all other safeguarding options and interventions have been exhausted and efforts to safeguard the adult have been unsuccessful because the person has made an unwise decision of their free will not to engage with services. The protocol could have been of value in Amira's case had safeguarding options and interventions been exhausted. As stated above, Amira's case was closed by Adult Care on two occasions without consideration of Section 42 or 'other' safeguarding enquiries.

6.73 In Amira's case, agencies could have been in a much stronger position to consider the risks she was facing and the risks involved in closing her case, if there had been some initial information gathering from partner agencies known to have had contact with her.

Were there any specific considerations around equality and diversity issues in respect of Amira 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?

6.74 The specific equality and diversity issues which merited further consideration in Amira's case were 'race, religion and belief' sex, and 'marriage and civil partnership'.

Race, religion and belief

6.75 It is assumed that Amira was a second generation ethnic minority migrant. In common with many in the second generation population, Amira was better educated than her parents' generation, although this large relative improvement in education between the parent and descendent generation still leaves second generation ethnic minority migrants at a disadvantage in terms of employment and wages compared to white British born peers (20). Second generation ethnic minority migrants may also experience tensions in assimilating to the host culture when this involves behaving in a manner which attracts disapproval from first generation family members which may result in higher mental health problems and lower life satisfaction (21).

6.76 In their feedback on this report the Home Office Quality Assurance Panel stated that there was a need to look again at the reasons why Amira's ethnicity may have been an 'add on' for services, rather than being fundamental to their response. This is a fair challenge to the SAR/DHR process. As a result the independent author has revisited the contact which professionals had with Amira to consider whether her ethnicity was treated as a peripheral rather than a fundamental to their response. As

indications arose that Amira may be subject to controlling behaviour by her father, it seems possible that professional curiosity about this may have been impeded by unspoken assumptions that the parents of British Pakistani women may impose greater restrictions on their lives than are experienced within the general population. Additionally, Amira's apparent reluctance to support prosecutions or engage in DASH assessments were not viewed as influenced by a wish to avoid being seen as impugning the so-called honour 'code' of her family or community. As previously stated the indications that Amira may have been at risk of forced marriage were overlooked by all professionals except for the GMP Sergeant (Paragraph 5.78). Overall, there may have been a reticence on the part of some professionals in enquiring into the dynamics of a British Pakistani family due to a lack of understanding of issues of race, culture and religion. This may have acted as a barrier to exploring issues of coercion and control in greater detail. There is no indication that Amira's statement that she would never kill herself because she believed in God affected professional's view of the risk she may present to herself (Paragraph 6.55).

Sex

6.77 As previously stated the police attended twenty seven domestic abuse incidents involving Amira. There was one occasion when Amira's brother disclosed assault and racial abuse by his sister. However, the overwhelming majority of the incidents involved Amira calling the police to report assaults by her brother including grabbing her by the throat, pulling her arm, twice hitting her on the head and also kicking her on the leg. She also reported three incidents in which her brother caused damage at the family home, on one occasion leading to a cut to her nose from flying glass after he smashed a door panel. She also disclosed threats to her person and threats to cause damage at the family home from her brother. There were times when police call takers recorded that Amira sounded fearful, even 'terrified' of her brother. This pattern of male on female violence is consistent with research which has found the difference between men and women to be stark, with men significantly more likely to be repeat perpetrators and men significantly more likely than women to use physical violence, threats and harassment (22).

Marriage and Civil Partnership

6.78 Amira was unmarried and was not in a civil partnership. However, this report considered whether Amira may have been at risk of forced marriage. The disclosure she made of being abandoned in Pakistan by her father, the indications of coercion and control by her father and her subsequent call to the police to ostensibly seek advice on behalf of a 'friend' in Pakistan who was at risk of forced marriage were indications that she had been, and possibly still was, at risk of forced marriage.

Good practice

6.79 Good practice is evident in the joint working evident between the Open Door mental health nurse and the community connector when Amira attended the Job Centre on 4th October 2019. A comprehensive mental health assessment was offered opportunistically.

6.80 NWAS made two safeguarding referrals in respect of Amira which were very detailed and provided her with details of a Women's Refuge in Rochdale.

6.81 Amira was well supported by the Job Centre on 3rd and 4th October 2019 which she appeared to regard as a safe place.

6.82 The EDT highlighted concerns to Adult Care that Amira may be subject to coercion and control.

6.83 When Amira contacted the police on 9th October 2019 purportedly to seek help for a friend who had telephoned her from Pakistan asking for her help as she believed that she was to be subject of a forced marriage, the Sergeant was concerned that Amira herself may be at risk of forced marriage and decided that the incident should not be finalised until Amira had been spoken to in a safe location, any safeguarding concerns had been considered and the Forced Marriage procedure applied.

7.0 Conclusion

7.1 Amira appeared to be in crisis when she came into contact with a range of agencies over 3rd and 4th October 2019. She had been experiencing domestic violence and abuse primarily from her brother, but also her father and she had recently been physically unwell and presenting as distressed. Over 3rd and 4th October 2019 several agencies responded well to Amira. The police dealt with the first two incidents of domestic abuse she reported early on 3rd October by taking positive action to safeguard her. The Job Centre provided her with a 'place of safety' over both days. NWAS made a safeguarding referral which highlighted a number of concerns. The Open Door mental health nurse conducted an unscheduled mental health assessment at the Job Centre in which Amira made further disclosures. When later contacted by the Open Door mental health nurse, the EDT practitioner recognised that Amira was at risk from coercion and control and ensured that this was documented.

7.2 Despite much single agency and some partnership working which was effective over 3rd and 4th October 2019, efforts to safeguard Amira were not successful. This was partly because Amira declined support and was considered to have the capacity to do so. However, at no stage did partner agencies consider holding a professionals meeting at which all of the accumulating concerns in respect of Amira could have been shared. Amira's case was subsequently discussed at a MAAST meeting but it seems that this forum only had a partial picture of the concerns about Amira and would not have had the capacity to fully consider a case of this complexity.

8.0 Lessons to be learnt and recommendations

Forced Marriage

8.1 Amira may, or may not, have been at risk of forced marriage but the disclosure she made of being abandoned in Pakistan by her father, the indications of coercion and control by her father and her subsequent call to the police to ostensibly seek advice on behalf of a 'friend' in Pakistan who was at risk of forced marriage were indications that she had been, and possibly still was, at risk of forced marriage.

8.2 It was good practice for the GMP Sergeant, after suspecting that Amira herself, rather than her friend may be at risk of forced marriage, to insist that the incident should not be finalised until Amira had been spoken to in a safe location and the forced marriage procedure applied. However, it is concerning that the forced marriage procedures were not apparently applied and the detectives who followed up on the incident appeared to accept the content of Amira's call at face value. This suggests that awareness and application of forced marriage procedures may be patchy in the force. Therefore Rochdale Safer Communities Partnership may wish to seek assurance from Greater Manchester Police on the steps taken to raise and maintain awareness of forced marriage and forced marriage procedures.

Recommendation 1

That Rochdale Safer Communities Partnership obtains assurance from Greater Manchester Police on the steps taken to raise and maintain awareness of forced marriage and forced marriage procedures.

8.3 Amira disclosed that she had been abandoned in Pakistan by her father to the Open Door mental health nurse and community connector but this issue was not apparently explored further or considered to be an indicator of risk of forced marriage which other disclosures by Amira - such as her financial dependence on her father, the evidence of domestic abuse and her apparent depression – reinforced. This suggests that professional awareness of the indications of forced marriage and the actions to take in response, particularly in agencies which primarily provide services to adults, may need to be heightened. Forced marriage is highlighted in most relevant local strategy documents but there would be value in the Safeguarding Adults Board and the Safer Communities Partnership embarking on an awareness raising campaign, possibly in conjunction with the Safeguarding Children Partnership as the complex safeguarding sub-group – which is responsible for the honour based violence workstream – is a sub group of both the Safeguarding Children Partnership and the Safeguarding Adults Board. Additionally, this case could

be a valuable case study which could be used to raise professional awareness when learning from this review is disseminated.

Recommendation 2

That Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership initiate a campaign to raise awareness of forced marriage and the action to take in response to suspicions that a person may be at risk of forced marriage, possibly in conjunction with the Safeguarding Children Partnership.

Recommendation 3

When learning from this review is disseminated, that Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership utilise the learning from this case to further reinforce their efforts to raise awareness of forced marriage and the action to take in response to suspicions that a person may be at risk of forced marriage.

Domestic Abuse: Coercion and Control

8.4 Despite the accumulating indications that Amira may be the victim of coercion and control, this was recognised only by the Adult Care EDT following contact from the community connector and the Open Door mental health nurse on 4th October 2019 and otherwise does not appear to have been prominent in single or multi-agency discussions.

8.5 It is unclear why this was the case. It is possible that Amira's presentation as an articulate University educated woman in her mid-twenties may have been a factor. Perhaps there was primarily a focus on Amira being at risk of domestic abuse and violence from her brother rather than her father. Perhaps there was a reticence in enquiring into the dynamics of a British Pakistani family due to a lack of understanding of issues of race, culture and religion. Whatever the causes of the lack of recognition of indications of coercion and control, it is of concern that Amira's vulnerability in this regard went largely unrecognised.

8.6 It is therefore recommended that when the learning from this review is disseminated, the opportunity is taken to use the indications of coercion and control present in this case to further raise professional awareness of how to recognise coercion and control.

Recommendation 4

That when the learning from this review is disseminated, Rochdale Safer Communities Partnership takes the opportunity to use the indications of coercion and control present in this case to further raise professional awareness of how to recognise coercion and control.

8.7 Amira's benefits were paid into her father's bank account. She had no separate bank account into which the Department for Work and Pensions (DWP) could pay her benefits and her efforts to open a separate bank account were unsuccessful. The DWP responded constructively by arranging for her benefits to be sent directly to her mobile phone by Payment by Exception (PES). Amira eventually abandoned her efforts to arrange for her benefits to be paid by PES for reasons which went unexplored.

8.8 In recent years there have been a number of studies of the nature and impact of the economic abuse of women. In the Women's Aid/TUC report *Unequal, Trapped and Controlled* (2015) found that many survivors of abuse had no money or were given an allowance by their abuser, that economic abuse was a barrier to leaving the abuser and that 77% of respondents said that economic abuse had affected their mental health (23). One of the recommendations of that report was that banks should deal with economic abuse more effectively by flagging accounts where abuse is known, improve policy and training and work with domestic violence services to develop expertise in handing situations of coercive control (24). As previously stated Rochdale Women's Welfare Association contributed to this review and said that they advise women who are unable to open a bank account to open a Post Office card account as it is simpler to open than a bank account. Additionally some banks and building societies offer 'basic' bank accounts where people have a poor credit rating or a low income. Additionally, the UK Finance's Financial Abuse Code of Practice (25) was introduced in 2018 which aims to bring increased awareness and better understanding of what economic abuse looks like for banks, building societies and other financial institutions and their staff as well as victims, potential victims and their families, and to ensure more consistency in the support available for those who need it. Furthermore the joint Refuge/Co-operative Bank report entitled *Know Economic Abuse* (26) was published in 2020. This report found that economic abuse is rarely the only form of abuse a perpetrator uses, that economic abuse can take many forms, that a third of survivors 'suffer in silence', that economic abuse can prevent survivors leaving abusers and that survivors can be left with substantial levels of debt as a result of economic abuse, preventing them from subsequently achieving economic stability. The report made the following recommendations:

- Banks and other financial services to create clear processes for customers who are in debt as a result of economic abuse and provide information about economic abuse.

- Credit reference agencies to take a greater role through the creation of a preferential credit rating repair system for the survivors of economic abuse.
- The creation of a cross-government fund for survivors.
- Reform of welfare benefits including automatic separate payments and advances for those fleeing abuse.
- A review of the impact of online and digital banking on the survivors of economic abuse.

8.9 There is an opportunity to address the recommendations of reports such as *Unequal, Trapped and Controlled* and *Know Economic Abuse* and engage with banks and financial services providers in the Rochdale area to support them in their efforts to address economic abuse of customers. This process of engagement will also provide an opportunity for banks and other financial service providers to advise on their progress in implementing UK Finance's Financial Abuse Code of Practice.

Recommendation 5

That Rochdale Safer Communities Partnership works with partner agencies to engage with banks and financial services providers in the Rochdale area to support them in their efforts to prevent economic abuse of customers. This process of engagement will also provide an opportunity for banks and building societies to advise on their progress in implementing UK Finance's Financial Abuse Code of Practice.

Familial Domestic Violence and Abuse

8.10 The incidents in which Amira was assaulted or threatened by her brother were responded to as domestic abuse. Positive action was taken by the police including arrest and charging. Prosecutions were attempted which Amira was not infrequently unwilling to support. On at least one occasion she appears to have been dissuaded from giving evidence against her brother by members of her wider family.

8.11 It is surprising that Amira was not referred for any domestic abuse support other than the multi-crime Victim Support service which is not equipped to provide more than short term support to victims of domestic abuse. Several of the incidents she reported to the police were assessed as 'medium' risk and at the time of writing the local domestic abuse service provided by Victim Support, Safenet and the multi-crime Victim Support service all provide support to the victims of 'medium' risk domestic abuse, although the review has been informed that the latter service has recently agreed to pass on cases to the former two services where they require more support than they can offer.

8.12 When the police responded to incidents of domestic abuse in Amira's family home, alternatives to going down the criminal justice route do not appear to have been frequently considered other than referrals of Amira's brother to Adult Care, mental health services and housing support in November 2017. The conflict between Amira and her brother only appeared to diminish when one or the other left the family home for a period. Had a 'problem solving' approach been adopted to the accumulating incidents in which efforts were made to identify and address any underlying issues and had the family been prepared to co-operate with this, there may have been an opportunity to find solutions to the conflict between the siblings without in any way diminishing the seriousness of some of the incidents when Amira experienced violence and the fear of violence from her brother. The violence Amira experienced from her brother was often perceived to relate to his mental health difficulties but it is also a possibility that the violence and threats of violence may have been associated with so-called 'honour' related issues.

8.13 It is unclear why Amira was not referred for support as a victim of domestic abuse other than the referrals to the multi-crime Victim Support service. As this report suggests, this may have been because familial domestic abuse, particularly when it involves two adult siblings, was not treated as seriously as other forms of familial domestic abuse or the much more frequently encountered intimate partner domestic abuse. It is also unclear why MARAC referrals were not considered on the grounds of escalation of concerns, repeat victimisation and professional judgement.

8.14 The Safer Communities Partnership may wish to seek assurance that familial domestic abuse is regarded as an issue which merits an effective response including referrals for domestic abuse support and escalation to MARAC where appropriate.

Recommendation 6

That Rochdale Safer Communities Partnership obtains assurance that familial domestic abuse is regarded as an issue which merits an appropriate response including referrals for domestic abuse support and escalation to MARAC where appropriate.

8.15 The review has been advised that there is a gap in respect of the sharing of information between GPs and the MARAC process. Although there is a pathway for GPs to share information with MARAC in cases in which children are involved, this is not the case when the case involves only adults. Successful recruitment has since taken place to a post of Specialist Safeguarding Nurse within the CCG Safeguarding Team. A key element of this role will be to ensure that safeguarding pathways are developed and maintained. It is recommended that the Safer Communities Partnership seeks assurance from the CCG that the issue of sharing of information

with MARAC by GPs in cases in which there are no children involved has been resolved.

Recommendation 7

That Rochdale Safer Communities Partnership seeks assurance from the CCG that the issue of sharing of information with MARAC by GPs in cases in which there are no children involved has been resolved.

Multi Agency Adult Safeguarding Team (MAAST)

8.16 Amira and her brother were referred to MAAST on a number of occasions. Clearly MAAST is an innovative approach to the management of the high number of referrals of adults assessed as vulnerable. However, this case has highlighted potential areas for further development of the MAAST. Firstly written records of MAAST decisions are very brief, probably because of the high number of referrals received. Secondly, the MAAST process may reinforce the tendency to consider incidents in isolation which is such an apparent aspect of this case. If MAAST is not fully aware of earlier referrals in respect of the same person, they may make decisions to screen out a case despite accumulating concerns. The stated objectives of MAAST include 'multi-agency recognition and recording of patterns in behaviour of repeat victims..'. It is unclear whether MAAST has the resources necessary to achieve this aim. Thirdly, it seems possible that a referral to MAAST may be considered by the referring officer to be a route into services which may preclude further consideration of alternative sources of support the person may benefit from by the referrer. This is one possible explanation for the surprising lack of referrals of Amira to specialist domestic abuse services. Finally, the documents shared with this review which set out the method of operating of the MAAST are not very specific and do not set out governance arrangements for the MAAST.

8.17 Partner agencies involved in the MAAST may wish to use the learning from this review to inform further development of the MAAST process. Therefore the Safeguarding Adults Board may wish to share this report with those responsible for overseeing the work of the MAAST so that the learning from this case informs further development of the MAAST process.

Recommendation 8

That Rochdale Borough Safeguarding Adults Board shares this report with those responsible for overseeing the work of the MAAST so that the learning from this case informs further development of the MAAST process including the clarification of governance arrangements.

Domestic Violence and Abuse: DASH risks assessments

8.18 There were several missed opportunities for non-police practitioners to conduct DASH risk assessments (Paragraph 6.39). Training in the use of the DASH risk assessments has been put in place but, on the basis of the learning from this case, there appears to be a reticence by some practitioners to use the risk assessment. It is not known why practitioners do not complete the DASH but it may be a lack of familiarity, confidence or a sense that this is primarily the responsibility of the police. The Safer Communities Partnership may wish to raise awareness of the need for non-police practitioners to conduct DASH risk assessments and encourage them to do so.

Recommendation 9

That Rochdale Safer Communities Partnership raises awareness of the need for non-police practitioners to conduct DASH risk assessments and encourage them to do so.

Safeguarding

8.19 It is of concern that neither NWAS safeguarding referral in respect of Amira was screened for either Section 42 Enquiry or for 'other' safeguarding enquiry by Adult Care. Given the concerns which Adult Care became aware of as a result of the NWAS safeguarding referral on 3rd October 2019 and the further concerns raised by the Open Door mental health nurse and the community connector a day later, it is surprising that it was decided to close Amira case without seeking out information from partner agencies or considering some form of multi-agency discussion.

8.20 The Safeguarding Adult Board may wish to seek assurance from Adult Care in respect of the process for assessing safeguarding referrals and screening for consideration of Section 42 or 'other' safeguarding enquiries.

Recommendation 10

That Rochdale Borough Safeguarding Adults Board obtains assurance from Adult Care in respect of the process for assessing safeguarding referrals and screening for consideration of Section 42 or 'other' safeguarding enquiries.

Suicide Prevention

8.21 Amira's death, apparently by suicide, was not anticipated by any agency in contact with her in the final months of her life. However, with the benefit of

hindsight, several antecedents of suicide were present in Amira's life (Paragraph 6.57). Additionally, Amira fell into five of the nine vulnerable groups targeted by the strategy for preventing suicide in England (Paragraph 6.61). Whilst it is important to note that the antecedents of suicide referred to above are not predictors of suicide risk, it would be helpful for practitioners to be aware of these antecedents.

8.22 It would also be valuable for what is understood about the links between domestic abuse and risk of suicide to be shared with practitioners, including research which suggests that suicidal ideation from victims of domestic abuse who experience feelings of entrapment and defeat, and for whom escape is not felt to be possible should be perceived as a 'cry of pain' (Paragraphs 6.62-6.64).

8.23 It would also be helpful if this report could be shared with those responsible for Rochdale's Suicide and Self-Harm Prevention Strategy so that the learning from this review can inform future suicide prevention measures, particularly the increased risk of suicide and self-harm experienced by victims of domestic abuse.

8.24 It should be noted that the Rochdale Coroners Service has a Coronial Bereavement Nurse working within their office who is available to provide immediate bereavement support to families or any other individuals who are suffering as a result of a death. The Coronial Bereavement Nurse provided support to the family in this case. Although the Coroner has promoted awareness of this service, there could be benefit in further highlighting the service to partner agencies in Rochdale and the Coronial Bereavement Nurse has offered to give a presentation to outline her role. When the learning from this case is disseminated, it could be of value to further promote awareness of this innovative service.

Recommendation 11

That Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership ensure that the learning from this case in respect of the antecedents of suicide and the links between domestic abuse and risk of suicide are shared with practitioners involved in safeguarding adults and in supporting the victims of domestic abuse.

Recommendation 12

That Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership shares this report with those responsible for Rochdale's Suicide and Self-Harm Prevention Strategy so that the learning from this review can inform future suicide prevention measures.

Recommendation 13

When the learning from this case is disseminated, that Rochdale Borough Safeguarding Adults Board and Rochdale Safer Communities Partnership arrange to further promote awareness of the service provided by the Coronial Bereavement Nurse.

Mental Capacity

8.25 When Amira was seen by practitioners in the final few months of her life, the question of whether or not she was making decisions of her own free will was not considered as a discrete question. Practitioners took the view that there was no reason to doubt Amira's mental capacity for making decisions and did not appear to consider whether her capacity could be affected by the indications of coercive control in her life. Nor did practitioners consider whether the series of decisions Amira took against professional advice could be construed as unwise decisions which merited further enquiry, including considering whether she could be making the decisions whilst influenced by undue pressure. However, no single agency became aware of the full extent of these unwise decisions.

8.26 When the learning from this review is disseminated, it would be of benefit to highlight the complex issue of mental capacity and coercive control and the need to enquire into cases in which a person with capacity repeatedly makes decisions which could be construed as unwise.

Recommendation 14

When the learning from this review is disseminated, that Rochdale Borough Safeguarding Adults Board highlights the complex issue of mental capacity and coercive control and the need to enquire into cases in which a person with capacity repeatedly makes decisions which could be construed as unwise.

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Glossary

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

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.

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
- economic
- 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.

A **Domestic Violence Protection Order (DVPO**) is a civil order which fills a 'gap' in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

An **Evidence-Led Prosecution** is one where the victim of domestic abuse decides not to support a prosecution, and in turn prosecutors need to decide whether it is possible to bring forward a case without that support.

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 Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity and represent their views to those who are working out their best interests.

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.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and empower those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Appendix A

Single Agency Recommendations

BARDOC Out of Hours GP Service

- No recommendations

Department for Work and Pensions

- No recommendations

Greater Manchester Police

- No recommendations

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group

- No recommendations

Northern Care Alliance

- No recommendations

North West Ambulance Service

- No recommendations

Pennine Care NHS Foundation Trust

- To complement PCFT mandatory safeguarding training develop staff support package to raise knowledge and awareness in relation to domestic abuse, so-called honour based violence and forced marriage.

- Review of PARIS guidance section in relation to trust approved documentation including mental health and risk assessment. Particular risks around domestic abuse and the consideration of forced marriage and honour based violence

- Open Door Standard operational procedure to include clear protocol for:

    - Referral process
    - Unplanned assessments
    - Guidance on relevant documents to complete and who should enter these on the system
    - Links to Safeguarding policy and associated documents

- Communication with GP/ referrer

At the SAR Sub Group meeting on 12th November 2020, Pennine Care requested the above single agency recommendation to be removed as the Open Door service had been de-commissioned. Pennine Care have been asked if the Open Door service has been replaced and whether the single agency recommendation will apply to any replacement service.

Rochdale Borough Council Adult Care

- Improvement is required in relation to knowledge and awareness of the Domestic Abuse, Stalking and Harassment (DASH) risk assessment and Multi Agency Risk Assessment Conference (MARAC).
- **Action:** Dissemination of a briefing to raise awareness and detail how to how to refer

- Improvement is required in an understanding of the indictors of coercive and controlling behaviour as this relates to adult safeguarding and of resources available that are specific to domestic violence.
- **Action:** Dissemination of a briefing to raise specific awareness of coercion and control and domestic violence, including the Agency training offer