DOMESTIC HOMICIDE REVIEW IN THE CASE OF DENISE

SALFORD COMMUNITY SAFETY PARTNERSHIP

FINAL OVERVIEW REPORT

PERIOD UNDER REVIEW: 29th JUNE 2012 - 31ST JUNE 2013

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SECTION 1 – INTRODUCTION

The subject, key people and key locations referred to in this report are set out below. All people and places have been anonymised.

The DHR Panel offers condolences to the family on the tragic death of Denise and thanks for their contributions to this review.

1.1 Key People

Pseudonym	**Relationship to the Subject**	**Address at time of incident**
Denise	Subject	Address 1
Child A	Oldest Child of Denise (age 7 at the time of the incident leading to Denise's death)	Address 2
Child B	Youngest Child of Denise (age 3 years 10 months at the time of the incident leading to Denise's death)	Address 2
Roland	Perpetrator	Various
Denise F	Friend of Denise	N/A
Child A Father	Father of Child A	Address 2
Denise S	Sister of Denise	N/A
Denise BIL	Brother in Law of Denise	N/A
Child C	Child of Roland	Address 3
Roland PP	Previous Partner of Roland and mother of Child C	Address 3

1.2 Key Locations

Address 1	Home of Denise – Address of Incident
Address 2	Home of Child A's Father, where both Child A and Child B resided temporarily
Address 3	Home of Roland's previous partner
Address 4	Home of Roland's mother
Address 5	Public House owned by Denise's Father

1.3 Incident leading to the Domestic Homicide Review

On 29th June 2013, police received a call from Denise's brother in law. Having been unable to contact Denise by phone for several hours, he had called at Address 1 but could not get a response.

He was joined at Address 1 by Denise's sister who had keys to the house. On entering the house, he could not see Denise. He went upstairs where he found Denise in her bed covered in blood. She had severe trauma to her face and ligature marks around her neck. He called the police who attended at Address 1 where Denise was pronounced deceased at the scene.

1.4 Decision to Conduct a Domestic Homicide Review

This Domestic Homicide Review was conducted under guidance contained in Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004).

The Salford Community Safety Partnership (CSP) was notified by Greater Manchester Police (GMP) of Denise's death. GMP informed the CSP that the circumstances of Denise's death were likely to meet the criteria for the conduct of a Domestic Homicide Review (DHR) and an initial scoping meeting was held.

Following notification to the Home Office, confirmation was received that the case met the DHR criteria and Salford Community Safety Partnership was instructed to undertake a DHR.

Salford CSP appointed an Independent Chair and Independent Author, neither of whom had any previous involvement with the case. A DHR Panel was convened that consisted of senior representatives from relevant local agencies. Further information on the DHR Panel is provided at Section 2.2 of this report.

1.5 Denise - Brief Overview

Denise was murdered by Roland on 29th June 2013. She was 25 years of age.

Denise's family described her as a young woman who was sociable, outgoing and great fun. She worked from time to time at the public house managed by her father and socialised there. It is understood that this is where she met Roland.

There is no indication that Denise knew or had had any relationship with Roland prior to this. Denise began a relationship with Roland in November 2012. Denise and Roland did not reside at the same address at any point during the period under review or at any other time.

Denise came from a close family who saw each other often, and who were in touch with each other by phone or text on a daily basis. Within a short time of starting the relationship with Roland, Denise introduced him to members of her family, although he was not perceived by them to be someone that Denise had a serious or permanent relationship with. Denise brought him to a couple of family gatherings when she first started seeing him. One of Denise's family members observed him to be a 'loner' and someone who did not want to interact or socialise.

It is not known whether Denise was fully aware of Roland's background as a violent offender, or whether she felt he posed any risk to her prior to the first alleged assault he made upon her in April 2013. At that time, their relationship was not known to any agency, although Roland was known to police and probation services as a serious violent offender who had perpetrated domestic abuse in a previous

relationship. The relationship between Denise and Roland became known to police following an alleged rape reported by Denise's friend, Denise F, on 29th April 2013.

It was noticed by family members that, as Denise spent more time with Roland, she became less confident and more withdrawn. Her family advised her that she should break up with Roland; they were suspicious of him and didn't like him, although at that time there was no disclosure by Denise of any physical or emotional abuse. Denise continued to see Roland throughout the winter of 2012/13. He did not form any close links with Denise's family and does not appear to have had significant contact with Denise's children.

Denise had been a victim of domestic abuse in her relationship with Child B's father, who was serving a custodial sentence in connection with violent offences. Denise had recently moved into a rented house, Address 1, with her two young children, Child A and Child B.

It may be that Denise's self-awareness in relation to domestic abuse victimisation was impacted by her earlier relationships, as she appeared to believe that she could mediate Roland's violent behaviour, or remove herself from his violence, apparently not fully appreciating the coercive and controlling nature of Roland. It is not possible to say with certainty that Denise minimised the potential for escalating violence in her relationship with Roland, although her behaviour and responses were indicative of a woman who was being coercively controlled by an abusive partner.

The first report received by police in relation to Roland abusing Denise was made by her friend on 29th April 2013. The friend said that she had been told by Denise that Roland had strangled her until she became unconscious and lost control of her bladder and then raped her. Denise had said she would not report this to the police as she was afraid of what Roland would do to her if he found out.

Following this first assault, about which Denise refused to make a formal statement, Denise gave assurances to agencies, and to her family, that she would split up with Roland and that she would not see him again.

A further violent assault upon Denise took place on 18th May 2013, when Roland assaulted Denise in the street after he had been drinking heavily. He head-butted Denise, dragged her away from a main road and said that he would kill her.

Denise reported to police that Roland was harassing and making threats to her on several occasions during May and June 2013. At this time, she moved out of her home temporarily as she was in fear of him, staying with family, who kept in close contact with her. Safety equipment was fitted to Address 1 to enable Denise to return there should she so wish. Denise's children were safeguarded by staying with Child A's father at his address.

During the period under review neither Child A nor Child B were subject to child protection arrangements.

It is not known whether Denise had any face-to-face contact with Roland after these assaults, until the night before her murder when she and Roland spent time at a friend's house, and then went by taxi together to Address 1.

A friend of Denise's confirmed to police that Denise and Roland spent the evening of Friday 28th June 2013 at her house, both having arrived together in a taxi around 9.00pm. They both left together in a taxi shortly after 02.00 on Saturday 29th June 2013 to return to Address 1. The police traced a taxi driver who recalls taking them both to Address 1 and dropping them off there**.**

Denise's brother in law said in a statement made to the murder investigation team that he arrived at Address 1 shortly after 5.30pm on Saturday 29th June and found the front door locked. There was no response to his knocking. Denise's sister met him at the house and they let themselves in with a spare key held by Denise's sister. They found Denise in her bed with multiple injuries and called the police.

A police officer arrived at Address 1 shortly before 6.00pm on 29th June and described the scene. There was evidence of blood smearing and disturbance in several rooms inside the house but no evidence of a forced entry. Denise was pronounced deceased at Address 1 on 29th June 2013.

1.6 Roland - Brief Overview

Roland lived at various addresses during the period under review. He has two children from a previous relationship. He has a history as a perpetrator of domestic abuse.

Roland was a known violent offender with a significant history of offending. He was previously known to the police and to Greater Manchester Probation Trust (GMPT). His contact with GMPT was outside of the timeframe of this Review, however, the Review Panel received a very detailed report of previous contacts with Roland and brief details of this have been included in this report, as they provide context for the events that took place in the review period.

Roland first came into contact with police in December 2001 when he was 16 years of age, in relation to a violent assault. Between December 2001 and May 2005, Roland committed a further eleven offences relating to serious assaults, criminal damage and witness intimidation.

In May 2005, he was sentenced to 54 months in a young offenders' institution. Following his release in 2008, Roland continued to offend and was arrested for offences of assault, criminal damage and harassment.

He had a history of domestic abuse towards a previous partner, including a warning under the Harassment Act in July 2009. It is unclear whether this information was shared with agencies and also whether police considered sharing information with Denise under the Domestic Violence Disclosure Scheme (Clare's Law). During the course of this review, this aspect was under investigation by the Independent Police Complaints Commission (IPCC). This report is not yet available from IPCC.

In the early part of 2012, Roland presented on two occasions to hospital medical services with injuries. It was noted that these injuries were likely to have been associated with alcohol intoxication.

In 2013, Roland was referred by his GP to mental health services. He was assessed as not having a mental illness and was referred to alcohol treatment services, where he was assessed as being a dependent drinker requiring structured interventions. He did not engage with the alcohol treatment service.

1.7 Time Period under Review

The time period for this Review was set by the Panel as 29th June 2012 (six months before the start of the relationship between Denise and Roland) to 31st June 2013. The Panel has included relevant information outside of the time period under review to provide additional context and understanding.

1.8 Parallel Processes

1.8.1 Investigation by the Independent Police Complaints Commission

The case was referred for investigation to the Independent Police Complaints Commission (IPCC).

The terms of reference for the IPCC investigation were:

1. To investigate whether:

   (a) The GMP response to the allegations made by Denise against Roland was appropriate;

   (b) The GMP enquiries to locate and arrest Roland were appropriate and sufficient;

   (c) GMP made appropriate and adequate effort to safeguard Denise and her children from the risk presented by Roland.

2. To assist in fulfilling the state's investigative obligation arising under the European Convention of Human Rights (ECHR) by ensuring as far as possible that the investigation is independent, effective, open and prompt, and that the full facts are brought to light and any lessons are learned.

3. To identify whether any subject of the investigation may have committed a criminal offence and, if appropriate, make early contact with the Director of Public Prosecutions (DPP). On receipt of the final report, the Commissioner shall determine whether the report shall be sent to the DPP.

4. To identify whether any subject of the investigation, in the investigator's opinion, has a case to answer for misconduct or gross misconduct, or no case to answer.

5. To consider the facts of this case as well as the recommendations of previous relevant IPCC investigations of GMP's handing of domestic violence cases, and report on whether these events identify further organisational learning including:

   - Whether previous recommendations have been acted upon;

- Whether any change in policy or practice would help to prevent a recurrence of the event, incident or conducted investigated;
- Whether the incident highlights any good practice that should be shared.

Following a request by the IPCC for primacy in respect of interviewing officers involved in direct or indirect contact with Denise during the period leading to her death, the author of the first Independent Management Report (IMR) was unable to hold discussions with any officers involved in the case prior to the submission of the first draft of this IMR report.

The IPCC has now concluded its investigations however a report is not yet available.

1.8.2 Her Majesty's Inspectorate of Constabulary (HMIC) Report into Domestic Abuse

An HMIC report published in April 2014 following a national review of UK police force responses to domestic abuse. The report makes numerous recommendations, some of which are highlighted in this report. (*Everyone's business: Improving the police response to domestic abuse. (Ref: ISBN-978-1-78246-381-8 www.hmic.gov.uk)*

The HMIC report has impacted significantly on GMP and has already prompted changes to police responses to domestic abuse across the force. More specifically, the divisional senior leadership team in Salford has also implemented changes at a local level as a direct consequence of the death of Denise.

1.9 Criminal Proceedings

Roland appeared for trial on 20th January 2014 and entered a plea of guilty to the murder of Denise. On 21st January, Roland was sentenced to life imprisonment for the assault and murder of Denise to serve a minimum term of 27 years. The allegation of rape is to lie on file.

The DHR Panel stood down from 18th December to 1st February 2014 due to the criminal proceedings.

1.10 Coronial Matters

No inquest has been held at the request of Denise's family.

1.11 Diversity Issues

There are no diversity issues to take into consideration in the case.

1.12 Delays to Submission of the DHR Overview Report

In November 2013, the CSP contacted the Home Office to advise that the review would be stood down until the completion of the criminal proceedings. This was to enable the criminal proceedings to go ahead without prejudice, and to enable material witnesses who may wish to contribute to the DHR to remain unimpeded by this process.

Following sentencing of Roland on 21st January 2014, the DHR Panel resumed on 1st February 2014.

The Review continued to gather information and formulate an action plan, however, the final report continued to be delayed due to the ongoing IPCC investigations and lack of access to a more detailed police report. A separate action plan shows which actions have been undertaken due to the length of delay.

In August 2014, a draft report was presented to the CSP. The joint Chairs requested that a further IMR be completed by GMP, despite the ongoing IPCC investigation. The independent author met with all Panel representatives to ensure they had overseen actions from their agency.

Home Office approval for the publication of the report was received in April 2016. A letter including their comments is attached to this report.

1.13 Brief Overview of Key Events

1.13.1 Events in April 2013

Roland's medical records show that, during this period, he was consulting his GP regarding episodes of paranoia. He was referred to psychology services and to Drug and Alcohol Services, where he received a triage assessment in which he was assessed as a dependent drinker who required structured interventions. However, Roland did not avail himself of this service and his alcohol misuse remained untreated.

The relationship between Denise and Roland first came to the attention of police when, on 29th April 2013, a close friend of Denise contacted the police to report that Denise had been raped by Roland the previous night. The friend was frightened and worried for Denise's safety and reported this alleged incident to the police.

The police log for 9th May, ten days after the incident was reported, shows this incident was recorded with an action to follow up.

1.13.2 Events in May 2013

On 9th May 2013, the police log indicates that an officer contacted Denise asking if she wanted to discuss the alleged attack. The officer asked Denise if she wanted to pursue the matter and she was asked whether she would complete a [1]DASH risk assessment (a standard risk assessment tool used by GMP and other agencies), but she declined to do so.

The officer dealing with the report informed Denise of the contact details of the Salford Independent Domestic Abuse Advocacy Service (SIDAAS) and provided information about the Rape Crisis Service, although Denise declined a referral to this service. The officer made a referral to Children's Services in line with procedure.

The officer placed a Domestic Violence (DV) marker on Denise's address and made an appointment for Denise to attend the police station on 8th May (**the log of this action appears to have been written after the event, according to the police report)**. Denise did not attend this appointment. The officer then recorded that

[1] A tool used to assess levels of risk of domestic abuse

contact would be made again with Denise on 22nd May 2013 on the officer's return from leave.

On 18th May, police received a further report from Denise's friend regarding a violent assault made by Roland upon Denise. This assault was alleged to have taken place in the street on the previous evening whilst Denise was walking home from a night out. It was alleged that Roland made threats to kill Denise during the assault.

Following this report, police contacted Denise and invited her to provide a witness statement. She agreed to this; however she declined to disclose any details in relation to the previous allegation of rape made on her behalf by her friend.

The report of assault was graded as high-risk due to Roland's previous violent behaviour towards Denise, and the indication that the relationship appeared to have continued following the rape allegation. The specialist officer assigned to the investigation was directed to refer the matter to a Multi-Agency Risk Assessment Conference (MARAC) and offer support and safeguarding to Denise, ensuring that the appropriate Domestic Violence alert markers were placed on the relevant addresses.

On 19th May, police and Children's Social Care (CSC) undertook a joint visit to Address 2 where both Child A and Child B were staying with Child A's father. Both children were due to be returned to Denise that same evening. Police and CSC considered that Denise's home address was not a place of safety and that Denise was at risk of failing to protect her children[2]. Arrangements were therefore made for Child A and Child B to stay at Address 2 with Child A's father as a short-term safety measure.

That same day, police attempted to arrest Roland whilst he was dropping Child C at the home of Roland PP. Roland arrived at the address in a taxi, where a police officer was waiting to arrest him. When he became aware of the police presence, he made off, leaving Child C in the taxi. Roland evaded police arrest and remained at large.

On 20th May, Denise attended the local Police Station and was subject to an achieving best evidence (ABE) interview providing victim/witness testimony regarding the alleged rape and assaults. Denise consented to the case being heard at MARAC and was informed that the case was to be heard on 11th June. She also consented to referrals to the Sanctuary Scheme and Fire Service for safety planning.

Denise reported to police that, at that time, she was not staying at her home address but that she was living between her sister's and her father's homes. On the same day, the Sanctuary Scheme conducted a security assessment of Denise's property and returned the following day and the day after to fit a range of security equipment. That same day, CSC and police discussed the safety of the children. The social

[2] Denise's family reported that this appeared to Denise as a threat to remove the children.

worker telephoned Denise to arrange a visit for 21st May; this visit took place as arranged.

During the course of the next two weeks, Denise reported to police on several occasions that Roland was continuing to harass her by phone, text and letter. Police were actively seeking Roland in order to arrest him. Roland evaded arrest during this period.

On 22nd May, police spoke to Denise to let her know that Roland had not yet been arrested. Denise told police that he had texted her the previous day asking 'why she had made lies up' about him but that she did not respond to him. Denise said she was going to return to Address 1 that evening with her children as she now felt more secure.

On 27th May 2013, Denise contacted police to say that Roland was continuing to harass her by text and by phone. He asked her what she had told the police and who she was with. The responding officers completed a DASH risk assessment. The Public Protection Investigation Unit (PPIU) at Salford created a PPI Log in respect of the incident, and the risk was set at 'medium'.

Roland remained on the 'Priority Arrest Board' as a suspect whom police wanted to arrest. It was noted by police that Roland was persistently harassing Denise.

On 28th May, CSC conducted a further home visit with Denise under Section 17 of the Children Act at which Denise signed a written agreement in relation to safeguarding Child A and Child B. This written agreement stipulated that Denise should not allow the children to have any contact with Roland.

On 29th May, and following management supervision, the social worker conducted a third home visit.

1.13.3 Events in June 2013

On 3rd June, CSC completed the Initial Assessment on Child A and Child B with an outcome of no further action, as Denise had had no contact with Roland and had no wish to resume a relationship with him. On 10th June, the social worker telephoned Denise, however she received no reply and left a message. The case was closed on 10th June.

As planned, a MARAC meeting was held on 11th June which was attended by multi-agency professionals. The Chair of the MARAC meeting said that police were actively seeking to arrest Roland due to the risk he posed to Denise. Professionals participating in the MARAC were informed of the continuing risk to Denise.

Following the MARAC meeting, police contacted Denise by telephone and established that she was safe and well. She said she was still supportive of the investigation and that she was willing to attend court. Denise also told police that Roland had harassed her by text on 8th June. She said that she also believed he had attended Address 1 one night during the previous week at around 01.30 a.m.

and kicked the door. Her brother, who was staying with her at the time, saw Roland from the window. This incident was not reported to the police at the time.

Between 11th June and 19th June, police had four proactive contacts with Denise. On 15th June, police called at Address 1 to talk to Denise. She answered the door to them but would not allow access to the property. Denise later rang police to say that she wanted to withdraw her statement in relation to the assault committed by Roland on 17th May.

Denise was informed that police would continue to investigate the allegations and that she would be contacted again. Denise was asked whether she needed support and whether she was being intimidated by Roland into withdrawing her statement. She said that she did not require support.

On 17th June, an enhanced risk assessment was completed and the risk assessed at 'medium'. On the same day, police recorded that Roland was still being traced and that safeguarding was in place for Denise.

On 19th June, police spoke to Denise for a second time, and she advised that she still wished to withdraw her statement.

On 25th June, police received a contact from Roland's solicitor saying that he was prepared to be interviewed in relation to the allegations made by Denise. Police did not act on this immediately as they wished to discuss this with Denise. On 26th June, police contacted Denise who remained adamant that she wished to withdraw her statement.

Police did not interview Roland with his solicitor as the officer responsible felt that he could not be certain about the quality of the information received from Denise's friend and from Denise herself, as Denise had said she wished to withdraw her statement.

On 29th June, Denise's brother in law called police officers to Address 1. Denise was found deceased in her bed with numerous injuries.

A murder investigation was launched and a public appeal made for information leading to the arrest of Roland. Roland could not be located and police undertook an extensive search. Subsequently Roland was arrested and charged with assault and the murder of Denise.

SECTION 2 – CONDUCT OF THE REVIEW

2.1 Conduct of Domestic Homicide Reviews (DHR) – Home Office Guidance

The guidance states: '*Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate'.*

The purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate;

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

The definition of domestic violence used in this report is in line with the Home Office definition (revised in September 2012) as follows:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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

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

** This definition, which is not a legal definition, includes so called 'honour'-based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

2.2 The DHR Panel

A multi-agency Panel of senior officers from the relevant agencies was established. An Independent Chair and Author were appointed in line with Home Office guidance.

The Independent Chair of the Panel is a family solicitor qualified for 15 years specialising in domestic abuse cases, and has been a leading solicitor in this area of law, having represented the majority of domestic violence agencies in Greater Manchester. The Chair sat on the project management team for Domestic Violence Prevention Notices (DVPNs) and Domestic Violence Prevention Orders (DVPOs) and was involved in the initial stages of Clare's Law. She is a member of the Domestic Violence in Greater Manchester Family Justice Forum. This forum implemented a new procedure for bridging the gap between civil and criminal courts relating to Non-Molestation Injunctions and Occupation Orders. The Chair completed the on-line learning module for DHR Chairs prior to commencing the Review.

The Independent Author works as an independent consultant and has considerable experience of domestic homicide and other serious case reviews, both as an author, Chair and lead reviewer. The Independent Author previously worked for a large metropolitan council in the north west of England at executive level, with lead responsibilities for public protection and community safety, including strategic leadership for domestic abuse. The author is also a member of a national working group on domestic abuse.

The Panel held six meetings between 4th August 2013 and 28th April 2014. Further meetings were held with individual Panel members and IMR authors between May and August 2014. Two meetings were held with officers of the Independent Police Complaints Commission, who also attended one DHR Panel meeting.

The Assistant Director for Community Safety left the authority before the Review was completed and the Independent Author completed all final work in relation to the review.

Panel Membership

Agency	**Title**
Independent Chair	
Salford Community Safety Partnership	Assistant Director
Salford Community Safety Partnership	Senior Community Safety Officer
Greater Manchester Police	Detective Inspector – PPIU
Salford Royal Hospital Foundation Trust	Assistant Director of Nursing
Salford Clinical Commissioning Group (GPs)	Deputy Designated Nurse – Safeguarding
Greater Manchester West Mental Health	Interim Assistant Director

Trust	
Salford City Council – Adult Services	Assistant Director
Salford City Council – Children's Services	Assistant Director
SIDAAS (Salford Independent Domestic Abuse Advocacy Service)	Service Manager
IN ATTENDANCE	
Independent Author	
Business Support Officer	

2.3 Sources of Information Used in the Review

Individual Management Reports (IMRs) and Short Reports were received from the following agencies:

Agency	**Format**
Children's Social Care – Salford City Council	Short Report Followed by IMR
Greater Manchester Police	IMR
Greater Manchester West NHS Foundation Trust	Short Report
GP for Denise, Child A and Child B	Short Report
Salford Royal Foundation Trust (SRFT)	IMR
GP for Roland	Short Report
Sanctuary Service	Short Report
SIDAAS	Short Report
MARAC	Audio Record of MARAC Meeting held on 11th June 2013.

2.4 Record of MARAC Meeting

The Independent Author heard an audio record of a MARAC meeting that took place on 11th June 2013 in the presence of the author of the police IMR. The recording was of a poor quality, therefore only a partial transcript could be made.

2.5 Family Involvement

The Review Panel identified members of the victim's family and friends who may wish to participate in the Review. The Panel wrote to Denise's family in August 2013 to inform them that a Domestic Homicide Review was taking place. The letter invited family members to participate in the Review. In addition, the family's Victim Support Officers and Family Liaison Officer were informed of the Review, and the Victim Support Officers attended interviews with family members.

Two family members were visited in October 2013. Neither of these family members had been identified as a material witness in the case for the prosecution.

A further family member and Denise F were also contacted as potential participants in the Review. Both were identified as material witnesses in the case for the

prosecution and could not be interviewed before trial[3]. Following sentence of Roland, both were again invited to participate but neither responded.

The Independent Author met with family members in May 2016 to discuss the final report with them. The family was disappointed at the delay in the Home Office response to the report and at the findings of the IPCC investigation. They were keen to stress that they believed that aspects of the management of incidents during the period under review by police and social care were inadequate to protect Denise. They were also of the view that CSC's approach to Denise made her feel that she was at risk of having her children removed rather than being a supportive approach.

The Panel is indebted to family members for their contribution to the Review and a summary of their accounts of events is summarised in section four of this report.

2.6 Quality Assurance

All IMRs were submitted within the agreed timeframe. The DHR Panel asked for amendments and clarifications to reports after consideration and discussion with authors at the third Panel meeting.

The GMP report was updated in September 2014 to enable the completion of this overview report. Officers involved in the case have still not been interviewed (see 1.7).

The independent author met with IMR authors from Children's Social Care and SRFT to discuss key findings and recommendations. All final reports were quality assured and signed off by senior officers in each of the reporting agencies.

2.7 Integrated chronology

An integrated chronology was prepared by the Chair providing information on contacts with all agencies across the period under review.

2.8 Executive summary

An Executive Summary has been prepared and will be available alongside the final report.

2.9 Delay in submitting the overview report

As described at 1.7, the DHR Panel took an initial decision to await the conclusion of the IPCC review due to not receiving a full IMR from GMP. This decision was reviewed in August 2014 when it became apparent that the IPCC investigation would not be concluded for a further period of time.

The joint Chairs of the Community Safety Partnership requested that GMP submit an updated report and that all agencies review their inputs and subsequent actions to enable a comprehensive and up-to-date overview report to be submitted.

2.9.1 Actions undertaken during the Review period

Due to the delays referred to above, agencies have already completed or begun to undertake actions in relation to the findings and recommendations emerging from this Review. These are highlighted in the attached action plan.

[3] NB No trial took place as Roland entered a plea of guilty to murder.

3. KEY LINES OF ENQUIRY

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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 policies and procedures as appropriate; and

- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The Home Office definition of domestic abuse and homicide is employed in this case[4].

Ten key lines of enquiry were agreed by the Panel; these are set out below.

All agencies providing reports were asked to answer each of these key lines, and to provide a critical analysis of their responses in the form of a narrative.

Each agency provided satisfactory responses to the key lines of enquiry. Due to the concurrent IPCC investigation, the IMR submitted by Greater Manchester Police was compiled from police records and without the benefit of interviews with officers involved in the case (see 1.7).

A summary of key lines of enquiry and agency responses is set out below. The responses are further analysed in the relevant agency sections of this report.

3.1 - Were the risk indicators of domestic abuse present in this case recognised appropriately, assessed and responded to in providing services to Denise and Roland and, where applicable Child A and Child B?

Prior to the report made to Greater Manchester Police by Denise F on 29th April 2013, none of the agencies involved in this Review were aware of domestic abuse upon Denise by Roland.

[4] https://www.gov.uk/government/collections/domestic-homicide-review

Roland received referrals to psychological services and alcohol treatment services; neither of those services conducted domestic abuse risk assessments. Psychological services do not routinely ask questions regarding domestic abuse and, in the case of the alcohol service, Roland only received an initial assessment and failed to engage with a second stage triage assessment, which would have included questions about domestic abuse.

Denise and Roland did not live at the same address at any point during the period under review or at any other time. Denise and Roland had separate GPs and were not known by any agency to be in a relationship prior to the report made to police on 29th April 2013.

After 29th April 2013, Greater Manchester Police had several further contacts with Denise in relation to domestic abuse.

The SIDAAS received information from GMP following an incident that took place on 18th May, and made contact with Denise. Denise declined the service. Following this, SIDAAS had no further involvement with Denise. SIDAAS was involved in the MARAC meeting that took place on 11th June 2013 and clarified that Denise had declined involvement with the service.

Children's Social Care was notified by Denise's friend of the alleged incident that took place on 29th April. This was discussed appropriately with Greater Manchester Police and a joint visit was undertaken to assess the safeguarding needs of Child A and Child B. Children's Services also contacted Health Visiting Services to request further information regarding the safeguarding needs of Child B. Children's Services attended the MARAC meeting held on 11th June 2013.

The MARAC meeting held on 11th June 2013 was attended by all agencies that had recent contact with Denise and her children. There were numerous cases discussed at the meeting and the time afforded to each case was short. Denise's case was discussed for four minutes, with the primary emphasis being upon the search for Roland and actions to safeguard Denise and her children. There was some confusion at the meeting about Denise's involvement with the independent domestic abuse advocacy service (SIDAAS) and whether or not Child A and Child B were subject to child protection planning. In line with usual procedures, Denise's GP was notified of the MARAC meeting and a note was made by the GP that Denise was a high-risk victim of domestic abuse. Following this notification, Denise's GP had no further contact with her.

3.2 - Were the services provided to Denise and Roland timely, proportionate and fit for purpose in relation to the levels of risk and need that were identified? Was there sufficient focus on reducing the impact of Roland's abusive behaviours towards Denise and were the reasons for Roland's abusive behaviour properly understood and addressed?

The services provided were timely and fit for purpose and to an expected standard, although there are lessons to be learnt in relation to specific areas of policy and practice, which are set out below.

GMP provided numerous responses to Denise, most of which were timely, proportionate and fit for purpose, although there are two clear exceptions to this. Firstly, the initial response to the report of alleged rape that took place on 29th April

was not followed up until 9th of May 2013. Secondly, the decision not to interview Roland with his solicitor on 25th June 2014 was considered by the Panel to be an error of judgement and a missed opportunity to question Roland.

The risk assessment for Denise moved from high to medium. The medium rating was based on Denise's account to police officers that she had stopped seeing Roland. Denise was referred to SIDAAS but declined a service from them. There appears to be confusion about Denise's involvement with SIDAAS in the MARAC recording. CSC said that Denise was involved with the service whilst the service manager of SIDAAS reports that Denise did not have any further contact.

Home safety services were provided at Address 1 on 20th May, following a security survey having been undertaken with Denise. On 21st May, security equipment was fitted with Denise's permission. The service was informed that Denise was staying with family members until Roland had been arrested.

Roland did not disclose that he was a perpetrator of domestic abuse to any of the services with whom he was involved. There was no information on any of Roland's medical records that would link him with Denise, therefore the relationship between Denise and Roland was unknown by any agency prior to 29th April 2013.

Roland was not involved in any programmes or services to address his behaviour as a perpetrator of domestic abuse during the period under review.

3.3 - Were arrangements made to determine the wishes and feelings of Denise about her circumstances and were these taken into account in the provision of services and support?

There is evidence in the information received by the Review Panel that arrangements were made to determine the wishes and feelings of Denise about her circumstances.

Police kept in frequent contact with Denise following the second allegation of assault. Denise said that she wished to withdraw her statement in relation to the assaults made upon her by Roland.

GMP remained in contact with Denise and encouraged her not to withdraw her statement. Whilst this may have been contrary to her wishes, it is deemed that this action by police was proportionate to the nature of the assaults committed and in the best interests of Denise. There is also evidence that police took into account that Denise may have felt intimated and in fear of Roland.

Children's Social Care acted in line with local and national procedures to safeguard Child A and Child B. Denise's wishes in relation to the children were taken into account in relation to safeguarding, and Denise was asked to sign a written agreement to safeguard her children.

SIDAAS offered a service to Denise which she declined. Denise also declined a referral to the Sexual Assault Resource Centre (SARC). In line with the service policy, Denise's wishes not to engage in the service were respected, which resulted in no follow up being made.

3.4 - Was the impact of drug, alcohol and mental health issues appropriately recognised and addressed?

Denise did not have any known drug, alcohol or mental health needs and had not presented to any agency in this regard.

Roland's mental health was assessed in both primary and secondary care services and responded to appropriately. Roland was assessed in secondary care and was not deemed to have a mental illness. Roland received behavioural therapies and interventions and from the information available to the Review Panel, appeared to comply with these services.

Roland was appropriately referred to Community Alcohol Services. An initial triage assessment was undertaken and Roland was assessed as being a dependent drinker requiring interventions. The initial triage assessment completed did not include questions regarding safeguarding children or adults (this is standard practice and safeguarding would only be considered as part of a full assessment).

An appointment was made for Roland to attend a full assessment. He did not attend and therefore this assessment was not completed, and no follow up was arranged.

3.5 - Was the impact of Child A and Child B's exposure to domestic abuse properly recognised and were their safeguarding and welfare needs adequately protected and promoted? If not what was the reason for this?

Safeguarding arrangements for Child A and Child B were made that protected them from Roland's violent and abusive behaviour toward Denise.

A written agreement was made with Denise regarding the children temporarily residing with Child A's father. A S47[5] strategy meeting was held to discuss the risks to Child A and Child B. This did not result in child protection proceedings.

Liaison between police and CSC was timely and effective in relation to safeguarding Child A and Child B, although health services were not invited to the initial strategy meeting.

In addition to the actions to safeguard Child A and Child B, actions were undertaken to ensure the safety of Roland PP and Child C. A police visit to Roland PP was undertaken to gauge her response to any threat posed by Roland. An offer of safeguarding measures, including a personal alarm, high profile police visits, and target hardening (home security) at her home address was provided. Police also sought to raise the profile of Roland PP's home address to local officers via electronic bulletin board briefings.

More generally, GMP launched a major operation to locate and arrest Roland following the death of Denise. This involved identifying and contacting several people whom the police perceived were potentially at risk from Roland, and these individuals were offered safeguarding measures. Roland PP was one of these individuals. On 2nd July 2013, police issued a 'threat to life notice' to Roland PP. This is a formal notice advising the recipient that the police acknowledge a potential threat to that person's life. (Article 2 European Convention on Human Rights)

By this time, Roland PP had already moved out of her home address to live with her sister and family. Additional security was offered to Roland PP (and her extended

[5] http://www.scie.org.uk/publications/introductionto/childrenssocialcare/childprotection.asp

family at the address) including a rapid deployment alarm and the inclusion of an immediate response marker on the address on the police system.

3.6 - Were single and multi-agency policies and procedures adhered to in the management of this case? Are single-agency policies and procedures fit for purpose in safeguarding and promoting the welfare of victims of domestic abuse, and is there evidence that they are embedded in practice?

All agencies involved in the Review provided evidence of adherence to multi-agency policies and procedures. The question of whether the multi-agency system is fit for purpose in relation to domestic abuse is the subject of further analysis in the overview report. A multi-agency recommendation is made in relation to strengthening multi-agency information systems and specific responses to domestic abuse.

3.7 - Was information sharing and communication with other agencies regarding Denise, Roland and Child A and B effective? Is there evidence of inter-agency co-operation and joint working in the management of this case?

There is evidence of inter-agency co-operation and joint working in the management of the case, although the strength and impact of this is questionable. See 3.6 above.

Once police had received information regarding the relationship between Denise and Roland, and the risks he posed to her and her children, information was quickly and effectively shared with CSC. In turn, CSC shared information appropriately and quickly with Health Visiting Services. However, 'Health' more broadly was not included in the telephone strategy meeting that took place regarding Child A and Child B. Communication between CSC and Health Visiting Services continued, although health visitors did not make face-to-face contact with Denise, despite trying to contact her on several occasions. If Denise had taken up their offer of contact, this may have provided additional support.

There is no evidence that GMP shared information under the Domestic Violence Disclosure Scheme with Denise regarding Roland's offending history, or that he was a known perpetrator of domestic abuse.

Information from the MARAC meeting appears to have been shared appropriately with the relevant agencies, however, the timeliness and effectiveness of multi-agency systems, including MARAC, is the subject of further analysis in this report and of a multi-agency recommendation.

3.8 - Did practitioners working with Denise, Roland and Child A and Child B receive appropriate supervision and support? Was there adequate management oversight and control in this case?

All agencies involved in the case reported that appropriate supervision and support arrangements were in place. There is no evidence of inadequate management oversight and control in this case.

3.9 - Were there any racial, cultural, linguistic, faith or disability issues that needed to be taken into account in the assessment and provision of services to Denise, Roland, and Child A and Child B? How were these issues managed within your agency?

There were no racial, cultural, linguistic, faith or disability issues that needed to be taken account of in the case.

3.10 - Were there any issues in relation to capacity or resources within your agency that affected your ability to provide services to Denise, Roland or the children, or to work with other agencies?

None of the agencies participating in the Review identified any issues in relation to capacity or resources that directly affected its ability to provide services.

The Drug and Alcohol Service made reference to reductions in funding that have impacted on services at local level, though this did not appear to affect the service provided in this case.

SECTION 4 – AGENCY INVOLVEMENT, ANALYSIS AND THE VIEWS OF THE FAMILY

4.1 Children's Social Care

CSC initially provided a short report covering their involvement. Following questions from family members regarding the role of CSC in responding to the needs of Child A and Child B, the Panel requested that a full IMR be submitted to the Review. The IMR was submitted on 21st December 2013. This further report did not provide sufficient information and further clarification was sought.

CSC received a referral on 3rd May 2013 regarding Roland's abusive behaviour towards Denise. The report said that Roland had strangled Denise twice during the past week. CSC was informed that neither Child A nor Child B had been present at these incidents. There was no significant history held by CSC: all the necessary checks were made with relevant professionals which revealed no concerns for the children's care or wellbeing. Denise had spoken to the police and had also informed them that the relationship had ended. It was decided in line with the Early Help Protocol that no further action was required and the case be referred to Early Intervention services. No contact was made with Denise.

On 19th May 2013, the Emergency Duty Team (EDT) received information from GMP that Roland had attacked Denise in a public place. A telephone strategy meeting took place between the Practice Manager and police as police were unable to attend a meeting (it is not unusual to hold telephone strategy meetings in these circumstances), however, no other agencies were involved.

On the basis of the information available and actions already taken to ensure the safety of the children, it was decided jointly that the referral did not meet the criteria for S47 risk assessment.

The children were not seen immediately by a social worker, although the case was allocated to a social worker for assessment, and the children were seen on 21st May. This was within timescales of Working Together to Safeguard Children guidance.

It was established that both Child A and Child B were staying at Address 2 with Child A's father, through an informal family arrangement. On 19th May, a joint visit was undertaken with police, and following this, both children remained with Child A's father. CSC began an initial assessment on 20th May. A telephone call was made to Denise to arrange a home visit on 21st May. The initial assessment was completed with information gathered during three visits, one of which involved Child A and Child B who were seen and spoken to alone by a social worker. The home of Child A's father (where the children were staying), was seen as the home of the paternal grandmother of Child A.

A further visit took place on 28th May. At this visit, which was conducted under Section 17 of the Children Act, Denise was asked to sign a written agreement about safeguarding the children, which she did. Denise had demonstrated that she was willing to work with the police and CSC in order to safeguard her children. Written agreements are not a legal requirement, but are used on a regular basis for

partnership working with parents in order to be clear about expectations from both them and CSC. In the written agreement, Denise agreed: not to allow the children contact with Roland; to inform the police and CSC if Roland made contact with her; to work openly and honestly with CSC, and; to engage in any assessments.

A third home visit took place on 29th May, and an initial assessment was completed on 3rd June. The outcome of this initial assessment was that no further action was necessary to safeguard the children. Child A remained with her father and Child B was returned to the care of Denise on 3rd June. On 10th June, a social worker telephoned Denise but received no reply and left a message. The case was closed by CSC on 10th June and Child in Need (CIN) status ended at that point.

On 11th June 2013, CSC attended a MARAC meeting regarding Denise. There was an action for CSC to investigate whether the children were still subject to CIN status. There are no further records from CSC within the timescale of the Review.

4.1.1. Analysis of Agency Involvement

CSC acted in line with local and national procedures and requirements to safeguard Child A and Child B. They shared information appropriately with other agencies and called and initiated relevant meetings. It is questionable whether the nature of the abuse reported on 3rd May was fully taken into consideration in safeguarding the whole family. The Panel would expect that reports of strangulation would be robustly investigated and may warrant the immediate initiation of S47 enquiries.

The strategy meeting that took place by telephone did not include other agencies. At the very least, health representatives should have been invited to this strategy meeting.

A written agreement was put in place to safeguard Child A and Child B from Roland. Although it is common and accepted practice to use written agreements, the Panel has made a recommendation in regard to the appropriateness of written agreements in high-risk domestic abuse cases.

The case was closed on 10th June by CSC. CSC was of the understanding that Denise had ended her relationship with Roland and was no longer at risk of domestic abuse. Child B was, at this time, residing with Denise. A social worker tried to contact Denise to inform her that the case was closed but could not do so. Following attendance at the MARAC meeting on 11th June, there was no further contact with Denise.

It would have been good practice for CSC to ensure that they had spoken to Denise before closing the case and after the MARAC meeting due to information shared at that meeting about the risk that Roland continued to pose to Denise.

4.1.2. Single-Agency Recommendations

Children's Social Care has submitted single-agency recommendations to the Review Panel, which are shown in Appendix 1.

4.2. Greater Manchester Police

Contacts in April 2013

At 09.52 on 29th April, Denise F contacted the police to report that Denise had been raped the previous evening by her partner Roland.

It was reported that Roland had also strangled her until she had slipped into unconsciousness and lost control of her bladder. Denise's friend said to police that Denise was afraid to speak to the police because of what Roland might do to her.

At 10.07 on the same day, Denise's friend was telephoned by an officer from the local Public Protection Investigation Unit (PPIU). She provided information which was recorded as follows:

The PPIU officer commenced a PPIU investigation log, took responsibility for the investigation and resolved to contact Denise for an account with the risk level assessed as medium. The police log contained the following guidance to the allocated officer:

> "*Key aspect of this report is to speak to and safeguard the victim. She should be encouraged to report any offence, whether it be violent or sexual, but primarily we need to ensure that she is safe from any future attack. The implications of delay have been discussed with Serious Sexual Offences Unit. The delay could have an impact on potential forensic evidence but this is outweighed by the necessity to treat the situation sensitively and ensure that the victim is safe. Forensic evidence would be negated, or at least argued, due to them being sexual partners and living in the same address."*

The log also shows that the guidance referred to securing evidence and a conviction. The officer was guided to speak with the informant, obtain a witness statement that should refer to any concerns about the children. It indicated that the matter should be referred to Children's Services and enquiries made with the family GP (this does not appear to have happened). It also indicates that the crime should be referred to the Serious Sexual Offences Unit.

At 10.44 on 9th May, the following entry was placed on the PPIU log by Detective Constable 1 (DC1):

> *"I have made contact with this victim. She told me that she had now separated from the perpetrator and that she no longer wanted to be in a relationship with him. I have explained the allegation that had been made. She told me that she had spoken to Denise F so she was aware what Denise F had told me. I asked the victim if she would like to meet me somewhere so we could discuss the allegation and her relationship with the perp. However, she did not want to. She kept saying "I'll be alright".*
>
> *I explained that if the allegations made were correct then this was a very serious incident and that she would be fully supported with any statement she made. Denise was thankful for my call but refused to meet me. She would not*

confirm that any offences had taken place. She would also not complete the DASH report.

I explained the role of Salford Independent Domestic Abuse Support Services (SIDAAS) and told her that she could speak with them in confidence and I told her about the counselling services with St Mary's but the victim has refused for either referral to be completed.

I have placed a DV marker on the victim's address. Referral made. Letter sent to victim should she want to change her mind in the future."

The officer also records that Denise's friend was invited to attend the police station to make a statement. She did not attend and, following telephone contact, said she was unsure whether she wanted to make a statement as she had fallen out with Denise. The officer recorded that this would be followed up again on return from leave.

At 16.25 on 18th May, Denise's friend again telephoned GMP to report that Denise had been assaulted by Roland the previous evening. She reported that Roland had head butted Denise, causing a nosebleed and a cut on the bridge of her nose.

Denise was spoken to in person at 17:38 by a police officer. She was at the home of her sister and indicated that she was too tired to be interviewed.

The officer submitted a crime report for the assault on Denise which had been reported by Denise's friend in her telephone call to the police at 16.25. The officer also completed a DASH risk assessment relating to Denise and Roland assessing the risk to Denise as 'high'. A further PPIU investigation log was created to facilitate the required further investigation into the assault allegation.

The risk level was confirmed as 'high' by the police supervisor due to the nature of the relationship between Denise and Roland.

The PPIU investigation log directed the officer in charge to refer the matter to MARAC and offer support and safeguarding to Denise, ensuring that the appropriate domestic violence alert markers were on the relevant addresses.

The log also records that Denise was not engaging and had refused to provide a statement of complaint in relation to the alleged rape, although she acknowledged that her friend had reported the matter and did not contradict the account given. At that time, police were attempting to safeguard Denise by offering her access to support services.

On 19th May, police conducted a joint visit with CSC. Arrangements were made not to return Child A and Child B to Denise until the investigation had progressed and until Roland had been arrested. It was judged that Address 1 was no longer a place of safety for Child A and Child B, and that Denise was at risk of being unable to protect her children.

At 14:06 on 19th May, the PPIU log was updated with guidance to include details of the conversation with the victim, to update on the whereabouts of the children and to refer to CSC (a note was included saying that Child A and Child B were to stay with their respective fathers – although only Child A's father was involved as Child B's father was serving a custodial sentence). There was also a note that the case had been discussed with the Serious Sexual Offences Unit (SSOU) of Greater Manchester Police. Child Protection Referral forms were generated in respect of both Child A and Child B.

At 16:05 on 19th May, the police received information from Roland PP that Roland had Child C with him and was due to drop her off at Address 3 that day at 18:00. The Divisional Hub was informed and undertook to deploy staff to effect the arrest of Roland.

At 16:18, a further call was received from Roland PP informing police that Roland sometimes drops the child off near her house. However, she undertook to get him to bring the child directly to the house on this occasion.

An operation to arrest Roland was mounted based on the intelligence provided by Roland PP. Nine officers were deployed but by 18:21 Roland had not appeared and police declared that the arrest attempt was negative, and that the officers should stand down with the exception of one officer who remained at the address.

At 19:21, the officer reported that Roland had returned to the address but had become aware of the police presence when he arrived at the address with the child in a taxi, abandoning the child in the taxi before making off and successfully avoiding capture. Child C was unharmed and returned to the care of Roland PP.

Following the failed arrest, a police log was created on 20th May noting a conversation with Roland PP where she confirmed that Roland had seen the police and absconded, leaving Child C in the taxi. The log records that the officer had spoken to CSC and that a strategy meeting was required. Actions to safeguard Roland PP and Child C were put in place.

On the afternoon of 20th May, Denise attended at the local police station and was subject of an achieving best evidence (ABE) video interview providing evidence regarding the alleged rape and assaults. A crime report was submitted and liaison took place with SSOU who agreed to take the investigation forward. Roland was recorded as 'wanted' and details were circulated via the Police National Computer.

The PPIU investigation log was updated to record that Denise had consented to MARAC and that the case was to be heard on 11th June. It was also recorded that Denise had consented to referrals to Salford Sanctuary Scheme for additional security to her home. There was also a referral to Greater Manchester Fire and Rescue Service (GMFRS) for upgrading security and fire prevention measures at her home. The log records that at this time, Denise was staying between her sister's and her father's addresses.

On 22nd May, responsibility for the investigation into the complaint of rape was allocated to a police officer. At 09:15 on 22nd May, the officer spoke to Denise and updated her that Roland had not yet been arrested. Denise stated that Roland had texted her the previous day asking why she had made lies up about him and that it was not too late and that it would stop him from seeing his kids. She did not respond. Denise indicated that she intended to return to her home address that evening with her children as all the security measures and fire alarms were in place and she now felt more secure.

On the 27th May, the officer recorded within the PPIU log that they would continue efforts to safeguard Denise while the investigations to locate and arrest Roland continued.

At 12:15 on 27th May, Denise contacted GMP to report that Roland was continuing to harass her by text, telephone and letter, reporting that Roland had telephoned Denise and quizzed her about what she had told the police about him and asking her who she was with. She said that she had refused to answer his questions and hung up.

The PPIU at Salford created a PPIU investigation log in respect of the incident and the risk was assessed at medium. The investigation was assigned to an officer, who made a referral to CSC.

At 16:38 on 27th May, a police officer endorsed the crime report in relation to the complaint of rape, noting that Roland remains on the 'Priority Arrest Board' and that the local police division was not aware of the complaint of rape. The record also notes that Denise was staying with her sister who was concerned for her safety.

At 16:51 on 31st May, police endorsed the crime report, stating that satisfactory progress had been made. The report noted that Roland should be arrested and that the local division was progressing this aspect. It was noted that Roland was persistently texting the victim and making threats to her. There was a note confirming that Denise was currently safe and well.
On 9th June, the lead officer commenced a period of annual leave and another officer was allocated the ongoing responsibility for safeguarding Denise. On the 11th June, this officer contacted Denise by telephone and established she was safe and well and still supportive of the investigation, stating that she was willing to attend court.

Denise also stated that Roland was still harassing her by text; the last occasion being on Saturday 8th June, and she believed he had attended at her house one night the previous week at 01:30 and kicked the door. Her brother, who was staying with her at the time, saw Roland out of the window. Denise did not report this to the police.

On the 11th June, a MARAC meeting was held. The police were the referring agency and presented the case.

The following actions arose from the MARAC meeting:

1. The officer in charge to maintain contact with Denise and encourage her to continue to engage. Discuss safety measures with Denise;

2. Establish if Denise has spoken to St Mary's Sexual Assault Referral (SARC) centre - would she like to talk to them if has not already done so - if so, refer or provide her with details;

3. CSC to establish whether an initial assessment had been conducted and whether the children were subject to child protection arrangements.

It was acknowledged by the MARAC that these actions might have already been discussed with Denise as there had been regular contact with her.

At 08:39 on 15th June, a police officer recorded a contact with Denise F by telephone as she had seen Denise the previous night. This contact prompted further enquiries. Two police officers attended at Address 1 on the morning of 15th June and spoke to a male (who was not identified) at Address 1. Denise was also present and spoke to the officers at the door, although she did not allow them into the property.

Denise said that she would make her way to the local police station and speak to the officers there. She was provided with the names and contact details of the officers.

A short time later, Denise called the police office and stated that she wanted to withdraw her statement of complaint. Denise was informed that the offences would still be investigated and that Roland would still be arrested in respect of the allegations. Denise was advised that an officer would contact her on Monday 17th June for this to be arranged.

On 17th June, police completed an enhanced risk assessment and the risk was assessed as 'medium'. On the same day, it was recorded that Roland was still being traced by the Division and that safeguarding was in place for Denise. It also records that Denise wanted to withdraw her statement. An instruction was issued that Denise should be contacted to clarify whether she was withdrawing her statement, why this was, and whether there was any flexibility in her decision, specifically to clarify whether any intimidation or threats were involved in her change of mind.

On 19th June, police contacted Denise and discussed the investigation and future prosecution with her. The record states that Denise was very clear that she did not want to go ahead with her complaint against Roland. A withdrawal statement was not taken at that time.

On 25th June, Roland's solicitors made contact with the police. They indicated that he was now willing to attend at a police station to be interviewed.

On 26th June, an officer spoke with Denise, who reiterated her wish to retract her complaint. The officer tried to talk her out of this course of action but Denise was

adamant that was what she wanted to do. Denise was offered further support but said that she did not need it. The conversation concluded with the police officer saying that they would contact Denise the following week to check on her welfare and establish whether she still felt the same.

One of the officers working on the case reported not wanting to arrest and interview the suspect if the victim had provided false information, and wanting to speak to the victim before arranging an interview with Roland. It is also recorded that contact would be made with the solicitors to advise them that police were not ready to proceed, and if any further enquiries were made, they should be directed to this officer.

At 17:55 on 29th June, the police were called to Address 1 where the deceased body of Denise had been discovered by Denise BIL and Denise S.

4.2.1 Analysis of Agency Involvement

NB: The following section sets out expected and good practice within GMP, but it does not critically address missed opportunities and any weaknesses in practice: this should be noted. Without interviewing individual officers, it is not possible to critically analyse information in relation to key events, particularly the failed attempt at arrest and any follow-up actions to the solicitors offer to interview Roland.

As the GMP IMR was written without the benefit of speaking to the officers concerned, the IMR author was unable to expand on why each decision was made in relation to the risk to Denise being assessed at various points in time, and as developments occurred.

It is apparent from the police IMR that the potential danger to both Denise and her children was recognised and acted upon by police, following the initial report by Denise F on 29th April 2013.

The attempts to safeguard Denise and her children which followed the initial report and were documented within the IMR provide evidence that the recognition, assessment and response to the identified risks were appropriate.

The safeguarding services provided for Denise commenced as soon as the police received the report of assault and rape from Denise F on 29th April were appropriate.

There was continual and repeated contact with Denise. The needs of Denise were constantly under review throughout this contact, as can be seen from the various safeguarding measures which were offered.

While it can be seen that Denise was encouraged to distance herself and separate from Roland, without speaking to the officers involved, the author of the police IMR was unable to comment further on this area.

Between 29th April 2013 and 29th June 2013, there were substantial attempts to arrest Roland in an attempt to prevent any further abuse by him towards Denise. Between the 29th April and the death of Denise, the police had no contact with Roland.

There are numerous references - within the crime report and PPIU investigation logs - to the complaints of rape and assault which noted that Denise was spoken to regularly by various police officers and that her wishes were frequently discussed.

Without detailed analysis of individual officer's daybooks and notes, the author of the IMR was unable to establish exactly how often Denise was contacted between 29th April and 29th June, but the evidence available within the documents referred to above suggests that there were many points of contact.

In the events detailed in the IMR, there is no evidence that either Child A or Child B was present when Denise was assaulted or allegedly raped by Roland. However, there was clear concern for both children given the nature of the risks identified, and these risks and the welfare of both children were addressed as a result. There are references to contact and referrals to Children's Social Care. There is a reference to ensuring that both Child A and Child B stayed with their respective fathers following a joint-agency visit between the police and Children's Social Care (although Child B's father was in fact serving a custodial sentence).

Denise was clearly very visible to all the different organisations that were potentially able to assist her, and there are examples of resultant positive action such as the installation of new fire alarms and safety equipment within her home.

The officers and staff working with Denise received close supervision and support throughout; this is evident in the police records.

Furthermore, there is evidence that the progress of the investigation and safeguarding work in relation to Denise and Roland was being supervised by the Detective Inspector within the Serious Sexual Offences Unit.

There was a substantial delay following the initial report of assault made by Denise F on 29th April, which was not followed up until 9th May. This is an unacceptable delay due to the seriousness of the allegation.

There is no evidence to suggest that police gave consideration to putting a Domestic Violence Prevention Order in place, nor is there evidence that police considered providing information to Denise under the Domestic Violence Disclosure Scheme.
(GMP was one of four forces trialling what later became known as the Domestic Violence Disclosure Scheme (Clare's Law)[6]. The GMP pilot scheme commenced on 6th September 2012. The scheme was introduced nationally on 8th March 2014).

6

http://www.gmp.police.uk/content/WebAttachments/88A190F67550078780257A71002E5DC8/$File/claire's%20law%20other%20people%20booklet.pdf

The decision not to interview Roland with his solicitor on 25th June 2013 is questionable. This decision was based on what was deemed by the officer to be inconclusive evidence of offences, as a result of Denise's unwillingness to confirm her statement and requests to withdraw her statement. Given the seriousness of the alleged offences and the vulnerability of Denise, it is the view of the Panel that the opportunity to speak to Roland should have been taken.

These matters were subject to investigation by the IPCC.

4.2.2. Single-Agency Recommendations

GMP has submitted a single-agency action plan which is attached at Appendix 1.

4.3 Greater Manchester Probation Trust

GMPT holds the statutory responsibility for the management and supervision of offenders.

Denise

Denise had no contact with this service.

Roland

Roland's last contact with the service was in April 2012 and is therefore outside of the Review Period. The IMR from GMPT contains a detailed record of Roland's offending history and contact with the service. The report refers to Roland having been a perpetrator of domestic abuse in previous relationships, and of his use of drugs and alcohol.

4.3.1. Analysis of Agency Involvement

As contact with Roland was outside of the period under review, the Panel has not included detail in this report. However, the service provided a comprehensive account of its involvement with Roland which satisfied the Panel that they had at all times operated within policy and procedural guidance. This also indicated the level of risk that Roland presented as a perpetrator or domestic violence and has strengthened these recommendations and GMP's response to high-risk perpetrators.

4.3.2. Single-Agency Recommendations

No single-agency actions are required due to contact outside the period. A multi-agency recommendation is made in regard to all agencies reviewing their assessment and information-sharing protocols around high-risk violent offenders in relation to domestic abuse.

4.4. Greater Manchester West (Secondary Mental Health Service)

Provides secondary mental health care to individuals experiencing symptoms of mental ill health that cannot be met within Primary Care.

Denise

Denise had no contact with this service.

Roland

Roland was referred from the Primary Care Psychology Service on 8th October 2012 as a non-urgent referral. An appointment was arranged for 5th November, 4 weeks later, which was within the agreed timeframe for non-urgent assessments. When Roland attended for the assessment appointment on 5th November, he was late and could not be seen immediately. He refused to stay for a later appointment. A subsequent appointment was arranged for 20th December, which Roland attended.

Following this initial assessment, the attending doctor concluded that, whilst Roland had some paranoid ideas, this was in the context of his previous violent behaviour. The doctor concluded that there was no mental illness indicated at that stage and planned to review the case with the consultant psychiatrist and offer a further outpatient appointment four weeks later, following which Roland would be discharged back to primary care.

Roland was seen again on 31st January 2013, and he disclosed that he had been admitted to hospital (SRFT) with possible hallucinations. He said he had taken his own discharge against medical advice. Given the change in clinical presentation, the attending doctor made the decision not to discharge Roland back to primary care, but planned to review his hospital medical notes and to see him again in two months' time, at which point, he would be discharged back to primary care unless his mental state indicated otherwise.

The attending doctor reviewed the hospital notes on 1st February and was able to conclude that the hallucinations Roland had experienced were of an organic origin, and not the consequence of any underlying mental illness. This indicated that Roland could be discharged from the community mental health team back to primary care. An appointment was made with Roland for 28th March for this to be carried out. Roland attended this appointment but would not wait to be seen. Subsequent appointments were made for 4th April and 13th June, neither of which Roland attended.

4.4.1. Analysis of Agency Involvement

The service provided a timely, proportionate and fit-for-purpose response to Roland. Roland was assessed on 20th December and the attending doctor could find no mental illness, and followed good practice by offering a further outpatient appointment to Roland prior to his discharge to primary care. Roland did not disclose domestic abuse on the two occasions that he was seen (20th December 2012 and 31st January 2013), nor was he asked about domestic abuse.

The attending doctor correctly sought supervision from the consultant psychiatrist in relation to the decision following the initial assessment on 20th December 2012.

It was clinically indicated that Roland did not require input from Secondary Mental Health Services and the decision had been made to discharge him at the next outpatient appointment.

It would have been good practice to write to Roland and his GP following his non-attendance at the Outpatient appointments on 4th April and 13th June 2013 to advise that he was being discharged from the service, though this did not happen.

4.4.2. Single-Agency Recommendations

A single-agency action plan is attached at Appendix 1.

4.5 Greater Manchester West NHS Foundation Trust (GMW)

SDAS provide community based alcohol services across the area.

Denise

Denise had no contact with this service.

Roland

Roland was referred to the Community Drug and Alcohol service by the Primary Care Psychology Service on 28th September 2012 for an assessment of his alcohol use. At this time, Roland was not in a relationship with Denise.

A face-to-face triage assessment was undertaken on the 15th October 2012. The results of the triage assessment indicated that Roland was a 'dependant drinker', requiring a comprehensive assessment to be undertaken with the likelihood of subsequent structured interventions (Tier 3 treatment). The triage assessment does not contain questions about domestic abuse.

It was agreed and arranged with the Community Mental Health Team (CMHT) that a joint-assessment of Roland's mental health and alcohol use would be undertaken by the Community Mental Health Team and SDAS professionals on the 5th November 2012.

Roland attended 20 minutes late for the appointment on 5th November 2012. There are no records relating to this appointment and no evidence of further contact made with Roland by the service. Roland had no further contact with the service.

4.5.1. Analysis of Agency Involvement

There is evidence that the triage was undertaken and completed in line with the policies and procedures in place at the time. The gathering of information through the triage assessment identified that Tier 3 treatment was required, and known current risks were taken into account by arranging a joint mental health and substance misuse assessment.

There is no record that domestic abuse was disclosed or identified in the initial assessment as this was a brief triage assessment, which is an initial screen of alcohol use.

Roland was appropriately assessed as requiring a more detailed assessment due to his levels of alcohol consumption. It was also noted that Roland had a long history of violent offending and convictions. A further appointment was made for Roland to attend a detailed assessment (Tier 3) and it was good practice to arrange for this to be undertaken jointly with the CMHT.

Roland attended late for this appointment and was therefore not seen. This assessment would have included a more detailed risk assessment, including risk factors for domestic abuse.

It appears that there was no follow up to the missed appointment as there are no records relating to any follow up or multi-agency communications and the case was closed.

4.5.2. Single-Agency Recommendations

A single-agency action plan is attached at Appendix 1.

4.6 General Practitioner Denise, Child A and Child B

Denise, Child A and Child B were registered with the same general practitioner (GP1) throughout the period under review. The Review Panel did not request access to the medical records of Child A and Child B as part of this Review.

A short report was prepared by the Designated Nurse for Safeguarding Children from the local Clinical Commissioning Group (CCG) and a CCG clinical lead who is a practising GP and Safeguarding Adults Lead for the Board. The report was of a good standard and appropriately addressed the key lines of enquiry.

Denise and Child A had limited contact with their GP during the period under review. No contacts were made with the GP practice in respect of Child B. From the GP report, it is noted that the general medical services provided to Denise in relation to presenting conditions were appropriate and timely.

Denise did not disclose domestic abuse to her GP, nor did she present with any indicators of domestic abuse that may have alerted the GP to make an enquiry into possible domestic abuse.

Denise attended the GP surgery to see GP1 on 3rd September and 28th September 2012. These appointments were for medical reasons that are unrelated to this Review. These consultations resulted in referral by the GP to specialist services at Salford Royal Hospital Foundation Trust (SRFT). Denise did not attend her appointment on the first occasion, but did present at a later date and received a surgical procedure. Denise did not attend an appointment that had been made for her to receive routine screening tests on 11th February 2013, but did later attend a subsequent appointment on 27th February 2013, following which she was referred to a specialist clinic which she attended on 10th April 2013. None of these contacts relate to this review.

Child A was seen on one occasion during the Review period. This was on 11th December 2012 when Child A was presented due to being unwell and was seen by GP1, and appropriate advice was given. There were no other contacts in relation to Child A.

On 17th June 2013, GP1 received notification of a MARAC meeting that had taken place on 11th June. Until that time, the GP practice was not aware that Denise was

in a relationship with Roland. Roland was registered with a different GP practice and was not linked to Denise through a shared address. The GP had no further contact with Denise following this notification.

4.6.1. Analysis of Agency Involvement

The general medical care provided to Denise and to Child A was appropriate and timely. The GP appropriately referred Denise to specialist services and followed up her non-attendance at this service.

The GP was unaware of Denise's relationship with Roland until the MARAC notification, and Denise did not disclose domestic abuse to the GP in any consultation. Denise did not present with any indicators of domestic abuse, therefore the GP did not make any form of screening or enquiry into domestic abuse.

Following the notification of Denise being classed as a high-risk victim of domestic abuse at the MARAC meeting on 11th June, the GP practice noted this. There was no further contact with Denise after this notification and no further opportunity for the GP to offer any screening or domestic abuse interventions.

4.6.2. Single-Agency Action Plan

No single-agency actions have been identified.

4.7 General Practitioner Roland

4.7.1. Contact Prior to the Period under Review

Two episodes of engagement with services are included in this report as, although they fall outside of the period under review. However, the Review Panel believes that they offer insight into Roland's behaviour which is relevant to this Review.

Roland discussed his criminal history and concerns about his mental health with his GP. The GP noted that this was a "long chat" and that Roland reported having no thoughts of harming himself or others, as he believed he would get better. GP2 also recorded that Roland reported that he was not carrying weapons. The GP liaised with GMW Mental Health Foundation Trust who requested that the GP practice make a referral to the Primary Care Psychology Service for cognitive behavioural therapy (CBT). This referral was made by the GP and Roland attended for CBT.

On 22nd June 2012, Roland saw his GP following an earlier telephone conversation. At this appointment, Roland reported feeling paranoid and anxious about risks to himself from others. Roland advised GP4 that he had not received the forms to enable a referral to be made to the Primary Care Psychology Service. Roland agreed to a further referral to the Primary Care Psychology Service and the GP action was to contact the service, re-referring Roland if necessary. This action was undertaken with a referral being made on 27th June 2012. This referral included a copy of the previous referral made on 26th April 2012.

4.7.2. Contact during the Period under Review

Although Roland did not immediately engage with the Psychology Service, he eventually attended four sessions of CBT between 7th September 2012 and 28th September 2012. The action plan detailed in the final letter was for the Cognitive Behavioural Therapist to contact Probation, to refer Roland to the Community Drug and Alcohol Team (CDAT) and to the Community Mental Health Team (CMHT) as Cognitive Behavioural Therapy was not considered appropriate for Roland.

The GP practice received an A&E notification on 29th January 2013, advising that Roland had presented there on 24th January. The presenting complaint was that Roland was behaving strangely and he was admitted to the Medical High Dependency Unit. The GP practice received a discharge summary from Salford Royal Foundation Trust following Roland's self-discharge from the Medical High Dependency Unit on 28th January which requested that the GP practice monitor Roland as necessary, given the self-discharge against medical advice. 'Unsafe levels of alcohol' was recorded as a risk factor on the discharge summary.

Roland's next contact with his GP was on 7th February 2013 where he telephoned to discuss concerns about the after-effects of hospital treatment. Roland attended the surgery that same day but made a decision to leave without being seen.

The GP practice subsequently received a letter on 11th February 2013 from Greater Manchester West Mental Health Trust; the letter was dated 6th February 2013 and advised that a psychiatrist had seen Roland on 20th December 2012. A further letter from Greater Manchester West Mental Health Trust was received on 12th February 2013 which was dated 8th February 2013 and advised that Roland had been seen by a psychiatrist on 31st January 2013.

Roland advised a member of the practice staff by telephone on 21st January that he wanted a prescription for medication to assist him in staying off alcohol. Roland then saw a GP later the same day who recorded that a referral was to be made to the alcohol team. On 22nd January, GP1 noted that Roland had asked not to be referred to the local CDAT, and the GP advised that the referral had to be made to this team but a different worker could be requested, or Roland could refer himself to Alcoholics Anonymous or similar. The GP spoke to Roland about this by telephone on this date and Roland advised that he did not want to go to the local service because he had had problems there in the past, knew too many people and that there were a lot of people there who used drugs. The GP advised Roland to try Alcoholics Anonymous (AA).

4.7.3. Analysis of Agency Involvement

Roland presented with complex needs given his previous offences and current mental health and alcohol issues. Information available to the GP practice from their own assessments of Roland and from information provided by Greater Manchester West Mental Health NHS Foundation Trust did not identify that Roland reported thoughts of harming himself or others. However, it is not evident that the practice specifically considered whether Roland posed a risk to children or young people in accordance with the GMC guidance entitled Protecting Children and Young People: The responsibilities of all doctors (GMC, 2012).

Page 11 of this guidance states that *"When you care for an adult patient, that patient must be your first concern, but you must also consider whether your patient poses a risk to children or young people".*

The guidance state that *"you must" is used for an overriding duty or principle.*

Additional guidance in relation to such GP responsibilities is included within the Framework for Assessment of Children in Need and their Families (Department of Health, Department for Education and Employment & Home Office, 2000).

Section 5.23 of this guidance states that *"The GP and the primary health care team are also well placed to recognise when a parent or other adult has problems which may affect their capacity as a parent or carer or which may mean that they pose a risk of harm to a child".*

The safeguarding policy developed by Salford Clinical Commissioning Group for GP practices includes advice in respect of managing domestic abuse concerns. However, as stated previously, the GP practice was not aware that Roland was a perpetrator of domestic abuse. Where GP practice staff members are aware of safeguarding concerns, there are processes in place to receive advice and support through the Practice Safeguarding Lead or by contacting the Salford CCG Safeguarding Team.

The GP practice responded appropriately to Roland's needs, undertaking assessments of his mental health issues and making required referrals. Good practice was evidenced by the GP practice in providing appointments for Roland on the same day after initially having telephone consultations with him on 26th June 2012 and 7th February and 21st March 2013.

The GP responded appropriately in relation to mental health by referring Roland for specialist assessment, and following up with Roland regarding his engagement with the psychology service. Further good practice was noted in terms of record keeping with detailed records being made of the consultations in relation to Roland's mental health.

The GP practice intended to refer Roland to a specialist alcohol service in order to enable him to obtain support for his alcohol misuse after he requested this support on 21st March 2013. This referral was not made because Roland was unwilling to attend the local service available through GP referral and he was therefore advised to contact AA. This advice was given to Roland by a member of the Practice Staff Administrative Team after having a discussion with him on 25th March 2013.

The practice did not subsequently make contact with Roland to ascertain whether or not he had obtained support to address this issue, and he did not contact the practice again within the review period. It is therefore not known whether Roland contacted AA to obtain support.

There was some delay in the GP practice making the first referral to the Primary Care Psychology Service with the letter requesting the referral received on 11th April 2012 and the referral being made on 26th April 2012.

Whilst letters received by the GP practice on 11th April, 8th October 2012 and 12th February 2013 provided the practice with timely feedback in respect of Roland's attendance at mental health service appointments with psychiatrists, it is a concern that the letter from GMW to advise the GP practice of Roland's attendance on 20th December 2012 to see a psychiatrist was not received by the GP until 11th February 2013.

It is also of concern that, following the two GP referrals to the Primary Care Psychology Service 26th April 2012 and then on 27th June 2012, a letter was not received by the GP from that service until 12th July 2012.

4.7.4. Single-Agency Action Plan

No single-agency actions have been identified. Sharing of information between services is highlighted in the multi-agency recommendations set out in section six.

4.8 Salford Royal NHS Foundation Trust (SRFT)

4.8.1. Contact Prior to the Period under Review

Outside of the period of this Review, SRFT provided maternity services to Denise in relation to Child B. During the new birth assessment for Child B, domestic abuse was discussed.

4.8.2. Contact during the Period under Review – Denise

Denise, in addition to her contact with SRFT Community Health Services also accessed services within the acute hospital setting on 9th October 2012 and 10th April 2013. These attendances were for investigations and necessary procedures. A computer-generated letter from SRFT provided the family GP and Denise with information relating to these attendances.

The attendance in April 2013 was to exclude a possible serious condition and this we can assume would have caused Denise some anxiety. Notification of a satisfactory result was sent by SRFT on 25th May. This was in the timeframe of the relationship with Roland and should therefore be considered as an additional stress factor for Denise. As aforementioned, the health visiting services were unaware of the health interventions from SRFT.

HV services are not routinely informed of adults' attendances at acute services unless there are safeguarding issues identified. There is no evidence of any safeguarding issues documented. Patient Confidentiality (Caldicott[7] Guardian Principles) would protect sensitive information being shared unless there were concerns relating to a safeguarding issue.

[7] http://systems.hscic.gov.uk/data/ods/searchtools/caldicott

4.8.3. Health Visiting Service

On the 7th May 2013, health information was requested by CSC, and it was noted that the information was requested due to concerns around the alleged assault to Denise. On the same day, the Health Visiting Team received a domestic abuse referral form (this related to the incident of abuse reported by Denise F). A letter was sent to Denise arranging a home visit for 16th May 2013. On 16th May, the Health Visitor (HV) attended a home visit. A family member informed the HV that Denise had moved address. A new address was provided by the family member and documented in health records. A letter was sent to the new address to arrange a visit on 24th May 2013 to discuss domestic abuse.

The social worker requested further information on 20th May due to concerns about violence to Denise from Roland. The school nurse informed the social worker of her concerns about previous domestic abuse in 2007; the social worker was unaware of this previous incident.

On the 22nd May, the HV left a message for the allocated social worker that it was the intention to visit Denise 'this week' to provide support.

On the 24th May, the HV visited Denise's new home address, however, she could not gain access. HV left a card to encourage Denise to contact the Health Visiting Service. The HV left a message for the social worker to say that access was unsuccessful and to update. On 30th May, the HV received a domestic abuse referral form.

On 3rd June, the HV made an opportunistic home visit, however, there was no access. A contact card was left and the HV informed the social worker. A telephone message was also left with a friend of Denise (no name recorded) asking Denise to contact the health visitor.

On the 6th June, the HV provided information for the MARAC meeting, which would take place on 11th June. A summary of the MARAC meeting was disseminated on 13th June; there were no identified actions for SRFT.

The Health Visiting Service had no further contact with Denise.

These responses from SRFT health professionals appear to have been appropriate, timely and within agency guidelines.

4.8.4. Analysis of Agency Involvement – Denise

Decisions made by health professionals were in accordance with SRFT policies and procedures and HV service specifications within the timeframe of the Chronology.

Following the receipt of the DASH risk assessment, risks were then identified and attempts to offer more intensive support were made, despite repeated attempts to make contact, Denise did not engage.

It is acknowledged by the Trust that victims of domestic abuse often tend to underestimate their risk of harm from the perpetrators of domestic violence.

However, the reason for the lack of engagement in relation to Denise's needs remains unknown.

The HV who undertook the assessments and attempted contacts established that the concerns were somewhat reduced following telephone contact with the social worker. This discussion established that the case involving Denise was closed by CSC following their initial assessment. The assessment indicated that there were no parenting concerns and that Denise was seeking legal advice. In addition to this information, the HV was aware that the MARAC process was ongoing and that she would be informed of any further actions required.

The wishes and feelings of Denise were assessed within the routine HV assessment. This was following the delivery of Child B, and pre-dated her involvement with Roland and the period under review.

The health services could be described as accessible to Denise from a professional's perspective, as the HV's contact details were made available on several occasions. However, the possible minimisation of domestic abuse or the lack of her own realisation that Denise was a victim may have thwarted her engagement.

There was no indication or evidence to suggest that Denise's mental capacity was in any way impaired, therefore an assessment was not required. There were no safeguarding plans applicable to this case. Health service practitioners appropriately recorded ethnicity on child assessments and on Denise.

4.8.5. Contact during the Period under Review – Roland

Roland was a patient within SRFT acute services. Within the specified timeframe, he attended Salford Royal hospital on two occasions.

On 24th January 2013, Roland had been found wandering in the street. He appeared confused, dishevelled, and agitated. An emergency ambulance transported Roland to SRFT Emergency Department. He was admitted to a ward for investigations. On 28th January 2013, Roland self-discharged against medical advice.

Roland re-presented to the Emergency Department on 6th February 2012. At triage, he stated that he had self-discharged from Ward HR2 ten days ago and he was complaining of lumps and pain in canula sites. Medical staff were called to see Roland but upon their arrival he had left the department. A routine letter was generated to Roland's GP.

SRFT had no further contact with Roland.

4.8.6. Analysis of Agency Involvement – Roland

Due to the uncooperative and aggressive nature of Roland's presentation and admission to SRFT 24th January 2013, the safeguarding questions within the documentation were not completed. It was noted that his next of kin was present, with this individual documented as being his mother.

The cause of Roland's presentation required further on-going investigation to establish whether this could be attributed to an organic reason or due to possible substance misuse, but his subsequent self-discharge prevented a definitive diagnosis. The documentation states that Roland remained uncooperative in some aspects of his care throughout the admission into SRFT. At no time did electronic documentation relating to Roland's nursing or medical care indicate any reference to Denise or dependent children.

Questions were not asked on Roland's second attendance within the ED as on this occasion Roland left the department without being seen by a clinician.

Throughout the MARAC process for all parties, it was considered that all Caldicott Principles were adhered to in accordance with [8]Department of Health guidance (2011).

The training that staff receive according to their roles and responsibilities includes identification of domestic abuse and its impact on the victim and children. This training is mandatory for all staff working within SRFT. Staff compliant with mandatory training are aware of their responsibilities to work in accordance with organisational protocols and procedures.

This case was not discussed within safeguarding supervision. Records indicate that the health practitioners involved accessed safeguarding supervision on at least three occasions throughout the chronology time period. However, this case was not brought to the attention of a safeguarding supervisor. The safeguarding supervision policy at this time recommends that cases of concern or threshold 2b of the Multi-agency Threshold of Need and Response Document should be discussed. The practitioners' decisions not to raise this case at supervision may be attributed to information received from Children's Services. The child health records (Child A's health records) indicated the case was closed following initial assessment and there were no concerns regarding Denise parenting her children. This supports the previous assessment of case at universal service of the core programme.

SRFT operates a satisfactory recording system in accordance with NHS Local Authority standards (2012). The opportunity to complete the questions, which could indicate some safeguarding issues, is available only within the Emergency Department and Paediatric (PANDA) unit. This could potentially restrict identification of safeguarding concerns.

In this case, crucial information regarding the relationship between Roland and Denise was dependent on disclosure from either party to health professionals involved, and this disclosure was never made.[9]

4.8.7. Single-Agency Action Plan

[8] http://systems.hscic.gov.uk/infogov/caldicott

[9] http://www.legislation.gov.uk/uksi/2012/3094/part/6/made

A single-agency action plan is attached at Appendix 1.

4.9. SIDASS (Salford Independent Domestic Abuse Support Service)

SIDASS provide safety planning, risk assessment, sanctuary and fire safety referrals. SIDASS also provide access to legal services.

GMP referred Denise to SIDASS. The service made contact with Denise, but she declined a service from them. SIDASS attended the MARAC meeting on 11th June and confirmed that Denise had not engaged with the service.

They had no further contact with Denise.

4.9.1. Analysis of Agency Involvement

SIDASS followed their procedures in relation to engaging with victims. Denise did not wish to engage with the service and therefore there was no contact after the initial referral.

4.9.2. Single-Agency Action Plan

No single-agency actions have been identified.

4.10 Salford Council Sanctuary Service

Salford Council commissions the domestic abuse services across Salford, and at the time of this Review this includes; 14 units of refuge in two locations in the city. At present, Salford Women's Aid provide these two services for the Council. The Sanctuary Scheme is designed to enable victims of domestic abuse to remain in their own homes by providing a tailored package of home security measures. The Housing Crime Reduction Team takes referrals primarily from SIDAAS and GMP Domestic Violence Unit based in Salford.

Referrals are also made by the Homelessness and Housing Advice Team, housing providers e.g. City West, social services, health visitors, Sure Start services.

When a referral is received, it is immediately put onto the Housing Crime Reduction Team database and a phone call made to offer an appointment to carry out a security assessment on the property. If the call is not answered, a log is made on the application, detailing the time and date the call was made and, where possible, a message is left asking the client to make contact, and a text message sent if a mobile number is provided. The message does not detail the team calling or the purpose of the call.

Two further telephone calls will be made to try and make contact. If contact is not made, a letter is sent to the client. The referral agency is also contacted and made aware that contact has not been made.

The visits are arranged as soon as is convenient for the client. They are always offered same day or next day appointments. Information on the referral form and the information provided by the client at the visit is used to help determine what additional security products would be best suited to protect the client. All works are ordered as a priority, and the contractors used by the Housing Crime Reduction team will make contact with the clients within one or two days. Where an immediate

lock change is required, a Housing Crime Reduction Officer will contact the client to check what type of door they have, and they will then contact the contractor and arrange for the locks to the changed the same day. A personal attack alarm is provided to every client and they are offered window vibrations alert alarms, which are fitted by the visiting officer. Door braces are also offered to clients with UPVC and wooden doors, and a demonstration is given on how to use the door brace.

On 20th May 2013, an officer at GMP referred Denise to the service by email. Denise had moved out of Address 1 to stay with her father until the Police had arrested the perpetrator. An officer contacted Denise shortly after the referral came through and made arrangements to carry out a home visit

The following day, two officers from the Housing Crime Reduction Team attended the property to carry out a security survey and spoke to Denise. The following works were ordered:

- Three new euro sash locks for the front, rear and patio doors (Roland had previously held a set of keys);
- Sash jammer was fitted to the children's bedroom at the rear because there was a large conifer near it and a window alert alarm fitted to the window;
- External mailbox – the letter plate had already been blanked;
- Two bolts fitted to the loft hatch;
- Dusk till dawn light – rear;
- Window vibration alert alarms were fitted by the attending officers to the downstairs windows;
- A personal attack alarm was provided to Denise for use when she was away from the property.

The officer also telephoned the contractor for Address 1 and asked them to attend as soon as possible. Also in the property were Denise's mother and sister. Safe and Secure (the contractor) attended the same day and completed all of the work, except the outside light, which they installed the next day.

4.10.1. Analysis of Practice

The Sanctuary Scheme provided a good level of service within the designated timescales.

4.10.2. Single-Agency Action Plan

No single-agency actions have been identified by this agency.

4.11 Views of Denise's Family

Two members of Denise's family participated in the Review at the start of the process[10]. The Review Panel is indebted to family members for participating in the Review.

Denise was described as a bright, caring and fun-loving young woman who was devoted to her two children.

Prior to meeting Roland, she had been in a relationship with the father of Child B, which had become violent.

Denise had recently moved to a new address and was beginning to get her life back together after the relationship ended with Child B's father. She was enjoying making a new home for the children and seemed happy and content.

The family is close knit, and Denise was in daily contact with her mother and sisters: they all helped each other out and supported each other. The relationship between Denise and her sisters was close and she confided in one of them about issues and concerns.

When Denise met Roland, he had some contact at a social gathering with a member of Denise's family. He presented as a 'loner' and someone who was not comfortable in social situations. He did not attempt to engage with the family and remained on the outside of Denise's family circle. He was not perceived as a permanent feature in Denise's life.

A member of Denise's family began to pick up signals from Denise that the relationship with Roland was not without problems. In the early part of 2013, it was noticed that Denise had become more withdrawn and was less communicative with her family. She had stopped discussing her feelings and evaded questions about Roland.

Denise's family were not fully aware of the extent of the problems Denise was experiencing with Roland, although following the assaults in April and May 2013, Denise's family became involved in supporting her, offering her a safe place to stay and continuing to advise her to end the relationship with Roland and to report any contacts from him to the police.

The family's view regarding agency involvement with Denise was that the police had done what they could to support Denise and that, following Denise's death, the police had provided good support to the family.

They queried why Roland had not been arrested following the assaults on Denise and why he had not been detained following contact from his solicitor on 25th June 2013. They also had concerns about agency involvement with Child A and Child B. They reiterated that Denise was a devoted mother who put the safety of her children first. They were not aware of a written agreement with Children's Social Care and asked that this be explored and explained within the DHR Review process.

[10] Two further members of Denise's family, together with Denise's mother, spoke to the author again before publication of the report.

The family asked to be kept informed about the DHR process and outcome. The Independent Author undertook to report back to the family once the DHR was nearing completion, taking into account that the trial of Roland and the IPCC investigation were likely to delay the completion of the process.

Following approval of the report by the Home Office in April 2016 the Independent Author met with members of Denise's family to share the report with them. They reiterated their views that CSC had not acted in Denise's best interests in their approach to safeguarding the children as they had witnessed a social worker saying that the children would be removed, which had frightened and worried Denise. They also reiterated their views about the missed opportunity to interview Roland with his solicitor.

5 Conclusions and Lessons Learnt

Denise was a young woman with two dependent children. She had begun a relationship with Roland, a violent offender, in November 2012. The extent of her knowledge about his history of domestic abuse is unknown, however, following an alleged violent sexual assault upon Denise in April 2013 and a further violent assault in May 2013, her relationship with Roland became known to agencies.

Denise's engagement with a range of services in relation to domestic abuse was inconsistent which is not unusual given the control, coercion and fear experienced by victims of domestic abuse.

Denise had confided to a friend that she was in fear of Roland, however, she appeared to minimise the abuse she was suffering at the hands of Roland when in contact with agencies. In hindsight, it is possible that an over-optimistic view of Denise's ability to disassociate and understand the risk that Roland posed was taken by the single and multi-agency professionals involved in this case.

Throughout the process of this Review, it has been evident that various multi-agency partners attempted to offer support and interventions to Denise. Denise commented to police that she felt 'harassed' by the number of agencies and contacts she received. There could be a suggestion that Denise was overwhelmed by professionals' attempts to engage her which had a paradoxical effect of discouraging Denise from engaging with services.

There was no single lead professional or advocate available to Denise who might have provided a more co-ordinated approach towards offering support and building a trusting relationship with her, and the Panel makes a recommendation in this regard.

Although both Denise and Roland had contact with a number of agencies prior to the reporting of the first alleged assault, they were not linked by agencies in any way as they did not live at the same address at any time.

Opportunities for the specialist domestic abuse service to intervene were limited by Denise's reluctance to engage with them. Whilst it is not possible to compel a victim to enter what is a voluntary engagement service, this Review poses questions about who (which agency) could have been an advocate for Denise, and whether family engagement in cases such as this, where the family is willing to support, may be more effectively sought and utilised.

Roland was a known violent offender with a significant history of domestic abuse and other violent offences. His relationship with Denise was unknown by any of the agencies involved in the Review prior to the incident that was reported to the police by Denise F on 29th April.

Following this incident, it was only possible for agencies to link Denise and Roland on self-reported information. However, there were opportunities to share information about the level of risk that Roland presented to Denise that were not acted upon. There is no indication that Denise was informed of Roland's history of domestic abuse under the Domestic Violence Disclosure Scheme.

Multi-agency information-sharing systems in relation to high-risk perpetrators, where they exist, do not address the dynamic aspects of risk management and there appears to be no 'whole system' approach for managing risk, other than the MARAC process which, whilst it is procedurally fit for purpose, receives a very high volume of cases and is held infrequently.

Children's Social Care took action to safeguard Child A and Child B, although a 'whole family' approach to reducing risk is not apparent. A stronger multi-agency focus on safeguarding the whole family that takes account of the victim's vulnerabilities is recommended by the Panel.

5.1 Findings

5.1.1. Finding 1 – Multi-Agency Information Sharing

There is no multi-agency information sharing system that would have enabled agencies to link Denise and Roland prior to the first reported incident in April 2013. Therefore, self-reported disclosure of domestic abuse by Denise or Roland would have needed to take place to enable agencies to act.

Following the incident in April 2013, after which Denise disclosed domestic abuse to the police who discussed this with other agencies through the MARAC process, she did not directly disclose domestic abuse to any other agency involved in this Review.

When Denise was referred to MARAC, relevant information regarding risk was shared with Denise's GP and other agencies, however, Denise did not have contact with any service other than police between the MARAC meeting and her death.

The specialist alcohol service identified the need to ensure that their protocol in relation to domestic abuse is updated and that information-sharing is improved.

This raises learning in relation to the disclosure and sharing of information between agencies for high-risk victims and perpetrators of domestic abuse (see Recommendation 1).

5.1.2. Finding 2 - Police Actions

The serious sexual assault report by Denise F on 29th April 2013 was not followed up until 9th May 2013. This is an unacceptably long period of time for an assault of such a serious nature.

Although Denise failed to attend a meeting with the police following the 9th May contact, the next contact from GMP was 18th May. Again, given the seriousness of the allegations this appears to be an unacceptably long delay.

It is the Panel's view that the decision not to interview Roland on 27th June with his solicitor was a missed opportunity.

Whilst it may not have impacted the police management of the case, the Panel was of the view that the risk rating applied to incidents should have remained at high, given the seriousness of the first reported incident and the known history of the offender.

5.1.3. Finding 3 – Safeguarding Children who witness/experience domestic abuse

Children's Social Care entered into a written agreement with Denise regarding the safeguarding of her children. It is the view of the Panel that a high-risk case such as this should have been considered immediately under S47, with subsequent support and intervention. Although the children's safeguarding was assured, the impact on Denise was not given sufficient consideration. A multi-agency full strategy meeting could have been put in place to provide a more holistic approach to Denise and her children. As it was, Denise was also perceived as presenting a risk to her children.

There is learning in relation to the role of Children's Social Care in high-risk domestic abuse cases. Whilst it is right that the focus should be on safeguarding the children, there is more to be done to safeguard the whole family.

5.1.4. Finding 4 – MARAC Processes

In this case the MARAC meeting that took place on 11th June was not clear in relation to the required actions by the agencies present and how these would affect outcomes in the case.

Discussion of the case was brief and centred on attempts to arrest Roland. The audio recording of the case is of poor quality, however, it is apparent that there is a lack of clarity in the recording of actions from the meeting and mechanisms for follow up.

5.1.5. Finding 5 – Engagement with Support Services

Denise had numerous contacts with police, so much so that she commented that she felt harassed by services. She was also offered support from Children's Social Care and from SIDAAS. She declined a service from SIDAAS and, in line with the agency's policies, no further attempts were made to engage Denise.

This Review raises the question as to whether there is a more effective means of engaging high-risk victims of domestic abuse in support services. The appointment of an advocate or lead professional, who could act as the single point of contact for the victim, has been discussed by the Panel and a multi-agency recommendation is made in this regard. The Panel also recommends that further work is done to maximise the engagement of supportive family members in protecting the victim and liaising with agencies (with the victim's consent).

5.1.6 Finding 6 – Communication and Liaison between Health Services

There is no single information system that links what may be broadly termed as 'health services' together. However, the sharing of information between primary and secondary care services could have been stronger. A recommendation is included at section 6 proposing that there is a multi-agency focus on improving the sharing of information in relation to high-risk cases of domestic abuse.

6 MULTI-AGENCY RECOMMENDATIONS

Based on the information available to the Panel during this Review, and in response to the findings of the Review, the Panel has made six multi-agency recommendations. A multi-agency action plan is attached at Appendix 2.

Recommendation One:

6.1 Multi-agency systems for information sharing need to be strengthened, particularly where this relates to high-risk victims and perpetrators of domestic abuse. The dynamic nature of domestic abuse and the potential for rapid escalation of risk should be addressed within multi-agency information sharing protocols and processes.

Recommendation Two:

6.2 The recent local review of MARAC is welcomed by the Panel. The CSP should ensure that: MARAC meetings are given full support from all agencies; that they are effectively chaired; that sufficient time is afforded for a full discussion of each case; that agencies actions are clear, and; that actions are linked more strongly to positive outcomes for the victim. If audio recordings are to be used to record meetings, it should be ensured that these are of sufficient quality to evidence actions from meetings.

The CSP should give consideration to introducing a system to increase the frequency of MARAC meetings (see recommendation 6.3 below).

Recommendation Three:

6.3 Multi-agency management of high-risk domestic abuse cases should be undertaken with greater frequency. The creation of a multi-agency safeguarding hub (MASH) designed to specifically address learning from this Review should be considered by the local Community Safety Partnership with the support and active involvement of all relevant agencies.

Recommendation Four:

6.4 The CSP should review the domestic abuse policy in relation to supporting and engaging victims, particularly where they are reluctant to engage with services. Consideration should be given to the role of the local independent domestic abuse service alongside the identification of an advocate or lead professional to act as the single point of contact for high-risk victims.

Recommendation Five:

6.5 The role of families in supporting victims of domestic abuse should be further explored to ensure that opportunities for support, advocacy and safeguarding are maximised.

Recommendation Six:

6.6 Children's Social Care should strengthen its policy and practice in relation to the use of written agreements to protect the children of high-risk victims of domestic abuse. An updated multi-agency policy in relation to the children of high-risk victims, that includes liaison with victim based services, should be put in place.