TEAM BURY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

19.10.2016

Jamie

This report is the property of Team Bury Community Safety Partnership. It must not be distributed or published without the express permission of the Chair.

Chair and Author David Hunter

October 2016

CONTENTS

1. INTRODUCTION 3

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW 5

3. BACKGROUND: 10

4. THE FACTS BY AGENCY 14

5. ANALYSIS AGAINST THE TERMS OF REFERENCE 24

6. LESSONS IDENTIFIED INCLUDING GOOD PRACTICE 42

7. CONCLUSIONS 45

8. PREDICTABILITY/PREVENTABILITY 48

9. RECOMMENDATIONS 49

Appendix A- Redacted Letter from Bury Safeguarding Children Board 50

Appendix B - Definitions 51

Appendix C – Health Visiting Policy 52

Appendix D – Action Plan 53

Appendix E - Letter from the Home Office 61

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Jamie	Victim [Less than 40 years]	White British
Roger	Offender and Partner of Jamie [Less than 40 years]	White British
Child 1	Child of Jamie and Roger	White British

1.2 The events described in this report begin in September 2009 when it is believed that Jamie and Roger formed a relationship and end with her death in February 2016. There was one domestic incident between them in 2010 and nothing else reported until late 2015 when the deteriorating relationship came to the attention of the police. As the events unfold it will be seen that Roger was a jealous person who displayed coercive and controlling behaviour towards Jamie. He had difficulty controlling his anger and in the months before the homicide the risk of serious harm he presented to Jamie increased. At the time of the homicide the relationship appeared to have ended and Roger had moved out of the home leaving Jamie living alone with Child 1.

1.3 In February 2016 Roger told a friend in a telephone call that he had strangled Jamie and left her unconscious at her home. The friend informed the police who attended the address.

1.4 On entering the house the police noted blood leading from the front room, through the hallway and up the stairs. They found Jamie's body on her bed; she was fully clothed apart from one shoe; the other had been discarded on the stairs. Jamie had a ligature tightly secured round her neck. She also had head, face and eye injuries. There was blood on her blouse, the bed and bedding. A post mortem determined Jamie's death was caused by manual strangulation. It is now known that Roger hid in the loft overnight and confronted Jamie the next morning as she was getting ready for work.

1.5 Child 1 was found physically unharmed in a playpen on the ground floor of the house and appeared to have been dressed for the day.

1.6 Roger was arrested nearby and charged with Jamie's murder. In early summer 2016 Roger pleaded guilty to Jamie's murder and was sentenced to life imprisonment with a minimum tariff of sixteen years. This means he will not be eligible for parole until that sixteen years has passed.

1.7 The Judge's sentencing remarks included, "This was a callous, calculated, pre-meditated and planned killing. You convinced yourself quite wrongly this lady had had sex with another man. You were told on a number of occasions that this was not true. But you chose to ignore that advice.

"You chose to continue to be driven by that jealousy and sheer possessiveness and you hatched a plan to wreak revenge. You hid yourself in the loft and awaited her return. I have no doubt that you intended to kill her".

"I reject your assertions that you were in the house because you just wanted to be close to your 'child', and that you just wanted to scare Jamie."

1.8 Jamie's family said she was, "A loving mother, daughter and sister and a great friend to so many. Jamie was fun-loving and hardworking, she had a big heart and will be forever missed." Child 1 now lives within Jamie's family.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

2.1 Decision Making

2.1.1 Team Bury Community Safety Partnership decided on 23rd February 2016 that the death of Jamie met the criteria for a Domestic Homicide Review[1] as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 [the Guidance].

2.1.2 The Guidance states the review should be completed within six months of the decision to hold a review being made. In this case that date was 23rd August 2016.

2.1.3 On 20th April 2016 Bury Safeguarding Children Board's Case Review and Learning Sub-Group screened Child 1's case and recommended that it did not meet the criteria for a child serious case review.

2.1.4 On 27th April the Chair of that Sub-Group wrote to the Chair of the Domestic Homicide Review requesting that five child safeguarding points be considered by the review and incorporated into the overview report.[2]

2.1.5 That request was supported by the Chair of the Community Safety Partnership and formally adopted by the review at its Panel meeting on 22nd June 2016. It was felt that the five points could be catered for within the existing terms of reference.

2.1.6 The completion date for the review was adjusted twice to cater for additional meetings the DHR Panel felt were necessary in order to thoroughly debate the case. The first adjustment was approved by the Chair of the Community Safety Partnership on 7th June 2016 and the second on the 25th August 2016. The final agreed completion date was 31st October 2016. The Home Office was informed.

2.2 Domestic Homicide Review Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 1st March 2016. He was supported by Paul Cheeseman. Both are independent practitioners who have chaired and written previous reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review and were judged to have the necessary experience and skills. The first of six panel meetings was held on 6th April 2016 at which the terms of reference were agreed.

2.2.2 Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

[1] Hereinafter referred to as the review, except when to do so would cause confusion.
[2] Letter at Appendix A

2.2.3 The core panel comprised:

Name	Role	Organisation
Martyn Burrell	Strategic Lead - Safeguarding	Bury Council Children Young People & Culture
Joyce Carroll	Administrator	Bury Council Communities & Wellbeing – Community Safety
Paul Cheeseman	Support for Chair	Independent
Clare Holder	Designated Nurse [Manager] Adult Safeguarding	Bury Clinical Commissioning Group [CCG]
David Hunter	Chair and Author	Independent
Safina Jabeen	Independent Domestic Violence Advocate	Victim Support
Anne Kubiak	Head of Safeguarding	Citywide NHS Safeguarding Team [Commissioning & and Quality] Manchester North, Central and South Clinical Commissioning Group
		Bury Clinical Commissioning Group
Maxine Lomax Head of Safeguarding		
Cindy Lowthian	Community Safety Manger	Bury Council
Amanda Murray	Detective Inspector	Greater Manchester Police
Sushma Parmar	Senior Probation Officer Partnership & Quality Lead	National Probation Service Manchester
Eileen Tighe	Specialist Nurse for Safeguarding Adults.	Pennine Care NHS Foundation Trust Community and Mental Health Services

2.3 Agencies Submitting Individual Management Reviews

2.3.1 The following agencies submitted Individual Management Reviews:[3]

- Manchester Citywide NHS CCG
- Early Years Bury Children, Young People and Culture Children Centre Bury Children's Social Care
- Children's Social Care Bury Council
- Greater Manchester Police
- National Probation Service
- Pennine Care NHS Foundation Trust.

2.4 Notifications and Involvement of Families

2.4.1 David Hunter wrote to Jamie's parents. The letter together with the Home Office Review leaflet for families and a leaflet from Advocacy After Fatal Domestic Abuse[4] were kindly delivered by the police Family Liaison Officer. The letter expressed the Review Panel's sincere condolences and explained that a review was underway and invited them to contribute. Jamie's parents were seen by the review chair/author on 22nd July 2016 in the presence of the Family Liaison Officer. They have seen the review report. Where their views appear in the report they are attributed.

2.4.2 The chair/author spoke with Jamie's brother on the telephone and his views appear as attributed.

2.4.3 A letter was sent to Roger's brother telling him about the review and asking him to take part. He replied by telephone on 11th July 2016 with the observation, 'There's nothing I want to say'.

2.4.4 Roger agreed to take part and was seen in prison by the chair/author on 19th August 2016 in the presence of his Offender Manager. Any views he expressed have not been verified.

2.4.5 Two of Roger's friends were seen on 19th August 2016 and their observations are noted in the report.

2.4.6 Jamie had three work colleagues who she spoke to about her relationship with Roger. The chair/author spoke with the company's head of personnel who approached the three colleagues about contributing to the review. None of them wanted to take part because they had already given statements to the police and the death of Jamie had left them shocked. They had received workplace support from the company and felt unable to revisit painful matters.

2.4.7 The colleagues' statements were made available to the review and the content used where appropriate.

---

[3] IMRs are written reports which critically examine an agency's involvement with the subjects of the review against the terms of reference.

[4] AAFDA is a charity that supports families involved in domestic homicide reviews.

2.4.8 The head of personnel was re-contacted by e-mail and requested to ask Jamie's three colleagues to reconsider their decision in light of their statements being seen. No reply was received. At a meeting of the review panel on 23rd August 2016 it was decided not to pursue contact with Jamie's work colleagues and instead consider relevant material from their statements.

2.4.9 The pseudonyms used in the report were chosen either by family or, in Roger's case, by himself.

2.5 Terms of Reference

2.5.1 The purpose of a Domestic Homicide Review 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, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7]

2.5.2 Timeframe under Review

The Domestic Homicide Review covers the period 20.09.2009 to 19.02.2016.[5]

2.5.3 Specific Terms

1. What if any indicators of domestic abuse did your agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?
2. How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?
3. Were single and multi-agency policies and procedures followed; are the procedures embedded in practice and were any gaps identified?
4. When dealing with the victim and/or offender did your agency take into account the child safeguarding issues and what did you do with them?[6]

[5] The start date is when the relationship began and the end date was extended to look at the child safeguarding arrangements post the homicide.

5. What knowledge did the family, friends and employers have of the adults' relationship that could help the Domestic Homicide Review Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

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

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

8. How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

9. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

---

[6] Term 4 was used to consider the points raised by Bury Safeguarding Children's Board.

3. BACKGROUND:

Note: The information in this section is drawn from the documents seen by the Panel and contributions from family members, friends and work colleagues. It also contains unverified information from Roger obtained by the chair/author during a meeting in prison.

3.1 Jamie

3.1.1 Jamie was one of two children born and brought up in Manchester. She was educated locally and on leaving school took up employment in hairdressing and after three years decided it was not for her. She then worked as a sales assistant in sports retail before moving on to 'project' management for a builder.

3.1.2 Jamie always wanted to work in banking and secured a post with a national high street bank. She formed a relationship with a man from another city. She moved home and transferred her employment and was due to be married in 2006. However, it did not happen.

3.1.3 Jamie returned to Manchester, bought a house and transferred back with the bank. She met Roger in September 2009 albeit she kept it quiet from her parents for a while. They did not take to Roger and while they knew something of his criminal past they had no idea of its extent. They believed he contributed nothing or very little to the household income after he moved in with Jamie. Her parents had to maintain a delicate balance between criticising/tolerating Roger. If they pushed too hard they were concerned that Jamie may stop seeing them as much.

3.1.4 After a while she obtained a job at a Bury wealth management firm and also had a part time job working in a bar/restaurant to supplement her income.

3.1.5 In February 2012 Jamie obtained employment at another national wealth management company. Her parents said she really enjoyed the job. She developed her career and was appointed as a risk manager. The head of personnel for the company said Jamie was very well thought of and had a promising career.

3.1.6 She owned and lived in her own home and was a successful woman and mother. Friends described Jamie as outgoing, caring, a really nice person who unselfishly helped others.

3.1.7 Her parents describe Jamie as; a loving doting mother: hard working and ambitious, very well-liked by people; she could be feisty and stubborn and was very kind. She is much missed and much loved by her child, parents, brother and friends. The family and friends cannot comprehend why Roger took Jamie's life. They remain devastated by the events.

3.2 Roger

3.2.1 Roger was the middle of three siblings from a Manchester family. His father left the family home when he was about six years of age. His mother told him he just walked out. His mother formed another relationship and he was brought up by his step-father who treated him well. When he was twelve his mother told him his father had been sent to prison. Roger has not seen his father and does not know if he is still alive.

3.2.2 Roger attended primary/secondary schools in Manchester. He was proud to say that he was a 'free reader' long before most of his classmates and that he was in the choir and leader of his school house. He described himself as 'very bright' and he was seen as 'a good lad'. That and his poor quality clothing singled him out as being different. He did not have many friends. He was permanently excluded from school aged about thirteen years. He said he just went off the rails following family bereavements.

3.2.3 From then on he lived on his wits and thieving. In his own words he was a 'scroat and a scally'. However, people looked up to him and he became popular, something he had not achieved at school. His only job was a week in a café which he secured after the owner was impressed with him because he took his empty plate back to the counter.

3.2.4 Prior to meeting Jamie he did not have any meaningful relationships and preferred brief encounters.

3.2.5 He was a heavy user of cannabis from the age of fourteen and also used other unlawful drugs such as cocaine. He recognised he was violent but only when people left him no option. He also recognised that he could be paranoid if he thought Jamie was in the company of other males. He was excessively jealous.

3.2.6 In the year before Jamie's death he had some work as a general labourer in the construction industry but his preference was for staying at home and passing his time on a Play Station.

3.3 Jamie and Roger's Relationship

3.3.1 Jamie met Roger in September 2009 at a Gay Pride event and they ended up sitting together. They spoke of shared childhood experiences and Roger said that Jamie was impressed by his empathy. Over the next few months the romance blossomed, culminating in him moving into her house just before Christmas 2009. He said he felt very 'comfortable' there and for the first time in his life he felt good about himself and the future.

3.3.2 Friends say that the relationship seemed normal and they socialised as a couple. It is known from local authority records that between 2010 and 2014 he claimed Housing Benefit. He said he gave this to Jamie as his contribution to the household income as he was never in regular work.

3.3.3 Roger's jealousy and paranoia soon emerged when in February 2010 he locked himself in a room and threatened suicide after Jamie went alone to a party, after finishing work in a pub/restaurant. [Paragraph 4.3.1]

3.3.4 Jamie's family said she was focussed on her work and was building a career. She was financially independent. Roger was transient in his work and held temporary jobs interspersed with unemployment. This divergent work ethic contributed to the strain in the relationship. Family and friends say that Jamie was unhappy about Roger's attitude to work. He was content to stay at home playing computer games and smoking cannabis.

3.3.5 Child 1 was born in 2014. It appears from the accounts of those who knew the couple that the natural impact on Jamie of having a baby to care for was not

helped by Roger's lack of practical support. There also faced additional financial pressure when Roger stopped claiming Housing Benefit.

3.3.6 The tensions between them continued to increase and in the last six months of Jamie's life it intensified to the point where there were several police interventions. It is now known from friends that during this time the arguments between them sometimes involved Roger pushing and shoving Jamie. A more serious episode took place when he injured her throat/neck following a dispute in the street over child care.

3.3.7 They bickered a lot and split up several times. However, Jamie always had him back telling friends she loved him. In the few months before her death Jamie told friends the relationship was over. Three weeks prior to the murder Roger moved out of the house and stayed with relatives. He visited daily to help look after Child 1 and the dog.

3.3.8 After Jamie's death a picture of controlling and coercive behaviour emerged. Roger was jealous and when Jamie went to London on a business trip he constantly telephoned and sent her text messages wanting to know what she was doing. Jamie told friends that at one point Roger would not let her out of the house.

3.3.9 Jamie and Roger were at a party the week end before her death. Roger wrongly formed the view that she had been intimate with another man during the evening. In the few days following the party his extreme jealously was evident. As will be seen later he asked the police to examine a stain on Jamie's clothing believing it would prove she had been with another man. He told one friend that he would torture Jamie to get the truth.

3.3.10 On the day of her death Jamie sent a text to Roger saying, 'Getting a restraining order against you so goodbye'.[7] She told a friend that she was frightened of Roger and was advised to lock and bolt her doors. But as is now known Roger was already in the house hiding in the loft.

3.4 Prison Visit with Roger

3.4.1 The chair/author saw Roger in prison. Also present was his Offender Manager from the National Probation Service. During the meeting in prison it became apparent to the chair/author that Roger had very fixed and inflexible views on relationships and his expectations of them. For example during one period of separation he turned up by appointment to look after Child 1. He said this did not fit Jamie's altered plans who told him to go away. Roger said she just could not do that and he insisted on taking Child 1 which was resisted by Jamie. The police then became involved.

3.4.2 On another occasion he telephoned the police to say he was going to collect Child 1 requesting they attend the house to ensure nothing happened. The police declined; he went to the house and demanded to take Child 1. Jamie refused and Roger told her she was not leaving the house with the child. Jamie called the police.

3.4.3 At this point in the interview he exhibited signs of what might be viewed as misogyny. Roger said the police only take incidents seriously when the woman telephones them; where were they when he telephoned. He added that 'girls want

[7] Jamie's parents say she did not see a solicitor.

to change you'. Another row was caused by what he said were unsolicited pictures of sparsely attired young women appearing on his Facebook account. Roger conceded to Jamie's 'demand' that he deactivate the account. Roger said if I did this she should do something in return as it was only right. He appeared not to understand the concept of compromise.

3.4.4 When spoken to about the 'throat' incident Roger claimed he only put his forearm across Jamie's throat as a defensive gesture following a dispute over who was going to look after Child 1. He said Jamie grabbed his hand in an attempt to stop him taking the child and in doing so she dug her nails into the back of his hand. He said the force of his forearm on her throat might have been a little excessive as a bruise later emerged on her neck. He said he told the police what he had done some weeks later.

3.4.5 He firmly believed that from day one of the relationship that Jamie held the balance of power; her home; her money. Roger claimed credit for motivating Jamie to seek the job with the second wealth management company. He said he urged her to go for it when money was tight.

3.4.6 There is no doubt that Roger was jealous of Jamie in terms of any friendship with males or opportunities for being alone with them. He did not acknowledge that threatening suicide was a means of getting his own way but justified the incidents by saying he was stressed and under pressure. Roger did not concede that such actions were controlling and coercive behaviour. He does acknowledge he has a short temper and has been violent to men when they left him 'no option'.

3.4.7 He said he was not looking for a face saving exit from the relationship and that all he wanted was to know whether Jamie had been with another man on the night of the party. [Jamie's parents point out that at that time the relationship was over so what business was it of Roger's who Jamie might have been talking to.] Roger felt Jamie should have subjected herself to hypnotherapy as that would have proved who was right, him or her. He said she could also have taken a lie detector test. Both of these suggestions reveal the extreme and wholly unreasonable views he held.

3.4.8 He was asked, 'Who do you blame for Jamie's death'? He immediately replied, 'the police". He believed the police should have sent someone when he was due to collect Child 1 so that there would be no friction; they should have tested the garment to determine whose semen it was; they could have hypnotised and/or subjected Jamie to a lie detector test to obtain the truth. He said the police always take the woman's side.

3.4.9 He then said there was manipulation/conspiracy to paint him in a very bad light in the press which resulted in him being on a vulnerable person's wing in prison.

3.4.10 The chair/author's view of Roger is that he is a violent immature man with rigid non-mainstream views on how relationships should work. He is an extremely jealous person who by his own admission is paranoid about being 'cheated' on and whose conflict resolution skills in such situations are intransigent, unhelpful and unrealistic. He is a minimiser and does not fully accept responsibility for Jamie's death.

4. THE FACTS BY AGENCY

4.1 Introduction

4.1.1 The agencies that submitted IMRs and chronologies are dealt with separately in the following narrative which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 5.

4.2 National Probation Service - Formally Greater Manchester Probation Trust

4.2.1 Roger was first convicted aged fifteen years and subsequently gathered twenty seven convictions including ones for violence and dishonesty. He offended to support his lifestyle of drink and drugs. His violence involved the unsolicited 'championing' of people who he felt had been unjustly treated. Here are two examples from the Probation report.

4.2.2 Roger sought out and assaulted a male who had insulted his friend. On another occasion, while living in Approved Premises, he was violent to a person who he felt was bullying his friend.

4.2.3 On 1st July 2006 Roger and a friend assaulted a Metro Link Guard because they wrongly thought he was 'hassling' a passenger for a fare. He received a 44 months Extended Public Protection sentence for a section 20 Wounding.[8] The sentencing Judge said the assault was, "Unprovoked, prolonged and disgusting … you broke his nose and gouged his eye. He could have been blinded". During the early stages of his sentence Roger remained nonchalant about the impact of the assault. While in prison Roger completed the Enhanced Thinking Skills Programme.[9]

4.2.4 He was released on licence on 18th January 2009 to Approved Premises.[10] He was registered as a Prolific Priority Offender and assessed using OASys[11] as posing a medium risk of causing harm to the public. He was managed by a Probation Support Officer.[12] The National Probation Service now view that risk assessment as

---

[8] Section 20 Offences Against the Person Act 1861

[9] Rather than targeting specific offending behaviour, TSP targets 'offenders who have been assessed as having particular cognitive and social dynamic risk factors'. TSP is intended for young adult and adult, male and female offenders, who (1) are assessed as medium and high risk of offending, (2) possess the treatment needs targeted by the programme, (3) have responsivity needs that can be met by the programme, and who (4) are ready, willing, and (5) able to take part in the programme. Source: Ministry of Justice The Thinking Skills Programme Submission Document February 2010

[10] Approved Premises provide controlled accommodation for offenders under the supervision of the probation service. They provide a greater degree of supervision for offenders than is possible in other forms of housing. Residents follow a structured regime, which includes an overnight curfew. There is 24-hour supervision at the Approved Premises by trained staff.

[11] Offender Assessment System is a risk and needs assessment tool used by the National Probation Service.

[12] Probation Support Officers do similar work to qualified Probation Officers but only supervise low and medium risk offenders.

inaccurate and that the actual risk posed by Roger was high. The reasons are explored under the terms of reference.

4.2.5 Roger was referred to Alcohol and Drug services but avoided contact. His abstinence from alcohol was apparent during his residency in Approved Premises. He acknowledged smoking cannabis and twice tested positive for cocaine. He mixed with former associates but despite awareness that mutual peer influence was an acute risk factor this was not challenged. On 24th April 2009 he was recalled to prison when he failed to return to the Approved Premises.

4.2.6 On 8th July 2009 he was released on licence to Approved Premises. Roger was again supervised by a Probation Support Officer with oversight by a qualified Probation Officer. He attended drug services on the day of release and continued to present anger management issues when challenged or if he perceived injustice.

4.2.7 Roger was required to undertake the Addressing Substance Related Offending programme.[13] His behaviour on this programme was inappropriate in that he held and expressed a grievance that his confidentiality had been broken when information he had given a member of staff about him 'coming across a lot of money' was shared with his Probation Support Officer.

4.2.8 On 22nd September 2009 Roger told his Probation Support Officer that he had met a girl who was a long term friend and that he was 'taking it easy'. He stated she is not a criminal and does not condone his cannabis use. It is now known this was Jamie.

4.2.9 In a subsequent session Roger said he had no intention of giving up cannabis and did not know why he was on the programme but would continue attending as he did not want to be recalled. He shifted that position in later sessions by suggesting he would 'cut down' his cannabis use. In the event the programme was terminated because the numbers attending made it unviable. He moved to other accommodation and remained under probation supervision. During one meeting in October 2009 Roger said he had stopped using cannabis because of its cost. He felt agitated and restless.

4.2.10 The Probation Support Officer wanted to visit Jamie at her home. This is a routine procedure. Roger was not happy about this and prevaricated. There is no record of a home visit being made.

4.2.11 On 19th November 2009 the following entry appears in probation's records. 'Review of Roger case – states that Roger to resume Addressing Substance Related Offending programme and then complete the Controlling Anger and Learning to Manage programme. The following day it is noted on the record that Jamie is a positive influence on Roger and that she does not have children.

4.2.12 Roger was warned about his behaviour in December 2009 when he threatened to spit in the face of a probation officer. In January 2010 he said during a training programme that, "he feels in some circumstances aggression is the only way to

---

[13] A drug and alcohol cognitive behavioural intervention designed to assist offenders address drug and alcohol related offending and to reduce or stop substance misuse.

deal with someone." On 12th January 2010 he was deregistered as a Prolific and Priority Offender.

4.2.13 In June 2010 Roger described his relationship with Jamie as brilliant. In August the same year he reported being in work at a national transport company in Greater Manchester.

4.2.14 On 24th September 2010 his licence terminated and he was no longer under the supervision of Probation.

4.3 Greater Manchester Police

4.3.1 There were eight contacts between Jamie and/or Roger and the police that are particularly relevant to the review. None of them concerned physical violence but do show elements of controlling and coercive behaviour by Roger against Jamie. The contacts were:

Relevant Contacts	
Date	Details
8.55 am 28.02.2010	Jamie reported that Roger had locked himself in a bedroom and was threatening to kill himself. They had argued as she had been out all night with friends but Roger believed she was seeing a man. Both appeared intoxicated and Roger was verbally aggressive and uncooperative with the officers. He agreed to leave the premises and the situation appeared to have been resolved.
5.53 pm 28.02.2010	Jamie reported dispute with Roger had continued. He had locked himself in a bedroom and was 'agitated and emotional.' He was arrested in order to prevent a breach of the peace. Both incidents were referred to the Public Protection Investigation Unit who assessed the risk to Jamie as 'Medium' and sent her a domestic violence letter.
11.11.2015	Jamie reported a dispute with Roger over Child 1. Roger left for work and had been 'verbally aggressive' towards Jamie, threatening to take Child 1. Jamie requested to be seen after work. When seen, Jamie stressed she and Roger had been arguing about child care and she simply wanted some advice. Details of the incident were referred to Public Protection Investigation Unit and the risk to Jamie assessed as standard. A STRIVE officer[14] visited the family at their home on 14.11.2015. The incident remained at standard risk. Details were shared with Children's Social Care and Health Visiting.

[14] STRIVE is a Greater Manchester wide multi-agency approach to help victims, perpetrators, families and friends resolve issues that can potentially escalate and become worse. There

The Contact form sent by the Police to the Multi Agency Safeguarding Hub[15] has the following entry. 'The couple are separated however are still currently residing in the same house'.

Nowhere on the form does it record the date of the incident.

16.12.2015 Police attended a disturbance in a street having been called by a neighbour.[16] Jamie and Roger were arguing over Child 1 who was being carried by Jamie in a car seat. Roger was trying to prevent Jamie from putting Child 1 into the car. Jamie stated the argument had been verbal and not physical. The incident log recorded that no offences had been identified and the risk was assessed as standard and referred to the Public Protection Investigation Unit who did not share the information through the Multi Agency Safeguarding Hub.

Post Jamie's death the Police learned that her next door neighbour had also witnessed the dispute and saw Roger grab Jamie by the throat. The neighbour called Jamie's father and told him what he had seen. Jamie's father called Jamie's brother, and relayed the message as he lived closer to the address.

A statement made by Jamie's brother said that after receiving the message from his father he went straight to the address where he saw Roger sitting outside crying. The police were still present. The brother said,

'I just walked past him, not breaking stride and I told him not to put his hands around my sister's throat'.

05.01.2016 Jamie reported that Roger had turned on the gas in the kitchen of her house and was threatening to kill himself following an argument. Roger had not assaulted or threatened her during the argument but suggested she left with the dog for their safety. Roger suffered no ill effects and was taken to hospital for assessment. Child 1 was not present during this incident. Jamie's father believes the child could have been in the car outside the house. The risk to Jamie was assessed as medium and referred to Public Protection Investigation Unit

A specialist officer concurred with the medium risk and discussed a safety plan[17]with Jamie for herself and Child 1. A domestic violence

---

is agreed criteria for STRIVE referrals [less than 3 police call outs, standard risk, no crime committed].

[15] This is a scheme whereby professionals from different agencies work together to share information and make decisions on child safeguarding. Contacts into the Multi Agency Safeguarding Hub can result in no further action, information shared, advice given or referrals into Children's Social Care.

[16] There is no information on the police log that this neighbour saw Roger assaulting Jamie.
[17] The plan comprised: general safety advice; the addition of the marker, lock the doors and not let Roger in. If there was an incident then she should phone 999 straight away and just

	marker was placed on the address; the matter was shared with Children's Services, Health Visiting and Probation. The Contact form sent by the Police to the Multi Agency Safeguarding Hub on 25th January 2016 has the following entry. '…He was to stay with brothers who reside near to the hospital for a couple of days to allow the situation to cool down. Jamie has advised that this is the end of the relationship and she will speak with Roger at a later date to advise him of this fact and she will ask him to move out and remove his property from her house but will make arrangements for Roger to see his daughter on a regular basis'.
11.01.2016	Jamie and Roger reported a dispute at her address. Roger was outside requesting access to Child 1. Jamie refused him entry. Jamie was about to take Child 1 to her mother's and was concerned that Roger would prevent her or try to take the child himself. Officers attended and advised them to seek legal advice and referred the incident to Public Protection Investigation Unit. This and the incident on 05.01.15 were assessed by a specialist who spoke to Jamie and discussed a safety plan for Jamie and Child 1. A domestic violence marker was created for the address. The risk assessment remained at medium and the information shared with the Multi Agency Safeguarding Hub.
11.02.2016	Roger reported to the police that he and Jamie had attended a house party and he suspected she had a 'sexual fluid' stain [semen] on her clothing and requested it be examined to identify the source. He said Jamie had no recollection of what he considered was a potential sexual assault. He was advised the police would need to talk with Jamie. He stated he had no fixed address. Despite the existence of a domestic violence marker on Jamie's address, no contact was made with Jamie to ascertain her or Child 1's safety or alert her to Roger's contact.
12.02.2016 7.47 am	A friend of Jamie's contacted police expressing concern for her welfare. The previous day, the friend had received a text from Roger stating that he was going to 'do her in.' The friend had just been awoken by a further text from Roger which simply stated 'too late.' Police officers went to her address and found her body. Child 1 was safe in her playpen.

4.3.2 The above events will be explored in more detail within the analysis. However, it is immediately apparent that in the three months prior to Jamie's homicide the relationship was deteriorating and the risk to Jamie increasing.

---

give her address details. If she was subjected to any more DV she should ensure that her and Child 1 got to a place of safety as soon as possible.

4.4 Children's Social Care

4.4.1 Bury Children's Social Care had a number of contacts with Jamie and Roger. These can be grouped round three events.

Event One

4.4.2 On 13th October 2015 Bury Children's Social Care received information from a neighbouring authority that when Roger was nineteen years old he stamped on the head of a fourteen year old and was sent to prison. This came to light when the neighbouring authority conducted checks when it was suggested that Roger could be a carer for a family member. Children's Social Care verified the information with Roger and said he was happy for checks to be made with Child 1's health visitor. He was also advised that Jamie would need to be spoken to and he became angry.

4.4.3 Two days later Jamie telephoned Children's Social Care who shared the information with her. Jamie said she was fully aware of Roger's history and she had no concerns for the welfare of Child 1 adding that a social worker could undertake an assessment and that it was alright for the family's health visitor to be contacted.

4.4.4 On 16th October 2015 a social worker contacted the health visitor who advised Child 1 was last seen on 11th September 2015 and that there were no concerns in Child 1's records.

4.4.5 The case was dealt with as no further action using the following reason. "Jamie has been spoken with and she has put into perspective what the family are currently going through hence the anger displayed by Roger. She informed, he was no risk to their child and she would not be with him if he was. She was happy for any checks to be undertaken. There is nothing to suggest that Roger would be a risk to his own child given the incident with the fourteen year old was twenty years ago".

Event Two

4.4.6 On 4th December 2015 the Multi Agency Safeguarding Hub received a domestic abuse referral from the police Public Protection Investigation Unit following the 11th November 2015 verbal dispute between Jamie and Roger over who should look after Child 1. The time it took the referral to be made will be examined in the analysis.

4.4.7 The referral stated that Roger was Jamie's ex-partner but later said they lived together and were hopeful of working things out. They were advised how to access the family court but urged to talk to each other first. Jamie accepted the risk which amounted to verbal arguments.

4.4.8 On the 7th December 2015 the health visitor reported she had no child safeguarding concerns and had last seen Child 1 on 11th September 2015.

4.4.9 In closing the case as no further action, it was noted:

"Toxic Trio - Substance Misuse - No, Mental Health Issues - No,
Domestic Abuse - Verbal Argument

4.4.10 A domestic abuse leaflet was sent to Jamie. The Panel noted that substance misuse and mental health featured in Roger's life and therefore in the lives of Jamie and

Child 1. It had been almost three months since Child 1 had been seen. These points are revisited in the analysis.

Event Three

4.4.11 On 25th January 2016 the Multi Agency Safeguarding Hub received two referrals from the police Public Protection Investigation Unit. They were for the 'gas' incident on 5th January 2016 and the dispute over Child 1 on 11th January 2016.

4.4.12 A Multi-Agency Safeguarding Hub worker spoke to Jamie on the telephone who said that the issues between her and Roger had been around his contact with Child 1 and his cannabis use. Roger contacted the Multi Agency Safeguarding Hub who advised him that any further domestic abuse incidents would result in a child and family assessment being undertaken. Both parents were told of the impact domestic abuse has on children. Jamie was provided with details of the on line freedom project.

4.4.13 The matter was concluded as no further action without health visiting having returned the Multi Agency Safeguarding Hub's calls. The rationale for closure was documented as:

'The father Roger … is smoking cannabis and has recently attended A/E due to poor Mental Health. There has been 4 D/V from 2010/15.

The mother Jamie … has been spoken to and confirms separation from Mr … She is in agreement to facilitate contact.

Should this couple have a relationship reconciliation they have been informed an assessment will need to be completed?

Ms … is currently acting as a protective mother. No further role. Advice give and information shared regarding the impact D/V can have on children if living in a hostile environment'.

4.4.14 The analysis will consider:- the time taken for the police to make the two referrals; the appropriateness of the advice given to Jamie and Roger [including signposting Roger to drug services]; the decision taken to 'no further action' a medium risk of harm case to an adult without information from health visiting and firm plans to alert the Multi Agency Safeguarding Hub should any agency professional know or suspect that Jamie and Roger had reformed their relationship.

4.5 Pennine Care NHS Foundation Trust

Health Visiting

4.5.1 Health Visiting provided its Universal Programme to Child 1. This changed to Universal Plus[18] on 10th December 2015 following notification by the Multi Agency

[18] Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children. NHS England 2015-16 National Heath Visiting Core Service Specification.

Safeguarding Hub of the domestic abuse incident of 11th November 2015. Appendix C explains the different levels of health visiting services. In essence Universal Plus meant that Jamie could approach the health visitor for advice on specific issues.

4.5.2 The first indication of domestic abuse in the family received by health visiting was on 16th October 2015 when contact was received from Children's Social Care to say that Roger had a history of violence. That fact was noted.

4.5.3 On 7th December 2015 information was shared by the Multi Agency Safeguarding Hub with the health visitor about a domestic abuse incident on the 11th November 2015. Health visiting was not previously aware of this and nothing had been reported by Jamie. On the 15th and 17th December 2015 a health visitor left messages for the referrer to provide an update. Those calls were answered on 29th January 2016 by a health practitioner within the Multi Agency Safeguarding Hub.

4.5.4 On 4th February 2016 the domestic abuse incident of 25th January 2016 was shared with the health visitor via the Multi Agency Safeguarding Hub. In response to this information the health visitor spoke with Jamie on the telephone on 11th February 2016 and gathered an important piece of information.

4.5.6 Jamie reported she and Roger had ended their relationship and he had moved out of the property. Jamie stated there had been several incidents of verbal arguments and malicious comments from Roger threatening to take Child 1. She discussed two further incidents reported to the police; Roger turning the gas on in the house with intent to harm himself, and the neighbour contacting the police when Roger had hold of Jamie's throat. Health visiting had been informed of the gas incident but not the incident reported by the neighbour. Jamie said there were no plans to resume their relationship. This [11th February 2016] was the first time Jamie disclosed to a professional that Roger had grabbed her throat.

4.5.7 Jamie declined the health visitor's offer to see her at home to discuss support, saying she had been informed by the police of what support was available. Jamie was encouraged to continue reporting any future incidents. Jamie said she had support from her parents. The health visitor encouraged Jamie to access the health visiting service. Jamie stated "I'm not worried about me; I'm just worried what would happen if he took Child 1". Jamie said Roger was not currently seeing his child due to his malicious comments. The health visitor respected Jamie's wishes not to visit and advised her to report any concerns to them or the police.

4.5.8 The important information was Jamie's disclosure that Roger had put his hands round her throat; an act witnessed by a neighbour. Immediately after the call, the health visitor spoke with a social worker in the Multi Agency Safeguarding Hub and shared the throat holding incident. The social worker said the case was 'closed' as no further action. The Children's Social Care individual management review author has spoken to the social worker who does not recall having a conversation with the health visitor.[19]

---

[19] The Social Worker does not recall the call taking place. The issue has been discussed again by the case review group of the Bury Safeguarding Children Board. To seek assurances that this was an isolated occurrence it has been agreed for Pennine Care and the Multi-Agency Safeguarding Hub team to examine ten cases identified by Pennine Care where the discussions did not result in an action in Children's Social Care and look at:

4.5.9 The analysis will explore why health visiting appeared to accept 'a no further action' decision after sharing the throat holding incident.

Mental Health

4.5.10 Male A, accessed community mental health services following a referral by his GP. He attended one anger management session and did not engage any further with this support group. There is no reason recorded why he failed to attend any further groups.

4.6 General Practitioner

4.6.1 There is nothing of significance to the terms of reference in the medical records of Jamie and Child 1. The position with Roger is different.

4.6.2 He had many appointments to deal with depression which wavered in intensity. He took his medication sporadically. He felt that the anger management courses he underwent did not help. It was noted he may benefit from counselling-psychiatry which should be explored with him when discharged from probation. He completed his licence on 24.09.2010.

4.6.3 He reported being angry with his family because of their offending history and suffered the bereavement of his mother and grandmother. Other disclosures included smoking cannabis since he was sixteen. It was recorded that he could not read or write.[20] The evidence from Probation is that he was literate as demonstrated by the work he undertook on various programmes.

4.6.4 In December 2013 it was noted, 'his cannabis use led to paranoid ideation about other races and aggressive behaviour at times. Worries about his own behaviour around others. Has had convictions for assault. Medication review: depressed, cries easily, loss of concentration, agitated, morbid thoughts. Long discussion, keen to improve, lives with partner who is supportive'. A referral made to psychiatry but rejected by fax the same day as the risk information was missing. This was not put right until 16th January 2014. That risk assessment indicated that he was a risk to others and himself and that the presence of Jamie in the home would reduce the risk to any professional visitors.

4.6.5 Significantly on 12th January 2016 it was noted, 'Relationship problems, kicked out of house by girlfriend, sleeping at brothers, thoughts of low mood, self-harm, wouldn't do anything as loves daughter. Crying initially. No hallucinations/delusions/violence. Bleeding per rectum, thought to be diet related. For self-referral for counselling, must contact them. For review in 2 weeks, or earlier if acute deterioration. Anti-depressant prescribed'.

4.6.6 Roger made a self-referral to Self Help Centre 19th January 2016. He was, having suicidal thoughts. A worker spoke to him on 28.01.2016 as the service had a waiting time of 3-4 weeks. Feels suicidal on and off, turned the gas on at home but thought about his daughter and his dog which stopped him. Given number for sanctuary whilst waiting. Says he sees a different GP each time he visits surgery

---

- how well the discussion was recorded
- how well were the decisions understood

[20] Roger told the chair/author that he is literate and the entry appears to be an error.

and has to retell his story. Request if possible that he be seen by a GP he has seen previously. Sick note issued. Feels positive and has started work, well kempt, positive eye contact, feels best thing that has helped is getting back to work, doesn’t want to take medication for now’.

4.6.7 The analysis will look at his mental health to see if it had any relevance to the death of Jamie, including any impact it had on his risk to himself and others.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

5.1 Introduction

5.1.1 Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the Individual Management Reviews and the Domestic Homicide Review Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken to avoid unnecessary duplication.

5.1.2 The child safeguarding aspects of the review are covered under Term 4.

Term 1

5.2 *What if any indicators of domestic abuse did your agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?*

5.2.1 The Greater Manchester Probation Trust [as was], hereinafter referred to as Probation, knew that Roger was violent but had no knowledge of domestic abuse incidents. There was an opportunity for Greater Manchester Police to tell them about the domestic related calls they dealt with in February 2010 when he locked himself in a room and threatened to self-harm. He was still on licence at this time and Probation should have been notified. At that time there was no system for routinely sharing such information; there is now.

5.2.2 In December 2009 Roger told Probation that he had fallen out with Jamie but the reason was not recorded. In February 2010 Probation knew he had threatened to spit in the face of a female probation officer. Roger told Probation he knew '…he would be jealous and suspicious of partner's possible behaviour while he was in custody, and that he knew he would give her a hard time upon his release'. This was said about a previous partner and not Jamie. That jealousy trait remained with him and frequently surfaced.

5.2.3 However, threatening to spit at a female and stating he would give a female partner a 'hard time' through jealousy suggests domestic abuse risk indicators and certainty indicates that he does not respect females and could pose a risk to them.

5.2.4 Probation acknowledges that the risk he presented to members of the public should have been 'High' instead of the 'Medium' it was. They offer the following reason for arriving at that conclusion.

5.2.5 'Throughout his period of custodial and community supervision Roger was assessed as posing a Medium Risk of Harm.[21] Roger had been convicted of an offence that attracted an Extended Public Protection sentence and assessed to have caused

---

[21] Medium risk means: '…there are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances'. For example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse' This definition is from 'Safelives' Domestic Abuse Stalking and Harassment guidance.

serious harm which would be considered as life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. However at the point of sentence there was limited evidence of protective factors being in place to support a Medium Risk of Serious Harm assessment. Had this case been appropriately assessed as High Risk of Serious Harm, Roger would have been subject to Phase 3 of the Offender Management arrangements (Ministry Of Justice 2008) – incorporating sentence planning processes that involves multi-disciplinary forum and assists the offender to identify suitable objective during his period in custody to address risk and need. He would have also been subject to robust management oversight through the Risk Administration Management Arrangements. These are level 1 risk accountability meetings chaired at the time by the Risk manager in the City. The purpose of this meeting is to ensure those eligible offenders are being supervised following an action setting and accountability process to manage the risk of serious harm they pose to the public and to provide guidance and support to staff dealing with such cases'

5.2.6 Probation's dealings with Roger finished in September 2010, almost six and a half years before the homicide. Nevertheless, the signs of his later attitude and behaviour were present. The Panel felt the under-assessment of risk probably had no bearing on the homicide of Jamie, because the risk he posed was to the general public and not partners. Also, there were other opportunities to assess his risk in the six months prior to Jamie's death.

5.2.7 Greater Manchester Police [the Police] was the agency that knew the historic and current indicators of domestic abuse. There were two domestic related incidents on the same day in 2010. Roger was assessed as posing a medium risk of causing serious harm to Jamie**.**

5.2.8 There was a five year eight month gap before the next recorded domestic incident in November 2015 followed by another in December 2015. These related to the care of Child 1. Jamie was assessed as facing a 'standard'[22] risk of being seriously harmed by Roger. The Panel thought in the circumstances the assessed risk was appropriate and the response of sending a STRIVE officer to see Jamie was in line with policy. Prior to STRIVE there would not have been face to face contact with a 'Standard' risk victim. They would have received literature in the post.

5.2.9 The December 16th incident was witnessed by two neighbours. The neighbour who prompted the police attendance did not witness Roger's hands around Jamie's throat. The other neighbour told Jamie's father that Roger had grabbed Jamie's throat. This led to her brother attending the address and remonstrating with Roger. The brother was there when the police attended but the important piece of information about Roger grabbing Jamie's throat was not elicited from him nor was the neighbour seen. Jamie's brother told the review that he assumed the police knew that Roger had grabbed Jamie's throat. The Panel felt that was a reasonable assumption to make. The neighbour's eye witness testimony would have opened other opportunities for the Police. Roger told the chair/author that he explained to the officers that he had pushed his forearm into Jamie's throat in a defensive act after she scratched his hand while tussling over Child 1. There is nothing on the December 2015 police log to this effect. However, when Roger contacted the police in January 2016 to seek help with access to Child 1, the police recorded he told

[22] In order of escalation the three levels of risk are Standard, Medium and High.

them about the December 2015 incident, including putting his forearm across Jamie's throat. This piece of information was not recognised by the call taker as significant. Ideally it should have been sent to the police Public Protection Unit where it could have been used to determine whether it altered the risk Jamie faced from Roger.

5.2.10 Other domestic homicide reviews have highlighted the importance of seeing family members and friends because they often know what is really happening to the victim. The Panel discussed whether the Police should have visited neighbours as a matter of routine and heard the following from the Police representative on the Panel.

'I have reviewed the actions taken by the attending officer in relation to the domestic incident on 16.12.15. What I feel is important to highlight is that the officer records on their update that they have spoken with Jamie on her own and she has told the officer that there has been no assault and that there was no more than a verbal argument between the two parties. Having reviewed the call into the Police there is no mention of a witness to any assault and sadly this information only came to the attention of the Police after the tragic death of Jamie. With the information presented to the Officer, I feel their actions were appropriate to the circumstances they were faced with. I understand it has been raised as to whether house to house should have been completed. I think it is important that we recognise that we are now viewing this with the benefit of hindsight. The Officer was given no information that an assault had taken place from the caller and this was the same information they were offered by Jamie. The Officer must then balance the wishes and account of the victim with the necessity to do enquiries with third party witnesses, such as house to house enquiries. With the circumstances they faced I feel their actions were entirely appropriate'. The DHR Panel agreed with this finding.

5.2.11 The incident with the 'gas' in January 2016 was more serious in that it represented an escalation in the danger Roger presented to Jamie, Child 1 and probably himself. Gas is a dangerous product if misused and the potential for causing an explosion was present in this incident.

5.2.12 Section 2 of the Criminal Damage Act 1971 says:

'A person who without lawful excuse makes to another a threat, intending that that other would fear it would be carried out,—

(a) to destroy or damage any property belonging to that other or a third person; or

(b) to destroy or damage his own property in a way which he knows is likely to endanger the life of that other or third person;

shall be guilty of an offence'.

5.2.13 While Roger did not use words to put Jamie in fear, his actions probably did i.e. he was threatening to kill himself following an argument [a gas explosion] and suggested she left with the dog for their own safety [because they might be harmed in a gas explosion]. The Panel believed Roger's actions provided evidence with which to arrest him. He could then have been interviewed and consideration given to a charge. This would have been an opportunity to involve specialists to speak to Jamie and might have led to a disclosure about the throat grabbing incident which could have formed another charge. At this point Jamie wanted the

relationship to be over so there was a real opportunity to take some substantive action.

5.2.14 If Jamie had disclosed the fact he had grabbed her throat, with the addition of the 'gas' incident, there might have been sufficient to consider an alternative charge under the Serious Crime Act 2015 offence of controlling or coercive behaviour in intimate or familial relationships (section 76). This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on at least two occasions or it has had a substantial adverse effect on the victim's day to day activities. The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she ought to have known it would have that effect. If Roger has been arrested it would have provided an experienced investigator with the opportunity to really understand what was going on in the relationship and ensure Roger received an appropriate sanction/order to ensure Jamie and Child 1 were protected. Turning the gas on and using it almost as a 'weapon' to threaten Jamie was a clear escalation in Roger's behaviour and one that went unchallenged.

5.2.15 The subsequent risk assessment showed that Jamie faced a medium risk of being seriously harmed by Roger. A specialist domestic violence officer spoke to Jamie on the telephone and discussed a safety plan for her and Child 1 and arranged for a domestic violence marker to be placed on her address.

5.2.16 In light of the above analysis [escalating behaviour, manipulation, dangerous acts] the Panel felt the medium risk assessment was inappropriate and the real risk Jamie faced was high.

5.2.17 The Panel very carefully considered whether the missed opportunity to assess Jamie as a high risk victim in January 2016 had any impact on her homicide a month later. It was clear the risk faced by Jamie from Roger was escalating as evidence by the increasing frequency of domestic abuse episodes and the dangerous act of turning the gas on. This act was immature and potentially very dangerous. Moreover, it was consistent with his 2010 approach of resorting to threats of self-harm as a response to domestic disputes, probably in an attempt to regain control. However, in the 'gas' incident he was also placing other people at risk.

5.2.18 A high risk assessment would have seen the case referred to a Multi-Agency Risk Assessment Conference. That in turn would have enable an Independent Domestic Violence Advocate to meet with Jamie and more accurately assess the risk she faced and equally importantly would have provided her with an immediate and comprehensive safety plan for herself and Child 1. The Panel looked at the timings of the Multi Agency Risk Assessment Conferences around that time.

Incident Date [gas]	Conference Date	Conference Referral Cut Off Date [emergency referrals are possible]
05.01.2016	13.01.2016	24.12.2015
	27.01.2016	14.01.2016

Has Jamie been assessed as a high risk victim after the gas incident, there was an opportunity for her case to be referred and heard at a Multi-Agency Risk Assessment Conference before her death. Such a referral would have seen contact between Jamie and an Independent Domestic Violence Advocate, thereby providing Jamie with an opportunity to say what had happened in the relationship. However, the DHR Panel thought there were too many variables[23] between the gas incident and the death of Jamie to say whether a referral to a Multi-Agency Risk Assessment Conference, would have prevented her death. It would however have provided an opportunity to manage the risk she faced.

5.2.19 On 11th January 2016 there was a dispute over access to Child 1. Jamie refused Roger entry to the house. By this time it is believed Roger was no longer living there with Jamie. Advice was given to the pair by the police to seek a legal remedy concerning contact between Child 1 and Roger and the matter referred to a specialist officer in the Public Protection Investigation Unit. That officer spoke with Jamie and ensured the domestic abuse marker was still on the address and discussed a safety plan for her and Child 1. Jamie was assessed as facing a medium risk of serious harm from Roger.

5.2.20 The Panel felt the increase in frequency of reporting, together with the history and nature of the incidents should have resulting in Jamie being assessed as facing a high risk of serious harm from Roger. At this time the couple had separated, adding a further risk factor to the situation. The benefits for Jamie being assessed 'high' appear at 5.2.18.

5.2.21 The last contact with the Police came on the eve of Jamie's death when Roger suspected that Jamie had a 'sexual fluid' stain on her clothing and requested it be examined to identify the source. They had been to a party and Jamie could not remember how she obtained the stain, leading Roger to believe she must have been sexually assaulted. He was advised that the Police did not undertake such tasks in the circumstances described. The Panel felt that Roger's behaviour was founded in jealousy and aimed at identifying 'the other man'. The irony is that after Jamie's death the 'sexual fluid' was identified as semen belonging to Roger.

5.2.22 During the request to have the stain examined, Roger stated he was homeless but despite the existence of a domestic violence marker on Jamie's address, no contact was made with Jamie to ascertain her or Child 1's safety or alert her to Rogers' contact. The Panel felt this was a significant oversight, particularly so as it came within twenty four hours of Jamie's death. It appears the need to do a welfare check did not occur to the officer.

[23] E.g. time, Jamie's ability to disclose and the impact of any safety measures taken by the conference.

5.2.23 Jamie and Roger went to different medical surgeries. Roger's general practitioner knew of a number of risk factors that are associated with domestic abuse offenders. These included his, drug misuse; mental health needs; the use of violence in a non-domestic setting; relationship problems with his partner and the ending of that relationship. However, these risk indicators are also present in many other people who are not domestic abuse perpetrators. The practice's knowledge of domestic abuse was very limited.

5.2.24 Jamie's general practitioner did not have any indicators that she was a victim of domestic abuse. However, her surgery did not have any training relating to domestic abuse which would help staff identify possible risk factors and give them the confidence to ask the right questions.

5.2.25 The Individual Management Review concluded that, '…neither practice had information or knowledge re local resources or processes such as referrals to Multi Agency Referral and Assessment Conferences or use of risk assessment tools such as Domestic Abuse Stalking Honour. Conditions for good practice in relation to domestic abuse were not sufficiently in place and there is a clear need for training which would address all of these issues'.

5.2.26 The Panel noted this position and the agency recommendation to remedy it, but nevertheless was disappointed that the pre-eminent health care providers for Jamie and Roger should have such as significant gap in their knowledge base. A previous domestic homicide review in Bury had similar findings for general practitioners. However, in this review the practices were in the Manchester catchment area.

5.2.27 Despite the missed opportunity [January 2016] for Roger's general practitioner to explore 'relationship problems', the Panel thought there was no link between that opportunity and the death of Jamie.

5.2.28 In summary there were many indicators of domestic abuse held by agencies and family/friends which if discovered and brought together would have indicated that Jamie faced a high level of risk from Roger.

5.3 Term 2

How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

5.3.1 Jamie was registered at a small practice therefore was far more likely to see the same doctor. The relationship between doctor and patient is important and establishing trust is essential to creating an environment where disclosures can be made.

5.3.2 Roger's position is very different. He was seen by twelve different doctors at the surgery and it is noted in his records that he wanted to see the same doctor to avoid having to re-tell his story. The Individual Management Review puts it this way, 'Patient-doctor relationship is crucial in establishing trust and compliance with medications, especially in relation to mental health and facilitation of help-seeking'.

5.3.3 The Panel wondered whether Roger's December 2013 remark to his doctor about his aggressive behaviour, potential racial discrimination[24] and his own behaviour around others would have been explored better if he had continuity of care. However, the Panel did not find a direct causal link between Roger's mental health care and the death of Jamie; there were simply too many variables to do so. Nevertheless, mental health is a frequent theme in domestic homicide reviews. The domestic abuse training delivered in Bury covers the connection between mental health and domestic abuse.

5.3.4 The Police responded to Jamie's calls and listened to her complaints of Roger's behaviour, none of which contained an allegation of a criminal offence. They gave her appropriate advice to obtain legal help over Roger's access to Child 1. The STRIVE team visited Jamie which provided further opportunities to explore the relationship issues with her.

5.3.5 It is now known that Jamie did not disclose to the police that Roger had grabbed her throat or that he was controlling and coercive. She did tell her friends. The reason why victims sometimes feel unable to disclose are well documented. Here are the findings of one study[25]:

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

The reasons the victims we surveyed gave for not reporting the domestic abuse to the police were: fear of retaliation (45 percent); embarrassment or shame (40 percent); lack of trust or confidence in the police (30 percent); and the effect on children (30 percent).

5.3.6 The challenge to community safety partnerships is to create an environment where victims of domestic abuse feel confident in coming forward and discussing their circumstances without fear of making the situation worse.

5.3.7 Pennine Care provided health visiting services to Jamie and listened to the routine concerns of a new mother. A more specific concern arose in February 2016 following health visiting's knowledge of domestic incidents. The health visitor offered to visit Jamie at home and provide support. Jamie declined saying, 'I'm not worried about me; I'm just worried what would happen if he took Child 1'. The Health visitor respected Jamie's position that she did not want visiting at home and advised Jamie to report any concerns to them or the police. The Panel felt that was an appropriate response.

[24] When seen in prison Roger had no recollection of this remark and said he was not a racist nor did he feel racial threatened by any group.

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

5.3.8 Roger's interaction with Pennine Care was limited to his attendance at one anger management session in 2012 before he was discharged for not attending further appointments.

5.3.9 Probation's involvement with Roger ended in 2010 but there is evidence in their files that his views were listened to.

5.3.10 When Roger was seen in prison he felt that the police did not listen to him when he requested their attendance to ensure the peace was kept when he picked up Child 1. The Panel felt that this was not a role for the police in the circumstances described and that Roger's expectation was unrealistic. The Panel felt that the very fact of him wanting the police present was in itself controlling behaviour and further evidence that he lacked self-control and conflict resolution skills.

5.3.11 Overall, the Panel thought that agencies provided opportunities for Jamie and Roger to express their needs and responded appropriately. The exception was Roger's general practice who could not meet his wishes to be seen by the same doctor. However, the Panel felt that had no impact on the death of Jamie.

5.4 Term 3

Were single and multi-agency policies and procedures followed; are the procedures embedded in practice and were any gaps identified?

5.4.1 This term confines itself to the policies relating to adults; child policies are covered under the next term of reference. Police followed its domestic abuse policy on all but one occasion. The single oversight was not sharing information with health visiting following the December 2015 dispute between Jamie and Roger over access/care of Child 1. The time it took the Police to make some referrals is looked at under term of reference 6. There were occasions when Probation policy was not followed. These were around case allocation and risk assessment following Roger's arrest in 2010 for the domestic abuse incident where he locked himself in a room and threatened self-harm. These 2010 oversights were not relevant to Jamie's death in 2016.

5.4.2 Pennine Care found some gaps in its health visiting policy on responding to domestic abuse reports and to its information sharing policy which the Panel felt did not influence the outcome for Jamie.

5.4.3 Pennine Care has an escalation policy that allows staff to raise concerns with a manager over another agency's decisions. The health visitor told the social worker that Roger had grabbed Jamie's throat and recorded that the social worker had said the case was closed.[26] Pennine Care believes that the health visitor should have invoked the escalation procedure because on the face of it the decision by the Multi Agency Safeguarding Hub to 'close' the case and not refer it to Children's Services seemed premature in light of the information that Roger had assaulted Jamie by putting his hands round her throat. The Panel support this view and feel the Multi

[26] The case had been screened in the Multi Agency Safeguarding Hub and closed there. It had not been referred to Children's Services and therefore was never an open case with them.

Agency Safeguarding Hub should have sent the details to Children's Services for consideration of a child and family assessment.

5.4.4 The two general practices are in Manchester and did not have domestic abuse policies which the Panel found disquieting given the importance of medical practitioners as recipients and disseminators of domestic abuse information. However, the Identification and Referral to Improve Safety training[27] will be delivered to these practices by the end of 2016. The funding and commissioning has taken place. Identification and Referral to Improve Safety confirmed they do not provide a domestic abuse policy for practices. Manchester Safeguarding Adults Board and Manchester Safeguarding Children Boards have developed a domestic abuse policy for general practitioners which is imminent. The Clinical Commissioning Group Safeguarding Team will write a policy for general practitioners that is aligned to the Boards' policies. This will be offered to doctors for use in their surgeries. General practitioners are independent contractors so do not have to comply with it. The new Care Quality Commission inspections in practices will look at their compliance with domestic abuse policies.

5.4.5 In Summary, all agencies, except the general practices, had domestic abuse policies in place, and during the six months before Jamie's death, adherence to them was generally good. The exception is health visiting's non-use of its escalation policy on the eve of the homicide.

5.4.6 The Panel carefully considered whether health visiting's lack of challenge over the Multi Agency Safeguarding Hub's decision not to relook at the case following the receipt of the new information [throat incident] would have altered the outcome for Jamie and believed it would not have done. The rationale for that belief stems from the knowledge that even if the case had been reconsidered by the Multi Agency Safeguarding Hub and sent to Children's Social Care, there would have been no time for an assessment before Jamie's death the following day. The knowledge that Roger had grabbed Jamie by her throat eight weeks earlier, would not have warranted immediate intervention for Jamie or Child 1.

5.5 Term 4

When dealing with the victim and/or offender did your agency take into account the child safeguarding issues and what did you do with them?

5.5.1 This term has been broken down into the following five points.

Point 1

Consider whether the police shared historic information on the perpetrator with partner agencies in order to safeguard the child.

5.5.2 The Police's standard response to sharing information in domestic abuse cases where a child lives in the household is to inform the Multi Agency Safeguarding Hub which then considers if the information necessitates a referral on to the Children's Social Care Team for assessment. This decision may be informed by further

[27] IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. www.irisdomesticviolence.org.uk/iris/

screening within the Multi Agency Safeguarding Hub. As part of that screening, dependent upon the assessed level of risk, a health employee based in the Multi Agency Safeguarding Hub may have sight of the information. It will be their decision whether to make further notifications within health services, including the health visitor. In Bury the police Public Protection Investigation Unit send a separate e-mail to health visiting when there is a child in the home who is receiving health visiting services.

5.5.3 In this case all but one of the domestic abuse incidents between Jamie and Roger were shared with the Multi Agency Safeguarding Hub. The exception was the December 2015 disturbance in street when it was later discovered Roger had grabbed Jamie by the throat. Had a referral been made it would not have contained the 'throat' detail as it was unknown to the police at the time. However, it would have provided an opportunity for the health visitor to contact Jamie and offer support. It is now known that when contact with the health visitor came on 11th February 2016 Jamie did tell her about being grabbed by the throat. Had the information arrived in health visiting sooner, then the opportunity for Jamie to disclose domestic abuse also have come earlier thereby allowing more time for assessment, support and safety planning.

5.5.4 The contact forms from the Police to the Multi Agency Safeguarding Hub contain details of the incidents which led to their submission. They are not designed to contain a full forensic history of Roger. That bigger picture, including Probation's 2010 assessments of Roger, could be obtained by staff in the Multi Agency Safeguarding Hub undertaking research.

5.5.5 However, that research would only be done if the incident leading to the Multi Agency Safeguarding Hub contact appears to warrant it and therein lies the dilemma. If the Multi Agency Safeguarding Hub's level of concern is not raised by the initial information, is it reasonable to expect that they will trawl through agencies' databases looking for every piece of evidence that may be relevant to assessing risk in the current case.

5.5.6 The Panel felt that the depth of research should be guided by the level of the initial risk assessment and professional judgement. The Panel felt a useful and logical rule of thumb could be, 'the higher the level of initial risk, the more in-depth the research should be'. Professional judgement and experience have an important role in risk assessment.

5.5.7 The Panel felt that the police did share sufficient information for partner agencies to safeguard Child 1.

Point 2

Understand the reasons for the poor quality of information and delay in referrals from the Police Public Protection Unit to Children's Social Care and the amalgamation of two incidents into one referral in respect of the incidents on 11 November 2015, 5 and 11 January 2016.

5.5.8 The Police had four opportunities to share information relevant to safeguarding Child 1 with the Multi Agency Safeguarding Hub who in turn would determine whether the incident warranted a referral to Children's Social Care. These were:

Date	Incident	Date Shared
11.11.2015	Dispute over child care	04.12.2015
16.12.2015	The throat incident	Not shared
05.01.2016	The gas incident	25.01.2016
11.01.2016	Dispute over access to Child 1	25.01.2016

5.5.9 The Police Individual Management Review does not address the twenty three day delay in sharing the November incident. Subsequent enquiries were answered thus. The police acknowledge this is too long and explained it reflects the fluctuating demands and available resources and felt this was an exception to an otherwise reasonable referral timescale. High risk cases would be referred the same day.

5.5.10 The December incident should have been referred to the Multi Agency Safeguarding Hub. The attending officer assessed the risk as 'Standard' and the case log was routed to the Police Public Investigation Unit who recorded, 'No offences, standard risk. No issues.' However, a referral was not made to the Multi Agency Safeguarding Hub and neither did the STRIVE officers identify it as a case to pursue. The December incident was not identified by STRIVE because it seems that as a fledgling service the processes and practices were not fully developed and this was compounded by the absence of a separate STRIVE policy. The Police IMR notes that 'due to the experimental nature of their [STRIVE] work, no policy of engagement exists but staff were directed to scan domestic incident reports and identify those graded as standard risk, where no evidence of criminality had occurred and it was between the first and third report to the police by victim or perpetrator'. The December 2015 incident fitted exactly into this brief and it appears that simple oversights within the STRIVE team meant that is was not identified for intervention.

5.5.11 The Police offered the following explanation for the time it took to share the two January incidents.

'Due a backlog of work generated by the high level of demand over the Christmas holiday period, coupled with staff leave absences, these incidents were not assessed until 23rd January 2016. On this occasion, that delay is not known to have had a significant impact upon the police response or the safety of Jamie and Child 1. In the event, the consideration of the two incidents taken together provided a fuller picture of the developing pressures in Jamie's and Roger's relationship. Consequently the risk assessment and action provided a mirror response for both incidents'.

5.5.12 The Panel noted the reasons for the delays and recognised resourcing is a daily problem for agencies. However, delays in completing domestic abuse assessments arising from resourcing pressures do come with risks in that a child will continue to live in an unassessed situation. When the health visitor contacted Jamie after receiving the much delayed contact, Jamie disclosed an important piece of information [hands around her throat] that had a direct bearing on the risk she faced. A prompt notification to health visiting would have afforded Jamie an earlier opportunity to disclose. There is no certainty Jamie would have made the

disclosure. However, has she, a Domestic Abuse Stalking and Harassment risk assessment would have been completed by the health visitor with the possibility of a referral to Children's Social Care and a Multi-Agency Risk Assessment Conference.

Point 3

Consider whether agencies considered the cumulative effect of the past history and current incidents on the welfare of the child.

5.5.13 There was nothing in Jamie's background to suggest she did not treat the welfare of Child 1 as her priority. In fact all the evidence points to Jamie taking all the steps necessary to protect Child 1. For example she worked with Roger to reduce his cannabis use, reported incidents to the police, cooperated with professionals and did not leave Child 1 in his care when she judged it would not be appropriate. The probable reasons why Jamie did not directly tell the Police she had been grabbed by the throat are discussed elsewhere. She did however tell the health visitor when an opportunity arose.

5.5.14 Roger's history of offending was significant. The Police reported that:

'Between 1994 and 2009, Roger was arrested on over forty occasions for a wide variety of criminal offences; he was considered to be a prolific offender. He served several terms of imprisonment which culminated in his release on licence from Her Majesty's Prison Manchester on 8th July 2009 with conditions to reside in a bail hostel and participate in the Prolific and Priority Offender programme'.[28]

5.5.15 However, 'hidden' among Roger's convictions was an incident from 1996 when as an adult he stamped on the head of a fourteen year old, causing him to be hospitalised for 2 days. Roger served a prison sentence and was released in 1997.

5.5.16 That information surfaced in October 2015 when Manchester Children's Services undertook checks to determine his suitability as a potential carer for a relative. Bury Children's Social Care verified that information with Roger and discussed the implications for Child 1 with Jamie. In arriving at a decision to take no further action Children's Social Care sought and received positive feedback from the family health visitor and closed the file with the following rationale.

'Jamie has been spoken with and she has put into perspective what the family are currently going through hence the anger displayed by Roger - she informed he was no risk to their child and she would not be with him if he was - she was happy for any checks to be undertaken.

There is nothing to suggest that given the incident 20 years ago that Roger would be a risk to his own child. No further role for Bury Children's Services'.

5.5.17 When the Police dealt with the November 2015 call by Jamie they did not identify the two domestic abuse calls from 2010. This is explained by that information not being readily available because of migration to new databases. The panel felt that knowing the history would have bettered informed the assessment. It would also

[28] A Government Scheme aimed at reducing offending of individuals who are responsible for large quantities of crimes.

have enable the Multi Agency Safeguarding Hub to consider what had happened in the relationship in the intervening years and why there had been a renewal of domestic incidents.

5.5.18 Child 1 was less than sixteen months old when Jamie died. Therefore Child 1 was unable to say whether witnessing domestic abuse between parents had any impact. Nevertheless the negative effect on children of witnessing domestic abuse is not in doubt.[29]

5.5.19 Child 1 was present or nearby in three of the four incidents and therefore will have absorbed some information but it is not known whether that will have any lasting impact.

5.5.20 The Police acknowledge that their focus was on the adults and that while referrals were made to the Multi-Agency Safeguarding Hub on most occasions, the safeguarding aspects were largely overlooked.

5.5.21 Social workers who had telephone contact with Jamie discussed the impact of domestic abuse on Child 1 but did not suggest or make a referral to a domestic abuse service or assess risk. However they did provide Jamie with details of the Freedom Programme.[30]

5.5.22 It appears the focus of professionals was on child access and not on domestic abuse. Children's Social Care told Jamie that any further incidents of domestic abuse would lead to a children and family assessment. The Panel noted that while that was a right position to take there was a danger that Jamie may minimise, deny or conceal any future domestic abuse. There is no evidence that in 2015/2016[31] any agency offered Roger support to deal with his issues or sign posted him to services that could have helped him. It was suggested he seek legal advice about contact

---

[29] The physical, psychological and emotional effects of domestic violence on children can be severe and long-lasting. Some children may become withdrawn and find it difficult to communicate. Others may blame themselves for the abuse. All children living with abuse are under stress. www.refuge.org.uk

[28] The Freedom Programme © was primarily designed for women as victims of domestic violence, since research shows that in the vast majority of cases of serious abuse are male on female. However, the programme, when provided as an intensive two day course, is also suitable for men, whether abusive and wishing to change their attitudes and behaviour or whether victims of domestic abuse themselves. www.freedomprogramme.co.uk

[31] In January 2014 Roger's general practitioner referred him to Gateway [Manchester Mental Health & Social Care Trust's first point of contact] who spoke to him in February. The referral revealed anxiety and depression, which had been ongoing for 13 years. He's finding it difficult to cope and becoming increasingly frustrated. Reports he needs help controlling his anger and would like help to stop thinking he would be better off killing himself. His partner is supportive. Roger said he also has problems with anger, reporting losing his temper with ex-girlfriend the relationship has now ended, he said he was "horrible" towards ex-partner for no reason and needs help with his anger. Plan: Roger was in agreement for referral to self-help services for management of mood, anxiety and anger and to self-refer to drug services.

with Child 1, which is very different to identifying and treating his likely underlying jealousy, anger and paranoia.

5.5.23 The final opportunity to consider the welfare of Child 1 came the day before Jamie's death. Roger called the Police about the 'stain' on Jamie's clothing. The Police review author has read the full transcript of the call. Roger said he and Jamie have argued over the matter but the fact that no one thought to establish her or Child 1's safety probably reflects a lack of awareness between the two issues. The Panel felt it was very difficult to 'teach' such awareness.

5.5.24 Earlier in the report the Panel said that Jamie should have been assessed as facing a high risk of serious harm from Roger and as such believes that the Multi-Agency Safeguarding Hub should have referred the case to Children's Social Care for formal assessment. The 'no further action' decision by the Multi Agency Safeguarding Hub is incongruous with the escalation in risk faced by Jamie and Child 1.

5.5.25 The Panel felt that overall the cumulative impact of domestic abuse on Child 1 was not given the consideration it should have been. While some attention was paid to Child 1, the emphasis was on the adults. It should have been on both.

Point 4

Consider whether agencies considered the direct risk to the child from the father following his threats to snatch her.

5.5.26 The Panel thought the direct risk to Child 1 was the physical and psychological harm likely to be caused when the parents were arguing over 'possession' of Child 1.There is no evidence that any thought was given to whether Roger might remove Child 1 from Jamie's care without her permission. Jamie feared he would and consequently called the police.

5.5.27 Jamie provided reassurances that Roger would not harm Child 1 and these are recorded in Children's Services and Police documents thereby indicating these two agencies considered the direct threats to Child 1.

Point 5

Consider whether agencies took into account the increased risk to the victim and therefore to the child at the point of the relationship ending.

5.5.28 There is evidence that the Police considered the increase in risk.[32] This is evidenced by their assessment that Jamie faced a medium risk of serious harm from Roger. This was an escalation from the November and December assessments of standard risk. Part of the response to the medium risk incidents was to place a domestic abuse maker on Jamie's address and discuss a safety plan with her which included provision for Child 1.

5.5.29 There is no evidence that social workers or health visiting discussed safety planning with Jamie and this was a missed opportunity. The Multi Agency Safeguarding Hub

[32] Victims who attempt to end a violent relationship are strongly linked to intimate partner homicide. Many incidents happen as a result of child contact or disputes over custody. http://www.dashriskchecklist.co.uk/

Management believes it is not always the staff's role to make safety plans with victims. This would be dependent upon the presenting circumstances.

5.5.30 On balance the Panel thought that insufficient cognisance was placed on the heightened danger faced by Jamie at the time of separation and by association Child 1.

5.6 Term 5

What knowledge did the family, friends and employers have of the adults' relationship that could help the Domestic Homicide Review Panel understand what was happening in their lives; and did family and friends know what to do with any such knowledge?

5.6.1 In a December 2015 Citysafe Liverpool examined thirteen domestic homicide reviews. In nine[33] of the reviews it was found that family and/or friends had knowledge of domestic abuse.

5.6.2 In this review Jamie's neighbour witnessed Roger with his hands round her throat and immediately passed the information to her father. He in turn told his son who visited the address and warned Roger not to repeat his behaviour. The Police were in attendance but did not hear the exchange nor did they elicit the information from the son.

5.6.3 Jamie told a friend that Roger had put his hands round her neck and also pushed and shoved her on other occasions. Jamie asked her friend to get her husband to tell Roger to calm down. It appears the general view is that Roger was volatile but would soon calm down after his rows with Jamie. It does not appear that the impact of such behaviour on Jamie or Child 1 was considered. The friends knew that Jamie had informed the police of some incidents and did not judge it necessary to inform the police of their knowledge.

5.6.4 Jamie worked for a local branch of a national wealth management company. The review chair engaged with the Head of Human Resources who having made enquires with the office where Jamie worked in was able to say the staff did not want to contribute to the review as they were still distressed by the death of their colleague. They had received work placed counselling following Jamie's' death. The Panel noted their views and respect their decision. As an alternative to being able to see her colleagues the Panel relied on documentary accounts they gave to the criminal investigation. A summary of those accounts follows.

5.6.5 Jamie did not take Roger to work social events saying 'It was not the right environment for him'. There appeared to be some 'ups and downs in the early years of the relationship. These intensified following the birth of Child 1. This is consistent with other people's accounts and also evidenced by the couple's contact with the police. There is also evidence that Roger would constantly telephone Jamie throughout the day while she was at work. He was described by one colleague as very possessive.

[33] 69%

5.6.6 On one occasion Jamie said that she received a telephone call from Roger who said, 'You better come home, pick [Child 1] up and take her to your mums, I have not had my breakfast yet'.

5.6.7 Jamie also disclosed that she was extremely upset about the incident where Roger 'strangled' her and that the police were involved. Roger sent text messages to Jamie in which he called her a 'slag' 'whore'. Jamie came to work just before Christmas 2015 with a bruise under her jaw. It is believed this came from the 'strangling' incident on 16th December 2016. Jamie said she had 'kicked' Roger out of the house in January 2016 and had ended the relationship.

5.6.8 The Panel recognised her friends and work colleagues were describing the physical and coercive and controlling elements of domestic abuse. However, because the Panel was unable to speak with the employees it is not known whether they were in a dilemma over Jamie's disclosures and if they were, where to go to for advice.

5.6.9 The Head of Human Resources said the company does not have a specific policy on domestic abuse, as it does not for a whole range of issues, e.g. compassionate leave, Instead managers are empowered to make decisions against the corporate principles of caring for employees.

5.6.10 Employees have direct access to Occupational Health services and an Employee Assistance Programme both delivered by the same external organisation. Details of these schemes are on the company's intranet which Jamie had access to. There is no evidence that Jamie accessed these.

5.6.11 The Head of Human Resources was confident that managers in Jamie's office would have referred her to Occupational Health had she made any disclosures of domestic abuse.

5.6.12 Team Bury Community Safety Partnership already provides advice for family and friends who receive disclosures of domestic abuse. This arose from a previous domestic homicide review.

5.7 Term 6

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

5.7.1 Overall the Panel thought there was inconsistent compliance with information sharing between agencies. There were delays in the Police passing information to the Multi-Agency Safeguarding Hub resulting from staff shortages and public holidays. Children's Social Care and health visiting shared information when the former was making decisions on how to respond to an enquiry from a neighbouring authority.

5.7.2 There was one significant gap. On 11th February 2016 Jamie told the Health Visitor that Roger has grabbed her by the throat. The Health Visitor has a record of sharing this information during a telephone call with a social worker in the Multi-Agency Safeguarding Hub. The social worker does not remember the conversation.

Enquiries by Children's Social Care show the Social Worker accessed the electronic file on the 11th February 2016 but had not inputted any conversation or contact. The Social Worker said that had that conversation taken place they would have checked it with a Manager, due to the risk. The Panel made no comment on what actually happened and noted Children's Social Care decision to undertake some audit work on 'closed files'.

5.7.3 The Health Visitor experienced some delays in getting replies from a colleague in the Multi Agency Safeguarding Hub and Pennine Care observed: 'This was a concern as to how effective is the process for inter-agency information sharing as this could have promoted contact by the health visiting team'. Pennine Care has made an appropriate recommendation.

5.7.4 Roger's history of violence was not shared with the Multi-Agency Safeguarding Hub. This aspect was explored at paragraphs 5.5.4 to 5.5.6

5.8 Term 7

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

5.8.1 Jamie, Roger and Child 1 were white British with English as their first language. Child 1 was too young to have intelligible speech. Roger's mental health was looked after by his general practitioner.

5.8.2 Neither the Panel nor the agencies contributing to this review, saw any evidence that the services provided to the family were inaccessible in any way because of their individual characteristics.

5.9 Term 8

How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

Note: This term was confined to examining case management supervision as opposed to general or clinical supervision.

5.9.1 Probation stated that in 2010 the management oversight of the case in the area of assessing Roger's risk could have been better. The Panel believed that lapse had no connection with Jamie's death some six years later.

5.9.2 The Panel saw no issues with the supervision and management of staff; the same was true for Children's Social Care and Pennine Care.

5.9.3 The exception to the above is the incident on 16th December 2016 [strangulation] which was routed by the attending officer to the police Public Protection Investigation Unit where it was filed no further action. The Panel thought a police supervisor should have identified the incident as requiring additional attention.

5.10 Term 9

Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim?

5.10.1 The single resource issue was the delays in the Police sharing information with other agencies following reports of domestic abuse. The reasons have been outlined early and involve staff absences, public holidays and fluctuating demand.

5.10.2 Bury Children's Social Care noted the following.

'As identified in the recent Ofsted Inspection[34]: "Police administrative resource limitations are cited as the reason why domestic abuse notifications are received in 'batches' at the MASH. Although serious incidents are fast tracked, instances which appear to the attending officer as less serious may not be triaged at the MASH for many days after the event, and therefore do not benefit from a comprehensive analysis of agency involvement and historical information'.

[34] Inspection of Services for Children in Need of Help and Protection, Children Looked After, and Care Leavers. It was completed in spring 2016 under the Ofsted Single Inspection Framework.

6. LESSONS IDENTIFIED INCLUDING GOOD PRACTICE

6.1 Greater Manchester Police

Good Practice

6.1.1 The Police believe that the STRIVE initiative being piloted in Bury is an example of good practice in that it identifies standard and medium risk domestic abuse cases that may require additional attention. In this case Jamie was seen by STRIVE officers when in pre-STRIVE times a face to face meeting would not have happened. The STRIVE initiative is scheduled to be evaluated by the University of Central Lancashire.[35]

Lesson

6.1.2 The Police did not identify any lessons. The Panel's lessons will identify some points for the police to consider.

6.2 Greater Manchester Probation Trust [as was]

Good Practice

6.2.1 The challenge by a manager of Roger's behaviour towards a member of staff was judged to be exemplary by Probation.

Lesson

6.2.2 Roger's risk was under assessed; it was medium but should have been high resulting in him being managed by a qualified Probation Office. This did not have an impact on Jamie's death which happened about six years later.

6.3 Pennine Care NHS Foundation Trust

Good Practice

6.3.1 On 15.12.15 health visiting increased the level of need to Universal Plus following the November 2015 dispute between Jamie and Roger over the care of Child 1.

Lesson

6.3.2 There was a delay in responding to domestic abuse incidents once health visiting was informed. This means that families may not receive timely support. Future consideration should be given towards reviewing the existing guidance for staff relating to responding to domestic abuse notifications.

6.3.3 There was a delay in responding to information as health practitioners attempted to contact each other in order to gain clarification. Future consideration should be given to reviewing the current Multi Agency Safeguarding Hub information sharing Pathway within the Trust.

---

[35] The STRIVE Project Manager reports: We are aiming to conduct an interim mid-year evaluation for Year 2 at the end of October 2016, which should be more informative given the higher volume and richer data set. The end of year 2 (full project) report will be in April / May 2017. The emerging findings are positive.

6.3.4 There was evidence of good practice in the sharing of information with the health visiting service from accident and emergency departments following attendances by Child 1. There had been four attendances in six months. However, this had not triggered a response by the health visiting service. The process for reviewing accident and emergency attendances by the health visiting service and the service's response should be updated.

6.3.5 Health visiting provided information to a social worker that Roger had grabbed Jamie by her throat. The social worker said the case was closed and would not be reopened.[36] Trust staff working with children and families should be competent and confident in their knowledge and skills to challenge decisions they feel uneasy with.

6.4 Children's Social Care

Good Practice

6.4.1 The Multi Agency Safeguarding Hub social worker obtained an email address for Jamie, and sent her information about the Freedom Programme, a resource that if accessed would have explained clearly the complexities of domestic abuse and given Jamie access to support.

Lesson

6.4.2 Multi-Agency Safeguarding Hub social workers appeared to accept the risk levels given to them by the police. They should feel able to challenge and review risk assessments presented to them principally by Police referrals; for example the last two Police referrals indicated escalation in risk but an assessment of medium risk by the Police Officer.

6.5 General Practitioners

Good Practice

6.5.1 None identified by the agency or the Panel

Lessons

6.5.2 There is a need to ensure that GP practices are aware of risk factors relating to domestic abuse and to know what to do if a concern arises. This has been a previous recommendation in a Bury domestic homicide review and an Identification and Referral to Improve Safety training plan is now in place.

6.5.3 The GP practice[s] did not have a domestic abuse policy or procedures. This may mean that victims may not be identified and offered support.

6.5.4 The GP practice was unable to provide Roger with the continuity of care he requested. Continuity of care promotes patient compliance and would maximise opportunities to identify risk and offer support

6.6 Panel Lessons

One [Recommendation 1 applies]

---

[36] This contact was not recalled by the social worker.

6.6.1 Greater Manchester Police assessed the level of risk faced by Jamie was medium. The Panel felt it should have been high, thereby enabling the case to be considered at a Multi-Agency Risk Assessment Conference. Under assessing risk, by not recognising all the risk factors, denies victims the benefits of additional protective measures being put in place and exposes them to unmanaged risk.

Two [Recommendation 2 applies]

6.6.2 There was enough information known to agencies to have assessed Jamie as facing a high risk of serious harm from Roger. Family and friends knew additional detail. Professionals who assess risk should look for opportunities to determine whether additional information is available from these sources. However, the Panel recognised that it may not always be possible for reasons of proportionality and permission for all agencies to make such enquiries. Not seeking information from family and friends when a legitimate opportunity arises could lead to risk being understated and victims under protected.

Three [Recommendation 3 applies]

6.6.3 Family and friends may not know what to do with disclosures of domestic abuse, particularly when they are sworn to secrecy by the victim. This can place them in a dilemma. That dilemma can be eased if good quality independent advice is readily available. While victims can benefit from sharing what is happening to them, family and friends need to know what to do, and not to do, with such disclosures.

Four [Recommendation 4 applies]

6.6.4 Domestic abuse has an impact on children living in the home. Sometimes separation of the victim and perpetrator is used by agencies as a protective factor for the children. Therefore if reconciliation happens the risk to the children may return. Not knowing when reconciliation has happened can leave children exposed to unmanaged risk.

7. *CONCLUSIONS*

7.1 At the time Jamie formed a relationship with Roger in 2009 she was forging a career in the financial sector, owned her home and was seen as a strong, successful and determined young woman. Her family was very proud of her achievements.

7.2 Roger came to the relationship with a history of offending, including significance violence and a conviction for assaulting a fourteen year old boy by stamping on his head.

7.3 He was also on licence from prison having committed a Section 20 Wounding. At the time he was assessed as presenting a medium risk of causing serious harm to the public. That was judged to be inaccurate and that his actual risk should have been high. However, that under-assessment stemmed from 2009/2010 and did not have any impact on the death of Jamie in 2016. However, it demonstrates he was prone to using violence as a method of dealing with problems.

7.4 Roger was known to have anger management difficulties and also used cannabis and alcohol, together with his mental health issues, as demonstrated by his threats of self-harm, this probably made him a difficult person for Jamie to be around at times. Jamie's friends testify to this. There are several references in the review papers to say that Jamie did not like Roger's heavy use of cannabis and her opposition to it intensified after Child 1's birth.

7.5 Early in the relationship Roger's known jealousy surfaced when in 2010 he locked himself in a room and threatened to kill himself because he thought Jamie had seen another man. The dispute continued throughout the day and around teatime he was arrested by the police to prevent a breach of the peace.

7.6 This event was followed over six years later by a quintet of contacts with the Police beginning in November 2015 and ending in mid-January 2016. Three disputes were around Roger's care of/access to Child 1, one saw him turn the gas on and ask Jamie to leave the house and the last referred to semen on her clothing. The frequency of calls increased and Roger's behaviour meant that the risk he posed to Jamie increased from standard to medium resulting in some safety measures being put in place. The Panel's believed the risk was high and an opportunity was missed to take the case to a Multi-Agency Risk Assessment Conference. That might have seen a recommendation to make Jamie's house more secure by changing the locks and offered an opportunity for a discussion with an Independent Domestic Violence Advocate.

7.7 By January 2016 it was apparent that the relationship had no future. There were a few weeks of separation followed by about five days of reconciliation when Roger moved back into the house. While they lived under the same roof the reconciliation was fragile and it seems Jamie wanted to end the relationship. A bout of severe jealousy ensued during which Roger continually challenged and harassed Jamie about his perception that she had seen another man. He told her friend that he would torture Jamie to make her tell the truth. It is well established that when separation happens, the risk to victims of domestic abuse increases. This case provides more evidence of the point.

7.8 It is also apparent that Jamie was struggling with the decision to permanently separate from Roger or was waiting for the right circumstances to make the final break. This can be evidenced when on 23rd January 2016 she told a STRIVE officer that Roger was with her visiting Child 1. Jamie said they were not back together and that it was a 'grey area at this time with no decision made'. However on the eve of her death she told him by text that she was going to obtain a Restraining Order against him.

7.9 Information sharing from the Police to Children's Social Care and health visiting was generally good but there was one missed opportunity for the Police to share information. There was a delay in the Police notifying partners about the incidents and also some delays in health visiting making contact with social workers and seeing Jamie. The missed opportunity and delays did not contribute to Jamie's homicide.

7.10 The incident not shared by the Police took place in December 2015. Jamie reported a verbal dispute with Roger over access to Child 1. The police attended and provided advice. In fact during this dispute Roger had grabbed Jamie by the throat; an act witnessed by a neighbour who told Jamie's father. Jamie later told a friend about the incident. The police did not discover these facts until after Jamie's death. This case is another example of where family/friends have important information which the Police did not identify in real time.

7.11 Roger was known to have anger management problems and also used cannabis and alcohol. These together with his mental health issues as demonstrated by his threats to self-harm, probably, at times, made him a difficult person for Jamie to be around. Her friends provided examples given to them by Jamie of his controlling and coercive behaviour.

7.12 It also appears that Roger used the threats of self-harm as an instrument to control Jamie and get his own way. This behaviour has been observed in other domestic homicide reviews.

7.13 Roger's jealousy was again evidenced the day before Jamie's death. He thought she was intimate with a man and asked the Police to analyse a stain on her clothing. At that time he claimed to be homeless. The Police declined the request but did not think to check on the welfare of Jamie or Child 1.

7.14 Thereafter Roger quickly formed a plan. He lay in wait overnight for Jamie in the loft of her house and killed her the next morning. His motivation was evident from the texts he sent to friends and family: For example, on the evening before the homicide one text he sent said; 'Can't cope with this anymore I will take her out soon if this isn't resolved quickly', a later text said; 'Well I only got one answer, staying on my own but I'm gonna do her in. I get locked up we both lose except I'm still gonna have a life, not having it anymore Pal'. These remarks show his continuing disrespect for Jamie and an absolute disregard for Child 1.

7.15 The child safeguarding aspects of case were recognised and appropriate information shared with the Multi Agency Safeguarding Hub and health visiting in all but one case. The depth of Roger's offending was not known to either. One of the protective factor's for Child 1 was the parents' separation. The Multi Agency Safeguarding Hub recorded they would intervene if the couple reconciled. No action appears to have been taken by the Safeguarding Hub to request partners to tell

them if any professional knew, or suspect, Jamie and Roger had reformed the relationship.

7.16 The final conclusion of the domestic homicide review Panel is that Roger was a violent jealous man who had exerted coercive control over Jamie and when she decided to leave him he resorted to ultimate violence to maintain control. His sentiment in the text message recognised he would continue with his life whereas Jamie would be dead. Nowhere does he express remorse for his actions or concern for their child.

8. PREDICTABILITY/PREVENTABILITY

8.1 The Panel looked carefully and objectively at these points and sought evidence for its determinations.

Predictability

8.2 There is no doubt that Roger presented a risk of causing serious harm to the public. In 2009/2010 that risk was assessed as medium but it should have been high. He was not assessed as presenting a risk to partners.

8.3 As their relationship developed his history of jealousy materialised. On several occasions he challenged Jamie when he suspected, without foundation, that she was seeing other men.

8.4 In 2010 he was assessed by the Police as presenting a medium risk of causing serious harm to Jamie following what was reported as a verbal domestic dispute. In reality it was an early example of controlling behaviour.

8.5 Their relationship deteriorated in 2015. The tensions in the family were around Roger's heavy use of cannabis and the impact that had on childcare. Jamie did not trust him to look after Child 1 safely. He was employed sporadically whereas Jamie had a stable well paid career.

8.6 In the three months before her death the risks faced by Jamie increased from standard to medium and proportionate measures were put in place.

8.7 Jamie's case would have benefitted from a closer look in a multi-agency forum but did not reach the numerical threshold for a Multi-Agency Risk Assessment Conference and the level of concern did not trigger a referral via the professional judgement route. Jamie's case should have been identified as one requiring a Multi-Agency risk Assessment Conference.

8.8 Question 15 of the Domestic Abuse, Stalking and Harassment risk assessment asks, '. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you'?

8.9 Had it been known that Roger grabbed Jamie's throat the chances of the case going to a conference via the professional judgement criteria would have increased. When all the risk factors are taken together, including the 'gas' incident, the Panel felt he presented a high risk of causing her serious harm but it could not reasonably be predicted he would end her life.

9. RECOMMENDATIONS

9.1 Introduction

Agencies' Recommendations

9.1.1 The agencies' recommendations appear in Appendix D and are not repeated here.

Panel's Recommendations

9.1.2 These Are:

1. That Team Bury Community Safety Partnership considers whether its constituent agencies training on assessing risk in domestic abuse cases needs enhancing to ensure all risk factors are identified before setting the final risk level.

2. That Team Bury Community Safety Partnership considers how it can best reinforce the importance of professionals being aware that family and friends very often hold additional information to that which a victim reports, and to determine how such information might be accessed within an agency's confidentiality framework.

3. That Team Bury Community Safety Partnership reviews whether its advice to family and friends who have knowledge of domestic abuse has penetrated the community effectively.

4. That Team Bury Community Safety Partnership considers how it can work together to know when a reconciliation between a victim and perpetrator has, or is thought to have, taken place when separation is seen as a protective factor for a child.

Appendix A- Redacted Letter from Bury Safeguarding Children Board

Dear Sirs

NOTIFICATION REGARDING SCREENING OF CASE A16 BY BURY SAFEGUARDING CHILDREN BOARD (BSCB) CASE REVIEW & LEARNING SUB GROUP

I am writing to inform you that the above case was screened by the BSCB Case Review and Learning Sub Group on Wednesday 20 April 2016. The Case Review and Learning Sub Group recommended that the case does not meet the criteria for holding a serious case review as sub group members felt that the child had not suffered significant harm. It was, however, noted that there is a potential for impact on the child's emotional and psychological wellbeing in the future.

However, Sub Group members agreed that the following points need to be considered:-

• Consider whether the police shared historic information on the perpetrator with partner agencies in order to safeguard the child.

• Understand the reasons for the poor quality of information and delay in referrals from the PPIU to Children's Social Care and the amalgamation of two incidents into one referral in respect of the incidents on 11 November 2015, 5 and 11 January 2016.

• Consider whether agencies considered the cumulative effect of the past history and current incidents on the welfare of the child.

• Consider whether agencies considered the direct risk to the child from the father following his threats to snatch her.

• Consider whether agencies took into account the increased risk to the victim and therefore to the child at the point of the relationship ending.

We would be grateful if you could incorporate these points into the terms of reference for your current domestic homicide review to avoid asking agencies to duplicate work. Once it is available, please could you also provide me with the completed Domestic Homicide Review report so that it can be considered by the BSCB Case Review and Learning Sub Group and any learning relating to safeguarding children incorporated into the BSCB Case Review action plan trackers. I would be grateful if you could confirm whether this is possible.

Thank you for your assistance with this. Please do not hesitate to contact me if you require any further information.

Yours sincerely

Maxine Lomax

MAXINE LOMAX CHAIR OF BSCB CASE REVIEW & LEARNING SUB GROUP/
DESIGNATED NURSE FOR SAFEGUARDING, NHS BURY CCG

Appendix B - Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

   "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.03.2013 is:

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

   - psychological
   - physical
   - sexual
   - financial
   - emotional

3. *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.

4. *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.

Appendix C – Health Visiting Policy

Health Visiting Services

[From www.england.nhs.co.uk]

The 4 Levels of Health Visiting Services.

These levels set out what all families can expect from their local health visitor service:

- Community: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.

- Universal (the 5 key visits): health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.

- Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.

- Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

Appendix D – Action Plan

Panel Recommendations							
No	**Scope of Recommendation**	**Action to Take**	**Lead Agency**	**Lead Officer**	**Key Milestones Achieved in Reaching Recommendation**	**Target Date**	**Date of Completion & Outcome**
1	That Team Bury Community Safety Partnership considers whether its constituent agencies training on assessing risk in domestic abuse cases needs enhancing to ensure all risk factors are identified before setting the final risk level.	Gain agreement from all agencies via CSP that they will re-visit their processes for assessing risk to ensure that their procedures for assessing risk are appropriate.	CSP	Tom Hoghton	Write letter to agencies requesting they check the points in the recommendation have been written Determine whether there is a gap in agencies risk identification practice. If a gap is found, develop a written plan to fill it.	31 Jan 17	
2	That Team Bury Community Safety Partnership considers how it can best reinforce the importance of professionals being aware that family and friends very often hold additional information to that which a victim reports, and to determine how such information might be accessed within an agency's confidentiality framework.	Contact Safe Lives to gain agreement that they will consider adding a section to the Dash for the customer to agree that they can contact friends/family to discuss the	CSP	Tom Hoghton	Contact made with Safe Lives and proposal made	31 Jan 17	

		situation.					
3	That Team Bury Community Safety Partnership reviews whether its advice to family and friends who have knowledge of domestic abuse has penetrated the community effectively.	1. Tap into the evaluation from the GM 'Sitting right with You' campaign which will look to assess awareness of DVA. 2. Aim to see whether public spaces such as libraries and doctor's surgeries are displaying materials raising awareness of DVA	CSP	Tom Hoghton	1 Approach made to Head of Comms at OPCC who agreed to try and produce some localised data from the evaluation. 2. Programme of visits to surgeries and libraries established by Community Safety Team	31 Jan 17	
4	That Team Bury Community Safety Partnership considers how it can work together to know when a reconciliation between a victim and perpetrator has, or is thought to have, taken place when separation is seen as a protective factor for a child.	To work with relevant teams to ensure that, where possible, warnings are added to systems highlighting that in the event of reconciliation, the relevant agency is informed	CSP	Tom Hoghton	Discussions taken place with Children's Services, Housing Assessment Teams	Jan 17	

Single Agency Recommendations Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1.	The level of knowledge and awareness concerning child safety for all police response staff is reemphasised and reinforced	This can be achieved by the production of a training package to be circulated to all Divisions for self-delivery at training or CPD days.	As evidenced by the production of the training package and accompanied by statistical data of staff that have completed the training on each division.	Greater knowledge and understanding of child safety issues for response staff.	DCS Rumney Head of Public Protection Division.	1st April 2017
2.	The Head of the Public Protection Division to commission work to evaluate the effectiveness of the STRIVE programme, and consider its implementation with a structured and established police input into the process.	A full evaluation of the effectiveness of the STRIVE initiative to be conducted in order to consider the most effective means of providing an improved service delivery to victims of domestic abuse who fall within the standard risk category.	The success of the STRIVE initiative will be evidenced by a reduction in the levels of violence inflicted upon victims of domestic homicide who were categorised in the standard risk category	Potentially improved levels of service and levels of protection offered to victims of domestic violence categorised in the standard risk category.	DCS Rumney Head of Public Protection Division.	1st April 2017
3.	The Head of the PPD should ensure that awareness around	This can be achieved by the production of a	As evidenced by the production of the	Greater knowledge and awareness of safety issues	DCS Rumney	1st April 2017

	policy and procedure where DV markers are in place be reinforced for all staff throughout the response policing establishment.	training package to be circulated to all Divisions for self-delivery at training or CPD days.	training package and accompanied by statistical data of staff that have completed the training on each division.	for response staff concerning persons at addresses containing a DV marker.	Head of Public Protection Division.	

	Cheshire & Greater Manchester CRC					
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1.	Line Managers to implement individual actions plans in relations to PK and MM to ensure implementation of learning from this DHR	Ensure the delivery of good mandatory practices and policy.	Case audit screening Supervision and discussion notes	Robust actions are followed to ensure holistic risk assessments and management of domestic abuse perpetrators. Probing and critical enquiry is evident in supervision of cases Effective response to risk escalation.	Rebecca Flynn Interchange Manager, Cheshire & Greater Manchester CRC (Risk Lead) to develop plan and implemented by Rebecca Flynn (line manger to MM) Christopher Martin (Interchange	Completed October 2016

					Manager for PK)	
	North Manchester Clinical Commissioning Group					
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1.	There is a need to ensure that GP practices are aware of risk factors relating to DVA and to know what to do if a concern arises. This has been a previous recommendation and an IRIS training plan is already in place, together with training by the CCG link nurses.	The CCG to prioritise Practice 1 and 2 for Domestic abuse training.	Documented evidence of training sessions delivered by IRIS training and CCG. Evidence of completion of training.	Improved awareness of health indicators associated with DVA.		Immediate.
2.	There is a need for all GP practices to establish a DVA policy and procedure. This has been a previous recommendation and needs to be audited to assess compliance. This needs to include a system for recording health indicators for domestic abuse in line with the Guidance for responding to domestic abuse published by RCGP, IRIS, CAADA (2012)	NHS England (Greater Manchester) to review audit compliance of previous recommendation made in Blackley DHR AF1. CCG safeguarding link nurses to review compliance at their next visit of all practices.	Audit report. Documented evidence of visit and compliance.	DVA policies and procedures will be in place in all GP practices.	NHS England (Greater Manchester) Safeguarding Lead. Head of Safeguarding CCG.	Immediate
3.	There is a need to raise awareness of DVA and help and	GP practices to be encouraged to raise	Dissemination of learning and	Increased public awareness of domestic abuse and help	CCG Safeguarding	Immediate

	support services available, within GP practices to their patients.	awareness of domestic abuse and support services within their surgeries by the displaying of educational posters and leaflets. This is also included in IRIS training.	recommendation to all GP practices. Include within training.	and support services.	Lead.	
4.	Relationship Continuity of care was not provided to WM. It is know that this promotes patient compliance and would maximise opportunities to identify risk. Whilst this is not considered to be a significant issue for the practice, there may be usefulness in exploring this further.	GP Practice 2 to explore if there are practical ways of maximising relationship continuity using this case as a significant event. The RCGP toolkit for Continuity of Care provides a useful guide of how to do this.	Agenda item at practice meeting and significant event analysis.	Increased continuity of care evidenced in patient satisfaction surveys.	GP safeguarding lead Practice 2.	Immediate

	Pennine Care NHS Foundation Trust					
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**	**Lead Officer**	**Date**
1	Future consideration should be given towards reviewing the existing guidance for staff relating to responding to domestic abuse notifications.	Develop guidance for health practitioners on responding to domestic abuse notifications	• Production of Guidance • Evidence of training • Evidence in staff competency via appraisal • Evidence in supervision records	• Increase Awareness for staff • Improved client experience • Improved multi-agency communication • Timely assessments and referrals as appropriate	Bury Community Services Safeguarding Team. Health Visiting Team Leads	31.12.2016
2	Future consideration should be given to reviewing the current MASH information sharing Pathway within PCFT.	Review MASH information sharing Pathway within PCFT.	• Production of updated Information sharing pathway. • Evidence in supervision records. • Audit of the information sharing pathway.	• Increase awareness of staff • Improved client experience • Improved multi-agency experience • Timely assessments and referrals as appropriate	Bury Community Services Safeguarding Team.	31.12.2016
3	The process for reviewing A&E attendances by the health visiting service and the service response should be updated.	Review the current process for reviewing A&E attendances within health visiting PCFT	• Production of Guidance on the appropriate response to A&E attendances • Evidence in supervision	• Increase awareness of staff • Improved client experience • Improved multi-agency experience • Timely assessments and	Bury Community Services Safeguarding Team.	31.12.2016

			• records. Audit of the implementation of the A&E Guidance	referrals as appropriate	Health Visiting Team Leads	
4	All PCFT staff working with children and families should be competent and confident in their knowledge and skills to effectively challenge within health and partner agencies in complex decision making	• To develop a flow chart for practitioner to use detailing the process of challenge and escalation • To provide training on professional challenge	• Production of a flow chart • Evidence in supervision records.	• Increase awareness of staff • Improved client experience • Improved multi-agency experience • Timely assessments and referrals as appropriate	Bury Community Services Safeguarding Team Health Visiting Team Leads	31.12.2016

Appendix E - Letter from the Home Office

Home Office

Public Protection Unit
2 Marsham Street London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

6 April 2017

Dear Chief Superintendent Sykes,

Thank you for submitting the Domestic Homicide Review report for Bury to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21 March 2017.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a clear, easy to read report in which the dynamics of coercive and controlling behaviour have been well articulated and where relevant research has been referenced. The report has been enhanced by the contribution of family and friends. The Panel particularly commended the timely completion of the review.

There were, however, some other aspects of the report which the Panel felt could benefit from further analysis or be revised, which you will wish to consider:

- Given the particular circumstances of the case, the Panel concluded the review may have benefited from having a children's social care representative on the review panel. In the absence of such representation, the Panel suggested you may wish to review the commentary and analysis around children's social care to satisfy yourselves that appropriate learning has been identified ;

- It would be helpful if the action described in paragraph 6.1.2 could be more explicitly identified in the lessons set out in section 6.6;

- Please review the language used in the report. For example in paragraphs 7.4, 7.14 and 5.5.26;

- You may wish to consider the removal of paragraph 8.10 as the statement

cannot be absolute (under the revised statutory guidance there is no longer a requirement for DHR reviews to consider preventability and predictability);

- You may wish to consider whether risk factors, such as suicide threat and separation, have been sufficiently explored in the review;

- It would be helpful if the report could confirm whether the family provided the pseudonyms;

- Please proof read as the victim's real name appears in the report;

- In relation to the action plan, the Panel noted and particularly commended the programme of visits to surgeries and libraries. The Panel would welcome further information about these visits in due course as one of their key responsibilities is to identify effective local practice which can be disseminated as best practice at a national level.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to your PCC for information.

Yours sincerely

Christian Papaleontiou

Chair of the Home Office DHR Quality Assurance Panel