SAFER STOCKPORT PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

IN THE CASE OF MV

PERIOD UNDER REVIEW

1ST SEPTEMBER 2011 TO 20TH NOVEMBER 2012

OVERVIEW REPORT

Contents

1 – BACKGROUND AND INTRODUCTION

1.1 Key People and Locations

PSEUDONYM	RELATIONSHIP TO SUBJECT	ADDRESS AT TIME OF INCIDENT
MV	SUBJECT	Address 1
MVP	PERPETRATOR	Address 2 **
MVD1	DAUGHTER	Address 2
MVD2	DAUGHTER	Address 2
MVD3	DAUGTHER	Address 2
MVS	SON	Address 2
MVS1	SISTER OF MV	Address 1
MVBL	BROTHER IN LAW OF MV	Address 1
MVPNP	FRIEND OF MVP	N/A

MV is also referred to as 'the victim' in this report. MVP is also referred to as 'the perpetrator' in this report.

**** Address 2 is the family home where MV and MVP lived with their four children. Following separation, MV was not living at Address 2 at the time of the fatal incident.**

1.2 Brief Synopsis

MV died on 20th November 2012 following an incident at Address 2 in which he received a fatal stab wound. His common law partner, referred to in this report as MVP, was subsequently arrested and charged with the murder of MV. Following trial MVP was convicted of manslaughter and is currently serving a custodial sentence.

1.3 Background

MV previously lived with his common law partner MVP and their four children MVD1, MVD2, MVD3 and MVS. Three of the four children have complex and enduring health needs that require daily contact with health care professionals.

At the time that the fatal incident took place, MV and MVP had been in a relationship for approximately 13 years. MV and MVP were the primary carers for the three children with complex needs. Despite her young age, MVD1 also provided care to the children and was classed as a young carer.

Both MV and MVP had experienced mental health problems during the 18 months prior to the incident leading to MV's death. Both MV and MVP had been referred to, and received treatment and interventions from specialist mental health services. Two weeks before his

death MV took an overdose of drugs and alcohol. He told his family and medical staff that this overdose was an attempt at suicide and that he wanted to die. He was said to have written a suicide note, although the DHR panel did not have sight of this.

As part of the DHR process the Independent Chair and Independent Author of the Review conducted an interview with MVP in prison in which she disclosed that the relationship between herself and MV had been turbulent for some time.

According to MVP, the relationship deteriorated after MV had an illness in 2011. MVP referred to this illness as a stroke, however, this is not substantiated in any of the medical records (on further investigation the panel were able to ascertain that there is no medical record or evidence that MV had ever suffered a stroke). MVP said that MV's personality changed after this illness and that he was much more impatient with her and the children, although there was no suggestion that he had become physically aggressive, he did make threatening remarks to MVP.

MV and MVP were both previously known to Greater Manchester Police, although neither had a history of domestic abuse. More than ten years ago MVP was involved in an incident where she had assaulted a young woman with whom she had had a dispute.

The panel gave specific focus to the pressures brought to bear on the family because of the complex and enduring nature of the illness suffered by three of the children. There is no doubt that this must have placed additional strain on the family. The long-term caring responsibilities of MV and MVP may have impacted their mental health, although this was not formally assessed as a factor in either of their diagnoses. There is no evidence to suggest that these caring responsibilities resulted in domestic abuse. In large part professionals reported that both MV and MVP placed all of their energy and resources into caring for the children.

Other risk factors were present in the relationship. Both MV and MVP were treated for mental health conditions. MP was treated by his GP for depression and MVP experienced a form of psychosis. Neither partner cited any aspect of their relationship as contributing to their illness, and neither referred to any physical or other abuse as a factor in their illness. Both MV and MVP used alcohol excessively on occasion, with MV this was a more recent occurrence and was discussed with healthcare professionals. MVP said she had used alcohol in the past but had not done so with any frequency since the children were born.

Despite the presence of these risk factors there is no evidence of domestic abuse in the relationship. MVP confirmed that, other than the incidents that took place on 15th November and the fatal incident, there had not been physical violence in the relationship. This testimony must be considered in light of the source, however, there is no other evidence to support any other conclusion than that MV and MVP had a fractious and difficult relationship, but not one that was characterised by control, manipulation or violence.

The relationship between MV and MVP finally broke down in October 2012, this was initiated by MVP who said she could no longer live with MV and wanted to begin a new life with the children. MV moved out of the family home at Address 2 and stayed with his sibling at Address 1. He saw the children and MVP on a daily basis, calling round to put the

children to bed. MV and MVP still spent time together during this period, and continued to share responsibility for care of the children.

MVP had developed a close friendship with a male friend, referred to as MVPNP in this report. This became a cause of heightened tension between MV and MVP, as MV had been troubled by rumours about MVPNP's past.

1.4 Events Leading to the Fatal Incident

During November 2012, two significant incidents occurred which, in the view of the DHR panel, were precursors to the incident of 20th November 2012 in which MV sustained fatal injuries.

The first of these events took place on 5th November 2012 when MV made an attempt at suicide and was admitted to NHS1 for medical care and referred for psychiatric assessment.

The second event took place on 15th November 2012 when a dispute occurred at Address 2 which police attended following a call from MVP. It appears that during an altercation between MV and MVP, MV received a stab wound to the abdomen. There are conflicting accounts as to how this injury occurred and whether or not it was self-inflicted. These accounts are the subject of an Independent Police Complaints Commission (IPCC) investigation.

According to information given by MVP at interview with the DHR Chair and Author, MV had inflicted the wound upon himself. From the information available to the DHR panel (and to the police) MVP's account cannot be proved or disproved. MV did not seek medical attention for this injury and medical staff only observed the injury when MVP was admitted to hospital following the incident on 20th November that led to his death.

As stated above, the incident that took place on 15th November 2012 was referred to the IPCC and has been subject to investigation by them. Further information regarding the process and findings of the IPCC investigation are given at 1.6 below.

1.5 Period Under Review

The DHR Panel set the time period for the Review as 1st September 2011 to 20th November 2012.

The Panel took into account the length of the relationship between MV and MVP and the significant history that they had with Health and Social Care agencies. A full chronology of contact with all agencies was compiled. The chronology contained information from all agencies going back to Social Care records from 1994. Whilst there were numerous contacts and interventions with agencies during this period, none of these contacts ever involved disputes between MV and MVP. There were no reports or suspicions of domestic abuse within the relationship by any professional involved with the family.

The Panel therefore agreed that it would consider information relating to significant events and contacts outside of this period if deemed relevant by IMR (individual management reports) authors. Some of the Individual Management Reports and the integrated chronology include contacts and events falling outside of the agreed review period. This additional contextual information is not subject to detailed analysis in this report but is

included to assist in understanding the dynamics within the family and the relationship between MV and MVP.

1.6 Parallel Processes

The conclusion of the concurrent IPCC investigation resulted in a delay in completing this DHR. The Home Office were notified of this in the early stages of the Review.

The referral to IPCC by GMP was made following an initial assessment of the effectiveness of the police response to a domestic incident involving MV, MVP in the presence of two other adult males MVPNP and MVBL at Address 2 in the early hours of 15th November 2012. All four children were in the house at the time of this incident.

The referral to IPCC stated:

> *"It is alleged that the attending officers failed to investigate the circumstances of the domestic incident and failed to take positive action. It is also alleged that the officers falsely cited that the DASH (Risk Assessment Process) questions had been refused and failed to report the true circumstances which led to an inappropriate risk assessment and a lack of safeguarding measures being implemented'.*

On 28th February 2014, the Independent Chair and Independent Author of the DHR met with officers from the IPCC to discuss the outcome of their investigation, and the bearing that this would have on the final overview report of the DHR.

The IPCC investigation addressed matters pertaining to police conduct at the incident on 15th November 2012. The IPPC has made several recommendations to Greater Manchester Police in this regard.

It is not within the purview of this report to analyse or discuss these recommendations, as these are matters for GMP and IPCC. Whilst this report refers to the IPCC investigation, it does not include any of the deliberations or findings of that investigation. Because of the IPCC investigation, the original Individual Management Report (IMR) submitted by GMP did not include interviews with police officers involved in the incident on 15th November 2012.

On completion of the IPCC investigation report, the DHR panel invited GMP to provide a revised IMR. GMP said that they would not be able to provide a revised IMR as police officers are not available for interview and no further relevant information is available for inclusion. The DHR panel has therefore accepted the original IMR submitted by GMP as their account and analysis of contacts, and has used the information contained therein upon which to base its conclusions in relation to the terms of reference and key lines of enquiry in this review.

The delays in finalising this overview report have not hampered the implementation of lessons learned from the review. The Local Safeguarding Children Board has undertaken a management/learning review of the needs of the children and has acted upon its findings.

Greater Manchester police are in discussion with IPCC regarding their recommendations. During this time GMP have undergone an HMIC (Her Majesty's Inspector of Constabularies) inspection in relation to the domestic abuse policy, the findings of which are being implemented.

Stockport MBC has undertaken a full review of its domestic abuse strategy and a revised model is currently in the process of implementation. This case has informed that review and lessons learned have been implemented.

The conduct and disciplinary findings of the IPCC investigation are being pursued. The IPCC has made two recommendations to Greater Manchester Police that are relevant to this report, these are:

Recommendation 1

The force should identify a method in which a supervisory review of the DASH form is recorded. In doing this the force should identify a suitable method to report on the quality of DASH forms and an effective method to identify learning and/or training requirements in this area.

Recommendation 2

The force to consider an effective system to ensure that DASH forms are being used and completed as intended.

1.7 Criminal and Coronial Matters

In May 2013 MVP appeared for trial for the murder of MV. The jury found MVP guilty of manslaughter and sentenced her to nine years imprisonment. A copy of the judge's summing up was made available to the Review Panel for information.

MVP is currently serving a custodial sentence. There are no outstanding or pending criminal or coronial matters.

1.8 Diversity Issues

Three of the four children in the family have complex and enduring health needs that affected the lifestyle and well-being of the whole family.

MVD1 was classed as a young carer and was engaged with a non-statutory service that provides support for young people who are acting as carers.

Both MV and MVP were assessed and treated for mental health conditions during the period under review.

2 DHR PURPOSE AND PROCESS

2.1 Statutory Guidance and Purpose

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

NB: The Safer Stockport Partnership is aware of changes to the DHR Guidance that came into force in August 2013. This review commenced before the new guidance was issued and therefore it is not applied in this review. However, the recent HO updated guidance in relation to the inclusion of family and friends in DHRs has been taken into consideration.

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

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

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

The definition of domestic violence used in this report is in line with the Home Office definition revised in September 2012 (that became operational in 2013) as follows:

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

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

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and

capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

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

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

2.2 DHR Review Panel

A multi-agency panel of senior officers from the relevant agencies was established and an Independent Chair and Independent Author were appointed in line with Home Office guidance. Neither the chair nor author had had any previous involvement in the case.

The Independent Chair was a senior officer in the Greater Manchester Fire and Rescue Service who held the lead for partnership working and development. The Chair had strong links with Community Safety Partnerships and a thorough knowledge of local delivery structures. The Independent Chair had no direct contact with the case and no management or other responsibilities for any panel member or service included in the review.

The Independent Author is an independent consultant who was recruited via a commissioning process. The Independent Author has considerable experience of conducting serious case reviews, including child and adult SCRs and Domestic Homicide Reviews. The Independent Author works with a national statutory body developing domestic abuse guidance and quality standards and has a background in community safety and crime reduction.

The panel held seven meetings between February 2013 and April 2014. The Independent Chair and Independent Author also met with officers of the IPCC and interviewed the perpetrator in prison.

Panel Membership

Agency	Title
Greater Manchester Fire and Rescue Service	Independent Chair
Stockport MBC – Adult Social Care	Service Manager, Safeguarding Adults and Mental Capacity Act Service
Stockport MBC – Children's Social Care	Service Manager
Stockport MBC – Safeguarding	Head of Children's Safeguarding
Stockport MBC – Neighbourhoods & Community Safety	Deputy Head of Service
NHS	Designated Nurse Safeguarding Children
Greater Manchester Police	Detective Inspector
Pennine Care NHS Foundation Trust	Director of Nursing

IN ATTENDANCE	
Independent Author	
Community Safety Officer with responsibility for Domestic Violence	**Stockport MBC**

2.3 Sources of Information Used in the Review

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

Agency	Format
Children's Social Care – Stockport MBC	**IMR**
Greater Manchester Police	**IMR**
Pennine Care NHS Foundation Trust	**IMR**
Stockport NHS Foundation Trust	**IMR**
General Practitioner MV and MVP	**IMR**
Signpost for Young Carers	**IMR**
Stockport Homes	**Short Report**
University Hospital of South Manchester	**Short Report**
Primary School 1	**Short Report**
North West Ambulance Service Foundation Trust	**Short Report**

Authors of IMRs met with the DHR panel to discuss their IMR reports and findings. The panel also received minutes of Team around the Child (TAC) meetings; copies of the assessment criteria for Mental Health Services (Patient Assessment Document) and a copy of the DASH risk assessment checklist *(a standard risk assessment tool for domestic abuse developed by Co-ordinated Action Against Domestic Abuse – CAADA that is used across the Greater Manchester police force area).*

A link to the TAC process is provided at Appendix 2 for information.

2.4 Family Involvement

The DHR panel actively sought to involve family members in the review from the outset. Three family members were invited to contribute to the DHR at the start of the process. This invitation was made via the police Family Liaison Officer. There was no response to the invitation and family members were contacted again as the review progressed, however, there was no response from them. This report does not therefore include the views of family members. The DHR panel believe that a contribution from family members would have provided an important perspective on the victim's life however, they respect the decision of the family not to participate. The DHR panel notes the importance of contributions from family members and will, in future reviews, ensure that any advocates working with the family are used to support their participation.

MV and MVP did not have any significant friendships or contacts with neighbours. The family had according to MVP, become very isolated because of the children's illnesses.

There were therefore no other friends or community members for the panel to approach. It is not known whether MV or MVP had any religious beliefs.

2.5 Perpetrator Involvement

The perpetrator, referred to in this report as MVP, was invited to contribute to the Review to which she agreed. MVP was interviewed in prison in October 2013. MVP's views are referred to throughout this report and summarised at Appendix 3. The DHR panel do not represent the views of the perpetrator as fact and acknowledge that they have not been substantiated by other sources, other than where they relate to specific events recorded by other agencies.

2.6 Quality Assurance

All IMRs and short reports were quality assured by a senior manager in the reporting agency. All reports were received on time and all appropriately addressed the key lines of enquiry. Compliance with the process was excellent and reports were of a high standard.

Authors of key IMRs were invited to attend a meeting with panel members. This proved a very valuable exercise and offered additional insight into agency responses to significant events in the lives of the victim and perpetrator.

2.7 Multi Agency Chronology

An integrated multi-agency chronology was prepared that provided detailed information on contacts with all agencies during the period under review.

2.8 Executive Summary

An Executive Summary of the review is available at www.saferstockport.org.uk

2.9 Key Lines of Enquiry and Summary Responses

The panel agreed seventeen key lines of enquiry that are set out below, with a brief summary of responses.

1. **What contact did you have with family members?**

   Each agency responded outlining their contact with family members providing full and accurate information. These contacts are set out in more detail at section 3 of this report.

2. **What services did your agency offer to the subject and other family members? Were these services accessible, appropriate and sympathetic to the presenting needs?**

   In the majority of cases agencies demonstrated that the specific services they provided to the victim, his family and the perpetrator were accessible, appropriate and sympathetic to their presenting needs.

The review found that aspects of single agency, interagency and multi-agency working could have been improved and these aspects are addressed further under the analysis of each agency's involvement in section 3 of this report. In the main these observations relate to the conduct of Team around the Child (TAC) meetings, liaison between Adult Mental Health Services and Children's services, and the police response to the incident that took place on 15th November 2012.

The range and complexity of needs of the victim and his family was significant and further analysis of presentations and responses as they relate to this review are contained in section 3 of this report.

3. **Did your agency have knowledge of domestic abuse in this family? If so, how was this knowledge acted upon?**

The police Public Protection Investigation Unit (PPIU) had previous records of contacts with MVP. These contacts did not relate to domestic abuse, are outside the timeframe of this review, and did not involve MV.

Prior to the incident that took place on 15th November 2012, none of the agencies involved in this review had any previous awareness or knowledge of domestic abuse between MV and MVP.

Following the incident on 15th November 2012, during a home visit by the Social Worker, MVP informed the Social Worker of the incident. The Social Worker's response to this disclosure is addressed in section 3 of this report.

The police notification to Children's Services of the incident that took place on 15th November 2012 occurred on 20th November 2012. This is within the usual timeframe but in this case, after MV's death.

4. **What safety planning was offered to the victim / family members including referral to specialist domestic abuse services?**

No safety planning was offered to either MV or MVP following the incident that took place on 15th November 2012, apart from a standard letter sent to MVP (as the assumed victim of domestic abuse). As the panel have not received direct statements or testimony from police officers in the case (due to the concurrent IPCC investigation) it is not possible to say why the officers at the scene assumed that MVP was the victim of domestic abuse.

The actions of some police officers attending this incident in relation to safety planning is judged as being inappropriate and not in line with expected procedure. These actions are the subject of further analysis at section 3.7.5. of this report.

5. **What (if any) services were offered to the perpetrator of domestic violence?**

No services were offered to MVP as a perpetrator. Following the incident that took place on 15th November 2012 MVP was assumed by police officers to be the victim of domestic abuse. MVP was not asked questions from the DASH risk assessment at the scene and this was completed by police officers after the incident

6. **What knowledge did the victim's family and friends have about domestic abuse within the family composition and what did they do with it?**

Despite efforts to involve the family in the Review, the panel have been unable to establish whether the victim's family and friends had any knowledge about domestic abuse between MV and MVP.

7. **Was the impact of alcohol assessed or suitably recognised? What action did your agency take in identifying and dealing with alcohol misuse?**

Alcohol misuse was recognised as a concern by MV's GP and by Mental Health Services.

MV was assessed as requiring referral to an alcohol treatment service by Mental Health Services and was provided with advice and information on how to self- refer to the local community alcohol service. MV indicated that he wished to receive help with alcohol misuse, however, MV did not refer himself to the alcohol treatment service and did not inform either his GP or the Mental Health Service of this. Thus, neither the Mental Health Service nor the GP was aware that MV had chosen not to avail himself of the service and the advice was not followed up by professionals.

The panel has questioned the efficacy of relying on patients to self-refer to services following an episode of significant self-harm and where the individual has consented. A multi agency recommendation is made in this regard.

8. **Was the impact of mental health/ illness assessed or suitably recognised? What action did your agency take in identification and dealing with mental health issues?**

Both MV and MVP were referred to mental health services during the period under review. Both were assessed by mental health services and both received interventions.

The Panel received detailed reports from the providers of mental health services from whom MV and MVP received individual services.

Practice in relation to the provision of mental health services was to an expected standard, however the panel have noted that current systems and practice should be strengthened in relation to adult and child safeguarding.

In this case, there were two adult carers living in the same household, both of whom were receiving interventions in relation to mental health, which may have affected

their ability to provide adequate care to their children. A multi-agency recommendation is made in section 5 of this report.

9. How did agencies, family members, and friends deal with any confidentiality issues the victim might have requested of them?

Family members did not respond to invitations to participate in the review and the Panel can therefore not comment on this key line of enquiry.

The perpetrator was interviewed as part of the Review. She indicated that, although the relationship with MV had been turbulent for a number of years, it did not contain physical violence between the parties.

MVP described a change in MV's behaviour following 'a stroke' saying that MV had become bad tempered and less compassionate. The panel could find no medical evidence that MVP had suffered a stroke.

MVP said that she had never found it necessary to seek support from services, family or friends because of any form of abuse within the relationship. When interviewed, MVP said that she had spoken to a solicitor about obtaining an injunction but this cannot be substantiated.

She did not refer to MV ever having spoken to family or friends about their relationship or whether he considered the relationship to be abusive.

10. Were there any specific diversity issues relating to the subject/family.

Three of the children in the family experience an enduring and complex medical condition that affected them and the family in their everyday lives. The management of this condition required daily contact with health services accompanied by medical interventions, both in the family home and in a range of medical and social care settings.

MVD1 was classed as a young carer which affected her daily life and for which she received support services from a young carer's service.

The response from agencies to supporting young carers living in families with complex needs is the subject of a multi-agency recommendation in section 5 of this report.

Both MV and MVP received interventions for mental health conditions during the period under review.

11. Were issues with respect to safeguarding children and adults adequately assessed and acted upon?

Some issues in respect to safeguarding children and adults were not adequately assessed and acted upon on every occasion.

These are further explored and analysed in section 3.5.1, 3.7.5, 3.8.1, and 3.10.3 of this report. A multi-agency recommendation is made in relation to safeguarding children and adults in families with complex health and social care needs.

12. Were there issues in relation to capacity or resources in your agency that affected the ability to provide services to the victim and to work effectively with other agencies?

No issues in relation to capacity or resources were identified by any of the agencies contributing to the Review.

13. **Was information sharing within and between agencies appropriate, timely and effective?**

There are occasions on which information sharing within and between agencies was not timely and effective. These are explored and analysed further in section 3.5.1, 3.6.3, 3.7.5, 3.10.3, and 3.11.1 of this report and within the single and multi-agency recommendations emerging from this review.

14. Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?

Arrangements for risk assessment and escalation of concerns were in place but these were not always effective nor were they used on every occasion. This is explored and analysed further in section 3 of this report.

15. Do any of your agency's policies / procedures / training require amending or new ones establishing as a result of this case?

The effective chairing of Team around the Child meetings was raised as a training issue that will be followed up through the Children's Social Care single agency action plan.

16. Was it reasonably possible for your agency to predict and prevent the harm that came to the victim?

Had all police officers attending the incident on 15th November followed procedure this would have triggered a review by PPIU of the incident and safety planning may have been different. PPIU conduct a daily review of all incidents that have occurred within the past 24 hours and proactively assess the suitability of the grading. However, it remains the view of the panel that this would not have significantly affected the outcome of this case.

It is the view of the DHR Panel that none of the agencies involved in the review could have predicted or prevented the harm that came to the victim.

17. Is there any other information that you think maybe relevant to this review?

The GP practice pointed out that they are unaware of a system of notification from University Hospital for South Manchester for GP's when a patient dies in circumstances such as this. The GP found out about MV's death through press coverage of the incident.

The Panel have established that a new system of notification of death to General Practice is about to be launched which will ensure that GPs receive quick notification.

3 AGENCY INVOLVEMENT

3.1 Brief Summary

Set out below is a summary of agency contacts with MV and MVP during 2011 and 2012. This is expanded for each agency and accompanied by analysis at points 3.5 to 3.14.2.

3.2 Agency Contacts in 2011

Both MV and MVP had contact with police, health, and social care agencies prior to the period under review. As stated in the introduction to this report, three of the children in the family had complex and enduring health needs. This resulted in the family having daily contact with health agencies and frequent contact with social care agencies.

In September 2011, according to MVP, she began to experience unusual thoughts and feelings about her safety. *MVP described this time as 'when she went bonkers'.* On 29th September 2011 MVP called the police saying that unknown people were 'hacking' into her I-phone and that she was concerned about a shadow in her TV, which pulsated when the TV was on.

The police officer dealing with the call referred the matter to the Public Protection Investigation Unit (PPIU). This resulted in a referral to the Mental Health Access Team (MHAT) on 5th October.

This referral was picked up on 6th October and the MHATM recorded that the information had been shared by police regarding MVP. MHAT informed the GP of the contact and they took no further action in line with expected practice.

On 9th November, MVP attended a GP consultation where a depression risk assessment was undertaken. MVP scored as having severe depression and describing auditory

hallucinations. Anti-depressants were prescribed and a follow up appointment was made for 23rd November. The GP also made an urgent referral to the MHAT.

On 10th November, the Mental Health Access Team received an urgent referral from the GP in relation to MVP. They tried to arrange telephone triage with MVP but there was no reply.

MHAT made contact with MVP on 11th November and an appointment with a Psychiatric Nurse was arranged, which MVP attended. A further appointment was made with a Psychiatrist for 19th December. MVP did not attend this appointment and a further appointment was not offered.

During this time, MV was in contact with his GP and hospital services in relation to medical interventions following a previous injury to his hand. He had several appointments with the neurology department of a local hospital that are unrelated to this review (NB this was not related to the perceived 'stroke' referred to by MVP).

Both MV and MVP had daily contact with health services regarding interventions for the three children during this time. They also had contact with Children's Social Care and other agencies at Team around the Child (TAC) meetings that were held regularly to discuss the care of the children.

3.3. Agency Contacts in 2012

MVP attended a further appointment with psychiatric services on 11th April 2012. It was noted that MVP had suffered from psychosis and a working diagnosis was that she had suffered from a delusional disorder. The Senior House Officer and Consultant Psychiatrist in the outpatient clinic agreed a treatment plan that included continuing medication. An appointment was made for 9th May that MVP did not attend. This was not followed up by the service and this was the last time that MVP was seen by them in the review period.

On 8th March 2012, MV called an emergency ambulance reporting that he had been suffering migraine for five days. MV was assessed in the A&E Department of NHS1 and treated with intravenous fluids and pain relief. He was discharged the same day and referred back to his GP.

On 30th March 2012 MV presented to his GP reporting that he was feeling depressed. The GP undertook a depression assessment that showed a moderate depression. A mental health assessment was undertaken and alcohol consumption was recorded. MV said he was not drinking at all at this time. MV did not demonstrate any thoughts of self-harm but was anxious and irritable. MV was prescribed anti-depressants and offered counselling, which he declined.

In early October 2012 MV and MVP ended their relationship. It appears that MVP had initiated the break up although she still wanted MV to be involved with the children. MVP had begun to spend more time with a male friend (MVPNP). MV moved out of Address 2, the family home, and went to stay with a sibling at Address 1 where he resided until his

death. According to MVP, MV continued to visit the family home each evening to spend time with the children.

On 5th November 2012 an emergency call was received from Address 1 reporting that MV had possibly taken an overdose of tablets with alcohol. The call was made by MVS1, the sister of MV, who stated that he had 'fitted' twice and was 'irate'.

The Ambulance crew recorded that MV had said he wanted to take his life. The caller said that he had tried to get a knife from the kitchen and fitted a pipe to the exhaust of his car. MV had apparently left a suicide note (although this was not recovered).

North West Ambulance Service attended Address 1 where they found MV requiring medical attention. Ambulance crew had reported to police that they were attending Address 1 to attend a male who had tried to commit suicide by fumigation and by use of a knife. Police were asked to attend because MV was described as being aggressive and posing a potential threat to the safety of paramedic staff. Upon arrival, paramedics dealt with MV without risk to themselves and telephoned police to say that they did not require the presence of a police officer at Address 1.

North West Ambulance Service (NWAS) staff did not make vulnerable adult referral in relation to MV, as he did not meet the criteria set out in the NWAS vulnerable adult policy.

At 20.30 hours MV presented by emergency ambulance to the Emergency Department (ED) at the local Hospital where he was assessed by a Doctor and found to have taken an overdose of Zomorph (morphine sulphate tablets).

MV was transferred from the Emergency Department to the Medical Assessment Unit (MAU). It is documented in the notes that MV had been quite aggressive and his family had tried to keep him calm.

When handed over to MAU the 'cause for concern' procedure had not been completed as MV was aggressive. (Cause for concern is an internal process to identify adults who have children and whose presentation may impact on the welfare of their children). A family member accompanying MV provided his children's names and said that they were at home with their mother. MV was assessed and transferred to the psychiatric unit for observations.

MV did not wish to remain on the psychiatric unit and asked to be discharged. On 7th November 2012, following assessment by a consultant Psychiatrist, he was discharged to Address 1 and a follow up appointment was planned for *17th December 2012.*

On 15th November 2012 police attended Address 2 following a call that there had been a domestic incident. It appears that MV had sustained a stab wound at this incident which he mentioned to police officers attending, however the circumstances of this are unclear and no action was taken in relation to the wound. MV did not seek medical treatment for this

and the wound was not discovered until he was examined following the fatal incident that occurred on 20th November.

The conduct of police officers in relation to this incident is referred to elsewhere in this report and has been subject to IPCC investigation. It is understood that police officers did not undertake a DASH risk assessment at the scene, but completed this after the event, recording that MVP had refused to answer any of the DASH risk assessment questions. According to MVP, she was never asked any questions at the incident. The DHR panel has concluded that some police officers made the assumption that MVP was the victim in this incident.

On 20th November police were again called to Address 2 following a report that MV had been stabbed in the neck, the caller identified herself as MVP. On arrival the ambulance crew administered emergency support and MVP was taken to a local hospital where he died from his injuries.

1.4 Detailed Agency Contacts and Analysis

Agencies were asked to submit information based on their contact with MV during the period under review. The Panel also asked for information in relation to contact with MVP, MVD1, MVD2, MVD3 and MVS during the same period.

Because of the complex health needs of MVD2, MVD3 and MVS the family had daily contact with health care professionals. These contacts have not been analysed individually. A summary of any significant events in these contacts is provided below within the agency contacts set out below.

- Children's Social Care
- General Practitioner (MV and MVP)
- Greater Manchester Police
- North West Ambulance Service Foundation Trust
- Primary School 1
- Pennine Care NHS Trust (Mental Health Services)
- Signpost for Young Carers
- Stockport Foundation Trust (Medical Services)
- Stockport Homes
- University Hospital of South Manchester

Children's Social Care

Children's Social Care had been in frequent contact with the family since 1994.

The Panel gave careful consideration as to the level of detailed information that should be provided within this overview report in relation to the family's daily contacts with Health and Social Care agencies. It was judged that this would not add to understanding of the

case, save for the recognition of the additional caring responsibilities placed on MV and MVP and the strain that this would place on any relationship.

Contact within the review period was as follows:

The family was referred via the Children's Services contact centre on 9th November 2011 by a healthcare professional. A signed Common Assessment Framework (CAF) completed on 1st November 2011 supported this referral. The CAF highlighted that the parents found that the burden of care of the children was mentally and physically too much to cope with.

The family was subject to Team around the Child (TAC) arrangements. The TAC process is a national systematic response to working with children considered to be 'In Need' [Section 17 Children Act 1989]. A full description of the TAC process and outcomes can be found in the link at Appendix 3. In this case, TAC meetings were held every 8-12 weeks, slightly more often than the usual frequency, which would normally be every 12 weeks.

According to the Children's Social Care (CSC) record, 'chaotic' home conditions featured throughout the file recordings, with varying degrees of deterioration and improvement taking place across the period under review.
Throughout the period under review, one Social Worker managed the case at Team around the Child Level 3. During this period, there was a clear multi-agency commitment to the TAC process. All meetings were well attended by professionals and by MV and MVP with one exception in January 2012 when the parents did not attend.

During TAC meetings each agency contributed, minutes were taken and actions agreed upon. The management of the children's day-to-day care needs was well co-ordinated through the TAC meetings. The physical health needs of the children were the primary focus of TAC meetings. The mental health of MV and MVP was not discussed in the meetings because the information remained with mental health services.

MVD1 was not subject to an initial Common Assessment Framework (CAF) assessment and was therefore not an 'open case' to Children's Social Care, this in turn meant that she was not subject to any Initial Assessment or Core Assessment which would have explored her needs in more detail and resulted in a care plan.

MVD1 was considered in TAC meetings, and services were provided by Signpost for Young Carers. There is no evidence to suggest that MVD1 required more from services or that her safeguarding needs were not met.

Two consistent themes throughout TAC records are that MV and MVP felt they were being criticised by professionals, along with concerns about weight loss of one of the children. It does not appear that these issues were addressed with the parents on their own or in any specific way outside of the TAC meetings.

According to the Children's Social Care IMR it is difficult to determine whether the parental response to perceived criticism was a genuine emotive response, or a means of preventing

the issue being discussed in any meaningful way. It appeared that MVP in particular was often upset and that professionals did not feel able to progress the issue with her.

3.5.1. Analysis of Agency Involvement

The Children's Social Care practice between September 2011 and October 2012 was generally to an expected standard. However, events that took place in November 2012 should have received a more robust safeguarding approach, rather than attempting to manage these within the TAC process.

Within the case records and TAC meeting notes there is no reference or consideration of MV and MVP's lack of engagement with social care staff outside of TAC meetings. Nor is there any analysis of the impact that this had upon their ability to meet the children's needs. It would have been desirable to have considered this further as part of a thorough on-going assessment.

MV took an overdose on 5th November 2012 which was combined with a large quantity of alcohol. Although Children's Social Care was notified of the overdose by the hospital, there appears to have been no assessment in relation to the risk this may have presented to the children.

MVP's mental health was referred to on a regular basis at meetings. However, there was no explicit consideration given to the way in which MVP's mental health may impact upon her capacity to parent There does not appear to have been sufficient attention given to MVP's mental health in any parenting assessments that were undertaken.

Similarly, there is insufficient analysis in relation to MV's illness in April 2012 and its potential impact on his capacity to parent effectively. One month after this MV appears to have been undertaking the majority of the childcare. Professionals note he was struggling, whilst MVP attended to MVD2 in hospital however, no specific action was taken to address parenting capacity.

The incident involving NWAS where MV attempted suicide does not include reference to him having a knife in the records, although the Social Worker was made aware of this. Whilst there was good and swift dialogue between the Social Worker, the parents and respective agencies, it does not appear the knife issue was ever checked or qualified. When spoken to by the Social Worker MV could not recall ever mentioning the knife. Because of this, it did not go any further or feature in any risk assessment.

On 9th November 2012, MV was discharged from hospital following the suicide attempt. There was no discharge meeting held although a plan was formulated in discussion with the Social Worker. When MV was discharged from hospital, he stayed with MVS1 at Address 1. However, there was no risk assessment or safety plan completed by the Social Worker regarding his future contact with the children.

At that time, it also appeared that the MV and MVP were sharing information with the Social Worker about problems in their relationship that had not been previously disclosed. MVP cited mood and behaviour change in MV. It is clear that there was a difference

between what was observed and reported upon by professionals and seemingly, what was actually going on between the parents. In support of the professionals, there does not appear to be any strong evidence or observations that would suggest the parental relationship was breaking down at this stage.

On 14th November, the Social Worker became aware that MV was having contact with MVP and that he planned to move back in to the family home. (This is not borne out by MVP's account, she said that the meeting they had was to arrange for the care of the children as they were splitting up for good).

It remains unclear whether MV was aware that MVP did not want to resume the relationship. Following the disclosure by MV regarding resuming the relationship, there was no risk assessment completed or strategy discussion with the Police. The prospect of MV moving back into the family home could have been considered to be a child protection issue given MV's overdose and surrounding events that day.

In regard to the incident that occurred on 15th November, the records do not mention that a knife was involved in this incident. The police Domestic Violence report was received 8 days after the event and subsequent death of MV. At a home visit following the incident on 15th November, it is evident that the Social Worker advised MVP that as parents they need to sit down amicably and resolve the issues otherwise they would need to seek legal advice. However, it is unlikely that the difficulties experienced by MV and MVP could realistically have been resolved in this way and a Section 47 (Children's Act) strategy meeting should have been called to consider the wider safeguarding issues for all the children.

3.5.2. Single Agency Action Plan

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

3.5.3. Multi-Agency Recommendations

See recommendations 1a, 1b and 1c.

3.6 General Practitioner

All the family were registered with the same General Practice throughout the time period under review. The practice is a large local practice and the family were well known to the GP because of the complex and enduring health needs of three of the children. MV, MVP and the family used the practice with frequency and saw several GPs.

During the period under review MV's GP recorded 22 contacts with him or on his behalf.

The GP practice was aware that MV had had previous problems with alcohol misuse dating back to 2002 and 2006. This was documented on MV's records and discussed with him on two occasions, in March 2012 when he presented with depression and following his attempt at suicide in November 2012.

3.6.1. Contact 2011

On 18th October 2011 the GP surgery received a telephone call from the children's Paediatric Consultant expressing concern regarding MV and MVP's physical and mental health. This led to the GP sending separate letters inviting MV and MVP to a surgery appointment to discuss their mental and physical health needs. The children were placed on the 'vulnerable list' at the practice. Appointments were made for both MV and MVP on 26th October, but neither of them attended.

On 9th November MVP presented to the GP and received a depression assessment (PHQ9). The score was 27 out of 29, indicating 'severe' depression. The GP noted possible auditory hallucinations. A prescription was issued for anti-depressant medication and an urgent referral was made to the Community Mental Health Team (MHAT). This referral was received on 10th November 2011. MHAT attempted to contact MVP by phone to conduct triage, but were unable to reach her.

The Community Mental Health Team (CMHT) made contact with MVP the following day and an appointment was offered for 17th November. MVP attended the appointment and the Psychiatric Nurse completed a further assessment.

On 23rd November the Health Visitor conducted a home visit to assess MVP's mental health as requested by the GP. It was noted that MVP appeared stressed, saying that she was overwhelmed by the responsibilities of caring for the children. She was awaiting an appointment with the Consultant Psychiatrist following assessment with a Psychiatric Nurse.

3.6.2. Contact 2012

On 16th January the GP sent a letter to MV asking him to attend an appointment to discuss what he described as 'pressures'. MV did not attend not this appointment.

On 30th March, MV consulted his GP saying he was experiencing depression. The PHQ9 assessment tool was administered and gave a score of 10 out of 27 indicating moderate depression. A mental health assessment was completed and the GP enquired about alcohol use and any thoughts of self-harm.

MV reported that he was not drinking alcohol at present but that he was feeling irritable and 'keeps snapping'. He was prescribed anti-depressants and was offered counselling but he declined this.

On 20th April MVP was seen by Mental Health Services at a re-arranged appointment. MVP's 'differential diagnosis' was documented as delusional psychotic schizophrenia. A letter sent to the GP confirmed that there was no alcohol or illicit drug misuse reported and also confirmed that the service was aware of Team around the Child meetings. There was a request that the GP continue prescribing antidepressants and anti-psychotic medication and arrange ECG and blood tests

On 18th May a letter was sent from Mental Health Services informing the GP that MVP had cancelled an appointment scheduled for 9th May and that a new appointment would be

arranged. No action was taken by the GP as the letter indicated that a new appointment would be sent. However, there was no further correspondence to indicate whether this appointment was offered or whether MVP had cancelled or missed further psychiatric appointments. Nor was there any correspondence to confirm whether MVP had been discharged from Mental Health Services.

On 8th November the GP received a fax from Mental Health Services informing that MV had been admitted following overdose. This was recorded on MV's records and a letter sent with a GP appointment for 13th November.

On 14th November MV attended a GP consultation. He reported feeling depressed and the GP noted previous consultations and correspondence with mental health services. The GP also noted that MV had good eye contact and rapport and agreed to prescribe an anti-depressant for MV although this was limited to a two weeks prescription due to the recent overdose.

The GP noted clear instructions regarding follow up and access to emergency appointments if required.

3.6.3. Analysis of Agency Involvement

The Practice recognised the impact on the family as a whole having three young children with significant chronic illness. The care of the children involved multiple hospital appointments, home treatments and assessments, complex medication regimes and frequent hospital admission. Most of their care required specialised secondary care input.

Co-ordinating the extensive and frequent medical care, combined with routine appointments for immunisation and coping with family life including school attendance was recognised by the GP as a significant challenge for MV and MVP as carers.

The children were placed on the vulnerable list at the practice and all clinicians recognised the importance of information sharing where vulnerable children are involved. Information was shared within the practice team, letters were passed to the safeguarding lead, and discussions were held within the practice where relevant, and important information was documented. The practice contacted a member of the TAC team with important information regarding MV's overdose.

Both MV and MVP had mental health issues that are documented in the chronology record. This was recognised as a concern by the GP. The practice was proactive in trying to engage both MV and MVP to discuss the impact on their mental and physical health of their caring responsibilities. Missed appointments and follow up after hospital assessments were dealt with proactively.

There was no indication of domestic abuse within the family and therefore the GP did not undertake screening or enquiry into domestic abuse issues.

The GP did not receive minutes of the TAC meetings, which would have been helpful to them.

3.6.4. Single Agency Recommendations

There are no single agency recommendations from the General Practitioner.

3.7 Greater Manchester Police

3.7.1. Information Received in the GMP IMR

Greater Manchester Police submitted an IMR to the Review Panel setting out a factual record of police contacts with MV, MVP, MVPNP and MVBL during the period under review.

Before the IMR was completed a representative of the Police Federation informed the IMR author that all six officers involved in the incidents had declined to participate in the DHR process based on Police Federation advice. This response was anticipated. The officers are entitled to take this stance on the basis that they are at risk of personal sanctions for gross misconduct as a consequence of the IPCC investigation.

The IMR submitted to the DHR therefore contained no direct personal insight or testimony from any of the six officers who attended the incident at Address 2 on 15th November 2012, although reference is made to the content of witness statements made by them as part of the homicide investigation.

3.7.2. Contact Prior to the Review Period

Between May 2006 and May 2011 there were nine incidents involving family members of MV, which resulted in referrals to the PPIU. None of the nine reported incidents involved domestic disputes between MV and MVP.

Police also had previous contact with MVP for a number of incidents. These incidents do not have any bearing on this review and are considerably outside of its timeframe.

3.7.3. Contact 2011

On 29th September 2011 a police officer went to Address 2 after MVP called the police to report that she believed people were 'hacking' into her i-phone and taking photographs of her children. She told the officer that she was also concerned by a shadow in her television set which pulsated when the TV was on.

GMP safeguarding policy states that all FWINs (Force Wide Incident Notifications) relating to concerns for the welfare of a vulnerable person due to mental health issues should be endorsed with sufficient information to facilitate referral to partner agencies. The attending officer should also assess the level of risk of the individual concerned. PC4 attended Address 2 and summarised his assessment of the incident as follows:

> *'MVP has recently bought an 'iphone' however she is not used to its controls or 'App's'. She has downloaded her first 'App' today and believes that an unknown person has hacked her phone. Evidently, this was not the case, advice only on this occasion as no offences have occurred. False call good intent.*

The officer appropriately endorsed the FWIN with the correct closing code. This indicated 'concern for the welfare of an adult aged 18 or over'. This automatically generates a referral of the incident to the PPIU, therefore there was a formal referral of the circumstances to the Mental Health Access Team by the PPIU on 5th October 2011. A police officer assessed the level of risk as low.

3.7.4. Contact 2012

At 22.04 on 5th November 2012, police were notified of an incident at Address 1. North West Ambulance Service (NWAS) informed the police that they were attending to a report of a male (MV) who had taken an overdose. NWAS had notified police of the incident due to reference to MV being in possession of a knife. Police attendance at the incident was not requested. The original 999 call had been made by MVS1. The Police FWIN (Force Wide Incident Notice) records:

> *"MV tried to put a hose pipe in the car window, and tried to get a knife. He's been stopped from doing this, he is upset but calm."*

The FWIN was closed with an appropriate 'G17' code indicating potential mental health issues. This creates an electronic document that is seen and reviewed by PPIU. The PPIU report confirms that a referral was made to the local mental health team at 11.13am on 14th November 2012 by an adult safeguarding officer from PPIU2.

What is apparent however is that neither the call handler on the night or PPIU2 sought to obtain further information about the circumstances of the incident by contacting NWAS, the hospital or MVS1 after the incident. As a consequence, details contained in the subsequent referral were minimal.

On 15th November 2012 police attended Address 2 following a call that there had been a domestic incident, MVP made this call.

According to the police report, the background to this incident was that on the evening of 14th November 2012 MV and MVP had met at Address 2 to discuss the future arrangements for care of the children, following their decision to separate.

At some point in the late evening MV left to return to Address 1 where he was now living with his sister MVS1 and her family. After MV left, MVP contacted MVPNP and invited him to join her at Address 2 which he did. In the early hours of the morning MV returned to Address 2 and found MVPNP at the house.

According to the police log report, an argument broke out between the two and, in circumstances that have not been clearly established by the police investigation, MV sustained a puncture wound to his stomach allegedly from a knife. (According to MVP in her interview with the DHR Panel representatives this wound was self-inflicted). MVP telephoned the police and MV telephoned MVS1 and her partner MVPNP. MVPNP came round to Address 2 shortly after this call.

Police attended and dealt with the incident which became subject to IPCC investigation.

On 20th November 2012 police arrested MVP for the murder of MV following his admission to hospital with a fatal stab wound to his neck.

3.7.5. Analysis of Agency Involvement

The analysis contained in this report is subject to the following caveats:

- It is based on the police IMR that did not include interviews with the police officers concerned in some of the key incidents.
- A concurrent IPCC investigation has been conducted and recommendations have been made to the Force. These recommendations are set out on page 6/7 of this overview report.
- The DHR panel have not been provided with a copy of the IPCC report. The Independent Chair and Author have viewed the report.[1]

Prior to the incident that took place on 15th November 2012 between MV, MVP and others, police had no knowledge of domestic abuse within the relationship between MV and MVP. MVP was known to police from previous incidents, however these incidents were not related to domestic abuse and had occurred significantly outside of the time period of this review.

When MVP came to the attention of police in October 2011, following her self-report of being afraid that someone was hacking into her phone, the police response was timely and appropriate, generating a referral to the PPIU on the basis of adult vulnerability in relation to mental health. There is no mention in the IMR as to whether the safeguarding needs of the children were considered in relation to the incident and this has been raised as a potential area for learning from this review.

Police liaison reported on 5th November 2012 by North West Ambulance Service, when MV had taken an overdose, was dealt with according to agency standards and protocols and raises no issues for concern. However the fact that police did not attend or follow up the threat by MV to take his own life, despite indications of vulnerability, has highlighted a gap in GMPs graded response policy. In cases where no officer visits the scene of an incident, vulnerability can still be identified by a call-handler, and the FWIN may still be coded to reflect this, which would automatically forward it to the relevant PPIU for further action. On this occasion, neither the call taker nor the PPIU officer sought the required risk assessment information. This learning is reflected in the GMP single agency action plan.

In relation to the incident that took place on 15th November the case was assessed the following day by a PPIU officer as a non-priority domestic incident with a standard risk assessment.

Based on the available information from the FWIN and DASH risk assessment form the standard risk assessment was approved. A file note was created late in the afternoon for the departmental administrator to notify Social Care and Health partners of the circumstances

[1] The IPCC Report was published in March 2015

and a standard domestic incident 'victim' letter was sent to MVP that afternoon. The PPIU administrator did not work on Saturday 17th or Sunday 18th November. In addition, based on the available information the case was not identified as a priority. Because of this, it was not referred on Monday 19th November, because the priority on that day was to assess and refer medium and high priority cases that had been notified to the PPIU over the weekend. The case was identified for referral on Tuesday 20th November but the process was not completed and as a consequence the referral information was not sent.

The PPIU was provided with minimal information on 15th November 2012 although there was no indication prior to 20th November 2012 that this information was incomplete. Therefore, the case was never risk assessed above 'standard risk' and was not therefore prioritised. Despite this PPIU staff assessed the case appropriately, based on the available information and correctly identified a need to refer the circumstances to partner agencies. Bearing in mind the volume of similar referrals and the intervening weekend period the fact that the referrals were not made on either 19th or 20th November was not unusual.

In relation to the fatal incident that took place on 20th November the referral reports that had been prepared in anticipation of being sent on Wednesday 21st November were pended on the instructions of a supervisor. There were two reasons for this decision. (a) Police and partners were already in dialogue and information exchange was taking place as a consequence of the murder investigation and in order to co-ordinate efforts to ensure the safety and care of MVD1-3 and MVS.

The decision taken to pend the referrals on Wednesday 21st was reasonable and based on sound rationale bearing in mind that multi agency dialogue was already ongoing and had been since 21st November in order to facilitate both the murder investigation and safeguarding considerations in respect of MVD1, MVD2, MVD3 and MVS.

3.7.6. Single Agency Recommendations

A single agency action plan is provided at Appendix 1.

3.8 North West Ambulance Service

During the review period, North West Ambulance Service (NWAS) had three contacts with MV during the period under review.

The first contact was on 8th March 2012 when MV called an ambulance saying that he had had migraine for five days.

The second contact was on 5th November 2012 when a 999 emergency call was received at 21:59 from address 1. The call was made by MVS1 due to MV having possibly taken an overdose of tablets (Zomorph[2]) with alcohol. The caller stated that MV had 'fitted' twice and was being 'irate', she said he could be aggressive and he was heard shouting in the background 'get off me'. There was also mention that MV had been in possession of a knife.

An ambulance took MV from Address 1 to the local hospital. The crew noted that MV had said he wanted to end his life and that he had tried getting a knife from the kitchen and a

[2] An Opiate based drug

pipe to the exhaust of his car. MV had apparently left a suicide note, although this was not recovered. Police were informed of the call-out due to MV becoming aggressive, however they were not required to attend and did not do so. NWAS did not make a vulnerable adult referral as MV did not meet their criteria. As the call was from Address 1 there were no safeguarding issues noted at the address.

The third contact took place on 20th November 2012 in the form of Emergency 999 call at 23:29 to Address 1. The call was made by a female believed to be MVP (she described herself as MV's partner). Children could be heard in the background. MVP said there were four children in the house.

Basic life support instruction was given to MVP to help MV. An Advanced Paramedic arrived on scene at 23:37 followed by a two- person ambulance at 23:39. MV was transported by ambulance to hospital where basic life support and Advanced Life Support (using cardiac drugs) were commenced and continued en route to the receiving hospital. The Advanced Paramedic travelled in the ambulance with the crew. They arrived at hospital at 00:13, the hospital had been pre-alerted. Although there were known to be children at Address 2 *no safeguarding referral was made for the children.*

3.8.1. Analysis of Agency Involvement

NWAS provided appropriate emergency services on three occasions to MV which are well documented in their IMR.

The response to child safeguarding was insufficient. Following MV's overdose on 5th November 2012 NWAS did not make a vulnerable adult referral as MV did not meet the criteria for such a referral.

When the crew attended Address 1 on 20th November they were aware that children were present at the scene of the incident however, no safeguarding children referral was made. **The incident that they were responding to was a life-threatening situation and this had primacy.**

3.8.2. Single Agency Action Plan

There is no single agency action plan from NWAS, however they have noted learning in relation to safeguarding children and adults.

3.9 Primary School

Primary School is the school attended by all four children. The school had day-to-day contact with MV as he dropped off and collected the children from school and from out-of-hours provision. The School were also involved in TAC meetings which were originally convened and led by the local hospital due to health concerns regarding the children. MV also attended in-school training for school staff to administer medication to the three children (MVD2, MVD3, and MVS) and to give physiotherapy.

The school were supportive of the family and attended all TAC meetings, one of which was held at the school. They considered the pressures placed on the parents when engaging in TAC meetings.

TAC meetings were predominantly focused upon supporting MV & MVP in meeting the medical needs of the children. There were concerns within the meetings regarding the demands upon the family, and school administered some medical procedures to relieve the pressure upon the family. However, since September 2012, the family reported that they felt better able to manage the children's needs at home and reduced their hours at school's out of hours provision and as this was supported by external agencies at home, the school relinquished the medical support that it had previously offered. However, the family knew that school would offer support again if needed in the future.

3.9.1. Analysis of Agency Input

The school provided a high level of support to the children, including additional medical support as appropriate. They liaised with MV and MVP and were sensitive to their needs given the pressures of caring for three children with complex health needs.

The school also gave support to MVD1 as a young carer and liaised with the specialist support service.

The school were proactively involved in all aspects of the care of the children, both pastoral and academic and are to be commended for their input to a family with such complex needs.

3.9.2. Single agency action plan.

No single agency action plan is required from the school

3.10 Mental Health Services

The NHS Foundation Trust provides mental health and community services to people living in the boroughs of Bury, Oldham and Rochdale. They also provide mental health services in Stockport and Tameside and Glossop, as well as parts of the High Peak, East Lancashire and North Manchester.

Their services are located in hospitals and in the community and they work closely with local councils, NHS organisations and the community and voluntary sector. They provide a range of services for people who have serious mental illness such as schizophrenia and bipolar disorder, as well as more common mental health problems including depression, anxiety and dementia.

3.10.1. Contact with MV

During the period under review MV's first contact with Mental Health Services followed his admission to hospital in relation to overdose on 5th November 2012. MV was very upset on admission and said that he wanted to die. He was transferred to the Medical Assessment Unit (MAU) for observation, and was later referred to the psychiatric department for a mental health assessment. A 'cause for concern' was completed by the hospital and sent to Social Services.

On assessment, MV appeared low in mood and continued to express suicidal ideation. It was judged that MV was a high risk to himself and it was agreed that he would be admitted

informally to a psychiatric ward. He was admitted at 14.00 hours on the 6th November 2012, but on arrival he stated that he did not wish to remain as he felt this would increase his risks.

At 15.45 the Senior House Officer (SHO) received a call from the Children's Social Worker assigned to the family, she had received the 'cause for concern' that had been raised by the MAU and telephoned the ward to gather more information

The SHO reviewed MV again and talked to the Consultant Psychiatrist. It was judged that MV was no longer a risk to himself and that he did not warrant detention under the Mental Health Act. It was therefore agreed that he would be discharged that same day with a referral being made to the Home Treatment Team (HTT). They were to visit him at home the next day and complete a 48 hour follow up. MV was prescribed Fluoxetine and it was agreed that he would be followed up in an outpatient clinic. He was discharged to Address 1.

HTT completed a 48 hour follow up on 7th November 2012 that included a Mental Health Review. MV presented as low in mood but denied any current suicidal ideation. He recognised that alcohol could increase his risk of suicide and said he was avoiding this. He was self–neglectful having no appetite, weight loss, and was not eating or drinking anything unless this was prepared for him. He appeared disheveled and unshaven. He had poor sleep and said he lay awake at night, nor was he sleeping during the day. He had poor motivation and was socially isolated. Safeguarding issues relating to children were assessed and there were no concerns identified during this assessment and no further action identified.

An appointment was made for MV to see an Associate Specialist on 9th 2012 November for a review of medication and night sedation. A referral to the Community Alcohol Team was to be made. The HTT were to liaise with Social Services and the consultant psychiatrist as required.

On 9th November MV was visited at home by the Associate Specialist from the HTT. MV was noted to be pleasant, spontaneous and had good rapport and eye contact. He said he was speaking with his partner again and said he was to move back into the family home. There was no suicidal ideation at the time or prior to the recent impulsive overdose that was deemed to be fuelled by alcohol intoxication. His appetite had increased. His alcohol consumption was discussed and he said he was willing to contact alcohol services for support. He also said he had felt criticised by social services and felt that they were constantly scrutinising his parenting skills.

MV was commenced on Fluoxetine and was happy to continue with this. His risks were felt to be low unless he was to drink alcohol to excess. MV was then discharged from the HTT. He was to attend an alcohol misuse service to which he was advised to self-refer. He was given details of the Stockport Treatment-Access to Recovery Team (S.T.A.R.T.) and he was advised to see his GP regarding night sedation. Social Services were to be informed of his discharge. The Mental Health Review document was updated following this assessment. The children's Social Worker was informed of MV's discharge and provided with an update.

An outpatient appointment was made for MV to see the consultant psychiatrist on 17th December 2012. This did not take place due to MV's death on 20th November 2012.

3.10.2. Contact with MVP

Following presentation to her GP in November 2011, MVP was prescribed Citalopram on the 9th November. On the 10th November 2011 MVP's GP made an urgent referral to the Mental Health Access Team due to low mood, anxiety, auditory hallucinations, and delusional ideation regarding her mobile telephone and computer hacking.

She was offered an appointment with a Mental Health Practitioner on the 17th November which she attended. MVP was reported as having been angry, she had ripped the wires out of her computer, and she reported that weird things had been going on with the phone. She thought that someone had been hacking into the pictures of her children on her PC.

She had contacted the police; she said she had seen a camera lens in the computer screen and a lens in the TV. She said that when she contacted the police she became suspicious and was not sure that she was speaking to a police officer. The police had visited her house because of the nature of the complaint regarding images of her children. The police stated that they could not do anything and that no one was bugging or watching her.

The summary and formulation from the assessment included possible hallucinations one month ago. It was felt that she was no threat to self or others and that there were no immediate risks. It was recorded that there were ongoing meetings with social services and MVP aware of the need for support.

The assessment was discussed with the consultant psychiatrist (who would later see MV) on the 18th November 2011, and an outpatient appointment was arranged for the 19th December. MVP did not attend this appointment and the service wrote to her GP. A further appointment was not arranged but it was made known to MVP that the consultant was willing to see her again if she was willing to attend.

Following this, a further appointment was arranged for 8th February 2012 but was then rescheduled to 11th April by the hospital due to a change in duty rotas. MVP attended this appointment. It was recorded that MVP had suffered from psychosis and her current working diagnosis was delusional disorder. The SHO and consultant psychiatrist discussed the diagnosis in the outpatient clinic.

A further appointment was made for MVP on 9th May 2012, which was cancelled by MVP, it was noted on the clinic sheet that she intended to arrange another appointment. MVP was to be offered the next available appointment for a review. This is documented in the clinic letter to MVP's GP and it was also written on the appointment sheet sent back to Medical Records for the appointment to be arranged by them. It appears however that this appointment was never made either by the service or by MVP. There were no further appointments made for MVP.

On the 22nd November, the Mentally Disordered Offenders team contacted MVP's GP. The GP confirmed that MVP had been prescribed Citalopram 10 mg and Aripiprazole 5mg as an increasing dose on the 20th April 2012. MVP had not returned for a repeat prescription after this.

3.10.3. Analysis of Agency Involvement

Practice was of an expected standard in the delivery of interventions and there was good practice in relation to timely communication with general practitioners.

MV and MVP's presenting mental health conditions were not severe and this determined the responses from Mental Health Services. The clinical interventions offered to MV and MVP are in line with expected practice. However, there are a number of areas which need to be strengthened in relation to multi-agency working and safeguarding. The service has been proactive in identifying these and including them in its single agency action plan.

The first area to be strengthened relates to cancellation and rescheduling of appointments. There were two occasions on which appointments were cancelled and on the second occasion a further appointment was not offered to MVP following cancellation in May 2012.

It would have been good practice to follow up the assessments made on 17th November 2011 and 11th April 2012 with MVP and on 6th November 2012 with MV with Children's Social Worker as it was known on each occasion that MV and MVP had caring responsibilities for the children.

MVP should have been offered an assessment of her mental health following the police notification to the Mental Health Access on 6th October 2011 rather than this being sent to her GP.

Although it is not currently a service standard that advice on self-referral to Alcohol Services should be followed up by the advice giver, the DHR Panel feels that this would benefit patients in high-risk cases where they have given consent. A multi-agency recommendation to support this is made by the Panel.

There are also areas for improvement in relation to the completion of internal documentation. The service has recognised these issues and included them in its single agency action plan.

3.10.4. Single Agency Action Plan

Mental Health Services have submitted a single agency action plan, which is shown in full at Appendix 1.

Multi Agency Recommendations

See recommendation 2.

3.11 Signpost for Young Carers

Signpost for Young Carers is a registered charity that offers information and support services to young people aged 6 – 18 years who are providing care to another family member who has an illness or disability.

The agency provided a range of support services to MDV1 who acted as an additional carer to her three siblings.

MVD1 was referred to Signpost Young Carers Service on 15th March 2011 by Primary School. The school requested support for MVD1 in her caring role for her three younger siblings. School stated on the referral form that MVD1 was supporting parents in their caring role and often helped her siblings while they were at school. School 1 expressed on the referral form that MVD1 needed time to herself and a break from her caring role.

MVD1 engaged well with the service. MV and MVP did however not engage and the service had difficulty in contacting them, which resulted in MVD1 missing opportunities for further support. Despite this, the service remained proactively engaged with MVD1 and also attended TAC meetings and home visits.

The one to one sessions were used well in school by MVD1 and allowed time and space to talk about her caring role. MVD1's worker would then communicate MVD1's needs through the TAC process.

A number of efforts were made to engage with MV and MVP by Signpost Young Carers and school to support MVD1 to access their monthly breaks. Other services were available to the family, such as family support and benefits advice, however a lack of engagement on the part of the MV and MVP meant that these services were not taken up.

3.11.1 Analysis of Agency Involvement

Signpost was strongly focused on the needs of MVD1 as a young carer in a family where there were high levels of need. The service worked proactively to engage MV and MVP however, they had limited success in doing this, possibly due to the high demands placed on the parents and their own mental and physical health needs.

MVD1's key worker attended all relevant meetings and was proactively involved in the TAC meetings. However, there was some frustration expressed by Signpost that their input to such meetings was not given the same status as the statutory agencies.

3.11.2. Single Agency Action Plan

A single agency action plan has been received from the agency is shown in full at Appendix 1.

3.11.3. Multi Agency Recommendation

See recommendation 1c.

3.12 NHS Foundation Trust

The NHS Foundation Trust provided a range of medical services to MV, MVP and to the three children with complex health needs.

Stockport Foundation Trust (SFT) was involved with MV directly when he attended the emergency department twice in the review period for his own health concerns. The first of these presentations was in April 2012 when MV had telephoned 999 for an ambulance after suffering head pain for several days. He volunteered information that he did not drink alcohol. He was treated with intravenous fluids and pain relief and referred back to his GP.

MV presented by emergency ambulance at the Emergency Department of a local hospital on 5th November. He had taken a large quantity of Zomorph (Morphine Sulphate) tablets which were not prescribed to him. His sibling and members of her family had concerns about him being in possession of a knife.

The ambulance crew who had brought MV to hospital had noted on the call out that he was behaving in an aggressive manner and had a knife. They had called police to request that they attend Address 1 as they were concerned about staff safety. Upon arrival at Address 1 the crew decided that they no longer required the police and the call-out was cancelled.

Good practice was undertaken within the Acute Hospital Setting who raised a cause for concern with Social Care following MV's presentation to the Emergency Department.

3.12.1. Analysis of Agency Involvement

MV's admission to the Emergency Department was raised by emergency department staff as a 'cause for concern' in relation to safeguarding his children. A referral was sent to the hospital safeguarding team who were able to inform the paediatrician and respiratory nurse as lead health practitioners on the same day. This was good practice and enabled a follow up to take place when MV was discharged from hospital.

In addition to the contact centre being informed, the concern was discussed with the named social worker from the disability team, again on the same day. This timely sharing of safeguarding information regarding parenting capacity is evidence of good practice and of an effective, robust cause for concern pathway.

3.12.2. Single Agency Action Plan

No single agency action plan was received or required from this agency.

3.13 Social Landlord

The Social Landlord had no contact with either MV or MVP during the period under review.

3.14 University Hospital of South Manchester (UHSM)

UHSM had twelve contacts with MV, three of which were outside of the timescale of this review. Two of the contacts within the review period involved alcohol intoxication.

In September 2011, MV was referred by his GP to USHM Neurology Department for investigations into loss of sensation related to an earlier injury. Between September 2011

and January 2012 MV had a further seven contacts in relation to this referral. This culminated in MV cancelling his final appointment, to which there was no further follow up.

On 21st November 2012 at 00.10 hours MV presented via 999 ambulance accompanied by police. MV had stab wounds to his abdomen and neck (the stab wound to his abdomen was later determined to have been an 'old' injury). On presentation, MV was noted to be in Cardiac Arrest and Cardio Pulmonary Resuscitation continued. MV was ventilated prior to his attendance at the Emergency Department but was cold to touch and very pale. Due to lack of cardiac output and pulseless activity resuscitation was stopped and time of death certified at 00.25 hours.

Due to the nature of MV's presentation to the ED a children's services referral was completed by the ED team. In addition to this further follow up and liaison with Children's Services, School Health Professionals and the named Nurse for Safeguarding Children at the local hospital was completed. A Safeguarding Children information sheet was created providing a summary of the events and sent out to relevant professionals involved with the family and the Community Safeguarding Children Team.

3.14.1. Analysis of Agency Involvement

UHSM provided appropriate medical care and interventions at each presentation and appropriately liaised with other services as necessary.

They were proactive in notifying Children's Services and initiating safeguarding children actions following MV's admission and subsequent death.

3.14.2. Single Agency Action Plan

No single agency actions were proposed or required of this agency.

4 WHAT DO WE LEARN FROM THE CASE

4.1 Overview of Learning from the Case

The panel has considered the detailed information contained in the Individual Management Reports (IMR), single agency action plans and also invited IMR authors to attend a panel meeting to gain insight into agency involvement with this family.

The panel also reviewed documentation provided in relation to assessment and referral procedures and processes.

After careful consideration and investigation, it is the view of the Panel that the events that took place on 20th November 2012 that led to MV's death could not have been predicted or prevented.

There are however areas where agencies can learn from this case and where practice could be improved. These are discussed below within both single and multi-agency recommendations being proposed.

The panel has recognised that behaviour can be violent where physical violence is absent.

4.2 Views of the Family

As stated previously, the Panel invited family members to participate in the Review to deepen its understanding of the victim and family circumstances, and to identify lessons that can be learned from this case. Family members did not respond to invitations to participate in the Review and the Panel decided, after making two approaches to the family, that no further approach should be made to them. The panel has noted the importance of ensuring that any advocates working with the family are involved in future reviews.

4.3 Learning from Agency Involvement

It is apparent that the victim and his family were dealing with significant pressures and stressors arising from the demands placed upon them in managing three children with complex and enduring health needs.

There was good practice by professionals in helping MV and MVP to deal with the demands placed upon them as primary carers. Medical and social care interventions with the children were of a good standard and coordination of care services to the three children was effective. MVD1 required additional support as a young carer and, whilst the services provided by Signpost were of a good standard, there was insufficient focus by Children's Social Care (CSC) on MVD1's needs. MVD1 did not receive a CAF assessment and was therefore not technically an 'open case' to CSC., although she was in receipt of support services.

Professionals involved in Team around the Child meetings appear to have under-estimated, and therefore not fully taken into account, the degree to which these pressures exacerbated the pre-existing mental and physical health problems of both MV and MVP. The panel judged that the multi-agency professional response to the complex needs of the children obscured and overshadowed the needs of their parents and of MVD1 who acted as a young carer.

Although TAC meetings brought professionals together to review and plan for the children's health needs, many of the actions emerging from these meetings lacked an integrated approach to working holistically to address the needs of the adults and the impact that these had on all the children in the family.

Mental Health Services did not link MV and MVP (the IT recording system does not have the facility to produce a family genogram) therefore mental health services were unaware that MV and MVP were living together. As a consequence neither MV nor MVP received a full assessment of the impact of their individual mental health problems on their parenting capacity.

There was good practice in the local hospital when a 'cause for concern' was raised following MV's admission following an attempt at suicide on 5th November 2012.
Alcohol misuse was a feature in MV's attempt at suicide on 5th November and was assessed as being a significant co-factor in his self-harming behaviour. MV consented to referral to the local alcohol service however, he was advised to self refer and did not do so. This was not followed up and therefore an opportunity was missed to engage MV in alcohol treatment.

There was liaison between professionals working with the adults in the family at TAC meeting although Adult Mental Health professionals did not attend TAC meetings, nor did the GP. Because of the focus on the children's health needs in this forum, it proved an ineffective way of addressing the whole family's circumstances and needs.

The family received ongoing support from medical services in relation to the three children's medical care. MV and MVP also sought and received interventions for their own mental and physical health, initially through their GP who co-ordinated services and was proactive in following up appointments with other secondary services. It is the view of the panel that there was considerable good practice demonstrated by the GP.

The incident that took place on 15th November 2012 is clearly significant. It is the panel's view that the actions of police officers in relation to that incident present a number of missed opportunities. Firstly, the DASH risk assessment was not completed at the scene and questions were asked of MVP but it was completed the following day by the officer, contributed to an incorrect grading of risk as 'standard'. Some of the police officers did not take seriously MV's complaint of a knife wound, nor did they adequately assess or attempt to clarify who was the victim and who the perpetrator at the incident was.

MVP was clear that she felt threatened by both MV and BLMV and that she wanted them removed from Address 2. In MVP's conversation with representatives of the DHR panel the police officers present at the incident did not respond to her request, leaving her feeling unsafe.

It is the view of the panel that some police officers attending on the 15th November did not make an accurate assessment of who may be the victim of domestic abuse and who may be the perpetrator. When the DASH risk assessment was completed after the incident, the assumption was made that MVP was the victim. Whilst there is no evidence to suggest that MVP had assaulted MV, MV did complain of a stab wound. This was not taken into account by police officers in risk rating the incident, nor was it followed up in any way by officers.

In summary the DHR has identified a number of areas in which lessons can be learned and services strengthened.

The recommendations made arise from considerable discussion with the agencies involved in the review and will be the subject of a multi-agency action plan arising from the Review.

5 RECOMMENDATIONS

The DHR panel has carefully considered all material presented in this case and makes the following recommendations to the Safer Stockport Partnership.

Recommendation 1a

The case highlights a number of missed opportunities in relation to safeguarding the children in this case. The Panel recommends that the **Local Safeguarding Children Board** should initiate a multi-agency practice review of safeguarding children living in families where there are multiple complex needs and where one or both of the parents have mental health problems.

Recommendation 1b

The needs of MVD1 were not fully assessed or responded to. Despite her significant responsibilities as a young carer, and the fact that she lived with two vulnerable adults and three siblings with chronic medical conditions, she was not an open case to CSC, having never received a CAF assessment.

As recommended in 1a above, the LSCB should ensure that the learning review considers the fitness for purpose of multi-agency policies and procedures in relation to the needs of Young Carers.

Following the learning review all agencies should update their policy in relation to supporting young carers, recognising and meeting their specific needs.

Recommendation 1c

As part of the LSCB learning review the processes and systems for information sharing with voluntary sector agencies should receive focus. This should ensure that voluntary and third sector agencies have equal access to relevant information to safeguard vulnerable adults and children.

Recommendation 2

The CCG should be assured, by audit evidence, that the training delivered to and the supervision received by Pennine Care NHS FT (Mental Health) staff thoroughly explores the impact of adult mental health on parenting capacity including staff's responsibilities if concerns are identified.

Recommendation 3

MV was advised to refer to alcohol services and consented to this however, current practice does not require self-referral advice to be followed up by services. The DHR panel recommend that it would be good practice to initiate referrals in cases where the adult is

particularly vulnerable or high risk (i.e. where there has been a serious attempt at self-harm).

The **Drug and Alcohol Joint Commissioning Group** should develop the assessment and referral pathways for alcohol misuse where there are co-factors of mental health and domestic abuse. The aim should be to ensure that high risk adults with complex needs are referred to services and that the referral is followed up

Recommendation 4

Developing the skills and capacity of the local workforce in relation to identifying, referring and responding to domestic abuse is key to the success of the local domestic abuse strategy. The **Safer Stockport Partnership** should give specific focus to workforce development in its revised domestic abuse strategy, the focus should be on ensuring that all agencies build confidence amongst their workforce in dealing with domestic abuse.

Appendix 1

Single Agency Action Plans

Final Combined
(Anomyised) sinlge ac

Appendix 2 – Team Around the Child Processes

Team Around the Child process is outlined in the attached link.

http://www.stockport.gov.uk/services/education/cypd/childrenssocialcareandsafeguarding/commonassessmentframework/caftactrainingandlearning/

Appendix 3 – Summary of Interview with the Perpetrator

The views of the perpetrator came directly from conversation with her. It should be noted that officers from the IPCC in had interviewed the perpetrator prior to her being interviewed by the Chair and Author of the DHR.

The views of the perpetrator are not presented as fact or in any way intended to influence interpretation of this review now or in the future. The Review Panel has not qualified or changed the statements made by the perpetrator in any way. The information below was compiled from written notes. The interview with the perpetrator was not voice recorded.

The interview began with an explanation of the purpose of the DHR and what outcomes we hoped to achieve from conducting the review. We explained that it is a statutory requirement upon CSPs and that the final report would be published on the CSP website after it had been quality assured by the Home Office.

MVP said that she understood what the process was all about and that she did not have any issues with the final report being published. She said she had 'nothing to hide' and hoped that agencies, professionals and other people could learn from what had happened to her and the victim.

MVP told us that she had been in a relationship with the victim for 13 years. They have children with complex needs and she talked briefly about the demands this placed on them as a couple, however, she spoke about this pragmatically and indicated that in her life her main priority was 'the children'.

She told us that the victim had had a stroke about two years ago, following which his personality had changed a lot. She said he became more bad tempered with the children and with her and that he had begun to drink and take cocaine at this time (there was no other evidence presented in the review to suggest that MV was a user of cocaine).

She talked about MV's attempted suicide in 2012 and how 'ill' he was. She said she didn't know about his admission to hospital at the time as they had separated ,but she had received a telephone call from a psychiatrist at Stepping Hill Hospital (she received two calls). It became apparent to MVP that the psychiatrist had phoned the wrong person and that she (the Psychiatrist) had intended to contact the victim's sister MVS1

MVP thought that this was strange and an indication that the MV wasn't receiving proper attention. MVP spoke to the MV and she then realised that he was 'very ill'. She said that he had taken a large overdose of 'cancer' drugs and alcohol. She said she could not understand why he was discharged so soon after admission – she thought it was obvious to anyone that he was still really ill.

From the time that the MV took the overdose, things between them became more difficult. His behaviour was more aggressive. MVP said he was less 'compassionate'. He would scare and intimidate her and had become quite threatening.

She had talked to her Social Worker about whether she could get an injunction against him but was told that she would need to speak to the Police. She didn't get any further advice about what to do regarding an injunction. (At this point there had been no involvement with the Police).

MVP was asked whether or not MV had ever been violent. She said there had been two incidents of violence, one several years ago and one more recently where he had 'head-butted' her and intimidated her. She qualified this by saying 'it wasn't really a head butt' – just putting his head close to her with force.

MVP spoke about the time that she had had experienced delusional thoughts, she described this as 'when I went bonkers'. She said 'I really was bonkers but with hindsight I can see some of what was happening'. I had an I-phone and an I-Pad but I didn't know much about how they worked. He (MV) knew all about how they worked and he used to change my pass-words. I didn't know that you could get music to play from the computer onto the phone.

MVP did not suggest that the victim was interfering with the phone or computer but she did say that looking back he did take charge of some of these things. She didn't doubt that she was also behaving strangely and experiencing unusual thoughts and feelings.

MVP was asked about the events of 15th November 2012 when the victim sustained a stab wound. It was explained by the interviewers that, because of the ongoing IPCC investigation, we did not have a clear picture about the events of that night.

MVP said that what had happened was that MV had come round to the house to see the children and put them to bed but that he was behaving in an aggressive manner towards her. She said he had been drinking and taking cocaine, and he had cocaine with him (there is no other mention in any of the review material to suggest that MV was a cocaine user).

It appeared to MVP that one of the children had contacted him to say that MVP had hit her (MVP she hadn't done this) but that the MV was angry with her. She knew that an argument was going to happen and wanted him to leave the house, however he refused to do this. According to MVP the victim was terrorising her, saying that he was going to cut her throat and cut her head off.

MVP contacted her friend MVPNP to ask if he would come round. He didn't want to but eventually he did come round. The victim returned to the house and said that he had called his brother in law to come round and get MVPs friend out of the house. MVP was worried about this because she felt the brother in law was 'not a nice person and knew some horrible people'.

MVP said that there was a lot of arguing and shouting, she recalls MV going into the kitchen and returning with a knife. He was threatening to harm her and her friend and also to harm himself. He also said he was going to take all the cocaine (he had brought a large amount of cocaine into the house). During the argument MVP said that she saw the MV plunge the

knife into his abdomen, she said that there wasn't a lot of blood and that although she was surprised he had done this there didn't seem to be much of a wound and it didn't make her feel frightened.

The victim's brother in law arrived at the house and was very aggressive to MVP and her friend. MVP said that if the victim and his brother in law didn't leave the house she was going to call the police. She eventually did this but then felt frightened as she didn't think she had told the police where she was or who she was. However, within a few minutes she heard police sirens and was relieved that the police were attending the scene.

She recounted how the police officers behaved, she said that they weren't listening to her and they did not act on her request that they 'get the MV and his brother in law to leave her property'. She said the police officers did what they wanted, they said to her 'this is what's going to happen' – we will arrest your friend (by this time MV had accused MVP's friend of stabbing him). The police did not ask whether or not MVP had been subject to domestic abuse nor did they conduct a DASH risk assessment.

Eventually the victim and his brother in law left. MVP followed up the incident by asking the police if they could impose an injunction, however, they said that this was not possible.

MVP then talked again about the time that she was experiencing mental health problems.

We asked her about how this affected her engagement with services and what her relationship with the victim was like at this time.

She said that she had become very isolated, that MV took control of managing relationships with professionals e.g. school. She said that they didn't really spend time with other people – MVP mentioned that they didn't go round to other people's houses because they smoked and this was bad for the children (she and the victim smoked but they did so outside the house – although she mentioned that this would be frowned upon by health professionals who would still say it was bad for the children).

MVP didn't have keys to the family house so sometimes didn't go out for this reason. We asked about attendance at TAC meetings – MVP said that they attended when they could but there were reasons if they didn't attend (as outlined above). MVP said that the TAC meetings were not the right place to talk about problems in her relationship with the victim. She said she wasn't going to talk about intimate things in those meetings. She did talk to the Social Worker about some of the problems she was having.

MVP said that she would have thought that the family were a 'massive red flag' as there were so many issues for them.

During the time that she was experiencing mental health issues MVP recounted that the police had sent an email to her GP about her delusions – she was surprised that it took a month after the incident with the TV/voices for this to be sent out.

We then asked MVP about the fatal incident. She said that on that day she had been to see a solicitor to ask about getting an injunction to prevent MV from coming round to the house. The solicitor had told her it would cost £1500 to do this. MVP then phoned the victim to ask him to pick her up – he did this and they went out shopping together. We

asked why they would do this if she wanted an injunction. MVP said that the relationship between them was OK when he wasn't drinking or aggressive, which was usually at night. She said that she still wanted him to be involved with the children. It was when he came round at night and wouldn't go home that tensions flared up.

On that night another argument began. MV refused to leave the house and MVP said that she would call the police. She remembers being afraid of what would happen if he stayed and thought about the last time this situation occurred (15th November) and MV getting hold of a knife.

MVP isn't clear about stabbing the victim – she says she remembers picking up a knife but that she doesn't recall anything about what happened next. She remembers taking the knife out of his neck but nothing else about the actual incident.

We asked MVP what were the key things she thinks can be learned by agencies.

She felt that her requests to get an injunction were not listened to. She raised this with the Social Worker and no action or advice was given. She raised it with the Police and they said they couldn't help. She felt that had she been able to keep the victim away this may have changed what ultimately happened.

Before the fatal incident and subsequent enquiries MVP did not know anything about the DASH risk assessment, it was only when she was interviewed by IPCC that she learned that police should conduct a risk assessment to screen for domestic abuse. MVP said she was amazed that no one asked her any risk assessment questions at the incident on the 15th November. She said that everyone should be asked about domestic abuse in a situation such as that.

She also said that the TAC meetings were not the right place to discuss the family's problems as they were focused on the children, there was nowhere that they could talk about the wider problems, although the Social Worker was supportive it was mainly around the children.

Finally MVP said that she would say to anyone in her situation – 'just get away – get out of the house – throw some clothes in a bag and go'. She had tried to make him go but that hadn't worked.

We ended the interview by thanking MVP for being open with us. We assured her that her contribution would be reflected in the final report and we offered to see her again when the report had been submitted to the Home Office.

Appendix 4 - Safer Stockport Partnership Action Plan

SSP Action Plan.doc