Manchester Community Safety Partnership

Domestic Homicide Review

Victim – Suzanne who is believed to have died in April 2021

Independent Author – David Mellor BA QPM

Report completed on 9th May 2022 (amended September 2023)

1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Suzanne (a pseudonym), a resident in the Manchester City Council area prior to her murder which is believed to have occurred in early April 2021.

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

1.3 During June 2021 Suzanne's body was found in her home address by her housing provider after forcing entry to the property. Suzanne had not been seen since late March 2021 and her body was in a state of advanced decomposition. A subsequent post-mortem examination established that Suzanne's death had been caused by multiple stab wounds to her neck and back, some of which had required significant force. Suzanne's daughter Zoe, who had moved in with her mother at some stage prior to her death, was arrested by the police on suspicion of her mother's murder. During interview, Zoe stated that, having spent the evening together taking crack cocaine, an argument developed which led to Suzanne picking up a kitchen knife and moving towards her daughter. Zoe said that she managed to disarm her mother before inflicting the fatal injuries. Zoe stated that she covered her mother's body, disposed of the weapon and blood stained clothing and left the address and went to stay nearby. Zoe lied to relatives who enquired about her mother's whereabouts and withdrew funds from Suzanne's bank account until her mother's body was discovered. It is believed that the murder of Suzanne took place in early April 2021. Zoe was subsequently convicted of the murder of her mother at Manchester Crown Court and sentenced to life imprisonment with a minimum term of 17 years.

1.4 On 6th July 2021 representatives of Manchester Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) in respect of the murder of Suzanne.

1.5 The review will consider agency contact/involvement with Suzanne and the perpetrator Zoe which occurred between 1st January 2019 – the year in which GMP first attended an incident of domestic abuse involving the victim and the perpetrator - and the discovery of Suzanne's body during June 2021. Events which are of relevance to the review which occurred outside this timeframe have also been considered.

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

DHR Timescales

1.7 This review began on 31st August 2021 and was concluded in April 2022. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This review was completed in eight months. The slight delay arose as it was not possible to fully engage with the family members who wished to contribute to the review until after the conclusion of criminal proceedings.

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms have been agreed with Suzanne's family and used in the report to protect the identity of the individuals involved. At the time of the murder, the victim Suzanne was 58 years old and the perpetrator Zoe was 35. Both the victim and the perpetrator were of dual White/African Caribbean heritage.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case the victim leaves bereaved siblings, adult children and grandchildren. Manchester Community Safety Partnership therefore wishes to express sincere condolences to the family and friends of Suzanne.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

1. 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;

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

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

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

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

6. Highlight good practice.

2.2 The case specific terms of reference are as follows:

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

b. Did agencies recognise that the victim Suzanne may be at risk of familial domestic abuse and respond appropriately?

c. Were there any barriers to the victim Suzanne accessing support in respect of domestic abuse?

d. How effectively were the risks the perpetrator Zoe presented to herself and others assessed and managed? How effectively did agencies respond to disclosures by Zoe that she feared she might harm others?

e. What support was offered or provided to the victim Suzanne and the perpetrator Zoe to help them address their use of drugs?

f. How effectively did agencies respond to Suzanne's lack of contact with family, friends and agencies after 30th March 2021 and concerns that she may have come to harm?

g. The perpetrator Zoe had not been registered with a GP practice for several years prior to the homicide. How did agencies seek to engage with her during this period and support her to access any services she may have needed.

h. How effective was multi-agency working in this case?

i. Did the agencies Suzanne sought support from communicate and share information effectively with each other?

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

k. Were either the victim Suzanne or the perpetrator Zoe an 'Adult at Risk' i.e. a person 'who is or may be in need or community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of herself, or unable to protect herself against significant harm or exploitation'.

l. Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect the victim Suzanne or the perpetrator Zoe or impact upon the support provided or offered to them by agencies?

3.0 Methodology

3.1 On 14th June 2021 Greater Manchester Police referred the case to the Manchester Community Safety Partnership for consideration of holding a DHR. On 6th July 2021 representatives of Manchester Community Safety Partnership decided that the circumstances of the death met the criteria for a DHR.

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

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

Contributors to the DHR

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

- Change Grow Live
- Greater Manchester Police
- Manchester Health & Care Commissioning
- One Manchester – Landlord
- One Manchester – Support and Wellbeing Team

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

- Manchester City Council Adult Social Care
- BARDOC GP Out of Hours Service
- Department for Work and Pensions
- Manchester Probation Service
- Manchester University NHS Foundation Trust
- North West Ambulance Service
- Pharmacy

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

The DHR Panel Members

3.6 The DHR Panel consisted of:

Name	Organisation
Sheron Burton-Francis	Senior Probation Officer Probation Service
Lisa Collier	Service Manager, Change Grow Live
Leanne Conroy	Policy Specialist MCC
Lindsey Curry	Detective Sergeant GMP
Delia Edwards	Domestic Violence and Abuse Reduction Manager. MCC
Katy Endean	Specialist Safeguarding Nurse – Adults, CCG
Zylla Graham	Detective Inspector GMP
Ian Halliday	Policy and Performance Manager MCC
David Mellor	Independent Chair and Author
Howard Morrison	Safety and Wellbeing Lead, ONE Manchester
Bev Turner	Community Safety Manager, ONE Manchester

3.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions; 31st August 2021, 3rd November 2021, 26th January 2022 and 10th March 2022.

3.8 A Victim Support Homicide Worker made contact with Suzanne's family and provided support to a range of family members. The Victim Support Homicide Worker advised the DHR that Suzanne's son wished to contribute to the DHR and contact was made with him by the independent author. The independent author also made contact with a number of Suzanne's siblings and two of her brothers said that they wished to contribute to the DHR. Suzanne's son and her two brothers contributed to the DHR through telephone conversations with the independent author. Her son and one of her brothers expressed a wish to read and comment on the final draft report, although Suzanne's son eventually decided that he was unable to do so. Suzanne's brother read and commented on the final draft report and his comments have been incorporated into the final report. The second brother advised the independent author that he did not feel well enough to read and comment on the report. Suzanne's son and brothers did not wish to meet the DHR Panel.

Author of the overview report

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

Statement of independence

3.10 The independent chair and author David Mellor was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

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

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

Parallel reviews

3.13 An inquest may be held in due course. Change, Grow, Live conducted an internal review of their contact with the victim Suzanne which has been shared with this DHR.

Equality and diversity

3.14 The protected characteristics relevant to the victims are addressed in Paragraphs 6.50 to 6.57.

Dissemination

3.15 In additional to the DHR Panel members, the report will also be sent to:

- Suzanne's family
- The Greater Manchester Deputy Mayor for Policing, Crime, Criminal Justice and Fire
- North West Ambulance Service
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester Health and Social Care Commissioning
- Greater Manchester Police
- Manchester City Council Adult Social Care
- Manchester City Council Children's Social Care
- Manchester Community Safety Partnership
- Greater Manchester Health and Social Care Partnership
- Manchester Safeguarding Boards
- Change, Grow, Live
- *One* Manchester Housing Association
- HM Prison and Probation Service
- Office of the Domestic Abuse Commissioner (post QA)

4.0 Family and perpetrator involvement

4.1 Suzanne's son and two of her brothers have contributed to this DHR. Suzanne's son was asked if he would like to choose a pseudonym for his mother. He said he was content for a name to be chosen at random from popular names from the victim's year of birth. The same approach was adopted for the perpetrator.

4.2 One of the victim's brothers lived with Suzanne for a period and his involvement in her life is referred to in several paragraphs of the Chronology/Overview. This brother did not wish to contribute to the DHR. There is no obligation on family members to contribute to a DHR.

4.3 As stated, two of Suzanne's other brothers contributed to this review. The first brother reflected on Suzanne's childhood. He said that she was one of eight siblings, three girls and five boys. He said that their father had come to the UK from his native Jamaica to fight in the second world war and had met their mother who was born in the UK. He said that the family grew up in poverty, although, as a child, he didn't recognise that at the time. Initially the family lived in a three bedroomed house in Manchester. He said that his parents shared one bedroom, the three daughters shared another and the third bedroom was occupied by the five sons. The family later moved to a four bedroomed property in a neighbouring area of Manchester, which the family rented for four decades and in which Suzanne and one of her brothers cared for their mother until her death in 2014.

4.4 The first brother said that as a child he was vaguely aware that his mother was a sex worker whilst his father ran shebeens (unlicensed bars or clubs where alcohol is sold illegally). He said that his father was known to the police. He said he recalled being taken out shoplifting by his mother when he was a very young child.

4.5 He described Suzanne as a beautiful young woman who became involved with a person he described as a 'local gangster' who he said was a violent man who dealt in illicit drugs. Suzanne and this man had children together including Zoe and a son, who has also contributed to this review. The first brother said that Suzanne and her partner began taking drugs and Suzanne gradually became an addict and deteriorated over time into a person of gaunt appearance, who experienced poor general health, suffered broken relationships and had limited contact with her children. The first brother spoke movingly about the impact of drugs on his life and the lives of Suzanne and many of their siblings. He said that he had been 'clean' for 16 years, which had transformed his life and he had been actively engaged in drug prevention work for a number of years. He said that Suzanne had agreed to undertake a detoxification and rehabilitation programme around ten years ago – which he had set up – only to change her mind at the last minute. Looking back, he felt very sad about this but added that this had been a 'fork in the road' moment for him and his contact with Suzanne had been limited thereafter.

4.6 He said that Suzanne and another brother looked after their mother in her later years. He said that his mother developed Alzheimer's. He added that it was not unusual for Suzanne and her brother to be using crack-cocaine and heroin in the family home whilst caring for their mother. He and other family members were concerned about Suzanne and her brother 'robbing their mother silly' to fund their drug habit although he felt they cared for her well. He felt their drug addiction actually helped them because it prevented them fully processing their feelings and may have thereby reduced the distress that family members often feel when a close relative's cognitive abilities decline and they can no longer recognise them for example.

4.7 Turning to reflect on Zoe's life, the brother said his contact with her had been sporadic and fragmented and said that she was often estranged from other family members, although he added that she was not alone in this. He added that several members of his family had distanced themselves from each other, not because they didn't care, but because of shame and guilt. He said that Zoe also became addicted to illicit drugs.

4.8 The first brother felt that Suzanne and Zoe's use of crack-cocaine may have been a catalyst for the murder. In offering this theory, he was drawing on his own experience as a previous user of crack-cocaine. He said that taking crack-cocaine exaggerated and amplified experiences and caused delusional thinking in his experience.

4.9 A second brother also contributed to the review. He said he was homeless for around ten years and during this period he found it difficult to keep in touch with his family and lost contact with many relatives. He said he last spoke to Suzanne by phone 'once or twice' prior to Christmas 2020.

4.10 He said that Suzanne's first partner – the father of Zoe and Suzanne's elder son – was an extremely violent man and recalled an incident when he intervened when Suzanne's partner was threatening their mother with a 'long knife'.

4.11 The second brother expressed a number of concerns about agency contact with Suzanne on the basis of what he had heard about her murder when attending the trial. He asked why there was such a long delay in raising the alarm about Suzanne's disappearance. He felt that the delay was because 'no-one really cared about her' because she was seen as a 'druggie'. He said that thinking about his sister's body lying in a cupboard for over two months made him very upset. He also felt that Suzanne may have been scared of Zoe and reluctant to raise any concerns about her daughter's behaviour with professionals as a result. He felt that Zoe's previous convictions should have been given more weight by the police when they were called out to domestic abuse incidents involving Suzanne and Zoe.

4.12 Suzanne's eldest son also contributed to the review and he said that his mother was a 'very lovely, soft and caring person'. (He used the word 'soft' in the 'gentle' sense)

4.13 He said that from what he gathered, Suzanne was very 'easily led' as a young woman, having met his father when she was 16 and then putting up with a lot from him over the

years. He felt that she had been made to do things she probably didn't want to do such as sex work and being sent out by his father to 'rob'.

4.14 He said that his mother couldn't stay with his father because of his violence, adding that he was aware that his father had 'put her in hospital' on one occasion. He went on to say that his mother had started taking drugs as a young woman and it had been 'downhill from there'.

4.15 The son said that he was aware that there had been a 'custody battle' in court which his father had won and so the son and his elder sister Zoe lived with their father thereafter. He felt that his father had been able to 'fool' the court because he was better at concealing the fact that he was a heavy drugs user whilst, in Suzanne's case, it was evident from her physical appearance that she had a drug problem.

4.16 The son said that he hardly saw his mother from the age of eight - when his father was granted custody of his sister and himself – to the age of seventeen. The son said he believed that his mother had been involved in another violent relationship and been drawn 'deeper and deeper' into drugs use. He said that when he saw his mother again – when he was seventeen – she was unrecognisable because of the physical effects of drug use. He went on to say that although he felt that she had become hardened by the life she had lived she was 'soft' and 'very loving' towards him and seemed upset that she had not been in his and his sister's life.

4.17 The son went on to say that he later lived at his grandmother's house for a time whilst his mother Suzanne was caring for her. He recalled that his mother was making progress in tacking her drug addiction at that time but relapsed when her brother was released from prison and moved back to live with Suzanne and their mother. He said that after that, his mother went into a 'downward spiral'. He recalled one of his uncle's (the 'first brother' – see Paragraph 4.5 above) trying hard to get Suzanne into rehab.

4.18 The son finished by saying that although her drug addiction really adversely affected his mother for much of her adult life, it didn't detract from her personality and she always remained 'soft' and loving towards him.

4.19 The son then discussed his sister, the perpetrator Zoe who is two years older than him. He said that they grew up together and got on well as children and used to 'have a laugh'. He said that their father was very violent towards both of them, which led to Zoe being taken into the care of the Local Authority. He said that it made no sense to him that his sister was taken into care whilst he was left with his father who continued to be violent towards him. The son said that their father also neglected them both. He said that his father's only income was from state benefits which he would use to purchase basic food items and then spend the rest on illicit drugs for himself.

4.20 The son went on to say that he doesn't know what his sister's experience of being in care was like but that they ended up taking different paths in life. He added that his sister

liked to 'party' and take illicit drugs although he said that she always held down a job. He said that Zoe had a number of intimate relationships, primarily with women, although her most recent relationship had been with a male.

4.21 He went on to describe his sister Zoe's relationship with his mother Suzanne. He said that it was a very 'on and off' relationship. He felt that their contact would often occur when Zoe needed something – such as a place to stay or money.

4.22 He recalled Zoe contacting him around six months prior to the murder. She was upset having had an argument with her partner. She accused her partner of hurting her leg and sent her brother images of the injury. The son said he went to the house that Zoe shared with her partner and his child straight away and came to the conclusion that the injury to his sister's leg had been caused by her falling asleep next to a heater. He said that his sister was 'out of her head' on drugs and, because the situation seemed so volatile, the son decided to take his sister Zoe to stay with his mother Suzanne.

4.23 By this time he felt that his mother Suzanne was taking care of herself a little more and looking healthier. Although she continued to take drugs and he felt her life couldn't be described as stable, she was organised and had a routine. He said that he was in periodic contact with his mother at that time whilst continuing to keep her at 'arm's length'. He said that he remained hopeful that his mother would make changes in her life so that she could spend time with her grandchildren. Overall, he felt that it would be safer for his sister Zoe to stay with his mother for a while although he was aware that Zoe subsequently went back and forth between her partner's and their mother's addresses and that Zoe continued to have arguments with her partner over the phone.

4.24 The son said that Zoe murdering Suzanne 'was the last thing he expected', adding that when he was informed that his mother's body had been found, he was worried that Zoe had also come to harm.

4.25 Suzanne's son and two brothers were offered the opportunity to read and comment on the final draft of the DHR Overview Report. The first brother and the son expressed a wish to do so but the second brother said that he was not well enough to read the report but would welcome the opportunity to read the report when he was well again. Subsequent attempts to contact the second brother to arrange for him to read and comment on the report have not received any reply. The final draft of the DHR Overview Report was delivered to the home addresses of the son and the first brother. The independent author provided an overview of the findings and recommendations arising from the report and also advised them that they might find the report emotionally challenging to read. The son's Victim Support Homicide Worker was also involved. The son eventually decided not to read the report and after speaking to the first brother (the son's uncle) the son decided that he was content for the first brother to provide comments on the son's behalf. The son was offered additional time to read the report if he felt emotionally able to do so and the independent author will contact him again in due course.

4.26 The first brother said that he was satisfied with the DHR Overview Report, describing it as 'really good'. He said he was disappointed that the police had failed to pick up on indications that Suzanne was a drug user when they saw her in November 2019 (Paragraph 5.20) and felt 'very sad' that the police had not visited Suzanne's home after CGL raised the alarm on 10th June 2021 (Paragraph 5.80). He was disappointed that a number of professionals had not been able to encourage Suzanne to talk about the family problems she began to allude to from late 2020 and felt that the frequency with which her case was allocated to different CGL recovery co-ordinators may have been a factor which contributed to her reluctance to divulge any further details (Paragraph 6.9). The first brother felt that the continuity of CGL workers was an issue which should be addressed by the commissioners of the service.

Perpetrator involvement in the review

4.27 Zoe was contacted during the weeks following her conviction for the murder of her mother and asked if she wished to contribute to the DHR. The DHR was advised that after giving the matter some consideration and thought, Zoe decided that it was too soon for her to participate in such an interview.

4.28 It is worthy of note that interviews with perpetrators of domestic homicides invariably take place a relatively short time after their conviction and sentence to a lengthy term of imprisonment. They have often not been transferred to the prison where they will begin serving their sentence and they have not commenced any work to gain insight into their offending. This situation is unavoidable in order to complete DHRs expeditiously so as to facilitate the timely dissemination of learning from the review. As a result, perpetrators are not well placed to make a meaningful or insightful contribution to the DHR. The Home Office may wish to consider follow up interviews with perpetrators at a later stage in their sentences when they may be better placed to provide information which potentially makes a more valuable contribution to the aims of DHRs.

5.0 Chronology/Overview

Background information (Paragraph 5.1 and 5.2)

5.1 Suzanne was one of eight siblings. One of her brothers has informed this review that Suzanne and her siblings' upbringing was characterised by poverty and quite acute overcrowding. Suzanne had four children, one of whom is the perpetrator Zoe. Suzanne's eldest son has informed the review that their father was very violent towards Suzanne, and can remember him putting his mother in hospital on one occasion. Both her son and her brother described the impact of very long term illicit drugs use on Suzanne and her son recalled that this was an important factor in her losing custody of her children. Suzanne was known to the police and over a thirty year period (1977 to 2006) was convicted of over 30 offences relating to drugs, dishonesty and soliciting. Her son informed the review that some of Suzanne's offending may have been under duress from her partner. Suzanne disclosed suffering domestic abuse in subsequent intimate relationships. Suzanne received treatment

in respect of illicit substance misuse (crack cocaine and heroin) from at least 2007 and was prescribed opiate substitution therapy (OST). She successfully exited treatment on a number of occasions but later relapsed. Suzanne and one of her brothers provided informal support to their mother, with whom they resided for a number of years prior to their mother's death in 2014. Carer's assessments were completed in respect of Suzanne in 2012 and 2013 and professionals in contact with the family took the view that Suzanne's continuing substance misuse issues did not significantly impact on her care of her mother. This has been confirmed by family members who have contributed to this review. During the period in which Suzanne and her brother lived with their mother, other family members raised safeguarding concerns about financial abuse, mostly identifying the brother as the perpetrator, but all the concerns were found to be unsubstantiated.

5.2 Zoe declined to contribute to this review. She appears to have had quite a traumatic early life. Her mother Suzanne was drug dependent which appears to have been a factor in Zoe being brought up solely by her father from the age of 9. She became a Looked After Child and appears to have been placed in foster care between the ages of 14 and 16. Zoe's brother has informed this review that both he and Zoe suffered violence from their father. She is believed to have used cannabis from her teenage years and to have taken overdoses of unspecified drugs in 2001 and 2006. It is understood that a person described as Zoe's 'boyfriend' was shot and killed in 2001. She served four prison sentences, including a sentence of five years for a series of robberies of females in 2007. She disclosed being prescribed citalopram for depression whilst in prison. She was last supervised by the then Community Rehabilitation Company in December 2018. She had not been registered with a GP for a number of years.

5.3 Suzanne had been registered at GP Practice 1 since 2004. During the period on which this DHR focusses, the majority of her GP contacts related to the ongoing management of Chronic Obstructive Pulmonary Disease (COPD). The GP practice was aware of Suzanne's opioid dependency.

5.4 In July 2012 Suzanne transferred from her previous service provider to Change Grow Live (CGL). CGL is a voluntary sector organisation, working with adults and children/families who have been affected by substance misuse. Attendance is voluntary unless ordered by the courts within the criminal justice system.
CGL offer one-to-one key work sessions, group work (psychological and social interventions), opioid substitution therapy, alcohol detoxification and opportunities for peer support.

5.5 Following her mother's death in 2014, Suzanne was the sole tenant of her home in Manchester. From 2015 the landlord was One Manchester which is a provider of housing and community services which was formed in 2015 following a merger of two of Manchester's largest housing associations. During 2016 reports were made from a neighbouring property about noise, arguments between Suzanne and her brother, banging water pipes and slamming doors. Mediation was agreed by Suzanne and the neighbour but this did not go ahead as a result of Suzanne's unavailability for appointments. One

Manchester closed the anti-social behaviour (ASB) case later in 2016, but re-opened it briefly in January 2018 when similar complaints were raised by the same neighbour. Suzanne was not considered to need support from her landlord prior to January 2019 (see Paragraph 5.8) as she was known to engage with CGL independently.

5.6 A MARAC referral was made in respect of Suzanne's brother by his drug and alcohol key worker in 2015 or 2016 which identified Suzanne as the perpetrator of domestic abuse against her brother. The brother disclosed that he had been experiencing abuse for several months whilst living with Suzanne, adding that Suzanne recently cut his face with a piece of metal and often attempted to slap him when arguments broke out between them. He went on to state that his sister's 'heavy crack cocaine' use was impacting on her mental health which put him at greater risk from her. He added that he was finding it difficult to address his own drug use whilst living with his sister and would like support to obtain his own accommodation, so that he could be free from abuse. The referral was not heard at MARAC and the review has received no further information about the referral or any other outcomes.

2019

5.7 In January 2019 Suzanne was engaged in treatment with CGL. She had exited treatment following detoxification therapy in 2015 but had referred herself back into treatment following a relapse to heroin use in 2017. In January 2019 Suzanne was stable on prescribed opiate substitute therapy (OST) of 40mg methadone daily but reported using crack cocaine on a regular basis. (Her use of crack cocaine appeared to be problematic throughout the timeframe of this DHR).

5.8 Also during January 2019 One Manchester became aware that Suzanne was experiencing financial difficulties and provided her with material support including a washing machine, phone and bedding. Her landlord became aware of these material needs through her relationship with Graham (a pseudonym) who was a One Manchester tenant living in a different property. Graham was a former rough sleeper with complex needs who needed a high level of contact. Thereafter Suzanne occasionally needed emotional support when difficulties arose in her relationship with Graham.

5.9 In February 2019 CGL conducted a prescriber's review with Suzanne, during which she expressed concerns regarding her physical health (breathing difficulties) and a reduction in mobility associated with this. She reported no mental health issues. She disclosed previous domestic abuse from two former partners. A community reduction plan was agreed to support Suzanne to reduce her OST and a letter was shared with her GP.

5.10 Also in February 2019 One Manchester received noise complaints (front door banging, noise from visitors) from Suzanne's neighbours which she denied when contacted by her landlord, who sent her an advisory letter.

5.11 During April 2019 CGL contacted Suzanne by phone to check how the medication reduction regime was progressing. Suzanne said it was going well but mentioned an ongoing chest complaint and was advised to contact her GP, who saw her for a COPD review the following month.

5.12 Also in April 2019 the Department for Work and Pensions (DWP) made a hardship payment for 'gas/electric and food' to Suzanne.

5.13 During June 2019 Suzanne was present during a One Manchester visit to Graham's property. She said that she was supporting him to 'keep visitors out' of his home.

5.14 On 29th June 2019 Greater Manchester Police (GMP) attended an incident in which Suzanne disclosed an assault by her brother. A crime was recorded for common assault and battery, but no further action was taken as Suzanne declined to support a prosecution. A DASH risk assessment was completed which assessed the risk to Suzanne as 'medium'. The police documented that both parties were known to take drugs which may have contributed to the incident. Neither Suzanne or her brother were considered vulnerable. Suzanne consented to a referral to 'victim services'. The outcome of this proposed referral is unknown. Victim Support has no record of any referral in respect of Suzanne at that time. Suzanne was advised to contact her housing provider so that the locks could be changed. She advised One Manchester that her brother had moved out of the property on 2nd July 2019 but there is no reference to her asking for her locks to be changed, although she asked them to change the locks on Graham's property because she was concerned that her brother may 'take advantage' of him. One Manchester complied with this request. During July 2019 Suzanne also advised DWP that her brother had left her home. It is not known how long her brother had been living with Suzanne.

5.15 On 20th July 2019 Zoe was taken by ambulance to the Royal Bolton hospital emergency Department (ED). At that time Zoe was living at an address in Worsley in Greater Manchester. She told the ambulance crew that she had a panic attack earlier, felt as though she was not coping and felt suicidal on a daily basis. She was seen by the hospital mental health liaison team (provider Greater Manchester Mental Health NHS Foundation Trust (GMMH)). Zoe presented at tearful, having lost her job, experienced financial difficulties resulting in her selling her car to pay her rent. She said she struggled to develop relationships and felt isolated. She went on to discuss her upbringing which was documented to be 'traumatic'. She said that she was starting a new job in the near future would provide her with structure and alleviate her financial difficulties. Zoe added that her mood was usually stable, that she liked helping people and was sociable but had recently felt isolated. No past psychiatric history was reported although she had been seen by mental health services on several 'one-off' occasions in the past and had taken overdoses on two previous occasions. Zoe disclosed no thoughts of harming herself or others. She was discharged from the hospital mental liaison team and was advised to register with a GP so that they could prescribe any medication needed. Zoe was referred to primary care psychology but did not engage with that service and was subsequently discharged after being sent 'opt in' letters to which she did not respond.

5.16 During August 2019 CGL visited Suzanne at home owing to her breathing difficulties which were making it difficult for her to attend services. Her community reduction plan was documented to be going well but she continued to smoke crack cocaine daily. (Reference to one 'rock' of crack cocaine daily). Suzanne was said to be reluctant to address her use of crack cocaine but agreed to consider doing so following opiate reduction.

5.17 On 13th September 2019 Suzanne was documented to have completed her opiate reduction plan and CGL stopped substitute prescribing. At that time she reported no crack cocaine use. She expressed an interest in attending aftercare groups and relevant information was posted to her home address. However, on 19th September 2019 Suzanne recontacted CGL saying that she wanted to address her crack cocaine use but attempts to engage with her were unsuccessful and CGL closed her case on 9th December 2019.

5.18 Also during September 2019 a GMP Inspector followed up the incident to which the police attended on 29th June 2019 by phoning Suzanne. The Inspector documented that Suzanne was managing the situation with her brother well and did not need further support.

5.19 On 7th November 2019 Suzanne called the police to report that her daughter Zoe was coming 'to look after her' but that Zoe was threatening to take Suzanne's dog. Suzanne called police again later the same evening to say that things had calmed down between her and her daughter, but that she required assistance the following morning. The police were unable to attend the following morning (8th November 2019) due to the volume of incidents with which they were dealing. Suzanne rang the police again on the afternoon of 8th November 2019 to say that her daughter was due to arrive at 4pm that day and that she was in fear of violence from Zoe as she'd previously assaulted Suzanne, and that her daughter 'caused lots of arguments'.

5.20 Suzanne was advised to contact Citizen's Advice regarding the issue with her dog, and to call back if the situation escalated between herself and Zoe. Officers attended at some point and found no signs of injuries or an altercation. A 'standard' DASH risk assessment was completed and a 'toxic trio' assessment recorded 'no issues' in respect of alcohol, mental health and drugs.

5.21 Suzanne was present in Graham's property when One Manchester visited him on 6th December 2019. She introduced herself as Graham's 'girlfriend' and said that she was trying to help him 'keep out visitors' to his property, help him to settle and provide him with healthy food.

5.22 On 17th December 2019 Suzanne rang her One Manchester Place Co-ordinator requesting to speak to her about a personal matter but no record was made of the issue which Suzanne wished to discuss.

2020

5.23 On 10th March 2020 Suzanne re-referred herself back into CGL following a relapse onto heroin and crack cocaine use. On 25th March 2020 an assessment and prescriber assessment were carried out by telephone in line with Covid-19 guidance at the time. During the assessment, Suzanne said that she initially began using illicit drugs again following an accident in which she hurt her back and experienced ongoing pain. Suzanne said that she had support from her daughter who was staying with her, cooking her meals and looking after her. She denied any risks linked to domestic abuse or physical, psychological, sexual or economic abuse. She rated her psychological health as 13 out of 20, physical health 10 out of 20 and overall quality of life 12 out of 20. Suzanne was restarted on OST and was prescribed Espranor (a freeze-dried buprenorphine wafer which disperses very rapidly on the tongue which is a substitution treatment for opioids) starting at 4mg and titrating to 16 mg over three days dispensed every two weeks from her pharmacy. Suzanne was advised of safe practices, safe storage and risk of respiratory depression (a breathing disorder characterized by slow and ineffective breathing) should she not follow guidelines on taking the medication. She was provided with a safe storage box for her medication and naloxone - a drug which can reverse the effects of opioids and prevent death if used within a short period following an opioid overdose. CGL wrote to Suzanne's GP to advise that she had re-referred to CGL and shared information from their assessment.

5.24 In response to the Covid-19 pandemic CGL had conducted a review of the risks to clients of contracting the coronavirus whilst accessing community pharmacies. CGL decided that clients on take-home medication, such as Suzanne, would be provided with two instead of one weeks supply and were also supported with measures to help mitigate against the increased risk arising from larger supplies including provision of take-home Naloxone and safe storage boxes. Suzanne was identified as at high risk from Covid-19 as a result of her COPD.

5.25 In early April 2020 Suzanne reported no illicit substance misuse and that she planned to reduce her medication to CGL but later the same month reported that she was spending £20 daily on crack cocaine. At the end of the month CGL referred Suzanne to Acorn (a CGL subcontractor) to enable her to participate in their 1:1 telephone support offer to help her address her use of crack cocaine. She was also referred to RAMP (Reduction And Motivation Programme) and a workbook was posted out to her in June 2020.

5.26 During May 2020 Suzanne told CGL that she wanted to reduce her Espranor dosage and exit treatment prior to the forthcoming birth of her grandchild and had managed to reduce her use of crack cocaine during that week. During one CGL contact that month, Suzanne was unable to have a conversation as she was struggling to breathe.

5.27 During June 2020 Suzanne's prescription of Espranor was reduced to 2mg daily but she reported using crack cocaine daily. She said that she was taking her dog out daily for exercise during the first Covid-19 lockdown.

5.28 From early July 2020 Suzanne began attempting to halve the amount of Espranor she was taking, although she continued to use crack cocaine. The plan agreed with CGL was that Suzanne would engage with RAMP to address her crack cocaine use although her involvement with RAMP ended in late July 2020 as a result of non-engagement. CGL advised her GP practice that her last contact with CGL was on 20th July 2020 and that she was currently stable with no drug use reported by Suzanne (at her most recent contact with CGL) and no known adult or child safeguarding issues.

5.29 During August 2020 Suzanne called DWP to report 'issues with rent' and was advised to arrange for her Housing Benefit to be paid directly to her landlord. During the same month Suzanne appeared upset when she answered a phone call from CGL but she didn't wish to discuss why she was upset but said that her brother was going to spend time with her and provide support. Later in August 2020, Suzanne advised CGL that she was now a grandmother and had decided that she wanted to stop taking Espranor. In response CGL contacted the pharmacy on 27th August 2020 to arrange a prescriber review for Suzanne but the pharmacy advised that Suzanne had not collected her prescription since 11th August 2020.

5.30 During September 2020 Suzanne completed a home detoxification but continued to use crack cocaine on an occasional basis and was offered online group psychosocial interventions which she said she would consider.

5.31 On 19th October 2020 CGL wrote to Suzanne to ask her if she still wanted support from them and advised her that if she did not contact them with 7 days, CGL would close her case.

5.32 During November 2020 Suzanne phoned CGL to say she was upset but she didn't want to elaborate further at that time. A telephone appointment was made to which Suzanne did not reply. Later in the month Suzanne was phoned by a nurse from her GP practice and reported that she had relapsed into illicit drug use and had been having a difficult family time but did not elaborate further. Also in November 2020 Suzanne was supplied with a replacement washing machine by One Manchester as her previous machine was broken and she had no funds to buy a new one.

5.33 On 1st December 2020 CGL contacted Suzanne who reported that she had relapsed into heroin use soon after completing the earlier community detoxification and said that she was using heroin (£15 daily) and crack cocaine (£20 daily). Treatment was to be re-started and a prescriber review took place on 8th December 2020 following which she was commenced on Espranor 4mg daily. During this appointment Suzanne said that she was in contact with her daughter, was single through choice and had suffered domestic abuse from two previous partners. A Mental State Examination disclosed no concerns. No safeguarding issues were identified. Suzanne's GP practice was notified.

5.34 On 12th December 2020 Suzanne was allocated a new recovery coordinator following an internal change to CGL's structure and to make caseloads more equitable across the service.

5.35 On 16th December 2020 the DWP approved an advance for Suzanne for the purchase of carpets which was linked to her breathing problems.

2021

5.36 In January 2021 Suzanne's GP received a letter from CGL to advise that treatment had been re-started. The letter also advised that during her contact with CGL in December 2020, Suzanne had disclosed low mood in relation to family problems but had no thoughts of self-harm or suicide.

5.37 On 14th January 2021 Suzanne contacted GoToDoc, the Out of Hours GP service and reported anxiety and depression. Zoe was also spoken to during the call and she confirmed her mother's low mood. The outcome of the call was that Suzanne agreed to contact her GP for follow up.

5.38 On 20th and 26th January 2020 Suzanne had telephone consultations with her GP in respect of anxiety and depression. Antidepressants were prescribed for two weeks. The GP intended to review Suzanne after two weeks before a repeat prescription could be given but no further appointments for anxiety and depression took place. When a patient presents with anxiety and depression and this is entered into EMIS (electronic patient record system), a HARK (Humiliate, Afraid, Rape, Kick) electronic patient record prompt is triggered to remind the GP to ask all patients who present with anxiety and depression about domestic abuse if it is safe to do so. On these occasions HARK was not automatically triggered and there is no indication that Suzanne was asked about domestic abuse.

5.39 On 27th January 2021 Suzanne contacted One Manchester to request a phone which was authorised and delivered. Also during January 2021 Zoe contacted the DWP to say that she had been having issues with her phone. During the call, Zoe disclosed that she was living with her mother.

5.40 On 9th February 2021 Suzanne contacted DWP to advise that she was unable to use their online functionality and her claim was changed to a 'phone claim'.

5.41 On 10th February 2021 a GP practice nurse conducted a telephone review of her COPD with Suzanne. During the call Suzanne referred to having family problems but did not elaborate. Further tests for blood pressure and bloods were booked for 19th February 2021 but the GP practice has no record of whether Suzanne attended or not. She had no further contact with her GP.

5.42 CGL was unable to contact Suzanne by phone on 29th January 2021, 12th February 2021, 22nd February 2021 and 25th February 2021.

5.43 On 14th February 2021 GMP received an abandoned call from a female in distress. It was established that the call had been made by Suzanne from her home address. Officers attended and spoke to Suzanne and Zoe separately. Suzanne reported a verbal argument between her and Zoe, but said that she didn't want to report any offences. Zoe confirmed that she had had an argument with her mother. The argument appeared to concern Zoe's 'boyfriend' who Suzanne stated had assaulted her daughter, which Zoe denied. The police recorded a crime for common assault and battery with Zoe as the victim and her boyfriend the perpetrator. No further action was taken in respect of this recorded crime at the victim's (Zoe) request. The police concluded that there was no reason to remove Zoe from the house although they did not complete a DASH risk assessment as Suzanne declined to answer the relevant questions. However, the police assessed the incident as 'standard' risk. Officer's noted no safeguarding issues and took the view that the arguments between mother and daughter may have arisen because Suzanne 'did not like Zoe's relationship with her partner'. A toxic trio assessment was completed which identified no mental health issues although officers noted that Suzanne said she required 'mental health counselling'. Suzanne was documented to be a former drug addict and had 'crack psychosis'. The officers documented this to be a reason why the incident had possibly never happened. Suzanne reported having taken cocaine a few days earlier and said that she was taking Espranor on prescription. Officers noted that Suzanne was upset, clutched her chest and appeared short of breath. She was noted to use an inhaler. Zoe said that her mother had a diagnosis of COPD and the officers offered to call an ambulance but Suzanne declined this. (Suzanne's son has provided information to the review about an incident in which Zoe disclosed that her partner had harmed her which led to Suzanne's son taking Zoe to stay with Suzanne (Paragraphs 4.22 and 4.23). He estimated that this incident took place around six months prior to Suzanne's murder but added that Zoe subsequently went back and forth between her partner's and Suzanne's addresses and that Zoe continued to have arguments with her partner over the phone).

5.44 On 22nd February 2021 Suzanne was allocated a new CGL recovery co-ordinator as a result of a service restructure.

5.45 On 23rd February 2021 the DWP called Zoe who reported that she hadn't been well, and was struggling with her mental health which was 'making her sick'. She said that she planned to see a doctor. She said that she was caring for her mother who had COPD. Following the call Zoe re-contacted the DWP to advise them of an address change – to the Worsley area of Salford.

5.46 On 25th February 2021 Suzanne's new CGL recovery co-ordinator attempted to contact Suzanne but received no reply and there was no facility to leave a voicemail message. The recovery co-ordinator phoned Suzanne's pharmacy who told her that Suzanne had not collected her medication the previous day. The recovery co-ordinator left her contact details with the pharmacy to be passed onto Suzanne.

5.47 On Monday 1st March 2021 the CGL recovery co-ordinator managed to contact Suzanne by phone but Suzanne was unable to complete a review and so a further appointment was arranged for 3rd March 2021.

5.48 On Tuesday 2nd March 2021 Suzanne contacted One Manchester and disclosed that she had had a 'huge argument' with her daughter during which her daughter had slapped her. She said that she was really hurt (unclear whether this was physically, emotionally or both) as she said that her daughter had never done this before. The One Manchester member of staff advised Suzanne to report the matter to the police but Suzanne said that she was reluctant to do so as her daughter was going through a 'bad time'. Suzanne asked the One Manchester staff member not to tell anyone about the incident.

5.49 On Wednesday 3rd March 2021 the CGL recovery co-ordinator phoned Suzanne as arranged but Suzanne said that she had forgotten about the appointment and was unable to speak at that time. The appointment was rescheduled for 11th March 2021.

5.50 On Thursday 11th March 2021 the CGL recovery co-ordinator phoned Suzanne who was again unable to participate in a review as she said that she was 'helping her father'. (Suzanne's father had died many years previously and so it is assumed that there had been a misunderstanding between Suzanne and the CGL recovery co-ordinator). The appointment was rescheduled for 24th March 2021.

5.51 On Friday 19th March 2021 One Manchester phoned Suzanne to check on her but received no reply.

5.52 On Monday 22nd March 2021 Suzanne messaged One Manchester to say that she had 'sorted it out with CGL'. One Manchester phoned her back and Suzanne said that she was feeling better, having been to see her worker, presumably her CGL worker, and that she 'needed to get better for her kids'.

5.53 On Tuesday 23rd March 2021 Suzanne rang CGL to advise that she had not collected her medication on 17th March 2021. She was reminded that an appointment had been arranged for the following day with her recovery co-ordinator.

5.54 On Wednesday 24th March 2021 the CGL recovery co-ordinator phoned Suzanne and was able to conduct the delayed risk review. Her COPD was noted as was her low mood for which she was said to be receiving treatment from her GP. Suzanne was referred to stop smoking services. She reported using heroin (£20's worth) daily and smoking a cannabis spliff daily. No crack cocaine use was reported. No safeguarding risks were identified and a further appointment was arranged for 22nd April 2021. Suzanne was advised to collect her prescription from CGL's premises in Cheetham Hill, Manchester on 25th March 2021 (the following day).

5.55 On Thursday 25th March 2021 the CGL recovery co-ordinator spoke to Suzanne by phone and Suzanne said that she could not attend the CGL premises to collect her

prescription because of her COPD and lack of funds for a taxi. A further risk review was carried out and the main issues were COPD and low mood. Suzanne reported being prescribed antidepressants by her GP. No safeguarding issues were identified. CGL agreed to deliver her prescription to the pharmacy and a further appointment was made for Suzanne for 22nd April 2021.

5.56 This DHR had been advised that Suzanne collected her prescription from the pharmacy later the same day (25th March 2021). The source of this information is the GMP investigation into the murder of Suzanne. GMP has further advised that this was the last confirmed sighting of Suzanne prior to her death. In their contribution to this DHR the pharmacy has advised that the manager cannot remember when Suzanne last collected her prescription and they do not keep records of service users collecting prescriptions.

5.57 On an unknown date between Thursday 25th March 2021 and Friday 2nd April 2021 (Good Friday) Suzanne was stabbed to death by her daughter Zoe in Suzanne's home address.

5.58 During the course of the DHR it has come to light that there was an incident on Monday 29th March 2021 which resulted in several agencies having contact with Zoe. Zoe telephoned the Department for Work and Pensions (DWP). The time of the call is not stated. The DWP agent documented that Zoe was 'very upset' and was requesting an advance payment 'for rent' as her ex-partner had taken 'all monies' from her account. The DWP agent advised Zoe to make her landlord aware and call the police. The advance requested by Zoe was not approved. The DWP agent attempted to signpost Zoe to other sources of support which Zoe declined and ended the call. The DWP agent had an awareness of Zoe's 'health issues' and was concerned that Zoe 'was going to harm herself' and so called 999.

5.59 GMP received the 999 call from the DWP agent and documented that the DWP had received a call from Zoe advising that 'she is suicidal and intends to harm herself and/or end her life'. GMP also documented that the purpose of the call from Zoe had been to request an advance payment to 'tide her over for a month' as her ex-partner had 'hacked into her bank account and emptied all her funds'. GMP also documented that 'due to Zoe's history/circumstances', the DWP agent had been unable to offer an advance and so was attempting to suggest different advice and helplines when Zoe 'stopped the DWP agent in her tracks' and said "thank you, you've been a great help, if I die in the next couple of days will you let my family know?" and she then cleared the line.

5.60 The DWP supplied GMP with Zoe's details including a contact phone number and an address in Salford which Zoe had provided to DWP on 23rd February 2021.

5.61 GMP passed the call to the North West Ambulance Service (NWAS) who phoned Zoe at 15:00. NWAS noted that a different Salford address for Zoe was recorded on the NHS Spine. The NWAS call handler documented that Zoe said that she was 'OK', didn't require help, but sounded upset. It was also documented that Zoe was very grateful that NWAS had checked

on her, but she was 'fine'. Zoe was given 'worsening advice' to call 999 should her health and wellbeing deteriorate.

5.62 At 15:17 NWAS requested BARDOC, the provider of GP Out of Hours services, to contact Zoe. BARDOC documented the referral from NWAS to concern 'mental health, 36 year old female, conscious, breathing'. At 16:54 BARDOC attempted to phone Zoe on the telephone number provided and were unable to obtain an answer. The case was referred back to NWAS, who had kept the job open.

5.63 NWAS despatched an ambulance crew to the two Salford addresses but Zoe was not located at either address and so NWAS recontacted GMP for any further addresses they might have for Zoe. GMP supplied a further Salford address. An ambulance crew attended this address but was unable to locate Zoe. Additionally, NWAS made attempts to contact Zoe on the mobile phone number she had provided but no reply was received.

5.64 At 23:58 NWAS informed GMP that they had been unable to locate Zoe and ended their involvement in the case.

5.65 GMP assessed the incident using the THRIVE model (threat, harm, risk, investigative opportunities, vulnerability and engagement). GMP assessed the risk as 'low' based on NWAS phone contact with Zoe when she was documented to have said that she didn't require help.

5.66 The following day (30th March 2021) GMP called Zoe (time of call not known), who was documented to be slurring her words. Zoe said that she was at her mother's address, which she didn't wish to disclose. She then went on to say that she was at work 'in the morning' and just wanted to go to sleep'.

5.67 As previously stated following the murder of Suzanne, Zoe left her mother's address to stay elsewhere. It appears that she took her mother's dog with her. When asked about her mother's welfare and/or whereabouts Zoe lied repeatedly. She continued to withdraw funds from her mother's bank account until her arrest.

5.68 On 9th April 2021 DWP phoned Zoe who said that she was 'not too bad' although she said that she continued to struggle with her mental health. She said that she continued to care for her mother.

5.69 On 12th April 2021 Graham advised One Manchester that Zoe was staying with him. As Graham was considered to be a vulnerable adult with a history of being targeted, he was reminded to 'be careful'.

5.70 On 15th April 2021 One Manchester attempted to phone Suzanne to arrange for a repair to her property but received no reply.

5.71 On 22nd April 2021 the CGL recovery co-ordinator was unable to contact Suzanne for her appointment and so she contacted the pharmacy (on 27th April 2021) to request that a message was given to Suzanne to make contact with her. There is no record of whether CGL or the pharmacy considered if Suzanne had been collecting her prescription from the pharmacy.

5.72 On 4th May 2021 the CGL recovery co-ordinator tried unsuccessfully to phone Suzanne and left a voicemail and sent a text.

5.73 On 5th May 2021 a One Manchester operative attempted to contact Suzanne to carry out repairs. There was no reply to a knock on the door and no answer to a phone call.

5.74 Also on 5th May 2021 Zoe phoned the DWP, stating that she was in 'desperate need' of an advance and adding that she was short of money each month and had bills to pay. On 17th May 2021 Zoe again phoned DWP to update her telephone details. She also said that she had received a letter stating that she owed money and was provided with contact details for debt management. The DWP agent noted that Zoe 'seemed fine'.

5.75 On 20th May 2021 the CGL recovery co-ordinator again made an unsuccessful attempt to phone Suzanne. The following day the recovery co-ordinator again phoned the pharmacy and left a message for Suzanne to contact her.

5.76 On 25th and 26th May 2021 the CGL recovery co-ordinator again attempted to phone Suzanne, without success.

5.77 On 3rd June 2021 CGL sent a letter to Suzanne offering her an appointment for 10th June 2021.

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5.78 On 9th June 2021 Zoe contacted the DWP to advise that she was having to self-isolate due to her mother having Covid -19. When a DWP agent attempted to phone Zoe for a scheduled appointment later the same day, there was no answer.

5.79 On 10th June 2021 the CGL recovery co-ordinator was unable to contact Suzanne by phone for the appointment offered by letter. On the same date she phoned the pharmacy which advised her that Suzanne had not collected her prescription 'since April 2021' but they were unable to give a precise date when Suzanne had been last seen. The CGL recovery co-ordinator also rang Suzanne's GP practice which advised that they had not had contact with her since February 2021 and that her medication had not been collected 'since April 2021'. After consulting her team leader the CGL recovery co-ordinator requested GMP carry out a welfare check in respect of Suzanne.

5.80 GMP planned to conduct the welfare check but the officers allocated the task were diverted to another call and the police were unable to resource the welfare check during the remainder of the day. Overnight the police decided to contact CGL to ascertain what efforts

they intended to make to contact Suzanne before requesting police assistance. GMP later contacted CGL and suggested they get in touch with Suzanne's housing provider.

5.81 Shortly after midday on a date in mid-June 2021 a One Manchester Place Co-ordinator and a joiner forced entry to Suzanne's property after receiving no reply and discovered Suzanne's body. NWAS attended and pronounced life extinct.

6.0 Analysis

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

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

6.2 GMP officers responded to two incidents of domestic abuse involving Suzanne and her daughter Zoe – in November 2019 (Paragraphs 5.19 and 5.20) and February 2021 (Paragraph 5.43). Neither incident involved violence or the threat of violence although Suzanne was sufficiently disconcerted by the impending arrival of Zoe at her home in November 2019 to ring the police several times and disclosed that she was in fear of violence from her daughter as she'd previously assaulted Suzanne, and that Zoe 'caused lots of arguments'. The police assessed this November 2019 incident as 'standard' risk but do not appear to have fully explored the incident as the toxic trio assessment recorded 'no issues' in respect of alcohol, mental health and drugs. Suzanne and Zoe may have been reticent about what they disclosed to the police on this occasion but the police had access to information about their offending history on the Police National Computer (PNC) which would have suggested that Suzanne was a long term abuser of drugs.

6.3 The second domestic abuse incident attended by GMP took place 15 months after the first and occurred around seven weeks before the homicide. This was also assessed as a 'standard' risk incident although Suzanne declined to answer the DASH risk assessment questions. However, officers gained a more thorough understanding of Suzanne's vulnerabilities on this occasion – identifying that she was a 'former drug addict' who continued to use cocaine and was prescribed an opiate substitute. They also noted how unwell she was with COPD and offered to call an ambulance for her which Suzanne declined. It is unclear to what extent the clutching at her chest the officers observed was due to COPD or distress or a combination of the two. The officers documented that Suzanne had 'crack psychosis' which appeared to raise some doubt in their minds about the veracity of Suzanne's account. Whilst cocaine use can induce psychotic symptoms, this DHR has received no information to indicate that this was the case for Suzanne. It is unclear where the suggestion that Suzanne had 'crack psychosis' originated but officers need to avoid making assumptions about the reliability of what a victim of domestic abuse is saying on the basis of an officer's opinion. In this case the suggestion of 'crack psychosis' appears to have had no foundation in fact.

6.4 The DHR Panel felt that all professionals dealing with domestic abuse needed to be conscious of the effects unconscious bias. Unconscious bias is when we make judgements or decisions on the basis of our prior experience, our own deep-seated thought patterns, assumptions or interpretations, whilst being unaware that we are doing it (1). We are all affected by unconscious bias. The ability to distinguish friend from foe helped early humans survive. The ability to quickly and automatically categorise people according to social and other characteristics is a fundamental quality of the human mind that helps to give order to life's complexity. Police officers frequently need to distinguish between information which can be relied upon and information which cannot. In this case officers made a judgement that Suzanne's account my not have been true because she was a former drug addict who may have 'crack psychosis (Paragraph 5.43). In the event, this unconscious bias did not materially affect how the officer's responded to the call. They gained a thorough understanding of her vulnerabilities and their assessment of the incident as 'standard' risk does not appear unreasonable. However, this incident demonstrates how unconscious bias could lead to a victim of domestic abuse not being believed.

6.5 Just over two weeks after the February 2021 domestic abuse incident, Suzanne made a specific disclosure of physical abuse by Zoe to One Manchester (Paragraph 5.48), stating that Zoe had slapped her during a 'huge argument' which had really hurt her. It is unclear whether the 'hurt' Suzanne referred to was physical or emotional or both. Suzanne said that Zoe had never done this before which appears to have been a factor in the One Manchester member of support and wellbeing co-ordinator treating the disclosure as an 'isolated incident', although treating a disclosure of domestic abuse as an 'isolated' incident disregards the volume of evidence that before reporting an incident, or getting effective help, a victim may have suffered a substantial history of domestic abuse (2). The One Manchester support and wellbeing co-ordinator advised Suzanne to report the incident to the police but it was clear that Suzanne was reluctant to do so. Action expected would include a safeguarding referral, escalation to One Manchester management and the offer of ongoing support to a vulnerable tenant who had disclosed abuse by a family member who was known to be residing with her and providing care to her.

6.6 Looking back at the period prior to the homicide during which GMP responded to the domestic abuse incident on 14th February 2021 and Suzanne made the disclosure of domestic violence by Zoe to One Manchester on 2nd March 2021, there are possible indications that Suzanne *may* have been experiencing abuse from Zoe possibly in the form of controlling behaviour (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) or coercive behaviour[1] (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 (3)). Her CGL recovery co-ordinator struggled to make contact with her by phone and when she did so, Suzanne was frequently unable or unwilling to commit to a risk review, she disclosed low mood (Paragraph 5.54),

[1]Section 76 Serious Crime Act 2015 created the offence of controlling or coercive behaviour in an intimate or family relationship.

she did not collect her prescription from the pharmacy (Paragraph 5.46) and disclosed 'family problems' to the GP practice nurse on which she did not elaborate (Paragraph 5.41). However, these behaviours had been observed in Suzanne on many previous occasions. Agencies, particularly CGL had experienced difficulties in engaging with Suzanne over a number of years. This highlights a learning point that a history of *unwillingness or reluctance* to engage with professionals *could* mask a situation in which the person is *prevented* from engaging with professionals. However, this may be extremely difficult for professionals to recognise because of the pattern of the person's previous engagement. It is accepted that it is even more difficult to become aware of subtle changes in a person's behaviours when the majority of interactions are by telephone which was the case during the weeks prior to the homicide as a result of Covid-19 restrictions.

6.7 GMP have advised this DHR that Suzanne's person record in their IOPS information system contained a risk marker that she was a repeat victim. However, this marker was only added after Suzanne's death. The author of the GMP IMR concluded that this marker should have been added to Suzanne's record much earlier. According to GMP's Domestic Abuse Policy and Procedure, if a victim reports an incident of domestic abuse on more than one occasion, they will be considered a repeat victim, regardless of whether incidents reported involved the same or different perpetrators. As stated Suzanne had reported two domestic abuse incidents involving Zoe. Identifying a person as a repeat victim also enables officers to review previous safeguarding measures and utilise the RARA model to consider if existing safeguarding measures need to be increased or adapted, and whether referrals to partner agencies are required to intervene to prevent the victim from suffering further domestic abuse (GMP has made a single agency recommendation in this regard – see Appendix A).

6.8 GMP have also advised this DHR that following the second domestic abuse incident involving Suzanne and Zoe in February 2021, a DASH assessment was submitted as 'refused', when Suzanne declined to answer questions. According to GMP's Policy and Procedure, if a victim refuses to answer DASH questions, the officer responding should apply their professional judgement to make an assessment of risk. Officers should include their assessment of the victim's demeanour in the DASH, for example whether the victim is distressed, upset or frightened. In this case, although the officers did not complete a DASH risk assessment at the time, one was completed later (GMP has made a further single agency recommendation in this regard – see Appendix A).

6.9 Suzanne made no disclosures of domestic abuse to her CGL key workers, although she disclosed that she had been the victim of domestic abuse by two previous partners and she implied that because of this she was single by choice. However, Suzanne was supported by a number of different keyworkers (new keyworkers allocated to her in December 2020 and February 2021) which might have affected her willingness to make disclosures until a relationship of trust had developed. Additionally, the relationship between substance misuse keyworker and service user may not be a relationship which is particularly conducive to the service user making personal disclosures as the service user may not always be honest about their drug use. When Suzanne's brother read and commented on the final DHR

Overview Report, he said that the continuity of CGL workers was an issue which should be addressed by the commissioners of the service (Paragraph 4.26).

6.10 Suzanne made no specific disclosures of domestic abuse directly to any of the GPs or practice nurses during consultations. However, the CGL Manchester letter received by Suzanne's GP practice in December 2020 stated that Suzanne had previously been the victim of domestic abuse on two occasions with previous partners. The fact that Suzanne had previously been a victim in two previous relationships is an indicator that she may be at further risk of domestic abuse, however this information and potential risk was not coded onto her EMIS record.

6.11 Suzanne's GP practice has a coding system in place where all external letters received are read and forwarded to the GPs and coded accordingly. The author of the GP practice IMR has advised this DHR that past domestic abuse issues are contained within the social circumstances section of the letter, which was detailed and contained a range of information. The IMR author points out that the volume of external letters sent to practices in general and large workloads may mean that GPs tend to focus on any GP actions that are required in letters, rather than additional details. Due to the passage of time, it is not possible to say why in this specific case the domestic abuse issues were not picked up and coded on the system. The author of the GP practice IMR took the view that in this situation it would be good practice to pick up third party information and code the historic or previous domestic abuse issues, but it is not currently expected practice. However, Manchester Health and Care Commissioning (MHCC) has developed a single agency recommendation to address this issue (see Appendix A).

Did agencies recognise that the victim Suzanne may be at risk of familial domestic abuse and respond appropriately?

6.12 GMP recognised Suzanne as a victim of familial domestic abuse from her daughter Zoe and previously recognised her as the victim of familial domestic abuse from her brother. (Additionally a MARAC referral has been shared with this DHR in which her brother disclosed that he had been a victim of domestic abuse from Suzanne in 2015 or 2016 (Paragraph 5.6).

6.13 It is unclear whether One Manchester recognised Suzanne's March 2021 disclosure of physical abuse as familial domestic abuse.

6.14 Suzanne made no disclosures of familial domestic abuse to CGL who carried out risk reviews in July 2020, September 2020, January 2021 and March 2021. Risk of domestic abuse is explored during each risk review.

6.15 Suzanne's GP practice understood her to live alone. Whilst there is mention in the notes of depression linked to family problems, these were seen as non-specific in terms of potential familial domestic abuse.

6.16 No professional gained an understanding of the dynamics of the relationship between Suzanne and her daughter. The police gained some insight from their response to the two

domestic abuse incidents but at no stage did any professional have the opportunity to fully explore the dynamics. There are indications that Zoe provided some care for Suzanne who was not in good health and may have welcomed support from her daughter. However, Suzanne's son has advised this review that, in his opinion, his mother was organised, had a routine and said that he felt that it would be safer for Zoe to stay with their mother than with her partner (Paragraph 4.23). Suzanne herself had provided live-in care to her own mother in the years prior to her mother's death. Following her arrest Zoe disclosed that she and her mother had been using crack cocaine together but there is no indication that professionals became aware that they were using illicit drugs together prior to the homicide.

6.17 The Home Office provides guidance on abuse between family members (4), but the focus of this very helpful guidance, and the University of Oxford research on which it draws (5) is on adolescent to parent violence and abuse (APVA). Both the University of Oxford research and international research has found that adolescent to parent violence is predominantly a son-mother phenomenon. Given that the Home Office guidance on familial domestic abuse focusses primarily on violence by teenage boys against their parents – primarily mothers – there is a risk that practitioners might overlook the possibility of domestic abuse in a relationship between a 36 year old female and her 58 year old mother. However, recent research is beginning to shed more light on the homicide of older people by partners or family members (6) and has found that older people are almost as likely to be killed by their child as by a partner – which is a significant difference compared with domestic homicide in younger age groups where there is greater risk of homicide from partners. The research has also found that the overwhelming majority of perpetrators of familial domestic homicide of older adults are sons or grandsons (7). This suggests that the risk of domestic homicide involving the daughter as the perpetrator and the mother as victim is relatively rare, which could be another factor which may have obscured the risk Suzanne faced from her daughter from professionals in contact with Suzanne.

Were there any barriers to the victim Suzanne accessing support in respect of domestic abuse?

6.18 Suzanne did not access, nor was she referred to support in respect of the domestic abuse incidents involving her daughter Zoe. Both domestic abuse incidents were assessed as 'standard'. The DHR has been advised that 'standard' risk incidents would normally be considered for referral to the STRIVE project, which currently involves police, local authorities and other partner agencies working with the voluntary sector to signpost people to relevant support services, share best practice and prevent repeat victims of domestic abuse. There is no indication that Suzanne was referred to the STRIVE project, in respect of which, implementation - in the City of Manchester - has been patchy. The DHR has been advised that although implementation of STRIVE had been patchy, by the time of the second domestic abuse incident involving Suzanne and Zoe, which took place in February 2021, expected practice would have been for a referral to be made to STRIVE. The DHR Panel discussed whether lack of confidence in STRIVE as a referral option for 'standard' risk cases had resulted in more domestic abuse incidents being assessed as 'medium' or above in order to secure support for victims of domestic abuse.

6.19 Suzanne consented to a referral to 'victim services' following the domestic abuse incident involving her daughter Zoe (Paragraph 5.14). It is not known whether any such referral was made. Victim Support has advised this review that they have no record of any referral in respect of Suzanne at that time.

6.20 Agencies experienced some difficulties engaging with Suzanne, particularly CGL. Suzanne's involvement with CGL appeared to be driven by her relapsing into illicit drug use after detoxification and periods of abstinence and also by the level of Suzanne's motivation to change. For example the impending birth of her first grandchild appeared to be an important event in her life which prompted her to engage with CGL once more.

6.21 Professionals in contact with Suzanne described her as quite an unassuming person. There is some indication that she may not have fully articulated her needs to professionals at times. For example, One Manchester only became aware of her financial difficulties through her relationship with another tenant who had a high level of needs (Paragraph 5.8).

6.22 A potential 'system' barrier to Suzanne accessing domestic abuse support arose when she presented with anxiety and depression to her GP during January 2021. Her GP practice is an Identification and Referral to Improve Safety (IRIS) registered practice and the HARK (Humiliate, Afraid, Rape, Kick) electronic medical record prompt is a tool which can be used as trigger mechanism for GPs to consider domestic abuse when specific presentations occur – including anxiety and depression. Had Suzanne made any disclosures to the practice, or if she had disclosed domestic abuse on enquiry from a practitioner, then she would have been offered the opportunity to link with an IRIS worker for additional support.

6.23 Her January 2021 presentations for anxiety and depression did not trigger a HARK electronic medical record response. The DHR has been advised that the GP practice had recently changed their coding systems and that migration had taken place onto a new system. Enquiries with the IRIS GP lead have suggested that the EMIS electronic patient record system - to which the HARK template is linked – doesn't always automatically bring up the request for a HARK template for 'anxiety and depression'. The IRIS GP lead advised that she normally enters IBS (irritable bowel syndrome) to trigger HARK and add the 'read code' for 'anxiety and depression' to the patient's record subsequently. The IRIS GP lead advised that she had originally been told that this issue could be rectified at GP practice level but was later advised that representations had been made to EMIS and the response received was that the system could not be changed to enable 'anxiety and depression' to trigger the HARK template. The IRIS GP lead further advised that, in the light of the learning from this DHR, the matter needed to be escalated to IRIS through the NHS Manchester Clinical Commissioning Group (CCG) and IRIS.

6.24 The DHR Panel has been advised by NHS Manchester CCG that contact with their Data Quality Team has indicated that there is a national protocol which relates to the EMIS system prompting the HARK template when a patient presents with certain health conditions such as anxiety and depression. However, the Data Quality Team advised that EMIS system itself could disable the HARK prompt and GP practices could also disable the HARK prompt.

The DHR has been advised that GP practices sometimes disable the HARK prompt because it appears on the screen continually throughout the GP consultation due to the number of conditions/key words that trigger it. The Data Quality Team had tested the HARK prompt using fictitious patient details and found the HARK prompt to be triggered by 'anxiety and depression'.

6.25 However, it should be pointed out that the HARK trigger should not be solely relied upon and it should be standard practice to ask a question about domestic abuse in any presentations for anxiety and depression if it is felt safe to do so, for example if the patient is alone.

How effectively were the risks the perpetrator Zoe presented to herself and others assessed and managed? How effectively did agencies respond to disclosures by Zoe that she feared she might harm others?

6.26 Zoe's criminal history began in her teenage years and she was convicted of criminal offences on ten occasions, receiving community orders or custodial sentences. She was convicted for her most serious offence in 2007 when she was sentenced to five years imprisonment for two robberies of females whilst in possession of a knife. The victims sustained severe injuries and psychological distress. Following her release from prison in 2010 Zoe attended Hospital ED with low mood. During this attendance Zoe said that she was worried she will be aggressive to someone and that she would 'end up back in prison'. She went on to say that she often had feelings of anger and felt like she wanted to hurt someone – but hurt no individual in particular. The Hospital wrote to her GP who was unable to refer Zoe for anxiety management as she was of no fixed abode. She also declined a referral to the Homeless Service at that time. Zoe's most recent conviction was in November 2016 following an assault on her female partner who she kicked and punched. Her partner was unwilling to support a prosecution but the incident had been captured on CCTV which allowed a successful prosecution to take place. Zoe was originally sentenced to a twelve months community order but subsequently served a short prison sentence for breaching her community order and Probation Service involvement ended in early 2018. At this point Zoe was abstinent from drugs and alcohol – to which her offending had invariably been linked in the past. She was assessed as presenting a 'low' risk to herself and others at that time.

6.27 GMP has advised the DHR that they did not have any information or intelligence to suggest that Zoe presented a risk to herself or others at the time they attended the two domestic abuse incidents involving Suzanne and Zoe. However, Zoe's most recent conviction related to a 2016 assault on a female partner. GMP has advised this review that officers have a good awareness of familial domestic abuse and that it should not have made any difference to the officer's analysis of risk that Zoe's previous victim was an intimate partner rather than a family member. However, the Panel acknowledged that daughter to mother domestic abuse was less prevalent than other forms of familial domestic abuse.

6.28 GMMH has advised the DHR that when the hospital mental health liaison practitioner assessed Zoe on 20th July 2019 a standard risk assessment tool was completed. Zoe did not

verbalise any threats to others nor was she aggressive or angry. Zoe was deemed not to be a risk to others or herself at this time.

6.29 Whilst it was Zoe's choice not to register with a GP, this largely cut her off from primary care and the potential for referral from primary care to any specialist care she may have needed. In Zoe's case it meant that the mental health issues present in her life appear to have been largely self-managed. She only presented to mental health services at times of crisis. This also means that people without a GP, such as Zoe, are placing additional demands on emergency healthcare which could have been prevented if they had been accessing primary care. The lack of GP registration also affected how services were able to respond to her attendance at the Royal Bolton Hospital in July 2019. After completing their assessment of Zoe, the hospital mental health liaison practitioner had no GP practice to share the assessment with, which prevented any primary care follow up. The mental health practitioner advised Zoe to register with a GP but there is no indication that Zoe acted on this advice.

6.30 There is no direct link between Zoe's lack of contact with primary care for several years and the homicide but it is not unreasonable to make the point that the impact of any Adverse Childhood Experiences she likely experienced may have largely gone unaddressed during her adulthood other than at times of crisis. Had she accessed primary care, there is the possibility that the risks she presented to herself and/or others could have become more apparent.

6.31 The DHR Panel discussed how people could be encouraged to register with a GP. One Manchester highlighted a current project in which they assisted tenants to register with a GP.

6.32 The National Offender Management Service report entitled *Better Outcomes for women Offenders* concluded that in order to reduce reoffending amongst women and keep women who commit crime safe, the following seven areas should be a priority (8):
Addressing substance misuse problems – in Zoe's case, when Probation Service involvement ended in early 2018, she was abstinent from drugs and alcohol – to which her offending had invariably been linked in the past – and was assessed as presenting a 'low' risk to herself and others at that time.
Addressing mental health needs – in Zoe's case her lack of GP registration largely cut her off from primary care and the potential for referral from primary care to any specialist care she may have needed. It also meant that the mental health issues present in her life appear to have been largely self-managed. She only presented to mental health services at times of crisis and she had no GP for mental health services to refer her onto for follow up support.
Building skills in emotion management – it is unclear whether work on impulse control had been completed with Zoe in the past.
Helping women to develop and maintain a pro-social identity – Zoe demonstrated quite a strong level of self-sufficiency in terms of maintaining employment although when she presented as mentally unwell in July 2019, she had recently lost her job and does not

appear to have been in employment during the period she was living with her mother prior to the murder and was experiencing financial difficulties.
Helping women to believe in their ability to control their lives and achieve their goals
Improving family contact – which is usually regarded as a protective factor in reducing offending by women.
Helping women to resettle and build their social capital – Zoe's life had become less stable and secure, which was a key factor in her brother supporting her to move in with her mother.

What support was offered or provided to the victim Suzanne and the perpetrator Zoe to help them address their use of drugs?

6.33 CGL have reviewed the case support provided to Suzanne and have formed the view that what was offered was appropriate and took Suzanne's wishes into account. CGL acknowledge that there was a gap in contact with Suzanne during 2019 when her recovery coordinator was absent from work. Additionally, once the vast majority of appointments were changed from face-to-face to telephone or online from the outset of the pandemic, CGL took the view that there was no longer the same need for service users to be allocated to recovery co-ordinators from the CGL locality base which served the service user's address. Suzanne's most recent CGL recovery co-ordinator was not attached to the locality base which served her address, which had implications for the escalation of concerns internally when Suzanne stopped collecting her prescriptions and no longer answered her phone in the two months after her murder, which will be discussed later in the report. However, her most recent recovery co-ordinator felt that the severing of the local link together with only ever interacting with her by phone, impacted on her knowledge of Suzanne and her life. For example the recovery co-ordinator was unaware that Suzanne was of dual heritage.

6.34 Additionally, there appeared to be little consideration of the impact of Suzanne's illicit drug misuse on her financial situation. One Manchester provided support to Suzanne when they became aware of her financial difficulties but it is assumed that her drug habit consumed a substantial amount of her income from state benefits and may have led to debt, including debt to drug dealers which had the potential to adversely affect her mental health and wellbeing.

6.35 Suzanne's GP practice was aware that she was using drugs and accessing specialist drug services. Therefore, the GP practice focus was on providing support for additional medical issues rather than on her drug use. CGL regularly wrote to the GP practice to advise of the treatment Suzanne was receiving.

6.36 As previously stated, Suzanne used crack cocaine and in her interview with the police following Suzanne's murder, Zoe said that they began using crack cocaine together after Zoe moved in with Suzanne and Zoe said that they had both been using crack cocaine on the night the murder took place. It is not possible to prove or disprove this given the length of time which had elapsed between the murder and Suzanne's body being discovered. However, concern has been expressed about an apparent increase in the use of crack

cocaine and the impact of this on society. Public Health England (PHE) and the Home Office conducted an enquiry into the increased use of crack cocaine and published their findings in 2019 (9). Amongst the findings which may be of relevance to this DHR are that use of crack cocaine was available at 'pocket money prices' such as £5 per rock which had contributed to it changing from being a 'treat' to daily use, treatment workers and service users spoken to by the enquiry believed that crack use was responsible for causing mental health problems, paranoia and the tendency to make users more aggressive and
there was an absence of effective substitute treatment for crack cocaine and
activities to fill up user's days to help wean off crack cocaine. CGL have advised this DHR that they provide a number of treatment options to support people who are using crack cocaine, including group work. Whilst not substance specific, these treatment options are suitable for people using a range of substances including crack cocaine. Additionally, every person in treatment has a named recovery coordinator who will work in collaboration with the individual to agree a personalised treatment plan. In-patient detoxification is also available where appropriate.

6.37 Zoe is not known to have accessed support for her illicit drug misuse.

How effectively did agencies respond to Suzanne's lack of contact with family, friends and agencies after 25th March 2021 and concerns that she may have come to harm?

6.38 A period of over 70 days elapsed between the last confirmed contact by professionals with Suzanne and the discovery of her body. This is a very long period of time. She must have died very quickly after her daughter stabbed her several times in early April 2021 but had she been incapacitated rather than killed and been unable to communicate, a delay of over 70 days would almost certainly have led to her death.

6.39 The key opportunity to raise the alarm much more promptly was when Suzanne stopped collecting her prescription of Espranor. The review has also been advised that her GP medication (Sertraline) was last issued on 26th March 2021. It remains unclear why Sertraline was prescribed to Suzanne on 26th March 2021 as she had first been prescribed Sertraline by her GP in January 2021 (Paragraph 5.38) but only two weeks supply had been prescribed on that occasion and this was to have been followed up by a review before a repeat prescription was given. There is no record of the planned review taking place. The GP practice has advised the DHR that it is possible that the Sertraline may have continued to be prescribed in the absence of any review to enable Suzanne to obtain maximum benefit through uninterrupted use of the medication. The GP practice have also advised the DHR that they made unsuccessful attempts to contact Suzanne to arrange the review. However, the GP records do not record uninterrupted prescribing of Sertraline, nor do they record why Sertraline was no longer prescribed after 26th March 2021.

6.40 As stated, Suzanne visited the pharmacy fortnightly to collect her Espranor prescription from April 2020. Prior to that she collected the prescription weekly but this had been changed to fortnightly in order to reduce the risk from Covid 19. The pharmacy is familiar with CGL clients as it delivers observed supervised consumption and needle and syringe

exchange. Manchester Health and Care Commissioning – which is a partnership between Manchester City Council and Manchester Clinical Commissioning Group have contracts with pharmacies in respect of observed supervised consumption and needle and syringe exchange. The local contract for observed supervised consumption stipulates the action to be taken if a person does not attend the pharmacy for their prescription. However, Suzanne was collecting her Espranor to consume at home and so her category of patient was not covered by the local contract. The service provided by pharmacies to patients such as Suzanne is covered by the National Community Pharmacy Contractual Framework and does not stipulate the action to be taken if a person does not attend the pharmacy for their take home prescription. However, Manchester Health and Care Commissioning has advised this review that in the circumstances disclosed by this DHR, they would expect the pharmacy to have advised CGL as the prescriber and would have expected CGL to have cancelled the prescription.

6.41 Suzanne was well known to the pharmacy but interactions with her would have been largely transactional. The DHR has been advised that the pharmacy manager cannot remember when Suzanne last collected her Espranor. Normal practice is to give the patient an extra 1-2 days to collect. If a patient is later than this, the pharmacy would normally cancel the prescription and contact CGL to refer back to them or tell the patient to go back to CGL to have it reinstated. The pharmacy manager thinks in this instance the matter was referred back to CGL but they don't keep records of this. CGL has no record of any such communication from the pharmacy.

6.42 The CGL chronology disclosed a number of contacts between the CGL recovery co-ordinator and the pharmacy after the homicide (Paragraphs 5.71 and 5.75) but includes no indication that the pharmacy advised CGL that Suzanne had stopped collecting her prescription until CGL contacted the pharmacy on 10th June 2021 when the pharmacy advised the CGL recovery co-ordinator that Suzanne had not collected her prescription 'since April 2021' but they were unable to give a precise date when Suzanne had been last seen. (Paragraph 5.79). Suzanne cannot have collected her prescription in April 2021 as stated to CGL by the pharmacy. The focus of the communication from the CGL recovery co-ordinator to the pharmacy appears to have been to ask the pharmacy to request Suzanne to contact CGL rather than to clarify whether Suzanne was actually collecting the prescription or not. Improved record keeping by the pharmacy and more explicit communication between CGL and the pharmacy could have helped to establish that Suzanne was no longer in contact with either service much earlier on.

6.43 As stated Suzanne's most recent CGL recovery co-ordinator was not attached to the locality base which served her address (Paragraph 6.32). This had implications for the escalation of concerns internally when Suzanne stopped collecting her prescriptions and no longer answered her phone in the two months after her murder. This most recent recovery co-ordinator felt that as Suzanne was not known personally to any CGL staff in the locality base from which she (the recovery co-ordinator) was working, there was little value in raising Suzanne's case at the morning cluster meetings as no member of CGL staff would have been aware of how Suzanne usually presented or have been able to suggest

alternative methods of contacting her. CGL takes the view that the opinion expressed by Suzanne's most recent recovery co-ordinator represented the interpretation of one staff member.

6.44 Manchester Health and Care Commissioning has advised this DHR that in September 2021 a new post of GP & Pharmacy Quality and Governance Team Leader was commissioned by Manchester City Council Population Health to support both new and existing pharmacies to deliver observed supervised consumption and needle and syringe exchange services in accordance with guidance, ensure any training requirements are met and provide a single point of contact or liaison for support within CGL. However there is also flexibility to look at wider service delivery across the locality. The DHR has been advised that this postholder could also help to improve communication between CGL and pharmacies in respect of patients who collect opiate substitute prescriptions.

The perpetrator Zoe had not been registered with a GP practice for several years prior to the homicide. How did agencies seek to engage with her during this period and support her to access any services she may have needed?

6.45 This issue is largely addressed in Paragraphs 6.27 and 6.28

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

6.46 There was effective communication between CGL and Suzanne's GP practice in that letters were shared following prescriber reviews and GP summaries requested prior to CGL appointments.

6.47 As stated multi-agency working between CGL and the community pharmacy was not effective in relation to communication when Suzanne stopped collecting her medication.

6.48 CGL could have considered contacting Suzanne's housing provider earlier than the date on which her body was discovered.

6.49 GMP referred their handling of the welfare check requested by CGL to their Professional Standards Department. The police were initially unable to resource a visit to Suzanne's address because of other resource demands and subsequently re-contacted CGL to ascertain what efforts they intended to make to contact Suzanne before requesting police assistance. GMP later contacted CGL and suggested they contact Suzanne's housing provider. This led to a slight delay in a visit to Suzanne's address taking place.

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

The victim Suzanne

Race

6.50 Suzanne was of dual White and Black Caribbean heritage. It is not known whether she experienced any discrimination as a result of her race. CGL incorrectly documented that Suzanne was White British. As stated, her most recent recovery co-ordinator had no in-person contact with her and her previous recovery co-ordinator, who had had in-person contact with her, had not noticed that Suzanne's race had been incorrectly recorded. As a result her race would have been overlooked as an issue in any assessment of risk carried out by her most recent CGL recovery co-ordinator.

6.51 Suzanne made a number of disclosures. She contacted GMP to seek help following an assault by her brother (Paragraph 5.14), when in fear of Zoe (Paragraph 5.19) and following an argument with Zoe (Paragraph 5.43) although on this latter occasion Suzanne declined to answer the DASH risk assessment questions. She also contacted her housing provider to speak about a personal matter (Paragraph 5.22) and also contacted them to disclose that Zoe had slapped her (Paragraph 5.48). However, on two occasions Suzanne was upset when answering phone calls from CGL (Paragraphs 5.29 and 5.32). On neither occasion was she prepared to elaborate on what had caused her to be upset. CGL advised Suzanne's GP that she had told CGL that she was having a difficult family time but did not wish to elaborate further (Paragraph 5.32). Suzanne also disclosed family problems to a GP practice nurse but again, did not elaborate further (Paragraph 5.41).

6.52 When Suzanne's brother read and commented on the DHR Overview Report, he implied that a lack of continuity in CGL workers may have been a barrier which contributed to Suzanne's unwillingness to discuss her feelings with the service (Paragraph 4.26). However, ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism (10). The NHS Race and Health Observatory Rapid Review of Ethnic Equalities in Healthcare found that some ethnic minority people delayed or avoided help seeking for health problems due to past experiences of racist treatment by healthcare professionals or due to similar experiences of their friends and family (11). Professionals in contact with Suzanne described her as an unassuming person and, as previously stated, there is some indication that she may not have fully articulated her needs to professionals at times (Paragraph 6.21). It seems possible that what professionals saw as an 'unassuming' personality and a reticence to discuss why she was feeling upset on occasions may have been rooted in her past experiences of racial discrimination.

Disability

6.53 Suzanne had COPD which is a chronic lung disease which affects the ability to breath. Suzanne received care and treatment for her COPD but it is clear that it had quite a significant impact on her daily life and was noted to be affecting her particularly severely when the police attended the domestic abuse incident in February 2021. CGL arranged for

Suzanne to collect her Espranor from her pharmacy fortnightly rather than weekly in order to reduce her exposure to Covid-19 which was an appropriate adjustment to make in her treatment plan given her risk of serious illness should she become infected. Pre-pandemic, CGL also visited Suzanne at home when her breathing difficulties made it difficult for her to attend services.

6.54 Suzanne may have experienced Adverse Childhood Experiences (ACEs) - which are defined as 'stressful events occurring in childhood including domestic violence, parental abandonment through separation or divorce, a parent with a mental health condition, being the victim of abuse (physical, sexual and/or emotional), being the victim of neglect (physical and emotional), a member of the household being in prison and/or growing up in a household in which there are adults experiencing alcohol and drug use problems' (12). Whilst ACEs are found across the population, there is more risk of experiencing ACEs in areas of higher deprivation (13).

6.55 Suzanne's childhood experiences may have had a 'long reach' (14) into her adulthood. One of her brothers has informed this review that Suzanne and her siblings' upbringing was characterised by poverty and acute overcrowding (Paragraph 5.1). Poverty is regarded as one of the key drivers for women becoming involved in the sex industry. Suzanne appears to have been a sex worker. Her son has advised the DHR that he felt Suzanne was made to do things she probably didn't want to do such as sex work and being sent out by his father to 'rob' (Paragraph 4.13). 'Soliciting' was one of the offence types for which Suzanne was convicted during the period 1977 to 2006 (Paragraph 5.1). If Suzanne was involved in sex work whilst her son was in her care then this would have taken place in the late 1980s and early 1990s and the fact that she has convictions for 'soliciting' suggests that the dominant response to her sex working may have been a criminal justice response. If this was the case, then this could have contributed to Suzanne's reticence when interacting with agencies in later life. Assuming Suzanne was a street sex worker, research indicates that this is a highly marginalised and stigmatised group who carry an extremely high unmet burden of health need including the respiratory disease and health problems related to substance misuse evident in the period on which this DHR focusses (15). In addition to the domestic violence Suzanne appears to have suffered from the father of her children, her son suggests that he (his father) also coerced her into sex work where she may have experienced extensive trauma as a result of being exposed to further violence including sexual violence.

Intersectionality

6.56 Intersectionality has been defined as a 'metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking' (16). Suzanne's second brother felt that the lack of a swift response to his sister's disappearance indicated that 'no-one really cared about her' (Paragraph 4.11). This is an important challenge for the DHR to consider. Suzanne was of dual White and Black Caribbean heritage and so her interaction with services may have been shaped to an extent by experiences of racism. She was a long term drug user – which adversely affected her health, wellbeing,

employment prospects and financial independence. She had also been a sex worker which may have contributed to her substance misuse and respiratory problems. Additionally Suzanne lost the custody of two of her children and two further children appear to have been removed from her care very early in their lives. Women from whom their children have been removed at, or shortly after, birth have described the experience as 'deeply distressing and de-humanising' with shame and stigma also present (17). She also lived in a deprived area of Manchester. It is difficult to avoid the conclusion that Suzanne was a person who had become quite marginalised in society.

The perpetrator Zoe

Race

6.57 Zoe was also of dual White and Black Caribbean heritage. She was removed from the care of her father by the Local Authority and became a Looked After Child. Government figures show that black children are more likely to be looked after and less likely to be adopted compared with their share of the under 18 year old population (18), although Zoe's dual heritage younger brother was not taken into the care of the Local Authority. Prior to the life sentence imposed for the murder of her mother, Zoe served four prison sentences. Minority ethnic groups appear to be over-represented at many stages throughout the criminal justice system compared with the White ethnic group. One of the greatest disparities relates to the ethnic make-up of the prison population. Among minority ethnic groups, Black individuals are often the most over-represented (19). The aforementioned NHS Race and Health Observatory Rapid Review found evidence to suggest clear barriers to seeking help for mental health problems was rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare (20), which may have been a factor in Zoe choosing to largely self-manage her health issues, including her mental health. She was not accessing support from substance services at the time of the murder although she had managed to achieve abstinence from drugs and alcohol at the point at which Probation ended their involvement with Zoe in 2018.

Sex and sexual orientation

6.58 Zoe's brother advised the DHR that his sister's intimate relationships were primarily with women, although her most recent relationship - prior to the murder - had been with a male. The DHR has received no information which indicated that Zoe may have been treated less favourably as a result of her sexuality.

Intersectionality

6.59 Zoe decided not to contribute to the DHR and so it has not been possible to explore issues relating to inequality with her. She appears to have suffered a great deal of trauma during her childhood and early adulthood. Her mother Suzanne was drug dependent which appears to have been a factor in Zoe being brought up solely by her father from the age of 9. Zoe's brother has informed this review that both he and Zoe suffered violence from their father. She became a Looked After Child. She is believed to have used cannabis from her teenage years and to have taken overdoses of unspecified drugs in 2001 and 2006. It is

understood that a person described as Zoe's 'boyfriend' was shot and killed in 2001. She is a person of dual White and Black Caribbean heritage and a care leaver. Both ethnic minorities and care leavers are over-represented in the prison population. Although children in care and care leavers account for less than 1% of the general population (21) over 25% of the adult prison population has previously been in care (22). Although Zoe appears to have become estranged from family members and therefore may have lacked a strong family support network, she was able to turn to her younger brother for support when her relationship with her partner broke down.

Were either the victim Suzanne or the perpetrator Zoe an 'Adult at Risk' i.e. a person 'who is or may be in need or community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of herself, or unable to protect herself against significant harm or exploitation'.

6.60 Suzanne was not known to Adult Social Care at the time of her murder. Adult Social Care had contact with her several years earlier when she was caring for her mother. No adult safeguarding referral or any assessment of her care and support needs was considered at any stage. CGL has advised the review that regular risk reviews were carried out which did not identify her as an adult at risk. Nor did Suzanne's GP practice identify her as an adult at risk, given that she was engaged with drug treatment services. Suzanne's son has advised this review that his mother was organised and had her own routine.

6.61 Zoe's lack of contact with services, in particular the fact that she had not been registered with a GP practice for several years, meant that it was challenging for any agencies she came into contact with episodically, to make a judgement about whether or not she could be considered to be an adult at risk.

Did the restrictions imposed as a result of the Covid-19 pandemic adversely affect the victim Suzanne or the perpetrator Zoe or impact upon the support provided or offered to them by agencies?

6.62 The way in which agencies interacted with Suzanne was significantly changed as a result of the pandemic. Her last in-person contact with her GP practice was in September 2019. Subsequent contact with Suzanne was by telephone due to the restrictions placed upon services during the pandemic. However, if Suzanne had needed to be seen then a face-to-face appointment could have been offered based on clinical need.

6.63 As stated CGL changed Suzanne's prescribing regime because her diagnosis of COPD made her clinically very vulnerable. As a result she received a 14 day supply of OST rather than the previous 7 day supply, which meant that she needed to visit her pharmacy only once a fortnight. Additionally, as stated, CGL changed the vast majority of appointments to telephone or online. This was the case for Suzanne.

6.64 Suzanne's landlord's main contact with her was through the more frequent contact they had with Graham. As a result of the restrictions imposed in response to the pandemic, in-person contact with Graham reduced, a consequence of which was that the opportunities for One Manchester to engage with Suzanne in-person also diminished.

6.65 Overall, the pandemic restrictions reduced in-person contact with Suzanne from March 2020 onwards. It follows that agencies in contact with Suzanne were in a weaker position to observe any adverse impact the arrival of Zoe had on her health, wellbeing and safety.

6.66 As far as it is possible to reach a judgement, Suzanne appeared to personally cope with the pandemic quite stoically. She was able to get out of doors to walk her dog and exercise.

6.67 The Covid-19 pandemic and concern for personal safety may have been a factor in the decision making of a particular police officer involved in resourcing the welfare check on Suzanne requested by CGL on the day before her body was found.

6.68 It is difficult to say what impact the pandemic had on the perpetrator Zoe. As stated, she does not appear to have been in regular touch with services other than DWP. DWP were sufficiently concerned about her welfare on 29th March 2021 - around two days prior to the murder - to ring 999. The immediate source of Zoe's distress appeared to be financial worries but NWAS was unable to locate her to assess her medically and by the time the police were able to make telephone contact with her the following day, she presented as stable.

Good practice

6.69 In September 2019 on a review of the crime recorded in June of that year, an inspector contacted Suzanne about the incident, and Suzanne confirmed there were no further issues arising between them. The inspector noted on the log that whilst GMP had a responsibility to safeguard the victim, Suzanne was managing the situation well and did not need further support.

6.70 One Manchester responded promptly to Suzanne's financial difficulties after becoming aware of her difficulties through her relationship with another One Manchester tenant living in a different property.

6.71 When the DWP agent feared that Zoe might harm herself, the agent sought urgent assistance for her by calling 999.

7.0 Conclusion

7.1 Suzanne was murdered by her daughter Zoe. Zoe had moved into Suzanne's address some months previously following conflict with her (Zoe's) partner. During the period when Zoe was staying with her mother the police attended one incident of domestic abuse which was appropriately assessed as a 'standard' risk but Suzanne separately disclosed an assault by her daughter to her housing provider which did not receive a satisfactory response.

7.2 It is not known why Zoe murdered Suzanne. Suzanne's adult life was adversely affected by addiction to illicit drugs and she had been unable to parent Zoe for much of her

childhood. Both mother and daughter had been physically abused by Suzanne's partner (Zoe's father).

7.3 Suzanne had much reduced in-person contact with CGL, her GP practice and her housing provider following the onset of the pandemic which may have limited their opportunity to notice any indications that she may have been at risk from Zoe. Zoe had previous convictions for violence, particularly towards women, but was not perceived to present a risk to her mother.

8.0 Lessons to be learnt and recommendations

Standard risk domestic abuse referrals to STRIVE

8.1 'Standard' risk domestic abuse incidents would normally be considered for referral to the STRIVE project, which involves police, local authorities and other partner agencies working with the voluntary sector to signpost people to relevant support services, share best practice and prevent repeat victims of domestic abuse. Suzanne was not referred to the STRIVE project. The DHR has been advised that professional confidence in the value of making referrals to STRIVE may have been adversely affected by a patchy implementation. However, the DHR Panel understands that STRIVE will be discontinued at the end of the three-year funding timescale, and that an alternative set of arrangements for referral into support for domestic abuse crime and incident victims is proposed, using Victim Support trained staff.

Recommendation 1

That Manchester Community Safety Partnership seeks assurance in respect of the extent to which 'standard' risk domestic abuse incidents are referred into the Victim Support arrangements established following cessation of the STRIVE programme.

Automatic triggering of the HARK questionnaire in GP practice

8.2 Suzanne's consultations with her GP in January 2021 in which she presented with anxiety and depression did not trigger the HARK electronic medical record prompt, which can be automatically triggered when certain health conditions are entered into the EMIS patient information system. The triggering of the HARK questionnaire is helpful to GPs in prompting routine enquiry about domestic abuse. The DHR has been unable to establish precisely why the HARK questionnaire was not triggered or been able to establish how widespread the issue may be.

Recommendation 2

That the Manchester Community Safety Partnership requests NHS Manchester Clinical Commissioning Group to request GP practices to ensure that HARK templates are activated within their EMIS systems to support their prompt questions about domestic violence and abuse when consulting patients about anxiety and depression. NHS Manchester Clinical

Commissioning Group will also request the IRIS service undertake an audit of GP practices to ensure that the HARK template is activated and seek assurance from IRIS that this has been completed.

'Isolated incidents' of domestic abuse

8.3 Suzanne disclosed that Zoe had slapped her during a 'huge argument' which had really hurt her to her housing provider One Manchester (Paragraph 5.48) a month before the murder.

8.4 One Manchester treated this disclosure of domestic abuse as an 'isolated' incident, an approach which disregards the volume of evidence that before reporting an incident, or getting effective help, a victim may have suffered a substantial history of domestic abuse. This was a factor in the limited response to Suzanne's disclosure.

Recommendation 3

That when the learning from this DHR is disseminated, Manchester Community Safety Partnership will provide training to professionals to identify patterns of behaviour and avoid treating reports of domestic abuse as 'isolated incidents'.

8.5 The One Manchester response to Suzanne's disclosure of domestic abuse indicates a need for Manchester Community Safety Partnership to obtain assurance that Housing Providers have robust policies, supported by appropriate training to enable staff to recognise and respond effectively to domestic abuse.

Recommendation 4

That Manchester Community Safety Partnership obtains assurance that Housing Providers have robust policies, supported by appropriate training to enable staff to recognise and respond effectively to domestic abuse.

Awareness of unconscious bias

8.6 All professionals dealing with domestic abuse need to be conscious of the effects unconscious bias. In this case officers who attended a domestic abuse incident involving Suzanne and Zoe made a judgement that Suzanne's account my not have been true because she was a former drug addict who may have 'crack psychosis (Paragraph 5.43). This judgement was an assumption based on Suzanne's disclosure of drug addiction which appears to have had no basis in fact. This incident demonstrates how unconscious bias could lead to a victim of domestic abuse not being believed.

Recommendation 5

That when the learning from this DHR is disseminated, Manchester Community Safety Partnerships draws attention to the risk that unconscious bias could lead to a victim of domestic abuse not being believed.

Indicators of coercion and/or control may be masked as a result of the victim's limited engagement with services

8.7 Possible indicators that a person may be subject to coercive and/or controlling behaviour may be masked by a history of limited engagement so professionals need to be very sensitive to quite subtle changes in behaviour.

8.8 Looking back at the period prior to the homicide during which GMP responded to the domestic abuse incident on 14th February 2021 and Suzanne made the disclosure of domestic violence by Zoe to One Manchester on 2nd March 2021, there are possible indications that Suzanne *may* have been experiencing abuse from Zoe possibly in the form of controlling behaviour. Her CGL recovery co-ordinator struggled to make contact with her by phone and when she did so, Suzanne was frequently unable or unwilling to commit to a risk review, she disclosed low mood, she did not collect her prescription from the pharmacy and disclosed 'family problems' to the GP practice nurse on which she did not elaborate. However, many of these behaviours had been observed in Suzanne on many previous occasions. Agencies, particularly CGL, had experienced difficulties in engaging with Suzanne over a number of years. This highlights a learning point that a history of *unwillingness or reluctance* to engage with professionals *could* mask a situation in which the person is *prevented* from engaging with professionals. When Suzanne's brother read and commented on the final DHR Overview Report, he felt that a lack of continuity in CGL workers was an issue which may have affected Suzanne's willingness to say more about 'family problems' and that this should be addressed by the commissioners of the service (Paragraph 4.26).

8.9 Possible indicators that a person may be subject to coercive and/or controlling behaviour may be masked by a history of limited engagement so professionals need to be very sensitive to quite subtle changes in behaviour.

Recommendation 6

That when the learning from this DHR is disseminated, Manchester Community Safety Partnership takes the opportunity to raise professional awareness of the possibility that a history of limited engagement with services may mask indications of coercion and/or control.

Awareness of daughter/mother domestic homicides

8.10 The incidence of domestic homicide involving the daughter as the perpetrator and the mother as victim is relatively rare. Given that Home Office guidance on familial domestic abuse focusses primarily on violence by teenage boys against their parents – primarily

mothers – and research into the homicide of older people has found that the overwhelming majority of perpetrators of familial domestic homicide of older adults are sons or grandsons, professional awareness of the possibility that daughters could present a risk of domestic abuse to their mothers may need to be enhanced. Additionally, the lower prevalence of daughter to mother domestic abuse may mask the risk that daughter's present to mothers, even when – as in this case – the daughter had a previous conviction for intimate partner domestic abuse.

Recommendation 7

That when the learning from this DHR is disseminated, Manchester Community Safety Partnership takes the opportunity to draw attention to the various forms that familial domestic abuse can take including daughters as perpetrators and mothers as their victims and also draw attention to the need to consider the risks that a perpetrator of domestic abuse may present in both intimate partner and familial relationships.

Communication between CGL and the pharmacy

8.11 A period of over 70 days elapsed between the last confirmed contact by professionals with Suzanne and the discovery of her body.

8.12 Following Suzanne's last contact with a professional in late March 2021, her CGL recovery co-ordinator had substantial contact with the pharmacy from which she collected her prescription of Espranor fortnightly. There is no indication that the pharmacy advised CGL that Suzanne had stopped collecting her prescription – which is expected - but not contractually specified - practice - until CGL contacted the pharmacy on 10th June 2021 when the pharmacy advised the CGL recovery co-ordinator that Suzanne had not collected her prescription 'since April 2021'.
The focus of the communication from the CGL recovery co-ordinator to the pharmacy appears to have been to ask the pharmacy to request Suzanne to contact CGL rather than to clarify whether Suzanne was actually collecting the prescription or not. Improved record keeping by the pharmacy and more explicit communication between CGL and the pharmacy could have helped to establish that Suzanne was no longer in contact with either service much earlier on.

8.13 Manchester Health and Care Commissioning has advised this DHR that the relatively new post of GP & Pharmacy Quality and Governance Team Leader was created to support both new and existing pharmacies to deliver observed supervised consumption and needle and syringe exchange services in accordance with guidance, ensure any training requirements are met and provide a single point of contact or liaison for support within CGL. However there is also flexibility for this postholder to look at wider service delivery across the locality, including improving communication between CGL and pharmacies in respect of patients who collect opiate substitute prescriptions.

Recommendation 8

That Manchester Community Safety Partnership request Manchester City Council to make use of the new post of GP & Pharmacy Quality and Governance Team Leader to drive improvement in communication between CGL and pharmacies in respect of patients who collect opiate substitute prescriptions and improvement in record keeping by pharmacies.

Crack cocaine

8.14 In her interview with the police following Suzanne's murder, Zoe said that they began using crack cocaine together after she moved in with Suzanne and Zoe said that they had both been using crack cocaine on the night the murder took place. It is not possible to prove or disprove this given the length of time which had elapsed between the murder and Suzanne's body being discovered. However, the DHR report highlights the concern which has been expressed about an apparent increase in the use of crack cocaine and the impact of this on society. The joint Public Health England/Home Office report referenced in this DHR report suggested that there
was an 'absence of substitute treatment' for crack cocaine and
activities to fill up user's days to help wean them off crack cocaine. CGL have advised this DHR that they provide a number of treatment options to support people who are using crack cocaine, including group work although these are not substance specific.

8.15 CGL has suggested to this DHR that Manchester Metropolitan University – which has a reputation for leading research into drug use and associated behaviours – could be commissioned to scope the need for crack cocaine treatment provision. This may be a possibility that Manchester Community Safety Partnership wishes to explore.

The perpetrator's lack of a GP

8.16 The perpetrator Zoe had not been registered with a GP for several years. Whilst it was Zoe's choice not to register with a GP this largely cut her off from primary care and the potential for referral from primary care to any specialist care she may have needed. In Zoe's case it meant that the mental health issues present in her life appear to have been largely self-managed. She only presented to mental health services at times of crisis. This means that people without a GP, such as Zoe, are placing additional demands on emergency healthcare which could have been prevented if they had been accessing primary care.

8.17 Whilst there is no direct link between Zoe's lack of contact with primary care for several years and the homicide, it is not unreasonable to make the point that the impact of any trauma she experienced as a child and adolescent appears to have gone unaddressed during her adulthood other than at times of crisis. Had she accessed primary care, there is the possibility that the risks she presented to herself and/or others could have become more apparent.

Recommendation 9

That Manchester Community Safety Partnership requests that all Community Safety Partnership partners and Manchester Health and Care Commissioning consider how people might be encouraged by all service providers to register with a GP and take into account good practice in this area such as that involving housing providers encouraging tenants to register with a GP.

Perpetrator involvement in DHRs

8.18 The perpetrator Zoe was contacted during the weeks following her conviction for the murder of her mother and asked if she wished to contribute to the DHR. The DHR was advised that after giving the matter some consideration and thought, Zoe decided that it was too soon for her to participate in such an interview. DHR interviews with perpetrators invariably take place a relatively short time after their conviction and sentence to a lengthy term of imprisonment. They have often not been transferred to the prison where they will begin serving their sentence and they have not commenced any work to gain insight into their offending. As a result, perpetrators are not well placed to make a meaningful or insightful contribution to the DHR.

8.19 The Home Office may therefore wish to consider follow up interviews with perpetrators at a later stage in their sentences when they may be better placed to provide information which potentially makes a more valuable contribution to the aims of DHRs.

Recommendation 10

That Manchester Community Safety Partnership writes to the Home Office to suggest that follow up interviews with perpetrators should take place outside the DHR process at a time when perpetrators may be better placed to make a more valuable contribution to the aims of DHRs.

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Glossary

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

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

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

Appendix A

Single Agency Recommendations:

Change Grow Live (CGL)

- The service should consider a method of reviewing all basic data not just address and pharmacy. (The service to have up to date relevant demographic data for service users. This will ensure that diversity and equality characteristics can be considered).

- When reallocating service users to a new recovery coordinator the service user should be allocated to a recovery coordinator assigned to the base nearest the service users address.

NHS Manchester Integrated Care (Manchester Health & Care Commissioning will cease to exist from 1st July 2022)

- NHS Manchester Integrated care will highlight with GP practices, the importance of coding issues such as active/historical domestic violence, raised in external communications from outside services. NHS Manchester Integrated Care will form a briefing based on this (and other DHRs) to ensure that the allocated coding staff in practices fully review all incoming documentation for potential safeguarding issues. This can also be discussed at the lead safeguarding GP forum. The NHS Manchester Integrated Care safeguarding team will devise a list of issues that require coding and/or escalation for GP review (see Paragraph 6.11).

- Review the current coding system to ensure the HARK triggers are in place and functional.

- Remind all practitioners that presentations for anxiety and depression should prompt safe enquiry about domestic abuse and if safe enquiry is not possible this is recorded in the notes.

Greater Manchester Police (GMP)

- Repeat victim markers should be added to person records in accordance with GMP's Domestic Abuse Policy and Procedure. If a victim reports an incident of domestic abuse on more than one occasion, they are considered a repeat victim.

- If a victim refuses to answer DASH questions, the officer responding should apply their professional judgement to make an assessment of risk.

One Manchester (landlord)

- A recommendation for reviewing new reports of ASB and how we deal with those reports, i.e., more specific questions to be asked around those reports.
- Risk should also be considered based upon the answers to those questions.

- A recommendation to review how we approach those discussions with customers and what questions to ask when assessing any risk.

- A better use of recording notes on existing case management systems following calls that are transferred directly through to officers.

One Manchester (Support and Wellbeing)

- A full review of the Support and Wellbeing team has taken place as a result of the findings, this has also included a number of recommendations for action for the wider organisation.

Pharmacy

- Medicines Optimisation and the Local Pharmaceutical Committee – the body which supports community pharmacies in service development - will jointly issue communications to community pharmacies across Greater Manchester in order to reiterate best practice guidance to improve the management of non-collected medicines.

- A number of Greater Manchester pharmacies have signed up to the ANI (action needed immediately) scheme which has been launched to provide a codeword that enables victims of domestic abuse to ask for help in participating pharmacies. Awareness of this scheme will be raised further.