ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'Michelle' IN AUGUST 2021

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

REVIEW PERIOD

1st of JANUARY 2016 to AUGUST 2021

OVERVIEW REPORT

Independent Author: **John Doyle.**

FINAL DRAFT **January 2024.**

Contents **Page**

The Coronavirus-19 Pandemic

On the 31st of December 2019 the World Health Organisation (WHO) Office in the People's Republic of China picked up a media statement by the Wuhan Municipal Health Commission on cases of 'viral pneumonia' in Wuhan. The Country Office translated the media statement and passed it to the WHO Western Pacific Regional Office. At the same time, the WHO's Epidemic Intelligence Team picked up a media report about the same cluster of "pneumonia of unknown cause" in Wuhan.

On the 1st of January 2020 the WHO activated its Incident Management Support Team and on the 2nd of January informed the Global Outbreak Alert and Response Network (GOARN) about the cluster of pneumonia cases.

The UK Government issued a statement in Parliament on the 23rd of March 2020 stating that people 'must' stay at home, work from home, maintain social distance and that certain businesses must close. This has been described as the date when the first of a number 'lockdowns' and/or geographical tiered restrictions commenced in the UK.

The harm caused by the pandemic has been profound and distressing, and this has been exacerbated by the effect of the lockdown on usual social activity – socialising, schooling, shopping, going on holiday, and going to work. The effect on the public services has, at times, been almost overwhelming as the capacity to manage the impact of the pandemic has been tested to breaking point.

Preface

The Chair and the members of the Domestic Homicide Review Panel offer their sincere condolences to the family and friends of Michelle for their loss. The Chair and the members of the Panel would also like to extend thanks to those services who participated in the Review and assisted the Panel in its work.

The Panel recognised, of course, that this Review concerned an apparent suicide (the precise reasons for Michelle's death will be determined by the Office of the Coroner). In these circumstances, the Greater Manchester Police and the specialist staff from Victim Support were not in a position to allocate the resources of a Liaison Officer to support Michelle's family and friends. The Panel contacted the Greater Manchester Bereavement Service and they too noted that they had not been in a position to make resources available to support Michelle's family and friends during this difficult time. Consequently, in comparison to other Domestic Homicide Reviews, there was no direct face-to-face contact with an experienced professional who could introduce the Domestic Homicide Review process to Michelle's family and friends.

This placed the Panel in the position of making contact with Michelle's family and friends (from the details shared with the Panel by those agencies in contact with Michelle) and inviting them to participate in the Review. This contact took the form of a letter being sent to Michelle's Sibling. This letter was followed by an e-mail and then a telephone call. A letter was also sent to Michelle's friend (referred to in this Report as F1) and this letter was followed by a telephone call. Setting aside the effort made by the Panel to make a mindful introduction to the process, it was, nevertheless, an invitation offered 'out-of-the-blue'.

Section 1. Background

1.1 This Domestic Homicide Review concerns the death of Michelle, who died in August 2021. Michelle died in Hospital following an overdose.

1.2 The Greater Manchester Police investigated the circumstances leading to the death of Michelle and have concluded that there was no third party involvement in her death. However, there was evidence to suggest that Michelle was the subject of controlling and coercive behaviour and had made allegations of abuse and violence prior to her death.

1.3 Following the notification of her death, the Greater Manchester Police Service referred the matter to the Rochdale Safer Communities Partnership to be considered as a domestic homicide review. The reason for this consideration is:

1.4 Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act) states:
(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by -
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself,
held with a view to identifying the lessons to be learnt from the death.

1.5 Section 2 Para 18 of the DHR Guidance 2016 states:
Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

1.6 A more complete description of the key components of the Domestic Abuse Act 2021 can be found in Appendix 1.

1.7 The working hypothesis of the Greater Manchester Police is that Michelle died as a result of an overdose of medication. Whether this medication was prescribed or 'over-the-counter' will be a consideration for the Office of the Coroner, as will whether Michelle taking her own life was deliberate or accidental.

Incident leading to the Domestic Homicide Review

1.8 On a day in August 2021, Greater Manchester Police received a 999 call from the Accident and Emergency (A&E) Department at the North Manchester General Hospital (NMGH – part of the Pennine Acute Hospitals NHS Trust). NMGH stated that Michelle attended Hospital by ambulance and stated that her partner had assaulted her six days before her attendance. Greater Manchester Police were aware of this allegation of assault.

1.9 NMGH identified that Michelle was seriously ill and informed Greater Manchester Police that Michelle was unlikely to survive. Michelle died later the same day.

1.10 A Home Office appointed Pathologist completed a post mortem and concluded that, from everything observed, Michelle died as a result of a paracetamol overdose. The Pathologist concluded that there was no pathological evidence to suggest an assault contributed to the death of Michelle. The Pathologist noted that minor bruising may have been caused by her being assaulted, however this would not have caused or contributed to her death. The bruising may have also been caused by a fall or falls. There was no evidence that violence had caused her death.

1.11 Michelle was the Mother to four children and a Grandmother to one child.

Significant people in this case

1.12 Both pseudonyms and the name for the subject in this case have been chosen by the DHR Panel. The significant people referred to within this Overview Report are described, in brief, below:

Name or pseudonym	**Relationship to subject (if applicable)**
Michelle	The victim in this Review.
M1	The Partner of Michelle at the time of the incident.
S1/S2	Michelle's siblings. The Pseudonyms were chosen by the Panel. The Office of the Coroner held a record of two people they believe to be the siblings of Michelle and contact was made with one sibling (S1), but contact could not be maintained with S2.
C1	The child of Michelle.
C2	The child of Michelle.
C3	The child of Michelle.
C4	The child of Michelle.
F1	The friend of Michelle.

The use of pseudonyms

1.13 It should be noted that the DHR Panel established and maintained an excellent working relationship with the Office of the Coroner. This was a reflection of the connections already made by the Safer Communities Partnership in Rochdale.

1.14 The Review Panel sought to involve S1 in the Review. When the Review commenced, the Commissioning Officer and the Author sent a letter of invitation to S1. The letter expressed the condolences of the Panel, and invited

S1 to contribute to the Review. The Commissioning Officer did not receive a response to this letter.

1.15 At the same time, the Office of the Coroner made one contact with S2, via a telephone call. However, further attempts at contact were unsuccessful because the telephone number was subsequently recorded as unattainable. The Panel discussed the matter with the Office of the Coroner and it was decided to attempt to make contact with C2 by letter and also F1 by letter. C2 did not respond to efforts to contact them.

1.16 As the Review made progress, the Office of the Coroner informed the Author of the Review that they had made contact with S1 and that S1 had agreed to receive updates from the Author concerning the progress of the Review.

1.17 F1 also agreed to be contacted and spoke with the commissioning officer from the Rochdale Borough Council. The submission from F1, agreed with them at the time of transcribing, is included later in this Report.

1.18 S1 did respond to the invitation from the Author of the Review to participate and contribute (this was done by telephone and email). S1 was contacted via e-mail (on three occasions during the period December 2022 to January 2023) and also by telephone (on three occasions in the period January to February 20023). However, at the time of writing, S1 has not yet made a contribution to the Review.

Purpose and conduct of the review

1.19 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

1.20 This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the latest revisions of the guidance issued by the Home Office in 2016 to support the implementation of the Act.

1.21 As described above, this particular case was referred by the Greater Manchester Police for the consideration of a DHR in accordance with Section 2 Paragraph 18 of the DHR Guidance.

The time-period under review

1.22 At the first meeting of the Domestic Homicide Review Panel, held virtually in March 2022, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2019 to the date of the incident in August 2021. The rationale for this timescale was discussed by the Panel. It was apparent that the Greater Manchester Police (GMP) and the

Greater Manchester Probation Service (NPS)[1] became aware that Michelle was in a relationship with M1 (Michelle's Partner at the time of the critical incident) from mid-2019. The Greater Manchester Police received a report of assault against Michelle – with Michelle's Partner being identified as the alleged perpetrator – in July 2019.

1.23 However, the parameters of the formal scope were effectively removed because a number of agencies held records indicating that Michelle had been the victim of abuse for a number of years before this point (though not by her Partner prior to the incident). The Panel requested that those agencies and services invited to participate and make submissions to the Review should be urged to bear in mind that if issues had arisen prior to the 1st of January 2019, that were pertinent to the discussions of the Panel, then this information should still be submitted in order to provide context for the case.

1.24 A number of key agencies did make such submissions and, effectively, the scope of the Review includes incidents and events that occurred in 2016. This, therefore, served as the start date for the Review.

Proposed timescale

1.25 The first meeting of the DHR Panel was held on the 30th of March 2022. The Panel met again in June 2022, in August 2022, in September 2022, in November 2022, January 2023 and March 2023.

1.26 At the first meeting in March 2022, the Panel agreed an outline timetable of objectives and actions and this set the course for the completion of the Review and the production of the Report. This was achieved in compliance with the efforts made to respond to the Coronavirus – the completion of the Review being achieved via remote working and teleconference.

1.27 At the second meeting, the Panel began the process of scrutinising the submissions received from participating agencies and the draft integrated chronology. Additionally, progress concerning the involvement of the family was considered.

1.28 At the third meeting, the Panel continued to scrutinise submissions from participating agencies, sought clarifications from previously submitted reports, and the emerging integrated chronologies and narratives.

1.29 At the fourth meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies; the first draft of the overview report, particularly the responses to the key lines of enquiry, the lessons learnt and the emerging themes. There was also an update on the involvement of Michelle's Sibling, Child 2 and close friend, F1.

1.30 At the fifth meeting, the Panel considered the second draft of the Overview Report and an update on the progress made to involve S1 (Michelle Sibling)

[1] To avoid confusion with GMP (the Greater Manchester Police), the Greater Manchester Probation Service will be referred to as the NPS (National Probation Service) throughout this Report.

and the friend of Michelle, referred to in the genogram as F1 (below). The Panel also considered the emerging themes, the lessons learnt and the examples of good practice.

1.31 At the sixth meeting, the Panel considered the third draft of the Overview Report, the draft recommendations and an update on the involvement of S1.

1.32 At the seventh meeting, the Panel considered the fourth draft of the Overview Report and suggested final amendments. It was agreed that, once the amendments had been made, the Final Draft would be submitted to the Safer Communities Partnership.

Statement of Confidentiality

1.33 The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professionals outside the DHR process.

The Conduct of the Review and methodology

1.34 At its first meeting, the DHR Panel approved the use of an Individual Management Review (IMR) and Chronology template. The Commissioning Officer from the Rochdale Council, contacted each participating agency and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was, overall, excellent. The Panel, due to the COVID restrictions described earlier, made allowances for short delays in submission.

1.35 Together with the Commissioning Officer, the Chair/Author provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office, December 2016). The IMR Authors were not directly involved with the subjects of this case. IMR reports were quality assured by a senior manager countersigning the report.

1.36 Copies of IMRs were circulated to all the DHR Panel members prior to the scheduled meetings. The IMRs were then discussed and scrutinised by the Panel and significant events were cross referenced and any clarifications that were considered necessary from the IMR author were invited via the independent author and Commissioning Officer of the Overview Report.

1.37 The Panel agreed that a DHR should not simply examine the submissions received, but that the Review should be professionally curious, and in so doing identify which agencies had contact with Michelle, and which agencies were in contact with each other.

1.38 As stated, the review panel sought to involve the Sibling, Child and Friend of Michelle in the review and approached this with sensitivity and respect.

The Conduct of the Review (contributors and Panel members)

1.39 Following the notification of the death of Michelle, the Rochdale Safer Communities Partnership informed the Home Office that they would undertake

a Domestic Homicide Review and to commission this Review under the auspice of Rochdale Council.

1.40 The Panel received reports from agencies and dealt with any associated matters such as media management and liaison with the Coroner's Office.

1.41 The Commissioning Authority (Rochdale Council) appointed an independent Author, John Doyle, to oversee and compile the Review. John has extensive experience in public health management and has acted as author in several DHRs. John has completed the Home Office training concerning the completion of DHRs. John spent thirty years in public service and, having achieved registration at Consultant level with the UK Public Health Register, left the NHS in 2013. John had no connection with the subjects of the Review, no connection with any of the agencies involved in the review and no connection with the Commissioning Authority.

1.41 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. The members of the Panel were selected by their agency because they had no direct service contact with any of the subjects of the Review.

1.42 The views and conclusions contained within this overview report are based on findings from documentary submissions and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

1.43 The members of the Panel are described in the table below:

Name	**Organisation**
Wendy Stringer	Rochdale Borough Council (BC)
Linda Baron	Community Safety Team, Rochdale BC
Nicky Dean	Victim Support
Tracy Chatterton	Children's Social Care, Rochdale BC
Tracy Thorley	Adult Social Care, Rochdale BC
Alyson Harvey	Greater Manchester NHS Integrated Care (Heywood, Middleton, Rochdale - HMR)
Alison Troisi	Greater Manchester Police Service (GMP)
Janice France	Greater Manchester Probation Service (the acronym will be 'NPS' – National Probation Service)
Susan Hewitt	North West Ambulance Service NHS Trust
Salma Ali	Northern Care Alliance NHS Foundation Trust
Victoria Wardleworth	Rochdale Borough-Wide Housing
Victoria O'Callaghan-Lake	SafeNet
John Doyle	Independent Author

Contributors to the Review

Agency	Nature of Submission
Greater Manchester Probation Service	IMR
Greater Manchester Police	IMR
Rochdale Borough Council	IMR Adult Social Care,
Rochdale Borough Council	IMR Children's Social Care.
Rochdale Borough Council	IMR Housing Services
Greater Manchester NHS Greater Manchester Integrated Care (HMR)	IMR
Northern Care Alliance NHS Foundation Trust	IMR
North West Ambulance NHS Trust	IMR
Victim Support	Short Report
Safenet	Short Report

Parallel Reviews

1.44 Due to the circumstances leading to the death of Michelle, Greater Manchester Police (GMP) referred themselves to the Independent Office for Police Conduct (IOPC). The IOPC recommended that GMP undertake an internal Review. An internal review was conducted and a report was prepared. This report concluded that there was no individual learning, nor any unsatisfactory performance by any GMP officer.

Coroner's Inquest

1.45 As a matter of courtesy, the Office of the Coroner was informed by letter (from the Author and commissioning authority) that the Domestic Homicide Review was taking place and the expected time frame of the Review. The Coroner responded to the letter and asked if it would be possible to consider the DHR Overview Report prior to opening the Inquest.

1.46 The Panel considered this matter and, because there are no legal barriers, agreed that – with the caveat that the Report must not be made public – the Office of the Coroner could view a copy of the Report, once it had been approved by the Rochdale Safer Communities Partnership. On the 26th of September 2023, the Office of the Coroner held an Inquest into the death of Michelle. The Author of the DHR was invited and did attend the Inquest to address the final draft of the Overview Report.

The Purpose of a Domestic Homicide Review

1.47 The Panel noted that the over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;

- Prevent domestic violence, abuse 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; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

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

Specific Terms of Reference and Key Lines of Enquiry for this Domestic Homicide Review

a. To establish what contact agencies had with Michelle

This will require agencies to consider these issues:

1. What contact did each agency have with Michelle?
2. Did any agency know or have reason to suspect that Michelle was subject to any form of domestic abuse at any time during the period under review?
3. Had any mental health issues been disclosed by Michelle, or any mental illness diagnosed by an agency in contact with her?
4. Were there any complexities of care and support required by Michelle and were these considered by the agencies in contact with her?
5. Were assessments of risk and, where necessary, referral to other appropriate care pathways considered by the agencies in contact with Michelle?
6. Were issues of race, culture, religion and any other diversity issues considered by agencies when working with Michelle?

b. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Michelle.

This will require agencies to consider these issues:

7. What actions were taken to safeguard Michelle and were the actions appropriate, timely and effective?
8. What happened as a result of these action?

NOTE

1.49 The following three key lines of enquiry concerned information about Michelle's Partner, prior to the incident. The Panel noted that it is usually the case in DHRs that the Perpetrator is spoken to in Prison; but that in this case, there was no perpetrator and the Partner of Michelle denied any fault in the death of Michelle. The Panel noted that third party information concerning the Partner of Michelle has been shared with other bodies.

1.50 The Panel confirmed that information concerning Michelle and her circumstances (including her relationships) had been shared via the MARAC,

the Daily High Risk Meeting (DHRM), and other multi-agency arrangements. As with other statutory Reviews, it is usual that information concerning Partners, next-of-kin, and other associates is shared in an anonymous format in order to safeguard the subject of the Review.

1.51 It was agreed that Panel members would discuss this matter with their Information Governance Officer, and ask the question:- if information concerning the Partner of Michelle (and other relevant people) has already been shared anonymously with the MARAC, or other statutory functions, then can this same information in the same anonymous format be shared with the Panel?

1.52 This caveat is placed around these three KLOE pertaining to Michelle's Partner

c. To establish what contact agencies had with M1, who was the Partner of Michelle.

This will require agencies to consider these issues:

9. Was Michelle's Partner known to agencies and in what capacity?
10. Was Michelle's Partner known to any agency as a perpetrator of domestic abuse?
11. If so, what actions were taken to assess their risk to self and/or others?
12. Had any mental health issues been self-disclosed by Michelle's Partner or any mental illness diagnosed by an agency in contact with them?
13. Was Michelle's Partner known to misuse drugs or alcohol, including the misuse of any prescription medication?
14. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with Michelle's Partner?

d. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Michelle's Partner.

This will require agencies to consider these issues:

15. What actions were taken to reduce the risks presented to Michelle (and/or others) by Michelle's Partner and were these actions appropriate, timely and effective?
16. What happened as a result of these actions?

e. To establish whether there were other risks or protective factors present in the lives of Michelle or Michelle's Partner.

This will require agencies to consider these issues:

17. Were there any other issues that may have increased the risks and vulnerabilities Michelle lived with?
18. Were there any matters relating to safeguarding other adults at risk or children that the review should take account of?
19. Did Michelle disclose any domestic abuse to her family or friends? If so, what action did they take?
20. Did Michelle's Partner make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

f. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

This will require agencies to consider these issues:

21. Were effective whistleblowing procedures in place within agencies to provide an effective response to reported concerns about ineffective safeguarding and unsafe procedures.

g. To identify clearly what the lessons to learn are, and how (and within what timescales) they will be acted upon.

This will require agencies to consider:

27. What (if anything), in your view, should change as a result of this Review and the production of a multi-agency action plan

h. To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

i. To understand the impact of the COVID-19 Pandemic and address any improvements to service delivery.

This will require agencies to consider:

28. The impact that the management of the COVID-19 pandemic – including the restrictions associated with it – had on the planned delivery and provision of the services offered by agencies
29. To describe the impact the COVID-19 pandemic – including the restrictions associated with it – had on Michelle and Michelle's Partner individually, and as a couple

Equality and Diversity

1.53 The review panel was committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to Michelle, and Michelle's Partner, prior to the incident.

1.54 There was no evidence that Michelle was directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

1.55 The Panel considered the implementation of the Equalities Act and discussed the impact of the legislation on the services that were in contact with Michelle. It was noted that equality law recognises that bringing about equality may mean changing the way in which services are delivered. This is the 'duty to make reasonable adjustments' to the way things are done and the way services are provided in order to make them useable by everyone eligible to use them.

1.56 The Panel noted the guidance from the UK Government, stating that if an organisation providing facilities or services to the public or a section of the public, finds there are barriers to people in the way it does things, then it must consider making adjustments (in other words, changes). If those adjustments are reasonable for that organisation to make, then it must make them.

1.57 The Panel also noted that this duty is 'anticipatory', meaning that an organisation cannot wait until a person with a disability wants to use its services, but must think in advance (and on an ongoing basis) about what disabled people with a range of impairments might reasonably need, such as people who have a visual impairment, a hearing impairment, a mobility impairment or a learning disability.

1.58 The question posed by the Panel for those agencies in contact with Michelle was whether:

- the way it operated
- the physical feature of its premises, or
- the absence of an auxiliary aid or service

1.59 created a barrier which would have placed Michelle at a substantial disadvantage compared with other people using the service.

1.60 The Panel noted that the Greater Manchester Probation Service (or the Community Rehabilitation Company at the time), Petrus, Energy Works (part of the Groundworks Trust), Greater Manchester Police (GMP) and others were particularly responsive to Michelle's needs.

1.61 With regard to GMP, the Panel noted that at almost every incident they attended, Michelle was noted to be at high risk of domestic abuse. GMP submitted a number of DAB records (Domestic Abuse Investigation Records) and a care plan – a requirement when clients are recorded as living with a mental health difficulty (in this case, for example, when Michelle was detained under Section 136 of the Mental Health Act).

1.62 It is also the case that when the High Risk Daily Meeting (HRDM) in Rochdale discussed Michelle's case, they noted that she would occasionally struggle with her alcohol consumption (Turning Point[2] did offer support when invited to contact Michelle by the HRDM). The HRDM also noted that Michelle reported that she was struggling financially and had reported to her GP (and members of her family) that she was struggling with her mental health.

1.63 The Panel noted that sex and gender reassignment are protected characteristics under the terms of the Act and were cognisant of the fact that there is a disproportionate prevalence of women as victims of domestic abuse, coercion, control and violence. Please refer to Appendix 2 for further contextual information regarding the prevalence of recorded violence and abuse against women.

[2] Turning Point is a specialist drug and alcohol treatment service operating across Greater Manchester. Michelle declined the support offered.

Dissemination of the Overview Report

1.64 The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The Rochdale Safer Communities Partnership
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for Greater Manchester
- All agencies involved in the review
- The Office of the Domestic Abuse Commissioner
- Members of the family of Michelle (as contacted)

Section 2. Background information – the facts
A pen picture of Michelle – the focus of this DHR

2.1 The author of the Review, with the assistance of the Office of the Coroner and the Commissioner of the Review, made contact with S1, the sibling of Michelle. When the Review commenced, the Commissioning Officer and the Author sent a letter of invitation to S1. The letter expressed the condolences of the Panel, and invited S1 to contribute to the Review. The Commissioning Officer did not receive a response to this letter.

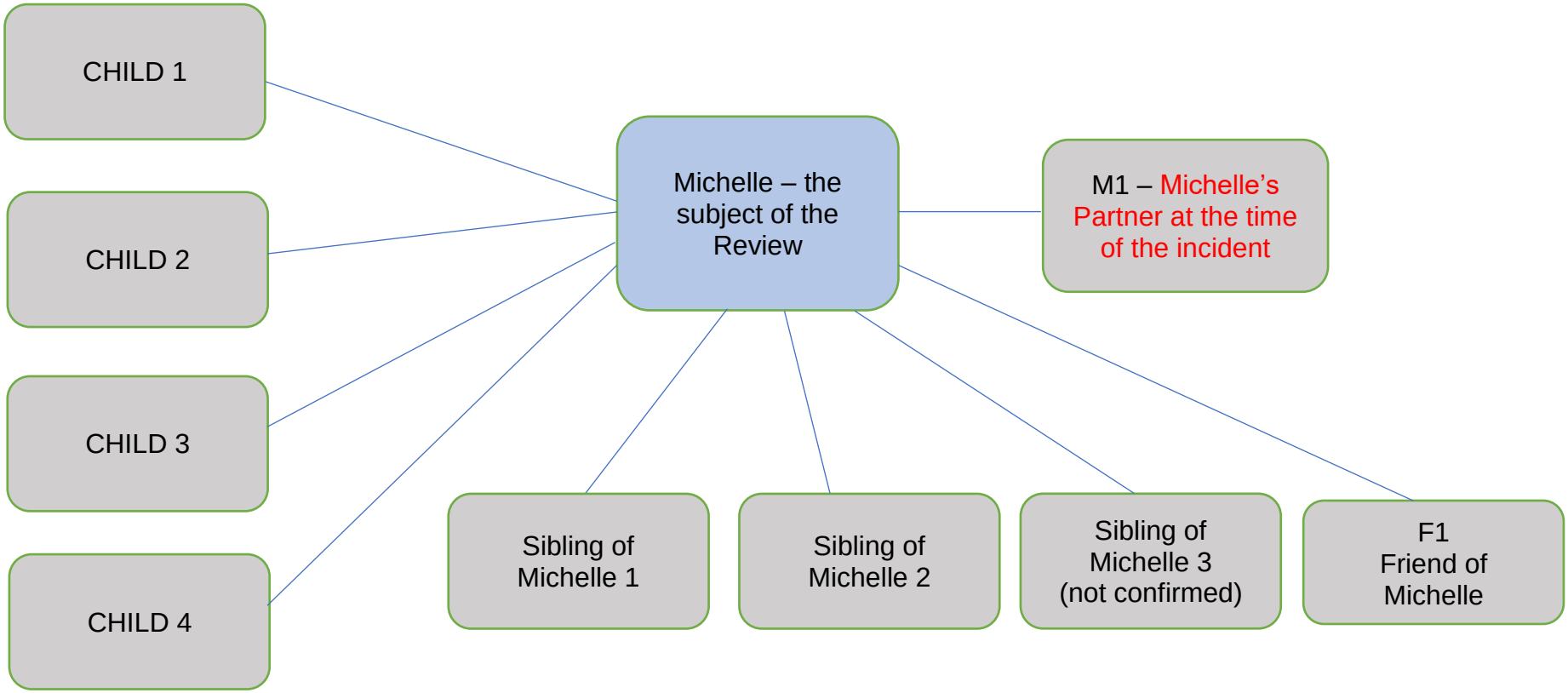
2.2 As noted, the Office of the Coroner made one contact with S2, via a telephone call. However, further attempts at contact were unsuccessful because the telephone number was subsequently recorded as unattainable.

2.3 As the Review made progress, the Office of the Coroner informed the Author of the Review that they had made contact with S1 and that S1 had agreed to receive updates from the Author concerning the progress of the Review.

2.4 F1 also agreed to be contacted and spoke with the commissioning officer from the Rochdale Borough Council. The submission from F1, agreed with them at the time of transcribing, is included later in this Report.

2.5 S1 did respond to the invitation from the Author of the Review to participate and contribute (this was done by telephone and email). S1 was contacted via e-mail (on three occasions during the period December 2022 to January 2023) and also by telephone (on three occasions in the period February to March 20023). However, at the time of writing (March 2023), S1 has not yet made a contribution to the Review.

A Genogram of the subjects referred to in this Review



The Panel worked closely with the Office of the Coroner to attempt to co-ordinate contact with family and friends. The Office of the Coroner held a record of two people they understood to be the Siblings of Michelle. They had a contact number for S2 and on one occasion made contact with them. However, future attempts were unsuccessful as the telephone number they used was recorded as unavailable. Greater Manchester Police held a record of three people who they understood to be the Siblings of Michelle.

The perspective of Michelle's friend

2.6 As noted earlier in this report, the eldest child of Michelle (an adult during the completion of this Review) declined the invitation to become involved in the conduct of the Review, and the Sibling of Michelle initially declined to become involved but their involvement is still pending. This placed the Panel in the regrettable position of feeling that it did not have a clear picture of who Michelle was.

2.7 The Panel then took the decision to contact F1, a close friend of Michelle. The contact details for F1 were shared with the Panel by the representative from the Greater Manchester Police. The Panel considered the subjects and questions that they wished to discuss with F1.

2.8 Consequently, F1 contacted the Development Officer from the Rochdale Borough Council, referred to here as R1. Following the conversation, R1 fed-back the information they had recorded and checked to make sure that F1 was happy to give their consent to share the information discussed with R1 with the panel.

2.9 R1 discussed a number of points with F1 concerning Michelle and the circumstances leading to the critical incident. The content of the conversation between R1 and F1 has been described below in a 'question-answer' format, primarily for ease of reading. However, it is important to note that the conversation itself was more informal than this format may portray:

2.10 **What was Michelle like as a person; where was she from; how long have you known each other as friends; how did you meet one another; did you have interests in common?**

F1 stated that they had been friends with Michelle for about 40 years and their friendship began in childhood. Both sets of parents were family friends. Michelle and F1 went through all the school years together. They attended Primary School together (in Rochdale) and then the local High School.

F1 said that Michelle was a protective and caring person; often taking the lead in speaking with teachers if Michelle and her friends were in trouble.

2.11 **What was Michelle like as a friend – was she considerate, good to share stories, secrets and concerns with?**

F1 said that Michelle was always very supportive. F1 said that Michelle was described by many as an 'Angel'. F1 said that Michelle was known to be a strong and fearless character and used this to fight against life's challenges. F1 said that Michelle was very family orientated and she liked to write letters and poems to her friends and family.

F1 said that Michelle loved her dog, and that she would prioritise food for her dog over her own. F1 said that Michelle was described by many as the 'life and soul of the party'. She was always fearless in everything she did and with the challenges she faced.

R1 asked about Michelle's children, and F1 said that as Michelle's children got older, they came back into her life. F1 said that Michelle was said to be happy about this and lived to see the children. F1 said that the contact with them made Michelle happy.

F1 said that Michelle ran arts and crafts sessions at a local Community Centre. F1 told R1 that all the members took to her, and they have had a bench put in the gardens for Michelle. (The local community centre referred to is a day centre for people who are homeless and people at risk of becoming homeless).

2.12 **R1 asked F1 if they knew any of Michelle's boyfriends, and if so, what were they like?**
F1 said that Michelle's relationship with the Father of Child 4 was a toxic relationship and resulted in the children being removed from Michelle's care. F1 said that losing the children was devastating for Michelle. F1 said that they felt Michelle had been let down by the services who removed the children and didn't offer support when it was needed. F1 told R1 that after the children were removed, Michelle became homeless and was living in and around Rochdale. F1 said that despite this, Michelle never showed any signs of depression. F1 said that Michelle moved back to her home town because her Dad was dying and she wanted to be close to them.

F1 said that Michelle met M1 (her Partner) after losing the care of her children and the death of her father and was experiencing, along with her Siblings, quite a lot of stress. F1 said that Michelle was vulnerable at the time of meeting M1 and F1 said that they never really took to M1. F1 saw them as controlling and abusive. F1 said that on one occasion, their Partner had thrown Michelle's Partner out of the house due to their abusive behaviour. Michelle had shared with F1 that she was scared of her Partner.

F1 said that they had reported Michelle's Partner to the police. F1 stated that Michelle's Sibling had done the same. F1 said that Michelle's Partner wouldn't leave Michelle alone and said that Michelle's Partner was obsessive. F1 said that on one occasion, Michelle's Partner had been seen going down the street shouting and insulting (with vile names) whilst holding a hammer in their hand making threats. F1 stated that Michelle's Partner did not care about their poor language in front of children. All of F1's children said they were scared of them.

F1 told R1 that they understood that Michelle's Partner is now in a new relationship.

2.13 **R1 asked if Michelle ever expressed any concerns to F1?**
F1 stated that Michelle was scared of her Partner; F1 said that Michelle was described as petite whereas her Partner was much bigger than Michelle. F1 said that Michelle's Partner's behaviour was threatening and F1 said this caused Michelle great fear; F1 said that Michelle didn't want to leave the home because of her children, which put her at more risk from her Partner. F1 stated that Michelle only let her Partner into the property out of fear of them and the fear of losing her property.

F1 said Michelle's Partner had punched Michelle on her arm a few days prior to her death; F1 said that the bruising had spread and F1 recalled that Michelle's whole arm and then other body parts turned green in colour in the run up to her going into hospital.

F1 stated that Michelle did not usually take any painkillers and never had any in the house. F1 said that someone had given Michelle some paracetamol due to Michelle being in pain and this occurred on the day of Michelle going into hospital. F1 said that she knew that Michelle had also been drinking, although F1 stated that Michelle was not a heavy drinker.

2.14 **R1 then asked F1 – with the caveat that there was no obligation to answer – if they had any contact with Michelle's children?**
F1 said that they did have contact with the children and that they have all been left with a huge hole in their world and are seeking answers as to why Michelle's death occurred. F1 said that all of the older children (C1, C2 and C3) are looking to have contact with Child 4. F1 said that Child 4 lives with their father and F1 felt that this may be a barrier to getting to know C4.

2.15 **R1 then asked F1 if they had any concerns about Michelle in the 6 months leading up to the critical incident?**
F1 said that they did, because Michelle was again at risk of eviction and was so scared of her Partner's controlling and violent behaviour that F1 worried for Michelle.

F1 claimed that Michelle's Partner had been giving Michelle pills on occasion and this was usually when Michelle was due to see her children. F1 said that Michelle's Partner was controlling and did things like this to prevent Michelle having contact with her children (F1 was not sure what pills they were)

F1 also spotted a change in behaviour: F1 said that Michelle always showered every day; however; on the Thursday prior to Michelle's death, F1 visited Michelle, who was in pain with her bruising and F1 noticed that Michelle had not showered and was not dressed, which was extremely out of character for Michelle. F1 stated that when Michelle went into hospital, it was not only her arm that had gone green, it had spread over her body.

2.16 **R1 then asked F1 if they had any questions she would like the Panel to try and answer?**
F1 said that Rochdale Borough Council knew that Michelle's Partner was violent, and that Michelle was at risk, and they did not support Michelle effectively. F1 feels they could have done more by putting restrictions on Michelle's Partner instead of 'having a go' at Michelle.

F1 stated that Children's Social Care could have done more to help Michelle; they should have listened to her, and better supported rather than removing the children and putting Child 4 into the care of their father.

Section 3
Abridged chronology

2016

3.1 In March of this year, Michelle was made subject to suspended sentence order, and convicted of a Section.39 assault against another partner, the father of one of her children. Michelle admitted to the misuse of amphetamine. This order was terminated in September 2016, following the successful completion of the WISER programme a course specifically for women offenders).

2017

3.2 Between July and October of this year, Michelle resided in the refuge in Rochdale because she had fled her abusive relationship at the time (this was not Michelle's Partner). The refuge was managed by 'Safenet' and provided Michelle with safe accommodation, safety advice and safety planning, alongside a number of other support and advice services provided by Safenet.

2019

3.3 In May, Michelle attended an appointment with her GP. Michelle discussed that she lived alone, was feeling low, crying for no reason and was having difficulty sleeping. The GP confirmed that Michelle was not experiencing any suicidal thoughts. An anti-depressant was prescribed.
** from the account provided by F1, it was during this year that one of Michelle's parents became ill and sadly died.*

It is assumed that Michelle began her relationship with her Partner at approximately this point

3.4 In July 2019, Michelle was convicted for a Public Order Act offence and she was sentenced to a 12-months Community Order with an 80 hours 'Unpaid Work Requirement' and a 'Rehabilitation Activity Requirement' (RAR) of 15 days.

3.5 Later in July, an allegation was made that Michelle was headbutted by her Partner. She said she had fallen to the ground and was unconscious for a while. At the time of reporting, Michelle was intoxicated and could not provide a statement or a DASH assessment. Several attempts were made to contact Michelle and follow up the crime. However, Michelle did not engage with the officers from Greater Manchester Police (GMP). The alleged offender (Michelle's Partner) was interviewed but they stated that they did not remember what happened. There was no CCTV coverage and the witnesses who were present would not provide statements. Without the help of Michelle, no prosecution was possible. The crime was authorised to be filed, as per force policy.

3.6 In September, Michelle was recorded by the Greater Manchester Probation Service (to avoid confusion with 'Greater Manchester Police, the Probation Service will be referred to as the *NPS – this is the National Probation Service*) as attending for Rehabilitation Activity Requirement (RAR) supervision sessions in Middleton. Michelle did this because she said she was frightened

of entering Rochdale at the time. It was not noted on the electronic record as to why Michelle was fearful of entering Rochdale.

3.7 In October, Michelle attended a Walk in Clinic and was seen by a Nurse who recorded that she had presented with "several infected bites/burns/impetigo on the top of her body and arms, and blisters to her feet". Michelle was signposted to her GP.
Later in October, it was noted that Michelle had attended the NPS service at Petrus (a service for people who are homeless or at risk of becoming homeless) with a high level of regularity (daily to weekly, as a minimum). Michelle stated that she was engaged with an art project; she spoke of her children and said that her 18 year old child was seeking contact with her.

3.8 Towards the end of October, the GMP recorded that a witness had heard Michelle shouting for help and for someone to ring 999. The witness saw Michelle trying to climb out of a bedroom window. It was alleged that Michelle's Partner had assaulted Michelle following an argument. Michelle's Partner was arrested at the scene for the assault. Michelle's Partner stated the couple had consumed two bottles of vodka and therefore a statement was not obtained from Michelle on the night of the assault. During police interview, Michelle's Partner denied assaulting Michelle and said that they were kicked by her. Michelle refused to open the door to officers when they returned, and they were unable to contact her by telephone. Michelle's Partner was released from custody without charge for the assault. A DVPO was granted on the 30th of October, expiring on the 12th of November. The Safeguarding Team[3] served the DVPN on Michelle's Partner but were unable to contact Michelle to inform her. GMP referred Michelle to the Multi-Agency Adult Safeguarding Team (MAAST)[4], recorded the risk assessment as high and a MARAC referral was made on 1st of November.

3.9 In November, Victim Support made two attempts to contact Michelle. These attempts were unsuccessful

3.10 The MARAC meeting was held on the 27th of November 2019 and was attended by an officer from Adult Social Care. The case for Michelle was not open to Adult Care at this point. The member of staff recorded on the Adult Care case record that the Independent Domestic Violence Advocate (IDVA) had attempted to contact Michelle, but the alleged perpetrator (Michelle's Partner) was answering her telephone. It was noted that Michelle had been referred to Turning Point[5]. There were two actions noted at the MARAC for the Community Rehabilitation Company (CRC) focused upon the allocated CRC worker to liaise with the IDVA around Michelle's engagement with services; an action for

[3] The DA triage officers are based within the Early Help and Support Hub (EHASH) at Rochdale and they completed this task.
[4] The MAAST is a meeting of relevant professionals based in Rochdale. They meet every Tuesday and Thursday to discuss wider Adult Safeguarding concerns. This was the only occasion when GMP referred Michelle to the MAAST.
[5] The commissioning officer of the DHR (from the Rochdale Council) contacted Turning Point to ask if they had any record of providing support to Michelle from this point to the date of the incident. Turning Point confirmed that they had no contact with Michelle.

CRC to refer Michelle to Children's Social Care concerning information about one of Michelle's Children; there was an action identified for the Homelessness Service to attempt to encourage Michelle to engage with their service and that the Housing Officer from Rochdale Borough-Wide Housing would also try and encourage her to make contact with services that could support her. All of these actions were delivered.

3.11 At the end of December, a call was received by GMP from an anonymous member of the public about Michelle who was standing outside an address shouting about the return of her dog. On arrival, Michelle's Partner told the Police that Michelle had become argumentative and assaulted them. Michelle's Partner said that Michelle was aggressive towards them and threatened them in the presence of the Officers. Michelle was arrested for the assault. At the time of arrest, Michelle's Partner said that they did not want any further action taking and refused to provide a statement; they signed the officer's pocket notebook retracting any complaint. When Michelle arrived at the police station, she presented with injuries to her arm and elbow which had to be treated at hospital. She said that the injuries were caused by her Partner and a male in the flat. When interviewed about the assault on her Partner, Michelle said she couldn't remember any of it. A DVPN was considered but deemed unsuitable because Michelle had not previously been the offender in alleged incidents of domestic abuse between the couple. Michelle was released from custody with no action taken.

3.12 A Domestic Abuse Investigation Record (referred to by GMP as a DAB)[6] was commenced with the initial Domestic Abuse risk assessed as medium. A separate DAB was created for the counter allegation made by Michelle (this was later closed to reduce duplication). When this was reviewed on the 11th of January 2020, the risk was changed to high due to the previous MARAC referral and because a DVPO had previously been served. A further MARAC referral was made on the 13th of January 2020 for Michelle and Michelle's Partner to be heard on the 5th of February. It was noted:

'*Both parties are living in separate addresses but still in a relationship. Michelle states she would like a referral to address or help with her alcohol consumption*'.

3.13 Following this incident, Michelle attended Fairfield General Hospital (FGH), part of the Northern Care Alliance NHS Foundation Trust. The Police were also present. It was noted that Michelle had an injury to her right forearm and a graze to her left elbow. The staff raised a query concerning the injury and Michelle noted that she was assaulted 3 hours ago; Michelle stated she was intoxicated at the time of the alleged assault. An X-ray of Michelle's elbow and forearm was completed and there were no abnormalities detected. Michelle was discharged with advice and analgesia.

[6] A DAB is the IT record updated by the attending officer. Medium and High risk incidents are subject to enhanced risk assessment by a triage officer.

2020

3.14 In early January, an Ambulance from the North West Ambulance Service (NWAS) attended Michelle who reported that she had been assaulted. The attending crew were met by police officers from GMP, who were already on scene. The NWAS crew undertook a safeguarding procedure and referred Michelle to Adult Social Care. The crew noted that Michelle stated she had consumed 1 litre of vodka and was at times hyperventilating and losing consciousness. The safeguarding concern documented that Michelle was conveyed to a general hospital Emergency Department (ED).

3.15 The A&E service at North Manchester General Hospital (NMGH) – which, at the time, was part of the Northern Care Alliance NHS Foundation Trust – noted the attendance of Michelle with Police officers, following an alleged assault. Michelle reported that she was assaulted by a stranger whilst walking the dog that evening. She had then reported the incident to her partner when she returned from the walk, and then contacted the police.

3.16 On the following day, the Rochdale Adult Social Care (ASC) service attempted to contact Michelle. However, the contact went to voicemail. Contact details were left for the locality team. The service made another attempt at contact on the 6th of January. However, that contact also went to voicemail. A contact letter was sent to Michelle from ASC and a further 3 calls were attempted to contact Michelle.

3.17 Later in January, Michelle was discussed at the High Risk Daily Meeting (HRDM – a multi-agency arrangement concerning domestic violence). A decision was made that Michelle should be heard at the MARAC on the 5th of February (noting that Michelle's Partner was going to be heard at the same meeting of the MARAC). It was decided that Michelle should also be allocated an IDVA. An urgent response Domestic Violence (DV) marker was also placed on the address of Michelle's Partner.

3.18 Later in the month, Rochdale ASC made an unannounced visit to Michelle. A friend of Michelle answered the door and advised that Michelle was at Michelle's Partner's address. Michelle's friend advised that Michelle had been seen that morning and reported that she was fine. Adult Care emailed the police to update them that Michelle was not at the property when visited and was 'still with her Partner'.

3.19 NPS completed a home visit, following Michelle reporting that she had a broken toe. The purpose of the visit was the identification of support needs, given Michelle's vulnerabilities linked to alcohol use, mental health and emotional wellbeing. The action set was to re-introduce Michelle back to the services offered by the local community centre (referred to earlier in this report) and to Petrus (a residential and day support service for people experiencing, or at risk of, homelessness).

3.20 In early February, Michelle attended an appointment with her GP. The key issue recorded was a skin infection with notes saying that her right finger had been

infected for a few days and that she 'keeps having infections'. The GP requested blood tests and prescribed an antibiotic.

3.21 One month after the home visit completed by NPS, recall proceedings were initiated following a failure by Michelle to comply with an agreed appointment.

3.22 In early March, following a verbal argument about their dog, Michelle contacted the Police and alleged that her Partner had pushed her, but caused no obvious injury. Michelle's Partner left prior to the police arriving. Michelle left the address and returned home. Michelle said that she had attacked her Partner prior to them pushing her. Both were described as possible offenders in the events. A Domestic Abuse Investigation Record (DAB) commenced, in addition to a crime report being raised for common assault, with Michelle being the victim. Michelle told officers that her relationship with her Partner was at an end. The DA risk assessment was considered as medium by the attending officer. When this was reviewed, on the following morning, the risk assessment was raised to high in line with the previous MARAC referrals. The incident was also referred to the HRDM. Some time later, the report of crime was closed, with no action being taken and this was authorised by a Detective Inspector.

3.33 Between the 5th of March and the 18th of March, Victim Support made six attempts to contact Michelle – all of them were unsuccessful.

3.34 Towards the end of the first week in March, Michelle attended an appointment with her GP and told them that she was feeling low, anxious and having difficulty sleeping. She also said that she had punched herself in the face. The GP asked Michelle about suicidal thoughts, illicit drug use and alcohol consumption. No suicide ideation or drug use was noted. The GP recorded in the notes that Michelle: 'lives with boyfriend – who is supportive'. The diagnosis was recorded as depression/anxiety. Michelle was prescribed an anti-depressant. There was a clear focus on mental health in this consultation.

3.35 NPS issued a summons for Michelle concerning a breach of her Order[7].

3.36 In early May, NPS made a telephone call to Michelle and she stated that she lived alone, but remained in contact with her Partner. The intervention focused on triggers for a lapse into alcohol use. Michelle described the local community centre she attended as having provided her with "huge support" and expressed a desire to return. Michelle wanted to avoid making the same mistakes. It was documented that Michelle's mental health was stable, but aggravated by alcohol use[8].

3.37 Michelle told her Offender Manager that she was having to stay with her Partner at their home as she had run out of benefits and did not have enough money to put her electricity on.

[7] COVID lockdown measures legally came into force on the 26th of March.
[8] On the 13th of May 2020: leaving or being outside one's home without a reasonable excuse is prohibited. Some restriction relaxed to allow outdoor exercise or recreation with one person from another household

3.38 At the end of May, GMP received a report stating that Michelle had been at her Partner's address and there had been an altercation. Michelle's Sibling called the police. Michelle said she had made an attempt at an overdose about five weeks ago. She said that she had been feeling suicidal every day and had made several attempts over the past few months. The ambulance service was called but the response was cancelled by the Police because they were taking Michelle to Hospital. Michelle was detained under section 136 of the Mental Health Act. Michelle was taken to Fairfield General Hospital (FGH). Michelle denied any thoughts of suicidal ideation or psychotic features. The attending clinician queried if there were children in the home and Michelle stated there was not. Michelle was transferred to the Oldham 136 suite with the Police, once medically fit, as the FGH suite was already occupied. Adult Social Care was informed of this attendance. The Pennine Care NHS Foundation Trust (of which Oldham Hospital is a part) noted the attendance of Michelle and recorded that Michelle had recently split with her partner, who had taken their dog. Following drinking alcohol, she was looking for her ex-partner and her dog and was making threats to harm her ex-partner. The Police were then called. Michelle was assessed by the doctors. The plan to discharge was:

1. Encourage Michelle to self-refer to Turning Point;
2. Michelle was provided with relevant contact numbers for support; and
3. Michelle was to contact her GP and/or A&E out of hours, if required.

3.39 At the beginning of June, Rochdale ASC contacted Michelle who had been discharged from the Section 136 Suite. ASC noted that there was no information concerning Michelle's destination following discharge. Adult Care contacted the Medical Centre who provided a new telephone number for Michelle. Michelle advised that she was at the home of her Sibling (S1) and that she was fine. Michelle declined any further support from Adult Care; she had some food; she stated that she didn't have any electric or gas and would not be paid until the 27th of June 2020. Michelle was offered the Adult Care number, however she declined to receive it[9].

3.40 In early July, Michelle made contact with the Greater Manchester Probation Service. Michelle was advised a warrant, not backed for bail, had been issued by the Court. Michelle asserted that she had been advised her Court date was in September and she was concerned that there was an active warrant for her arrest. At a home visit by the probation service in the following week, Michelle failed to engage and remained on warrant for over 12 months.

3.41 In early October, Michelle's Sibling reported to the Police (GMP) that Michelle had come to her home and told her that her Partner had assaulted Michelle a couple of days ago. The incident was created as a grade 2 priority as she was not with her Partner at the time of the report and was at a safe location. A report of a common assault was recorded. Michelle did not wish to pursue the complaint; she said that she reported it because she wanted police assistance

[9] On the 1st of June 2020: England moved to "step 2" of the government's roadmap in which restrictions on leaving one's home are removed. Gatherings of two or more persons indoors and more than six outdoors are prohibited. On the 15th of June 2020: Non-essential retail businesses are permitted to re-open

to retrieve her belongings from her Partner's address. The report of crime was closed with no further action[10].

3.42 A DASH assessment was completed and a DAB record updated. The following supplement to the submission from the GMP author was noted by the Panel:

'*I do not believe there is sufficient information to support a realistic prospect of conviction based on the evidence obtained so far. The victim does not support a prosecution. Referrals have been completed. There are not believed to be other sources of evidence that will strengthen the case'*.

3.43 Michelle went to live with her Sibling. Michelle's case was then heard at the high-risk daily meeting (HRDM). A recommendation was made for an IDVA to contact Michelle and offer further support. She was also referred to MARAC[11].

3.44 Between the 6th of October and the 9th of October, Victim Support made three attempts to contact Michelle – all were unsuccessful.

3.45 In early November 2020, NWAS received a 999 telephone call concerning a report of an assault. NWAS recorded that the Police had detained the alleged attacker. The NWAS response was subsequently cancelled by the Police as officers were taking the patient to hospital[12].

3.46 On the following day, Police officers from GMP were attending another incident when they heard Michelle cry for help. They attended and found her with a fresh cut to her head. They established that Michelle's Partner and Michelle were having a verbal argument during which Michelle's Partner had pushed Michelle. Michelle's Partner was arrested and charged with the assault. They were refused bail and appeared before a Domestic Violence Court. A DASH assessment was completed. Michelle told the investigating officer that the argument between the two was about her knowledge of their previous offending history from her Clare's Law disclosure[13]. She also told the officer that she was reliant on her Partner financially and had been living at their address for the past 18 months. Michelle was referred to MARAC which was to be heard on the 9th of December 2020. Safeguarding measures were in place and referrals to agencies were made. Following the MARAC meeting in December, GMP was given one action: to conduct a joint welfare visit with Rochdale Borough-Wide Housing to Michelle's home address.

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[10] On the 14th of September 2020: a restriction on gatherings of more than six persons indoors and outdoors (the "rule of six") is introduced

[11] The GMP DAB recorded that Michelle was referred to MARAC. However, when enquiries have been made, the SharePoint system noted that there was no agenda item for Michelle and/or Michelle's Partner to be discussed at the MARAC in November 2020

[12] On the 5th of November 2020: a second national lockdown was introduced which required people to stay at home

[13] On further investigation, GMP has not been able to locate any request for a DVDS made by Michelle in respect of her Partner, and GMP has not been able to locate any previous incidents of domestic abuse that would suggest a disclosure under Clare's Law would have been undertaken by GMP. However, it is known from the investigation that the Mother of Michelle's Partner's may have disclosed their offending history.

3.47 Between the 16th of November and the 28th of November Victim Support made three attempts to contact Michelle – all were unsuccessful.

3.48 In mid-November 2020, Rochdale ASC noted that the details of the incident, described above, were discussed at the High-Risk Daily Meeting, held on the 16th of November 2020. There were several agencies present, including: Early Help, Victim Support, NHS services, Police, Probation, Housing, Adult Social Care and Children's Social Care. The Victim Support service outlined how they had attempted contact, but this had not been successful (noting that the telephone was switched off and, of course, Victim Support were unable to leave a message). Rochdale Borough-Wide Housing reported concerns from neighbours about domestic abuse, but suggested Michelle's Partner was the victim. Adult Social Care updated the meeting and stated that their last contact was in May when Michelle was detained under Section 136 and that Michelle declined support from Adult Care. The Criminal Justice Mental Health Team advised the meeting that Michelle was assessed on the 30th of May 2020 following the S.136 detention and that Michelle was discharged back to her GP.

3.49 Actions were set for an IDVA to attempt to make contact and offer Michelle further support and for the housing services team to link in with Michelle and also offer further support.

3.50 In mid-December, Rochdale Borough-Wide Housing noted that a home visit was carried out and recorded no sign of occupancy. A Neighbour reported that they had not seen Michelle since October 2020 and other people have been using the flat. A short time later, Rochdale Borough-Wide Housing made a telephone call to Michelle and she stated that she was staying with her Sibling.

2021

3.51 In June, GMP received a report concerning a domestic assault between Michelle and Michelle's Partner. They recorded that Michelle attended her Partner's flat to allow them to see their dog. An argument broke out. A neighbour had called the police due to the noise, both parties apologised to the neighbour. A crime report was submitted for criminal damage and common assault. A DAB Report was made with Michelle assessed as a high risk[14].

3.52 The Panel noted that, at this point, it had been over seven months since the police had attended an incident involving the couple. The appropriate referrals were made to agencies and the incident was referred to the HRDM and the MARAC.

3.53 On the 24th of June, Victim Support noted that Michelle declined support and declined to complete a DASH. Michelle did tell the service that she had no

[14] On the 17th of May. Limit of 30 people allowed to mix outdoors. 'Rule of six' or two households allowed for indoor social gatherings. Indoor venues will reopen, including pubs, restaurants, cinemas. The COVID regulations were amended and up to 10,000 spectators can attend the very largest outdoor-seated venues such as football stadiums.

money left on her gas and electric and it is down to emergency supply. The IDVA agreed to make a referral to 'Energy Works'.

3.54 Two days later, Energy Works (a service that is a part of Groundworks) confirmed receipt of the referral and noted:

> "Michelle has a rescue dog that became very poorly and she had to pay £260 vet bills. Michelle now has no gas or electric on her meter and is behind with all of her household bills".

3.56 Following a second call to Michelle, made on the 25th of June, the service made contact and supported Michelle with payments towards her gas and electric meters. Michelle stated that she had her 21yr old child currently staying with her and that she had met someone (18 months ago) and moved in with them but that she was now living in her own property. Energy Works arranged to provide fuel vouchers that could be redeemed at a Pay-Point point in order to pay off some of the debt. They confirmed that these were later redeemed as expected. Energy Works arranged to get back in touch to help Michelle with claiming the Warm Homes Discount (WHD) from her energy provider later in the year when the application window was due to open. They attempted the calls to deal with the WHD on the 19th and 26th November.

3.57 At the end of June, officers from GMP recorded that Michelle had been to her Partner's flat and Michelle's Partner had become abusive and assaulted Michelle. Michelle's Partner then threatened to smash property at Michelle's flat. An officer attended and spoke to Michelle's Partner. Michelle had by then returned to her own address and could not be contacted. Several attempts were made to contact Michelle and on the 5th of July, crime reports were submitted for a Section 47 assault and threats to commit criminal damage. Michelle declined to assist any prosecution and the report of crime was filed. The DAB record was submitted as a high risk to Michelle. The incident was to be heard at the Daily High Risk Meeting (DHRM) on the 6th of July. The action agreed was that an IDVA was to make contact with Michelle. Michelle told the victim support worker that she was heavily intoxicated at the time of the incident and that she had instigated it. She said she was safe and well and did not require assistance for domestic abuse and declined to complete a DASH. At this contact, the IDVA offered Michelle the opportunity to move into a Refuge. Michelle declined the offer.

3.58 In early July, Michelle attended her GP Practice. Whilst taking blood, the Health Care Assistant noted bruising to the upper part of Michelle's right arm. Michelle said that the injury was caused by a fall from a push bike.

3.59 Between the 7th of July and the 4th of August, Victim Support made five attempts to contact Michelle – all were unsuccessful[15].

3.60 In early August, Michelle telephoned the police in a very distressed state reporting a domestic incident. The incident was created as a grade 1 response.

[15] On the 19th of July. Most legal limits on social contact were removed; closed sectors of the economy were re-opened

A search of the area was conducted to trace Michelle. She was found and arrested for a breach of a court order (the warrant was issued following non-compliance with an order to do unpaid work between 14/1/20- 20/2/20. Details of the warrant and power of arrest for Michelle had been circulated on the PNC). Michelle told officers that she did not want to pursue a complaint of assault. A DAB was commenced. Michelle provided an account to officers in which she said that on the 3rd August she had been drinking with her Sibling and later she was assaulted by her Partner. The officer recorded that:
'Michelle didn't state anything about the assault other than (her Partner) pulled her hair and dragged/shoved her to the floor'.

3.61 Michelle later told officers that she did not want to prosecute her Partner. Michelle told the police that she did not want a DVDS and that she was fully aware of her Partner's history. She was assessed as high risk and referred to the HRDM. Michelle was referred to an IDVA and she was due to be heard at the next MARAC, scheduled for the 29th of September. A crime report was submitted for the assault on Michelle, although it is described that Michelle provided very limited information about the assault. This crime report was closed. This meant the threshold test was not met for prosecution. Appropriate referrals were made to partner agencies.

3.62 A short while later, on the 4th of August, Michelle made a Court appearance (this concerned the summons issued by NPS following a breach of an Order) and at this appearance, Michelle's community order was revoked and Michelle was re-sentenced to 12 weeks imprisonment, suspended for 12 months with a Rehabilitation Activity Requirement (of 15 days) and 60 hours Unpaid Work Requirement. The Court did not request a Pre-Sentence Report at this hearing. However, domestic abuse and child safeguarding checks were requested and provided.

3.63 On the 9th of August, Rochdale Borough-Wide Housing noted a ASB report which stated that Michelle's Partner was being 'extremely aggressive'.

3.64 A week later, Michelle made a call to tell a member of NPS (*as an aide, this refers to the Probation Service in Greater Manchester*) staff that she had lost her phone and would not be able to take a planned call that week. An appointment was made for her to attend the office of NPS on the 19th of August.

3.65 Michelle attended that planned appointment. There was a focus upon collating and analysing risk assessment information. It was recorded that staff would make a referral to "Domestic Violence Advocacy" at the next appointment. There was also a recognition of alcohol having an impact upon Michelle's decision making and behaviour. Michelle stated she was no longer in a relationship with her Partner. Motivation to gain employment was noted, along with a desire for stable accommodation. Although no specific family member was noted, it was documented that Michelle was supported by her family and that they have an awareness of Michelle's previous relationships.

3.66 On the following day, NPS made a telephone call to request a quick response marker on Michelle's address – this was confirmed as added by the Police.

3.67 On the 26th of August, NPS had an appointment with Michelle to discuss a referral to the National Centre for Domestic Violence (NCDV) to support Michelle with an application for an order (*unspecified in the submission)* against her Partner. However, a person made a telephone call to staff (noted as probably being Michelle's Sibling) to advise that Michelle had been assaulted by her ex-partner and was waiting for police attendance. There was an agreement to re-schedule the appointment, following police intervention and investigation.

3.68 On the same day, GMP received a report of an incident. This was reported by Michelle's Sibling, stating that Michelle had been a victim of a domestic assault by Michelle's Partner on the evening of the 25th of August. She said that Michelle's Partner had started hitting Michelle. She said that Michelle's Partner was abusive just for fun; that they had also broken several mobile telephones belonging to Michelle. The incident was created as a grade 2 response as the incident was not on going and the parties were separated (Michelle was staying at her Sibling's home). An urgent response marker was already on the address because Michelle was considered at risk of Domestic Violence from her Partner.

3.69 During the report of the assault, Michelle disclosed that she had been assaulted on the 22nd of August. An update was recorded by a Police Constable a 'Specially Trained Officer' (referred to as a STO) about the allegation. Following this disclosure, the Criminal Investigation Department (CID) were made aware. A trained officer was allocated to attend and speak with Michelle in relation to her disclosure. That officer obtained an initial account from Michelle, thus:
'*I was at my home address with my child and grandchild, my Partner came in, they were going crazy. They went for me once, twice, three times they've gone for me. They threw a digital camera at my head….. They came in through my window.*

3.70 However, the officer was unable to complete their initial investigation due to Michelle suffering what appeared to be to a panic attack. It was requested that another trained officer re-attend the following morning to complete the enquiries. The initial attending officer submitted a crime report for assault and a DAB record, in line with policy.

3.71 The STO later updated the incident log. The suspect was named as Michelle's Partner. A crime report for the assault and a Care Plan were then submitted in line with policy, with relevant referrals being made to third party agencies.

3.72 On the following day (27th), GMP received a report that Michelle had been found with a gash on her forehead, broken teeth, and was becoming agitated. The incident was created as a high-risk grade 1 response, due to the risk to Michelle. When officers attended, they found Michelle with a laceration to her eyebrow and damage to her teeth. From enquiries with members of the public, the attending officers established that Michelle had fallen over that morning banging her head on the floor. The record stated:

Michelle declined to go to Hospital to seek medical treatment, and she refused an Ambulance to come to see her because she doesn't want to leave her dog.

3.73 The NWAS response was subsequently cancelled by the Police as they had taken Michelle to her own home.

3.74 Rochdale ASC noted that the case was heard at the HRDM. The outcome was that the IDVA was to make contact and offer further support. The case was also to be heard at the MARAC, scheduled for the 29th of September.

3.75 At the end of August 2021, an ambulance was dispatched to Michelle following a telephone call to the 111 service. Michelle was reported to have been assaulted by her partner approximately a week ago and had a fall 2 days before the call. She had been drinking heavily for the past 6 days and was reported to have been taking too much paracetamol. This had led her Sibling to become concerned. Michelle denied any alcohol or drug use and was transported to hospital. Michelle was at her Sibling's home and Michelle was transported to Hospital. NWAS documented that the Police were already involved due to the incident of domestic abuse. Michelle refused a safeguarding vulnerable person concern from the attending crew. Michelle had a GCS of 15 (the highest/most alert score on the Glasgow Coma Scale).

3.76 GMP received a report from North Manchester General Hospital (NMGH) stating that Michelle had presented to the Hospital and was very seriously ill. Whilst at A&E, Michelle spoke with a Doctor and disclosed she'd been a victim of assault. Michelle's Partner was arrested on suspicion of S.47 assault.

3.77 A short time later, Michelle died at hospital.

Section 4

Narrative – what the agencies in contact with Michelle knew about her and about Michelle's Partner

Hindsight bias

The Panel recognised that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do what we might now consider – with the benefit of hindsight – as "the right thing". It would be unwise not to recognise that a DHR will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid this inherent bias and has, as best it can, viewed the case and its circumstances as it would have been seen by the individuals involved at the time.

A number of agencies that submitted reports to this Review were involved with Michelle and Michelle's Partner far less frequently than other agencies. In these cases, those agencies have described their interactions in the form of a short narrative. The Panel used these 'short reports' as a basis to build a composite picture of the contacts with Michelle and/or Michelle's Partner. Those agencies that had more frequent contact, for a longer period of time, have addressed each 'key line of enquiry' in turn as a part of their Individual Management Review.

All the agencies involved in this review provided candid accounts of their involvement in order to identify the lessons to be learned, which are considered later in this Report. The involvement of each agency is captured in different periods of time and it is important to note that some of the contacts contained in the IMRs, that are reflected here, hold more significance than others.

Greater Manchester Police (GMP)

4.1 Michelle had a long history of contact with GMP, dating back to 1995. Between 2003 and August 2021, GMP recorded more than 40 reports of domestic abuse involving Michelle. In the majority of cases, Michelle was the victim. However, she was also named as the perpetrator in several reports. Four different male partners were named during the period 1995 to 2021. A common theme of the domestic abuse reports was the use of alcohol and drugs, used by both parties. The children of Michelle were removed from her care as a result of these incidents.

4.2 With regard to this Review, Michelle's Partner first became known to GMP in 2019. In July 2019 a report of an assault was received by GMP from Michelle. She said that her Partner headbutted her[16].

4.3 Following an incident on the 27th of October (described on page 22 of the chronology), DAB investigation records were made for the original allegation and the counter allegation made by Michelle's Partner. The reporting officer recorded that Michelle had a history of Domestic Violence incidents, but not with her Partner at the time. Initially, the risk was assessed as medium but on the 1st November, the incident was reviewed by the triage officer based with the

[16] Please see the abridged chronology for the 28th of July 2019 – further incidents of assault and neighbour disputes attended by GMP are also described in the chronology

Early Help and Safeguarding Hub (EHASH) and referred to the Multi-Agency Adult Safeguarding Team (MAAST).

4.4 Michelle was discussed at the MARAC meeting held on the 27th November 2019. There were four actions identified, none of which were actions for GMP.

4.5 Following the incident reported to the Police on the 31st December 2019, MARAC referrals were made for both Michelle and Michelle's Partner to be heard on the 5th of February 2020. A child referral was made for one of Michelle's Children, who was on a child in need plan at the time. However, the MARAC referral was withdrawn prior to the meeting as it was submitted with Michelle's Partner as the victim.

4.6 The Police were called to the address of Michelle's Partner on the 17th of June 2021, on the 30th of June and again on the 4th of August (please refer to the chronology on pages 28 and 29 for a description of the event and outcome). The Panel noted that, at this point, it had been over seven months since the police had attended any incidents involving Michelle and her Partner. The appropriate referrals were made to relevant agencies and the incidents attended in June and August were referred to the HRDM and to the MARAC

4.7 On the 26th of August, Michelle's Sibling reported an incident to the police stating that Michelle had been a victim of a domestic assault by Michelle's Partner on the evening of the 25th of August (please refer to the chronology on page 30).

4.8 A care plan was created. It was recorded on the care plan that Michelle was a high risk domestic abuse victim. A DAB record was also created. Referrals were made to the GP for support and to mental health services for support with anxiety and panic attacks.

Northern Care Alliance NHS Foundation Trust (NCA)

4.9 Michelle had contact with NHS services during the time frame of this review provided by Fairfield General Hospital (FGH), Rochdale Infirmary and the North Manchester General Hospital (NMGH).

4.10 It should be noted that on the 1st of April 2021, North Manchester General Hospital disaggregated from the NCA and transferred to Manchester Foundation NHS Trust.

4.11 Documented Health records state that on each occasion Michelle attended A&E, she was accompanied by the Police and either drug and/or alcohol use was a significant factor on each attendance.

4.12 Documentation provided by the NCA Named Nurse (for Children Services) indicated that Michelle's four children were removed, under police powers of protection, from the care of Michelle in July 2010. The documentation noted that the children had not been returned to Michelle since that time. However, the record noted periods of supervised contact. The records stated that Michelle's engagement with her children was "inconsistent". There was

relatively minimal contact with her four children within the timescales of this review.

Rochdale Borough-Wide Housing (RBH)

4.13 RBH were not aware of any incidents of domestic abuse concerning Michelle, until details were discussed during the high-risk daily meeting (HRDM) which was held with neighbourhood staff. This information was shared in December 2020.

4.14 Michelle's Partner has been a tenant of RBH throughout the scope of the Review and in 2020 RBH received reports of Anti-Social Behaviour concerning Michelle's Partner.

Victim Support

4.15 As noted in the abridged chronology, Victim Support made numerous and frequent attempts to make contact with Michelle. On the occasion when the service did engage with Michelle, she declined their offers of direct support. However, they noted Michelle's financial difficulties and referred her to 'Energy-Works' who provided assistance to Michelle regarding her utility bills.

Greater Manchester Probation Service (NPS)

4.16 Michelle was supervised by the Community Rehabilitation Company on 3 separate occasions for 2 sets of convictions, the first terminating following completion of the WISER programme. This programme aims to address thinking skills and decision making and is for women offenders.

4.17 This first order was active in 2016 and is relevant as it was committed within the context of domestic abuse. In this instance, Michelle was the perpetrator of abuse against her ex-partner. There was no known history of violence from them to her. However, there was a history of Michelle being the victim of domestic abuse with numerous partners.

4.18 In July 2019, Michelle was made subject to a further period of rehabilitation activity and unpaid work for an offence committed under the influence of alcohol. The Panel learnt that Michelle engaged with both the local Community Centre (referred to earlier) and with Petrus (referred to earlier) and during this period, experienced levels of relative stability whilst participating in art and other constructive activity, and was supported to gain control over her alcohol misuse.

4.19 Although at the point of commencement of the rehabilitation activity, Michelle stated she had ended the relationship with her Partner (who, from call out information provided by the Police, was known to have been abusive), Michelle later reconciled with her Partner. However, this relationship was noted to have remained fractious and abusive throughout. There is evidence of potential dependency linked to this relationship by Michelle. On one occasion she reported she stayed at the address during COVID isolation periods due to not having enough money to put her own electricity on.

4.20 Following the commencement of her order in 2019, Michelle's record had an active flag as a high-risk domestic abuse victim, and historic child protection proceedings were also noted.

4.21 Access to Petrus Women's provision temporarily ceased during the period of COVID. Michelle was still able to access services from Petrus via their day centre provision, at times focused on support for her alcohol misuse, voluntarily participating in constructive activities and specialist support and advocacy.

4.22 An exceptional delivery model (EDM) was introduced in the CRC (due to the management of the COVID pandemic) to provide standards underpinning the frequency and type of contact (virtual/home visit/in-office) depending on client risk and complexity. Most people on probation were subject to virtual contact made by telephone or doorstep home visits. Following induction, this was the main method of contact with Michelle, who was assessed as posing a low risk of harm. Following the unification of the probation service on the 26th of June 2021, a change of EDM requirements to new national standards was implemented. This occurred on the 23rd of August 2021. Michelle was then offered an office appointment.

4.23 The Panel learnt that Michelle's Offender Manager (referred to as OM1) referred Michelle to P3, (P3 is a national charity commissioned by NPS to provide a mentoring service to help Michelle maintain the stability she was able – at times – to achieve when she was within the community). P3 aim to facilitate access to services, and accompany people on probation and motivate them. Michelle was visited at home by OM1 and P3, with a view to engaging with her. The objectives that were set were linked to the management of Michelle's support needs. These included the need to effectively engage in offence focused interventions, and be able to implement a higher degree of self-management of her risks.

4.24 Prior to breach proceedings being initiated, Michelle's attendance was described by another Offender Manager (referred to here as OM2) as 'sporadic'. Compliance work featured in attempts to re-engage with Michelle, including doorstep home visits and telephone calls. A human centred approach to her wellbeing and safety was apparent from the records, and there was a flexible approach as to how contact was made and where Michelle attended. By way of example, Michelle received services from the provider at the Local Community Centre (already described), following Michelle reporting that she felt at risk should she enter Rochdale. OM2 noted that there were times when it appeared that Michelle did not report all pertinent matters to the Police or other statutory agencies.

4.25 Enforcement action was initiated following Michelle not being present at home for a pre-arranged visit on the 14th of January 2020 and a planned appointment at the Petrus service on the 20th of February 2020. This was followed by continued attempts to facilitate compliance. OM1 liaised with relevant colleagues concerning persistent unsafe levels of alcohol consumption and Michelle disclosed ongoing abusive behaviour from her Partner.

4.26 A warrant, not backed for bail, was issued by the Court when Michelle failed to attend a breach hearing on the 30th of June 2020. There was no further contact with probation providers until Michelle was arrested and appeared on warrant on the 4th of August 2021. It was documented that Michelle had continued to engage with some welfare services during the interim.

4.27 OM1 referred Michelle to a number of different agencies, but there is minimal follow up outside of MARAC with IDVA or Police, nor contact with Michelle's family who were viewed as supportive. This was most notable after Michelle did not attend an appointment on the 26th of August 2021. A family member (Michelle's Sibling) reported that Michelle had been assaulted by her Partner. Unfortunately, the next contact was when the Police notified the Probation Service of her death in hospital.

4.28 Having researched the record, including her OASys assessment, there was no documented history of self harm or suicidal ideation. The Author of the submission from the Probation Service was clear that Michelle's emotional self-management was linked to her offending behaviour.

Clinical Commissioning Group (from the 1st of July 2021, NHS Greater Manchester Integrated Care (HMR))

4.29 Michelle first registered with her GP practice in December 1994. During the last three years of the scope of the Review, Michelle was in regular contact with the Practice and attended the surgery on at least 16 occasions for appointments with the GP or Practice Nurse.

4.30 In May 2019, Michelle attended a GP appointment for help with low mood. Between mid June 2019 and the end of October 2019, Michelle attended a total of 8 appointments, 4 medication and sick note reviews, 1 routine health check and 3 appointments for the management of a treatable skin condition.

4.31 On the 2nd of January 2020, the GP Practice received notification from North Manchester General Hospital A & E that Michelle, whilst under the influence of alcohol, had been the victim of an assault. The GP was asked to review her case but Michelle was not seen until the 4th of February, 32 days after the notification, when she attended an appointment with concerns about an infected finger. No discussion of the assault was recorded as having taken place during this appointment.

4.32 Michelle attended a further GP appointment, on the 5th March 2020. She told the GP that she was feeling low and anxious. She denied having any suicidal thoughts and the GP notes indicated that she was living with her boyfriend at this time, who she described as 'supportive'.

4.33 Shortly after this last appointment, due to the management of the COVID Pandemic, general practices implemented predominantly remote consulting via telephone, video or online consultation platforms.

4.34 On the 19th of March 2020, during a telephone consultation, Michelle requested a repeat prescription of antidepressants and told her GP that she was feeling a little better.

4.35 As noted in the chronology (page 25), Michelle's GP, on the 29th of March 2020, received notification of the Section 136 detention and received a discharge summary letter from Royal Oldham Hospital. The Practice also received a MARAC notification on the 6th of October 2020.

4.36 Michelle had telephone appointments or face-to-face appointments with her Practice in April, June and July 2020. These appointments focused upon the management of physical health conditions and not on allegations of incidents of domestic abuse.

4.37 On the 4th of August 2021, the practice received a further notification that Michelle had been referred to MARAC and approximately 1 month later, the Practice received a notification that Michelle had died in Hospital.

Rochdale Adult Social Care (ASC)

4.38 Adult Care was involved with Michelle between February and May 2016. There was no further contact with Adult Care for approximately three and a half years until the 27th of November 2019, when Adult Care attended MARAC. Adult Care recorded on their system that at this time the IDVA service had attempted to contact Michelle. However, the alleged perpetrator, Michelle's Partner, was answering her phone. The Probation Service made a referral to Children's Services and Michelle was referred to Turning Point. There was no other information regarding the reason for the referral to MARAC nor were there any actions recorded for Adult Care.

4.39 As noted in the chronology (see page 23), on the 2nd of January 2020, Adult Care received an ambulance report from NWAS. Over the following four days, Adult Social Care made a number of attempts to contact Michelle, without success.

4.40 ASC also attempted to make contact with Michelle on the 14th of January 2020, again without success. Adult Care contacted the police on the 20th of January 2020 who e-mailed that their last update was from the 11th of November 2019 when they had served a DVPO to Michelle's Partner. However, at the time they had been unable to contact Michelle. Consequently, as described in the chronology on page 24, on the 22nd of January 2020, Adult Care made an unannounced visit to Michelle.

4.41 Adult Social Care, as noted in the chronology (on page 25), was aware of the incident at the end of May 2020 leading to Michelle being taken to Fairfield Hospital subject to a Section 136 Order.

4.42 On 06 July 2021, Adult Care attended the HRDM meeting where Michelle's case was discussed. It was reported at the meeting that after separating from her Partner, Michelle went to collect her belongings from the property (as noted

in the chronology on page 28). Michelle's Partner became verbally abusive and assaulted Michelle. Michelle declined further action from Police and the Court.

4.43 On the 27th of August 2021, Adult Care attended the HRDM where Michelle's case was discussed. Michelle had been physically assaulted by her Partner on the 25th of August. The outcome of the meeting was for the IDVA to make contact with Michelle and offer further support and the case was scheduled to be heard at MARAC on the 29th of September 2021. It was documented that Michelle was staying with S1 at this time.

SafeNet

4.44 Michelle resided in the Rochdale refuge – managed by Safenet, from 27/07/2017 to 20/10/2017. The IDVA service offered Michelle the opportunity to be referred into the Refuge in July 2021, but Michelle declined the offer.

North West Ambulance Service

4.45 NWAS had two face-to-face contacts with Michelle. On both occasions, Michelle was transported to hospital. On one occasion, Michelle was offered the opportunity to be referred as a safeguarding concern, but she declined the offer.

4.46 There were three further incidents recorded by NWAS whereby their attendance was cancelled by the Police – who were in attendance and were transporting Michelle to a S.136 facility or when Michelle had declined the offer of Paramedic support.

Section 5
Responses to the Key Lines of Enquiry

It is important to note that the responses set out below are determined by the line of enquiry and the agencies that were able to respond to the enquiry. If an agency (listed elsewhere in this report) had no pertinent or noteworthy comment to make, then no response is offered in this section.

The DHR Panel approved the inclusion of nine (9) 'headline' key lines of enquiry (KLOE) for this Review and twenty nine (29) supplementary lines of enquiry. For the ease of reading, the headline enquiries have been repeated within this section of the Report.

A. To establish what contact agencies had with Michelle

Safenet

5.1 Michelle was referred into Safenet Rochdale refuge by a member of staff from the Rochdale Council Neighbourhood Team on the 27th of July 2017. Michelle moved into refuge on the same day.

5.2 Whilst residing in refuge, Michelle was being supported by a member of staff from the Outreach Development Service in Rochdale. Michelle was on training courses as she wanted to gain employment as a forklift truck driver. Michelle told Safenet that one of her children had asked Children's Social Care for contact with her so she had 'letter-box' contact with them. The child was 11 years old at that time.

5.3 The reason why Michelle was in the Refuge was because she was fleeing a perpetrator of abuse (not Michelle's Partner). Michelle disclosed physical violence, controlling and jealous behaviour and that her partner had been lacing her cigarettes with 'spice'.

5.4 Whilst in the Refuge, Michelle disclosed she had been in the Rochdale refuge prior to 2017 but Safenet have no information regarding this as they did not hold the contract prior to 2017.

5.5 Michelle moved out of the refuge on the 20th of October 2017 into a new tenancy. There was no further contact with Safenet.

Adult Social Care

5.6 Michelle first became known to Adult Services on the 2nd of February 2016. The contact in 2016 concerned Michelle being homeless. Efforts made at this time to engage with Michelle were not successful. It was recorded by Adult Social Care that Michelle was staying with a friend and declined the offers of support.

5.7 During 2020, Adult Social Care made a number of attempts to contact Michelle (as described in the chronology on page 24) and in June 2020 they did speak to Michelle on the phone, following her S.136 hospital discharge. Michelle declined any support from Adult Care.

5.8 Adult Social Care was aware that Michelle was subject to domestic abuse because of their attendance at the meetings (described below) where Michelle was discussed. However, despite making efforts to engage, Adult Social Care was not directly involved with Michelle during this time:

- 27 November 2019 - MARAC
- 18 March 2020 – MARAC
- 16 November 2020 – HRDM
- 6 July 2021 – HRDM
- 27 August 2021 – HRDM

5.9 There were no Mental Health issues concerning Michelle disclosed to Adult Social Care during the scope of this Review. Adult Social Care noted that Michelle was assessed by a GMP Doctor on the 30th of May 2020 (as a part of the S.136 procedure) and no evidence of mental illness was diagnosed.

5.10 Whilst there were no complex care and support needs known to Adult Care, the Panel noted the view shared by Adult Social Care that, taking account of the nature of the contacts since 2016, Michelle had a difficult, multi-disadvantaged and abused history.

5.11 In the time period for the review, Adult Care only managed to speak to Michelle once and on that occasion she declined all support from Adult Care so no risk assessments could be undertaken and Adult Care could make no referrals to other agencies.

5.12 Adult Care did recognise Michelle's vulnerability caused by her trauma and made efforts to follow up calls, contacting the police and GP for their latest contact details and also undertook unannounced home visits in an attempt to engage with her.

Greater Manchester Probation Service

5.13 Michelle was known to the Community Rehabilitation Company (CRC) on 3 separate occasions, following conviction at Court for 2 separate matters in 2016 and 2019. Michelle did not fully comply with the requirements of the 2019 Order and, following a period of over 12 months on warrant, a third period of supervision on a suspended sentence order was imposed. This occurred two months prior to her death.

5.14 It was evident from the information provided by the Police that Michelle had been the victim of domestic abuse over a period of time. This was documented as a significant factor (alongside a record of substance misuse) underpinning the decision to transfer the care of her children into the local authority.

5.15 During the period 2019 to 2021, Michelle disclosed that she was a victim of continued abusive behaviour, perpetrated by her Partner. Police information provided to the CRC supported these allegations. Michelle was actively flagged on the probation system as the victim of domestic abuse. MARAC information detailed the efforts at engagement by a named IDVA and support from the 'placed-based' services.

5.16 Information from the Offender Assessment System (know as OASys) concerning Michelle did not provide any detailed analysis of her mental health issues, and there was no record of any enduring mental illness. However, Michelle reported that she had spoken to her GP about anxiety and it was clear to the service that alcohol had a significant impact on her emotional self-management. The Public Order and S.39 assault offences were both committed when Michelle was under the influence of substances.

5.17 Michelle's health and support needs were responded to by a number of agencies in this case, notably the local Community Centre (referred to earlier) and Petrus (as described elsewhere in this Report). This was in accordance with the needs and risks Michelle presented to the service with. The case management notes indicated that addressing factors linked to her own needs were key to driving Michelle's resistance to offending.

5.18 The author of the submission from NPS was not able to locate on record any assessment of Michelle's decision making capacity, particularly her misuse of alcohol and its effect upon her. In the view of the author of the submission, alcohol can be used as a maladaptive coping mechanism. In this case, routes into constructive activity and support around Michelle's alcohol use were present, as were specific support services to respond to her experience of victimisation (most notably, the IDVA).

5.19 Based on the fact that Michelle was a victim of sustained domestic abuse, she was viewed by the service as vulnerable. Coupled with this, of course, it should be noted that the children of Michelle had all been removed from her care.

Greater Manchester Police (GMP)

5.20 During the period of the review, GMP had numerous contacts with Michelle. This included a total of 20 incidents, 21 reports of crime and 12 domestic abuse/care plans. From the records held by GMP, Michelle was, predominantly, the victim of violence.

5.21 Whilst attending one particular incident (see the chronology on page 25), GMP noted that Michelle had told her Sibling (and later the attending officers) that she had thoughts of suicide and mental health problems and at this incident Michelle was detained by officers under Section 136 of the Mental Health Act.

5.22 The author of the submission from GMP noted that Michelle had complex needs. Her alcohol dependence and poor mental health were recorded in nearly all incidents. Michelle experienced domestic abuse in previous relationships and appeared to have had a chaotic lifestyle with instability in her housing and financial security, often finding herself in rent arrears and struggling to buy food and pay her utility bills. Her engagement with some agencies appeared to be sporadic, with her view being quite clear that on some occasions that she did not wish to receive support from certain agencies. There were a number of attempts from partner agencies to support Michelle, including a referral to Turning Point (who attempted to encourage Michelle to seek help

for her alcohol dependence) and contact from the IDVA and support from Rochdale Borough-wide Housing with her rent arrears.

5.23 Assessments of risk were completed with Michelle on those occasions when she co-operated with the officers who attended each incident. The author of the submission from GMP noted that Michelle, occasionally, refused to provide details. Whilst appropriate referrals were made, the author identified that there were some opportunities to discuss Michelle's case at MARAC which, on four occasions, did not happen. However, when the MARAC referrals did not occur as they should have done, the incidents were always discussed at the High Risk Daily Meeting (HRDM) and this multi-agency arrangement did share information and identified actions to try and offer support to Michelle and manage her risks.

Northern Care Alliance NHS Foundation Trust

5.24 Michelle attended the services of the A&E department in December 2019 (for treatment following an assault – see the chronology on page 23):; in January 2020 (for treatment for an assault – see the chronology on page 23); in May 2020 (as a part of the S.136 procedure – see the chronology on page 25) and then the critical incident in August 2021.

5.25 There were 3 occasions documented when Michelle reported that her injuries were a result of domestic abuse. However, there was no clear record concerning who the alleged perpetrator was. On every admission into A&E, Michelle was brought in by the police and therefore no DASH was completed by Healthcare staff as the assumption was made that the police had completed the DASH and referred onto the MARAC or other appropriate arrangement. The rationale for this course of action was that the police were the first responders to the Domestic Abuse incidents.

5.26 The Author of the submission from the NCA Trust noted a number of incidents that they considered were particularly pertinent to provide further context for the Review. These are described below:

- On the 21st of October 2014 Michelle attended the A&E Department at Fairfield General Hospital (FGH). It was recorded as an incident of drug abuse causing delirium and Michelle was recorded as a victim of domestic abuse. Michelle was found by a passer by and brought to the department with multiple bruising. Michelle self-discharged from the Hospital and left the department without treatment;
- On the 10th of September 2016, Michelle attended FGH following a concern for welfare following a suspected overdose. Michelle was found near a wall asking for help and brought to A&E.
- On the 16th of November 2016, Michelle attended Rochdale Infirmary and reported pain in her left elbow and stated that she had fallen two weeks ago. The Infirmary recorded a 'suspected fracture' and completed an X-ray. Conservative advice was given on discharge.

5.27 There was no documentation on the NCA records that stated any formal diagnosis of any mental health issues. However, there was reference to a medical history of anxiety and alcohol dependence. The GP summary record

highlighted significant alcohol consumption from January 2000 and there was a history of depression recorded from March 2020. The only reference to contact with specialist mental health services was documented on Michelle's admission to FGH on the 30th of May 2020 (at this incident, Michelle was transferred to the Section 136 Suite at Oldham for a Mental Health Act assessment).

5.28 There were no documented referrals or evidence that conversations were held with Michelle concerning support from any agency regarding her alcohol consumption. There was evidence in the records that Michelle was referred to mental health services to receive assessment and support, but no evidence that Michelle engaged with these services.

Clinical Commissioning Group

5.29 Michelle was in regular contact with her GP Practice, and in the three years leading up to the critical incident, Michelle attended the surgery on at least 16 occasions for appointments with the GP or Practice Nurse. Research conducted by the University of Manchester[17] indicates that, for all patients, the average number of GP appointments is around eight each year so attendances by Michelle were in this average range.

5.30 Michelle did not make any direct disclosure of domestic abuse to GP practice staff. The NICE guidelines state that staff should be alert to patients with symptoms which indicate a risk of domestic abuse (NICE)[18]. As a woman, Michelle was already at increased risk of experiencing domestic abuse. She presented on multiple occasions with low mood, sleep problems and traumatic injury and had reported at least two physical assaults and one incident of self-harm to her GP. These are all significant indicators which should have prompted direct and sensitive enquiries about domestic abuse. In addition, the practice received a range of correspondence from other agencies, including a A&E attendance notification from North Manchester Hospital on the 2nd of January 2020, a letter from Pennine Care Foundation Trust on the 29th of May 2020, two A&E attendance notifications from Fairfield General Hospital on the 30th of May and 10th of November 2020 and MARAC notifications on the 6th of October 2020 and the 4th of August 2021.

5.31 Setting aside her mental health needs, Michelle had no long-term health conditions or disabilities requiring support.

5.32 The only recorded use of a formal risk assessment within the timeframe was by the Healthcare Assistant on the 29th of May 2019. This was the alcohol use disorders identification test (AUDIT-C). This is an alcohol screening tool that can help identify patients who are hazardous drinkers or have active alcohol use disorders. Women who score 3 or higher drink above recommended limits and are at increased risks for harm. Michelle scored 5/12 when screened, however, there is no evidence within the record of advice or referral being offered.

[17] Please refer to the hyperlink for further information: University of Manchester

[18] Please refer to the hyperlink for further information: symptoms which indicate a risk of domestic abuse (NICE).

5.33 Michelle's low mood/depression was monitored via consultations which took place on the 23rd of May 2019, the 10th of June 2019, the 9th of September 2019, the 5th of March 2020 and the 19th of March 2020 and records indicate that during three of these consultations the GP completed a check to confirm that Michelle had no suicidal ideation. During the consultation on the 23rd of May 2019, Michelle told the GP that she was accessing counselling but by the 10th of June, she felt that this was not helping. There is no evidence within the timescale of this review, that the option of counselling was raised again with Michelle.

North West Ambulance Service

5.34 The crew who attended Michelle, following an alleged assault in January 2020, did not document who the alleged assailant was. However, NWAS crew would not be expected to investigate the allegation, particularly because the Police were already on scene at this particular incident.

5.35 NWAS documented that on the final contact with Michelle, she was reporting to be a victim of domestic abuse. The attending crew noted that Michelle had a global headache, blurred vision due to bilateral bruises and was unable to open her jaw and she had bruising to the right side of her abdomen. Once again, the Police were already involved in the response to this particular incident.

5.36 NWAS had no documented disclosures from Michelle concerning her mental health.

5.37 In all face-to-face contacts with Michelle, NWAS transported Michelle to hospital for appropriate care and support.

B. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Michelle.

Adult Social Care (ASC)

5.38 Following a reported assault in January 2020, between the 2nd and 14th of January 2020, ASC made 6 attempted phone calls to Michelle. Whilst an "unable to contact" letter was sent to Michelle during this period, an unannounced visit was also made to her home on the 22nd of January 2020 in an attempt to check on her welfare and offer support. Whilst the attempted phone calls were timely and appropriate, an earlier cold call visit may have been appropriate.

5.39 In June 2020, following the S.136 detention, Adult Care discovered Michelle had been discharged from that Hospital with no destination details. Adult Care contacted Michelle's GP surgery in an attempt to obtain an up to date contact number for Michelle. ASC then managed to speak to Michelle and she advised the service that she was at the home of her Sibling. Michelle declined any further support. However, it is recorded that Michelle told the member of staff that she did not have any gas or electric and would not be paid until the 27th of

June. Michelle declined to take the Adult Care contact number for future reference.

5.40 Whilst an Adult Care worker attended two MARAC meetings and three Hight Risk Daily Meetings where Michelle's case was discussed, there was no indication in the case records that Michelle had the appearance of care and support needs. No other agency raised any issues that would suggest a duty for Adult Care to undertake a Care Act assessment.

Greater Manchester Probation Service

5.41 A referral for welfare provision and support for Michelle was pursued by OM1 and these issues were discussed within the induction appointment and during supervision between Michelle's Offender Managers. These referrals also included a referral for advocacy in respect of the domestic abuse Michelle was enduring. It is unclear from the NPS record if consideration was given to speak with the IDVA (referred to in the actions from the meetings of the MARAC and the HRDM).

5.42 With regard to trauma informed interventions, no specialist support services were referred to by NPS. However, Michelle spoke of having discussed anxiety with her GP. The record does not document any work undertaken by the probation practitioners to identify factors precipitating substance misuse by Michelle. However, assumptions of trauma could be made based on Michelle's domestic abuse history, the loss of her children and the adversity linked to the ongoing nature of harm she experienced.

Greater Manchester Police

5.43 Safeguarding measures were considered for Michelle. Additionally, Michelle's Partner was arrested on several occasions, which was good practice. These arrests took place even though Michelle had indicated that she did not support the action the police had chosen to take. Officers applied for and obtained a Domestic Violence Protection Order and on one occasion Michelle's Partner was charged with assault. This was later discontinued by the CPS at court. In all incidents reported, it was correctly identified that Michelle was a high risk domestic abuse victim. Michelle was referred to MARAC twice but there were other opportunities to refer her to MARAC in line with the repeat referral criteria which was not completed. As noted earlier in this Report, however, GMP recognised that:
'*the Rochdale High Risk Daily Meeting is a good model and shows good oversight of managing risk to high-risk Domestic Abuse victims.*

5.44 Michelle was referred to MARAC and the HRDM on several occasions. These referrals had limited results as Michelle declined to engage with them. For example, on two occasions the HRDM noted that Michelle declined to assist any prosecutions. The IDVA sought to contact Michelle and when contact was successful, the IDVA offered appropriate support which was declined by Michelle.

Northern Care Alliance NHS Foundation Trust

5.45 There is evidence within the health care record which clearly documents the reasons for Michelle's admission (domestic abuse by her partner). However, further enquiry and professional curiosity does not appear to have been exercised and there was a failure to complete the DASH. One possible reason for this was that Michelle attended the A&E department in the presence of the police and there may have been an assumption that the DASH would have been completed by GMP. This was the assumption on every admission. Additionally, of course, it should be noted that A&E is an environment focused upon time limited and short-term interventions that address a specific clinical presentation. A&E records reflect this format and do not always easily lend themselves to recording a more complete account of other Social and Environmental factors that may have an impact on the individual patient.

Clinical Commissioning Group

5.46 Michelle did not make any direct disclosure of domestic abuse to GP practice staff and her mental and physical health needs remained the focus of all appointments. Information shared by other agencies, which included MARAC notifications, were not consistently coded and flagged on the patient record and there appeared to be little or no recognition of other risk indicators. Consequently, no action was taken by the practice to safeguard Michelle.

North West Ambulance Service (NWAS)

5.47 NWAS did not identify any lessons to be learnt in the way care was provided to Michelle. The final contact with Michelle was at the home of her Sibling and all information provided was relayed either by Michelle directly or by her Sibling. At one contact, where allegations of abuse were shared, the crew were informed that police were already involved due to the nature of the incident (domestic violence).

5.48 NWAS provided appropriate safeguarding for Michelle on one occasion, following an allegation of assault. The safeguarding concern had been shared with the duty officer from Adult Social Care. Michelle was then transported to hospital and relevant details were shared with hospital staff.

C. To establish what contact agencies had with Michelle's Partner. (Note the caveat described in the introduction to the key lines of enquiry)

THE PANEL HAS NOT RECEIVED CONSENT TO SHARE INFORMATION HELD ABOUT MICHELLE'S PARTNER BY THE AGENCIES IN CONTACT WITH THEM.

D. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for Michelle and Michelle's Partner. (Note the caveat described above)

Greater Manchester Probation Service

5.49 Any reference to Michelle's Partner is missing from the information contained in probation records, with the exception of being named as an alleged

perpetrator against Michelle. There is minimal recorded discussion of Michelle's Partner with Michelle.

5.50 With regard to Michelle, NPS noted the extensive history of victimisation, a propensity to reconcile abusive relationships, and being vulnerable to becoming engaged in unhealthy relationships. These elements were key to Michelle's longer term safety. The Author of the submission also noted that there may have been residual trauma stemming from the removal of her children and this may have had an impact on her actions, especially given that alcohol and drug misuse were a dominant factor in assessing parental capability. In the view of the Author of the submission, Michelle showed a desire to seek attachment, given the intimate relationships she quickly developed. There is no evidence within the Probation record to show any work being undertaken to assess or address this matter.

Greater Manchester Police

5.51 The Police records show that officers attended eleven reports of domestic abuse between Michelle and Michelle's Partner. The overriding themes recorded are that Michelle did not want to assist the police and declined to support any prosecutions. In most of the cases, officers recorded that the couple were separated, or were no longer in a relationship. Michelle's Partner was arrested on four occasions and Michelle on one occasion (not including her detention under S.136 of the Mental Health Act). Opportunities were missed by GMP to identify Michelle as a victim of coercive and controlling behaviour by her Partner. During the relationship there was evidence that Michelle was not able to communicate with professionals (and this was possibly as a result of actions by her Partner), and agencies could have explored options to enable her access to a telephone. Appropriate referrals were made to partner agencies and the Rochdale HRDM.

5.52 The safeguarding measures taken by GMP in the immediate aftermath of incidents did keep the couple apart and therefore, in the short term, they were effective. The arrest of Michelle's Partner resulted in only one case appearing at court and this did not result in a conviction. Michelle's Partner was also made subject of a DVPO. The lack of positive results in the other cases was due, in large part, to Michelle declining to support the judicial process. The ability to prosecute offences without the support of the victim is, of course, available. However, in these cases there wasn't the required corroborative evidence to be able do so.

E. To establish whether there were other risks or protective factors present in the lives of Michelle or Michelle's Partner. (Note the caveat described)

Adult Social Care

5.53 It has been reported – elsewhere in this Review – that Michelle relied on her Partner financially. It was known from police reports that Michelle had issues relating to alcohol use and drug use. It is clear that S1 was a supportive factor for Michelle, despite not living locally.

5.54 The Panel did note that Michelle did have a close personal friend – referred to in this Review as F1 – who submitted an account of their friendship with Michelle.

Greater Manchester Probation Service

5.55 It is documented that Michelle's family were a protective factor. However, there is no evidence that contact was made with Michelle's Sibling or an examination of how they may have supported her to keep her safe[19]. According to the Author of the submission, there is little doubt they would have been aware of Michelle's relationship history and abuse (at least due to the removal of the children from Michelle's care). The only contact noted is when the family telephoned to advise of Michelle's inability to attend for an appointment given an alleged assault by Michelle's Partner.

Greater Manchester Police

5.56 As noted in the chronology both Michelle's Partner and Michelle lived with the difficulties associated with alcohol and drug use. Michelle had a history of domestic violence with a number of partners. The records indicate that this was driven, in part, by the use of alcohol by the aforementioned partners. Michelle also had a history of mental health problems and, as noted elsewhere, was subject to a S.136 detention.

5.57 GMP was aware that Michelle told her sibling of domestic abuse and Michelle's Sibling reported two incidents of abuse. The Sibling of Michelle also provided a place of safety for Michelle to stay.

Northern Care Alliance NHS Foundation Trust

5.58 It appears from the evidence provided that Michelle had vulnerabilities that extended beyond the time period of this review. Of particular note was the removal of her children in 2010, the traumatic life events concerning abuse and assault by her partners, and the periods of her life when she was dependent upon drug and alcohol use.

5.59 There was no documented evidence in the health records that Michelle made any disclosures to staff that she had informed her family or friends about domestic abuse.

North West Ambulance Service

5.60 NWAS was not aware of any other issues that may have increased the risk or vulnerability of Michelle. During one face-to-face contact, following an alleged assault, the crew were concerned and documented a safeguarding concern for Michelle's welfare. Michelle was exhibiting clear signs of panic on this contact and had been drinking alcohol and she declined the offer for this safeguarding concern to be shared with Adult Social Care. Due to the seriousness and personal nature of the allegation, it was best practice to transport Michelle to hospital for treatment for the immediate health concerns and then allow

[19] It is important to note from the chronology that during the times when Michelle stayed with her sibling, there were no significant incidents reported and no incidents of abuse or assault.

Michelle to address the particular nature of the allegations once she was settled in a safe and secure environment.

5.61 NWAS does not hold any information in relation to Michelle disclosing Domestic Abuse to her friends and family. NWAS was told about domestic abuse on the final contact with Michelle. At this contact, Michelle was staying with her Sibling. It should be noted that NWAS do not hold a caseload for any patients, hence, any disclosures are dealt with in a timely manner at each contact. At this final contact, as noted, Michelle declined a safeguarding concern offered by the NWAS crew.

F. To establish whether agencies have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

5.62 All of the agencies in contact with Michelle – including NWAS, General Practice, NCA, Adult Social Care, NPS, GMP and others had appropriate and contemporary policies in place for safeguarding, escalation of concerns, whistle-blowing, and many others matters.

5.63 The services also deliver various levels of training concerning safeguarding, domestic abuse and the escalation of concerns.

5.64 The Panel did note the type and range of procedures in place, but highlighted that, on occasion, not all of these procedures were executed or executed effectively at various points of contact with Michelle.

5.65 The Northern Care Alliance NHS Foundation Trust (NCA) noted that emergency departments are usually the first point of contact when patients attend due to consequences or injuries from events where domestic abuse has occurred. Management of urgent health needs is usually a presenting priority, closely followed by protection and safety planning for those involved. A DASH risk assessment needs to be completed with the individual in a safe place. As noted previously, this is often a challenge for staff, particularly when they are managing other emergency situations within high pressured busy areas.

5.66 From an internal governance process, the NCA – including Fairfield General Hospital – have strengthened the SAR/DHR arrangements to include divisional sign off of actions resulting from such Reviews and these are audited through the internal safety summit.

G. To identify clearly what the lessons to learn are, and how (and within what timescales) they will be acted upon.

Adult Social Care (ASC)

5.67 The ASC noted a number of lessons that can be learnt from this Review. They are explored more fully under the section concerning the scrutiny of key events (later in this report). In brief, these key points include:

- The application of the safeguarding criteria (particularly following receipt of domestic violence disclosures) contained within Section 42 of the Care Act;

- Adult Care workers should record domestic abuse reports received from GMP or NWAS on the adult care management system as a safeguarding concern. This is so the Care Act s42(1) criteria can be applied. A "responding to Domestic Abuse" procedure will help cement this expectation";
- An assessment of the risk caused by the domestic abuse should take place and actions with associated appropriate timescales commensurate to the level of risk should be clearly articulated;
- Actions from other agencies offered at MARAC and at the High-Risk Daily Meeting (to examine cases of domestic violence) were not recorded on the individual's case management information system. A procedure is needed about recording expectations following a worker's attendance at such meetings. This should be robustly shared with assessment workers and their managers;
- Increased awareness of the Domestic Abuse strategy and materials on Domestic Violence should be shared with all staff;
- Within Adult Care, concerns about Michelle were dealt with on duty, with different officers picking this case up on a daily basis in January 2020 and May/June 2020. Rochdale Adult Care, as part of their front door/duty review, should consider allocating cases promptly to a named worker when safeguarding concerns are indicated within referrals to the service.

Greater Manchester Police

5.68 Further safeguarding training needs to be provided to officers dealing with and supporting vulnerable adults. A planned training programme to do this is due to commence in November 2022.

5.69 GMP are to remind Triage Officers of the necessity to refer repeat victims back to MARAC when the criteria for repeat referrals to MARAC are met, notwithstanding their referral to other multi-agency arrangements.

Northern Care Alliance NHS Foundation Trust (NCA)

5.70 The NCA noted that a number of measures have already been implemented to enable front line staff to recognise and respond to domestic abuse. These are reflected in the single agency action plan of the NCA and, briefly, include the following:

- The Adult and Children Adult Level 1/2 training programme is to be undertaken by all staff members across the NCA. This programme of training includes reference to domestic abuse and advises front line staff on internal policies and procedures, response/referral processes to multi-agency partners when Domestic Abuse has been identified;
- Adult and Children Level 3 Safeguarding training has extended the cohort of staff who are required to undertake this level of training as per the intercollegiate document. From November 2022 all registered staff members will have the Level 3 adult and children attached to their mandated training matrix. The NCA mandated training matrix is incremental and therefore all staff undertake this training and Domestic Abuse is a core element within the training programme. Additionally, the adult and children Level 3 training is aligned with Health Education England Core Skills Framework, offering a consistent training programme aligned nationally across the NHS;

- Both Corporate and Internal governance processes have recently been strengthened to ensure organisational sign off with respect to formulated actions and learning from SARs and DHRs. The strengthened oversight arrangements are reviewed via an internal safety summit to ensure the learning is held within the Organisation with dissemination across a wider footprint;
- FGH have recently recruited a hospital based IDVA which is to be piloted across the estate for a 12-month period. Early indications offer a positive response from A&E with a number of enquiries referred to this service;
- The NCA have recently increased the domestic abuse resource with the recruitment of a domestic abuse lead, with a view to offering further bespoke Domestic Abuse training sessions across the NCA.

H. To recommend to organisations and partners of all agencies any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

5.71 The Rochdale Adult Social Care service noted the following:

- For all partner agencies to consider, in all domestic abuse cases, whether the victim has care and support needs and if so, to refer directly to Adult Care for a needs assessment;
- For all partners to be aware of the national framework for what constitutes a safeguarding concern where there are concerns about abuse and neglect, which includes domestic abuse[20];
- For all partners agencies to consider making domestic abuse training mandatory within their own organisations to improve shared responses to domestic abuse victims.
- Information sharing between hospitals and neighbourhood teams should improve

I. To understand the impact of the COVID-19 Pandemic and address any improvements to service delivery.

Greater Manchester Probation Service

5.72 The EDM in place within the Community Rehabilitation Company and probation service allowed for extensive contact with Michelle and it is clear that a welfare considered approach was taken by other agencies who remained in contact with her during this period. However, oversight and verification of alcohol consumption levels was not fully documented, nor was there any review of the significance of this on her behaviour. It may be the case that, due to the non-commission of further offences or her disclosures of controlled consumption, attention was distracted from escalating this for more intensive treatment routes.

Greater Manchester Police

5.73 Since the Covid 19 Pandemic, GMP has found that referrals into MARAC have increased significantly and concerns have been raised by partner agencies

[20] Please refer to this hyperlink: Understanding what constitutes a safeguarding concern and how to support effective outcomes (local.gov.uk)

regarding how to respond to this increased demand. GMP's Public Protection Governance Unit is working with the Greater Manchester Combined Authority (GMCA) concerning the MARAC process.

Northern Care Alliance NHS Foundation Trust

5.74 During the initial phase of the management of the Covid–19 Pandemic, the NHS/NCA Accident and Emergency Department had robust partition arrangements in place to prevent the nosocomial spread of COVID infections. These arrangements had a significant impact on staffing levels with staff working in both contaminated and non contaminated areas. The NHS and the Trusts within it were operating on reduced staff levels due to staff members contracting COVID themselves or having to isolate due to family members being infected with the virus. The impact of the COVID-19 legislation requirements, particularly for those infected with the virus, resulted in long periods of staff absence. Additionally, the NHS experienced a significant increase in the number of hospital admissions and an increased mortality rate. The management of COVID–19 continues to exert an impact on the NHS with a number of front line staff experiencing post traumatic stress due to the nature of the virus and witnessing patients dying without their loved ones being able to be present.

5.75 During this period the NCA Safeguarding Service anticipated an increase in domestic abuse, and the team offered a "business as usual" model, visiting wards and departments to ensure that DASH risk assessments were completed and forwarded to MARAC, as appropriate.

Clinical Commissioning Group

5.76 From the start of the pandemic, the impact of COVID-19 on primary care, and those working within it, was significant. In a letter on 5th March 2020, NHS England advised practices to move to a 'total triage' access model, using a combination of telephone, online, and video consultations. However, it was acknowledged that some face-to-face contact remained necessary. By the first months of the first lockdown, data from 'NHS Digital' shows that, after dropping considerably in April 2020, the total number of GP appointments started to pick up from June 2020 (with the end of the first national lockdown) By September 2020, the number of GP appointments was broadly in line with figures for the previous year.

Section 6

Good practice

Greater Manchester Police

6.1 The use of the DVPO was good practice. Safeguarding measures for Michelle were considered and put in place. Additionally, Michelle's Partner was arrested on several occasions which is good practice. These arrests took place even though Michelle had indicated at the point of arrest that she did not support police action. Officers also applied for and obtained a Domestic Violence Protection Order and Michelle's Partner was charged with assault on one occasion, but this was later discontinued by the CPS at court.

6.2 In all incidents reported it was correctly identified that Michelle was at a high risk of domestic abuse.

Northern Care Alliance NHS Foundation Trust (NCA)

6.3 The NCA noted a number of examples of good practice, briefly described below:

- Michelle's home circumstances were discussed at one attendance at Fairfield General Hospital and she reported that she lived with her boyfriend and there were no children in the property.
- A password was put in place on Michelle's record, specifically for information sharing purposes.

6.4 The NCA also informed the Panel that Fairfield General Hospital (FGH) are piloting the presence of an IDVA within the A&E department to support staff when managing patients who are victims of domestic abuse.

NWAS

6.5 During a face-to-face contact following an alleged assault, the crew were concerned and documented a safeguarding concern and a concern for welfare. The crew noted that Michelle was very 'panicked' on this contact and had been drinking alcohol. Due to the seriousness and nature of the allegation, it was best practice to transport Michelle to hospital for immediate treatment and then allow Michelle to address any issues once settled in a safe and secure environment.

HRDM

6.6 The Panel noted that the Rochdale High Risk Daily Meeting is a good model and shows good oversight of managing risk to high-risk Domestic Abuse victims. There is good, documented evidence of the meetings taking place, who attended and information that was shared and actions being allocated to agencies. Michelle was always referred to the IDVA Service, provided by Victim Support in Rochdale, despite some of the incidents not being referred to the MARAC. The IDVA sought to contact Michelle on a number of occasions and when contact was successful, the IDVA offered appropriate support, though this was declined by Michelle.

The IDVA Service

6.7 It was noted by the Panel that the IDVA – at the invitation of both the MARAC and the HRDM – made numerous attempts to contact Michelle. Their perseverance was commendable and, despite the offer they eventually made to Michelle being declined, they did refer Michelle to 'Energy Works'.

Energy Works

6.8 This service is hosted by 'Groundworks' and, at the invitation of the IDVA service, they made contact with Michelle and assessed her financial situation. They noted that Michelle had received a significant bill for the treatment of her dog and, as a consequence, did not have sufficient money to pay her utility bills (electricity and gas). Energy Works helped Michelle to pay these bills and attempted to contact her again when the window for applications for the Warm Homes Discount opened. However, by this time, Michelle had sadly passed away.

The local Community Centre and Petrus

6.9 Michelle attended these services and received support from them when she was referred there by the Greater Manchester Probation Service. The local community centre and Petrus provides support to people who are homeless or at risk of becoming homeless. It is apparent from the submissions received via the NPS that Michelle achieved a period of significant stability when she was in contact with these services and benefited from the support they provided.

Section 7

Lessons learnt from this case by the agencies submitting information.

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are some of the lessons learnt that have been identified by the agencies that had contact with Michelle and/or Michelle's Partner.

These lessons and the matters raised by the scrutiny of the Panel helped to refine the emerging themes and the action plans agencies will be expected to address at the end of this Review. The lessons learnt and any opportunities perceived to have been missed are set out agency by agency.

7.1 Rochdale Borough Council – Adult Social Care.

7.1.1 For the Adult Social Care service, this review highlighted that there were a number of missed opportunities, gaps in practice and a clear lack of written documentation. This has highlighted a number of key lessons to be learned, ranging from improvements in practice, more complete documentation, greater multidisciplinary working. Learning these lessons will ensure that a consistent response is applied to cases of domestic abuse. Recommendations from these lessons are reflected in the Recommendations section later in this Report.

7.2 Greater Manchester Integrated Care (Heywood, Middleton & Rochdale - HMR)

7.2.1 For the CCG (now referred to as the NHS Greater Manchester Integrated Care HMR), there are a number of conclusions to be drawn from the Review, including:

- An ongoing need to raise GP awareness of what constitutes effective record keeping, including detailed narratives of key discussions with patients, the outcome of risk assessments, the recording of information from third-party sources and the consistent use of alerts. The author of the submission noted that is important to stress that if a discussion or assessment is not documented, it must be assumed that it never happened;
- All primary care staff, including administrative staff, need to continue to improve their confidence in recognising and responding to domestic abuse;
- There is a need to improve the understanding of MARAC processes within primary care;
- There is a continuing need to promote the importance of direct, sensitive enquiry when patients present with indicators of domestic abuse;
- A template domestic abuse policy should be made available to all GP Practices across HMR.

7.2.2 Specific recommendations are described in the single agency action plan from the ICB and, where appropriate, reflected in the recommendations made later in this Report.

7.3 Greater Manchester Police (GMP)

7.3.1 GMP had many contacts with Michelle during the review period, with one such contact, shortly prior to her death, being the subject of an investigation by the Professional Standards Branch (PSB).

7.3.2 Following the death of 'Michelle', GMP referred themselves to the IOPC. The IOPC determined that further investigation should be conducted at a local level by the PSB.

7.3.3 An investigation was conducted and a report was prepared. The conclusion of that investigating officer, as described in the submission received from GMP, is described below:

"Individual Learning
I have not identified any individual learning as a result of my investigation
Unsatisfactory Performance
Unsatisfactory performance means an inability or failure of a police officer to perform the duties of the role or rank they are currently undertaking to a satisfactory standard or level.
During the course of this investigation, I have not identified any officer whose performance was deemed to be unsatisfactory.
Standards of Professional Behaviour
I have not identified any GMP police officer or member of GMP police staff, who has committed any criminal offence, nor have I found any that behaved in such a way that fell below the required levels of professional standards or any that is so serious as to justify disciplinary action".

7.3.4 This case demonstrates the difficulties faced by GMP, and other partners, when victims of domestic abuse decline to engage with the criminal justice system. The Panel did note, however, that on occasion, Orders and Prosecutions were obtained without Michelle's engagement.

7.3.5 GMP will share within the Rochdale District, the learning that has been identified by all of the agencies involved in this Review. Particular emphasis will be placed upon ensuring that opportunities to refer to MARAC are completed when referral criteria are met.

7.3.6 To supplement the advice from this Review, Police Officers will be reminded that when responding to an allegation of a sexual offence, where a person is alcohol dependent, early liaison should take place with the on-call Doctor at the Sexual Assault Referral Centre to seek advice in facilitating a forensic examination. It will be underlined that intoxication should not delay a forensic examination.

7.3.7 In terms of ongoing safeguarding training for frontline officers, the Panel was informed that in November 2022, GMP began to deliver a large-scale domestic abuse training programme, called "Domestic Abuse Matters". This is a College of Policing approved training programme. It is intended that this will further enhance the skills and knowledge of officers to respond to domestic abuse and

the support required by victims who report to GMP. Additionally, the Panel was informed that during 2020, GMP delivered training to all frontline officers on National Crime Recording Standards (NCRS) with a particular focus on the correct identification of Controlling and Coercive behaviour and Stalking and Harassment Offences. This was in response to recommendations from (at that time) Her Majesty's Inspectorate of Constabularies, Fire, and Rescue (HMICFRS).

7.4 The Northern Care Alliance NHS Foundation Trust (NCA)

7.4.1 The NCA Trust noted that there was evidence of missed opportunities for further enquires to be made directly with Michelle and for referrals to be made by health staff concerning the particular presentations at A&E by Michelle. In particular, enquiries and referrals could have been pursued concerning the disclosure by Michelle that her injuries were a result of domestic abuse and violence.

7.4.2 Additionally, discussions could have taken place (and been documented) with Michelle concerning a referral to specialist Alcohol and Substance misuse services. A referral to the drug and alcohol service could have provided an alternative safe space for Michelle to discuss her ongoing trauma.

7.4.3 The NCA Trust were aware that Michelle experienced traumatic events in her life and professional curiosity could have been exercised by health staff and, at appropriate points, a DASH/RIC could have been completed as a tool to support this conversation.

7.4.4 The Panel noted that the NCA has supported their Safeguarding Team to provide significant assistance to front line staff to support victims of domestic abuse. This includes the extension of staff groups mandated to undertake the Adult and Children Safeguarding Level 3 training (which contains an element that addresses domestic abuse as part of the programme).

7.4.5 In addition to the above, the Panel noted that the NCA has increased the resource within the Safeguarding team to support staff to respond to domestic abuse, and the Panel noted that the NCA has recruited a hospital based IDVA.

7.4.6 Specific recommendations are described in the single agency action plan from the Northern Care Alliance NHS Foundation Trust (a number of which have already been subject to action since the critical incident occurred) and, where appropriate, they are reflected in the recommendations made later in this Report.

7.5 Greater Manchester Probation Service (NPS)

7.5.1 NPS noted that Michelle had endured domestic abuse for over a decade. Her children had been removed from her care – partly as a as a result of this abuse, coupled with periods of dependency on alcohol or other substances. The Author of the submission could find no documented records to describe whether these problems were present prior to her having children or whether they occurred as a result of her abuse.

7.5.2 The author of the NPS submission concluded that NPS practitioners worked in a way that aimed to develop Michelle's level of self-efficacy and self worth. However, the Author noted that there was nothing documented in the records to highlight any significant attempts to engage her in safety planning or reviewing the impact of her continued abuse. It may have been the case that there was more exploration of the factors impacting upon Michelle being unable to extract herself from abusive relationships and sustain her independence, but this was not clearly documented.

7.5.3 The records held by the Probation Service provide evidence of a desire to keep Michelle engaged in supervision, escalated during those periods when Michelle was inclined to dis-engage. Specialist women's service provision was sought, but it was difficult to see from the record what the impact of these services were for Michelle, who continued to engage with abusive partners and consume alcohol. The extent of the problematic nature of her alcohol use was not fully documented, and it is possible that this was more significant than reported.

7.5.4 With the exception of self disclosed anxiety (information she shared with her GP), there was no evidence of self harm or suicidal ideation on the NPS record. With regard to 'risk to self', there was no reporting during the periods of supervision of feeling low or wishing to take her own life, nor any attempts to take an overdose. Referral for peer mentoring and approaches taken to support Michelle were clearly made (they were evident on the electronic record) and this was considered as a clear attempt to develop a foundation to be able to address her offending behaviour. Michelle did not fully comply with the attempts made to engage with NPS and whilst attempts were made to re-engage her attendance, it remained sporadic.

7.5.5 The Author of the submission noted that there was a lack of contact with any family members. This would be done to ascertain the support network available to Michelle, especially when Michelle reported that she had ended the relationship with her Partner. The Panel did note that, when Michelle was staying with S1, there were significant periods in the chronology when Michelle's life was relatively stable. Nevertheless, for NPS, there was no recorded discussions concerning the protective strength of family support.

7.5.6 Two actions are described in the NPS single agency action plan and, where appropriate, these are reflected in the recommendations made later in this Report.

7.6 NWAS

7.6.1 Whilst participating in the Review and completing their IMR, NWAS noted that it appeared to them that little was known about Michelle's Partner and their relationship with Michelle. It is not clear to NWAS which agencies knew of the relationship and/or whether Michelle had received any support around Domestic Abuse.

7.6.2 NWAS did not know that Michelle had experienced domestic abuse until the final contact they had with her. NWAS noted that, in their experience, victims of

domestic abuse may not disclose the abuse for a number of reasons, including being in a pre-contemplation stage regarding any disclosure.

7.6.3 NWAS recommended that the panel consider accessibility to domestic abuse services and the ease with which self-referral to these services can occur.

Section 8
Scrutinising events and incidents and identifying emerging themes.

This section of the Overview Report is a consideration of the responses to a number of key incidents described by what the services knew about Michelle, the responses to the key lines of enquiry, coupled with observations from the Panel.

The Panel considered the key elements from the aforementioned sections of the Report for some time in order to distil the information shared by the agencies during and prior to the formal scope of the Review.

This consideration illuminated a number of complex points upon which the circumstances that led to Michelle's death seem to turn. These points are not in any order of priority.

Introduction

When considering this Review for Michelle, the Panel noted that a number of agencies – GMP, Social Care Services, NPS and others – recorded an extensive history of victimisation and abuse, a propensity to reconcile abusive relationships, being vulnerable to developing further unhealthy relationships, and enduring trauma were key characteristics in the life of Michelle and had an impact on her longer term safety. The Author of the submission from NPS also noted that there may have been residual trauma stemming from the removal of her children and this may have had an impact on her actions, especially given that alcohol/drug misuse was a dominant factor in assessing parental capability.

8.1 Michelle's mental health and the actions of agencies to recognise it

8.1.1 Michelle was a repeat victim of domestic abuse and violence. GM Police and GM Probation Service noted a number of previous partners abused Michelle and were violent towards her. The Panel recognised that evidence suggests that poor mental health can either effect domestic abuse or be a significant risk factor for victimisation[21].

8.1.2 From the information submitted to the Panel, Michelle had a clear history of episodes anxiety or depression, and this was raised by her when consulting her GP on more than one occasion and may have coincided with particular incidents. F1 noted that when Michelle's parent passed away, Michelle became anxious and depressed and, for a period of time, was homeless. The Panel noted that on one reported occasion, Michelle's Sibling contacted the Police because, during one incident with Michelle's Partner, they were concerned about Michelle's mental health. The Police attended the scene of the incident and noted that Michelle declined to be taken to Hospital and declined the offer of attendance of a Paramedic. Consequently, the Police removed Michelle to a place of safety under Section 136 of the Mental Health Act.

8.1.3 Michelle clearly had difficulty with her dependence upon alcohol. There were periods when Michelle expressed a desire to control her alcohol dependence.

[21] See Trevillion, et al, 2012, published by Safe Lives in 2015

8.1.4 In 2019, Michelle attended an appointment with her GP and discussed that she lived alone, was feeling low, crying for no reason and was having difficulty sleeping. The GP confirmed that Michelle was not experiencing any suicidal thoughts and that she was seeing a counsellor at MIND. An anti-depressant was prescribed. During this consultation, the GP did record that Michelle lived alone. The author of the CCG (Greater Manchester Integrated Care – HM&R) submission considered whether this led to an assumption that she was not at risk of domestic abuse[22].

8.1.5 In early 2020, Michelle attended another appointment with her GP and told the GP that she was feeling low, anxious and having difficulty sleeping. The GP asked Michelle about suicidal thoughts, illicit drug use and alcohol consumption. No suicide ideation or drug use was noted. The GP recorded a note stating: 'lives with boyfriend – supportive'. Whilst there was a clear focus on mental health in this consultation, there was no evidence of professional curiosity around Michelle's claim that she had punched herself in the face and the previous history and underlying causes were not considered or addressed.

8.2 Assessing risk (DASH/RIC) and recording abuse and vulnerability

8.2.1 During the scope of the Review, Michelle was discussed at the MARAC (or the High Risk Daily Meeting) on six separate occasions.

8.2.2 The Panel received a clear description of which agencies attended each MARAC, or HRDM, the actions that were defined for each agency, and whether these actions were completed.

8.2.3 On the 2nd of January 2020, Michelle's GP Practice received a notification from North Manchester General Hospital that Michelle, whilst under the influence of alcohol, had been the victim of an assault. The GP was asked to review her case, but Michelle was not seen until the 4th of February, 32 days after the notification. When Michelle attended the appointment with concerns about an infected finger, no discussion of the assault was recorded as having taken place during this appointment.

8.2.4 Michelle attended her GP Practice in July 2021 and, whilst taking blood, the Health Care Assistant noted bruising to the upper part of Michelle's right arm. Michelle said that the injury was caused by a fall from a push bike. The author of the CCG submission noted that, as there were no safeguarding alerts or domestic abuse flags on Michelle's record, the Health Care Assistant recorded the details in line with expected practice, but this would not have alerted the GP. Further, on 6th October 2020, a MARAC notification was received by the GP Practice. The letter was added to patient record but no coding was added to highlight that Michelle was a victim of domestic abuse.

8.2.5 The Northern Care Alliance NHS Foundation Trust (NCA) noted three occasions when Michelle reported that her injuries were a result of domestic abuse. However, there was no clear record concerning who the alleged

[22] It is important to note that the Domestic Abuse Act and post separation abuse are now included in GP training.

perpetrator was. The NCA noted that on every admission into A&E, Michelle was brought in by the police and therefore no DASH was completed by Healthcare staff because the assumption was that the police had completed the DASH and referred Michelle onto the MARAC. The rationale for this was that the police were the first responders to the Domestic Abuse incidents.

8.2.6 In their submission, the NCA acknowledged that, due to the consequences and/or injuries from incidents of domestic abuse, emergency departments are usually the first point of contact when patients attend. The Panel acknowledged that the management of urgent health needs is clearly a presenting priority, closely followed by protection and safety planning for those involved. The NCA stated that, in accordance with usual procedure, a DASH risk assessment needs to be completed with the individual in a safe place, and the person needs to be willing and safe to disclose the details. However, this is often a challenge for staff managing other emergency situations within a high pressured busy areas.

8.2.7 The Greater Manchester Police noted that they missed opportunities to clearly identify Michelle as a victim of coercive and controlling behaviour by her Partner. As previously noted, during the relationship, there was evidence that Michelle was not able to effectively communicate with professionals (and this was possibly a result of actions by her Partner), and agencies could have explored options to enable her access to certain resources, for example, a telephone. However, appropriate referrals were made to partner agencies and to the Rochdale MARAC and HRDM.

8.2.8 In their submission to the Panel, the Adult Social Care service noted that the necessary Care Act S.42 safeguarding criteria was not applied on the receipt of any Domestic Violence disclosures. They noted that staff in Adult Social Care should record domestic abuse reports that they receive from GMP or NWAS on the adult care management system and that this should be recorded as a safeguarding concern[23].

8.3 Hearing the voice of Michelle at the MARAC and the HRDM

8.3.1 The Panel received information that described the multi-agency arrangements that exist to discuss the circumstances encountered by clients at high risk of domestic violence, and to respond appropriately to those circumstances. There is the MARAC, the High Risk Daily Meeting and the Rochdale Multi-Agency Adult Safeguarding Team (MAAST) – though this has a far wider remit than domestic abuse and Michelle was referred into the MAAST arrangement only once. There was acknowledgement that the HRDM is an example of a good model for inter-agency working and offers good oversight of the management of risk to high-risk victims of domestic abuse.

[23] An assessment of the risk caused by the domestic abuse should take place and actions with associated appropriate timescales commensurate to the level of risk should be clearly articulated. The Manager should hold the responsibility to ensure that actions are followed up in a timely manner and escalate where there are difficulties.

8.3.2 Additionally, there is good documented evidence of the MARAC meetings that took place, who attended those meeting, the information that was shared and the actions that were agreed and allocated to each agency[24].

8.3.3 The Panel concluded that in all incidents reported it was correctly identified – either at the time of the report, or by the HRDM – that Michelle was a high risk victim of domestic abuse.

8.3.4 Michelle was referred to MARAC and the Daily High Risk Domestic Abuse meeting on several occasions. These referrals had limited results as Michelle declined to engage with the services and support offered to her as a result of the actions agreed by the meeting. On two occasions the High Risk Daily Meeting recommended that Michelle would not be referred to MARAC and the actions were pursued by the HRDM.

8.3.5 The author of the GMP submission noted that Michelle was always referred to the IDVA Service, provided by Victim Support in Rochdale (whether via the MARAC or the HRDM). The IDVA sought to contact Michelle and when contact was successful, the IDVA offered appropriate support, which was declined by Michelle.

8.3.6 In their submission to the Panel, the Adult Social Care Service noted that the actions from other agencies discussed at MARAC and the HRDM meeting were not recorded on the individual's case management information system. The ASC stated that makes it difficult for staff to know which agencies are involved and what support they are offering, should the individual be re-referred or re-present to Adult Care. Adult Social Care have suggested that a procedure is needed concerning the recording of expectations following staff attendance at such meetings.

8.4 Engaging with Michelle

8.4.1 Rochdale ASC attempted to make contact with Michelle on a number of occasions. Frequently, their efforts to make contact with Michelle were unsuccessful (telephone messages would go to voicemail and on one occasion M1, Michelle's Partner at the time, answered her telephone). On each occasion, contact details were left with Michelle for the locality team.

8.4.2 The ASC did inform the Panel that, albeit infrequently, this difficulty was magnified because opportunities were missed to share information across the adult care team and share the case-load. For example, when discharging Michelle, an opportunity was missed by the hospital to refer to a Social Worker or an IDVA to meet with Michelle and discuss support and safety prior to discharge.

8.4.3 In their submission, NPS (this is the Greater Manchester Probation Service) noted that Michelle was referred to a number of different agencies, but noted that there was minimal follow up outside of the MARAC and/or the HRDM. For

[24] The MARAC Operating Protocol was revised and updated by the GMP (the Police Service) Public Protection Governance Unit in September 2020. It is over 50 pages long and is available upon request.

example, there does not appear to have been very much contact with the family of Michelle who were viewed as supportive. For NPS, this is most notable after Michelle failed to attend an appointment on the 26th of August 2021, and a member of Michelle's family reported that Michelle had been assaulted by her Partner. The next time NPS heard about Michelle, it concerned a notification of her death.

The Panel did note that the Greater Manchester Probation Service (or, as it was known at the time of the contact, the Community Rehabilitation Company), Petrus (an independent agency providing support to people who are, or at risk of becoming, homeless), Energy Works (part of the Groundworks Trust), Greater Manchester Police (GMP) and the IDVA service were particularly responsive to Michelle's needs.

With regard to GMP (the Police Service), the Panel noted that at almost every incident they attended, Michelle was noted to be at high risk of domestic abuse. GMP submitted a number of DAB records (Domestic Abuse Investigation Records) and a care plan – a requirement when clients are recorded as living with a mental health difficulty (in this case, for example, when Michelle was detained under Section 136 of the Mental Health Act).

It is also the case that when the High Risk Daily Meeting (HRDM) in Rochdale discussed Michelle's case, they noted that she would occasionally struggle with her alcohol consumption (Turning Point[25] did offer support when invited to contact Michelle by the HRDM). The HRDM also noted that Michelle reported that she was struggling financially and had reported to her GP (and members of her family) that she was struggling with her mental health.

These examples did cause the Panel to reflect upon why Michelle may have engaged with some service and not others. Whilst recognising that such issues are not uncommon in Domestic Homicide Reviews, it is noteworthy that in this case it appears that Michelle engaged when the contact was more direct and/or clearly focused – for example, the NPS (Probation Service) are required by law to exercise the actions they take; GMP (the Police Service) likewise; and when Petrus and Energy Works had contact with Michelle, they had one clear objective in mind that, in the view of the Panel, would not cause Michelle the anxiety of whether their actions would lead to something over which she had no control.

8.5 Professional curiosity and the application of NICE Guidance

8.5.1 The Panel acknowledged that symptoms of depression, anxiety, suicidal tendencies or self-harming and alcohol or other substance misuse are common indicators of Domestic Abuse and should trigger a concern in health care staff and prompt them to enquire about domestic abuse.

8.6.2 The Panel sought assurance from each NHS service to determine if the relevant NICE guidance was applied.

[25] Turning Point is a specialist drug and alcohol treatment service operating across Greater Manchester. Michelle declined the support offered.

8.6 Enduring abuse and violence and the reluctance to pursue prosecution

8.6.1 From the submissions received it appears that Michelle may have been subjected to control and coercion and was subjected to domestic violence and abuse for more than a decade. Incidents of abuse occurred before she was in a relationship with her Partner prior to the incident (referred to abbreviation as M1).

8.6.2 The Panel noted a familiar pattern that, following allegations of assault, Michelle would often be reluctant to provide a statement in order to support the process of prosecution and would not encourage the Police to arrest her Partner (and when Michelle was violent towards her Partner, they declined to support a prosecution).

8.6.3 Following the incident in March 2020, a DASH assessment was completed and a DAB investigation commenced. The following record submitted by GMP (from a Detective Inspector) was noted by the Panel:
'*I do not believe there is sufficient information to support a realistic prospect of conviction based on the evidence obtained so far. The victim does not support a prosecution. Referrals have been completed. There are not believed to be other sources of evidence that will strengthen the case'*.

8.6.4 NPS (*the Probation Service*) raised the issue of evidence led prosecutions. In their submission to the Panel, Greater Manchester Police noted that the lack of positive results in the other cases was due, in large part, to Michelle declining to support the judicial process. The ability to prosecute offences without the support of the victim is, of course, available. However, in these cases there wasn't the required corroborative evidence to be able do so. GMP shared with the Panel the recently completed Domestic Abuse Policy, which contains advice on evidence led prosecutions and refers to the guidance issued by the College of Policing.

8.6.5 There was one event noted by the Panel, referred to in the submission made by the NPS. The event concerned assisting Michelle to make contact with the Domestic Violence help-line and to then explore the possibility of applying for a non-molestation order against her Partner. This was discussed at a planned appointment in mid-August. Michelle's next planned appointment was cancelled – the Probation Service had received a call that Michelle had been assaulted by her partner and was not able to attend. Shortly afterwards, the Probation Service received notification that Michelle had died.

8.7 Supporting victims with complex needs

8.7.1 We know that a successful pathway for a client is dependent on the willingness of the client to follow through on the actions agreed with them at the time. When clients do not attend (DNA), this can create a barrier to help, particularly when a client is motivated one day but then is fragile and changes perspective the next.

8.7.2 Generally, having an enhanced multi-agency response to complexity would, potentially, improve outcomes for clients who live with domestic abuse. There

may be scope to consider initiatives such as 'Team Around Me' and/or a 'Multiple Disadvantage Outreach Service' – initiatives which are being developed by other areas besides Rochdale.

8.8 Financial pressure and dependence

8.8.1 In may 2020, the NPS (*the Probation Service*) noted that Michelle had maintained weekly contact with the mentoring and case management support service until this date. At this point, Michelle told staff that she was having to stay with her Partner at their home address because she had run out of benefits and did not have enough money to put her own electricity on.

8.9 The removal of Michell's children from her care

8.9.1 Michelle lived with a number of complex difficulties, including episodes of depression and anxiety, the use of alcohol and other substances, and, of course, Michelle was the victim of domestic abuse and violence by a number of partners.

8.9.2 The Panel learnt that in 2010, or thereabouts, when Michelle was living with an abusive partner (not her Partner prior to the incident), the Rochdale Children's Social Care Service removed her children from her care and the children became looked after by the local authority. Michelle had four children at this time and the removal of the children arose because of a combination of domestic abuse (where Michelle was the victim), and alcohol use. This combination posed a significant risk to the children. F1 in their submission noted that Michelle loved her children and this event traumatised her. The Panel has no doubt that this is true. As noted by F1, it was the case that, as time passed, Michelle's children began to make contact with her and re-entered her life. The Panel was cognisant of the fact that this dynamic was managed my Michelle, her children and the father of her children[26].

[26] The Panel invited the Children's Social Care (CSC) Service in Rochdale to check their records concerning support for Michelle during this period. The Development Officer (Domestic Abuse), who was a member of the Panel, identified that Michelle had been offered support at the time (to assist in establishing contact with her children) and the date of the last offer from CSC was recorded as June 2021. Michelle declined these offers of help and support.

Section 9
Conclusion

9.1 The Domestic Homicide Review Panel that completed this Review recognised, of course, that this Review concerned an apparent suicide. In these circumstances, where no homicide had occurred, the Greater Manchester Police and the specialist staff from Victim Support were not in a position to allocate resources to support Michelle's family and her friends. Consequently, in comparison to other Domestic Homicide Reviews, there was no direct face-to-face contact with an experienced professional who could introduce the Domestic Homicide Review process to Michelle's family. This placed the Panel in the position of making direct contact (via a variety of routes) with Michelle's family and friends and inviting them to participate in the Review. Setting aside the effort made by the Panel to make a mindful introduction to the process, it was, nevertheless, an invitation that was received 'out-of-the-blue'.

9.2 Michelle died in Hospital in August 2021. The Pathologist noted that her death was a result of an overdose of paracetamol. The Greater Manchester Police investigated the circumstances leading to the death of Michelle and concluded that there was no third party involvement in her death. However, there was evidence to suggest that Michelle was the subject of controlling and coercive behaviour and had made allegations of abuse and violence prior to her death.

9.3 When considering this Review for Michelle, the Panel noted that, when working with Michelle, a number of agencies recorded some key characteristics, including an extensive history of victimisation and abuse, a propensity to reconcile abusive relationships, being vulnerable to developing further unhealthy relationships, from time to time, being dependent upon alcohol and enduring trauma (stemming from the removal of her children). These factors had an impact on Michelle's longer term safety.

9.4 It is documented that Michelle's family were a protective factor. However, there is no evidence that contact was made with Michelle's Sibling or an examination of how they may have supported her to keep her safe. The Panel noted that, during the times when Michelle stayed with her Sibling, there were no significant incidents reported and no incidents of abuse or assault. The Panel concluded that there is little doubt they would have been aware of Michelle's relationship history and at least a number of incidents of abuse, if not all of them.

9.5 A close friend of Michelle assisted the Review by providing information about Michelle – allowing the Panel to understand who Michelle was and what she was like in life. The friend, referred to as F1, told the Panel that Michelle loved her dog, that she would prioritise food for her dog over her own, that she was described by many as the 'life and soul of the party', that she was always fearless in everything she did and with the challenges she faced in her life.

9.6 F1 told the Panel that losing her children (they were removed from her care in 2010) was devastating for Michelle. F1 said that they felt Michelle had been let down by the services who removed the children and didn't offer support when it was needed.

9.7 The Panel noted that not all of the agencies working with Michelle appeared to be cognisant of the full picture of her life. The majority of services were aware of the complexity surrounding Michelle, of her vulnerability, her occasional dependence on substances and were aware of the allegations of abuse. The Panel did note the submission from Rochdale Adult Care that recorded that they had attended two MARAC meetings and three High Risk Daily Meetings where Michelle's case was discussed. The outcome of these attendances, however, did not indicate in the case records that Michelle had the appearance of being eligible for any care and support needs under the relevant legislation. Additionally, no other agency raised any issues that would suggest a duty for Adult Social Care to undertake a Care Act assessment.

9.8 Whilst this is undoubtedly significant, it should also be noted that when the Adult Care services made contact with Michelle and offered support, she declined all attempts to engage her in the services offered.

9.9 The Panel also noted that, on a number of occasions, Michelle's GP completed a number of important consultations with Michelle that were focused upon her mental health (specifically, anxiety and depression and suicidal ideation). Michelle's GP may have concentrated so intensely on these matters, that other complexities – most notably allegations of assault – may have been missed.

9.10 By way of example, On the 2nd of January 2020, the GP Practice received notification from North Manchester General Hospital that Michelle, whilst under the influence of alcohol, had been the victim of an assault. The GP was asked to review her case but Michelle was not seen until the 4th of February, 32 days after the notification. No discussion of the assault was recorded as having taken place during this appointment. The Panel also noted that in March 2020, the Practice received notification of the Section 136 detention, and notification from MARAC on the 6th of October 2020. During appointments with the Practice in June and July 2020, allegations of domestic abuse were not discussed.

9.11 The Panel noted that Michelle was perfectly open and willing to engage with services. For example, Michelle had – in 2017 – spent some time in the Refuge managed by Safenet (Rochdale). Coupled with this, she received support from the local Community Centre and Petrus and the submission from NPS demonstrated that these times of Michelle's life appeared to be the most stable and fulfilling. In these places, Michelle developed aspirations and a desire to manage her consumption of alcohol. With regard to this final matter, the submission from NPS noted that the extent of the problematic nature of Michelle's alcohol use may not have been fully documented by all of the agencies she was in contact with, and it is possible that this was, therefore, more significant than reported. The NPS record did not document any work undertaken by probation practitioners to identify the factors that may have precipitated Michelle's substance misuse.

9.12 The Panel did note that at the end of June 2021, the IDVA service (hosted by Victim Support) offered Michelle the opportunity to move into a Refuge. However, Michelle declined the offer. No clear reason was given, but – at the

risk of giving the impression of being superficial – considering other Reviews, having a pet appears to have a significant bearing upon a client's willingness to enter a refuge.

9.13 A theme within this Review – and replicated in other DHRs – was, following reports of abuse, a reluctance to support the process of prosecution. Consistently, Michelle declined to support the Police when they expressed a desire to pursue a prosecution of her Partner. As noted in the Report, the Greater Manchester Police did pursue a 'evidence led prosecution' but this was discontinued by the CPS because it did not meet the required threshold.

9.14 This was a tragic case for the Panel to review. The information considered by the Panel described a woman who had been subjected to abuse and violence for more than 10 years and whose circumstances became so grievous to endure, she may have decided to take her own life.

9.15 Michelle was the Mother to four children and a Grandmother to one child and the Panel offer their condolences to Michelle's family and her friends.

Section 10
Rationale and Recommendations

These DRAFT recommendations have been developed from a synthesis of the scrutiny of the submissions, the lessons learned and the themes identified during the process of consideration by the Panel. These Recommendations are not in any order of priority.

10.1 **The Panel recommends**:

That the Rochdale Safer Communities Partnership (SCP) is assured that a process is in place to identify "domestic abuse victim suicides";

That the Rochdale Safer Communities Partnership (SCP) share the learning from this DHR with the Greater Manchester Bereavement Service;

That the Rochdale Safer Communities Partnership (SCP) supports the recommendations from the National Confidential Inquiry into Suicide and Mental Health (NCISH) research findings and works with the local Suicide Prevention service, the GM Bereavement Service and the local Public Health lead for suicide prevention to raise awareness of these findings.

The Panel encourages the SCP to support the local delivery of the following elements from the NCISH research:

- That clinicians become aware of the suicide risk of patients living with domestic abuse/violence;
- That any assessments of suicide risk undertaken by the commissioned mental health services should include direct and sensitive professional curiosity about violence in the home;
- GPs should be encouraged to consider violence in the home when engaging in consultations concerning suicidal ideation;
- That the family of the person who has taken their own life is identified and bereavement support is offered to the family of the victim as soon as practicable.

That the Rochdale Safer Communities Partnership (SCP) identify examples of other statutory Reviews where residents have taken their own life and note the recommendations made by these Reviews and aim to make the Recommendations from both Reviews inter-operable

10.2 **The Panel recommends:**

That the Rochdale Safer Communities Partnership (SCP), with support from the Adult Social Care Service, ensures:

- That in all domestic abuse cases, where the victim has care and support needs, to refer the client directly to Adult Care for a needs assessment;
- That Rochdale Adult Care, as part of their front door/duty review, to consider promptly allocating such cases to a named worker when safeguarding concerns are indicated within the referral to the service;
- Adult Care workers record domestic abuse reports received from GMP or NWAS on the adult care management system as a safeguarding concern.

This will ensure that the Care Act s42(1) criteria can be applied. A "Responding to Domestic Abuse" procedure will help cement this expectation.

10.3 The Panel recommends:

That the Rochdale Safer Communities Partnership (SCP), with the support of Adult Social Care, should ensure that all partners are aware of the national framework for what constitutes a safeguarding concern (where there are concerns about abuse and neglect, which includes domestic abuse). This can be located at: Understanding what constitutes a safeguarding concern and how to support effective outcomes (local.gov.uk)

That the Rochdale Safer Communities Partnership (SCP), with the support of Adult Social Care, should be assured that procedures are in place to assess the risk caused by incidents of domestic abuse, and that any actions are clearly articulated.

The Rochdale Safer Communities Partnership (SCP) should be assured that the ASC Manager holds the responsibility to ensure that actions are followed up in a timely manner and can escalate concerns where there are difficulties with delivery of those actions.

That the Rochdale Safer Communities Partnership (SCP) is assured that there is a clear procedure for recording expectations following an officer's attendance at meetings such as the MARAC, MAAST, HRDM, etc. This procedure should be shared with assessment staff and their managers.

That the Rochdale Safer Communities Partnership (SCP), with the support of the Safeguarding Board(s) and Adult Social Care, review the content of the safeguarding training – and other forms of awareness raising for staff – that is currently provided and aim to encourage providers to ensure that their training programme includes:

- The utilisation of the Rochdale Council Intranet resources concerning Domestic Abuse;
- The Domestic Abuse Strategy, and guidance aimed at 'Understanding Risk In the context of Domestic Abuse';
- Identifying perpetrators of domestic abuse and the management of risk;
- Proactively addressing the link between domestic abuse and suicide

The Rochdale Safer Communities Partnership (SCP) should seek assurance from the Greater Manchester Domestic Abuse Board that the mapping exercise undertaken in June 2021 to identify the application of NICE Guidance PH50 and Quality Standard 116 contains no outstanding concerns or gaps.

Taking account of the learning from this specific Review, the Rochdale Safer Communities Partnership should work with the Safeguarding Board(s) and explore the possibility of providing safeguarding training – as an enhancement to their Level 3 Safeguarding training programme – to include staff from both Adult Social Care and Children's Social care

10.4 **The Panel recommends**

That the Rochdale Safer Communities Partnership (SCP) works with HM&R Integrated Care and seeks assurance that:

- The Local Care Organisation (LCO)[27] can ensure that all practitioners, including those within the Primary Care Networks, can fulfil their statutory safeguarding duties; and
- That the Rochdale Safer Communities Partnership seeks assurance from the LCO that the learning and recommendations from this review will be embedded into practice

10.5 **The Panel recommends:**

That the Rochdale Safer Communities Partnership (SCP), with the support of the ICB, ensures that independent practitioners (i.e., General Practitioners and other independent contactors) are aware of their safeguarding duties;

That the Rochdale Safer Communities Partnership (SCP), together with the NHS Greater Manchester Integrated Care (HMR), emphasise and promote awareness and application of NICE Quality Standard 116 and NICE Guidance PH50 within all primary and NHS secondary care settings in Rochdale

That the Rochdale Safer Communities Partnership (SCP) supports the NCA to assess the impact of the bespoke Domestic Abuse training sessions across the NCA being delivered by the lead officer for domestic abuse in that NHS Trust

10.6 **The Panel recommends:**

That the Rochdale Safer Communities Partnership (SCP) supports the NCA to assess the impact of the following training programmes:

- The Adult and Children Level 1/2 safeguarding training programme being undertaken by all staff across the NCA. This programme of training includes reference to domestic abuse and advises front line staff on internal policies and procedures, and response/referral processes to multi-agency partners when Domestic Abuse has been identified
- The Adult and Children Level 3 Safeguarding training will be extended. From November 2022 all registered staff members will have the Level 3 adult and children training attached to their mandated training matrix. Additionally, the adult and children Level 3 training is aligned with Health Education England Core Skills Framework offering a consistent training programme aligned nationally across the NHS.

[27] Local Care Organisations (LCOs) are public sector partnership organisations that provide NHS community health services and adult social care services with the NHS and local authority working as one team. The hyperlink - One Rochdale Health and Care :: Northern Care Alliance gives the details of the Rochdale Local Care Organisation. The LCO has a Business Plan, a Board and an Independent Chair who are responsible for delivering actions agreed with the LCO.

That the Rochdale Safer Communities Partnership (SCP) supports the NCA to assess the impact of the recently recruited hospital based IDVA which is to be piloted across the estate for a 12-month period. Early indications offer a positive response from A&E with a number of enquiries referred to this service. It is recommended that the evaluation of this service should be coupled with the evaluation of the Hospital IDVA service provided for the Wigan, Wrightington and Leigh NHS Foundation Trust by Manchester University

10.7 **The Panel recommends**

That the Rochdale Safer Communities Partnership (SCP) seek assurance that trauma informed training is rolled out across the Borough of Rochdale and that trauma informed practice is embedded within all commissioned services.

That the Rochdale Safer Communities Partnership (SCP):

- Notes the outcome of the Trauma informed Practice (TiP) launch event that occurred on the 18th of May 2023 and the pledge made by key stakeholders to become 'Trauma Informed Rochdale';
- Ensure that the TiP training provided across the key stakeholder system is consistent and accords with an agreed set of service standards;
- Review the current provision of TiP training being provided by the Mental Health Team and evaluate the impact of the training on the practice of the cohort of staff who have received the training to date;
- Considers the available evidence from other Districts and proposes the most effective and efficient model for the provision of TiP training to satisfy the pledge made by key stakeholders.

Single agency action plans

Name of Agency: Adult Care, Rochdale Borough Council,	IMR Report Writer: Serious Incident Review Officer, Adult Care
Name of the Victim: Michelle	

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1	Improved responses to ensure Domestic Abuse cases are dealt with efficiently and timely from the initial receipt of them.	To create a "Responding to Domestic Abuse procedure" which should include the expectation that Adult Care workers should record all domestic abuse reports as a safeguarding concern. The procedure should also provide guidance on timescales to follow up with further calls, letters and visits in initial contact is unsuccessful.	Procedure 'Responding to Domestic Abuse' in place	Improved efficient responses to Domestic abuse cases.	TBC	Mar 2023
3	An assessment of risk should take place in all situations relating to domestic abuse and actions with	Briefing to Adult Care staff to ensure all DA contacts are recorded on ALLIS as a safeguarding concern	Audits demonstrates that risk assessments are evident in cases where DA is a feature.	Quicker identification of risk level ensuring that it is managed appropriately.	TBC	Sept 2023

	associated appropriate timescales commensurate to the level of risk should be clearly articulated.	so that a risk assessment can be completed on ALLIS which has oversight by the team manager.				
4	To improve recording on ALLIS following a practitioner's attendance at MARAC and High Risk Domestic Abuse panel meetings	A procedure is needed about recording expectations following a worker's attendance at MARAC and High Risk Domestic Abuse panel meetings The procedure should be robustly shared with assessment workers and their managers.	Audit demonstrates that multi agency actions from MARAC and High risk DA panel are recorded on SU case record.	Improved understanding of multi- agency involvement in individual cases by all Adult Care workers accessing the care record	TBC	Dec 2022
5	Improved knowledge amongst Adult Care staff regarding domestic abuse.	All Social care Staff to attend Domestic Abuse training as a mandatory requirement.	Numbers of staff attending DA training	Staff will be more confident in recognising and responding to Domestic Abuse	PSW and Strategic Safeguarding Lead	July 2023
6	Improved consistency of response for victims of Domestic Abuse.	Rochdale Adult Care, as part of their front door/duty review, to consider allocating cases promptly to a named worker safeguarding concern	INT Managers to allocate such cases accordingly.	This will ensure a streamlined response to DA victims and provide ownership in regards to required actions.	INT Managers	March 2023

		referrals indicate safeguarding concerns.				

Name of Agency: HMR CCG/GM ICS	IMR Report Writer: Alyson Harvey
Name of the Victim: Michelle	

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	That training delivered by HMR CCG to all GP Practices across the borough is updated to include learning from this review.	Updates to level 3 safeguarding training package. Delivery of Domestic Abuse webinars: Domestic Abuse recording and information sharing	Number of Primary Care Staff attending training and training evaluation. GP Challenge visits evidence the impact of training.	Consistent and comprehensive record keeping across GP Practices, ensuring appropriate continuity of care and an integrated response.	Alyson Harvey	Complete
2.	Administrative staff in primary care should receive domestic abuse training which is appropriate to their role, including recognition of risk indicators in third party information, coding and flagging, MARAC pathways	Development and delivery of domestic abuse training for administrative staff in GP Practices.	Number of Primary Care Staff attending training and training evaluation. GP Challenge visits evidence the impact of training.	Consistent and comprehensive record keeping across GP Practices, ensuring appropriate continuity of care and an integrated response.	Alyson Harvey	Complete

	and electronic access to records.					
3.	That a domestic abuse policy template is included within the HMR CCG Domestic Abuse Toolkit for primary care.	Domestic abuse policy template developed and shared with GP Practices across HMR	Percentage of HMR GP Practices that adopt the policy	Primary Care staff understand their roles and responsibilities in relation to domestic abuse and patients receive effective support.	Alyson Harvey	September 2022
4.	Ongoing work is needed to embed and evaluate the effectiveness of the HMR CCG MARAC information sharing pathway, which commenced from 01.10.21.	Standard Operating Procedure developed and shared with GP Practices. Training sessions on the pathway delivered to GP Practices.	Quarterly reporting in place Number of Primary Care Staff attending training and training evaluation		Alyson Harvey/Nick Gainsborough	October 2022

Name of Agency: Rochdale Borough-Wide Housing Services	IMR Report Writer:
Name of the Victim: Michelle	

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Quality assurance of safeguarding cases	Safeguarding coordinator to monitor open cases	Template designed to ensure consistency and provide constructive actions for employees	Clear actions set Consistent approach to safeguarding cases	V Wardleworth	ongoing
2.	Make different attempts and approaches to engage tenants	Training communication	Recorded in CRM	Better engagement	V Wardleworth	ongoing
3.	Training for all front line staff in awareness of domestic abuse	Review safeguarding training		Improved knowledge and understanding	V Wardleworth	ongoing

Name of Agency: Probation Service	IMR Report Writer: Janice France
Name of the Victim: Michelle	

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Alcohol Treatment	Turning Point specialist assessment to consider treatment options	Consideration for liaison and referral to TP in cases which evidence sustained misuse of alcohol.	Assessment of effective pathways for treatment	Janice France	TP already have a presence in the probation office and access to consultation and ease of referrals is facilitated by this. Briefing to staff re TP service already undertaken. Review September 2022 within reducing reoffending for outcomes
2.	Liaison with specialist provision	Review of essential contacts within the risk management plan to address specific vulnerabilities or risk	Contact with specialist services within electronic records (e.g., IDVA for victims of domestic abuse, or documentation as to why IDVA not involved)	Appropriation of necessary supports		Review Sept 2022

Name of Agency: Greater Manchester Police	IMR Report Writer: Iain Butler
Dates as given in Terms of Reference:	1/1/19- 1/9/21
Name of the Victim: Michelle	

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	GMP to reinforce safeguarding training to remind officers of the measures available and the MARAC process.	November 2022 GMP will be delivering a large-scale domestic abuse training programme, DA Matters, this is a College of Policing approved product.	Dates of DA Inputs and officers in attendance.	Officers will be aware of initial safeguarding measures required to prevent DA victims from future harm.	PPD Governance	
2.	GMP to remind Triage Officers of the necessity to refer repeat victims back to MARAC.	Officers are to be reminded of the conditions of referral to MARAC in particular that '*ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC*' (Multi agency	Triage Training Course to be developed and implemented.	Appropriate and timely referrals will be made to MARAC in relation to repeat victims.	PPD Governance	

		MARAC operating protocol 2020).				
3.	GMP to remind officers of the coercive and controlling behaviours that amount to offences and therefore should be recorded.	NCRS Compliance Training. Think Victim.	June 2020, GMP delivered training to all frontline officers on National Crime Recording Standards (NCRS) with a particular focus on the correct identification of Controlling and Coercive behaviour and Stalking and Harassment Offences. This was in response to recommendations from Her Majesties Inspectorate of Constabularies, Fire, and Rescue (HMICFRS).	NCRS compliant crime recording and investigations completed in relation to C&C behaviours.	PPD Governance	
4.	GMP to remind officers that when responding to a sexual offence where a person is alcohol dependent, early liaison should take	PPD to liaise with district in relation to the actions arising from this review.	Autumn 2022, GMP will be one of 14 forces that are part of an expansion project called Operation Soteria. The aim of this project is to	improve the Criminal Justice response to Rape and Serious Sexual Offending.	PPD Governance	

	place with the on-call Doctor at the Sexual Assault Referral Centre to seek advice in facilitating a forensic examination.		nationally improve the Criminal Justice response to Rape and Serious Sexual Offending.			

Appendix 1

Domestic Abuse

The new Domestic Abuse Act 2021 defines domestic abuse as a behaviour by a person towards another and:

a) Both persons are each aged 16 or over and are personally connected, and
b) The behaviour is abusive

Where perpetrators direct their conduct towards another person (e.g., the child of a victim), this is also considered to be abusive behaviour towards the victim. Behaviour is considered abusive if it consists of any of the following:

- Physical or sexual abuse.
- Violent or threatening words or actions.
- Controlling or coercive activity.
- Economic abuse (see notes below).
- Psychological, emotional, or other abuse.

Economic abuse means any behaviour that has a substantial adverse effect on a victim's ability to acquire, use, or maintain money or other property, goods, or services.

Personally Connected

The new definition seeks to ensure that opportunities for identifying domestic abuse are not limited and includes where people:

- Are, or have been, married to each other.
- Are, or have been, civil partners of each other.
- Have agreed to marry one another (whether or not the agreement has been terminated).
- Have entered into a civil partnership agreement (whether or not the agreement has been terminated).
- Are, or have been, in an intimate personal relationship with each other.
- Is a child in relation to whom they each have a parental relationship.
- Are relatives.

Section 63 (1) states that a "relative" in relation to a person means:

a) the father, mother, stepfather, stepmother, son, daughter, stepson, stepdaughter, grandmother, grandfather, grandson or granddaughter of that person's spouse, former spouse, civil partner or former civil partner, or
b) The brother, sister, uncle, aunt, niece, nephew or first cousin (whether of the full blood or of the half-blood or by marriage or civil partnership) of that person or of that person's spouse, former spouse, civil partner or former civil partner.

For further information on this subject, please refer to the College of Policing, Authorised Professional Practice (APP) on Domestic Abuse.[28]

Positive Action

Police officers have a positive obligation to take reasonable action, within their lawful powers, to safeguard the rights of victims and children. This includes the duty to:

[28] College of Policing, Authorised Professional Practice (APP) on Domestic Abuse

- make an arrest where it is necessary and proportionate to do so, see the authorised professional practice (APP) on detention and custody, lawful arrest
- protect the victim and vulnerable people within the household from harm

Children as victims in their own right
Under section 3(2) of the Domestic Abuse Act 2021, a child is a victim of domestic abuse **for the purposes of the Act** where they see, hear, or experience the effects of domestic abuse and are related to either a perpetrator or victim of abuse, or either individual has parental responsibility for the child

The 2021 Act does not create a specific offence of domestic abuse against a child and there are no requirements to record a crime on the basis of a child either being present or residing at the location of the abuse.

The purpose of this Act is to ensure that children's needs are appropriately assessed and met. **Existing safeguarding, risk assessment and referrals processes and procedures should be followed** to ensure children receive support and remain visible in the multi-agency response to domestic abuse. Statutory guidance in Working Together to Safeguard Children sets out expectations for inter-agency working to safeguard and promote the welfare of children, including those experiencing domestic abuse.

Stalking or Harassment
Stalking and/or harassment are clear indicators of future harm to a victim and can be very common in domestic abuse incidents. Offences of stalking or harassment are classed as "as well as crimes" and must be recorded in addition to any other offences under NCRS/HOCR.

Stalking
Stalking is a pattern of fixated, obsessive, unwanted, and repeated behaviour which is intrusive and causes fear of violence or serious alarm or distress. Stalking tends to focus on a person, rather than a dispute.

Harassment
Harassment is unwanted behaviour which can be found offensive, or which makes the victim feel intimidated or humiliated. Harassment tends to focus on a dispute rather than a fixation with a person.

Controlling or Coercive Behaviour
Section 76 of the Serious Crime Act 2015 provides the offence of controlling or coercive behaviour where the perpetrator and victim are personally connected. In this legislation, 'personally connected' means intimate partners, or former intimate partners, or family members who live together. The Domestic Abuse Act 2021 introduced an amendment to the legislation which removes the co-habitation requirement. This ensures that post-separation domestic abuse and familial domestic abuse is accounted for when the victim and perpetrator do not live together.

Acts of controlling or coercive behaviour may include: isolating a person from their family or friends; monitoring a person's time; using spyware to monitor a person; taking

control over aspects of a person's everyday life (such as where they can go, who they can see, what they can wear, and when they can sleep); repeatedly putting a person down (such as telling them they are worthless); threats to harm a child; and many other types of behaviour.

Harmful Traditional Practices
This is a broad term used to describe a combination of practices used principally to control and punish the behaviour of a member of a family or social group, to protect perceived cultural and religious beliefs in the name of 'honour'. There is currently no statutory definition of honour-based abuse.

Appendix 2
The MARAC National Dataset

There are approximately 290 MARAC across the UK. MARAC data is data submitted to SafeLives, by individual MARAC, on a quarterly basis. It comprises the date of meetings held within the quarter and basic information about the cases discussed at each meeting date (for example, the total number of cases, number of cases referred by a certain agency, number of cases where the victim has a disability, etc). Each quarter the data is collated and published to create the national dataset shown below.

Overview	**Latest Quarter 12 months 01/07/2021 to 30/06/2022**	**Previous Quarter 12 months 01/04/2021 to 31/03/2022**
Total number of MARAC who submitted data	293	290*
Number of cases seen at these MARAC	120,634	120,495
Year-on-year change in number of cases	+4%	+6%
Number of children	152,504	151,207
Number of cases per 10,000 adult females	46	47
% of repeat cases seen at these MARAC	33%	33%
% of partner agency referrals to these MARAC	33%	33%

Key statistics about domestic abuse in England and Wales

- Each year nearly 2 million people in the UK suffer some form of domestic abuse - 1.3 million female victims (8.2% of the population) and 600,000 male victims (4%)
- Each year more than 100,000 people in the UK are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse
- Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- In 2013-14 the police recorded 887,000 domestic abuse incidents in England and Wales
- Seven women a month are killed by a current or former partner in England and Wales
- 130,000 children live in homes where there is high-risk domestic abuse.
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others
- On average victims at high risk of serious harm or murder live with domestic abuse for 2-3 years before getting help

- 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse

What are the characteristics of victims that mean they are more likely to be abused?

- **Gender:** Women are much more likely than men to be the victims of high risk or severe domestic abuse: 95% of those going to MARAC or accessing an IDVA service are women.
- **Low income:** women in households with an income of less than £10,000 were 3.5 times more at risk than those in households with an income of over £20,000
- **Age:** Younger people are more likely to be subject to interpersonal violence. The majority of high risk victims are in their 20s or 30s. Those under 25 are the most likely to suffer interpersonal violence
- **Pregnancy:** Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant [6]
- **Separation:** Domestic violence is higher amongst those who have separated, followed by those who are divorced or single
- **Previous criminality of the perpetrator:** domestic abuse is more likely where the perpetrator has a previous conviction (whether or not it is related to domestic abuse)
- **Drug and alcohol abuse:** Victims of abuse have a higher rate of drug and/or alcohol misuse (whether it starts before or after the abuse): at least 20% of high-risk victims of abuse report using drugs and/or alcohol
- **Mental health issues:** 40% of high-risk victims of abuse report mental health difficulties

How long do victims live with domestic abuse?

- On average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for 3 years before getting help

Appendix 3
Bibliography

a. The MARAC Operating Protocol – this was reviewed and revised by the Greater Manchester Police in September 2020. A copy is available on request.

b. The Memorandum of Understanding for the operation of the MAAST (October 2020)

c. Domestic Abuse Policy – Greater Manchester Police (August 2022)

d. College of Policing – Evidence led prosecutions

Appendix 5

Glossary of common acronyms

CP	Care Plan
CMT	Case Management Team
CPS	Crown Prosecution Service
CSI	Crime Scene Investigator
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking/Harassment, Honour-Based Abuse
DVDS	Domestic Violence Disclosure Scheme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
GMCA	Greater Manchester Combined Authority
GMP	Greater Manchester Police
HRDM	High Risk Daily Meeting
IDVA	Independent Domestic Violence Advisor
MAAST	Multi-Agency Adult Safeguarding Team
MARAC	Multi-Agency Risk Assessment Conference
MARM	Multi-Agency Risk Management meeting
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
PNC	Police National Computer
PND	Police National Database
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability, Engage