Diane

Died March 2022

Final Report

March 2024

AUTHOR – Nicki Walker-Hall

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1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Diane, a resident of Rochdale, prior to the point of her death on the 4th March 2022.

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

1.3 Diane first disclosed domestic abuse (DA) to professionals in June 2020. Diane informed that James was violent towards her and had been for many years. Following this initial disclosure, a number of services within multiple agencies offered support and tried to introduce measures to safeguard Diane. Agencies were not able to engage Diane and her abuse continued.

1.4 On the 3rd March 2022 Diane's husband (James) dialled for an ambulance. James reported he had come home from work and found Diane had fallen from bed. Diane was described by her husband to be alert, answering appropriately and he stated he had had a conversation with her. Two and a half hours later James made a further call indicating Diane was now unconscious.

1.5 The ambulance crew felt the history given by James, was not consistent with Diane's presentation. Diane was noted to be unconscious with noticeable bruising. James did not ask how Diane was and did not appear to be concerned. The North West Ambulance Service (NWAS) crew on noting a DV flag that automatically linked to the address, immediately requested Police. The NWAS crew transported Diane to Fairfield General ED. Diane sadly passed away the following day.

1.6 This review will consider agencies contact/involvement with Diane and James from 1st May 2020 until Diane's death on the 4th March 2022. This timeframe includes the period of time when agencies first became alert to DA following a disclosure made by Diane.

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

2. Timescales

2.1 A decision was made that this case met the criteria for a DHR on the 31st March 2022. Guidance suggests reviews should be completed, where possible, within six months of commencement of the review. The review began on the 24th June 2022 and initially concluded on the 20th December 2022. However, following conclusion of the Coroner's Inquest approaches were made to James and Diane's friends for their information.

3. Confidentiality

3.1 The content of this review have been anonymised in order to protect the identity of both Diane and James. The information within reviews is confidential. Information has only been made available to participating officers/professionals and their line managers. The use of

pseudonyms was discussed with Diane's brother who indicated he was happy with the suggested pseudonym of the panel (Diane). The pseudonym of James was chosen by the panel for Diane's husband. These pseudonyms have been used throughout the report.

3.2 Diane was 55 years old and James was 47 years old at the time of the fatal incident; both parties are of white British origin.

4. Terms of Reference

4.1 The following terms of reference were agreed by the DHR panel:

1. Explore the interface between processes which were used to help safeguard Diane (MARAC[1] and MRM[2]) and the effectiveness of these multi-agency systems in complex cases.
2. What did professionals do to understand the impact of Diane's multiple conditions/needs? Consider whether the support offered had the potential to address Diane's health needs and reduce the level of risk within her relationship.
3. Were professionals making full use of agencies policies and procedures relating to engagement of clients when working with Diane, and how effective were they in Diane's case?
4. What support was offered to James? By virtue of his caring role, James was entitled to a Carers Assessment. Is there evidence this was offered? What prevented a Carers Assessment being undertaken? Were there any further powers/actions professionals could have used to address James's actions?
5. Is there evidence that professionals were considering coercion and control in their interactions with Diane?
6. In terms of domestic abuse, was every action taken that could have been to safeguard Diane?
7. Is there evidence professionals were considering Diane's mental capacity and whether she was making unwise decisions?

4.2 In addition authors were directed to consider the questions contained within the national guidance[3] to aid them in their analysis and promote wider thinking and learning from the case.

5. Methodology

5.1 Following notification of the circumstances of Diane's death by the Police, Rochdale Safeguarding Communities Partnership and the Safeguarding Adults Board came together on 31.03.2022 to consider and screen the notification. It was not clear whether Diane's injuries were as the result of a fall, domestic abuse or an alternate cause. Following considerable deliberation as to whether this case should be a DHR or a Safeguarding Adults Review,

[1] The role of the Multi Agency Risk Assessment Conference (MARAC) is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

[2] A Multi Agency Risk Meeting (abbreviated to MRM or MARM) is a multi-agency forum to discuss, identify and document serious current risks for high risk cases, formulate action plans, and identify appropriate agencies responsibility for actions. It also provides a mechanism for review and re-evaluation of the action plan.

[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

agreement was reached and a decision made that the case met the criteria for a DHR in accordance with the Domestic Violence Crime and Victims Act 2004 section 9.

5.2 This Review was subsequently commissioned by Rochdale Safer Communities Partnership.

5.3 An initial set up meeting took place where the review team was established and the timeframe of the review agreed. A further meeting took place to clarify the terms of reference and agree which agencies would be required to complete Individual Management Reviews (IMR) in addition to the chronologies already supplied.

5.4 Discussions took place regarding the potential of meeting family members and neighbours and whether there was benefit of holding a practitioners event. Advice was sought from the Senior Investigating Officer (SIO) who indicated contact with a family member would be possible, but suggested the results of pathology should be awaited prior to contact with friends and neighbours and before any potential practitioners event.

5.5 In light of this the panel agreed that no practitioners event would be held, but each IMR author would ensure they included discussions with their agency's practitioners involved with Diane during the review period.

5.6 All IMRs were reviewed and agreed at a further panel meeting, following which the Overview Report was completed.

6. Involvement of Family, Friends, Neighbours and Wider Community

6.1 Initially, as stated in 5.4 there were barriers to involving friends and neighbours in the review process as decisions regarding prosecution had not been made. Diane's friends and neighbours had provided statements to the police, therefore the chair and author was cognisant of the SIO's opinion regarding when/if these individuals should be approached. The police panel representative requested the SIO allow the friends and neighbours summary statements be made available to the chair and author.

6.2 The SIO was agreeable to contact with Diane's brother but not with friends and neighbours. Diane's brother kindly provided a copy of his police statement and had a conversation with the Chair and Author; the chair and author is grateful to him for the insight this provided. Diane's brother indicated he did not want to be involved further in the review and declined an offer to be part of the panel or receive a draft of the report.

6.3 The SIO agreed to the chair and author having sight of the summary statements by neighbours and friends. These have further informed the information within this report.

6.4 Following the Coroner's inquest and a decision by the Police not to pursue a criminal prosecution a decision was made that James, and Diane's friends, could now be approached. Letters were sent to James and all the friends and neighbours who had provided statements to the police. Two of Diane's friends spoke at length to the Chair and Author; the content of those conversations has been included where relevant and informed the analysis. The Chair and Author is grateful for their contributions to the process and has agreed to share the learning from the review at the end of the process.

7. Contributors to the review

7.1 The following agencies provided information to the screening process which was made available to the chair and author:

Greater Manchester Police
Pennine Care NHS Foundation Trust
Rochdale Adult Care
Turning Point
Victim Support
Probation Service
Care4U Home Care Agency
North West Ambulance Service NHS Trust
BARDOC
Northern Care Alliance NHS Foundation Trust
NHS Heywood, Middleton, and Rochdale Clinical Commissioning Group (HMR CCG) (replaced by Greater Manchester Integrated Care Partnership on the 1st July 2022)
Thinking Ahead

7.2 The following agencies were deemed to have had sufficient involvement and information with Diane to warrant the completion of an IMR.

Greater Manchester Police

Rochdale Adult Care

Care4U Home Care Agency
North West Ambulance Service NHS Trust
Northern Care Alliance NHS Foundation Trust
Greater Manchester Integrated Care Partnership (HMR CCG)

7.3 All the authors of the IMR's were independent having had no direct contact with Diane. All IMRs were signed off by a senior executive within each organisation.

7.4 The following agencies were required to provide a short report:

Thinking Ahead
BARDOC
Pennine Care NHS Foundation Trust
Turning Point
Victim Support

7.5 Letters were sent to all the Chief Executives of these agencies with requests to IMRs. A letter of introduction was drafted for Diane's brother to inform him of the review. GMP approached and informed Diane's brother of the review and invited him to contribute. Diane's brother spoke to the chair and author on the 22nd November 2022. The chair and author has kept the coroner up-to-date with the reviews progress in writing on the 27th June 2022, 17th October2022 and the 8th November 2022.

8. The review panel members

8.1 The following multi-agency panel was established:

Role	Organisation
Independent Chair/Author	Clear Outcomes Consultancy Ltd
Det Sgt Investigation and Safeguarding Review Team	Greater Manchester Police
Director of Nursing	Pennine Care NHS Foundation Trust
Serious Incident Review Officer/Principal Social Worker and Strategic Safeguarding Lead Adult Care and Support	Adult Care
Safeguarding Lead	Turning Point
Operational Manager	Victim Support
Assistant Chief Officer/Head of PDU	Probation Service
Development Officer (Domestic Abuse	Rochdale Safer Communities Partnership
Manager	Care4U home care agency Ltd
Safeguarding Practitioner Greater Manchester Safeguarding Practitioner 111 & EOC	NWAS
Assistant Director of Nursing Safeguarding Adults/LD/Autism/Dementia/Falls	BARDOC
Assistant Director of Nursing Safeguarding Adults/LD/Autism/Dementia/Falls	NCA
Adult Safeguarding Designated Professional	NHS Greater Manchester Integrated Care (HMR CCG)

8.2 The panel met on five occasions. All but the Care4U member had not had direct involvement with Diane and were therefore independent. Care4U is a small organisation and it was unavoidable that Lisa Lees represented the organisation.

9. Author of the review report

9.1 Nicki Walker-Hall was commissioned as Chair and Author for this review. Nicki is an Independent Safeguarding Consultant with a background in health. Nicki is a Registered General Nurse, Registered Sick Children's Nurse who has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki has worked in safeguarding roles for over 25 years, both in acute, community, PCT and Mental Health and Learning Disability services and was a former Designated Nurse Child Protection prior to becoming independent in 2009. Nicki is an experienced chair and author of safeguarding children and safeguarding adult reviews. In a previous role Nicki set up systems, authored guidance and represented both Primary and Secondary Health Services at Multi-Agency Risk Assessment Conference's (MARAC) meetings. Nicki has previous experience of authoring health IMR's for Domestic Homicide Reviews and has completed online training in relation to completion of Domestic Homicide Reviews.

9.2 Nicki has had no previous connection to Rochdale Community Safety Partnership and has not been employed by any agency within Rochdale. Nicki was independent of any line management of the case and had no contact with the possible perpetrator.

10. Parallel Reviews

10.1 This case has been subject to criminal investigation throughout the DHR. It took time for Pathology results to be received which delayed decisions regarding whether criminal proceeding/ coroners inquiry would be advanced. This initially influenced the parameters surrounding the review which was mindful of not impacting on any potential future proceedings.

10.2 Rochdale Adult Care completed a Serious Incident Practice Review following Diane's death. The contents of that review have been incorporated into their Agency IMR.

11. Equality and Diversity

11.1 In completing this review the chair and author has been cognisant of the nine protected characteristics under the Equality Act[4]. Including examining barriers to accessing services.

11.2 Throughout the review period Diane having been diagnosed with Guillain-Barré syndrome in July 2020 was increasingly less physically able. Guillain-Barré syndrome is a rare and serious condition that affects the nerves. It mainly affects the feet, hands and limbs causing problems such as numbness, weakness and pain and is therefore a debilitating illness.

11.3 Research has identified that Diane's gender, her disability and her isolation meant she was more likely to be a victim of Domestic Abuse.

11.4 Women experience more repeated physical violence, more severe violence, much more sexual violence, more coercive control, more injuries and more fear of their partner[5]. People with a limiting disability are two times more likely to have experience domestic abuse in the past year than people with no disability. Disabled women are significantly more likely to experience domestic abuse than disabled men and experience more frequent and more severe domestic abuse than disabled men[6].

11.5 An impairment raises the risk of domestic abuse for disabled people because it creates social isolation and the need for assistance with health and care needs, and potential increases situational vulnerabilities.[7]

11.6 The chair and author has not identified any discriminatory practice within this review however, not all agencies have demonstrated full awareness of Diane's diverse needs.

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[4] Legislation.gov.uk. 2010. Equality Act 2010.

[5] National Institute for Health and Care Excellence. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. London: National Institute for Health and Care Excellence, 2014.

[6] Adding insult to injury: intimate partner violence among women and men reporting activity limitations. Cohen, M. et al. 8, 2006, Annals of Epidemiology, Vol. 16, pp. 644-651.

[7] Public Health England (2015) Disability and domestic abuse Risk, impacts and response

11.7 In October 2020 Diane indicated her intention to raise a formal complaint regarding the GP practice. Diane indicated she was unhappy with the service, felt that the reception staff and practice manager were not helpful and that she had been trying for an appointment with the GP for 4 days. This incident occurred during Covid-19, at a time when practices had been advised by NHS England to move to "total triage' using a combination of telephone, online and video consultations. The GP practice was experiencing additional constraints with some GPs self-isolating and some off sick. The chair and author considers the difficulties experienced by Diane were not as a result of discrimination. There is evidence that the GP made reasonable adjustments – e.g. arranged for FIT notes to be sent to her home rather than collected, which was good practice. Diane did not go ahead and make a formal complaint.

12 Dissemination

12.1 The following recipients will receive a copy of the review report:

The Home Office
The Coroner
Diane's brother – Offered a copy but declined
All involved agencies
Members of the Community Safety Partnership
The Police and Crime Commissioner
The Domestic Abuse Commissioner's office

13 Background Information (The Facts)

13.1 Diane was a 55 year old married lady who had been lived at her home address in Rochdale with her husband James. The couple had met through work and been married for eight years; they had no children. Diane worked full time as a Civil Servant and enjoyed her work. Diane's brother indicated they developed a shared interest in horse racing and socialising; they liked to visit different race tracks and public houses.

13.2 Diane's friends describe Diane and James as a friendly, sociable couple who were often seen together in the local club. Diane liked crafting and she and friends would spend time in each other's houses crafting.

13.3 Diane was reported by her brother to dress well and always took a pride in her appearance and her home. Diane's brother indicated there was a five year age gap between him and Diane and as a result they had never been particularly close. Diane's father had misused alcohol. In recent years they had lost touch and he was unaware of Diane's medical condition. Diane's brother had not been aware of, or suspected, any domestic abuse between the couple.

13.4 During the review period and initially, as a result of Covid-19, Diane was working from home part time as a customs officer; this increased Diane's isolation. During lockdown, Diane's friends reported she didn't like being confined to home.

13.5 James finished work at lunchtime and returned home to care for Diane.

13.6 The couple reported there had been several deaths within the family within a short space of time, which had caused extra stress on the couple. Both Diane and James had reportedly been drinking to excess.

13.7 In July 2020 Diane was admitted to hospital due to neurological symptoms. Diane had been experiencing weakness, lethargy, diarrhoea and numbness in her fingers and toes which was impacting on her mobility. Diane also had calf tenderness. Diane originally went against her GP's advice regarding admission indicating her husband would be upset if she called an ambulance. Following admission Diane remained in hospital for a month during which time she was diagnosed with Guillain-Barré syndrome.

13.8 Over time Diane's condition restricted her mobility, which she told friends she found frustrating; her friends noticed Diane was drinking more alcohol.

13.9 On the 3rd March 2022 at 14:43 James dialled 999 for an ambulance. James reported during the call that he had come home from work and found Diane had fallen from her bed. Diane was described by James to be alert and answering appropriately. James stated he had had a conversation with her. As a result of James's description the call was categorised as Category 3[8]. At 17:17 hrs James made a further call stating Diane was now unconscious; an ambulance was sent immediately.

13.10 The Ambulance arrived on scene at 17:23. James told the paramedics he had arrived home and found Diane on the floor awake and alert, he had tried to get her off the floor, but her legs weren't working so he called the ambulance. It became apparent that the history given by James was not consistent with Diane's presentation. Diane was noted to be unconscious. Bruising was noted on multiple sights of Diane's body. The NWAS crew noted the warning linked to the address that Diane maybe the victim of DA, and immediately requested Police attendance.

13.11 NWAS noted James appeared nervous, and his behaviour appeared somewhat unusual in the circumstances. James didn't ask any questions as to where NWAS would be taking Diane and remained at the house when they took his wife to hospital. The NWAS crew quickly transported Diane to Hospital.

13.12 At hospital Diane remained unconscious and an initial scan revealed her injuries to be a subdural haemorrhage[9]. Diane was placed on life support. As a result of police enquiries at the hospital and with NWAS, James was arrested, on suspicion of Section 18 assault, at 19:20 hrs on the 3rd March 2022. Diane passed away the following day after it had been determined that the level of her injury was not survivable, thus life support was terminated. Following Diane's death, James was further arrested on suspicion of murder and coercive/controlling behaviour between 1st January 2019 and 3rd March 2022 whereby he subjected his wife to numerous occasions of physical abuse and during the relationship, sought to control finances and other aspects of the victim's life.

13.13 A forensic post-mortem was completed, and the medical cause of death was inconclusive. There was no evidence of a recent assault; tissue samples including the brain were sent off for examination and pathology was awaited. James was released from police custody and remained under investigation.

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[8] *Category three* – for people who require urgent help but it isn't an emergency. In these cases the patient may be treated by *ambulance* staff in their own home.

[9] A subdural haemorrhage (haematoma) is a serious condition where blood collects between the skull and the surface of the brain. It's usually caused by a head injury.

13.14 The Coroner's Inquest took place in July 2023 recording the medical cause of death as:

- Subdural Haemorrhage
- Decompensated liver failure, alcoholic liver disease, cerebral atrophy, acute alcohol toxicity and alcoholic ketoacidosis.

13.15 The conclusion of the Coroner as to the death records – Accident where recent excessive alcohol consumption and long-term alcohol use were significant contributory factors.

13.16 The police concluded their investigation with no charge.

14 Chronology

14.1 For a full chronology, please see the attached integrated chronology at Appendix 2.

14.2 The following are the key events during the review period:

Date	Event	Action taken	Outcome
June 2020	Diane had a fall. First disclosure of Domestic Abuse to NWAS. James controlling, screening calls, emails etc, Reported daily alcohol use.	Taken to hospital. Referral made to Adult Care.	Self-discharged. Declined Adult Care input.
July 2020	Diane diagnosed with Guillain-Barré Syndrome.	Support offered in the form of Safenet[10] and Adult Care support, but declined as "Adult Care would only cause additional problems".	Discharged home.
August 2020	Collapse in bathroom. Diane reported James was verbally and physically abusive to her when NWAS attended, and ED staff concerned as Diane appeared fearful and wanted help. Disclosed historic rape and torture (not James).	Diane admitted to hospital. Adult Care discussed the support that could be offered but Diane felt that there was no service or person that could help her. Care Act assessment and daily care services were offered to support Diane and	Diane declined all support, contact numbers and information.

[10] Safenet are an organisation operating in the North West of England who offer a safe place to stay if needed, along with support, guidance and practical help to those suffering domestic abuse

		reduce her reliance on James.	
May 2021	Diane's neighbour raised concerns regarding Diane's health after Diane had sent her a photo of a bruise.	Diane was admitted to Royal Oldham Hospital. Bruising to Diane's upper arms and strangulation marks to her neck were noted in the ED department. A Safeguarding referral was submitted. A referral to MARAC was also completed. A DASH[11] risk assessment was completed and reviewed by the IDVA (Independent Domestic Violence Advocacy) service. A MCA assessment was completed in relation to unwise decisions. Crime submitted for section 47 assault.	Diane declined IDVA involvement and advised she would take legal action if staff persisted to discuss. Threats to sue impacted on practitioners engagement with Diane.
July 2021	Diane was taken to A&E by ambulance crew with bruising on back, left arm, right elbow, left thigh. Diane disclosed that her husband has hit her she has been a victim of domestic violence.	Diane was admitted for three weeks. A DASH risk assessment was completed and a referral to MARAC on professional judgement was completed. Mental capacity was assessed and Diane deemed to have capacity.	Diane did not want safeguarding concerns reporting to the police. Diane refused a MARAC referral when offered this on 3 separate occasions. Diane agreed to a referral to Adult social care to have help and support at home.
September 2021	GMP created a DAB (Domestic Abuse record) on receipt of the MARAC referral from Health. The referral stated a potential escalation in DV following Diane being	The case was heard at MARAC on the 15th September and at MRM on the 21st September. It was discussed that the	Professionals working with Diane were informed that if Diane consented and would engage with the police they would re-

[11] DASH - A Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment used to assess levels of risk

	taken to hospital by NWAS in July (see above entry).	crime investigation had closed	open the investigation.
November 2021	A SW Spoke to Diane and discussed the DV situation. Diane was unable to speak freely and stated that she 'couldn't leave'. Diane was also experiencing a decline in her physical health condition due to the Guillain-Barré Syndrome.	The SW spoke to Diane's husband who discussed the option of an occupational therapist assessment of the home environment for possible equipment. The option of carer support was discussed with James, which he was open to. The option of psychological support and also assistive technology for Diane was discussed; he stated he would discuss this with Diane.	James called the GP to request a visit to Diane due to pain and not sleeping. James stated he felt under pressure and when at work he was concerned that Diane may fall. James suggested an appointment when he was having a day off so he could take part in the assessment.
November 2021	Diane reported she had been assaulted by her husband. Diane had disclosed to a social worker that her husband had assaulted her bruising her arms and hand.	Ambulance sent. Police Officers attended Diane's home to speak to her, but Diane denied she had been assaulted claiming she had fallen.	Officers arrested James and in interview he denied the offence; he was bailed to an alternate address.
November 2021	Diane was referred for a package of care.	Swift action was taken to provide Diane care.	Diane later repeatedly refused entry to the care workers
14th December 2021	The GP visited Diane and had concerns regarding a possible bleed on the brain resulting from a reported 'fall' two days previously.	GP felt Diane needed a CT scan or MRI scan as he could not rule out a bleed on the brain. Diane declined hospital admission. Diane was experiencing a decline in her health	Alcohol and mental capacity assessment completed. Referred to Neuro-Rehab.

		due to Gillian-Barré syndrome.	
13th January 2022	Informed SW she did not feel 100% safe, James had taken her bank card and was always angry.	Police informed and visited. James declined their assistance.	Crime submitted for controlling/coercive behaviour. DAB completed. Information shared with MARAC and MRM.
3rd March 2022	James reported Diane had fallen out of bed. Diane was unconscious. Excessive bruising was noted and blood on all pillows.	Admitted to hospital. Subdural haematoma – Admitted to ICU.	Diane sadly passed away the following day.

15 Overview

15.1 The following section includes summaries of the information that was known to all the agencies involved with Diane from June 2020 until her death. This includes multiple Diane's contact with health professionals during her five admissions to Hospital, in addition to her contacts with the 111 and Ambulance Service, A&E, Acute Medical Ward Staff, the GP, the Drug and Alcohol Service workers, Social Workers, Allied Health Professionals - Occupational Therapists, Physiotherapists, Police Officers and Care Staff.

June 2020

15.2 Diane had a fall and disclosed domestic abuse to an ambulance crew, indicating that she had experienced domestic abuse for 10 years and was afraid of her husband. Diane indicated to the ambulance crew her concerns that James might kill her but declined consent to refer; despite this NWAS raised a safeguarding concern, referring Diane to Adult Care.

15.3 Over the next, few days' there was a number of attempted contacts made by Adult Care to Diane who declined any input.

July 2020

15.4 Diane made a disclosure to 111 regarding her husband's controlling behaviour however Diane again declined any input from Adult Care. Diane was experiencing numbness in her fingers and toes, she was not able to walk due to sudden lack of strength to legs. Diane was diagnosed with Guillain-Barré syndrome.

August 2020

15.5 Diane collapsed in her bathroom at home. Diane informed the Ambulance crew she had been diagnosed with Guillain-Barré syndrome and had experienced an 8 year history of domestic violence from husband. Diane indicated she felt scared and the abuse was worsening since the recent deterioration in her health. The ambulance crew gained consent from Diane, passed the disclosures over on verbal handover, and raised another safeguarding concern notification. Diane was admitted to the

Fairfield unit but declined input from Adult Care who were unable to reach Diane despite a number of attempts.

May 2021

15.6 Diane contacted 111 indicating she was experiencing worsening mental health, fatigue and vomiting. Diane stated she had not eaten a proper meal since December and her condition had deteriorated. Diane informed she also had suicidal thoughts. An ambulance was dispatched. Diane again disclosed to the ambulance crew that she had suffered years of physical abuse from her husband. Bruises were noted and financial abuse was also disclosed. Diane was admitted to Royal Oldham hospital. The staff carried out body mapping of the injuries and made a referral to Adult Care who advised staff to contact the police.

15.7 Police officers attended the ward and spoke to Diane who was very unhappy that the police had been contacted and indicated she was under the impression that speaking to hospital staff would be confidential. Diane would not engage with the police officers, telling them that getting involved with the police would ruin her life and destroy her marriage. Diane did however tell the police that the previous month, she had been very drunk and had fallen off the toilet getting wedged at the side of the toilet. Diane indicated that her husband had been very annoyed that he had to help her up. During this incident, Diane indicated that James had got into a scuffle with her, and this had caused the bruising to her arms.

15.8 Hospital staff told officers that Diane initially told them that she had been abused over a long period of time, and that James had told her to say that she had sustained the injuries by falling out of bed; he allegedly tried to force this version of events upon her. Diane stated that after that incident, James continued drinking alcohol and attempted to take his own life by taking painkillers and whisky and was admitted to Fairfield Hospital. Police informed Diane they would need to contact James to carry out a welfare check. Diane stated she would complain regarding the police contacting her husband as he already felt bad enough about what had happened. Diane indicated that the incident was a one off and James was not a violent person. Crimes for assault were recorded. Both were seeking marriage guidance.

15.9 Diane wanted the case to be closed and didn't want to speak with anybody from adult care. Diane advised that the accusations that had been made were completely false, she wanted to return to her husband and did not see the need to discuss this any further with any member of adult social care. The case was the subject of Multi Agency Risk Management (MARM) and referred to MARAC and Victim Support[12]. When contacted by the IDVA Diane declined support. Diane was discharged home on 20th May.

June 2021

15.10 On the 10th June a GMP CAP record (care plan) was created following a request from a social worker over safeguarding concerns for Diane. It included results of the Multi Agency Risk Assessment Meetings and attempts to provide support to Diane since the initial report in May 2021. Adult Care continued to liaise with the police and the GP and the case was heard at MARAC on 23rd June and the Social worker proceeded

[12] Victim Support offer support to victims of crime and traumatic incidents

with the MRM process. No role was identified for the IDVA service who later closed the case.

15.11 Adult Care continued to attempt to contact Diane without success.

July 2021

15.12 James dialled 999 on Diane's behalf. James indicated Diane had had multiple recent falls and had multiple bruises; photos of bruising were taken with consent. Diane admitted to consuming alcohol daily and had not had any recent help with her alcohol misuse. Diane was transported to Fairfield ED. Another safeguarding referral was made. Diane declined a referral to MARAC and police involvement. However the police were contacted as a duty of care, and the MARAC referral was also made without consent due to the nature of the situation. Diane stated what happened with her husband was an accident and occurred while he was assisting her up. Diane received an inpatient detox for her alcohol misuse.

15.13 Diane made a 999 call to the police, reporting there were "Thieves on". Diane was whispering to the call taker that she could hear someone in the address. Police attended the location, and it was established that Diane was in hospital. Staff were spoken to and confirmed that she was on the ward. Diane later indicated she did not know why she had called the police.

15.14 A safeguarding strategy meeting under s42 of the Care Act was held on 26th July. There was a plan for the IDVA to explore safety planning with Diane, this was to include alternatives to returning home, use of a burner phone, methods of seeking support as needed. Diane later declined this.

15.15 Diane declined to speak to the Social Worker whilst in hospital and threatened legal action as she felt pressured and stated that it was 'all a misunderstanding'.

August 2021

15.16 Diane was transferred to Royal Oldham Hospital on 3rd August and had input from the alcohol liaison worker. However, Diane declined input from Adult Care and declined a referral to Turning point (Community Alcohol services). A referral was made by Adult Care to legal for advice on 20th August and the process of the MRM was continued.

September 2021

15.17 Adult Care continued to liaise with Diane's GP. NWAS and A&E put markers in place. As Diane was not engaging with the IDVA her case was once again closed.

15.18 GMP created a DAB on receipt of an external MARAC referral from Health. The referral stated a potential escalation in DV following Diane being taken to hospital by NWAS. The ambulance staff recorded bruising to Diane's back, arm and thigh and when asked how the injuries were sustained, James told the crew Diane had fallen out of bed. One of Diane's friends who attended at Diane's request indicated she thought the mark on Diane's back looked like a footprint. Diane made the comment "you hurt me". This was the second attendance at A&E in two months where Diane had made allegations of domestic abuse. Diane told staff her husband did not love her anymore and she had "no fight left in her". Diane was adamant she did not want the police informing but consented to an Adult Care referral. Diane's friends reported she could be stubborn. The case was heard at MARAC on the 15th

September and at MRM on the 21st September. It was discussed that the crime investigation had closed however, professionals working with Diane were informed, if Diane consented and would engage with the police then they would re-open the investigation.

October 2021

15.19 Diane refused further input from the GP and stated that she felt harassed. Adult Care continued to attempt contact.

November 2021

15.20 The SW managed to speak to Diane on 25th November and discussed the DV situation. Diane was unable to speak freely and stated that she 'couldn't leave'. Diane was also experiencing a decline in her physical health condition due to the Guillain-Barré Syndrome.

15.21 The SW spoke to Diane's husband who discussed the option of an occupational therapist assessment of the home environment for possible equipment. James called the GP to request a visit to Diane due to pain and not sleeping. James stated he felt under pressure and when at work he was concerned that Diane may fall. James suggested an appointment when he was having a day off so he could take part in the assessment.

15.22 The option of carer support was discussed with James, which he was open to. The option of psychological support and also assistive technology for Diane was discussed; he stated he would discuss this with Diane.

15.23 Contact was made with the 111 service and an ambulance sent after report that Diane had been assaulted a few days before by her husband. Diane had disclosed to a social worker that her husband had assaulted her bruising her arms and hand. Diane did not give any further details to the social worker. The social worker reported this to the police due to safeguarding concerns, however, Diane stated she would not tell the police any information as she feared the repercussions and would claim that she had sustained the injuries by falling over. Officers attended Diane's home to speak to her, but Diane denied she had been assaulted claiming she had fallen. Officers arrested James and in interview he denied the offence and stated Diane regularly fell due to her medical condition which was made worse by her drinking alcohol and that is how she would have received the bruising. Diane's friends report Diane would tell them different versions of the same events making it difficult to establish the truth.

15.24 The ambulance crew attended and were informed James has been arrested by police and removed from the home. Diane reported she was not willing to attend hospital, the crew offered to raise a safeguarding concern but Diane declined. Diane also declined the crew's request to contact her GP to share information. The ambulance crew noted Diane had capacity to refuse assistance at that time. PPU were contacted due to concerns of domestic abuse and coercive control.

15.25 James was given conditional bail until the end of December 2021 whilst the investigation continued. Following her husband's arrest, Diane rang the police on numerous occasions and emailed the officer in the case several times stating she wanted her husband home for Christmas and that she had made the whole thing up. Information was also received from a social worker on the 28th November that James

had broken his bail conditions by meeting Diane at the war memorial and was contacting her via friends. When Diane was spoken to about this, she admitted that she had met her husband and it was of her own free will. Officer were powerless to take any action regarding this, as in order for the breach of bail to be proven Diane would have needed to provide a statement of evidence as the meet had not been witnessed by a third party therefore James was not arrested for breach of bail.

15.26 A medium risk referral was sent by Adult Care to Victim Support however, Diane once again declined IDVA support and her case was closed.

15.27 The police made a domestic abuse record and assessed the risk as high. Victim Support received a referral from the police.

15.28 Adult Care continued to offer support to Diane who strongly declined police and GP involvement.

15.29 James was bailed the following day to another address and Diane was asking for him to return home on 29th November and declined input from victim support.

15.30 Later that day a Social Worker made an emergency call on Diane's behalf. An ambulance crew attended and noted a recent package of care started for Diane and she had support from a SW. The crew discussed and noted that Diane did not feel her alcohol consumption was problematic; a friend and carer were on scene. Pictures were taken of Diane's bruising with consent. Diane was advised to ring 101 and request an update regarding her husband from the Police. Clinical observations were within normal range. Diane was not transported to hospital.

15.31 Diane declined home visits and said that she felt safe to remain in the home with her husband that evening, Diane was asked her if she required support to leave and she said she can't leave. Diane asked if she required an ambulance and she informed that her condition isn't serious enough for an ambulance. Diane's husband contacted Adult Care and advised that Diane has fallen outside yesterday and sustained a facial injury and hurt her hand. James informed that he had called the GP and there was an appointment arranged for the next morning. James consented to a home visit from social care on Friday 3rd December.

15.32 On 29th November Diane disclosed to a neighbour that she had been 'beaten up badly' and the GP attempted a home visit without success. It was reported that Diane met up with James on 29th November.

15.33 A MASS Daily Domestic Abuse Meeting was held on the 30th November. The IDVA was asked to attempt contact again.

<u>December 2021</u>

15.34 Diane continued to decline support from victim support, Care4U and Adult Care.

15.35 On the 4th December the Care4U Manager, contacted the police regarding concerns for Diane. They were providing care for Diane following James's arrest for assault, as he had been her full-time carer. Diane had been disengaging with new carers and had requested no carers visit her on the evening of the 3rd December. This was agreed with the social worker and carers provided phone contact. Carers visited on the morning of the 4th December and Diane was not at home and not in phone contact. Diane rang the manager at 18:52 hrs on the 4th December and said she had been for a walk. The manager offered to send a carer around, but Diane refused. The caller heard crying at the end of the call. The caller was concerned that Diane was staying with James or having him at her address when carers were not there.

15.36 The following morning police visited and spoke to Diane who was seen to have dried blood on her face. She told officers she was on her way out and would not allow the officers into her address. There were two wine bottles on the doorstep; Diane was not aware where they had come from. She told officers she had fallen over in the bathroom the previous night due to her condition. She declined any medical attention. Diane was asked if there was anyone else in her home and she told them there wasn't. Officers did not have a power of entry into the address without Diane's consent and would have to have had a reasonable suspicion that James was present, which they had not. Diane also told the officers that she did not want the carers in her home as they were "pointless and don't do anything". The attending officers submitted a care plan. Triage was completed and information was shared with the allocated social worker as Diane was the subject of MRM

15.37 On the 6th December a '999' call was made by care staff. An ambulance crew and the Police attended the scene to explore the circumstances. Diane reported she had fallen in the local shop. Diane denied domestic violence. The ambulance crew offered to raise a safeguarding concern notification but Diane declined. Diane refused transport or further support and signed the refusal statement. The ambulance crew noted Diane had capacity. Diane was left with Police who conducted a welfare check due to concerns and non-engagement. Diane had dried blood on her face however; this was as result of her reopening her previous fall injury.

15.38 Diane was asked if her husband had any involvement, but she was adamant that was not the case and that her husband had not been back to the property due to his bail conditions. Diane told officers that carers attended her home to support her with physical tasks however; she felt she had lost her independence and that upset her. She reported her carers were unreliable or rude when they turned up at the address and this was causing her to be reluctant in allowing them into the property. She was struggling by herself and felt lonely.

15.39 After speaking to Diane at length, the attending officer was extremely concerned that Diane would decline in terms of mental and emotional health. Diane gave consent for this information to be shared. The information was shared with her social worker. A CAP record was created, and an Adult at Risk marker was added. A MRM meeting took place on the 08/12/21.

15.40 Diane received contact almost daily from Adult Care throughout December and there were ongoing concerns regarding her physical and mental health. Diane was offered the option of 24 hour residential placement which was declined and she continued to state that she wanted her husband back home.

15.41 The GP visited Diane on the 14th December and had concerns regarding a possible bleed on the brain resulting from the reported fall. Diane was experiencing a decline in her health due to Gillian-Barré syndrome. Diane was constantly contacting GMP to request the crime to be closed.

15.42 On the 16th December 2021, the investigating officer for the offence in November of the same year visited Diane who confirmed what she had previously disclosed to her support worker that her husband had assaulted her, but she indicated that what she had said was a lie and that she had not been assaulted by her husband. Diane stated she had made up the allegation as she was under considerable stress and had consumed a bottle of wine and had fallen over on that day causing the bruises. Diane

provided a statement to that affect whilst alone and seemingly not under any duress. A line management review was completed and the crime filed.

15.43 Visits from Adult Care and care agency visits continued to be declined by Diane over the next week. Welfare calls by Adult Care continued. Diane stated that the option of formal care was intrusive. Safety planning was discussed with Diane.

January 2022

15.44 Welfare calls were made in the New Year to Diane who stated that things had 'calmed down.'

15.45 Adult Care discussed with Diane's husband his caring role. James indicated he did not feel that it had a negative impact on his wellbeing. Diane continued to decline Formal support.

15.46 On the 13th January the SW made an unannounced visit; Diane had Covid-19. Diane agreed to an OT visit but stated that it would need to be when her partner was not present as they were 'not getting on'. Diane reported James had taken her bank card and was 'angry all of the time'. Diane stated that she did not feel 100% safe. James had not been helpful in regards to personal care support.

15.47 Diane explained that she could not leave the home address due to the mortgage being in both their names. Diane stated that she would like her husband to leave the property, however suggested she would not be able to afford the bills on her own. Diane declined temporary safe accommodation at the time of visit. She wanted somewhere she could take her cat. She continued to decline the reinstatement of formal support as it would make her husband angry. Diane agreed to a referral to victim support. Low mood was observed but Diane indicated she had no plans to self-harm.

15.48 The SW contacted the police. The police visited the same day but Diane denied the officer entry into the house, so they spoke on the doorstep. It was explained to Diane that the police were there to check on her welfare because of a third-party report and she was asked if she wished to report any crime/incident. Diane stated nothing had occurred and she did not require the police and wished the police would leave her alone. The officer offered Diane victim support advice. A DAB was created and assessed as high. A crime was recorded for coercive/controlling behaviour however, without victim co-operation or other tangible evidence it was deemed there was no realistic prospect of a conviction, and the crime was filed. Information was shared with MARAC on the 19th January.

15.49 Diane declined an OT visit on 19th January. On the 21st January Diane declined support from Care4U. Welfare calls by Adult Care continued into February. Diane continued to decline OT.

February 2022

15.50 On the 17th February – Diane alleged to the social worker that James had changed recently and was remorseful for his actions. Diane continued to decline support from care line and Care4U. She stated she currently felt safe and declined a SW and OT visit. Diane cancelled a further planned SW visit on 22nd February.

March 2022

15.51 Diane's case was discussed at MARAC on the 2nd March. A welfare call was attempted by a SW on 3rd March, there was no answer so a message was left.

15.52 On the 3rd March a 999 call on Diane's behalf was made by James who stated Diane had "Lost use of legs got no strength fallen out of bed". James reported he had come home from work and found Diane had fallen from bed. Diane was described by James to be alert, answering appropriately and he stated he had had a conversation with her. The ambulance service categorised the call as Category 3.

15.53 The Ambulance arrived on scene at 17:23. It became apparent that the history given by the husband was not consistent with Diane's presentation. Diane was noted to be unconscious. Significant bruising was noted. NWAS crew note they heeded the warning that automatically linked to address that alerts NWAS staff that Diane maybe the victim of DVA and Police were immediately requested. The ambulance crew recorded that husband appeared nervous, and his behaviour appeared unusual. James didn't appear concerned about Diane; he didn't show any emotion towards his wife and ate his tea whilst the crew dealt with Diane. James didn't ask any questions as to where they would be taking Diane and remained at the house when they took his wife to hospital. The ambulance crew transported Diane to Fairfield General ED.

15.54 At hospital, Diane remained unconscious and an initial scan revealed her injuries to be a subdural haemorrhage. As a result of police enquiries at the hospital and with NWAS, James was arrested on suspicion of Section 18 assault at 19:20 hrs on the 03/03/22. Diane passed away the following day as it was determined that the level of injury was not survivable and life support was terminated. Following Diane's death, James was also arrested on suspicion of murder and coercive/controlling behaviour between 1st January 2019 and 3rd March 2022 whereby he subjected his wife to numerous occasions of physical abuse and during the relationship sought to control finances and other aspects of the victim's life.

15.55 A forensic post-mortem was completed, and the medical cause of death was inconclusive. There was no evidence of a recent assault; tissue samples including the brain were sent for examination.

15.56 James was initially released from police custody under investigation. Following the full results of the post-mortem the Coroners Inquiry took place and no charges were brought by the Police.

16 Analysis

16.2 The following section will provide analysis in relation to the key lines of enquiry agreed by the DHR panel.

Explore the interface between processes, which were used to help safeguard Diane (MARAC[13] and MRM[14]) and the effectiveness of these multi-agency systems in complex cases.

16.3 The first three reports of domestic abuse by Diane were when she had sought medical attention. Appropriate referrals were made to Adult Care however Diane

declined support and Adult Care involvement at that time. Having not been assessed as high risk Diane was not referred to either MARAC or MRM; this was in line with policy. Whilst Diane was signposted to services that support those experiencing domestic abuse Diane did not take these up. Lack of engagement meant there were limited opportunities at that time to develop trusting relationships between Diane and statutory services.

16.4 Following Diane's disclosure in May 2021 of physical and financial abuse from her husband, with potential evidence in the form of bruises, Adult Care and the Police were notified. Of note all the reports of domestic abuse of Diane by James to the police, were third party from medical staff and social workers.

16.5 It is clear that following this referral swift and appropriate action was taken to involve statutory agencies. A strategy meeting was held and information shared between those agencies present. Not all agencies working with Diane at that time were present. Referrals were made to MARAC, to assist in the support of Diane and reduce the risk of further abuse, showing good use of multi-agency escalation and risk management processes. The case was appropriately assessed as high risk and the MARAC and MRM processes were initiated as per procedure.

16.6 Diane was heard at MARAC on three occasions in the 10 months prior to her death. On each occasion it was noted that there was a lack of engagement with Diane.

16.7 At the MARAC meeting in September 2021, attendees discussed Diane's alcohol use. Diane had reported she was alcohol free. Diane also reported she was back in work. Diane was not consenting to contact from Turning Point (Drug and Alcohol Recovery Service) and declined any further involvement. No action was planned.

16.8 Through this review Greater Manchester Police have identified issues with respect to the recording of MARAC results and actions within Police systems which may have limited officers knowledge of the case when attending incidents – a suitable recommendation has been made.

16.9 From May 2021 Diane was also the subject of MRM meetings. Not all agencies involved or to whom Diane had been referred, were invited to, or attended, these meetings. NWAS a key agency, as Diane made most of her disclosures to their staff, attended the majority of multi-agency meetings in relation to Diane which was good practice. If unable to attend, and on other occasions, the NWAS Safeguarding Practitioner for Greater Manchester communicated directly with the social worker involved with Diane to ensure the sharing of information between agencies and to arrange the adding of an alert to Diane's address.

16.10 Regular two monthly MRM meetings took place and the Risk Management Tool was updated following each meeting. Agencies all identified they were struggling to engage Diane in their services and Diane consistently declined the support she was offered. It was not established why Diane made disclosures to 111 and NWAS staff but would not follow this through with reports to the police, however this is not an uncommon feature within domestic violence and abuse cases. NWAS and the 111 service are contacted in medical emergencies or when someone has reached crisis point. It is feasible that once the initial crisis point has passed, Diane's perceived need for help had abated. However, coercion and control may have played a part in the lack of report to the police and other services, or her lack of engagement might have been linked to her care and support needs which were being provided by James.

16.11 When practitioners encouraged Diane to report, Diane would quote legislation and threaten legal action; this may be evidence that Diane was trying to take control of aspects of her life because she was experiencing being controlled in other areas of her life. Care professionals reported that the way Diane responded made them feel coerced, controlled, and made them cautious. One of Diane's friends indicated their opinion that Diane was trying to control contact between her and James and that Diane was trying to conceal aspects of her life from James; for example, she did not want him to know she had taken time off sick from work. The impact of Diane's threats to take legal action on professionals was not considered within meetings. Diane's brother indicated she could be blunt and would invite you to leave; he never got to know who she was and indicated it was difficult to be friends. Neighbours reported it difficult to establish the truth and believed Diane had lied on occasions. Diane's brother reported she was a fantasist.

16.12 Many attempts were made to find and introduce care and support packages acceptable to Diane, however her lack of ability to accept the care and support offered, alongside her reluctance to engage, left her increasingly vulnerable in the context of her alcohol misuse and her increasing mobility issues.

16.13 There is evidence of effective information sharing from Adult Care to the GP Practice following Diane's admission to hospital and disclosure of domestic abuse. As a result of the information shared, the practice was able to place an alert on Diane's record, identifying her as a victim of domestic abuse and she was later prioritised for GP home visits. However, the GP was not as forthcoming in sharing information and did not attend the MRM meetings. Whilst attending meetings can be problematic for GPs there is an expectation that they share information to inform the meetings. Whilst hospital Alcohol Liaison Service was in attendance, they do not appear to have had the up-to-date information regarding Diane's alcohol use when the group met in September 2021. They shared information known to them in the immediate aftermath of Diane's alcohol detoxification where she was abstinent and her mobility had improved, however, Diane had disclosed she was drinking ½ a bottle of wine to a Bury alcohol worker in August 2021.

16.14 Lack of information from the GP, the sharing of out-of-date information and the lack of inclusion of Care-4-U and mental health services, potentially reduced the effectiveness of the multi-agency approach. Inclusion of all agencies who could potentially support Diane and explore and advise on ways of effectively engaging with Diane were missed. Greater involvement of, or information from all those working with or recently involved with Diane, may have brought about greater consideration of domestic abuse in the context of Diane's Guillain-Barré diagnosis, whether this was placing Diane at greater risk requiring a more cohesive multi-agency plan with increased joint working between services. An escalation process is in place whereby Adult Care can contact the Adult Safeguarding Designated Professional if they do not get adequate engagement from the GP; this was not utilised.

16.15 At the MRM meeting held in December 2021, it was brought to the attendees' attention that Diane had been making regular contact with the police insisting they dropped any criminal charges against her husband. A decision was made that the MRM would continue until the risk had reduced but it is not clear how it was thought this would be achieved. On review of the minutes of this meeting and the associated

risk management tools the chair and author notes no action was planned to try and address Diane's alcohol misuse.

16.16 In general actions identified within MRM meetings were frequently not completed as a result of Diane's reluctance to engage. Work was carried to increase Diane's safety through alerts on systems however, preventative measures that could have been taken were impacted by the decisions Diane was making.

16.17 A safety plan which was initially tasked to the hospital and then Diane's GP was not achieved as Diane refused to discuss it. Safety planning, was eventually discussed by the social worker however there was no evidence of a plan in relation to this.

16.18 The chair and author questions MRM forum is sufficiently robust to manage the level of complexity in this case. Whilst physical and alcohol related issues were discussed the action plans that were formulated did not include measures that had the potential to address these.

What did professionals do to; understand the impact of Diane's multiple conditions/needs? Consider whether the support offered had the potential to address Diane's health needs and reduce the level of risk within her relationship.

16.19 Whilst Diane was never referred to as having disabilities it is clear that her multiple conditions and needs were severely limiting her physical abilities. It is known that disabled women are twice as likely to experience domestic abuse compared to women without disabilities and are more likely to be at high risk of serious harm. That said, statistics collated by 'Co-ordinated Action Against Domestic Abuse' (CAADA) about people identified as being at high risk from domestic abuse show relatively low numbers of people with health and social care needs. This may be because for this group, domestic abuse is even more underreported or recognised than in the general population[15].

16.20 Following Diane's admission to hospital in June 2020 Adult Care contacted the hospital and requested that Diane was not discharged until seen by a Social Worker. This was to provide an opportunity for Diane to discuss her situation freely and discuss support options. Unfortunately Diane was discharged before any assessment took place; the Hospital did not notify Adult Care of Diane's discharge. This was a missed opportunity both to inform Adult Care of Diane's needs, and for Adult Care to start to build a positive relationship with Diane around supporting her physical health needs.

16.21 When Diane was referred to new services, there was not always sufficient information shared regarding the history of the case and the severity of the situation. If this information had been shared it might have brought a different response. Care4U indicated it would have assisted in them in determining their approach to Diane with regards to communication and enabled this to be handled more effectively and sensitively. If Care4U had understood the difficulties in engaging Diane, the manager indicated, they would have conducted more face to face visits as opposed to telephone contact. It was also reported that information was not shared with Care4U in relation to potential risks regarding Diane's husband and whether he might pose a risk to carers entering the property.

[15] LGA – Adult Safeguarding and Domestic Abuse: A guide to support practitioners and managers

16.22 Diane was referred to and closed by, Victim Support on five occasions. Adult Care made two of those referrals and perceived that Victim Support had closed the case quickly. Victim Support closed the case either because, Diane declined support, they couldn't make contact with Diane and, on two occasions following the case being heard at MARAC and no action being deemed to be required by Victim Support. A more flexible approach with joint working between Adult Care and Victim Support in complex cases where there are identified difficulties in engaging a vulnerable individual is required.

16.23 Diane had brief involvement with Alcohol Liaison Teams between July and August 2021. The team were aware of Diane's condition and that a safeguarding referral had been made and that Diane had been seen to have bruises on her arms. On one occasion, the nurse attempted to discuss this with Diane but she would not. No further attempts were made to discuss this or Diane's other health issues; concentration was solely on her alcohol misuse. Diane discussed her alcohol intake and her motivation to address her alcohol misuse. Diane underwent an alcohol detoxification during her admission. Following discharge, the Bury Alcohol Liaison team spoke to Diane on the phone. Diane indicated she was drinking ½ bottle of wine daily. Diane declined referral to drug and alcohol services.

16.24 There is little evidence held on the early records within Police systems documenting a clear understanding of Diane's health conditions or needs. However, there would have been flags indicating the high Risk DA. There are references within some of the reports when Officers had attended at the property, during which Diane had informed them of a lack of confidence in her care providers, however the records held do not make it clear what the connotations of this were. Nor do they identify what impact Diane's health conditions would have on any subsequent assessments of her capacity to refuse to give evidence, or provide statements to the Police retracting her evidence.

16.25 For NWAS there are particular issues, as they do not have access to patient's full histories so during each incident the crew must use their professional judgement and clinical skills to assess the patients' medical or social needs. As a result, the crews involved could only assessed Diane and her needs on how she was presenting at each incident using the information, which was provided by Diane or any individuals on scene at the time. The individual nature of each incident can make it challenging for crews to determine the full extent of a patient's needs if the patient or those involved are only willing to provide limited information. As result, the author of this report notes good practice that an alert was added to the address of Diane, which identified to attending crews that Diane was a high-risk victim of domestic abuse. This information meant that all attending crews would be alert to this high-risk history and would be able to act appropriately if they noted any reason for concern.

16.26 There is evidence of the effectiveness of this system during the last NWAS incident with Diane on 03/03/2022 when the attending crew noted the alert and requested immediate Police attendance due to Diane's unconscious presentation, the inconsistent history of events described by the husband and apparent bruising noted to Diane's body. This demonstrates good practice by NWAS in recognising the risk and vulnerable position of Diane, and acting decisively. The attending crew were able to use this alert along with their own professional judgement of the current situation to seek additional support for Diane.

16.27 Diane's GP Practice was her main point of contact for general healthcare. The Practice held her full patient health record and details of her past and ongoing health needs. GP consultations focused on Diane's physical and mental health and the impact of her health problems, including shielding in the early stages of the pandemic, feelings of isolation, her limited mobility, weight loss, low mood and concerns about losing her job. On one occasion, Diane indicated her husband was having an affair with her best friend.

16.28 Support offered included assessment, diagnosis and treatment, referrals to secondary health services and provision of sick notes.

16.29 Greater involvement of Diane's GP, either by linking in or by sending a representative from the practice to MRM meetings, would have created opportunity for the GP's information regarding Diane's condition to be shared and the likely impact on both Diane and James be considered. Diane indicated her GP and James were friends; this information was fed back to the practice for consideration of allocating Diane to an alternate GP. The IMR author has rightly indicated that evidence suggests that routine or universal healthcare screening for domestic abuse improves levels of victim identification in primary care and many studies have also found that time pressures in clinical practice can be a barrier to screening. However, when domestic abuse is known to be a feature there is an expectation that GPs should be considering this at each contact; there is no evidence this occurred in this case.

16.30 Diane would not agree to a Care Act Assessment however, despite this, when James was prohibited from returning to the family home a care package was swiftly organised. Adult Care had offered to source Diane alternate accommodation however; this was rejected as Diane wished to remain in her home. Adult Care staff also remained in regular contact with Diane but despite Diane agreeing to a care package were not able to gain Diane's full cooperation.

16.31 Care4U, once commissioned, sought to provide a good service to Diane. Despite Diane's reluctance to accept the care and support Care4U offered, the service continued to be in regular contact with Diane, ready to respond if or when Diane felt more able to accept a care package. Care4U were also in regular contact with Adult Care, updating them with their concerns.

16.32 The multi-agency work within this case was largely based around domestic abuse. Diane's case was complicated as she had multiple medical issues including Guillain-Barré syndrome, alcohol misuse, mental health issues, liver and kidney disease. Diane's complex needs needed to be better understood by all professionals and a wider more cohesive approach taken. There is evidence of some excellent single agency practice. However, not all agencies were privy to information that could have enhanced their relationships and working practices with Diane. When working with cases were individuals are reluctant to engage or refuse the service offered, it is essential that all agencies work collaboratively if they are ever to achieve a successful outcome and deliver the care and support required. If Diane had reached a point of acceptance of the care and support offered it had the potential to address her health needs and keep her safe.

Were professionals making full use of agencies policies and procedures relating to engagement of clients when working with Diane, and how effective were they in Diane's case?

16.33 There is a mixed picture across agencies to this term of reference. The ambulance service demonstrated full compliance with the NWAS Safeguarding Vulnerable Persons Policy and Procedures with crews raising safeguarding concern notifications and sharing information with other agencies. On all occasions, Diane was asked to consent to share information. NWAS shared information with Adult Social Care on 5 occasions in relation to Diane, 2 of which were shared without consent due to the severity of the concerns and the risk that Diane was experiencing. NWAS were not informed of the outcome of their referrals

16.34 Following Diane's admission in August 2020 Adult Care indicated they experienced difficulties in gaining information from both a Doctor on the Fairfield Unit and Diane's GP. In addition, the Doctor at the Fairfield unit refused to discuss Diane, or allow Adult Care access to visit Diane; this ultimately prevented an opportunity for early intervention and safety planning.

16.35 With regards to contacting the GP, difficulties have previously been identified as at that time Adult Care tended to use a generic email inbox for the GP, which wasn't always checked on a daily basis. In October 2021, HMR CCG (now NHS GM ICP) shared details of GP Practice phone numbers (including 'backdoor' numbers) and Practice Managers email addresses with Rochdale Social Care to improve access/communication pathways). They can also escalate to the Adult Safeguarding Designated Professional if they are unable to get through. Whilst Diane was not consenting to Adult Care, involvement NWAS had, in the interests of safeguarding Diane, made a safeguarding referral. In these circumstances, there is an expectation that all health professionals will override patient consent in order to safeguard their patient.

16.36 Diane was in regular contact with her GP Practice throughout the timeframe of the review, via telephone consultations and home visits. Diane often did not follow the advice of GPs, for example, Diane disclosed that she had not taken the anti-depressant medication prescribed, she refused referral to Gastroenterology and refused ambulances for hospital admission on three occasions during the review period. Clinicians are guided by the; General Medical Council Guidance, which is clear that clinicians must respect a competent patient's decision to refuse an investigation or treatment, even if they think their decision is wrong or irrational. They may advise the patient of their clinical opinion but must not put pressure on them to accept their advice. GP practice staff followed this guidance to the letter; however, as will be discussed further in section 16.54, they were assessing Diane's capacity to refuse treatment but not considering the impact of DA coercion and control on her choices.

16.37 The GMP IMR author indicated that on the whole officers attended incidents and made professional judgements in line with GMP's domestic violence policies, in all cases undertaking some safeguarding actions and interacting well with partner agencies. Positive action was taken on one occasion to arrest the perpetrator following a report of assault however, on most of the occasions, due to the lack of support; these incidents did not result in criminal charges. Whilst there is an opportunity for consideration of an evidence led prosecution where there is a lack of support, each incident must be considered on its own merits to establish whether the threshold is met for CPS to consider charging without the support of the victim. The GMP IMR author was of the opinion that some incidents may not have meet the

threshold however, they felt that more police action may have been taken with respect to safeguarding; James was only arrested on one occasion. Diane continued to disclose to partner agencies about domestic abuse and consideration should have been given to arresting James on further occasions. The police could have attempted to work with partner agencies in a more dynamic fashion to engage with Diane and make sure she had the support in place when her husband was out of the house.

16.38 It is the overview author's opinion that a more cohesive multi-agency approach in this case was necessary.

What support was offered to James? By virtue of his caring role, James was entitled to a Carers Assessment. Is there evidence this was offered. What prevented a Carers Assessment being undertaken? Were there any further powers/actions professionals could have used to address James's actions?

16.39 James had been Diane's carer following her diagnosis of Guillain-Barré Syndrome in June 2020, and was carrying out this role whilst still maintaining full time employment.

16.40 The Care Act[16] defines a carer as someone who 'provides or intends to provide care for another adult' (but not as a volunteer or contacted worker). The local authority has a duty to assess a carers needs for support to maintain their well-being – including protection from abuse.

16.41 It was reported by Diane, to professionals, that there was no extended family who could offer support so it was clear all caring responsibilities would fall to James. It does not appear that James was offered any support following Diane's initial diagnosis.

16.42 Later offers of a carers assessment were declined by Diane on James's behalf and this was not challenged by professionals.

16.43 Little is known to the reviewer about how this new role impacted on James however, it is clear that there would have been an inevitable change in the dynamics of their relationship. Diane's brother indicated the couple's relationship was built around a shared love of horse racing, frequenting race courses and public houses. It is inevitable that Diane's' reduced mobility, and deteriorating physical condition, would have negatively impacted on these activities.

16.44 Both Diane and James indicated there had been recent bereavements within the family, which had added to the stress within their relationship. As a result, it was reported that James had begun drinking to excess and could be extremely depressive. These reports should have triggered a carers assessment and discussion about referring to drug and alcohol services, as substance and alcohol abuse are

[16] The Care Act (2014)

known to be associated with the perpetration of partner violence.[17] [18] It should be noted that whilst alcohol may exacerbate domestic abuse, it is not the cause.

16.45 Following the alleged assault on Diane in May 2021, it was reported by Diane that James had attempted to take his own life by taking medication and alcohol; although this has not been substantiated, no carers' assessment was offered at that time. James on being told by a neighbour that they were ringing the 111 services indicated agreement and stated he had been telling Diane for weeks and she would not accept any help. Following this incident, Diane reported they were receiving marriage counselling privately. This appears to have provided a degree of reassurance that the couple were working through their issues, however marriage counselling is not appropriate in situations where there is domestic abuse and this disclosure should have prompted practitioners to consider whether this increased their levels of concern .

16.46 At the strategy meeting in July 2021 it was acknowledged that a carers assessment had not been offered; the Hospital team were tasked to explore a carers assessment and referral to the Recovery & Reablement service; there is no evidence this occurred. It must be acknowledged that care and treatment of Diane was during the Covid-19 pandemic when patient visiting, was restricted. NCA hospitals were experiencing unprecedented pressures whilst recovering from a peak period of outbreak. The impact of Covid-19 would be significant for the majority of the time period, as restrictions were in place across the NHS from June 2020 – September 2021.

16.47 It was not until September 2021 following an admittance to hospital, that Diane consented to an adult social care referral to explore help and support at home. However, no 'in the home' care was commenced until James's arrest in November 2021. This, and his subsequent bail conditions, meant he was not allowed contact with Diane therefore carers were employed to assist Diane with daily tasks out of necessity. Diane disengaged with carers prior to the end of James's bail conditions; Diane had no additional practical carer support from this time up until her death. The Adult Care Social Worker remained in regular telephone, and occasional face to face, contact up until Diane's death. Extensive efforts were made to engage Diane and offers of alternate accommodation and onward referral to additional support services were made.

16.48 Despite the identified stresses in the couple's relationship there was no carers assessment completed with Diane's husband until January 2022. It was noted that the reason for this not being offered in the earlier stages of the review period was lack of consent by Diane. However, as a carer James was legally entitled to a carers assessment in his own right; Diane's consent was not required to do this. Diane was not challenged regarding this and James was not contacted. When the social worker did get an opportunity to speak with James about his caring role, and despite

[17] Abbey, A., Wegner, R., Woerner, J., Pegram, S. E., & Pierce, J. (2014). Review of survey and experimental research that examines the relationship between alcohol consumption and men's sexual aggression perpetration. *Trauma, Violence & Abuse*, 15(4), 265–6.

[18] Leonard, K. E., & Quigley, B. M. (2017). Thirty years of research show alcohol to be a cause of intimate partner violence: Future research needs to identify who to treat and how to treat them. *Drug and Alcohol Review*, 36(1), 7–9.

indicators to the contrary, he indicated that he did not feel that it had a negative impact on his wellbeing. This would be difficult for professionals to challenge but may be further evidence of James wishing to keep control.

16.49 The carers assessment in February 2022 did not identify any additional support needs; the outcome of James's carers assessment had not been shared with other agencies prior to Diane's death.

16.50 There were a number of opportunities where all professionals could have referred James for a carer's assessment. This was only offered on two occasions known to the reviewer and only once directly with James. On this occasion, he accepted the assessment, which suggests he may have done so earlier.

16.51 James could also have been referred to a perpetrator programme. There is now a perpetrator programme panel that considers whether perpetrators are candidates to attend the perpetrator programme. The programme is aimed at perpetrators of domestic abuse who pose a serious risk of harm to those they are in relationships with. It aims to break patterns of high-risk abuse.[19]

Is there evidence that professionals were considering coercion and control in their interactions with Diane?

16.52 It is clear that all those professionals actively involved with Diane were focused on evidence of domestic abuse although not always clearly articulating issues of coercion and control during their contact with Diane.

16.53 However, on one occasion in November 2021, following discussion with Diane and then James, the Adult Care SW emailed the Public Protection Unit (PPU) due to concerns regarding domestic abuse and coercive control. A crime was recorded for engaging in controlling/coercive behaviour and was finalised as Diane told officers that nothing had occurred. In the absence of any witnesses or CCTV evidence, there was insufficient evidence to provide a realistic prospect of conviction. Appropriate referrals to safeguarding were made. The inspector authorised no further action be taken and the crime was closed.

16.54 The safeguarding concern notification raised by NWAS on in July 2020 included the disclosure from Diane that James was controlling her. Diane disclosed to the 111 Health Advisor that she was reluctant to access additional support as 'her husband checks her phone logs'; this constitutes technology-facilitated abuse. Diane advised that any calls made to her for support could only be done so between the hours of 9 and 12 when James was at work, and this information was included in a safeguarding notification. This demonstrates good practice by NWAS 111 as the Health Advisor (call handler) identified the controlling behaviour which Diane was experiencing, and documented a possible solution to be used by support services when contacting Diane. Diane's friends indicated there had been no change to the frequency and content of the messages Diane sent them and that Diane had not alerted them that James was monitoring her phone.

16.55 There is no evidence within the patient record that GPs were considering coercion and control in their interactions with Diane. Diane's disclosure of domestic abuse was shared by Adult Social Care on 11.06.21. There were three consultations, prior

[19] http://driveproject.org.uk/

to this date, which offered the GP opportunities for further professional curiosity and direct enquiry about domestic abuse. Specifically, Diane's disclosure in July 2020, that her husband would be upset if she called for an ambulance, suggests a level of coercion and control; this did not appear to be recognised.

16.56 The Local Government Association (LGA) guide to support practitioners and managers[20] - draws attention to fact that being at risk of harm can limit an individual's capacity to safeguard themselves due to the psychological process that focusses an individual on acting within the immediate context of the threats that they face, in order to limit the abuse and its impact. This can lead victims to identify with the perpetrator and can prevent them from acknowledging the level of risk they face. It commonly prevents people leaving or ending a relationship.

16.57 The GP received a copy of the May 2021 safeguarding referral regarding domestic abuse. However, when they next saw Diane in June 2021, there is no evidence to indicate that Diane's refusal of anti-depressants, her refusal of Gastroenterology referral, or her refusal of ambulance services, were ever considered as indicators of ongoing coercion and control indicating a lack of professional curiosity.

16.58 Whenever practitioners are working with clients there is a need to understand their history however, there is little evidence to suggest practitioners were considering whether aspects of Diane's childhood, or adult experiences might be influencing some of her behaviours. The chair and author now understands that Diane's father misused alcohol. This, alongside her disclosure that she had allegedly been raped historically, suggests she had experienced multiple traumas, which are likely to have led to some of her behaviours. Practitioners need to exercise greater professionals' curiosity.

In terms of domestic abuse, was every action taken that could have been to safeguard Diane?

16.59 All occasions when Diane disclosed domestic abuse resulted in actions being taken.

16.60 The actions of NWAS were excellent; they recorded and reported every disclosure made by Diane to Adult Care and, when appropriate, the Police.

16.61 There were a number of missed opportunities for professionals to make direct enquiries about domestic abuse. Diane's negative response to enquiries acted as a barrier.

16.62 The guiding best practice principles of safeguarding indicate survivors should be; respected, believed, protected, supported, updated, heard, safeguarded, informed and empowered[21]. Whilst it is clear practitioners were respecting, believing, and updating Diane, and were striving to support, empower, protect and safeguard her, this proved impossible to achieve. The allocated SW made regular contact with Diane, even though Diane did not always welcome the contact, in order to try to; empower, support and protect her. The care provider was put in place to support Diane however, Care4U reported they were reluctant to make enquire about domestic abuse as they were struggling to engage Diane, but also because they had

[20] Local Government Association (2015) Adult Safeguarding and Domestic Abuse – a guide to support practitioners and managers

[21] Guiding Best Practice Principles the Care Act 2014

not been trained and were unskilled in doing so; arrangements have been made to train Care4U staff.

16.63 Despite police officers consistently responding to allegations of domestic abuse, Diane refused to engage however, following each police interaction; Diane continued to disclose abuse to partner agencies. On one occasion, Police took appropriate positive action following a third-party report of assault despite lack of victim confirmation, arresting James and imposing bail conditions when the evidential threshold was not met.

16.64 The police IMR author has been clear that on other occasions there were a number of further actions open to the police including consideration to DVPN/O[22] when Diane was unsupportive of Police action. This is a finding within a previous DHR in Rochdale[23]. On one occasion, an attending officer considered a DVPN and discussed this with his Inspector. The inspector did not feel it was appropriate in the circumstances, due to the lack of evidence and Diane's refusal to engage. The Police IMR has identified additional issues relating to the closure of CAP/DAB report upon referral to MARAC, and the recording of actions arising from MARAC and timescale for Police – the IMR author has made acceptable recommendations, which are already being progressed.

16.65 GMP have also recommended changes to the EHASH processes. The closure of GMP CAP/DAB reports upon referral to MARAC was identified as not appropriate and leads to a lack of information retention in the event of subsequent incidents arising. GMP highlighted that MASH officers lack a bespoke training program and this has been addressed with the Organisational Training and Delivery Group commissioning the People and Development to put a full package together, with the intention to be able to deliver this to all Triaging officers and staff in 2023. Consideration should be given to the implementation of a team of specialist Domestic Abuse Officers to undertake investigations for all offences reported within cases where High Risk of Domestic Abuse is assessed. This would involve a single point of contact for each case and ensure optimal information retention and coordination around positive action and bail/welfare checks. In some areas, this has been undertaken; in others, the contingency remains for escalation of the allocation policy to PIPL2 trained officers by MASH triage staff through supervision – enhanced training as described above would improve this outcome.

16.66 Awareness of powers of entry/search and arrest should be raised amongst Officers attending to welfare/bail/DVPO checks with respect to high-risk cases of domestic violence. These should be undertaken on a joint agency basis where appropriate.

16.67 There is little evidence to suggest agencies were routinely enquiring about domestic abuse despite Diane's disclosures. On the whole, agencies reacted to Diane's disclosure but were not proactively seeking information.

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[22] DVPN – A Domestic Violence Protection Notice is an emergency non-molestation and eviction notice which can be issued by the police when attending to a domestic abuse incident, to a perpetrator. It is effective from the time of issue. Within 48 hours of the notice being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard.

DVPO – Domestic Violence Protection Order can prevent the perpetrator from returning to the residence and from having contact with the victim for up to 28 days.

[23] https://rochdalesafeguarding.com/assets/c31bdc8b/sardhr_amira_final_report_21.08.2022.docx.pdf

16.68 In January 2022 when it was suggested to Diane that she consider leaving the family home, Diane provided a number of reasons, which were preventing her from leaving, including the mortgage being in both their names, not being able to afford the bills on her own, and wanting somewhere she could take her cat. These factors are not uncommon in paralysing victims of DA from escaping the perpetrator[24]. The manipulation of money and other economic resources is one of the most prominent forms of coercive control, depriving women of the material means needed for independence, resistance and escape. It is a barrier to leaving; lack of access to economic resources is a reason why many women feel that they have no choice but to stay with an abuser. With it comes increased risk; economic barriers to leaving can result in women staying with abusive men for longer and experiencing greater danger, injuries and even homicide as a result.[25]

16.69 **Pets can also become part of the abusive tactics used by perpetrators, as a prime means to coerce and control. The emotional ties a victim feels towards their dog or cat is used to ensure that they don't leave. In a survey carried out by the Dogs Trust in 2019** 95% of professionals said that survivors will not leave their home without knowing their pet would be safe.[26]

16.70 The lack of ability to engage Diane in developing a safety plan acted as a barrier to finding solutions to address these issues but they could have been discussed in greater detail within MRM meetings.

Is there evidence professionals were considering Diane's mental capacity and whether domestic abuse was impacting on her decisions?

16.71 There is evidence that professionals were considering Diane's mental capacity, this is particularly evident in the recordings on NWAS documentation, which clearly indicate Diane had not demonstrated any behaviour to cause concerns around her capacity and were clear she did have capacity; the only exception was when she was unconscious.

16.72 GP record shows that Diane's mental capacity was considered on occasions when she refused hospital admission, when she asked the GP for help because she could not walk, and when the GP had advised her of the serious risks associated with her head injury and the need for further assessment. This last assessment was very plainly documented in the GP record with clear detail of the discussion

16.73 During a period of confusion when Diane was in hospital, legal advice was sought and conversations were had, regarding potential application for a Deprivation of Liberty Order in order to safeguard Diane however, her confused state lifted and no such order was sought.

16.74 GMP and Care4U hold no information that a Mental Capacity assessment[27] was ever undertaken. Care4U have indicated that this is not something they would do. If an adult is known or open to Adult Care then it would be for the SW to complete a Mental Capacity assessment. Whilst care providers would not do the assessment,

[24] The National Coalition Against Domestic Violence ncadv.org
[25] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/financial-abuse/
[26] https://www.oasisdaservice.org/the-oasis-blog/domestic-abuse-and-pets
[27] Mental Capacity Act (2005)

they need to be confident to know when and in what circumstances to request one. Adult Care did complete a Mental Capacity assessment on the 30th November 2021.

16.75 Although mental capacity was considered in respect of domestic abuse, wider consideration of whether Diane's alcohol misuse could be impacting on her mental capacity causing fluctuation was not. Victims of domestic abuse may use alcohol or drugs in order to cope with, or 'block out', what is happening to them.

16.76 When a person who appears to have mental capacity also appears to be choosing to stay in a high-risk abusive relationship then careful consideration must be given to whether they are making that choice free from the undue influence of the person who is causing them harm or others. It may be that the relationship is more important to them than the harm that is being done.

16.77 The MCA Code of Practice states that 'there may be cause for concern if somebody repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character'. The Code of Practice adds that 'these things do not necessarily mean that somebody lacks capacity...but there might be need for further investigation, taking into account the person's past decisions and choices'. The Code of Practice suggests issues worthy of further investigation might include whether the person has 'developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information to help them understand the consequences of the decision they are making?' [28] This is an area which could have been explored further in MRM meetings and with legal representatives.

17 Conclusions

17.2 In this case, it is clear that all professionals responded positively when Diane made disclosures of domestic abuse. Following the initial disclosure, appropriate referrals to Adult Care were made. The lack of a specific incident and refusal of consent meant Early Help and preventative services were not able to become involved. The impact of lack of consent and retraction of allegations cannot be overestimated. Lack of consent meant the police were unaware of the earliest incident and were not approached for advice; its' effect was to reduce the number of agencies involved and to leave those partner agencies who remained, largely, powerless to respond.

17.3 What could have made a difference in this case was development of a positive relationship with Diane and greater professional curiosity from agencies into understanding any barriers that Diane might have experienced to engaging with services. Diane's brother was clear that Diane was not someone whom it was easy to make friends with, it is possible that aspects of her personality would always have impeded services developing positive relationships, however when Diane indicated she was not open to engaging with Victim Support, the service was quick to close her case. Further efforts, could have been made to encourage engagement and promote the message that the service was there, and had the expertise to support Diane. The SW remained in regular contact with Diane and it is apparent that overtime the

[28] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf

relationship between them developed to a point where Diane did disclose further abuse.

17.4 A previous local DHR[29] identified that multi-agency forums were not being referred to e.g. MARAC; this has not been the case here, which is a positive. However there is still the need for greater multi-agency working, timely and comprehensive information sharing, and involvement of all agencies who have a remit to work with individuals experiencing domestic abuse (even when their service had been declined). Had this been achieved there would have been a better informed the multi-agency plan. Accurately identifying all the risks and exploring corresponding actions would have identified gaps that could not be addressed without Diane's cooperation. Identifying risk that the professional group are unable to reduce and helps professionals to understand when cases need to be escalated and legal advice sought. In addition, there was some potential for increased joint visiting and a more comprehensive and clear safety plan.

17.5 It is clear the James was experiencing his own difficulties in coping with recent bereavements and, undertaking his new role as Diane's carer whilst working fulltime. James was suffering from depression and following an incident of domestic abuse whilst in alcohol, it is reported that he attempted to take his own life. Greater work could have been done to understand the impact of caring for Diane on James and, despite Diane's reluctance to engage, a carer's assessment should have been offered to James in July 2020 when James commenced his caring role of Diane following her diagnosis of Guillain-Barré syndrome. Consideration should have been given within the MARAC to referring James to a perpetrator programme.

17.6 Diane's abuse was reported during the Covid-19 pandemic, this impacted on hospital staff having contact with James as there was no visiting and the GP practice in terms of speed of response to offer Diane an appointment. In general, most services have not reported this impacted on their delivery of services to Diane. As with all UK citizens there would have been an impact on James and Diane who would have been in each other's company for increased time periods. Several countries have reported a significant increase in domestic violence cases since the Covid-19-induced lockdowns and physical distancing measures were implemented. The Covid-19 health crisis has been cited for increasing the severity and frequency of domestic violence[30]. Refuge' (a UK-based charity supporting victims of domestic abuse) reported a 25% increase in calls to the national domestic hotline since lockdown began (Refuge, 2020[31]). During the Covid-19 lockdowns abuse by current partners as well as family members increased on average by 8.1% and 17.1%[32].

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[29] https://rochdalesafeguarding.com/assets/c31bdc8b/sardhr_amira_final_report_21.08.2022.docx.pdf

[30] Deniz Ertan, Wissam El-Hage, Sarah Thierrée, Hervé Javelot & Coraline Hingray (2020) COVID-19: urgency for distancing from domestic violence, European Journal of Psychotraumatology, 11:1, DOI: 10.1080/20008198.2020.1800245

[31] Refuge. (2020). 25% increase in calls to national domestic abuse helpline since lockdown measures began. https://www.refuge.org.uk/25-increase-in-calls-to-national-domestic-abuse-helpline-since-lockdown-measures-began/

[32] Ria Ivandić, Tom Kirchmaier, Ben Linton, Changing patterns of domestic abuse during Covid-19 lockdown (2020)

18 Lessons to be Learnt

18.2 The following lessons have been learnt:

Multi-agency

1. There should be greater inclusivity in MRM/Multi-Agency meetings. All agencies involved with the subject or to whom the subject has been referred should be represented. Those representing services should ensure the information they are sharing is up-to-date. Non-attendance or non-contribution should be challenged and escalated. Actions and minutes agreed in MARAC and MRM meetings should be shared with all involved agencies. Incomplete actions should be reviewed again and if unachievable be escalated. All areas of risk should be identified and have an associated action.
2. Diane's case was complicated as, in addition to domestic abuse, she had multiple medical issues including Guillain-Barré syndrome, alcohol misuse, mental health issues, liver and kidney disease. The chair and author questions whether the MRM forum was being used to the full to recognise the increased risk Diane's condition brought in relation to domestic abuse and to manage Diane's complex needs, a wider more cohesive approach needed to be taken.
3. When working with cases where there are issues around engagement or refusal of the services offered, it is essential that all agencies work collaboratively if they are ever to achieve a successful outcome and deliver the care and support required. If Diane had reached a point of acceptance of the care and support offered it had the potential to address her health needs and keep her safe.
4. There needs to be a consistent approach to referring carers for a carer's assessment and perpetrators to perpetrator programmes.
5. When working with adults who are assessed as having mental capacity but are making decisions that appear unwise, professionals need to consider whether alcohol or substance misuse, economic abuse, and or coercion and control may be having an adverse impact on mental capacity. In these circumstances, further legal advice should be sought within multi-agency forums to support professionals practice.
6. All care providers need to be provided with guidance regarding mental capacity act assessments.
7. Where clients are not engaging with services designed to support victims of domestic abuse, the services needs to adopt a flexible approach, working jointly with partner agencies to support the client.

Adult Care

1. Domestic Abuse Training should be essential for all staff in assessment teams including managers in adult social care.
2. Adult Care need to be assured that there is an escalation protocol in place for when there are concerns regarding lack of engagement from other agencies.
3. Escalation Policy to be devised/reviewed for Adult Social Care.

4. Practitioners should be aware of the perpetrator programme Panel for perpetrator and In Domestic Abuse cases, practitioners to consider referrals to the perpetrators programme panel to address the behaviour of the perpetrator.
5. Increased awareness required regarding the IDVA Service– Independent Domestic Violence Advocacy.

NHS GM Integrated Care

1. It is essential to acknowledge the time constraints within primary care and to provide GPs with a domestic abuse-screening tool, which is simple to use, short, safe and validated.
2. There is a need for GP Practices follow RCGP safer video consultation guidance'.
3. Primary care staff need to routinely record mental capacity assessments, which evidence defensible decision-making.

Care4U

1. Care4U's involvement was hampered by difficulties in engaging Diane despite the services creative use of a number of tactics to encourage this
2. The importance of receiving comprehensive background information regarding previous DV incidents.
3. The homecare agency felt that conducting a mental capacity act assessment was outside of their remit.
4. When care home agencies are involved in the care of individuals who are being discussed in MARAC or MRM, they need to receive, and have the opportunity to share, information which could increase safety.

19 Recommendations

19.2 The following recommendations have been made by the overview author as a result of conducting this review and are in addition to those identified within the single agency report. Please see the action plans below:

Overview report additional recommendations

1. Strengthen the effectiveness of MRM meetings by ensuring the meetings include representation of all services in direct contact with the subject, and all agencies with expertise to support the work of those services e.g. drug and alcohol services, mental health services, so expert advice can be provided. Membership to be updated as new services become involved. MRM meetings to routinely consider whether all applicable non-statutory services available in Rochdale have been offered to both client and carer.
2. Non-compliance and non-attendance at MRM and MARAC meetings by key partners should be challenged and if unresolved escalated. The multi-agency escalation policy to be reviewed.
3. Adult Care to ensure Carer assessments are offered to all carers, in line with legislation, even if the referred client declines involvement.
4. MARAC needs to evidence referral of perpetrators to perpetrator programmes.
5. Where subjects are felt to be making unwise decisions, services are struggling to engage them, and alcohol or substance misuse, and or coercion and control may be

having an adverse impact on mental capacity, legal advice must be routinely sought to ensure all legal options have been explored.

6. Guidance to be produced for all care agencies in relation to mental capacity assessments.
7. Victim support services to revisit their way of working with clients who are not engaging, to include joint working with partner agencies.

19.3 The following recommendations have been made by each of the agencies involved within this review to address the lessons learnt. Please see the action plans below:

Police

1. Consideration to DVPN/O should be given at all stages to cases of DA wherein victims are unsupportive of Police action. This should include following arrest - and referenced in the recorded rationale within the force policy for Detainees Leaving Police Custody against the consideration for imposing conditional bail – as well as within the closure rationale for crime and DAB reports
2. GMP MASH processes should include the recording of actions arising from MARAC and timescale for Police review.
3. Awareness of powers of entry/search and arrest should be raised amongst Officers attending to welfare/Bail/DVPO checks with respect to high-risk cases of domestic violence. These should be undertaken on a joint agency basis where appropriate.

Adult Care

1. Domestic Abuse Training should be essential for all staff in assessment teams including managers in adult social care.
2. Adult Care need to be assured that there is an escalation protocol in place for when there are concerns regarding lack of engagement from other agencies.
3. Escalation Policy to be devised/reviewed for Adult Social Care.
4. Practitioners should be aware of the perpetrator programme Panel for perpetrator and In Domestic Abuse cases, practitioners to consider referrals to the perpetrator programme panel to address the behaviour of the perpetrator.
5. Increased awareness required regarding the IDVA Service– Independent Domestic Violence Advocacy.
6. Early referral for legal advice required. An earlier referral for Legal advice should have taken place in this case following non- engagement with the safeguarding enquiry and ongoing risk/concerns on 20.8.2021.

NHS GM Integrated Care

1. It is essential to acknowledge the time constraints within primary care and to provide GPs with a domestic abuse screening tool which is simple to use, short, safe and validated.
2. There is a need to ensure that GP Practices have access to the safer online/ remote consultation guidance
3. There is a need to increase GP awareness of the availability and value of the electronic mental capacity template.

Northern Care Alliance

1. Recommendations in relation to actions for NCA are in relation to training and development and raising awareness of potential indicators of Domestic Abuse. Adherence to NCA policy in relation to early escalation and multiagency involvement. Also, assurance that learning from Domestic Homicide Reviews will continue to be shared across NCA. As an organisation, a project in Oldham; “Open Door Project”, has been commissioned to focus on Domestic Abuse in Older People. NCA are supporting this work and developing some video resources that will be utilised to raise awareness of Domestic Abuse within this age category.

Care 4 U

1. Care4U to routinely request information regarding domestic violence prior to agreeing and commencing a package of care.
2. Care4U staff need to increase their knowledge in respect to Domestic Violence through training.
3. Care4U staff need clear guidance and training on when, how and where to obtain assistance in assessing mental capacity.

Diane

Died March 2022

Domestic Homicide Review

Rochdale Community Safety Partnership

Executive Summary

May 2023

AUTHOR – Nicki Walker-Hall

Table of Contents

THE REVIEW PROCESS

This summary outlines the process undertaken by Rochdale Community Safety Partnership domestic homicide review panel in reviewing the homicide of Diane who was a resident in their area. The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

Diane – victim
James – alleged perpetrator

Diane was of White British origin and 55 years old at time of the fatal incident, James was also of White British origin and 47 years old

Criminal proceedings have yet to be completed.

The process began with an initial meeting of the Community Safety Partnership on 31.03.2022 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Diane and James prior to the point of death were contacted and asked to confirm whether they had involvement with them. Twelve of the agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

The following agencies provided information to the screening process which was made available to the chair and author:

Greater Manchester Police
Pennine Care NHS Foundation Trust
Rochdale Adult Care
Turning Point
Victim Support
Probation Service
Care4U Home Care Agency
North West Ambulance Service NHS Trust
BARDOC
Northern Care Alliance NHS Foundation Trust
NHS Heywood, Middleton, and Rochdale Clinical Commissioning Group (HMR CCG) (replaced by Greater Manchester Integrated Care Partnership on the 1st July 2022)
Thinking Ahead

The following agencies were deemed to have had sufficient involvement and information with Diane to warrant the completion of an IMR.

Greater Manchester Police
Rochdale Adult Care
Care4U Home Care Agency
North West Ambulance Service NHS Trust
Northern Care Alliance NHS Foundation Trust
Greater Manchester Integrated Care Partnership (HMR CCG)

All the authors of the IMR's were independent having had no direct contact with Diane. All IMRs were signed off by a senior executive within each organisation.
The following agencies were required to provide a short report:

Thinking Ahead
BARDOC
Pennine Care NHS Foundation Trust
Turning Point
Victim Support

Letters were sent to all the Chief Executives of these agencies with requests for IMRs. A letter of introduction was drafted for Diane's brother to inform him of the review. GMP approached and informed Diane's brother of the review and invited him to contribute. Diane's brother spoke to the chair and author on the 22nd November 2022. The chair and author has kept the coroner up-to-date with the reviews progress in writing on the 27th June, 17th October and the 8th November.

THE REVIEW PANEL MEMBERS

The following constituted the multi-agency panel:

Role	Organisation
Independent Chair/Author	Clear Outcomes Consultancy Ltd
Det Sgt Investigation and Safeguarding Review Team	Greater Manchester Police
Director of Nursing	Pennine Care NHS Foundation Trust
Serious Incident Review Officer/Principal Social Worker and Strategic Safeguarding Lead Adult Care and Support	Adult Care
Safeguarding Lead	Turning Point
Operational Manager	Victim Support
Assistant Chief Officer/Head of PDU	Probation Service
Development Officer (Domestic Abuse	Rochdale Safer Communities Partnership
Manager	Care4U home care agency Ltd
Safeguarding Practitioner Greater Manchester Safeguarding Practitioner 111 & EOC	NWAS
Assistant Director of Nursing Safeguarding Adults/LD/Autism/Dementia/Falls	BARDOC
Assistant Director of Nursing Safeguarding Adults/LD/Autism/Dementia/Falls	NCA
Adult Safeguarding Designated Professional	NHS Greater Manchester Integrated Care (HMR CCG)

The panel met on five occasions. All but the Care4U member who had not had direct involvement with Diane and were therefore independent. Care4U is a small organisation and it was unavoidable that Lisa Lees represented the organisation.

AUTHOR OF THE OVERVIEW REPORT

Nicki Walker-Hall was commissioned as Chair and Author for this review. Nicki is an Independent Safeguarding Consultant with a background in health. Nicki is a Registered General Nurse, Registered Sick Children's Nurse who has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki has worked in safeguarding roles for over 25 years, both in acute, community, PCT and Mental Health and Learning Disability services and was a former Designated Nurse Child Protection prior to becoming independent in 2009. Nicki is an experienced chair and author of safeguarding children and safeguarding adult reviews.

Nicki has had no previous connection to Rochdale Community Safety Partnership and has not been employed by any agency within Rochdale.

TERMS OF REFERENCE FOR THE REVIEW

The following terms of reference were agreed by the DHR panel:

1. Explore the interface between processes which were used to help safeguard Diane (MARAC and MRM) and the effectiveness of these multi-agency systems in complex cases.
2. What did professionals do to, understand the impact of Diane's multiple conditions/needs? Consider whether the support offered had the potential to address Diane's health needs and reduce the level of risk within her relationship.
3. Were professionals making full use of agencies policies and procedures relating to engagement of clients when working with Diane, and how effective were they in Diane's case?
4. What support was offered to James. By virtue of his caring role James was entitled to a Carers Assessment. Is there evidence this was offered. What prevented a Carers Assessment being undertaken? Were there any further powers/actions professionals could have used to address James's actions?
5. Is there evidence that professionals were considering coercion and control in their interactions with Diane?
6. In terms of domestic abuse, was every action taken that could have been to safeguard Diane?
7. Is there evidence professionals were considering Diane's mental capacity and whether she was making unwise decisions?

In addition authors were directed to consider the questions contained within the national guidance[1], to aid them in their analysis and promote wider thinking and learning from the case.

SUMMARY CHRONOLOGY

The following are the key events during the review period:

Date	Event	Action taken	Outcome

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

June 2020	Diane had a fall. First disclosure of Domestic Abuse to NWAS. James controlling, screening calls, emails etc, Reported daily alcohol use.	Taken to hospital. Referral made to Adult Care.	Self-discharged. Declined Adult Care input.
July 2020	Diane diagnosed with Guillain Barré Syndrome.	Support offered in the form of Safenet and Adult Care support, but declined as "Adult Care would only cause additional problems".	Discharged home.
August 2020	Collapse in bathroom. Diane reported James was verbally and physically abusive to her when NWAS attended, and ED staff concerned as Diane appeared fearful and wanted help. Disclosed historic rape and torture (not James).	Diane admitted to hospital. Adult Care discussed the support that could be offered but Diane felt that there was no service or person that could help her. Care Act assessment and daily care services were offered to support Diane and reduce her reliance on James.	Diane declined all support, contact numbers and information.
May 2021	Diane's neighbour raised concerns regarding Diane's health after Diane had sent her a photo of a bruise.	Diane was admitted to Royal Oldham Hospital. Bruising to Diane's upper arms and strangulation marks to her neck were noted in the ED department. A Safeguarding referral was submitted. A referral to MARAC was also completed. A DASH risk assessment was completed and reviewed by the IDVA. A MCA assessment was completed in relation to unwise decisions. Crime submitted for section 47 assault.	Diane declined IDVA involvement and advised she would take legal action if staff persisted to discuss. Threats to sue impacted on practitioners engagement with Diane.
July 2021	Diane was taken to A&E by ambulance crew with bruising on back, left arm, right elbow, left thigh. Diane disclosed that her husband has hit her she has been a victim of domestic violence.	Diane was admitted for three weeks. A DASH risk assessment was completed and a referral to MARAC on professional judgement was completed.	Diane did not want safeguarding concerns reporting to the police. Diane refused a MARAC referral when

		Mental capacity was assessed and Diane deemed to have capacity.	offered this on 3 separate occasions. Diane agreed to a referral to Adult social care to have help and support at home.
November 2021	Diane reported she had been assaulted by her husband. Diane had disclosed to a social worker that her husband had assaulted her bruising her arms and hand.	Ambulance sent. Police Officers attended Diane's home to speak to her, but Diane denied she had been assaulted claiming she had fallen.	Officers arrested James and in interview he denied the offence MR was bailed to an alternate address.
14th December 2021	The GP visited Diane and had concerns regarding a possible bleed on the brain resulting from a reported 'fall' two days previously.	GP felt Diane needed a CT scan or MRI scan as he could not rule out a bleed on the brain. Diane declined hospital admission. Diane was experiencing a decline in her health due to Gillian Barré syndrome.	Alcohol and mental capacity assessment completed. Referred to Neuro-Rehab.
13th January 2022	Informed SW she did not feel 100% safe, James had taken her bank card and was always angry.	Police informed and visited. James declined their assistance.	Crime submitted for controlling/coercive behaviour. DAB completed. Information shared with MARAC and MRM.
3rd March 2022	James reported Diane had fallen out of bed. Diane was unconscious. Excessive bruising was noted and blood on all pillows.	Admitted to hospital. Subdural haematoma – Admitted to ICU.	Diane sadly passed away the following day.

Diane was a 55 year old married lady who had been lived at her home address in Rochdale with her husband James. The couple had met through work and been married for eight years; they had no children. Diane's brother indicated they developed a shared interest in horse racing and socialising; they liked to visit different race tracks and public houses.

Diane was reported by her brother to dress well and always took a pride in her appearance and her home. Diane's brother indicated there was a five year age gap between him and Diane and as a result they had never been particularly close. Diane's father had misused alcohol. In recent years they had lost touch and he was unaware of Diane's medical condition. Diane's brother had not been aware of, or suspected, any domestic abuse between the couple.

During the review period and as a result of Covid-19, Diane was working from home part time as a customs officer; this increased Diane's isolation.

James finished work at lunchtime and returned home to care for Diane.

The couple reported there had been several deaths within the family within a short space of time which had caused extra stress on the couple. Both Diane and James had reportedly been drinking to excess.

In July 2020 Diane was admitted to hospital due to neurological symptoms. Diane had been experiencing weakness, lethargy, diarrhoea and numbness in her fingers and toes which was impacting on her mobility. Diane also had calf tenderness. Diane originally went against her GP's advice regarding admission indicating her husband would be upset if she called an ambulance. Following admission Diane remained in hospital for a month during which time she was diagnosed with Guillain Barré syndrome.

On the 3rd March 2022 at 14:43 James dialled 999 for an ambulance. James reported during the call that he had come home from work and found Diane had fallen from her bed. Diane was described by James to be alert and answering appropriately. James stated he had had a conversation with her. As a result of James's description the call was categorised as Category 3[2]. At 17:17 hrs James made a further call stating Diane was now unconscious; an ambulance was sent immediately.

The Ambulance arrived on scene at 17:23. James told the paramedics he had arrived home and found Diane on the floor awake and alert, he had tried to get her off the floor, but her legs weren't working so he called the ambulance. It became apparent that the history given by James was not consistent with Diane's presentation. Diane was noted to be unconscious. Bruising was noted on multiple sights of Diane's body. The NWAS crew noted the warning linked to the address that Diane maybe the victim of DA, and immediately requested Police attendance.

NWAS noted James appeared nervous, and his behaviour appeared somewhat unusual in the circumstances. James didn't ask any questions as to where NWAS would be taking Diane and remained at the house when they took his wife to hospital. The NWAS crew quickly transported Diane to Hospital.

At hospital Diane remained unconscious and an initial scan revealed her injuries to be a subdural haemorrhage[3]. Diane was placed on life support. As a result of police enquiries at the hospital and with NWAS, James was arrested, on suspicion of Section 18 assault, at 19:20 hrs on the 3rd March 2022. Diane passed away the following day after it had been determined that the level of her injury was not survivable, thus life support was terminated. Following Diane's death, James was further arrested on suspicion of murder and coercive/controlling behaviour between 1st January 2019 and 3rd March 2022 whereby he subjected his wife to numerous occasions of physical abuse and during the relationship, sought to control finances and other aspects of the victim's life.

A forensic post-mortem was completed, and the medical cause of death was inconclusive. There was no evidence of a recent assault; tissue samples including the brain were sent off

[2] Category three – for people who require urgent help but it isn't an emergency. In these cases the patient may be treated by ambulance staff in their own home.

[3] A subdural haemorrhage (haematoma) is a serious condition where blood collects between the skull and the surface of the brain. It's usually caused by a head injury.

for examination and pathology is awaited. James was released from police custody and remains under investigation.

KEY ISSUES ARISING FROM THE REVIEW

The following key issues arose from this review:

1. The importance of having information from and the presence of key agencies at all multi-agency forums where domestic abuse cases are being discussed
2. The need to develop comprehensive safety plans which aim to address all the identified issues
3. The importance of sharing all relevant information, communicating and working together to ensure all a client's needs are being addressed.
4. The importance of building a relationship with the client.
5. The need to offer carer assessments to all carers even when the client is not accepting of services.
6. The police need to consider whether there are any further actions they can take on all occasions when a person has disclosed domestic abuse but is not supporting a prosecution.
7. The need to make full use of the MCA code of practice in cases where a person is repeatedly making unwise decisions.

CONCLUSIONS

In this case it is clear that all professionals responded positively when Diane made disclosures of domestic abuse. Following the initial disclosure appropriate referrals to Adult Care were made. The lack of a specific incident and refusal of consent meant Early Help and preventative services were not able to become involved. The impact of lack of consent and retraction of allegations cannot be overestimated. Lack of consent meant the police were unaware of the earliest incident and were not approached for advice; it's effect was to reduce the number of agencies involved and to leave those partner agencies who remained, largely, powerless to respond.

What could have made a difference in this case was development of a positive relationship with Diane. Diane's brother was clear that Diane was not someone whom it was easy to make friends with, it is possible that aspects of her personality would always have impeded services developing positive relationships, however when Diane indicated she was not open to engaging with Victim Support, the service was quick to close her case. Further efforts could have been made to encourage engagement and promote the message that the service was there, and had the expertise to support Diane. The SW remained in regular contact with Diane and it is apparent that overtime the relationship between them developed to a point where Diane did disclose further abuse.

A previous local DHR[4] identified that multi-agency forums were not being referred to e.g. MARAC; this has not been the case here which is a positive. However there is still the need for greater multi-agency working, timely and comprehensive information sharing, and involvement of all agencies who have a remit to work with individuals experiencing

[4] https://rochdalesafeguarding.com/assets/c31bdc8b/sardhr_amira_final_report_21.08.2022.docx.pdf

domestic abuse (even when their service had been declined). Had this been achieved there would have been a better informed the multi-agency plan. Accurately identifying all the risks and exploring corresponding actions would have identified gaps that could not be addressed without Diane's cooperation. Identifying risk that the professional group are unable to reduce, helps professionals to understand when cases need to be escalated and legal advice sought. In addition there was some potential for increased joint visiting and a more comprehensive and clear safety plan.

It is clear the James was experiencing his own difficulties in coping with recent bereavements, undertaking his new role as Diane's carer, whilst working fulltime. James was suffering from depression and following an incident of domestic abuse whilst in alcohol, it is reported that he attempted to take his own life. Greater work could have been done to understand the impact on James and, despite Diane's reluctance to engage, a carers assessment should have been offered to James in July 2020 when James commenced his caring role of Diane following her diagnosis of Guillain Barré syndrome. Consideration should now be given within the MARAC to referring James to a perpetrator programme.

Diane's abuse was reported during the Covid-19 pandemic, this impacted on hospital staff having contact with James as there was no visiting and the GP practice in terms of speed of response to offer Diane an appointment. In general most services have not reported this impacted on their delivery of services to Diane. As with all UK citizens there would have been an impact on James and Diane who would have been in each other's company for increased time periods. Several countries have reported a significant increase in domestic violence cases since the Covid-19-induced lockdowns and physical distancing measures were implemented. The Covid-19 health crisis has been cited for increasing the severity and frequency of domestic violence[5]. Refuge' (a UK-based charity supporting victims of domestic abuse) reported a 25% increase in calls to the national domestic hotline since lockdown began (Refuge,2020[6]). During the Covid-19 lockdowns abuse by current partners as well as family members increased on average by 8.1% and 17.1%[7].

LESSONS TO BE LEARNED

The following lessons have been learnt:

Multi-agency

1. There should be greater inclusivity in MRM/Multi-Agency meetings. All agencies involved with the subject or to whom the subject has been referred should be represented. Those representing services should ensure the information they are sharing is up-to-date. Non-attendance or non-contribution should be challenged and escalated. Actions and minutes agreed in MARAC and MRM meetings should be shared with all involved agencies. Incomplete actions should be reviewed again and

[5] Deniz Ertan, Wissam El-Hage, Sarah Thierrée, Hervé Javelot & Coraline Hingray (2020) COVID-19: urgency for distancing from domestic violence, European Journal of Psychotraumatology, 11:1, DOI: 10.1080/20008198.2020.1800245

[6] Refuge. (2020). 25% increase in calls to national domestic abuse helpline since lockdown measures began. https://www.refuge.org.uk/25-increase-in-calls-to-national-domestic-abuse-helpline-since-lockdown-measures-began/

[7] Ria Ivandić, Tom Kirchmaier, Ben Linton, Changing patterns of domestic abuse during Covid-19 lockdown (2020)

if unachievable escalated. All areas of risk should be identified and have an associated action.

2. Diane's case was complicated as, in addition to domestic abuse, she had multiple medical issues including Guillain-Barré syndrome, alcohol misuse, mental health issues, liver and kidney disease. The chair and author questions whether the MRM forum was being used to the full to manage Diane's complex needs, a wider more cohesive approach needed to be taken.
3. When working with cases where there are issues around engagement or refusal of the services offered, it is essential that all agencies work collaboratively if they are ever to achieve a successful outcome and deliver the care and support required. If Diane had reached a point of acceptance of the care and support offered it had the potential to address her health needs and keep her safe.
4. There needs to be a consistent approach to referring carers for a carers assessment and perpetrators to perpetrator programmes.
5. When working with adults who are assessed as having mental capacity but are making decisions that appear unwise, professionals need to consider whether alcohol or substance misuse, and or coercion and control may be having an adverse impact on mental capacity. In these circumstances further legal advice should be sought within multi-agency forums to support professionals practice.
6. All care providers need to be provided with guidance regarding mental capacity act assessments.

Adult Care

1. Domestic Abuse Training should be essential for all staff in assessment teams including managers in adult social care.
2. Adult Care need to be assured that there is an escalation protocol in place for when there are concerns regarding lack of engagement from other agencies.
3. Escalation Policy to be devised/reviewed for Adult Social Care.
4. Practitioners should be aware of the perpetrator programme Panel for perpetrator and In Domestic Abuse cases, practitioners to consider referrals to the perpetrators programme panel to address the behaviour of the perpetrator.
5. Increased awareness required regarding the IDVA Service– Independent Domestic Violence Advocacy.

NHS GM Integrated Care

1. It is essential to acknowledge the time constraints within primary care and to provide GPs with a domestic abuse screening tool which is simple to use, short, safe and validated.
2. There is a need for GP Practices follow RCGP safer video consultation guidance'.
3. Primary care staff need to routinely record mental capacity assessments which evidence defensible decision making.

Care4U

1. Care4U's involvement was hampered by difficulties in engaging Diane despite the services creative use of a number of tactics to encourage this
2. The importance of receiving comprehensive background information regarding previous DV incidents.

3. The homecare agency felt that conducting a mental capacity act assessment was outside of their remit.
4. When care home agencies are involved in the care of individuals who are being discussed in MARAC or MRM, they need to receive, and have the opportunity to share, information which could increase safety.

RECOMMENDATIONS FROM THE REVIEW

The following recommendations have been made by the agencies involved within this review to address the lessons learnt: Please see the action plans below:

Overview report additional recommendations

1. Strengthen the effectiveness of MRM meetings by ensuring the meetings include representation of all services in direct contact with the subject, and all agencies with expertise to support the work of those services e.g. drug and alcohol services, mental health services, so expert advice can be provided. Membership to be updated as new services become involved. MRM meetings to routinely consider whether all applicable non-statutory services available in Rochdale have been offered to both client and carer.
2. Non-compliance and non-attendance at MRM and MARAC meetings by key partners should be challenged and if unresolved escalated. The multi-agency escalation policy to be reviewed.
3. Adult Care to ensure Carer assessments are offered to all carers, in line with legislation, even if the referred client declines involvement.
4. MARAC needs to evidence referral of perpetrators to perpetrator programmes.
5. Where subjects are felt to be making unwise decisions, services are struggling to engage them, and alcohol or substance misuse, and or coercion and control may be having an adverse impact on mental capacity, legal advice must be routinely sought to ensure all legal options have been explored.
6. Guidance to be produced for all care agencies in relation to mental capacity assessments.

11.1 The following recommendations have been made by each of the agencies involved within this review to address the lessons learnt. Please see the action plans below:

Police

1. Consideration to DVPN/O should be given at all stages to cases of DA wherein victims are unsupportive of Police action. This should include following arrest - and referenced in the recorded rationale within the force policy for Detainees Leaving Police Custody against the consideration for imposing conditional bail – as well as within the closure rationale for crime and DAB reports
2. GMP MASH processes should include the recording of actions arising from MARAC and timescale for Police review.
3. Awareness of powers of entry/search and arrest should be raised amongst Officers attending to welfare/Bail/DVPO checks with respect to high-risk cases of domestic violence. These should be undertaken on a joint agency basis where appropriate.

Adult Care

1. Domestic Abuse Training should be essential for all staff in assessment teams including managers in adult social care.
2. Adult Care need to be assured that there is an escalation protocol in place for when there are concerns regarding lack of engagement from other agencies.
3. Escalation Policy to be devised/reviewed for Adult Social Care.
4. Practitioners should be aware of the perpetrator programme Panel for perpetrator and In Domestic Abuse cases, practitioners to consider referrals to the perpetrator programme panel to address the behaviour of the perpetrator.
5. Increased awareness required regarding the IDVA Service– Independent Domestic Violence Advocacy.
6. Early referral for legal advice required. An earlier referral for Legal advice should have taken place in this case following non- engagement with the safeguarding enquiry and ongoing risk/concerns on 20.8.2021.

NHS GM Integrated Care

1. It is essential to acknowledge the time constraints within primary care and to provide GPs with a domestic abuse screening tool which is simple to use, short, safe and validated.
2. There is a need to ensure that GP Practices have access to the safer online/ remote consultation guidance
3. There is a need to increase GP awareness of the availability and value of the electronic mental capacity template.

Northern Care Alliance

1. Recommendations in relation to actions for NCA are in relation to training and development and raising awareness of potential indicators of Domestic Abuse. Adherence to NCA policy in relation to early escalation and multiagency involvement. Also, assurance that learning from Domestic Homicide Reviews will continue to be shared across NCA. As an organisation, a project in Oldham; “Open Door Project”, has been commissioned to focus on Domestic Abuse in Older People. NCA are supporting this work and developing some video resources that will be utilised to raise awareness of Domestic Abuse within this age category.

Care 4 U

1. Care4U to routinely request information regarding domestic violence prior to agreeing and commencing a package of care.
2. Care4U staff need to increase their knowledge in respect to Domestic Violence through training.
3. Care4U staff need clear guidance and training on when, how and where to obtain assistance in assessing mental capacity.

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

[redacted]
Development Officer (Domestic Abuse) Neighbourhoods
Rochdale Borough Council
Floor 2, Number One Riverside
Smith Street
Rochdale
OL16 1XU

21st December 2023

[redacted]

Thank you for submitting the Domestic Homicide Review (DHR) report (Diane) for Rochdale Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd November 2023. I apologise for the delay in responding to you.

The QA Panel felt the report contained a sense of Diane throughout and it was positive that Diane's brother was engaged with towards the end. The report rightly raises concerns that GPs and health providers need to provide details for inclusion of reports to allow for a more detailed history of abuse.

There were aspects of the report which the Panel felt needed further revision. On completion of these changes the DHR should be resubmitted to the Home Office for review by **21st March 2024.**

Areas for development:

- The QA panel felt that this report was prematurely completed with the criminal investigation still outstanding. It was felt if the report was completed post outcome, information from family and friends, including James, would add depth. It is within the guidance to delay completion until the outcome of a criminal investigation if this may benefit the review.

- It is not clear if James' name is a pseudonym.

- There was a lack of professional curiosity from agencies into understanding any barriers that Diane might have experienced engaging with services. For

example, the report references that James was monitoring Diane's phone, emails and devices – this is technology-facilitated abuse. The report would benefit from some analysis and exploration to see if Diane was reluctant to

engage due to the monitoring of her devices and include any actions which may arise from this analysis.

- The report references economic abuse however there are no actions taken for agency learning.

- There are issues identified for Victim Support (16.21 and 17.2) however no associated recommendations which would be beneficial.

- There is some victim blaming language which should be reviewed, such as ‘prioritising of the relationship over safety’; ‘is there evidence professionals were considering Diane’s mental capacity and whether she was making unwise decisions?’; and ‘to assist in support of Diane to deal with this abuse’.

- The report would benefit from acknowledging that marriage counselling, in the context of providing reassurance to professionals (16.44), is not appropriate where there is domestic abuse.

- Whilst it Is positive that Diane’s brother was engaged, the report would benefit from explaining how they were kept updated about the report, and if the terms of reference were shared, whether they were invited to a panel meeting and invited to see the draft report or provide comments.

- There are no names provided for the panel list as required by the statutory guidance and it would be beneficial to confirm if the authors were independent of any line management of the case or whether they had any contact with the possible perpetrator.

- It would be beneficial to confirm whether the chair has any experience working on domestic abuse or has undertaken any training to equip them as a DHR chair.

- It may be beneficial to explore Diane’s equality and diversity needs in more depth and whether an action was warranted around working with those needs where there is domestic abuse.

- The dissemination list should include members of the CSP, the Police and Crime Commissioner and the Domestic Abuse commissioner’s office.

- 14.1 references a full chronology at Appendix 2 but this is not attached to the report.

- The QA panel felt that given the six individual management reviews (IMRs) and five short agency reports, that there would likely be more events than the nine events listed in the chronology. It may be appropriate to combine some of the chronology provided in the overview section. The overview section would benefit from providing a summary of the information known and professions involved.

- There are instances of claims made which could be supported by references of research or guidance, for example 16.9,16.61,16.67 and 16.74.

- The statement at 16.10 that ‘Care professionals reported Diane’s response made them feel coerced and controlled and made them cautious’ seems an odd statement in response to the victim stating her rights and threatening legal action if they are not respected.

- 16.43 states that ‘substance and alcohol abuse are well known to be associated with the perpetration of partner violence’ referencing research about 1) the relationship between alcohol consumption and men’s sexual aggression, and 2) how alcohol is a cause of intimate partner violence. Both lean to apportioning responsibility of men’s violence to alcohol and some balance could be achieved by being clear that, while alcohol may exacerbate domestic abuse, it is not a cause.

- The report would benefit from a good proof-read and inclusion of a glossary to explain the many acronyms used.

On resubmission, please clearly indicate where changes have been made by using a different colour font or highlighting the added or amended text in the report. If paragraph numbers have changed, please give revised location of the answer to the feedback comment. Please make it clear in the subject line of your email that the documents contained are revised versions for reconsideration. The deadline for this resubmission is 21st March 2024.

I look forward to receiving an updated report.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Home Office

Resubmission return template – Rochdale (Diane)

Please complete this return template explaining if and where the evidence of development has been taken.

Area of Development	Evidence of Development Taken
The QA panel felt that this report was prematurely completed with the criminal investigation still outstanding. It was felt if the report was completed post outcome, information from family and friends, including James, would add depth. It is within the guidance to delay completion until the outcome of a criminal investigation if this may benefit the review.	NWH – has added the outcomes from GMP, friends have been revisited and further information sought. Completed action
It is not clear if James' name is a pseudonym.	Text added to confirm James is pseudonym Completed action
There was a lack of professional curiosity from agencies into understanding any barriers that Diane might have experienced engaging with services. For example, the report references that James was monitoring Diane's phone, emails and devices – this is technology-facilitated abuse. The report would benefit from some analysis and exploration to see if Diane was reluctant to engage due to the monitoring of her devices and include any actions which may arise from this analysis.	NWH- extended to include this information Completed action
The QA panel felt that this report was prematurely completed with the criminal investigation still outstanding. It was felt if the report was completed post outcome, information from family and friends, including James, would add depth. It is within the guidance to delay completion until the outcome of a criminal investigation if this may benefit the review.	Updated information
The report references economic abuse however there are no actions taken for agency learning.	NWH-referenced in learning and recommendations .5
There are issues identified for Victim Support (16.21 and 17.2) however no associated recommendations which would be beneficial.	NWH- added in overview report additional recommendations at point 7
There is some victim blaming language which should be reviewed, such as 'prioritising of the relationship over safety'; 'is there evidence professionals were considering Diane's mental capacity and whether she was making unwise decisions?'; and 'to assist in support of Diane to deal with this abuse'.	NWH- amended the report 16.11 to reduce victim-blaming language.
The report would benefit from acknowledging that marriage counselling, in the context of providing reassurance to professionals (16.44), is not appropriate where there is	completed

domestic abuse.	
Whilst it Is positive that Diane's brother was engaged, the report would benefit from explaining how they were kept updated about the report, and if the terms of reference were shared, whether they were invited to a panel meeting and invited to see the draft report or provide comments.	NWH -6.2 & 12.1 added information
There are no names provided for the panel list as required by the statutory guidance and it would be beneficial to confirm if the authors were independent of any line management of the case or whether they had any contact with the possible perpetrator.	NWH- amended 8.1
It would be beneficial to confirm whether the chair has any experience working on domestic abuse or has undertaken any training to equip them as a DHR chair.	NWH –amended 9.1
It may be beneficial to explore Diane's equality and diversity needs in more depth and whether an action was warranted around working with those needs where there is domestic abuse.	NWH-Learning point 2
The dissemination list should include members of the CSP, the Police and Crime Commissioner and the Domestic Abuse commissioner's office	NWH - Completed -12.0
14.1 references a full chronology at Appendix 2 but this is not attached to the report.	NWH- added appendix at the back of the report
The QA panel felt that given the six individual management reviews (IMRs) and five short agency reports, that there would likely be more events than the nine events listed in the chronology. It may be appropriate to combine some of the chronology provided in the overview section. The overview section would benefit from providing a summary of the information known and professions involved	NWH amended 15.1
There are instances of claims made which could be supported by references of research or guidance, for example 16.9,16.61,16.67 and 16.74.	NWH-amended 16.5, 16.36,16.68,16.74
The statement at 16.10 that 'Care professionals reported Diane's response made them feel coerced and controlled and made them cautious' seems an odd statement in response to the victim stating her rights and threatening legal action if they are not respected	NWH- amended action 16.11
16.43 states that 'substance and alcohol abuse are well known to be associated with the perpetration of partner violence' referencing research about 1) the relationship between alcohol consumption and men's sexual aggression, and 2) how alcohol is a cause of intimate partner violence. Both lean to apportioning responsibility of men's violence to alcohol and some balance could be achieved by being clear that, while alcohol may exacerbate domestic abuse, it is not a cause.	NWH- amended 16.44
The report would benefit from a good proof-read and inclusion of a glossary to explain the many acronyms used.	NWH- completed Acronyms included

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

[redacted]
Development Officer (Domestic Abuse) Neighbourhoods
Rochdale Borough Council
Floor 2, Number One Riverside
Smith Street
Rochdale
OL16 1XU

26th March 2024

[redacted]

Thank you for resubmitting the report (Diane) for Rochdale Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in March 2024.

The QA Panel felt the report contained a sense of Diane throughout and it was positive that Diane's brother was engaged with towards the end. The report rightly raises concerns that GPs and health providers need to provide details for inclusion of reports to allow for a more detailed history of abuse.

The QA Panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel