MANCHESTER COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW INTO THE DEATH OF 'AJ' IN NOVEMBER 2021

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

REVIEW PERIOD

1st of JANUARY 2018 to NOVEMBER 2021

OVERVIEW REPORT

Independent Author: **John Doyle BSc (Hons)**

FINAL DRAFT **July 2023**

Contents **Page**

The Coronavirus-19 Pandemic

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

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

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

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

Preface

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

The Panel recognised, of course, that this Review concerned an apparent suicide (the precise reasons for AJ's death will be determined by the Office of the Coroner). In these circumstances, the Greater Manchester Police were not in a position to allocate a Liaison Officer to support AJ's family and friends and the specialist homicide staff from Victim Support do not have the remit and did not have the capacity to support families and friends in these circumstances. The Panel contacted the Greater Manchester Bereavement Service and, via their contacts, it was confirmed that it had not been possible to provide specialist bereavement support to AJ's family and friends following the incident. Consequently, in comparison to other Domestic Homicide Reviews, it appeared to the Panel that there was no direct face-to-face contact with an experienced professional who could introduce the Review process to AJ's family and friends, nor any support for the grief they were enduring.

This placed the Panel in the position of making contact with AJ's family and his friends (from the details shared with the Panel by other agencies in contact with AJ) and inviting them to participate in the Review. This contact took the form of a letter, and/or e-mail, and/or telephone call and/or text message. Setting aside the efforts made by the Panel to make a considerate and mindful introduction to the process, it was still an invitation received 'out-of-the-blue'. This issue is discussed in more detail later in this Report, but, in summary, one of AJ's Siblings did respond to the invitation to help the Review Panel and their contribution is described in Section 2 of this Report.

Section 1. Background

1.1 This Domestic Homicide Review concerns the death of AJ, who died in November 2021. The working hypothesis of the Greater Manchester Police was that AJ died at his home following a suspected overdose.

1.2 The Greater Manchester Police investigated the circumstances leading to the death of AJ and concluded that there was no evidence available that the death of AJ was a consequence of any third party involvement.

1.3 Following the notification of his death, the Greater Manchester Police Service referred the matter to the Manchester Community Safety Partnership to be considered as a Domestic Homicide Review. The reasons for this consideration are:

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

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

1.6 The working hypothesis of the Greater Manchester Police (GMP) was that AJ died as a result of an overdose of medication. Whether taking his own life was deliberate or accidental is a matter for the Inquest to be held by the Office of the Coroner. GMP noted records that stated AJ had alleged that he had been the victim of domestic abuse.

Incident leading to the Domestic Homicide Review

1.7 On a day in November 2021, the Greater Manchester Police (GMP) received a call from a Paramedic employed by the North West Ambulance Service. The Paramedic had received a call from a person referred to, for the purposes of this Review, as P1 (the Partner of AJ during the period leading up to his death). P1 raised a concern that they were unable to raise AJ at his home address.

1.8 Officers from GMP attended the address and noted that the Paramedic had forced entry and found AJ deceased in the bedroom of the address. The Paramedic expressed concern that AJ may have taken an overdose of prescribed medication.

1.9 An Officer from GMP examined the inside of the door of AJ's property. This appeared to be locked from the inside when entry was forced with a bolt lock at the bottom and a thumb lock across the middle of the door. All other entry and exit points were secure.

1.10 In the kitchen, GMP found numerous medications. The drugs that were found included a number that were prescribed and can be fatal if taken in large doses, including Diazepam and Oramorph.

1.11 The Police also found a repeat prescription in AJ's name. This appeared to confirm which of the medications found were prescribed to AJ. Amongst others, Oramorph was not on the repeat prescription list.

Significant people in this case

1.12 The pseudonyms in this case were chosen by the DHR Panel. The name of the subject of the Review – 'AJ' – was approved by their Sibling, referred to as S1. The significant people referred to within this Overview Report are described, in brief, below:

Name or pseudonym	Relationship to subject (if applicable)
AJ	The victim in this Review.
P1	The Partner of AJ at the time of the incident.
P2	Previous Partner of AJ
S1	AJ's sibling. The Pseudonym was chosen by the Panel.
S2	AJ's sibling. The Pseudonym was chosen by the Panel.
F1	A friend of AJ
F2	A friend of AJ and his joint tenant in 2020
C1	Child of P2 and AJ
C2	Child of P2 and AJ

The use of pseudonyms

1.13 The Review Panel sought to involve AJ's siblings in the Review. When the Review commenced, the Commissioning Officer and the Author sent a letter of invitation to S1 and S2. The letter expressed the condolences of the Panel, and invited S1 and S2 to contribute to the Review. The Commissioning Officer did not receive a response to these letters.

1.14 The Author of the Review contacted – first by letter – P1, AJ's partner at the time the incident occurred. The letter was returned to Manchester City Council as 'not known at this address'. The Panel discussed this matter and asked the Author to contact P1 via e-mail. P1 responded to the e-mail and, initially, agreed to participate in the Review. The Author sought a date to talk to P1 and prior to the telephone conversation, P1 contacted the Author via e-mail and stated that they could not talk about the case because they were still traumatised by the events and wished to concentrate upon their bereavement.

1.15 The Panel then decided to contact F1 (a friend of AJ's) and F2 (a friend and joint-tenant during the scope of this Review). Both F1 and F2 were sent a letter of introduction and an invitation to help the DHR Panel complete the Review. The letter to F2 was returned to Manchester City Council as 'not known at this address'. F2 was then sent an e-mail (on two occasions) inviting them to assist the DHR Panel with the Review. F1 did not respond to the letter of invitation. The Panel then decided to send a short text message to both F1 and F2. Neither F1 nor F2 responded to the text.

1.16 The Panel also sent a letter of invitation to P2, AJ's ex-partner. P2 did not respond to the letter of invitation.

1.17 In December 2022, the Office of the Coroner contacted the Author of the Review and stated that AJ's sibling may be willing to share some information with the Panel in order to assist with the production of a 'pen-picture' of AJ. The Author contacted S1 and S1 made a submission to the Panel and this is reflected later in this Report. S1 also stated that they would be happy to receive further information describing the progress of the Review. S1 was also in contact with the Office of the Coroner and was involved in the Inquest into the death of AJ.

1.18 The Author of the Review made contact with S1 in January 2023 to discuss the issue of using a name or pseudonym. S1 stated that they had discussed the matter with the family and they agreed to use to name "AJ".

1.19 Taking into account the involvement of AJ's family and friends, the Panel assumed responsibility for assigning names and pseudonyms for the other subjects of the Review.

Purpose and conduct of the review

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

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

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

The time-period under review

1.23 At the initial meeting of the Domestic Homicide Review Panel, held virtually in April 2022, it was agreed that the timeframe for the Domestic Homicide Review

should cover the period from the 1st of January 2018 to the date of the incident in November 2021.

1.24 The rationale for the time period was discussed by the Panel. It was apparent from the information received, that AJ had made an attempt to take his own life in July 2018; in February 2018, AJ's sibling had made a call to Greater Manchester Police expressing concern for AJ's welfare and in January 2018, there was an allegation of assault made by AJ against P1.

1.25 However, a number of agencies held records indicating two things – albeit unconnected: one being AJ had been in a relationship with P1 for a number of years prior to 2018; and secondly, some years prior to 2018, AJ had been admitted to Hospital on a number of occasions following incidents of overdose. Consequently, the agencies and services invited to participate and make submissions to the Review were reminded that, if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, such information should still be submitted in order to provide context for the Review. A number of agencies did make such submissions, dating back to 2010.

Proposed timescale

1.26 The first meeting of the DHR Panel was held on the 21st of April 2022. The Panel met again in June 2022, in July 2022, in August 2022, in October 2022, in November 2022, in December 2022, in February 2023 and March 2023.

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

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

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

1.30 At the fourth meeting, the Panel continued to consider and scrutinise the submissions and clarifications from participating agencies; the first draft of the abridged chronology was discussed, along with the responses to the key lines of enquiry, and service narratives. There was also an update on the involvement of AJ's Sibling, and a discussion concerning the invitation made to P1 and consideration of inviting AJ's close friends (F1 and F2) to participate.

1.31 At the fifth meeting, the first initial draft of the overview report was considered. There was also a consideration of additional submissions from two General

Practice Services. These services came to light during the fourth meeting of the Panel. There was also continued discussion regarding the involvement of P1, F1 and F2.

1.32 At the sixth meeting of the Panel, the second draft of the Overview Report was considered, along with the submissions from the General Practice services discussed in the fifth meeting of the Panel. Updates were also discussed concerning contact with P1, F1, F2 and also P2.

1.33 At the seventh meeting of the Panel, held in December 2022, the Panel discussed the third draft of the Overview Report, the submission from S1 and began the process of developing recommendations for action from the Review.

1.34 At the eighth meeting of the Panel, held in February 2023, the Panel considered the fourth draft of the Overview Report and the draft recommendations for action.

1.35 At the ninth meeting of the Panel, following final amendments, the Panel agreed that the final draft could be submitted to the Manchester City Community Safety Partnership.

Statement of Confidentiality

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

The Conduct of the Review and methodology

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

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

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

1.40 As stated, the review panel sought to involve the Siblings, Partner and Friends of AJ in the review and approached this with sensitivity and respect.

The Conduct of the Review (contributors and Panel members)

1.41 Following the notification of the death of AJ, the Manchester Community Safety Partnership informed the Home Office that they would undertake a Domestic Homicide Review and to commission this Review under the auspice of Manchester City Council.

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

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

1.44 Panel members were appointed based on their seniority within relevant and appropriate agencies, their ability to direct resources to the review and to oversee implementation of review findings and recommendations.

1.45 The members of the panel were independent. They had no direct contact with AJ or AJ's family, they had no operational or supervisory involvement in the case and no immediate line management responsibility for any staff whose actions were scrutinised as a part of the Review.

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

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

Name*	**Role**	**Organisation**
Leanne Conroy	Policy Specialist	Manchester City Council (MCC) Community Safety Partnership
Ian Halliday	Policy and Performance Manager	Manchester City Council
Matthew Berry	Detective Inspector	Greater Manchester Police Service
Samera Khan	Independent Domestic Violence Advocate	LGBT+ Foundation

Claire Howard	Acting Lead Nurse Safeguarding Adults and Vulnerable Groups	Manchester University Foundation NHS Trust
Thomas Dainty Cathryn Buckley Joanne Glynn	Team Manager, Early Intervention Service Head of Adult and Child Safeguarding Safeguarding Adult Lead	Greater Manchester Mental Health NHS Foundation Trust
Anna Davies	Corporate Safeguarding Team	BCUHB
Kerry Owen Lorna Campbell	Project Manager	Change, Grow Live
Tracey Hurst Hazel Chamberlain	Designated Nurse Adult Safeguarding Deputy Designated Nurse	Tameside and Glossop CCG (ICB)
Michelle Mottershead	Advisor	MCC Homelessness Team
Katie Procter	Clinical Governance Manager (Primary Care)	BCUHB -
Tyler Andrew	Domestic Abuse Services Manager	LGBT Foundation
Caroline Horne	Independent Domestic Violence Advocate	Jigsaw Homes Group
Katy Endean	Specialist Nurse	NHS Manchester CCG (from July 2022, referred to as the Integrated Care Board)
Sarah Khalil	Designated Nurse Adult Safeguarding	NHS Manchester ICB
Daisy Eames	Senior Specialist Safeguarding Adult Nurse	Manchester University Foundation NHS Trust
Ivan Wright	Assistant Director	Jigsaw Homes – Neighbourhoods
Lisa Wright	Operational Manager	Bridges Domestic Abuse Service
Rachel Hughes	Attachment Coordinator	Motiv8 (Building Better Opportunities)
Delia Edwards	Domestic Abuse Reduction Manager	Community Safety Team, Manchester City Council
John Doyle	Independent Author	

Contributors to the Review

Agency	**Nature of Submission**
Greater Manchester Mental Health NHS Foundation Trust	IMR
Betsi Cadwaladr University Health Board	IMR
GP1 (North Wales)	IMR
Manchester University Hospitals NHS Foundation Trust	IMR

Bridges Domestic Abuse Service	IMR
Motiv-8	IMR
Jigsaw Homes	IMR
LGBT Foundation	Short Report
Greater Manchester Police Service	IMR
Change Grow Live	IMR
Homelessness Service, MCC	Short Report
Salford City Council Housing Options Service	IMR
IDVA Service, MCC	Short Report
GTD Healthcare Service (primary care)	IMR
North West Ambulance Service	IMR
GP2 (Manchester)	Short Report
GP for P1	IMR
GP3 (Stockport)	Short Report
GP4 (Manchester City)	Short Report
Survivors Manchester	Short Report

Section 75 Agreement

1.48 The DHR Panel learnt that Manchester City Council commissioned – under the terms of Section 75 of the NHS Act 2006 – the Greater Manchester Mental Health Services NHS Foundation Trust to discharge a number of responsibilities for safeguarding, as described by the Care Act 2014.

1.49 Section 75 of the NHS Act 2006 allows partners (NHS bodies and Councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission specified elements of social care.

Parallel Reviews

1.50 There were no pertinent parallel processes reported for the Panel to consider.

Coroner's Inquest

1.51 As a matter of courtesy, the Office of the Coroner was informed that the Domestic Homicide Review was taking place and the expected time frame of the Review. During the timeline of the Review, the Office of the Coroner opened the Inquest into the death of AJ.

The Purpose of a Domestic Homicide Review

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

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

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

a. To establish what contact agencies had with AJ

This will require agencies to consider these issues:

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

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

This will require agencies to consider these issues:

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

NOTE

1.54 The following three key lines of enquiry concerned information about P1, the Partner of AJ prior to the incident. The Panel noted that it is usual – in other Domestic Homicide Reviews – for the Perpetrator to be invited to contribute to

the Review. In this case, of course, there was no perpetrator and the Partner of AJ was not implicated in the death of AJ. The Panel noted, however, that information concerning the Partner of AJ will have been shared with other bodies, including the MARAC.

1.55 The Panel confirmed that information concerning AJ and his circumstances had been shared via the MARAC arrangement, and, as with other statutory Reviews, it is usual that information concerning Partners, next-of-kin, and other associates is shared in an anonymous format in order to safeguard the subject of the MARAC meeting.

1.56 It was agreed that Panel members would discuss this matter with their Information Governance Officer (or equivalent), and ask the question:- "if information concerning the Partner of AJ (and other relevant people) has already been shared anonymously with the MARAC, or other statutory arrangement, then can this same information in the same anonymous format (i.e.no name to be listed) be shared with the Panel?"

1.57 As the Review moved on and contact was made with P1, this obviated the need for this conversation because P1 did not provide consent for any specific personal information held by any agency in contact with them to be shared with the Panel.

The caveat was placed around these three KLOE pertaining to P1

c. To establish what contact agencies had with P1, who was the Partner of AJ.
This will require agencies to consider these issues:

10. Was P1 known to agencies and if so, in what capacity?
11. Was P1 known to any agency as a perpetrator of domestic abuse?
12. If so, what actions were taken to assess their risk to self and/or others?
13. Had any mental health issues been self-disclosed by P1 or any mental illness diagnosed by an agency in contact with them?
14. Was P1 known to misuse drugs or alcohol, including the misuse of any prescription medication?
15. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with P1?

d. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for AJ and P1.
This will require agencies to consider these issues:

16. What actions were taken to reduce the risks presented to AJ (or others) and were the actions appropriate, timely and effective?
17. What happened as a result of these actions?

e. To establish whether there were other risks or protective factors present in the lives of AJ or P1.
This will require agencies to consider these issues:

18. Were there any other issues that may have increased the risks and vulnerabilities of AJ?
19. Were there any matters relating to safeguarding other adults at risk or children that the review should take account of?
20. Did AJ disclose any domestic abuse to his family or friends? If so, what action did they take?
21. Did P1 make any disclosures regarding domestic abuse to their family or friends? If so, what action did they take?

---

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

This will require agencies to consider these issues:

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

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

This will require agencies to consider:

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

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

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

This will require agencies to consider:

24. The impact that the management of the COVID-19 pandemic – including the restrictions associated with it – had on the planned delivery and provision of the services offered by agencies
25. To describe the impact the COVID-19 pandemic – including the restrictions associated with it – had on both AJ and P1 individually, and as a couple.

Equality and Diversity

1.58 The review panel were committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to AJ.

1.59 There was no evidence that AJ was directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and*

maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.

1.60 The Panel noted that the agencies contacted in relation to this Review identified a specific diversity issue concerning AJ – the agencies recorded and noted that AJ was a gay man. It was encouraging to the Panel that this suggested that these agencies were aware of equality and potential discrimination as it pertains to the Equality Act 2010.

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

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

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

1.64 The question posed by the Panel for those agencies in contact with AJ was whether the way it operated; the physical feature of its premises; or the absence of an auxiliary aid or service created a barrier which would have placed AJ at a substantial disadvantage compared with other people using the service. The Panel found no evidence that this was the case.

1.65 Taking account of the submissions received, the Panel took particular note of the involvement of a number of services that responded to AJ's needs. This involvement, by a number of services, extended to over a decade.

1.66 The Panel scrutinised and discussed the contact that these services had with AJ and the outcome of these discussions is described later in this Report.

Dissemination of the Overview Report

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

- The Manchester City Council Community Safety Partnership
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for Greater Manchester
- All agencies involved in the review
- AJ's family
- The Office of the Domestic Abuse Commissioner
- The Welsh Assembly (to be confirmed)

Section 2. Background information

A pen picture of AJ – the focus of this DHR

2.1 As noted earlier in this Report, the Panel pursued a number of opportunities to make contact with AJ's family and friends. The majority of these efforts were unsuccessful, except for AJ's sibling. Set out below is a brief 'pen-picture' of AJ which has been drawn from the information shared by his Sibling, referred to in this Report as S1:

2.2 AJ was born in Wales and he was the youngest child of a large family.

2.3 AJ was unwell as a baby and whilst this was a significant episode in his younger life, he seemed to grow out of it and this caused no problems for him later in life. AJ attended school, and after leaving school, AJ worked with his father in the family business and he also worked in a public house that his family owned.

2.4 AJ was known as being good at singing and entertaining people, and he would travel around different public houses to sing for the patrons.

2.5 AJ's sibling told the Panel that AJ knew that he was gay from being a little boy but living in a small country village, he assumed that he would never be accepted, so he tried his best to hide this from both his family and his friends. When an adult, AJ met P2 (who, at the time, had a child of their own). AJ and P2 shared the responsibility for parenting and caring for P2's child.

2.6 As the relationship between AJ and P2 progressed, they had another child together. AJ's sibling noted that AJ did not treat this second child any differently to the first child he and P2 were parents to. AJ's sibling said that AJ and P2 were intending to marry, but AJ couldn't go through with it. After planning the wedding, AJ's sibling said that AJ gained the courage to confide in P2 that he was gay, and he couldn't do it. AJ's sibling said that AJ and P2 remained very close friends, and that from time to time, AJ would stay over in P2's house when he returned back home from Manchester.

2.7 AJ's sibling stated that AJ moved to Manchester, once he had told everyone that he was gay.

2.8 AJ's sibling told the Panel that AJ enjoyed spending time with his family, and that he also liked the Manchester night life. They said that AJ was a 'free-spirit' and would travel around to see family and friends; that he would help out at the family business; and that he also had his own business, which he really enjoyed.

2.9 S1 stated that they knew that AJ took some drugs, but they were not sure which drugs he was taking' They said that AJ would: "party for a few days at a time, he wouldn't have much contact with his family, but he would sometimes return to Wales to recover from his party.

2.10 AJ's sibling said that they could not clearly recall when AJ was diagnosed with a long term chronic condition, but were sure that it was quite a number of years prior to the circumstances leading to his death. They recalled that AJ said he'd had some problems with his condition a few years ago, when the medication seemed to stop working. S1 said that AJ was really worried about this at the time, and he saw several different specialists. S1 understood that this condition had been under control for a while before AJ died.

2.11 AJ's sibling did note that they knew AJ drank alcohol and said that for AJ this was a social thing to do – not a daily thing to do.

2.12 S1 told the Panel that AJ really struggled with his mental health and had done for most of his life. They said that AJ's anxiety could be bad, and at times the family were of no help to him, and that he needed to be by himself. However, S1 noted that this also was bad for AJ because AJ had attempted suicide many times before he died. S1 recounted a number of occasions when members of the family – including his Mother and Father – had to cut him down from a tree, and that the Police rescued him in a flat in Manchester. S1 said that AJ had taken medication lots and lots of times, and they knew that AJ had been in intensive care in Hospital in Manchester several times.

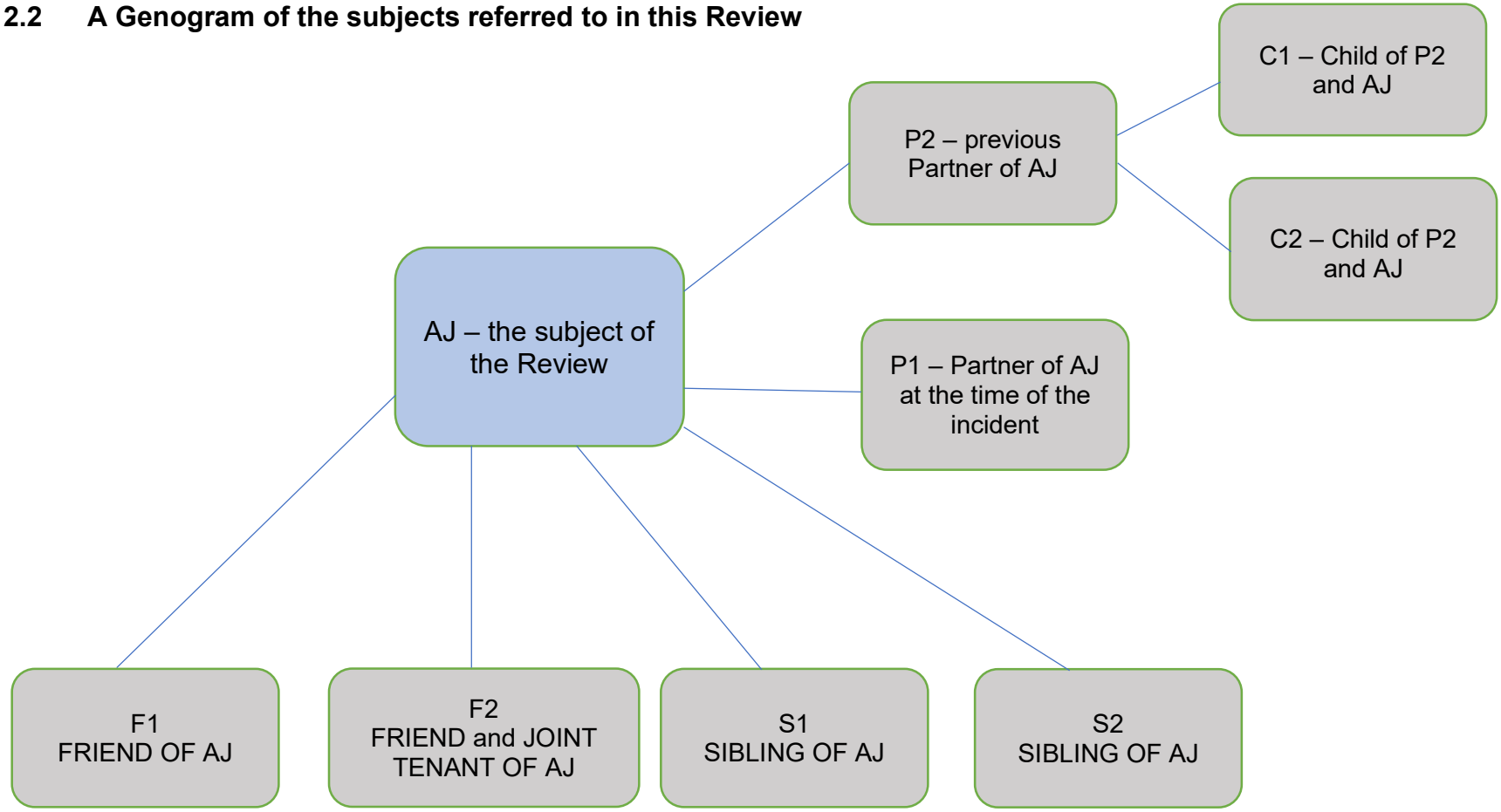
2.13 AJ's sibling stated that AJ and P1 had a very volatile relationship and it seemed that each time they had a drink, they ended up arguing and fighting.

2.14 S1 then spoke about the death of their Mother and said that when their Mother was really poorly, the family would take it in turns to stay with her to look after her through the night. But that for AJ, this was difficult because S1 said that AJ would have to have P1 on facetime and keep showing P1 his Mother to prove he was with her and that he was where he said he was. S1 stated:
"AJ struggled with Mum's death but I think everyone had their own struggles so we didn't really have time to support AJ at that time".

2.15 S1 said their Mother was the head of the family so after her death it changed everyone and everything.

2.16 S1 stated that at the time of AJ's death, they understood that AJ and P1 had split up, but believed they were together the night before AJ died.

2.2 A Genogram of the subjects referred to in this Review



Section 3
Abridged chronology

Outside of the formal scope of the Review

The Panel noted a record from a healthcare provider (which was shared with the Panel) that stated AJ endured a significant adverse experience as a child. The Panel surmised that this would have had a profound impact upon his mental health – both as a child and as an adult.

13/06/2010

3.1 Following an overdose, AJ presented to the Emergency Department (ED) at Wythenshawe Hospital. AJ was admitted for 2 days and discharged following an assessment by the Mental Health Liaison Team (MHLT).

09/04/2011

3.2 Following an overdose, AJ presented to the ED at Wythenshawe Hospital. AJ was discharged following an assessment by the MHLT

29/04/2013

3.3 Following a 'mixed overdose', AJ arrived at the ED at Wythenshawe Hospital. AJ self discharged before being seen by the MHLT.

13/05/2013.

3.4 Following comments that he may take his own life, AJ attended the ED at Wythenshawe Hospital. AJ was bought to the ED by the Greater Manchester Police (GMP) and, following an assessment by the MHLT, he was discharged.

18/02/2015

3.5 Following an incident of self harm, AJ was brought to the ED at Wythenshawe Hospital. AJ was subject to a Section 136 detention. AJ agreed to a voluntary admission.

28/03/2015

3.6 Following comments that he may take his own life, AJ attended the ED at Wythenshawe Hospital. Following an assessment by the MHLT, AJ was discharged.

13/08/2016

3.7 Following comments that he may take his own life, AJ attended the ED at Wythenshawe Hospital. AJ stated there were issues with his ex-partner. Following an assessment by the MHLT, AJ was discharged.[1]

12/06/2017

3.8 Following an incident where AJ consumed an amount of "recreational drugs", AJ attended the ED at Wythenshawe Hospital. AJ self discharged and was not

[1] In the period between June 2010 (the first incident of overdose) and August 2016 (the second threat to take his own life), AJ received an assessment from the MHLT on five separate occasions

reviewed by the MHLT. He stated at the time that he took recreational drugs with no intent to harm himself

Within the formal scope of the Review

2018

3.9 In January, GMP received a report alleging that, following an argument, P1 punched AJ and AJ then left the address. A crime of Common Assault was submitted. Following invitation, AJ did not wish to provide a statement and did not support any further police involvement. A DASH was submitted as medium risk and safeguarding procedures were completed.

3.10 In February, GMP was contacted by AJ's Sibling expressing concern for AJ's welfare. Officers attended AJ's address and found AJ safe and well. He told officers he did not feel suicidal, and stated that he suffers from depression and anxiety which gets worse when he takes drugs. He stated that he intended to stay with his family.

3.11 In April, GP1 received a letter advising them that AJ was now living out of the practice area and had been advised to register with a GP local to his new address (Manchester)

3.12 AJ presented as homeless to the Manchester City Council (MCC) Homelessness Team (Housing Solutions). The Team completed an assessment and noted a number of physical and mental health needs. In May, the MCC Homelessness Team referred AJ's case to the Brokerage Team.

3.13 Between July 2018 and July 2020, AJ received support from the 'Northern Contraception, Sexual Health and HIV Service', hosted by the Manchester NHS Foundation Trust (MFT).

3.14 In July, GMP received information from an undisclosed source stating they had received a text from AJ saying: "Tell my family I love them and will watch over them". Police attended AJ's address and forced entry. They found AJ unconscious with empty medication cases and a bottle of brandy on the floor next to him. The Ambulance Service attended and AJ was taken to Manchester Royal Infirmary (MRI). AJ was admitted to the Intensive Care Unit at MRI and was discharged on the 2nd of August with a plan for intensive home treatment with the Central Mental Health Team (CMHT).

3.15 In early August, Change Grow Live (CGL – the specialist drug treatment service) received a referral for AJ from the Mental Health Liaison Team at Manchester Royal Infirmary (MRI). An appointment was offered to AJ for him to attend for an assessment.

3.16 At around the same time, the Greater Manchester Mental Health Service NHS Foundation Trust (GMMH) completed an assessment for AJ. They noted that the overdose was in reaction to a relationship breakdown with his partner at the

time (not P1). Upon assessment, AJ disclosed a history of abuse including repeated "abusive relationships" transcending childhood and adulthood. The assessment noted that AJ:
"had taken a number of overdoses in the past and on one occasion attempted to hang himself".

3.17 AJ also described being unemployed and living alone; that he was "falling out with friends" and "as a result has nobody to talk to". Additionally, AJ reported housing difficulties with his current landlord and a marked increase in drug and alcohol use. AJ also shared that he'd had a "tumultuous" intimate relationship with his partner (not P1). AJ described this Partner as controlling. The assessing practitioner in the Mental Health Liaison Team referred AJ for a community assessment with the Home-Based Treatment Team (HBTT). AJ remained under the care of the HBTT, initially with good effect. However, the Panel noted that this was a missed opportunity to refer AJ to a Domestic Abuse support service. At the assessment, AJ told the HBTT that he often went back to stay with his family and/or his Siblings in Wales[2].

3.18 On the 10th of August, GP2 (AJ's GP in Manchester) received their first reference to AJ's relationship with his Partner (not P1) and the impact this had on AJ via a letter from GMMH. A week later, GP2 received another letter from GMMH. When seen by the HBTT, AJ was described as enduring a deterioration in his relationship with his Partner (not P1). This relationship was characterised as chaotic, the Partner was described as unfaithful, and AJ had begun taking a number of substances. AJ also disclosed to the HBTT that his previous relationships were physically and mentally abusive.

3.19 In mid August, CGL completed the entry-into-service assessment for AJ. A referral was made to the LGBT Foundation for support around the reports that AJ engaged in sex parties where drug use featured prominently. There was no record that AJ engaged with the service.

3.20 At the end of August, GMP received a contact from a friend of AJ's stating they were concerned for AJ. They had been contacted by AJ's partner (not P1) who told them that AJ was trying to take his own life. Police attended AJ's address and spoke with him. He told officers he had been in a relationship with this Partner for a few months and that on the previous night, they had argued and AJ left the address. The Partner had then ended the relationship. AJ told police he had been receiving counselling and he stated he was fine. The police officer conducted a DASH and a 'Toxic-Trio' assessment. No referrals were required.

3.21 On the 1st of September, Officers from GMP escorted AJ to the Emergency Department at Manchester Royal Infirmary. Due to concerns about AJ's mental health, GMP had exercised a Section 136 detention. Police stated that they had attended AJ's residence, following a call from his family expressing concern for

[2] This may have had an impact on the regularity and quality of intervention being made available by the HBTT.

AJ's welfare. Police located a note at the address, stating that AJ had an intention to take his own life. AJ was found by officers from GMP in woodland with a backpack and a "broken length of rope". AJ agreed to an informal inpatient admission.

3.22 Just over two weeks later, AJ was discharged from inpatient services with a recommendation that he be referred to the HBTT for enhanced community support. The Patient Flow Team at GMMH attempted to review AJ at home on the 17th of September 2018, but without success. The GMMH practitioner made contact with AJ's GP, to update them and further contact details were exchanged. The Practitioner then made contact with AJ's Mother, who confirmed that AJ was staying with her in Wales. AJ confirmed that he planned to return to Manchester in a short time and a face-to-face review was scheduled for the date of his return.

3.23 In early October, AJ was assessed and accepted for HBTT support. AJ continued to move between Wales and England, stating he felt "safe" in Wales and felt "overwhelmed" being alone in Manchester. AJ stated that he would temporarily return to Wales to stay with his family and a referral was made and accepted by the equivalent HBTT in Wrexham.

3.24 On the 6th of October, following receipt of the referral, the Betsi Cadwalladr University Health Board (BCUHB) arranged an assessment by their Home Treatment Team (HTT). AJ disclosed a history of poly-drug use, though denied using substances since being discharged from Manchester Royal Infirmary. AJ told the Home Treatment Team (HTT) that he came back to Wales because he was afraid of his ex-partner in Manchester who had, in the past, been mentally and physically abusive. AJ also reported that his current accommodation in Manchester was unsafe. AJ also stated that he did not want to stay in Wales. The Home Treatment Team did ask AJ about current incidents of domestic abuse and AJ denied abuse had occurred in the recent past. AJ told the HTT that he was disappointed that his attempts to take his own life were unsuccessful. A risk assessment was completed and a follow-up visit was arranged for the 12th of October.

3.25 At the follow-up assessment by the HTT, AJ reported feeling 'bored' and wanted to move back to Manchester. AJ's family were not supportive of this. AJ told the HTT that he no longer needed daily contacts.

3.26 Nevertheless, the BCUHB Home Treatment Team saw AJ again and the practitioner noted that he appeared to be vulnerable to exploitation. AJ stated that he was due to attend a 'Survivors Group' in Manchester[3]. AJ reported that

[3] AJ had a referral made to 'Survivors Manchester' by GMMH on the 28th of September 2018. The ISVA from Survivors made a number of attempts for a face to face meeting and spoke with AJ and he declined the ISVA service but wished to engage with the therapy services. AJ was assessed by the therapy team on the 23rd of October 2018 and placed on the waiting list. AJ was offered one to one therapy to start on the 4th of March 2019. Several calls were made to AJ to gain insight to begin therapy but no answer

he did not intend to resume his relationship with his abusive ex-partner. An assessment for Personality Disorder was on-going at this time.

3.27 In mid October, AJ reported to the HTT that he was looking forward to starting the survivors counselling. AJ reported that he had remained abstinent from substances, except from cannabis and low levels of social alcohol use.

3.28 On the 20th of October, AJ reported that his mood was recovering and he was 'almost ready to return to Manchester'.

3.29 On the 22nd of October, at a consultation with the HTT, AJ reported that the Survivors Group was starting. No Mental Health concerns were recorded and preparations for discharge from the HTT were made for the 24th of October 2018. AJ stated that he was considering moving back to Manchester.

3.30 At an assessment by the HTT on the 26th of October, AJ's care and treatment plan was reviewed as AJ was scheduled to be discharged. However, it was noted that AJ's anxiety was high due to issues with his property in Manchester and AJ stated that the survivor's counselling session would not begin until the new year. The HTT practitioner delayed discharge to support AJ with his housing issues.

3.31 On the 14th of November, the BCUHB. Home Treatment Team (HTT) sent a letter to AJ's GP (GP2) in Manchester. This contained a detailed summary of the involvement of the HTT. It also included details of a diagnosis of Emotional Unstable Personality Disorder - impulsive type. GP2 received this discharge summary on the 20th of November.

3.32 On the 4th of December, GP2 received a letter from the Manchester Foundation NHS Trust (MFT). The letter referred to AJ being in a violent relationship since his last review but no longer having contact with that person at that time. A short while later, a GP from GP2 refused to let AJ's ex-partner pick up his prescriptions. This was due to the information received concerning the abusive relationship.

2019

3.33 In mid January, AJ was discharged from the services provided by CGL. AJ was spending time with this family in North Wales.

THERE WAS THEN A GAP IN SIGNIFICANT INCIDENTS BEING REPORTED OR RECORDED BY ANY AGENCY.

3.34 On the 1st of October, the Northern Contraception, Sexual Health and HIV Service noted in their records that AJ had very poor engagement with the service and had missed numerous planned appointments.

---

following an assessment by the Mental Health Liaison Team (MHLT).

3.34 On the 1st of October, the Northern Contraception, Sexual Health and HIV Service noted in their records that AJ had very poor engagement with the service and had missed numerous planned appointments.

2020

3.35 In early February, AJ attended another Medical Practice (referred to here as GP3) and received a prescription for 6 weeks of medication.

3.36 In early March, AJ was briefly registered with another Medical Practice (referred to here as GP4). He was seen on the day he registered and requested his usual medications. The practice prescribed 1 week of medication as they did not have the records at that time from GP3. GP4 was unaware that AJ had received 6 weeks of medication from GP3. This was the only interaction GP4 had with AJ.

3.37 On the 9th of March AJ presented to the Manchester City Council (MCC) Homelessness Team. AJ told the team that had been told that he could not return to his property. He had a dispute with the landlord and had been asked to leave but no notice had been served. AJ was advised that it was likely he would not be considered as homeless as the action appeared to be an illegal eviction. AJ agreed to arrange to stay with some friends and re-approach when he had information from Shelter regarding the legitimacy of the eviction.

3.38 Subsequently, the MCC Homelessness Team received a call from Shelter regarding AJ's referral. Shelter stated that AJ was being unlawfully deprived access to his tenancy by his landlord. He was a joint Assured Shorthold Tenant of a Flat. He had been informed by his landlord that he cannot re-enter the property due to a dispute relating to allegations of noise nuisance. The landlord failed to follow a lawful procedure to end his tenancy and his tenancy was ongoing.

3.39 On the 11th of March, AJ again presented to the MCC Homelessness Team as homeless. AJ stated that he was living in Manchester but intended to move to Stockport.[4]

3.40 By mid April, AJ had returned to Wales and contacted his GP (GP1) stating that he needed his medications on a weekly prescription at present.[5]

[4] 16 March PM says "now is the time for everyone to stop non-essential contact and travel"
23 March PM announces the first lockdown in the UK, ordering people to "stay at home"
26 March Lockdown measures legally come into force

[5] 16 April Lockdown extended for "at least" three weeks. Government sets out five tests that must be met before restrictions are eased
10 May PM announced a conditional plan for lifting lockdown, and says that people who cannot work from home should return to the workplace but avoid public transport
13 May 2020: leaving or being outside one's home without a reasonable excuse is prohibited. Some restriction relaxed to allow outdoor exercise or recreation with one person from another household.
15th of June 2020: Non-essential retail businesses were permitted to re-open

3.41 In mid-July, AJ attended the Emergency Department at BCUHB. AJ had called the police because he was feeling suicidal and wanted mental health support. AJ was seen by the Psychiatric Liaison service and a number of 'social stressors' were recorded. AJ was referred to the Community Mental Health Team (CMHT) and ICAN (a counselling service). AJ was discharged to his mother's address as AJ reported he was of 'No Fixed Abode'.[6]

3.42 On the 20th of July, AJ was brought to the Emergency Department (ED) at BCUHB by the police after he contacted them in a distressed state and was voicing suicidal thoughts. AJ was referred for a mental health assessment. AJ informed the practitioner that his mood had been low for several months and that prior to the COVID lockdown he had been evicted from his home in Manchester. Following the 'eviction', AJ had received help from 'Crisis Point' in Manchester. Following that, he had returned to his family's address in Wales.

3.43 On the following day, AJ made a request to the Northern Contraception, Sexual Health and HIV Service that he would prefer his sexual health care to be transferred to BCUHB. This transfer was then undertaken.

3.44 On the 7th of August, AJ's GP (GP1) noted the transfer of AJ's care from the specialist service in Greater Manchester. AJ was assessed and re-commenced his medication. A follow up appointment was arranged for September 2020. At the review at the Clinic in BCUHB, it was noted that AJ had missed his last appointment (due to difficulties with his mental health). AJ said that he had used recreational drugs whilst in Manchester, but he was now away from the 'Manchester Crowd'.

THERE WAS THEN A GAP IN SIGNIFICANT INCIDENTS BEING REPORTED OR RECORDED BY ANY AGENCY.

2021

3.45 In mid January, GMP received a report of a violent domestic incident. The caller stated that they could hear raised voices and banging coming from the address.

---

[6] 4 July 2020: most remaining national restrictions are removed as pubs and restaurants re-open.
14 August Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play
14 September 'Rule of six' – indoor and outdoor social gatherings above six banned in England
22 September PM announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector
31 October PM announces a second lockdown in England to prevent a "medical and moral disaster" for the NHS From the 5th of November, the UK was in its second national lockdown.
2 December Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions
15 December PM says Christmas rules will still be relaxed but urges the public to keep celebrations "short" and "small"
19 December PM announces tougher restrictions for London and South East England, at Home' alert level. Christmas mixing rules tightened.
21 December Tier 4 restrictions come into force in London and South East England
26 December More areas of England enter tier 4 restrictions

Police attended and spoke to both AJ and P1. Both stated they had begun arguing over comments made by P1 to AJ. P1 stated that AJ had started strangling them and they hit AJ in self defence. AJ alleged P1 punched him in the face. A DASH was completed and considered as medium risk. AJ left the address. Neither party wished to register a complaint with the Police.[7]

3.46 At the beginning of February, GMP noted that AJ was residing in Wales and visited P1 from time to time. AJ visited P1 in early February and they had engaged in an argument. AJ left and sent a text message to P1 stating: "I can't do this anymore". P1 then thought that AJ was suicidal and reported him missing to the police. A search commenced and AJ was found. He told officers he was not suicidal. AJ was taken to his friend's house to spend the night. A DASH was completed and assessed as Medium risk. Later the same day, P1 contacted the police to ascertain if a risk assessment had been carried out on AJ because AJ had been taken to hospital.

3.47 NWAS had received a call from a friend of AJ's who had found him unresponsive and struggling to breath and not waking up. CPR advice was given to the caller over the phone and the caller (referred to in this Report as F1) carried this out while awaiting the crew from NWAS. On arrival, AJ remained unresponsive and continued to need assistance with breathing on his journey to hospital. AJ was then transferred to hospital staff. AJ was admitted to the Intensive Care Unit (ICU) at MRI. The Ward handover documentation identified potential concerns regarding domestic abuse. The MRI NHS Trust safeguarding team advised ward staff to complete a domestic abuse referral form with AJ. Ward staff stated that AJ was unwilling to disclose any information regarding the potential domestic abuse and self discharged before this was completed. AJ reported that he wished to be seen in 'The Orange Room' at Tameside, due to moving to the area with his partner. The Orange Room were informed. GMP then received a call from Manchester Royal Infirmary reporting that AJ was missing. MRI stated that AJ was not allowed to leave because he was subject to a Section 5.2 detention (of the Mental Health Act). AJ was found several hours later at the home of P1 and he was returned to hospital by the Police.

3.48 Between February 2021 and the date of the critical incident in November 2021, AJ received support with his treatment from 'The Orange Rooms' in Tameside (this is a service hosted by the Manchester University Hospitals NHS Foundation Trust – MFT).

3.49 On the 3rd of February, the Mental Health Liaison Service from GMMH completed an assessment and the assessing clinician noted that AJ appeared to have capacity (as defined by the Mental Capacity Act (MCA) 2005) to make

[7] 4 January PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher. One the 6 January 2021: All areas of England are moved into Tier 4's stay at home restrictions. This is the third national lockdown

decisions about his treatment. AJ was subsequently discharged back to the care of his GP.

3.50 Following notification of AJ's overdose, when AJ was seen by the GU Medicine Consultant in BCUHB, they made an urgent referral to the Consultant Psychiatrist at BCUHB. There is no evidence that AJ attended the consultation with the Psychiatrist.

3.51 Towards the end of February, AJ informed the Northern Contraception, Sexual Health and HIV Service that he was in Wales with his family and that his mother was terminally ill. AJ reported that he had appointments with the Sexual Health Services in Wales.

3.52 In mid-March, GP1 completed a review of AJ's health. AJ reported feeling low, that his Mother had passed away, and he was struggling to cope with anxiety. AJ stated that he had started a new relationship in December. GP1 noted that AJ stated he needed counselling, and would like to re-start medication. The GP referred AJ to the mental health team at BCUHB.

3.53 In mid April GMP received a report that AJ was 'struggling' following the death of his Mother. Due to the COVID-19 restrictions, he had been unable to attend the funeral. AJ stated that he had argued with P1 and, consequently, the Police had attended the scene. When they arrived, AJ was leaving the address of P1 and intended to return to Wales to, as he stated: "try and sort himself out". P1 was remaining at the address. No offences were alleged. All safeguarding procedures were completed. A DASH was completed and the risk level determined as medium.

3.54 Approximately, one week later, P1 reported an assault to GMP. P1 stated that they had been strangled by AJ and had to punch AJ in self defence. On police arrival, AJ was seen with a bloodied nose, and alleged he had been arguing with P1 and left. P1 had followed him and attacked him. Both parties were arrested for a Section 47 assault. Both crimes were eventually determined as 'no further action' due to the conflicting evidence. A DVPN was authorised and served on AJ. On the 23rd of April a DVPO was granted and DVPO Compliance visits were completed. A DASH was completed and assessed as medium risk.

3.55 In early June, P1 contacted GMP following a heated argument with AJ. P1 stated they had asked AJ to leave but he refused. When the Police arrived, AJ was outside the address. AJ stated that he intended to go to Manchester and get a train to Wales. The Police took AJ to the station to get back into Manchester. A DASH was completed and assessed as medium risk.

3.56 On the 9th of June, AJ had a telephone consultation with GP1. AJ stated that he was not in a good place; that he had an appointment with the mental health team in July; and was asking for more medication. AJ reported that his partner (P1, who lived in Manchester) was controlling.

3.57 Five days later, AJ attended The Orange Rooms with his Partner for a walk-in appointment. AJ shared that his Mother had passed away earlier in the year and he was now back in Manchester. He stated that he was struggling with his mental health and awaiting an appointment with a Psychiatrist in Wales, which he was keen to keep despite moving back to Manchester.

3.58 On the 1st of July, AJ attended a face to face appointment with a Clinical Nurse Specialist at The Orange Rooms. During the appointment, AJ discussed his mental health. AJ also discussed his relationship with his Partner, reporting that although they had been together for the previous 6 months they had had an 'on/off relationship' spanning 10 years. AJ disclosed a very difficult relationship with his Partner stating violent behaviour from both parties but perpetrated more seriously by his Partner. AJ also described features of emotional manipulation and controlling behaviour within the relationship. The Clinical Nurse specialist discussed the possibility of a referral to the Multi-Agency Risk Assessment Conference (MARAC) and safety planning with AJ, offering support with housing and making contact with the police. AJ did not want to take any action because he was fearful that his partners job would be affected. Hence the referral to MARAC was not able to be completed at that time.

3.59 On the 20th of September, AJ informed the Northern Contraception, Sexual Health and HIV Service that he was back in Wales because he had split up with his partner and was looking after a family member who was unwell. An appointment was booked, but AJ did not attend.

3.60 On the 1st of October, Jigsaw Homes received a phone call from an onsite caretaker at P1's address. They advised that there had been an incident at P1's property – that the two occupants (this was the first time the officer from Jigsaw was made aware that there maybe an additional person living at the property) appear to have had a row and one of them had taken items out of the flat and dumped them in the communal hallway. This included furniture and clothing. The housing officer called P1 on the telephone and P1 stated that it had been a difficult breakup with their partner and although there had been a history of domestic abuse there was nothing like that at the moment. The officer completed a risk assessment. Despite P1's assertion, the service did discuss all aspects of abuse and talked about coercive behaviour. P1 stated that they were fine at the moment. The Officer considered the comment "at the 'moment" to be quite significant. The officer asked if they could speak to P1 again the following week to discuss the matter further, but P1 declined the offer.

3.61 On the same day, AJ had a telephone appointment with a Clinical Nurse Specialist at The Orange Rooms in Tameside. AJ was very upset during the appointment. AJ said that he wanted to end his relationship but would not have anywhere to live. The Clinical Nurse Specialist contacted housing services to assist AJ and he was signposted to Tameside Housing Advice for temporary accommodation. AJ also discussed his mental health. He disclosed that he was beginning to feel suicidal due to current stressors. The Clinical Nurse Specialist advised that AJ should attend A&E if this became too much.

3.62 Three days later, AJ had a telephone appointment with a Clinical Nurse Specialist at The Orange rooms. A plan was made to complete a domestic abuse referral form later in the week. During the telephone appointment, AJ reported that he had returned to Wales. He disclosed that his partner had given him a 'flying kick to the ribs' when AJ refused to engage in drug taking behaviour. Following this, AJ's partner instructed the apartment concierge to escort AJ from the building. At this time, AJ was unsure whether he wanted to transfer his care back to Wales.

3.63 On the 8th of October, the Clinical Nurse Specialist from the Orange Rooms had a telephone appointment with AJ to complete a Domestic Abuse referral form (to refer to the MARAC). AJ decided that he would not complete the form over the 'phone as he was still staying with his family in Wales. A follow-up telephone call was booked for the following week. AJ kept the appointment and at that call, AJ said that he was still in Wales but that his partner was constantly trying to contact him and his family. The Clinical Nurse Specialist asked if he wanted to transfer his care to Wales but AJ declined, stating that he would "end up back with his partner" so wanted to keep his care in Tameside.

3.64 Two days later, AJ attended a face to face appointment with a Clinical Nurse Specialist at The Orange Rooms. The domestic abuse referral form was completed. The Clinical Nurse Specialist also contacted the Rapid Interface Assessment and Discharge (RAID) team (hosted by GMMH) and spoke with a member of staff regarding the concerns around AJ's mental health.

3.65 The domestic abuse referral form was assessed as high risk and was sent to the Manchester Foundation Trust Safeguarding Team for referral to the MARAC. AJ reported that he planned to return to Wales on the same day. The Clinical Nurse Specialist reported that they had significant concerns about his safety as he had no ongoing support from Mental Health services and had recurring suicidal thoughts. AJ stated he had no exact plan to end his life, but that he had been stockpiling medication (including some medication used by his Mother). AJ was advised to hand in any stockpiled medications that he may have and to book an appointment with his GP (AJ did not want to go to A&E for an assessment).

3.66 On the 15th of October, the Adult Safeguarding Team from MFT received the Domestic Abuse Stalking and Harassment form (DASH) and noted the score of 18 on the risk indicator checklist (RIC). The DASH/RIC was uploaded to the share-point system for listing for a MARAC hearing. Whilst AJ would not disclose the full details of the alleged perpetrator, it was submitted with his consent. The MARAC Referral Document was uploaded and allocated to the Independent Domestic Violence Advocate (IDVA) service at 'Bridges' (this is a service hosted by Jigsaw Homes). There was an e-mail exchange between the IDVA and the Orange Rooms and the IDVA confirmed they would make contact with the referring party (AJ) to discuss safety planning.

3.67 On the 19th of October, the Bridges IDVA Service telephoned AJ. The IDVA had made a referral to assist AJ in accessing a further package of support to assist overcoming his current complex situation (Substance misuse, Domestic Abuse, Homelessness & Employment support). On the same day, 'Motiv8' (a service also hosted by Jigsaw Homes) received a referral via e-mail from the IDVA service. AJ was allocated to the Motiv8 Attachment Team for them to commence the initial eligibility checks to attach AJ onto Motiv8. The referrer from the IDVA service advised Motiv8 to use SMS to initiate contact with AJ. On the following day, Motiv8 called the IDVA service and advised that they had sent a text to AJ but had not heard from him. The IDVA advised that it was ok to say it was Motiv8 as AJ would know who that was and he may then respond. The IDVA advised that AJ's phone was not monitored by AJ's partner. The IDVA service stated that they were intending to invite AJ into the office and would inform Motiv8 if they were successful so that a joint meeting could be arranged to enable AJ to be 'signed-up' to the service.

3.68 On the 22nd of October, the Bridges IDVA Service had a face-to-face meeting with AJ and supported AJ with a referral to Tameside Housing Advice (THA) to seek an Emergency Accommodation Placement and an Individualised Safety & Support Plan (ISSP). A Food Parcel Voucher was provided via Motiv8. THA moved AJ into Temporary Accommodation as emergency support. The IDVA notified the team at Bridges that AJ had moved into Temporary accommodation via Tameside Housing Advice. Motiv8 were also present during the meeting with AJ and advised what screenshots were required. AJ provided his passport. He was provided with a new contact number to access appropriate staff. Motiv8 provided vouchers to AJ for use over the following weekend.

3.69 On the 25th of October, the Bridges IDVA Service engaged in direct work with AJ. The IDVA provided alternative Housing Options to AJ for a possible move to Salford or Manchester. This was because AJ didn't wish to return to Tameside and stated he would seek support via Manchester or Salford Local Authorities as he had links and support in those two areas.

3.70 At a meeting with the IDVA service at Bridges on the following day, AJ stated that he wanted to avoid placements in Tameside, Wales and Stockport. AJ stated that he felt alone and spoke about missing his Mum. It was recorded that AJ was due to travel to Wales on the following day to pick up his medications. THA had provided alternative options for AJ's accommodation and the IDVA would support this work. The Bridges IDVA Service gave Safety Advise to AJ concerning contact with his ex partner.

3.71 On the 26th of October, GMP noted that the high risk referral (for AJ) was due to be discussed at the Tameside MARAC on the 9th of November. However, it was noted that AJ had left the area and consequently, the referral was transferred to the 'North MARAC' to be discussed on the 25th of November, a delay of just over two weeks.

3.72 On the 29th of October, Salford City Council Housing Services confirmed that they had placed AJ into Temporary Accommodation. AJ stated to his Motiv8 advisor that this accommodation was in much nicer condition so his mood had improved and he said that he could finally see forward to the future. He advised that P1 did not know where he was or know his new telephone number. AJ advised that he had told P1 that he was in Wales. He discussed completing his attachment to the Motiv8 service and advised that 'Friday would be a good day for him' and that he would prefer a face to face appointment. Motiv8 stated that they would update the IDVA service at Bridges and they could provide information on restraining orders.

3.73 On the 4th of November, Salford City Council Housing Services noted an e-mail concerning a transfer of the MARAC hearing to Manchester. A telephone call was made and it was agreed that the IDVA would manage the transfer of the case to Manchester MARAC and would check which IDVA service would be supporting AJ. On the same day, the Bridges IDVA Service noted the request to transfer the MARAC hearing to Manchester City. The MARAC Transfer Referral Document was uploaded to the Share-point, via GMP. The IDVA spoke to AJ and noted that he had been placed in a self contained property and then discussed the transfer of the MARAC. They advised AJ of the service support available now that AJ had moved from Tameside. AJ spoke about feeling positive, and having contact with Orange Rooms for support. AJ informed the Clinical Nurse Specialist at the Orange Rooms that he had moved into temporary accommodation and had been referred to Motiv8 for help with finances. AJ reported that he was feeling positive and was "smiling again for the first time in ages". AJ was encouraged to register with a local GP. AJ reported having no current suicidal thoughts or plans.

3.74 On the 8th of November, the LGBT+ Foundation IDVA service received the referral from Manchester City Council and called and spoke to AJ to offer support. He said he couldn't speak at that time but now that he had the LGBT+ Foundation number and would call back when he could speak

3.75 On the 9th of November, Salford City Council Housing Services, Bridges IDVA Service, Motiv8 all recorded that they were unable to contact AJ. The IDVA service had attempted a check-in call with AJ, but there was no answer. A text was sent by Motiv8 to AJ advising they had seen his message, hoping that all went well with Salford Housing and for him to let Motiv8 know his availability for a call.

3.76 On the 11th of November, the LGBT+ Foundation telephoned AJ but received a message that the dialled number was not correct. The Foundation then telephoned AJ's sibling and they said they would ring AJ and pass the LGBT Foundation number to him. On the same day, GMP received a call from P1 to raise issues concerning an ongoing argument with AJ. When the police arrived, P1 stated there was no violence and he had called the police because AJ was not leaving his address. On police attendance, AJ left the address to stay with a friend for a few nights. P1 declined any referrals and did not disclose any

offence. Safeguarding procedures were completed, a DASH was completed and assessed as standard risk.

3.77 On the following day, GMP received a call from a Neighbour stating they had heard two males arguing. Police attended and found AJ outside P1's address. He appeared very confused. AJ initially told the officer he had gone to P1's flat to collect some things and he was working with MARAC and has a safe house. He then told officers he had been there on and off since Wednesday and was helping P1 who was, AJ said: "in a mess" as a consequence of their drug use. AJ told officers that they had argued and P1 had grabbed him by the throat and elbowed him in the face. AJ stated on Body Worn Video (BWV) that he would not support a prosecution and that the MARAC were helping him. A DASH was completed and assessed as medium risk.

3.78 On the 18th of November, AJ had a telephone appointment with a Clinical Nurse Specialist at The Orange Rooms. The Clinical Nurse Specialist completed a referral to the Community Mental Health Team on the day of the telephone appointment. AJ reported that he was back in Wales. AJ said that Motiv8 were assisting him to register with a Manchester GP. AJ said he had been to see his partner recently. He also reported that his mood was not good and he had been having intrusive thoughts of self-harm, but had no active plans to attempt suicide. AJ consented for a referral to the Community Mental Health Team. GMMH NHS Trust received the referral made by the Specialist Nurse citing concerns regarding AJ's mental state. The referral indicated AJ had "recently fled from a violent, abusive relationship", had an IDVA and the case was due to be heard at MARAC. He was housed in temporary accommodation and had recently stockpiled medication with an intent to overdose – and had been advised to safely dispose of the stockpiled medication. The referral noted historical difficulties including a "chaotic lifestyle" making adhering to appointments difficult, alongside moving between Wales and Manchester.

3.79 On the 19th of November, The Bridges IDVA Service noted contact from the MASH, who wished to discuss the recent incident between AJ and P1. The IDVA contacted AJ and he confirmed that he wanted to pursue charges against his ex-partner, P1. This was fed back to GMP.

3.80 On the same day, the LGBT Foundation received a text from AJ saying:
"Hi It's AJ can you please call me please. Thank you."

3.81 The LGBT Foundation sent a text message to AJ saying:
"yes are you free to speak now or when's convenient?"

3.82 AJ didn't respond to this text. The LGBT Foundation decided to try and call again the following day. The call went straight to voicemail. A text was sent, requesting AJ let the LGBT Foundation know when it was the best time to speak so they could offer support.

3.83 By the 23rd of November, the LGBT Foundation had not received a response from AJ and planned to follow up the following week. The LGBT Foundation noted that AJ wished to engage, but would often be with P1 when the calls were made by the Foundation. The Foundation wished to give AJ the space to engage when he felt ready and at a convenient time.

3.84 A short time later, NWAS received a 999 call from P1. NWAS crew attended and recorded that the property was secure on their arrival. Police were requested to attend. AJ was pronounced deceased by a Paramedic at the scene. The NWAS crew noted on the e-PR that P1 reported to them that AJ and P1 had recently had food and drinks together, and that AJ was active on social media on the 21st of November. GMP received the call from NWAS. CID attended the scene. A large amount of medication was found at the address

3.85 A Community Psychiatric Nurse from CMHT North East (part of GMMH NHS Trust) screened the referral from the HIV Specialist Nurse and concluded that it was “unclear” if AJ resided in Manchester because it appeared that he was still registered with a GP in Wales. They noted that AJ was “uncontactable by phone” and it was “unclear on the need for secondary care services”. The referral was closed to CMHT without further liaison with AJ or his GP.

Section 4
Overview of what the services involved knew

Hindsight bias

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

4.2 A number of agencies that submitted reports to this Review were involved with AJ and P1 far less frequently than other agencies. In these cases, those agencies have described their interactions in the form of a short-report narrative. The Panel used these 'short reports' as a basis to build a composite picture of the contacts with AJ and/or P1. Those agencies that had more frequent contact, for a longer period of time, have addressed each 'key line of enquiry' in turn as a part of their Individual Management Review. These responses are considered in the next Section.

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

North West Ambulance Service (NWAS)

4.4 From 2017 NWAS had two contacts with AJ (including the critical incident) and three contacts with P1.

4.5 All contacts, apart from the critical incident, were through the NWAS 111 service, so neither AJ or P1 was seen in person by NWAS prior to the critical incident. NWAS did not identify or raise any safeguarding concern notifications for AJ or P1, and all contacts were dealt with following 111 procedures. During the critical incident in November 2021, AJ was declared as deceased at the scene. The Police were informed and they attended the scene.

Greater Manchester Mental Health NHS Foundation Trust

4.6 As noted in the chronology GMMH completed an assessment for AJ and he described his history of abuse. AJ also described his current situation (see the chronology on page 21-22). The assessing practitioner in the Mental Health Liaison Team referred AJ for a community assessment with the Home-Based Treatment Team.

4.7 AJ responded well under the care of the Central HBTT. He made further disclosures concerning his relationships, and his substance abuse. AJ described his HIV status and appeared traumatised by the circumstances that led to his diagnosis.

4.8 Towards the end of the scope of this Review, AJ was referred by the HIV Specialist Nurse to the Community Mental Health Team (CMHT) North East, citing concerns regarding AJ's mental state. The referral indicated that AJ had "recently fled from a violent, abusive relationship", that AJ had been allocated an IDVA and that the case was due to be heard at MARAC. The referral also noted historical difficulties including a "chaotic lifestyle", making adhering to appointments difficult, alongside moving between Wrexham and Manchester. The referral was screened by the CMHT and was closed because it was not clear if AJ was a resident of Manchester and appeared to be registered with a GP in Wales (see the chronology on page 35).

Manchester Foundation NHS Trust (MFT)

4.9 AJ received care from the Northern Sexual Health Service from July 2018 to July 2020. MFT noted that during this time-frame, AJ had relatively poor engagement with the service and declined to attend a number of arranged appointments. In July 2020, AJ requested that his sexual health care be transferred to the equivalent service in Wales.

4.10 MFT noted AJ's admission to their intensive care unit, following an intentional over-dose (see the chronology on page 26), and that following this episode, AJ was referred to the Orange Rooms in Tameside for his ongoing sexual health care.

4.11 MFT noted that AJ presented to the Emergency Department (ED) at MRI on several occasions within the timeframe of this review, primarily with concerns relating to a deterioration in his mental health or the use of illicit substances.

4.12 MFT informed the Panel that the first documentation they had reporting that AJ may have been a victim of domestic violence and abuse was during his admission to MRI on the 2nd of February 2021. However, MFT informed the Panel that at that time, an appropriate DASH assessment and referral was not completed. The Panel was cognisant that at this incident, AJ was unwilling to disclose information and self-discharged before the DASH could be completed.

4.13 Professionals at the Orange Rooms were able to work with AJ and ensure a domestic abuse referral form was eventually completed and this was referred to the Multi-Agency Risk Assessment Conference (MARAC).

GP1 (Wales)

4.14 AJ's relationship with GP1 was long-standing and characterised by a series of de-registrations and re-registrations. In short, AJ was:

- de-registered on the 6th of March 2009 and re-registered on the 25th of June 2009

- de-registered on the 12th of November 2009 and re-registered on the 27th of April 2015
- de-registered on the 24th of April 2018;
- and re-registered on 20th of April 2020.

4.15 Within the formal scope of this Review, AJ was seen regularly and appropriately by various GPs in the practice for a range of consultations.

Betsi Cadwalladr University Health Board

4.16 Based on the chronology submitted, AJ had sporadic contact with the Mental Health services and two attendances at the Emergency Department during the specified scope of the Review. AJ was also known to BCUHB services for the treatment of a long-term medical condition.

Greater Manchester Police (GMP)

4.17 From the abridged chronology, the Panel noted a number of incidents where GMP responded to concerns regarding AJ and/or P1.

4.18 In January 2018 AJ told officers that he and P1 had been in a relationship for around two months but had known each other for eight years. AJ said the relationship was casual but AJ said he did not want to be in a relationship. He had been arguing with P1 and stated that P1 had punched him (see the chronology on page 21*)*. AJ was taken back to his home address. AJ informed officers that he did not wish to support a prosecution at that time.

4.19 GMP responded to requests regarding a concern for the welfare of AJ on a number of occasions, including:

- a call in July 2018 regarding a text suggesting that AJ may take his own life (see the chronology on page 21);
- In August 2018 police attended AJ's home after AJ's Partner (not P1) rang the police concerned that AJ was intending to try and take his own life and believed he may be in possession of a noose (see the chronology on page 22);
- In February 2019, AJ's Sibling contacted the police. They were concerned for the welfare of AJ who had not been heard from since the previous night. Officers attended AJ's home and found him safe and well.

4.20 The Panel noted that, following this latter incident, the police did not have any contact with either AJ or P1 for almost a year. However, the incident they attended after this period of time was significant and occurred in January 2021. The Police attended a domestic incident that had occurred between AJ and P1. Both parties made counter allegations of assault. A DASH was completed and assessed as medium risk. Safeguarding advice was given by officers at the scene and both parties were made aware to contact the police if there were any further issues. The Police noted that no referrals were required. The Panel also noted that officers from GM Police witnessed AJ leaving P1's address and leaving the scene of the incident. GM Police were assured that this minimised any continuing risk.

4.21 The Police informed the Panel that, according to their information, AJ had been living in Wales but would return to Manchester from time to time to visit P1. On one of these visits (see the chronology on page 26), P1 contacted the police concerned for AJ's welfare. AJ was circulated as a missing person and when he was found, AJ was taken to a friend's house to spend the night. The Police informed the Panel that at this incident, AJ was adamant he would be continuing his relationship with P1. A DASH was completed. The risk level was assessed as medium.

4.22 In the early hours of the 2nd of February 2021, AJ was taken to Manchester Royal Infirmary and was receiving care in the Intensive Care Unit. The Panel noted that AJ self discharged from this admission and, because of the Order AJ was subject to, he was returned to the hospital by a police officer. This police officer then recorded a care plan.

4.23 By April 2021, police had responded to two further domestic incidents which had been reported by neighbours. On both occasions safeguarding was undertaken and a DASH was completed. The Panel noted the incident on the 21st of April 2021 when the police attended a domestic incident between AJ and P1 in which both made allegations of assault against each other. As a result, both parties were arrested for Section 47 Assaults. The Panel noted that a Domestic Violence Protection Notice (DVPN)[8] was authorised and served on AJ. Further, on the 23rd of April a Domestic Violence Protection Order (DVPO)[9] was granted to protect P1 from violence/threats of violence and prohibited AJ from contacting P1 or attending his home address. The Police confirmed that there were no breaches of the order and it expired on the 21st of May 2021[10].

4.24 The Panel then considered the process leading to the submission to the MARAC in October 2021. The Panel recalled the chronology (see the chronology on page 31) and noted that the referral was made by The Orange Rooms and that the original submission was transferred from the Tameside MARAC to the City of Manchester MARAC. This led to a 14+ day extension of the date of the hearing. The Police noted that, at the time of the MARAC referral, AJ was unaware of any police involvement[11].

[8] DVPN is issued by the police and provides immediate emergency protection to victims. It will include prohibitions and restrictions.

[9] DVPO within 48 hours of DVPN been issued, an application will be made to the Magistrates Court for a DVPO. The order protects the victim from violence or the threat of violence and will last for a minimum of 14 days and a maximum of 28 days.

[10] The GMP Author was clear that the attending officers took positive action at the scene to safeguard both AJ and P1 and arrested them, thus reducing the risk of further abuse.

[11] From the GMP Author: As per policy, if an offence is revealed during discussion at the MARAC, GMP officers are obliged to record the crime to ensure NCRS compliance. For those cases where the victim has indicated that they do not wish to engage with the police, the crime will be recorded but it is important to note that "no further action" will be the conclusion only when the matter has been considered by a Detective Inspector. This consideration will include the wishes of the victim, the prospect of an Evidence-Led Prosecution and the risk posed to the victim of pursuing a prosecution, effectively, against their wishes.

4.25 The Panel noted from the GMP submissions that AJ stated he would not support a police prosecution, and it was evident that he was still in contact and in some form of relationship with P1. GMP stated that they did consider arresting P1 without AJ's support, but recognised that this would have been against AJ's wishes and that any arrest would be unlikely to result in a charge. Furthermore, GMP acknowledged that any police action that was not supported by AJ could potentially put him at further risk as he remained in a relationship with P1.

4.26 The Panel then considered the final occasion when the Police had contact with AJ. This occurred on the 12th of November 2021 when P1's neighbours contacted the police after hearing two males arguing. On police attendance they found AJ outside. He appeared very confused and initially told officers he was at the flat to collect some of his things, that he had been working with MARAC and had a 'safe house' to live in.

4.27 The attending officers reported that they found it confusing to work out if AJ was talking about things that had happened at that precise time or at some point in the past. AJ was spoken to on Body Worn Video (BWV) and told officers he would not support a prosecution as he had a plan in place, and he was working with the Bridges service. AJ intended to drive to Wales for his father's birthday which was on that day.

4.28 A referral was sent to MARAC for this incident to be heard alongside the previous incidents (scheduled for the 25th of November). A crime was submitted for Common Assault and was reviewed by an Inspector who stated that whilst there were vulnerability issues, there was very little prospect of detection of this crime without the assistance and support from the victim.

Manchester City Council Homelessness Service

4.29 The Homelessness service had contact with AJ on two occasions. On both occasions, AJ presented as homelessness. Following assessment of AJ's circumstances, the regulations determined that AJ was not afforded a homeless duty because both presentations were "prevention cases".

4.30 At AJ's first presentation (see the chronology on page 21) he was referred to the 'Brokerage Team' (now known as the Private Rented Team). The case was closed on the 22nd of May 2018 as positive prevention

4.31 On the second occasion when AJ presented to the service (see the chronology on page 24), a homelessness assessment was started. It transpired that AJ was subject to an illegal eviction by his landlord. The last contact with AJ was on the 12th of March 2020

Change Grow, Live (CGL)

4.32 Change, Grow, Live is a registered charity that supports people to achieve personalised goals with regard to their substance misuse. AJ first became known to Change Grow Live Manchester following a referral that had been made by the Mental Health Liaison Team at Manchester Royal Infirmary (MRI)

on the 2nd of August 2018. AJ attended an appointment for a Personalised Assessment on the 22nd of August and was not seen again by CGL. AJ was discharged from CGL on the 24th of January 2019.

Motiv8

4.33 Motiv8 is a non-statutory service to which people can be referred or self-refer. Motiv8 supports people aged over 25 across Greater Manchester who need support with their health, alcohol and/or drug use, domestic violence, debt, homelessness or other challenges and barriers to living a prosperous life. AJ was known to Motiv8 between the 19th of October and the date of the critical incident in November 2021.

4.34 In brief, the Panel noted that AJ had the following contacts with Motiv8:

- A referral was made by the IDVA on the 19th of October 2021. Both Motiv8 and Bridges are services delivered by Jigsaw Support (part of the Jigsaw Homes Group)
- The Motiv8 Attachment Co-ordinator attempted to contact AJ via SMS text between the 20th of October and the 22nd of October to discuss acquiring his eligibility evidence to access the Motiv8 programme. Motiv8's funder (the European Social Fund/National Lottery Community Fund) requires evidence of the right to live and work in the UK and evidence of economic status prior to service entry.
- A face-to-face meeting took place between AJ, the Motiv8 Attachment Co-coordinator and the Bridges IDVA on the 22nd of October. The Motiv8 Attachment Co-coordinator maintained contact with AJ, the Housing Support Worker and Bridges IDVA.
- A programme attachment appointment was arranged for the 5th of November 2021 but was cancelled by AJ and re-arranged for the 19th of November.

LGBT Foundation

4.35 The LGBT Foundation informed the Panel that their engagement with AJ was often difficult because on contact, AJ was often with P1, and this made it difficult to have a confidential conversation regarding allegations of abuse. The Foundation also told the Panel that their staff were aware that AJ made a number of attempts to leave the relationship, but this resulted in frequent contact from P1, some of which included emotional intimidation urging AJ to return to the relationship. The Foundation told the Panel that they believed AJ did wish to leave the relationship and engage in receiving the domestic abuse support offered by the Foundation, but he was unable to do so.

Bridges Domestic Abuse Support

4.36 Bridges is a non-statutory service to which people can be referred/self-refer. It supports victims of Domestic Abuse within Tameside. As noted under the submission from Motiv8, both Motiv8 and Bridges are services hosted by the Jigsaw Homes Group. AJ was supported by the Bridges service between the 18th of October 2021 and the 19th of November 2021. Bridges informed the Panel that AJ engaged positively with the support offered throughout this time. Bridges completed a Risk & Needs Assessment on the 22nd of October.

Subsequently, an action plan was completed and contained the following elements:

- To provide AJ with a mobile phone for personal safety and to keep in touch with agencies;
- A referral to be made to Motiv8;
- A referral to CMHT for mental health support;
- Referral to Tameside Housing Advice for emergency temporary accommodation.

4.37 The Panel noted that the referral made to the Community Mental Health Team was not accepted due to AJ not being registered with a local GP. Consequently, the plan was amended for AJ to be supported to register with a local GP. This process was underway when the critical incident occurred.

Salford Housing Services

4.38 On the 27th of October 2021, an e-mail was received by the generic housing advice service from Jigsaw Homes Group advising that AJ had been placed in temporary accommodation by the Tameside homelessness team. The e-mail stated that AJ was fleeing domestic violence. The e-mail stated that AJ did not want to remain in Tameside. AJ was contacted on the same day and a homelessness assessment began. Tameside stated they would continue to provide temporary accommodation for one further night and then AJ would be transferred to Salford. Consequently, a request for temporary accommodation was made to commence on the following night.

4.39 The homelessness assessment was completed with AJ over the telephone. AJ said that he did not want to go back to P1 but feared he wasn't strong enough. The Housing Options Advisor told him to call the police if he felt at risk. AJ stated that he had been working with the IDVA and the Orange Room for some time without P1 knowing. The Housing Options Advisor contacted the IDVA to discuss the transfer of the MARAC from Tameside to the City of Manchester.

4.40 On the 8th of November, the Housing Options Advisor received an e-mail from the Supported Tenancies Officer for AJ saying they had posted through his door the forms that needed signing by AJ for his homelessness application. They did this because they had been unable to get a response from AJ on the telephone. On the 9th of November, another e-mail was received from the Supported Tenancies Officer advising they had no contact from AJ. On the 11th of November, the Housing Options Advisor e-mailed AJ asking him to complete the form and informed AJ that the Supported Tenancies Officer had been trying to contact him. That was the last attempt at contact prior to the critical incident.

Jigsaw Housing

4.41 P1 became a tenant of the Jigsaw Homes Group on the 21st of September 2020.

General Practice Services in Greater Manchester – GP2, GP3, GP4

4.42 AJ had contact with three Greater Manchester GP practices during the scope of this Review. These were:

- GP4 between March and April 2020
- GP3 between February and March 2020
- GP2 between April 2018 and February 2020

4.43 During his registration with GP2, AJ was seen regularly – approximately monthly. At times he was seen weekly, which corresponds with his admission after an overdose in 2018 and the need for weekly prescriptions to manage the risk of suicide. The GP contacts were largely reviews for anxiety and depression. An adult safeguarding concern was noted on the 16th of August 2018, following the overdose. The GP also noted a number of other vulnerability markers, including excess alcohol and drug use, attending 'chem-sex parties' (and AJ alleged that he would be given drugs if he had sex with older men) and blaming himself for contracting HIV. However, a formal adult safeguarding referral was not sent.

4.44 AJ was registered with GP4 in March-April 2020. It appears from the record that AJ was seen on the day of registration and requested his usual medications, saying he had run out. One week of medication was given until the surgery could get his records from the previous practice (GP3 in Stockport).

4.45 From the 16th of November 2021 (when GP1 received a request for summary notes) it was apparent from the submissions that AJ was in the process of registering with a GP in Manchester and was intending to become a permanent resident in Salford.

Section 5 Analysis

Responses to the Key Lines of Enquiry

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

5.2 The DHR Panel approved the inclusion of nine (9) 'headline' key lines of enquiry (KLOE) for this Review and twenty five (25) supplementary lines of enquiry. For the ease of reading, the headline enquiry has been repeated within this section of the Report.

1. To establish what contact agencies had with AJ

5.3 As noted, NWAS, had one contact with AJ during the scope of this Review, prior to the critical event and this was with NWAS 111 regarding a repeat prescription request

5.4 The Manchester City Council IDVA Service received a MARAC referral for AJ on the 5th of November 2021 and referred the case to the IDVA employed by the LGBT foundation.

Greater Manchester Mental Health NHS Foundation Trust (GMMH)

5.5 In brief, the services involved in the care of AJ, provided by GMMH were:

- 2018 – Central Manchester Mental Health Liaison Team, Central Manchester Home Based Treatment Team, and inpatient services;
- 2021 – Central Manchester Mental Health Liaison Team and North East Manchester Community Mental Health Team (safeguarding screening).

Manchester Foundation NHS Trust (MFT)

5.6 As noted in the chronology and narrative, MFT provided care to AJ following a number of attendances, including two occasions when AJ attempted to end his life. On all occasions, AJ was also seen by the Mental Health Liaison Team (MHLT) based within the hospital and was discharged from their service.

GP1

5.7 AJ was seen regularly and appropriately within the scope of this Review and by various GPs in the practice for a range of health consultations.

Betsi Cadwalladr University Health Board (BCUHB)

5.8 During the formal scope of the Review, AJ had sporadic contact with mental health services. AJ did receive support from the Home Treatment Team (HTT) during October 2018 when he moved from Manchester to North Wales. Necessary risk assessments had taken place, and they were frequently

reviewed and updated. It was clear in the records that AJ was listened to and risk assessments were updated.

5.9 AJ attended the Emergency Department (ED) in North Wales during the scope of the Review. In July 2020, AJ stated he was feeling suicidal and called the police. A robust plan was formulated and shared with GP1. This recognised AJ's substance misuse and suggested AJ self-refer to the Substance Misuse Service. This is a service that requires the consent of the individual to be given in order for a referral to be made.

5.10 It is noted in the records from the ED, mental health services and sexual health services that AJ was a victim of domestic abuse, but no perpetrators were named. They were referred to as 'ex-partner/boyfriend'. There is one documented recording of Domestic Abuse screening on the 6th of October 2018 when the HTT became involved. However, the screening recorded a very low risk. This was likely to have been as AJ stated that he was no longer in a relationship with the perpetrator at that time and had moved back to North Wales.

5.11 It was recorded that AJ had 2 daughters, C1 and C2. The records noted that at the time of assessment AJ was in a same-sex relationship. This was known and recorded by all professionals who provided care to AJ.

5.12 There was evidence of appropriate liaison between services in North Wales and Manchester relating to AJ's mental health, and care provided by the HTT. The letter to the GP in Manchester dated the 14th of November 2018 outlined the diagnosis of Emotional Unstable Personality Disorder – Impulsive Type.

Greater Manchester Police (GMP

5.13 AJ was both a victim and perpetrator of domestic violence. The complexity of this case was magnified by different aspects of AJ's life, including his enduring mental illness, family bereavement, domestic abuse, and his general healthcare needs.

5.14 Throughout the time he was residing in Manchester, AJ regularly returned to Wales and his family, in particular his Mother, who played a huge part in his life and supported him.

5.15 It was, as noted elsewhere, in January 2018 that GMP first became aware that AJ was in a relationship with P1. GMP attended a domestic incident at that point. However, the Police did not attend any further incidents of domestic violence between AJ and P1 until early 2021. The Panel noted the incidents attended by GMP in April, June and November 2021 – as described in the chronology and the narrative.

5.16 The Panel recognised that GMP held information (from 2011) that AJ had mental health issues and had endured these over several years. Officers responded appropriately to incidents involving AJ where his mental health was

a factor in the nature of the incident. These included incidents when AJ was transferred to Hospital following an over-dose; responding to concerns from family and friends about AJ's welfare; and responding to calls that AJ had intimated that he may take his own life.

5.17 The Panel noted that, following the incident in February 2021 (see the chronology on page 26), GMP reviewed their response and noted that it appeared that the concerns for AJ's mental health were not recorded in detail on the DASH. Also, it was noted by the author of the GMP submission that a care plan should have been submitted on every occasion where the Police respond to a person presenting with mental health related concerns.

CGL

5.18 AJ was referred to Change Grow Live by the Mental Health Liaison Team at Manchester Royal Infirmary on the 2nd of August 2018 for support with his substance misuse. AJ did not attend this initial appointment for a personalised assessment, but he did attend a second appointment on the 22nd of August and was seen by a Recovery Worker.

5.19 AJ's goal was to stop going to parties and stop using drugs; to remain abstinent from alcohol for 90 days; and to socialise without the need to use substances. AJ accepted a referral to the LGBT+ Foundation service for additional and more specialist support. As noted elsewhere, AJ was discharged from treatment by CGL on the 24th of January 2019.

LGBT Foundation

5.20 The Foundation made multiple attempts to engage AJ in support with the LGBT IDVA (refer to the chronology on pages 30 and 31) but no appointment for assessment or further support was able to be made.

Bridges Domestic Abuse Support

5.21 The service made contact with AJ on several occasions over the telephone. There was one face to face meeting and they also exchanged text-messages and WhatsApp messages.

Salford Housing Services

5.22 The service did not see AJ face to face at any point as the Housing Options Service was closed due to the pandemic. Contact was via telephone and e-mail.

General Practice in Greater Manchester

5.23 AJ attended GP2 on a regular basis, largely for reviews of anxiety and depression. The safeguarding lead GP at GP2 advised the Panel that AJ would occasionally turn up on an ad-hoc basis and there was a flag on his notes for staff to provide him with an on-the-spot appointment with one of two GPs at the practice. This showed the practice recognised the complexities of care and support required by AJ. They considered them and responded to them in a patient-centred way to provide continuity of care and prevent a crisis where

possible. There was also a significant amount of correspondence into the practice from mental health and hospital services.

2.	**Did any agency know or have reason to suspect that AJ was subject to any form of domestic abuse at any time during the period under review?**

Greater Manchester Mental Health Services NHS Trust (GMMH):

5.24 GMMH noted that engagement with GMMH preceded the formal scope of this review. In 2015, whilst receiving services from the South Manchester HBTT, a description of his difficulties was noted. This included significant interpersonal challenges, repeated turbulent relationships with partners who "committed serious physical abuse" against AJ and a current relationship "which includes two-way physical abuse". These characteristics featured throughout his journey with GMMH services.

5.25 In 2018, whilst under the Central Home-Based Treatment Team (HBTT), AJ disclosed attending "sex parties" with his partner, where he "was paid in drugs to have sex". Critically, this information does not appear to have been assimilated into a wider trauma informed picture of AJ's difficulties, particularly his use of drugs and Para-suicidality whilst intoxicated. Neither a safeguarding nor a domestic abuse referral was made at this point. AJ disclosed an incident of historical child abuse and, consequently, HBTT supported AJ with a referral to 'Survivors Manchester' (please refer to the footnote on page 23).

Manchester Foundation Trust

5.26 An initial disclosure of domestic violence and abuse was made by AJ during his admission to MRI on the 2nd of February 2021. The ward staff were advised to complete a domestic abuse referral form with AJ but, as already noted, for a number of reasons (AJ would not disclose further necessary information about the abuse, would not provide consent for referral to MARAC, etc), the referral form could not be completed prior to his discharge.

5.27 As noted in the chronology and narrative, the Clinical Nurse Specialists (CNS) working with AJ at The Orange Rooms sought to further explore the disclosures he made around the ongoing domestic violence and abuse. The Clinical Nurse Specialist (CNS) team at the Orange Rooms continued to work with AJ to encourage him to complete a domestic abuse referral and this was completed with AJ on the 15th of October 2021. The information disclosed on this referral identified the abuse as high risk and was uploaded to Share-point by the Trust safeguarding team for hearing at MARAC

GP1

5.28 AJ disclosed to his GP that he was the victim of domestic abuse on the 9th June 2021 during a telephone call review for his anxiety and depression. He stated that his partner was controlling and that his partner lived in Manchester. At that time, AJ was living in Wales. There is no clear record to describe what GP1 did in response to receiving this information.

5.29 AJ did not disclose any domestic abuse to CGL nor to the Manchester City Council Homelessness Service. However, the referral received by **Motiv8** did describe an incident of alleged domestic abuse.

LGBT+ Foundation

5.30 The Foundation was aware of domestic abuse – due to the referral they received and the information contained in the submission to the MARAC.

Bridges DA Support

5.31 Bridges was aware and noted that the Sexual Health clinic had assessed the domestic abuse risk to AJ from P1 to be high – hence the MARAC referral and the referral into the Bridges service.

Salford Housing Services:

5.32 The service was aware because the reason for contact concerned AJ fleeing domestic abuse from his partner. AJ stated that he wanted housing in Salford where he had some support networks, and away from P1.

General Practice in Manchester

5.33 The first reference received was contained in a letter from GMMH, whereby AJ was described as upset at the breakdown of his relationship with his Partner. The next reference is another letter from GMMH which stated that when seen by the HBTT, AJ described a deterioration in his relationship, which was characterised as chaotic, the partner was unfaithful, and AJ had begun taking a variety of drugs. AJ also disclosed previous relationships that were physically and mentally abusive.

5.34 On the 20th of November 2018, the Mental Health Service in Wales sent a discharge summary to GP2 referring to treatment for low mood following the breakdown of a domestically abusive relationship. On the 4th of December 2018 a letter from the HIV services, hosted by MFT, referred to AJ being in a violent relationship since his last review but no longer having contact with that person at that time.

5.35 The Panel noted that most of the information about domestic violence held by General Practice in Manchester appeared to come from correspondence, with direct records in GP notes referring to a past rather than a current relationship. From the information reviewed it does not appear that any of the GP services in Manchester referred AJ to a domestic abuse support service. There does not appear to be a direct question to AJ regarding Domestic Violence or Abuse in the GP records and the reason was that GPs 2, 3 and 4 considered that reference to abusive relationships concerned historical incidents, not incidents with his current partner.

3.	**Had any mental health issues been disclosed by AJ, or any mental illness diagnosed by an agency in contact with them?**

GMMH

5.36 AJ had a diagnosis of Anxiety and Depression, complicated by polysubstance use. Throughout the review period he presented with depressed mood in the context of significant psycho-social stressors. Suicidal and parasuicidal acts, particularly whilst intoxicated, were a feature in both 2018 and 2021. It was difficult to assess AJ's mental state without robust consideration of his complicated relationship with substances. Often it appeared that AJ's use of these substances led to sexual behaviour that put him and others at risk. It is important to reflect on why AJ used substances, often appearing to suppress difficult emotions connected to low mood, coercive and controlling behaviour, physical abuse, sexual abuse, loneliness, interpersonal conflict, and financial difficulties.

MFT

5.37 AJ attended the ED at MRI on several occasions due to a deterioration in his mental health and attempts to end his life. During the scope of this report, AJ reportedly made attempts to end his life on three occasions.

5.38 The CNS team at the Orange Rooms made enquiries in relation to the mental health support given to AJ. On the 14th of June 2021, the CNS made contact with AJ to discuss his mental health directly with him. AJ reported that he had a forthcoming appointment with a psychiatrist in Wales that he wished to keep. This appointment does not appear to have been attended by AJ.

5.39 Professionals at The Orange Rooms also provided further support for AJ's mental health needs on the 15th of October 2021, when AJ reported that he was 'stockpiling medications' with a view to ending his life. The CNS contacted his assigned mental health team and advised AJ to return these medications to a Pharmacy to preserve his safety whilst his mood was reportedly good.

GP1

5.40 Within the scope of the Review, there were several appointments and incoming communications which referenced AJ's mental health issues. In April 2020, AJ had a medication review whereby the GP reviewed medications (including Diazepam for panic and anxiety) and prescribed these on a weekly prescription, which was post-dated and passed to the community pharmacy.

5.41 The GP was informed in August 2020 that AJ did not attend his appointment with Mental Health services. Following this non-attendance, the practice wrote to AJ advising him to re-book the appointment or make an appointment with the practice who could re-refer to the mental health team. The GP practice was informed of AJ's overdose in February 2021 and following this, the GP practice was informed that the GUM Consultant in Wrexham had urgently referred AJ to

a Consultant Psychiatrist. He had a depression review with the GP in March 2021 and a further review of his depression and medication in April 2021. The GP continued to review AJ's mental health in May, June and October 2021

CGL

5.42 At the time of AJ's referral to Change Grow Live, the Mental Health Liaison Team had documented a risk of intentional overdose. AJ advised that he had been diagnosed with anxiety and depression and that he had been receiving support from his GP and the Mental Health Team.

Motiv8

5.43 Information gathered from the referral and the assessments completed with AJ noted that:

- He was not currently working with the Community Mental Health Team in Tameside;
- AJ suffered with Anxiety and depression. He said that he tried to take his own life in February 2021 and recently had suicidal thoughts. He believed these were linked to the loss of his Mother;
- On the 19th of November 2021, AJ stated that he had recent suicidal thoughts, that he had been referred to the mental health team. AJ said that he had spoken to the team on the 18th and had stated to them that there was no current risk;
- AJ stated that he was open to support to improve his mental well being.

LGBT Foundation

5.44 The Foundation was aware, due to the details contained within the referral to the MARAC, that AJ had attempted to take his own life and that reference to suicidal thoughts had recently increased.

Bridges DA Support

5.45 AJ informed staff that he had a Personality disorder and anxiety and that he was taking 4 separate types of medication.

Salford Housing Services

5.46 AJ informed staff that he had a personality disorder, anxiety and depression.

General Practice in Greater Manchester

5.47 AJ was seen, primarily, by his GP for anxiety and depression and was known to GMMH following significant incidents of overdose. A discharge summary from the Welsh mental health services gave AJ's diagnosis as Emotionally Unstable Personality Disorder – impulsive type. However, this was not seen in either his GP or his GMMH notes. However, the submissions from GP2, 3 and 4 noted that AJ's care and support needs related to his mental health issues.

4. Were there any complexities of care and support required by AJ and were these considered by the agencies in contact with them?

GMMH

5.48 The services noted a number of complexities associated with care and support for AJ and categorised these complexities, thus:

Difficulties in maintaining appointments and interventions
- Consequently, care was fragmented with episodic interventions, often focused on direct crisis management.

Cross border travel between Manchester and North Wales
- As highlighted in the 2021 safeguarding screening, AJ appeared to be registered with a GP in Wales, which complicated referrals to commissioned services such as psychological therapy.

'Chem-sex'
- This is a complexity in this case which should be viewed through the lens of safeguarding and domestic abuse. The Panel noted that the GMMH author correctly underlined the point that a fuller understanding of the complex cultural, social and psychological features of Chem-sex needs to be understood, along with why an individual may find themselves repetitively exposed to these environments.

Suicidality and Para suicidality
- AJ had several events of attempted suicide or significant self-harm whereby he was ambivalent as to his safety. These events often took place in the context of polysubstance use and intimate interpersonal conflicts, which GMMH often noted, yet failed to form a meaningful action plan to support AJ to either resolve them or reduce the risk they posed.

Polysubstance use
- AJ disclosed using multiple substances, often in social settings but services appeared to find it difficult to formulate 'why' he continued to do this. AJ disclosed using them in Chem-sex settings as a form of "self harm", yet a clear assessment of risk did not take place.

5.49 As noted, **MFT** recorded AJ's complex mental health needs and that these were magnified by his drug use. This made his engagement with services sporadic. The staff at The Orange Rooms made numerous attempts to make contact and offer services to AJ and to be as flexible and accommodating to AJ and his circumstances as possible.

GP1 and GP2, GP3, GP4:

5.50 All noted that AJ was known to have complex medical needs.

5.51 As already described, **Motiv8** were aware of AJ's complex needs, as were the **LGBT Foundation**, the **Bridges DA Support service**, and **Salford Housing Services**. These services were aware of AJ's complexity from the referrals and presentations made to these services.

5. Were assessments of risk and, where necessary, referral to other appropriate care pathways considered by the agencies in contact with AJ?

GMMH:

5.52 during the Mental Health Liaison Team assessments in 2018, AJ informed staff of a controlling relationship with his partner. He also reported housing issues, social isolation and polysubstance use, often attending Chem-sex parties. There was no evidence of a safeguarding adult referral being made. Critically, there was no evidence of specific questioning around Domestic Abuse or any formally recognised DVA assessment tool such as a DASH.

5.53 In February 2021, following discharge from the ICU (when AJ was admitted following an overdose), the assessing clinician at GMMH noted that AJ appeared to have capacity to make decisions about his treatment. AJ was subsequently discharged back to the care of his GP. There does not appear to have been consideration regarding a referral to HBTT or routine enquiries specific to domestic abuse. Consequently, no DASH was completed and there was no referral to MARAC or safeguarding adult referral.

MFT

5.54 As already noted, whilst AJ was an inpatient at MRI, staff were advised by the safeguarding team to complete a domestic abuse referral form. For reasons already outlined, this was not possible.

5.55 The Orange Rooms were thorough in their attempts to offer support to AJ for both his sexual health needs, his mental health needs, and following the disclosure of domestic violence and abuse, the completion of a domestic abuse referral form. The Clinical Nurse Specialist (CNS) team did manage to build an effective therapeutic relationship with AJ which encouraged him to engage in the domestic abuse referral process

GP1

5.56 The GP did ask appropriate questions to assess risk when AJ disclosed he was a victim of domestic abuse (this was in 2018). The outcome of that assessment was the risk was very low – based upon the disclosure by AJ referring to a previous Partner. During the contact with GP1, AJ was known to be living in North Wales and his partner was residing in Manchester.

Bridges DA Support:

5.57 The service did complete client risk assessments and domestic abuse risk assessments and referrals were made to the Community Mental Health Team, Motiv8 and also to the Manchester MARAC.

Salford Housing Services:

5.58 The service noted that a DASH had been completed by the Orange Room and a referral into MARAC was completed. Discussion was held with the IDVA from Jigsaw to discuss who would continue to support AJ through the process.

General Practice in Greater Manchester

5.59 In terms of risk management, AJ was on weekly prescriptions due to his history of significant overdose. His use of drugs and alcohol was a recognised risk, and he self-referred to the drug treatment service. The Panel noted that GP2 refused to allow AJ's Partner – who AJ had disclosed had been abusive in the past – to collect his prescription for him.

6. Were issues of race, culture, religion and any other diversity issues considered by agencies when dealing with AJ?

5.60 All of the services that had contact with AJ (that is on more than one occasion) were aware that AJ was a gay man. They also knew that AJ had a history of polysubstance misuse, mental health difficulties and attempts to take his own life.

5.61 GMMH noted that case specific complexities were not always well understood, most notably the trauma AJ experienced from his HIV diagnosis, his polysubstance misuse in the context of Chem-sex and male to male intimate partner violence.

5.62 There is no record held by any agency that of AJ was registered as disabled and no other protected characteristics were recorded.

7. Were any issues highlighted concerning AJ's contact with services in North Wales and contact with services in Greater Manchester?

GMMH

5.63 Cross border travel between North Wales and Manchester was a significant complicating factor in this case. This had an impact on the continuity of care and purposeful information sharing to appropriately manage risk and ensure AJ was offered treatment – including access to medication, adhering to regular appointments and information sharing for safeguarding purposes. As highlighted in the 2021 referral, AJ appeared to be registered with a GP in Wales. This excluded him from certain commissioned services in Manchester.

MFT

5.64 Whilst AJ moved often between North Wales and Manchester, professionals at The Orange Rooms sought to maintain good communication and offered to transfer his care to an appropriate service in North Wales.

Motiv8

5.65 AJ advised the service (in October 2021) that his last medication review was completed by GP1. AJ stated he was not currently registered with a GP in Manchester and that his Housing worker would be supporting him to make a registration.

Bridges DA Support

5.66 The service noted that because AJ was registered with a GP in Wales, this was a barrier to him accessing mental health support in Greater Manchester and also caused issues around access to his medication.

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

GMMH:

5.67 Taken in the round, the actions of GMMH concerning AJ were:

- August 2018 – appropriate steps were taken in relation to AJ's mental health after admission to ICU following an overdose of substances. A referral for community support from the Home Based Treatment Team was accepted. This clinical decision was robust. However, as noted, a safeguarding adult's referral under the Care Act 2014 should have been made at this point and there was no evidence of a DASH being completed. Whilst under the care of the HBTT, AJ disclosed attending "sex parties" with his partner. The author of the submission noted that a safeguarding adult referral and liaison with the GM Police safeguarding colleagues should have happened at this point, including an urgent assessment of risk, but this did not occur.
- September 2018 – AJ was detained under section 136 of the Mental Health Act and an informal inpatient admission was agreed. AJ was under the care of the HBTT. He disclosed further traumatic events leading to his admission. Critically, a multiagency response – facilitated by the Care Act 2014 – was not actioned at this point.
- February 2021 – the Mental Health Liaison Service completed a review of AJ's mental health in line with GMMH policy, noting his wish to return home so he could complete pre-arranged employment. However, no referrals to the HBTT for further assessment, or specialist substance misuse services were completed. This is a missed opportunity to support AJ. He was subsequently discharged back to the care of his GP. Critically, there were no enquiries specific to domestic abuse. The assessment noted: "nil identified at present". This was fundamentally untrue given AJ's historical disclosures, mental state and vulnerability.
- November 2021 – The safeguarding practice fell below GMMH expectations and well outside the clear procedural guidance and rules set out in GMMH's 'Safeguarding Adult's at Risk" policy. The screening clinician did not contact AJ

to discuss the concerns set out in the referral, nor did they have a professional discussion with the referrer in this case. A letter sent to GP1 stated: "we could not determine from the referral a need for secondary care mental health services at this time". However, a fundamental expectation when exploring this would be to discuss his presentation with the referrer, who knew AJ well and had consent from him to contact CMHT.

MFT

5.68 As already described, for understandable reasons, Ward staff at Manchester Royal Infirmary were not able to make a domestic abuse referral for AJ. However, staff at The Orange Rooms did seek to complete a domestic abuse referral form with AJ and this was completed with AJ in October 2021. The CNS team also attempted to provide support and complete referrals for AJ's mental health concerns and housing concerns (taken immediately when concerns were raised in July 2021) whilst they were working towards the completion of the domestic abuse referral form.

GP1

5.69 The actions taken by the GP included working with AJ and prescribing his medications on a weekly basis rather than monthly. When AJ disclosed he was a victim of domestic abuse, the GP completed a risk assessment, established that he was already in contact with specialist services and referred AJ into mental health services. This was done by both the GP and GUM Consultant (who made an urgent referral to Psychiatry).[12]

Betsi Cadwalladr University Health Board

5.70 Following AJ's discharge from Manchester in October 2018, he received intense support and monitoring from the North Wales Home Treatment Team. There is evidence in the records of the plan for AJ to be seen by the Survivors Team in Manchester and HTT were supporting and encouraging AJ to engage in this.

5.71 Following this period of involvement, AJ received a diagnosis of Emotional Unstable Personality Disorder – Impulsive Type. This information was shared with the GP in Manchester when AJ had moved back there.

GMP

5.72 On each occasion that police attended incidents involving AJ, officers carried out safeguarding procedure. On all but one occasion, when AJ told officers he had been assaulted, AJ declined to make a formal complaint and as such further police action was not taken.

5.73 On the one occasion when AJ reported an assault to the Police, at the same incident, P1 made a counter allegation of assault against AJ. As a result, both parties were arrested for Section 47 Assaults[13].

[12] The Panel concluded that this appointment with the Psychiatrist was declined.

[13] The Panel considered this matter and explored the possibility of P1 and/or AJ being referred into a suitable Voluntary Perpetrator Programme (VPP). The Panel sought specialist advice from the

Bridges DA Support and Motiv8

5.74 The actions taken by Bridges (for example, to provide a telephone, help secure safe accommodation out of area, etc) prior to the referral to Motiv8 (to assist with AJ's financial management, etc) were appropriate and the liaison between these two services was effective.

Salford Housing Services:

5.75 AJ was placed in temporary accommodation in a location that was not known to P1. The temporary accommodation placement was made available from the date the homelessness application was accepted.

General Practice in Greater Manchester

5.76 AJ's GPs in Greater Manchester were aware of his mental health concerns and significant overdoses and suicide attempts. The GPs noted that AJ was on a weekly prescription to reduce the risk of further overdoses. The GPs noted that AJ was receiving some medications that are usually prescribed on a short-term basis. AJ appeared to have been on these medications throughout the scope of the Review.

5.77 When speaking to the safeguarding lead GP at GP2, they described "inheriting a mix of prescription medications" following AJ's stay in inpatient care at MRI (following AJ's overdose). AJ presented to GP2 as agitated at first and the thought was that it would be better to build a relationship with him first and then address his medication use. AJ was then out of the area for a period of time and there was no chance to challenge what medications AJ was taking. There was also the knowledge that he was under the care of the mental health service in North Wales and there was a reluctance to change medications if it was felt they had oversight of AJ's prescription.

5.78 The GPs informed the Panel that all prescribing should be done by primary care, with the mental health services giving clear recommendations on starting or stopping medications. As AJ was accessing two secondary mental health services it was unclear to the GPs in Manchester which organisation had the CPA/responsible Clinician role and which service had clear oversight of his medications.

5.79 GP2 recorded 'adult safeguarding concern' on AJ's file following his HBTT assessment (which highlighted excess alcohol/drug use, and attending sex parties). In retrospect, GP2 felt that they became focused upon AJ's mental health struggles and concentrated on these issues almost exclusively. GP2 was not aware of the specialist Chem-Sex services available at the time.

9. What happened as a result of these actions

omplexity from the referrals and presentations made to these services.

9. What happened as a result of these actions

MFT

5.80 A referral to MARAC was made by The Orange Rooms based on the domestic abuse referral form completed with AJ in October 2021. This determined that the abuse AJ was experiencing was high risk.

GP1

5.81 There were multiple letters from Mental Health Services explaining that AJ ha failed to attend appointments. There is evidence that the practice followed up on these missed appointments by writing to AJ and advising him to contact the department to make another appointment.

CGL

5.82 The service made appropriate referrals into more specialist services and **Motiv8** was able to contact AJ to complete the attachment process

LGBT Foundation

5.83 Despite multiple attempts to engage AJ in support and AJ being aware that support was available, were not in a position to complete an assessment or develop the casework for AJ.

Salford Housing Services:

5.84 As a result of the action taken, AJ was able to be removed from P1 and into an address that was not known to P1.

General Practice in Greater Manchester

5.85 The practices maintained regular appointments with AJ and correspondence to the practice suggested he had been referred to a drug and alcohol treatment service and Survivors Manchester. The GPs advised that they had not themselves considered a referral to psychotherapy as the usual assumption was that if someone was under the care of the mental health services, that service will make referrals or ask the GP to action such referrals if discharging a patient back to GP care.

5.86 While there was information within the record regarding domestic abuse, the GP noted that AJ would talk about an abusive ex-partner but would then refer to leaving these relationships. The GP's impression was that AJ could remove himself from abusive relationships if necessary. However, the Panel acknowledged that this doesn't recognise the increased risk of violence that victims face when leaving an abusive relationship[14] or the impact of coercive control from an abusive relationship.

[14] Humphreys C, Thiara RK (2003) Neither Justice Nor Protection: Women's Experiences of Post-Separation Violence, Journal of Social Welfare and Family Law, 25(3)

5.87 The GPs felt the practices had possibly missed the significance of domestic abuse, which had been referred to in correspondence into the practice.

10.	**To establish what contact agencies had with P1, who was the Partner of AJ.**

5.88 The Panel did not receive consent to disclose responses concerning P1.

11.	**To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities for AJ and P1**

NWAS

5.89 The service followed expected practice and procedures when providing care to AJ and P1. All care provided to AJ and P1 prior to the critical incident was based upon "hear and treat", meaning that the adults were never seen face to face by NWAS prior to the critical incident.

The GP for P1

5.90 Prior to September 2021, there was no evidence to show that clinicians involved in P1's care were aware that he was in a relationship with AJ. It is documented within previous records that P1 lived alone with no family or friends.

MFT

5.91 In addition to the actions described elsewhere in this Report, professionals at The Orange Rooms also provided support to alleviate the risk to AJ of his deteriorating mental health. The CNS team often explored how AJ was feeling during telephone consultations and provided advice accordingly. For example, when AJ disclosed that he was 'stockpiling' medications in order to potentially end his life, the CNS referred to the RAID team and advised AJ to hand over the medications to a pharmacy whilst his mood was not so low

5.92 At the time when AJ was in temporary accommodation (with Salford Housing), and was receiving support from Motiv8 to support him with his finances, AJ disclosed that he was feeling better and he was "smiling for the first time in ages". However, at a later consultation in November 2021 (see the chronology on page 32), AJ reported having intrusive thoughts of self-harm and suicide. Consequently, a referral was made to the community mental health services hosted by GMMH.

GP1

5.93 Due to a past history of overdoses, medication was prescribed on a weekly basis with regular medication reviews. This was completed following discussion with AJ and at AJ's request.

5.94 During the formal scope of the Review, there were frequent mental health reviews with GPs in the Practice. There was evidence in the GP records that READ codes were used to document and flag that AJ had been a victim of domestic abuse, had taken several overdoses and that there was an adult safeguarding concern. The GP checked to ensure that AJ was referred to Mental Health services and was known to the victim support team and caution was taken when changing AJ's dose of medication.

Betsi Cadwalladr University Health Board

5.95 From a consideration of the records, it appeared that during the contacts with BCUHB, AJ reported to be single but acknowledged that he was often in abusive relationships. There is no mention of a referral or a signposting into a Domestic Abuse support service, or further assessment of risk, setting aside that done by the GP in 2018.

5.96 The sexual health service referred AJ into the mental health services in February 2021. This followed a routine appointment where AJ had spoken about self harming following his Mother's terminal diagnosis. The Consultant was concerned that AJ did not appear to be receiving Psychiatric support. The Single Point Assessment and Allocation (SPOAA) service attempted to make contact with AJ. However, the telephone number did not work and so a letter was sent asking AJ to make contact. The address at the time was his parents address in North Wales.

GMP

5.97 On each occasion a report of a domestic incident was made to the police, officers attended the scene and attempted to de-escalate the situation. This was usually done by either P1 or AJ leaving the scene. Safeguarding procedures were completed, and a DASH submitted. GM Police attended a number of incidents where concerns had been raised about AJ's mental health.

5.98 GMP has a policy and procedures in place for when officers attend incidents of alleged domestic abuse and for people presenting with mental health related concerns. These procedures describe how information is recorded so that risk can be managed and the appropriate safeguarding procedures put in place. On Police contacts with AJ, it is highlighted that these policies were not always adhered to. GMP informed the Panel that they will address this as a matter of urgency to ensure all officers comply with current policies and procedures.

5.99 Following the one contact with **CGL,** AJ was referred to the LGBT+ Foundation service for additional support.

5.100 As noted, the **LGBT Foundation** made multiple attempts to contact AJ following the receipt of AJ's referral. However, these were not successful.

Bridges DA Support and Motiv8

5.101 These services worked together and with others to support AJ and provided him with a mobile phone, referrals to relevant services and helped AJ to secure safe

accommodation. These actions were all completed within a few days of the initial contact.

Salford Housing Services

5.102 AJ was placed in temporary accommodation as soon as a homelessness application was accepted to provide him with safe accommodation without P1. The Panel clarified that this action was in line with the duties of Salford Housing Services, under the relevant homelessness legislation.

General Practices in Greater Manchester

5.103 Primarily, when registered in Manchester, GP2 mitigated risks to AJ by maintaining him on weekly prescriptions due to his history of overdoses and attempts at suicide. They saw him on a regular basis and were aware that there were periods when he spent time in Wales. His notes do record AJ had previously been in abusive relationships and this suggests a missed opportunity to consider referring to IRIS for support, given that separation can increase the risk to victims of abuse and the chance of entering a new abusive relationship is higher in those who have experienced it in the past. The Practices noted that there is learning around referring to specialist domestic abuse services when someone appears to enter abusive relationships repeatedly and also, of course, recognising male victims of domestic abuse.

5.104 The Panel noted that consideration was not given to making a safeguarding referral for AJ. GP2 noted AJ's mental health concerns, his drug use and participation in chem-sex parties, and focused attention on AJ's mental health. This was seen as the primary concern. GP2 advised the Panel that they would see AJ on an ad-hoc basis when he attended the practice without appointments. They also made a note on his record for one of two specific GPs to see him – this was for the purpose of consistency. These were appropriate actions aiming to reduce his risk of harm and increase his engagement.

5.105 The GPs informed the Panel that AJ was prescribed a significant number of medications and was known to use illicit drugs. As he was under the care of the mental health service in North Wales, the GPs in Manchester did not know this element of AJ's care particularly well and so did not challenge his prescription. GP4 took steps to safeguard AJ, though they did not have a full account of his history. GP4 prescribed one week of medication when he made the request on the day he registered with them.

5.106 There is further work to be undertaken about the interface between mental health and primary care services and prescribing responsibilities and there are lessons to be learned about prescribing when GP practices do not hold full records for a new patient.

12. To establish whether there were other risks or protective factors present in the lives of AJ or P1

5.107 The services in contact with AJ within and out-with the scope of this Review noted that he had a history of Illicit drug use, depression and anxiety, and this made AJ vulnerable as his mental health would deteriorate often leading to him accessing services following attempts he made to end his life.

5.108 AJ also had a diagnosis of a long term medical condition – he was HIV positive. He was receiving the care of specialist services based in Greater Manchester and in North Wales – depending on where AJ was living at the time. AJ received this care from the point of his diagnosis to his death in November 2021.

5.109 All of the GPs, GMP and other services supporting him, noted that AJ participated in "chem-sex" parties.

5.110 As noted in the chronology (see page 27), during the Covid 19 pandemic and the lockdown period, AJ's mother became ill and subsequently died. AJ was living in Manchester at the time and due to the restrictions in place, he was unable to visit his mother immediately before she died or attend her funeral.

5.111 Motiv8 also noted that, setting aside AJ's mental health needs, they were supporting him to reduce his debt. Motiv8 informed the Panel that AJ's debt could have increased his risk and vulnerability.

5.112 Additionally, GMMH recorded that AJ had endured abuse during childhood, was often isolated and alone (when in Manchester), was unemployed and attended chem-sex parties where AJ was given drugs to have sex with other men. The Panel noted that this may not have been recognised as exploitation and this was the reason why no referral was made.

5.113 BCUHB noted that there was reference in the notes to his family not being supportive of AJ's decisions to return to Manchester. Whilst in North Wales, AJ would always stay (for some of the time at least) with his parents.

5.114 A number of agencies knew that AJ had a child from a previous relationship who lived with their Mother in Wales. It is believed that AJ had contact with his child and they would, occasionally, visit him in Manchester. However, it is unclear if this was still the case at the time of his death.

5.115 Whilst there is no documentation that specifically demonstrates that AJ's family or friends were aware of the ongoing domestic abuse, MFT noted that family members did attend hospital to be with AJ on a number of occasions (following episodes of overdose). Additionally, the submission from AJ's sibling demonstrates that members of his family were aware of AJ's relationship with P1 and that the relationship may have been abusive and controlling.

GP1

5.116 GP1 noted that within the timeframe of the Review, there was no mention of AJ disclosing domestic abuse to family or friends. However, the Practice also noted that p*rior to the timeframe of this review*, the practice made a MARAC referral following AJ disclosing he was the victim of domestic abuse. This was in 2016. The practice also gave AJ contact information for counselling services (in relation to domestic abuse and drug/alcohol use). A GP in the Practice also referred AJ to the George House Trust in Manchester, as they recognised that there was no Terrence Higgins Trust or equivalent services available in Wales and that AJ would benefit form their expertise. The practice coordinated a meeting between the Domestic Abuse Advisor and AJ at the practice. They also wrote to support AJ's application for housing benefit and PIP. Due to previous attempts at overdose, the practice arranged with AJ and his Mother a process for the safe handling of prescribed medication. AJ's mother agreed to keep the medication in a locked place and would give AJ a dose at a time.

GMP

5.117 AJ appeared close to his siblings and would have contact with them regularly either in person or on the phone. On one occasion, he contacted one of his Siblings before contacting the police following a domestic incident with P1. They, in turn, contacted the police to report the incident.

LGBT Foundation

5.118 AJ's Sibling informed the IDVA that they were aware of the abusive relationship with P1 and they were trying to help AJ.

General Practices in Manchester

5.119 The Practices held no record regarding AJ disclosing domestic abuse to family or friends.

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

5.120 All of the agencies in contact with AJ – including NWAS, General Practice, GMMH, MFT, GMP, BCUHB and others have appropriate and contemporary policies in place for safeguarding, procedures for NHS staff to raise concerns, whistle-blowing, Mental Capacity, Clinical Risk, Care Programme Approach Procedures, and many others.

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

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

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

GMMH

5.123 Following analysis of the factors described previously, the practice changes recommended by GMMH (and reflected in their single agency action plan) include:

Domestic Abuse

GMMH as an organisation can improve staff awareness of the prevalence of domestic abuse. Including increased reference to same sex intimate partner violence and understanding of commonly recognised themes present in these cases.

Safeguarding

- Robust procedural guidance on the importance of using structured risk assessment tools such as the DASH.
- The domestic abuse training module to be updated
- Safeguarding Adults Level 3 training module to include information on 'Chem-sex' as a complexity factor
- GMMH 'Safeguarding Adults at Risk' policy to be updated to include clear guidance on clinical expectations when 'screening' safeguarding referrals made by other agencies

5.124 These issues are reflected in the Recommendations in this Report[15].

MFT

5.125 The service noted, within the scope of this Review, that AJ tended to reside in both Manchester and Wales. This appeared to hamper the ability of services to engage with him effectively and so truncated their ability to ensure continuity and consistency – a challenge that was magnified when AJ, from time to time, disengaged from the service. This does demonstrate that in some case where there are complexities, services should be more proactive to ensure individuals are not discharged from services before getting the support they require. MFT also suggested that additional training and support for frontline staff is required so they are confident in building therapeutic relationships quickly with complex vulnerable individuals. This could enable more timely referrals to services by making the most out of even very brief encounters with services.

GMP

5.126 As already noted, highlighted their policy and procedures when attending domestic incidents and incidents when persons are present with mental health related concerns. These procedures dictate how information is recorded so that risk can be managed, and the appropriate safeguarding put in place.

[15] The Panel supported these strategic intentions and encouraged the GMMH Trust to introduce a programme of mandatory training to ensure that staff become capable and confident to achieve these outcomes.

BCUHB

5.127 Noted that it was important to ensure that agencies offer referrals to support services for those who are in abusive relationships, including those who might have separated.

Bridges DA Support and Motiv8:

5.128 Noted that, when support is transferred across boundaries, gaps in service provision may, temporarily, have occurred. Hence, they recommended that a 'Team Around the Person' meeting could have taken place to manage the transition with other agencies involved.

LGBT Foundation

5.129 Stated that they felt there was a problem with a loss of support and communication between services for AJ when he moved from Tameside to Manchester.

General Practice in Greater Manchester

5.130 AJ's medical record showed that other agencies who corresponded with primary care were aware of previous relationships that were physically and mentally abusive, one of which was recent (2018) and appeared to have precipitated a significant overdose. Given the information identified within the primary care record, it is reasonable to suggest that consideration might have been given for a referral to IRIS by the GP for further assessment and support. However, it would be equally reasonable to assume that those other agencies – who were aware of abusive relationships – should make the appropriate referrals.

5.131 Correspondence with, and a direct disclosure to, primary care noted that AJ was participating in chem-sex parties with his partner. It is unclear if the GP recognised that AJ was being exploited in this situation, but the disclosure might have warranted a referral to the LGBT Foundation (or other) specialist Chem-Sex worker, a safeguarding referral due to the deleterious impact on AJ's mental health and an IRIS referral due to the alleged role of AJ's intimate partner in the exploitation.

5.132 The Panel noted that GP2 was unaware of the Chem-Sex Worker at the time, so the service has now been publicised within primary care. AJ was seen as being an adult safeguarding concern due to substance misuse, his risk taking behaviour at chem-sex parties, and his mental and physical health. Consideration should be given to making dual referrals in such instances

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

5.133 This line of enquiry is addressed under the section concerning lessons learned and recommendations.

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

NWAS

5.134 Continued to operate throughout the Covid-19 pandemic. NWAS did not have any contact with AJ throughout the period of the pandemic lockdown.

General Practices

5.135 Noted that during the pandemic, all GP practices remained open but operated in a modified way. Practices offered remote consultations predominantly (often via phone), rather than face to face appointments. This was to reduce the risk of transmission of Covid–19. Face to face appointments were available but based on risk assessment and clinical need. This was based on advice provided at a national level.

BCUHB

5.136 Noted that there was no evidence in the notes to suggest that the Covid-19 pandemic had a negative impact on AJ whilst receiving health care services from BCUHB.

Motiv8

5.137 Was operating a normal service, including face to face, video and telephone support at the time AJ was referred to service.

Bridges DA Support:

5.138 Was operating a normal service at the point AJ accessed the service and COVID-19 did not have an impact on the service received by AJ.

Salford Housing Services

5.139 The delivery and provision of services were affected. It was not possible to offer a face to face homelessness assessment with AJ. However, the service was able to complete an assessment over the telephone and to offer temporary accommodation in line with their statutory duties.

5.140 For **GMMH** and **MFT**, there was nothing in the record to indicate that the management of the COVID-19 Pandemic had a significant impact on the care and support offered to AJ.

GMP

5.141 Noted that during the Covid-19 pandemic, when incidents were reported to the police, a risk assessment was carried out prior to officers attending. However, this did not have an impact on the quality of service provided by Greater Manchester Police.

5.142 The Panel did note that it appeared that the impact of the Covid-19 pandemic on AJ was acute. His mother died through this period and the restrictions that were in place at the time meant that AJ could not see her prior to her death and

could not attend the funeral. In April 2021 police attended two domestic incidents involving AJ and P1 where AJ told officers he was struggling to come to terms with the death of his mother due to the impact of the Covid restrictions. This in turn must have had an impact on the relationship between AJ and P1.

5.143 Both AJ and P1 suffered with a number of mental health conditions. The lockdown periods would no doubt have had a detrimental effect of their mental health

Section 6

Good practice

Throughout the Overview Report, reference is made to examples of good practice exercised by the services in contact with the subjects of this case. The Panel wishes to focus upon a number of these examples – set out below – to underline the learning that has been generated by this Review. These examples are simply that – this is not an exhaustive list of the good practice exercised by the services involved in this case.

Bridges

The IDVA put multiple safeguarding measures in place around the domestic abuse risk, AJ's mental health and his wellbeing.

The IDVA provided AJ with a mobile phone so that the professionals involved could remain in contact with him. The IDVA supported him to access safe accommodation, which was, initially at least, unknown to the perpetrator. The IDVA shared information with relevant services involved – including the police. The IDVA supported AJ in terms of accessing support for mental health support and also referred to other relevant services. The IDVA continued to offer support once AJ had moved out of area.

GMP

When officers attend domestic incidents, there are occasions when parties make counter allegations of assault and officers then have to make an informed decision as to what action to take. Officers who attended a domestic incident in April 2021 took positive action at the scene when both P1 and AJ made counter allegations of assault, the attending officers arrested both parties thereby de-escalating the situation and safeguarding both victims.

When there was insufficient evidence to proceed with a criminal charge the officers issued a DVPN and subsequently obtained a DVPO from the court for a four-week period, which ordered no contact between AJ and P1. Compliance visits were also completed whilst the order was in place and there were no breaches to the order, thus safeguarding both parties.

GP1

AJ was registered at this practice from being a child. He registered with GP practices in Manchester on three occasions, but returned to GP1.

From reviewing the full set of GP records, it can be seen that AJ predominantly consulted with a small group of longstanding GPs. As a consequence, AJ had a consistent approach to his medical management.

There is evidence that incoming communications from external agencies, including North Wales Police, were shared consistently with a specific named GP - ensuring continuity of care.

It can be seen (outside of the timeframe of this review) that the GPs in the practice referred AJ to agencies within Wales, but also in Manchester, ensuring that he could access the services he required.

Whilst waiting for a mental health review, the GP gave AJ 'safety net' advice. This was done to support AJ and to help him if he endured any suicidal thoughts. When AJ failed to attend any of his mental health appointments, the practice wrote to AJ and gave him advice on rebooking his appointment or how to be re-referred by the practice

Greater Manchester GPs
Risk minimisation was supported by his General Practitioners who prescribed his medications on a weekly basis. Two GPs were identified at one practice to see AJ if he turned up without an appointment – this flexibility and continuity of care was good practice, particularly for AJ whose mental health presentation could become a serious risk very quickly. One of the GPs also prevented his abusive ex-partner from collecting his prescriptions for him which was another positive method of risk management.

Manchester University NHS Foundation Trust (MFT)
The persistence of the professionals at The Orange Rooms to provide support to AJ is an obvious area of good practice. Despite AJ's episodes of disengagement from the service, staff always continued to re-book appointments and to make contact with him via different means of communication. Eventually, this work led to a relationship where AJ felt comfortable to make a full disclosure and consent to a domestic abuse referral form and referrals to mental health support in the community being made.

Additionally, when AJ's mental health was stable and relatively positive, the Orange Rooms advised AJ to safely dispose of any stockpiled medications that he may have had.

GMMH
There is some evidence of good mental health practice in this case. Of note, in 2018, Central HBTT attempted to build a supportive working relationship with AJ, who would often miss appointments and travel to North Wales whilst under their care. AJ appeared to build positive relationships with some HBTT staff, openly disclosing distressing and intimate information.

Section 7

Lessons learnt from this case by the agencies submitting information.

Learning lessons from a Domestic Homicide Review is, amongst other things, a combination of reflection, professional scrutiny, policy review and practice development. Set out below are some of the lessons learnt that have been identified by the agencies that had contact with AJ and/or P1.

These lessons and the matters raised by the scrutiny of the Panel will help to refine the emerging themes and the single agency and multi-agency action plans agencies will be expected to address at the end of this Review. The lessons learnt are set out agency by agency:

7.1 Salford City Council Housing Options Service

7.1.1 The service had limited contact with AJ. However, learning has been taken from the Review in particular, aiming to ensure that, wherever possible, temporary accommodation is provided away from the alleged perpetrator.

7.2 Bridges Domestic Abuse Service

7.2.1 The service noted that AJ had insufficient access to support with his mental health needs. As the Review made progress, the service agreed that all referrals to the Bridges Domestic Abuse Service that disclose low mood/suicidal ideation will be referred to the Jigsaw Support Wellbeing Navigator team for support and signposting into other support services.

7.2.2 Additionally, the service has set a policy whereby when a client has re-located, a three way meeting will take place between the client, the Bridges IDVA and the IDVA from the service where the client has relocated to, and this will be embedded into the process to ensure that transition and continuation of support is achieved and maintained.

7.3 Betsi Cadwaladr University Health Board (BCUHB).

7.3.1 The service recognised that there were opportunities for the assessment of risk in relation to domestic abuse (using the Safe-Lives DASH/RIC) to have been undertaken and the offer of a referral into a specialist Domestic Abuse support service for AJ. The learning and the report (once approved) will be shared within BCUHB and a 7 minute briefing will be produced for staff.

7.4 LGBT Foundation

7.4.1 The Foundation noted that, taking account of the themes from this specific Review, they will establish a list of key contacts and agencies that they can speak to regarding concerns about the risk to victims posed by perpetrators. The Foundation also noted that clarification around the process for information sharing for future cases needs to be clearly established.

7.4.2 Additionally, the Foundation suggested that a protocol needs to be established to ensure that risk is better managed when a victim moves from one area to another and referrals are required to be transferred. Protocols need to be established to ensure risk assessment doesn't look solely at Domestic Abuse, but also at any other risks to the victim (such as a risk to their mental health).

7.5 Motiv8

7.5.1 Taking account of the themes included in this Review, Motiv8 have confirmed that referrals received who disclose low mood and/or suicidal ideation will now be contacted weekly by Motiv8 wellbeing navigators for support and signposting. This includes referral to agencies and this will continue until the client has been attached and allocated to a dedicated key worker.

7.5.2 The Motiv8 Attachment Co-ordinator will also explore any potential opportunities that could have reduced the timescales to attach AJ to the programme.

7.5.3 Motiv8 will make every effort to establish contact with all relevant agencies when referrals have been made and disclosed by the client.

7.6 Change Grow Live

7.6.1 The service will continue to explore elements of learning and have identified that increased scrutiny will be applied for service users (i.e., closer monitoring) who are open to support, but not accessing appointments/interventions,

7.6.2 The review has identified, from the limited notes available, that it appears AJ was not offered a follow up appointment after the initial assessment was completed. Change Grow Live has since reviewed its processes and monitoring with regard to appointment booking systems. This is to ensure that all service users receive a next appointment after assessment and that it is documented appropriately. Where there are gaps in support being offered/delivered, this can easily be identified and monitored.

7.6.3 Training continues to be delivered to staff on the timely recording of case notes, and that regular audits are completed to ensure appropriate monitoring of this standard.

7.6.4 The discharge process has also been reviewed and a new process implemented to ensure that service users are contacted via telephone and in writing prior to being discharged. Where contact cannot be established, partner agencies will be informed.

7.7 Greater Manchester Police

7.7.1 When GMP attended one particular incident, a DASH assessment was submitted but some of the questions were left blank. According to GMP's policy and procedure, if a victim refuses to answer DASH questions, the officer responding should apply their professional judgement to make an assessment

of risk. Officers should include their assessment of the demeanour of the victim in the DASH; for example, whether the victim is distressed, upset, or frightened.

7.7.2 The policy states that, at present, a DAB (a Domestic Abuse Report) should be submitted in preference to a Care Plan when mental health issues are identified during a DA incident. This requirement has not changed, even though in Chief Constable Orders 2020 it stated that a Care Plan be submitted for all Mental Health incidents. The Chief's order was instigated because officers attending Mental Health incidents were not submitting any kind of care plan. This will be addressed by GMP as a matter of urgency.

7.8 Manchester University NHS Foundation Trust

7.8.1 Staff at The Orange Rooms spent a considerable amount of time building a close clinical and therapeutic relationship with AJ and they also managed to complete and submit a domestic abuse referral form to their Safeguarding Team to submit to the MARAC..

7.8.2 The Panel noted that it is important to ensure staff are aware that, when necessary, they can refer their clients to MARAC (and other multi-agency arrangements) without the consent of the client.

7.9 GMMH

7.9.1 A critical feature throughout 2018 and 2021 was the failure to support AJ through a multi-agency arrangement, such as Safeguarding Adults under the Care Act 2014. A multiagency response would have supported enhanced information sharing, shared risk management practice and a coherent response to the complex factors – described in detail elsewhere in this Report – operating within AJ's life.

7.9.2 As noted, at the beginning of this Report, the Panel learnt that a Section 75 agreement was in place during the scope of this Review (between Adult Care and GMMH) and, consequently, Adult Care would not have been involved in the case management of AJ's complex needs.

7.10 Greater Manchester NHS Integrated Care Partnership, Manchester Locality (previously the Clinical Commissioning Group)

7.10.1 As noted above, the ICP identified a number of elements of the Review from which General Practices could learn, including:

- AJ's medical record showed that other agencies who corresponded with primary care were aware of previous relationships that were physically and mentally abusive;
- Correspondence received by primary care advised that AJ was participating in chem-sex parties with his partner and that on occasion, he was being paid in drugs to have sex with other men. It is clear that the agencies that held this information (including his GPs) did not recognise that AJ was being exploited in this situation, and that the disclosures may have warranted a referral to the LGBT Foundation Chem-Sex worker (and other appropriate services) and also a safeguarding referral due to the deleterious impact on AJ's mental health.

The mental health services also did not make a safeguarding referral to address these concerns.

- AJ was seen as being an adult safeguarding concern due to his substance misuse, risk taking behaviour at chem-sex parties, and his mental and physical health. Consideration should have been given to making referrals in such instances to adult safeguarding, domestic abuse support services and the mental health services.

7.10.2 From these elements, the ICP noted the learning for General Practices includes:

- Being paid in drugs for sex within chem-sex parties should be recognised as a form of sexual exploitation (rather than a lifestyle choice) that warrants a safeguarding referral;
- AJ was coded as being an adult safeguarding concern, but no safeguarding referral was made as professionals focused on his mental health. Consideration should be given to making dual referrals in such instances;
- Where there are prescriptions initiated by a mental health need, practices should work with colleagues within mental health services (who hold CPA responsibility) to share oversight of prescribing and patient management;
- Where patients transfer care between GP practices, the previous records should be requested without delay, particularly when there is a risk to the patient, such as when addictive substances have been prescribed;
- Lessons learnt from this and previous DHRs must be re-emphasised through continued training and policy development, including:
    a. The risk of domestic abuse does not diminish when a relationship is over (it can increase) so an IRIS referral should still be offered when DVA is disclosed;
    b. Male victims of domestic abuse can, of course, be as vulnerable as female victims and professionals should be professionally curious, and enquire about DVA and refer appropriately.

7.10.3 The ICP also noted that they would pursue the following action:

- To promote referral protocols or pathways to referring agencies to increase knowledge of the support services that are available.

Section 8
Key Themes Emerging from the Review

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

The Panel considered the key elements from the aforementioned sections of the Report for some time in order to distil the information shared by the agencies during and prior to the formal scope of the Review. This consideration illuminated a number of points upon which the circumstances that led to AJ's death may seem to turn. These points are not in any order of priority.

8.1 AJ was loved and supported by his immediate family. However, AJ endured traumatic experiences and a highly stressful life – both in childhood and as an adult – and this led to a number of attempts to take his own life and significant expressions of anxiety from his family and his friends

8.1.1 There are a number of examples described throughout this report.

8.2 In his adult life AJ had a number of intimate relationships which were characterised by violence and abuse and this may have damaged his capacity to engage in personal relationships

8.2.1 When speaking with a number of agencies, but particularly the mental health services provided by GMMH, AJ focussed on a "tumultuous" intimate relationship with his partners (not just P1).

8.3 Supporting people with complex needs and Adverse Childhood Experiences

8.3.1 The Panel recognised that trauma, shared by AJ on a number of occasions with a number of organisations, is described by MIND as:
"….going through very stressful, frightening or distressing events".

8.3.2 In this respect, trauma causes a person to become vulnerable.

8.3.3 The national charity NAPAC (National Association for People Abused in Childhood) recognises that childhood trauma, in all forms, has a significant impact on the lives of victims, as children and into adulthood.[16]

8.4 The treatment of AJ's long term mental health issues appeared, for a variety of reasons, to have been truncated at various points

8.4.1 The author making the submission on behalf of GMMH noted that there was no evidence of a safeguarding adult referral made under the Care Act 2014. Given

[16] www.napac.org.uk

the disclosure of controlling behaviour, isolation, and vulnerability, GMMH expected that this would have occurred.

8.4.2 In early 2021, the Mental Health Liaison Service from GMMH completed an assessment and the assessing clinician noted that AJ appeared to have capacity (as defined by the Mental Capacity Act 2005) to make decisions about his treatment. AJ was subsequently discharged back to the care of his GP. The author of the submission from GMMH informed the Panel that there did not appear to have been a consideration regarding a referral to the Home Based Treatment Team (HBTT) or routine enquiries about domestic abuse. The author of this submission considered this an incomplete assessment, particularly given AJ's significant history of abuse in childhood and in adulthood.

8.4.3 Towards the end of 2021, a Community Psychiatric Nurse from GMMH screened a referral made for AJ and concluded that it was "unclear" if AJ resided in Manchester because he had a registered GP in Wales. The CMHT screening does not reference reflection on the seriousness of a MARAC referral or demonstrate professional curiosity about the impact of domestic violence, trauma and bereavement on AJ's mental state.

8.5 Professional curiosity and professional Guidance

8.5.1 The Panel noted that symptoms of depression, anxiety, suicidal ideation and/or self-harming and alcohol or other substance misuse are common indicators of Domestic Abuse.

8.6 Securing safe accommodation in the right place

8.6.1 AJ presented as homeless to the MCC homelessness team and was supported to manage an illegal eviction. AJ moved into accommodation in Stockport and then temporary accommodation in Trafford, whilst applying for accommodation (presenting as homeless) to the Salford Housing Service.

8.7 The stockpiling of medication

8.7.1 Towards the end of the scope of this Review, AJ had told the CNS that he had no exact plan to end his life, but that he had been stockpiling medications (including some medication used by his Mother).

8.8 The transfer of the referral to MARAC, supporting a prosecution, seeking a restraining order

8.8.1 The Panel received information concerning the management of the three MARACs that operate across the City of Manchester. These MARAC occur in North, Central and South, and they operate fortnightly and have done so for a number of years. The MARAC are chaired by the Detective Inspector (Vulnerability) from GMP and the MARAC is administered by a GMP Operational Support Officer (OSO) in each area. Referrals are submitted onto the 'Share-point' system (used across Greater Manchester), from which those

for each meeting are collated and checked prior to being included on the agenda. Action notes from each meeting are recorded and distributed.

8.8.2 Following a period of successful support from Bridges DA Support and others, AJ agreed to complete a domestic abuse referral form and, consequently, his case was due to be discussed at the Tameside MARAC. However, when AJ requested a move of accommodation (and began working with Salford Housing Service), the case was transferred to the City of Manchester MARAC. AJ, at that time, had an IDVA who was supporting him and was in contact, but this ceased when his case was transferred to Manchester and a new IDVA, from the LGBT Foundation was appointed.

8.8.3 Whilst this process was on-going, the Police attended an incident whereby AJ and P1 had had an argument. It was a verbal argument and P1 denied assaulting AJ. Officers completed a DASH which was assessed as medium risk and the Panel noted that this was despite AJ having a High Risk DV victim marker on his record. A referral was sent to MARAC for this incident to be heard alongside the previous incidents and this was scheduled for the 25/11/21. A crime was submitted for Common Assault and was reviewed by Inspector 02226 who stated there were vulnerability issues. However, it was noted that there was very little prospect of detection of this crime without the assistance and support from AJ. A DVPN was considered but not required and the crime was finalised. The author of the report from GMP noted that due to the previous domestic history, consideration should have been made to arrest P1 for assault and if AJ was unwilling to support a prosecution, a victimless prosecution could have been considered. The author also noted that a DVPN could also have been authorised to safeguard AJ. Although AJ stated he was in the process of obtaining a Restraining Order, a DVPN would have come into immediate effect.

8.8.4 The IDVA from Bridges informed the Panel that they also liaised with the police to confirm that AJ did wish to pursue a prosecution against P1.

8.9 Cross border residency

8.9.1 AJ spent time in Manchester and time with his family in Wales. There were a number of occasions when AJ requested that his care and treatment be transferred from one service, across the border to another.

8.9.2 Cross border travel between North Wales and Manchester is a significant complicating factor in this case, particularly ensuring continuity and purposeful information sharing to appropriately manage risk and ensuring AJ was offered treatment.

8.10 The nature of bi-directional abuse.

8.10.1 Information submitted to the Panel from the Greater Manchester Police and others demonstrated that AJ and P1 had a history of assaults against Partners.

8.11 Services were offered in the period of the Pandemic. Did this magnify AJ's social isolation and loneliness

8.11.1 According to the submissions made by GMMH and others, AJ described that his life was stressful and lonely, he was unemployed and had few friends to talk to. There is published research – from the Home Office and others – concerning the incidence of suicide during the periods of COVID lockdown.

8.12 Engaging in 'Chem-Sex' Parties

8.12.1 During an assessment, AJ shared with GMMH that he occasionally participated in chem-sex parties with his partner and that on occasion, he was being paid in drugs to have sex with other men. It is clear that the agencies that held this information (including his GPs) did not recognise that AJ may have been exploited in this situation, and that the disclosures may have warranted a referral to the LGBT Foundation Chem-Sex worker (and other appropriate services) and also a safeguarding referral due to the deleterious impact on AJ's mental health. The mental health services also did not make a safeguarding referral to address these concerns.

8.12.2 The Panel was informed – by colleagues from the Public Health Department – that a specific Chem-Sex service had been commissioned a number of years prior to the critical incident occurring and that the drugs used in the Chem-Sex scene have been noted in local drug-use trend surveys. These surveys occur on an annual basis.

8.12.3 The Panel were encouraged to note that this work – focusing upon Chem-Sex services – is ongoing and that in 2023, the LGBT Foundation (and others, including 'The Men's Room' and Manchester Metropolitan University) are focusing upon the development of a digital resource to support the provision of specialist Chem-Sex services.

Section 9
Conclusion

9.1 This Domestic Homicide Review concerns the death of AJ, who died in November 2021. The working hypothesis of the Greater Manchester Police was that AJ died at his home following a suspected overdose of medication.

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

9.3 The Greater Manchester Police investigated the circumstances leading to the death of AJ and concluded that there was no evidence available that the death of AJ was a consequence of any third party involvement.

9.4 The Panel noted that the agencies contacted in relation to this Review identified a specific diversity issue concerning AJ – the agencies recorded and noted that AJ was a gay man and were cognisant of this fact when they were providing support to him. It was encouraging to the Panel that it became clear that the agencies involved in the Review were aware of equality legislation and the potential for discrimination as it pertains to the Equality Act 2010. During the completion of the Review, the Panel identified no examples of direct or indirect discrimination.

9.5 AJ's Sibling (referred to as S1) informed the Panel that AJ was born in Wales and he was the youngest child of a large family. They told the Panel that AJ knew that he was gay from being a little boy and that living in a small country village, he assumed that he would never be accepted, and so he tried his best to hide this from both his family and his friends. When a young adult, AJ met P2 and they had a child together (P2, at the time, had a child of their own). AJ and P2 shared the responsibility for parenting and caring for both of P2's children.

9.6 AJ's sibling told the Panel that AJ moved to Manchester, once he had told everyone that he was gay.

9.7 A number of agencies involved in completing this Review – including Greater Manchester Police, Manchester Foundation NHS Trust, Greater Manchester Mental Health Services NHS Foundation Trust, GP1 – held information that noted AJ had endured many years of mental distress, anxiety, depression, drug use and domestic abuse.

9.8 The Panel learnt that, prior to the formal scope of this Review, AJ had attempted to take his own life on at least four occasions – including incidents of significant overdose and on one occasion, an attempt at hanging.

9.9 It is important to note that AJ was both a victim and a perpetrator of domestic violence. The complexity of this case was magnified by different aspects of AJ's life, including his enduring mental illness, family bereavement during the period of the initial phase of managing the COVID Pandemic, domestic abuse, and his general healthcare needs.

9.10 Throughout the time he was residing in Manchester, AJ regularly returned to Wales to spend time with his family, in particular his Mother, who played a huge part in his life and supported him. It is noteworthy that when AJ spent time in Wales, reports of significant incidents ceased. During one period within the formal scope of this Review, there were no significant incidents recorded for almost 12 months. However, when incidents did occur, they were significant and appeared to have a damaging effect on AJ's health.

9.11 Throughout the review period AJ presented to a number of services with depressed mood in the context of significant psycho-social stressors. Suicidal and parasuicidal acts particularly whilst intoxicated were a feature in AJ's contact with GMMH in 2018 and 2021.

9.12 It was difficult for agencies – particularly mental health services – to assess AJ's mental state without robust consideration of his complicated relationship with substances. Often it appeared that AJ's use of these substances led to sexual behaviour that put him and others at risk. It is important to reflect on why AJ used substances, often appearing to suppress difficult emotions connected to low mood, coercive and controlling behaviour, physical abuse, sexual abuse, loneliness, interpersonal conflict, and financial difficulties.

9.13 In 2018, whilst receiving support from the Central Home-Based Treatment Team (HBTT) provided by GMMH, AJ disclosed attending "Chem-sex parties" with his partner. This information did not appear to be incorporated into a wider 'trauma informed' assessment of AJ's circumstances and behaviour. Neither a safeguarding nor a domestic abuse referral was made at this point.

9.14 At various times during the Review period, AJ informed Salford Housing, the LGBT Foundation, his GPs in Wales and Greater Manchester, Bridges Domestic Abuse Service, Motiv8, GMMH, and others that he had suicidal thoughts and was enduring depression.

9.15 As noted, within and out-with the scope of this Review, AJ had several events of attempted suicide or significant self-harm whereby he was ambivalent about his safety. These events often took place in the context of poly-substance use and/or intimate interpersonal conflicts. The mental health services in North Wales and Greater Manchester noted these matters and the Panel noted that this knowledge was not always utilised to form a meaningful action plan to support AJ to either resolve them or reduce the risk they posed.

9.16 The Panel considered this matter and noted that – as the timeline moved closer to the critical incident – there was a complication (or perhaps confusion) associated with which mental health service held CPA and prescribing responsibility. It may also be the case that this matter was further convoluted by the responsibilities delegated by the Section 75 Agreement.

9.17 A theme within this Review – and replicated in other DHRs – was, following reports of abuse, a reluctance to support the process of prosecution. Consistently, AJ declined to support the Police when they expressed a desire to pursue a prosecution of P1. As noted in the Report, on the occasion when AJ did support a prosecution, P1 made a counter allegation and both AJ and P1 were arrested for a Section 47 assault. The Panel noted that on one occasion, GMP served a DVPN on AJ.

9.18 The Panel did note that it appeared that the impact of the Covid-19 pandemic on AJ was acute. His mother died through this period and the restrictions that were in place at the time meant that AJ could not see her prior to her death and could not attend the funeral. In April 2021 police attended two domestic incidents involving AJ and P1 where AJ told officers he was struggling to come to terms with the death of his mother due to the impact of the Covid restrictions. This in turn must have had an impact on the relationship between AJ and P1.

9.19 AJ suffered with a number of mental health conditions and the lockdown periods would, no doubt, have had a detrimental effect of his mental health.

9.20 This was a tragic case for the Panel to review. The information considered by the Panel described a young man who had suffered significant mental distress and trauma, had made numerous attempts to end his life and had been subjected to abuse and violence for a number of years. The information shared with the Panel described circumstances which must have become so grievous to endure, AJ may have decided to take his own life.

9.21 AJ was a Son to his Mother and Father, a Brother to his Siblings, a Father to two children and a friend to many. It was also noted by the Panel that, soon after the completion of the Review, AJ's eldest child had a child – this would have made AJ a Grandfather. The Panel offer their sincere condolences to AJ's family and his friends.

Section 10
Recommendations

Rationale	DRAFT recommendation
1 Ensure that DASH/RIC, Safeguarding and other assessments are applied in a timely and appropriate way The Review found that services in both primary care and secondary care were aware that AJ had made disclosures about domestic abuse. However, it was not always apparent that further direct and sensitive enquiry or professional curiosity was exercised. Whilst there may have been a clear focus on the presenting need and a desire to establish a strong therapeutic relationship, all NHS providers (in Greater Manchester and North Wales) have a clear process for completing the DASH risk assessment and escalating any concerns to their Safeguarding Team and all General Practices have access to a specialist safeguarding lead. The Panel were acutely aware that recommending amendments to existing training provision (focused upon domestic abuse, violence and safeguarding) can be far from straightforward. In making these Recommendations, the Panel wish to stress that a process should be in place to identify what is already provided, what gaps may exist in light of the findings from this Review, what capacity exists to fill these gaps and which metrics should be adopted to assess the impact of the revised training programme. As described in the Report, the Adult Care Service in Manchester has commissioned GMMH – under the conditions of Section 75 of the NHS	The Panel recommends: • The Manchester Community Safety Partnership works with the Manchester Safeguarding Partnership, the Manchester Integrated Care Board, IRIS Manchester and the Betsi Cadwalladr University Health Board to seek assurance that all independent practitioners (General Practitioners and other independent contractors) are aware of their safeguarding duties and receive training and support to deliver these duties;[17] • Manchester CSP seeks assurance from GMICS that the IRIS training that they commission contains reference to: Trauma informed Care Referral pathways for perpetrators of domestic abuse The link between domestic abuse and suicide. Same sex partner intimate violence. Poly substance abuse • The Manchester CSP, with the support of Adult Social Care, should ensure that all partners are aware of the national framework for what constitutes a safeguarding concern, which includes domestic abuse, and how to respond to such concerns. • The Manchester Community Safety Partnership works with the aforementioned organisations and other secondary care providers involved in the care of the subjects of this Review, to review the content of the safeguarding training – and other forms of awareness raising for staff – that is currently provided and aim to encourage providers to ensure that the training programme:

[17] It should be noted that a number of GP services are managed by BCUHB and some GP services are entirely independent.

Act 2006 – to undertake a number of responsibilities described by the Care Act 2014. The Panel noted a number of examples from the submissions made that, simultaneously, described incidents when AJ was not subject to a safeguarding adult alert but recorded as being an adult safeguarding concern due to his substance misuse, his mental health and suicidal ideation, his attendance at parties where he was given drugs to participate. An assessment should take place in all situations relating to domestic abuse, the assessment should be personalised and along the same principles as "Making Safeguarding Personal".	○ Raises awareness of 'Chem-sex' parties and their impact upon vulnerable adults (they can be considered as a form of potential exploitation); ○ Raises awareness so staff are mindful of any coercion or exploitation and if these issues are identified, to make a child or adult safeguarding referral (as appropriate) and to seek advice from the specialist advice that is available.
2. This Review concerns an apparent victim-suicide. Panel members were aware of the research conducted by Professor Jane Monckton-Smith concerning the eight stage timeline leading to the suicide of victims of domestic abuse. The Panel noted that both the direct and indirect impact of apparent suicide on family and friends is significant and that support for those affected by such trauma should be prompt and timely.	The Panel recommends: • That the Manchester CSP share the learning from this DHR with the Greater Manchester Bereavement Service; • That the Manchester CSP share the learning from this DHR with the National Suicide Prevention Group in Wales and with the Mental Health Division within the BCUHB; • That the Manchester CSP supports the recommendations from the National Confidential Inquiry into Suicide and mental Health (NCISH) research findings and works with the Suicide Prevention Partnership, the Public Health Leads for suicide prevention and others to raise awareness of these findings.
3. Supporting General Practice and Primary Care A referral to IRIS was not considered in this case because the GPs in Greater Manchester (GPs 2, 3 and 4) stated that it appeared to them that the abuse disclosed by AJ occurred in previous relationships. The author of the GP submission felt the practices had missed the significance of domestic abuse referred to in correspondence with them	The Panel recommends: The Manchester Community Safety Partnership, supported by the Integrated Care Board, seeks assurance that the IRIS training made available to General Practitioners is reviewed in light of the themes identified in this and other DHRs and that: • An update is provided to GP Safeguarding Leads to reinforce the point that the risk of domestic abuse does not diminish when a relationship

because the correspondence referred to relationships in the past. The Panel noted that at least one GP in contact with AJ was IRIS trained at the time[18].	is over (it can increase) so an IRIS referral should still be offered when DVA is disclosed. This is in the context of historic relationships not just recently ended ones. • An update is provided to GP Safeguarding Leads to reinforce the point that male victims of DVA can, of course, be as vulnerable as female victims and professionals should be 'professionally curious', enquire about DVA and refer appropriately**.**
4. Chem-sex support services A number of services in contact with AJ were aware that he attended 'chem-sex' parties and AJ disclosed that he would, on occasion, be offered drugs to participate in these parties. Noting the point that this is potential exploitation not a "lifestyle choice", the Panel agreed that it is necessary for services to become aware of the provision of the specialist 'chem-sex' services provided across Greater Manchester[19].	The Panel recommends: The Manchester CSP, supported by the LGBT+ Foundation and the Northern Centre for Sexual Health, should: • Develop a programme to determine the most effective way to promote the service and raise awareness of the pathways to access the service; • Encourage partners on the CSP to reflect in their safeguarding updates that chem-sex parties are recognised as a potential form of sexual exploitation that, coupled with other co-existing risks, may warrant a safeguarding referral.
5. Adverse Childhood experience In Manchester there is an ambition to be an ACE-aware, trauma informed and trauma responsive city. A city with a coordinated approach to reducing exposure to ACEs, where all practitioners work with residents to prevent or mitigate the consequences of trauma; helping children, families, and communities to build resilience; and improve outcomes for residents by working in a trauma responsive way. The CSP will c**ontinue** to work towards all practitioners working in Manchester to be trauma informed and able to apply an ACE's focus to ensure their practice is 'Trauma Informed'	The Panel recommends: • The Manchester CSP ensures that trauma informed training is rolled out across Manchester City Council, including the promotion of the existing availability of the 7 Minute Briefing on ACEs to all partners.

[18] IRIS is not available within the BCUHB area.
[19] The Greater Manchester Specialist Chem-Sex services based at the REACH Clinic; the 1:1 support provided by the LGBT Foundation (ChemSafe and SMART Recovery support groups). It should be noted that such services are not available in Wales.

6. The 'stockpiling' of medication The Panel noted the submission from the Greater Manchester Police describing the scene of the incident where it appeared AJ took his own life, particularly the presence of prescribed medications and other medications. The Panel also noted the submission from the CNS at the Orange Rooms encouraging AJ to safely dispose of the medication he was 'stockpiling'. The issues described in the submissions concerns a wider programme of medicines management and control.	The Panel recommends: • The Manchester CSP, supported by the Health and Wellbeing Board, examines if there are any existing communication strategies in place to support the promotion of the safe disposal of unused medication; • In the absence of such strategies, Director of Population Health (MCC) to consider developing a public health message to reinforce the need for unused medications to be returned to any dispensing Pharmacy[20].
7. Dual residency, moves of accommodation The complications arising from the issue of residency appeared to overshadow a compelling case to provide support. AJ was discharged from the mental health team (in 2021) and felt that the Home Based Treatment Team had dismissed him. The actions of the GP (with the support of the Bridges Service) centred on getting AJ re-referred back into mental health services. The LGBT Foundation noted that there appeared to be a problem with loss of support for, and communication with, AJ that resulted from him moving his residence. These matters magnified the difficulty in addressing AJ's mental health needs and his risk of domestic abuse. The author of the submission from GMMH stated that the screening procedure undertaken in November 2021 was incomplete and incorrect.	The Panel recommends: • The Manchester CSP, with the support of the ICB, issues a briefing note to all Partners outlining the national policy regarding 'temporary residence' when registering with a general practitioner and the implication of temporary residence on the opportunity to receive all commissioned services for that GP catchment[21]; • The Manchester CSP invites the GMMH NHS Trust to provide a clear outline for all local agencies and services of i) the structure of the Home-Based Treatment Team (HBTT), ii) the range and nature of provision, and iii) the referral pathways • An evaluation of the procedure being developed by the Bridges Domestic Abuse Service is undertaken and shared with all CSP Partners. (Bridges have stated in their submission that, where a client has re-located, a three-way meeting will take place between the client, the Bridges IDVA and the IDVA from the service where the client has moved from, and that this new procedure will be embedded into the process to ensure that transition/continuation of support is achieved and maintained[22]).

[20] BCUHB currently manage the delivery of a joint Public Health/Pharmacy health protection message concerning how to dispose of excess prescribed medicines and out of date medicines. These are run on a quarterly basis. Additionally, national campaigns are amplified on a local basis by the joint public health/pharmacy programme.
[21] This would supplement any guidance contained within the Section 75 Agreement, referred to elsewhere.
[22] The MARAC procedure applied by Jigsaw Homes has been produced and is available from Jigsaw directly.

8. Managing AJ's mental health The Panel noted that AJ was known to several agencies in Manchester, across Greater Manchester and in North Wales. The majority of the services in contact with him knew that he had significant healthcare needs. There was also evidence of ongoing domestic abuse and a discharge summary from the mental health service in Wales concerning a diagnosis of Emotionally Unstable Personality Disorder – impulsive type. This diagnosis does not appear to have been on AJ's GP record or his GMMH notes. It appeared that AJ was accessing, at various points within the scope of this Review, two secondary mental health services (though not, we think, simultaneously) and it was unclear to his GPs which organisation had the CPA/responsible Clinician role and which had a clear oversight of prescribed medications. The Panel noted that, in circumstances similar to these, if the move from one area to another was for only a matter of weeks, it would be difficult to deliver a meaningful package of support, particularly from a therapeutic perspective as the evidence is clear: it needs to be the same therapist throughout the intervention in order for the intervention to be successful.	The Panel recommends: • The Manchester CSP supports the designated NHS safeguarding teams to liaise with the medicines optimisation teams and GMMH NHS Trust to support best practice across Greater Manchester, and work with MIC to circulate a clear description of best practice to GPs when they are working with patients who transfer from secondary mental health care services into primary care; • The Manchester CSP supports the Integrated Care Board, to work with the medicines optimisation teams to support GPs when it is necessary to question mental health service led prescriptions. Additionally, it was noted that all shared care prescribing should adhere to the Greater Manchester Medicines Management Group (GMMMG) policies to ensure safe prescribing for patients who transfer into primary care. Please see: https://gmmmg.nhs.uk/shared-care/gmmmg-approved-shared-care-protocols/ • Additionally, where there are mental health initiated prescriptions, GPs should work with the mental health service with CPA responsibility to share oversight of prescribing to, and management of, the patient. GPs should be provided with regular updates on the patient medication reviews carried out by the mental health services and if they do not receive them, they should flag this up on the Datix system; • An evaluation of the ICB pilot programme of working with people who are street homeless (whereby the care co-ordinator follows the patient if they remain within the Greater Manchester boundary, regardless of their Borough of residence) is shared with all partners on the CSP.

9. Male victims of domestic abuse The learning from this Review identified that men can be both victims of abuse and also perpetrators of abuse; that abuse can be bi-directional in any relationship; that the importance of the DASH should be reinforced and that it may be possible to supplement the questions posed by the RIC to underline professional curiosity and to capture other relevant matters.	The Panel recommends that the Manchester Community Safety Partnership: • Shares the learning from this DHR with the Greater Manchester Male Victims Working Group and invites the Group to discuss the findings from this DHR and works with the CSP to identify appropriate pathways into support and advice for male victims of domestic abuse and violence[23]; • Seeks assurance from GMP that they utilise the D66 recording code for all LGBTQ+ incidents involving domestic abuse; • Seeks assurance from all partners that when they refer cases to the MARAC (using SharePoint), they capture the sexual orientation of the victim (this will trigger an automatic alert to the LGBT Foundation IDVA team).

[23] It should be noted that BCUHB apply the SafeLives referral form for referrals to MARAC. This form includes a section on diversity and includes reference to LGBTQ clients.

Appendix A

Single Agency Recommendations:

Bridges Domestic Abuse Support Services

- All Bridges referrals that disclose low mood/ suicidal ideation will be referred to the Jigsaw Support Wellbeing Navigator team for support and signposting.

- Three-way meeting between client, Bridges IDVA and IDVA service where client relocated to will be embedded into process to ensure transition/ continuation of support.

Greater Manchester Police

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

- When officers from GMP attended one particular incident, a DASH assessment was submitted but some of the questions were left blank. According to GMP's policy and procedure, if a victim refuses to answer DASH questions, the officer responding should apply their professional judgement to make an assessment of risk. Officers should include their assessment of the victim's demeanour in the DASH

- Officers from GMP attended one particular incident and spoke to P1. It transpired that AJ and P1 had engaged in an argument and P1 said it was a verbal argument and denied assaulting AJ. A referral was sent to MARAC for this incident. A crime was submitted for Common Assault and it was concluded that there was little prospect of a detection of the crime. A DVPN could have been authorised to safeguard AJ

- GMP has policy and procedures in place when attending domestic incidents and incidents when persons present with mental health related concerns. This dictates how information is recorded so risk can be managed, and the appropriate safeguarding put in place. GMP policy states, at present, that a Domestic Abuse Plan (referred to as a DAB Plan) is to be submitted over a care plan when Mental Health issues are identified during a Domestic Abuse incidents. On police contact with AJ, it is highlighted that these policies were not adhered to.

GMMH

- GMMH as an organisation can improve staff awareness and consciousness of the prevalence of domestic abuse. Including increased reference to same sex intimate partner violence and understanding of commonly recognised themes present in these cases.

- Robust procedural guidance on the importance of using structure risk assessment tools such as the ‘Domestic Abuse Stalking and Honour Based’ risk assessment checklist (DASH).

- Level 3 Safeguarding Adults/Domestic abuse training module to be updated to include specific information on same sex intimate partner violence and other complexity factors such as polysubstance use.

- Safeguarding Adults Level 3’ training module to include information on ‘Chemsex’ as a complexity factor to raise staff awareness and to inform them of specialist advice available.

- GMMH ‘Safeguarding Adults at Risk’ policy to be updated to include clear guidance on clinical expectations when ‘screening’ safeguarding referrals made by other agencies, including documentation required and professional communication with the referrer.

Appendix 1

Domestic Abuse

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

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

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

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

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

Personally Connected

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

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

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

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

For further information on this subject, please refer to the College of Policing, Authorised Professional Practice (APP) on Domestic Abuse.[24]

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

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

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

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

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

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

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

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

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

Controlling or Coercive Behaviour
Section 76 of the Serious Crime Act 2015 provides the offence of controlling or coercive behaviour where the perpetrator and victim are personally connected. In this legislation, 'personally connected' means intimate partners, or former intimate partners, or family members who live together. The Domestic Abuse Act 2021 introduced an amendment to the legislation which removes the co-habitation

requirement. This ensures that post-separation domestic abuse and familial domestic abuse is accounted for when the victim and perpetrator do not live together.

Acts of controlling or coercive behaviour may include: isolating a person from their family or friends; monitoring a person's time; using spyware to monitor a person; taking control over aspects of a person's everyday life (such as where they can go, who they can see, what they can wear, and when they can sleep); repeatedly putting a person down (such as telling them they are worthless); threats to harm a child; and many other types of behaviour.

Harmful Traditional Practices

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

Appendix 2
The MARAC National Dataset

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

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

Key statistics about domestic abuse in England and Wales

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

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

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

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

How long do victims live with domestic abuse?

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

Appendix 3

GMC prescribing guidance (Good practice in prescribing and managing medicines and devices (gmc-uk.org)) states:

27 You must only prescribe if it is safe to do so.

a. It's not safe to prescribe if you don't have sufficient information about the patient's health or if the mode of consultation is unsuitable to meet their needs.

28. Before prescribing, you must consider whether the information you have is sufficient and reliable enough to enable you to prescribe safely.

For example, whether:

you have access to the patient's medical records or other reliable information about their health and other treatments they are receiving
you can verify other important information by examination or testing
the patient would be at risk of death or serious harm if they are also obtaining medication from other sources.

37. If you need more information to help you decide which options would serve the patient's needs, you must ask for it before recommending an option or proceeding with treatment.

60. If you don't have access to relevant information from the patient's medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important.[18] Exceptions to this are when no other person with access to that information is available to prescribe without unsafe delay and it is necessary to:

a. avoid serious deterioration in health or avoid serious harm
b. ensure continuity of treatment where a patient is unexpectedly without access to medication for a limited period.

61. In these circumstances, you should provide a limited quantity and dose – one that is sufficient to make sure the patient receives suitable care until a) they are able to see an appropriate health professional who has access to the relevant information from their medical records or b) you are able to verify that information yourself. In making this decision you should consider the possibility that the patient may be obtaining medicines from other sources.

The guidance advises doctors to use professional judgement around the safety of their prescribing of dependence forming medications but does not appear to categorically prohibit it. We are working with the medicines optimisation team to address if this is an issue at an individual practice level or if there is a need to develop a protocol for the Manchester primary care economy.

Appendix 4
Section 75 Agreement

The DHR Panel learnt that Manchester City Council has commissioned – under the terms of Section 75 of the NHS Act 2006 – the Greater Manchester Mental Health Services NHS Foundation Trust to discharge a number of responsibilities for safeguarding, as described by the Care Act 2014.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care.

Under Section 42 of The Care Act 2014[25], there is a duty for Local Authorities to make an enquiry where a Local Authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In this instance the Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

People's wellbeing is at the heart of the care and support system under the Care Act 2014, and the prevention of abuse and neglect is one of the elements identified as going to make up a person's wellbeing. Local authorities also have safeguarding responsibilities for carers and a general duty to promote the wellbeing of the wider population in the communities they serve. Safeguarding duties apply regardless of whether a person's care and support needs are being met, whether by the local authority or anyone else. They also apply to people who pay for their own care and support services.

An adult with care and support needs may be:
- an older person
- a person with a physical disability, a learning difficulty or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living;
- victims of sexual exploitation, domestic abuse, modern slavery.

This list is not exhaustive

[25] http://www.legislation.gov.uk/ukpga/2014/23/enacted

Adult safeguarding duties apply in whatever setting people live, although there are differences for prisons and bail hostels. They apply regardless of whether or not someone has the ability to make specific decisions for themselves at specific times.

There may be times when a person has care and support needs and is unable to protect themselves for a short, temporary period. People with care and support needs are not inherently vulnerable, but they may come to be at risk of abuse or neglect at any point due to:

- physical or mental ill-health;
- becoming disabled;
- getting older;
- not having support networks;
- inappropriate accommodation;
- financial circumstances; or
- being socially isolated.

Local authorities have a duty to make sure that the care and support services they commission are provided safely and to a high standard, while also recognising and tackling the abuse and neglect that happens in community and domestic settings.

Working with their partner organisations – including housing organisations, the National Health Service (NHS) and the Police – local authorities should make sure that adults who may be at risk of abuse or neglect are enabled to live as safely and independently as possible, making their own decisions and taking control of their own lives.

The representative from Adult Care informed the Panel of the process agreed with GMMH for safeguarding adults within the City – including adults living with domestic abuse. This process has been ratified by the Professional Lead for Social Work and Senior Managers at GMMH.

<u>In brief, the process involves the following elements:</u>
All cases within the Multi-Agency Safeguarding Hub (MASH) will be triaged by the appointed mental health practitioner. They will provide recommendations based on their specialist knowledge of mental health and the services available to be provided;

If the mental health practitioner requires additional support or clarification concerning the GMMH internal patient pathways, or – in general terms – the recommendation they wish to make, then they will seek advice from the Professional Lead for Social Work or the social care leads in their absence

If the Professional Lead for Social Work/divisional lead recommends that a non-open case is referred to mental health services, then the mental health practitioner will describe this in their case-notes and ensure that this is included in the safeguarding workflow on ‘Liquid logic’ (the case management system used by Adult Care in Manchester).

Upon receipt of this referral (at what is referred to as 'the gateway'), staff will notify the Community Mental Health Team (CMHT) of the information collated, the referral and the action(s).

If the Professional Lead for Social Work (or divisional leads in their absence) recommends that a case should be referred to a CMHT, they will accept this from 'the gateway' and not return it.

Any work that is agreed to be sent to the Community Mental Health (CMH) Gateway:

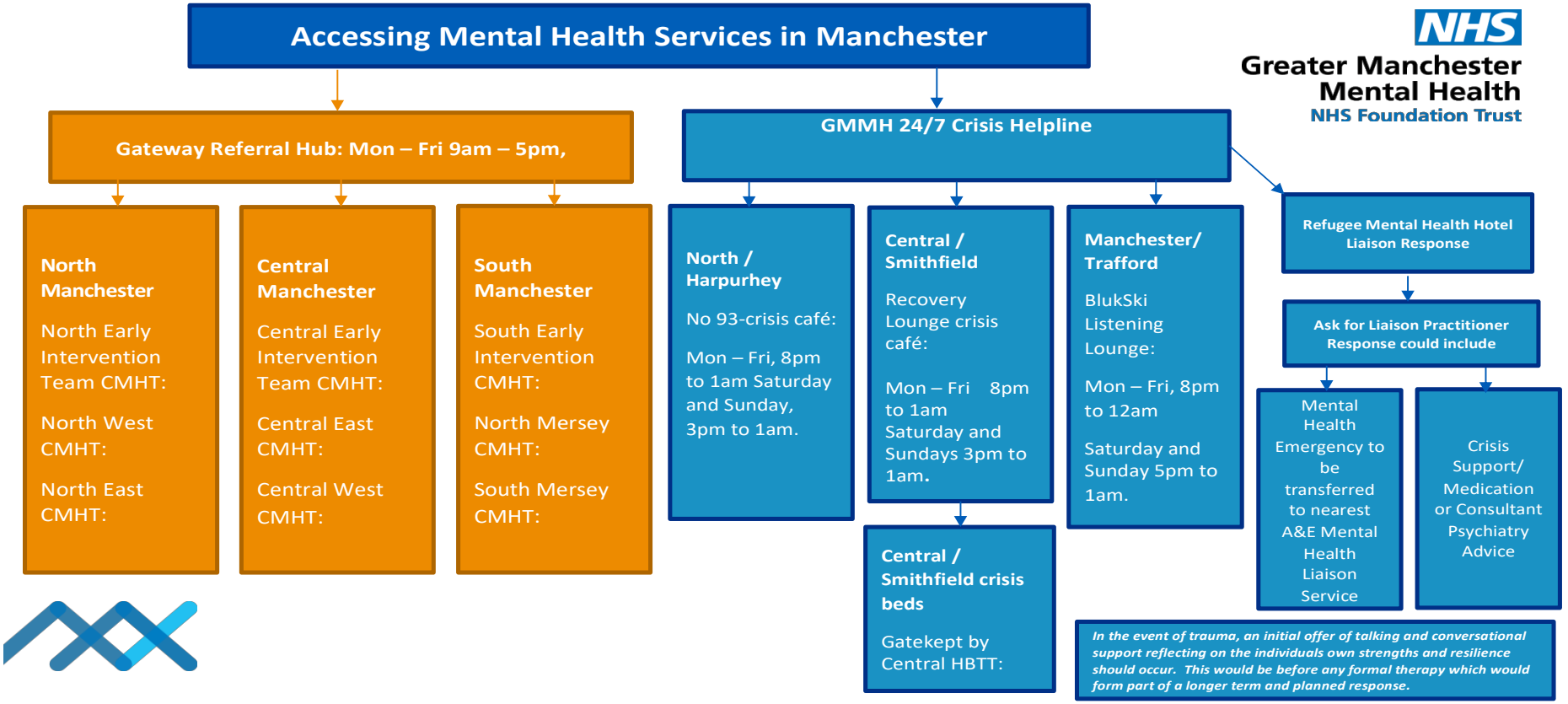
- should have the contact completed;
- should be placed on a MASH screening form; and
- in the SA re-assign option/spanner, one of the recommendations outlined below should be added.

Recommendations and agreed notes for CMH Gateway are as follows:
MASH recommends – S42
MASH recommends – Urgent assessment
MASH recommends – Non-urgent assessment
MASH recommends – Care Act assessment
MASH recommends – Information – to inform assessment
MASH recommends – Information – no action required

The Greater Manchester Mental Health NHS Foundation Trust provided the Panel with an illustrated description of the routes available for residents requiring mental health support. This is replicated below.

Confidential – not for circulation

Appendix 5



Glossary of common acronyms

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

Bibliography

a. The MARAC Operating Protocol – Greater Manchester Police

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

d. College of Policing – Evidence led prosecutions

e. The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales. James Rowlands; Sarah Dangar. The Journal of Family Violence. January 2023.