Salford Community Safety Partnership (CSP)/Salford Safeguarding Adults Board (SSAB)

Domestic Homicide Review/Safeguarding Adults Review in the Case of Susan (Pseudonym) who died in July 2020

Final Report

Revised January 2024

Independent Chair/Author: Maureen Noble

CONTENTS

Section 1: Overview

1.1 This review is about Susan, a resident of Salford, who tragically died in July 2020. Susan was 26 years of age. An inquest into Susan's death was held in June 2021 at which the coroner found that Susan had died of a self-administered drug overdose and that she had taken her own life. The review panel offer condolences to Susan's family on their tragic loss.

1.2 Susan had lived in Salford for around ten weeks at the time of her death, having recently moved from Scotland where she had lived with her partner Jake since she was around 17 years of age. N.B. Susan was born in Salford, and she had family in the area.

Confidentiality

1.3 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers.

1.4 Pseudonyms have been used in this report to protect the identity of the individuals involved: N.B. Although Susan's family have not participated in the review at the time of writing pseudonyms have been confirmed with them both in writing and at the inquest.

1.5 The key people in this review are:

Susan (Deceased), Ethnicity: White

Jake (partner of Susan)

Susan and Jake's Children who are referred to as Child 1, 2, 3 and 4

Incident Leading to the Review

1.6 On the date of Susan's death Greater Manchester Police were called to an address in Salford following a request for assistance by North-West Ambulance Services (NWAS) in relation to a 26-year-old female who had called for an ambulance, reporting that she had taken an overdose. Paramedics responded to the call and Susan let them into her home. After a brief discussion about what medication she had taken, Susan began to 'fit'. Two police constables attended Susan's home and found a letter which appeared to be a 'goodbye' letter from Susan to her family. Susan was transported by emergency ambulance to Salford Royal Hospital (SRFT). A short time after arrival at hospital Susan sadly died.

1.7 Police determined that there were no suspicious circumstances in relation to Susan's death and therefore no criminal investigation has taken place.

Section 2: Methodology

2.1 This joint DHR/SAR was commissioned by the Salford Community Safety Partnership and the Salford Safeguarding Adults Board. [1]

Decision to conduct a DHR/SAR

2.2 Following initial notification to the Salford Safeguarding Adults Board (SSAB) from Greater Manchester Police in July 2020 and a subsequent referral to the Community Safety Partnership (SCSP) on 15th December 2020, the SCSP and SSAB decided to commission a joint Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR), this decision was made on 18th December 2020. N.B. The delay in implementing the review was due to initial uncertainty about whether the case met the criteria for SAR and for a DHR. After seeking further information, the CSP decided that a DHR was indicated due to historic disclosures of domestic abuse, and of Susan's long-term issues in relation to mental health difficulties and self-harm.

Period Under Review

2.3 The period under review is April 2020 (when Susan moved from Scotland to Salford) to the date of Susan's death in July 2020.

[1] This review is a joint DHR/SAR, and it should be acknowledged that both review processes use very different terminology. However, both processes are about learning lessons in how local professionals and agencies worked together to safeguard the adult.

The DHR/SAR panel has agreed that the language used within this report needs to be clear and transparent, there has been an added challenge due to the review covers two countries within the United Kingdom (England and Scotland) where terminology is again different, and the panel recognizes that different agencies and professionals from all the agencies have different ways of understanding and describing needs.

Below is an explanation of key terms used in this report and their respective interpretations.

Domestic Homicide Reviews (England)	Safeguarding Adult Review Care Act 2014 (England)	Adult Support and Protection Act 2007 (Scotland)
Victim	Adult at risk	Adult at risk of harm
Perpetrator	Adult alleged to be responsible for abuse or neglect/ adult of concern	Alleged perpetrator/alleged harmer

A glossary of all agency acronyms is also attached at Appendix 1.

2.4 Information on Susan's contact with services in Scotland dating back to 2015 is included as the panel agreed this contains important background and context.

Impact of Covid 19 Pandemic

2.5 Susan's move from Scotland to England took place during the first 'national lockdown'. As set out throughout this report agencies reported significant pressures resulting from the demand on services because of the pandemic. The review was conducted 'virtually', and all meetings and conversations were conducted by Microsoft Teams or by telephone.

2.6 Services in Scotland and Salford reported that lockdown had a significant impact on face-to-face contacts and accessibility of some services which is reflected in this report.

2.7 The review has been completed in accordance with the regulations set out in the Domestic Violence Crime and Victims Act (2004)[2] and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide has been used in this review.

2.8 The review is compliant with statutory guidance set out in the Care Act 2014 which states that Safeguarding Adults Boards **must** arrange a SAR when:

- an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2.9 Although there is no statutory requirement to conduct DHRs in Scotland, it was agreed by both the CSP and the SSAB that insight into Susan's history and contact with services in Scotland would enable the panel to better understand Susan's lived experience.

2.10 The review therefore contacted relevant authorities in Scotland who provided contact details for a senior officer from the Adult Protection Committee (APC) [3] in the area where Susan had lived until April 2020. The senior officer

---

[2]https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004

[3] https://www.gov.scot/policies/social-care/adult-support-and-protection/ The Adult Support and Protection (Scotland) Act 2007 set up multi-agency Adult Protection Committees (APCs) in every council area. The Committee monitors and reviews what is happening locally to safeguard adults. It is made up of senior staff from many of the agencies involved in protecting adults who may be at risk. These include staff from the council, the NHS and the police. APCs are chaired by independent convenors, who cannot be members or officers of the council.

joined the review panel and provided a high level of support and co-ordination to the review. In addition, a senior representative from the local Health and Social Care Partnership (HSCP) in the area where Susan lived provided support to the review. Both officers were full members of the review panel and assisted with agency contacts and advising on policy and practice in Scotland. It was agreed that the review should formulate recommendations for services in Scotland both for victims of domestic abuse and adults with care and support needs. These are provided at Appendix 2.

Family Involvement in the Review

2.11 Susan's family were notified in writing at the commencement of the review. Initial contact was made through the children's social worker in Salford as a trusted professional known to the family. The terms of reference for the review were shared with the family.

2.12 N.B. The review panel discussed whether Susan's children should be involved in the review. The panel noted their young ages and the trauma they had recently experienced. The panel decided that any decision to involve the children should be made by Susan's family, who were caring for the children at this time. The children's social worker supported this decision. Susan's family will be contacted again prior to publication and involvement of the children will be discussed with them as appropriate.

2.13 The Chair provided information to Susan's family about the review and an information leaflet produced by Advocacy after Fatal Domestic Abuse (AAFDA) was given to the family. The family indicated to the children's social worker at that time that they would be willing to participate in the review. The Chair provided several dates to meet, however there was no response from the social worker or family.

2.14 There was a change in social worker following which the Chair then contacted Children's Services again in May 2021 to request details of the new social worker to arrange a meeting with the family, however no dates were provided.

2.15 The Chair attended the Inquest for Susan in June 2021, for which a summary report had been provided to the coroner and shared with the family. The family were present at the Inquest and the Coroner offered an opportunity for them to ask questions about the review/report. At that time the family had no questions. At the Inquest the Chair undertook to contact the family in writing following inquest and wrote to Susan's father requesting that he make direct contact with the Chair to arrange for the family to be involved in the review. No reply was received to this letter.

2.16 In early September the Chair wrote again to Susan's father but did not receive a response. The Chair wrote again to father at the beginning of October 2021 however it appears that this letter did not reach the family as they had recently moved.

2.17 Following confirmation of the new address, the Chair wrote again to Susan's family in January 2022 however no response was received.

2.18 The review panel agreed that no further attempts should be made to contact the family other than to arrange to send a copy of the report prior to submission to the Home Office and to invite them to make any comments directly to the Chair.

2.19 The Chair wrote to Susan's family in September 2022 asking if they wished to see a copy of the report prior to submission to the Home Office and to offer to meet with them. Susan's father contacted Salford CSP requesting a copy of the report but declining a meeting.

2.20 The report was sent by recorded mail to Susan's father with a request that any comments be received by 10th November and offering a further opportunity to meet with the Chair. At the time of writing no response has been received.

2.21 A recorded delivery letter was sent to Susan's father prior to publication of the report offering a further opportunity to meet with the Chair and/or see a final version of the report. No further communication has been received prior to publication.

Involvement of Jake

2.22 The review panel discussed whether Jake should be invited to contribute to the review. The panel were aware through contact with Children's Social Care that Jake had refused to accept that he had perpetrated domestic abuse in his relationship with Susan and his contact with the children was minimal.

2.23 The panel decided that it may be detrimental to the stability of the children's care arrangements for Jake to be involved in the review, and, on that basis, he was not invited to participate.

2.24 The panel acknowledged that information regarding Jake's involvement with services would provide insight into the nature of the relationship with Susan, however, it was recognised that Jake's consent would be required to access records relating to him and Jake had already expressed his unwillingness (through a parallel process) to share information. On that basis the panel decided not to make requests to access Jake's health and other records.

2.25 There were no other family or friends identified to participate in the review.

Purpose of DHRs and SARs

2.26 The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, 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.
- Use learning from the DHR to prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children.
- Draw up and implement a co-ordinated multi-agency action plan that ensures that learning in relation to domestic abuse is acted upon at local, regional, and national level.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

2.27 The purpose of a Safeguarding Adults Review (SAR) is to

- Learn lessons - SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.
- It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

2.28 Terms of Reference and Key Lines of Enquiry

1. To establish what contact agencies had with Susan; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard Susan and risk assess the perpetrator.
3. To establish whether Susan’s family and/or significant others knew about domestic abuse and whether they sought or received help.
4. To establish whether there were other risk factors present in the lives of Susan and the perpetrator (e.g. mental health issues, substance misuse, adverse childhood experiences).
5. To establish whether other safeguarding issues (including safeguarding children and/or adults at risk were appropriately identified and acted upon.

6. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
7. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities.
8. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.
9. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
10. To consider specific issues relating to diversity.

2.29 Key Lines of Enquiry – Questions to be answered by agencies involved in the review.

KL1: Did your agency know that Susan was subject to domestic abuse by Jake or any other person at any time during the period under review?

If so, what actions were taken to safeguard Susan and were these actions robust and effective?

KL2: Was Jake known to your agency as a perpetrator of domestic abuse and if so, what actions were taken to reduce the risks presented to Susan?

KL3: Did your agency know that Susan and/or Jake were experiencing difficulties in relation to drugs, alcohol, mental health, or other vulnerabilities/risk factors (this might include vulnerably accommodated/homelessness, issues around mental capacity (executive capacity), self-neglect or self-harm/suicidality)?[4] These links are explored in detail in research referred to below and later in this report.

KL4: Were you aware of any other factors, including adverse childhood experiences (ACEs) in relation to Susan or Jake that may have increased their risks and vulnerabilities.

KL5: Did Susan and/or Jake disclose domestic abuse to family and/or friends, if so, what action did they take? Was anyone in the local community aware of domestic abuse, if so, what actions did they take and what was the outcome?

[4] https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf

KL6: Did your agency undertake any risk assessments or other actions in relation to safeguarding the children of Susan and Jake. What were these actions, who was involved and what were the outcomes?

KL7: Were protected characteristics as defined in equalities legislation considered in relation to Susan?

KL8: How did agencies work together in this case, was this effective (this should include working across geographic (national) boundaries).

KL9: Did Covid 19 affect working practices in any way, if so, how were these impacts mitigated? Was the impact of Covid 19 on Susan and her family taken into consideration in the way agencies worked with them?

Contributors to the Review

2.30 A panel of senior representatives from relevant agencies was established and met on seven occasions to oversee the review. There were no conflicts of interest and none of the panel members had direct contact with Susan or her family. The panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner's Office.

2.31 Following initial scoping for the review the following agencies were identified as having had contact with Susan and were asked to secure their records. Individual Management Reviews (IMRS) and short reports were received as set out below.

Agency/Abbreviation	Report Requested/Received	Single Agency Action Plan Yes/No
Police Scotland (Police)	IMR	No
Children's Services in Scotland (CSS)	IMR	No
Emergency Department in Scotland (EDS)	Short report and conversation with Chair	No
Drug and Alcohol Service in Scotland (DASS)	Short Report	No
GP 1 GP2 GP3	Brief Information received via questionnaire. Printout of Medical records received.	No No No

GP4	Printout of Medical records received. Brief information received	No
Housing Service in Scotland (HSS)	Short Report	No
Maternity Services in Scotland (MSS)	Short Report	No
Mental Health Services in Scotland (MHSS)	Short Report and conversation with the Chair	No
Primary School in Scotland (PSS)	Meeting with Chair	No
Women's Aid in Scotland (WAS)	IMR	Yes
Greater Manchester Mental Health (GMMH)	IMR	Yes
Greater Manchester Police (GMP)	Short Report	Yes
Salix Homes (SH)	Short Report	No
Salford CCG (GP5)	IMR	Yes
Salford Children's Services (SCS)	IMR	No
Salford Housing Options (SHOP)	Short report	No
Salford Royal Foundation Trust (SRFT) Northern Care Alliance	IMR	Yes
Salford Primary School (SPS)	Meeting with Chair	No

Salford Survivor's Project (SSP) (N.B. it should be noted that this is a small voluntary sector agency and is not a service commissioned by Salford CSP).	IMR	Yes

2.32 In addition to receiving written agency reports the Chair held 'Teams' meetings with the Head Teacher from the primary school in Scotland (PSS) and with the Head Teacher of the primary school in Salford (SPS). Key points from these conversations are included in the chronology within this report.

2.33 The review sought advice from the Salford Public Health Team Suicide Prevention Co-ordinator who attended two meetings with the panel and advised on the suicide prevention aspects of the review and the final report. The Chair of the Greater Manchester Suicide Prevention Board attended the final sign-off meeting for the review and has been fully sighted on the review and recommendations. N.B. Further exploration of the links between suicidality and domestic abuse and how this impacted Susan's lived experience is set out within the body of this report and in the conclusions and recommendations.

2.34 Single agency action plans will continue to be updated. Not all agencies identified learning.

2.35 There were no conflicts or declarations of interest recorded during the review. Authors of Individual Management Reports and short reports were not directly connected to Susan.

2.36 The review panel membership is set out below:

Name	Agency/Job Role
Maureen Noble	Independent Chair and Author
Brenda Walker	Senior Officer, Adult Support and Protection, Adult Protection Committee (Scotland)
Alison Troisi	Detective Sergeant, Greater Manchester Police (GMP)
Elizabeth Walton	Assistant Director Safeguarding and Quality/ Designated Nurse Safeguarding Adults Salford CCG
Rebecca Marchmont	Named GP for Adult Safeguarding Salford CCG
Vicky O'Neill	Deputy Designated Nurse for Safeguarding Adults Salford CCG
Joanne Glynn	Safeguarding Adult Lead, Greater Manchester Mental Health (GMMH)
Dawn Redshaw	Chief Officer, Salford Women's Aid (Independent DA Advisor to the panel)

Elizabeth Stewart	Children and Families Senior Manager, Children's Services Scotland (CSS) Health and Social Care Partnership (Scotland)
Gail Winder	Assistant Director of Nursing, Safeguarding Adults, Northern Care Alliance
Eileen Conneely	Principal Manager Safeguarding, Salford Adult Care Services (ASC)
Jane Bowmer	Board Manager, Salford Safeguarding Adults Board (SSAB)
Jane Anderson	Head of Housing Advice and Support, Salford Housing Options Service (SHOP)
Alison Maxwell	Head of Integrated Social Work and Principal Social Worker, Salford Children's Services (SCS)
Helen Byrne	Tenancy Sustainment and Partnership Development Manager, Salix Homes (SH)
Roselyn Baker	Principal Policy Officer, Salford City Council (CSP Lead)

Chair/Author of the Overview Report

2.37 The Community Safety Partnership/Safeguarding Adults Board appointed Maureen Noble as independent Chair and Author to oversee and direct the Review, and to write the overview report.

2.38 The Chair has worked as an Independent Consultant specialising in safeguarding and domestic abuse for 11 years and has undertaken numerous Child and Adult Safeguarding reviews and Domestic Homicide Reviews. She has undertaken pro-bono work with NICE and SCIE in relation to domestic abuse.

2.39 She was previously employed by Manchester City Council as Head of Crime and Disorder. She left Manchester City Council in 2012.

2.40 During the course of the review the Chair was employed as Independent Chair for the Trafford Strategic Safeguarding Partnership. She left this role in March 2023.

2.41 Throughout the review process the Chair was independent of all agencies and individuals involved in the review and the CSP and SSAB were satisfied that there were no conflicts of interest.

Parallel Reviews

2.42 The Safeguarding Children Partnership (SCP) in Salford conducted a case review in relation to involvement with Susan and her children. The SCP review identified learning which has been shared with this review. The findings of the SCP review are referenced throughout this report.

2.43 An inquest has taken place, the findings of which are shown at 1.1.

Timescales for the Review

2.44 The first meeting of the review panel took place in February 2021. The panel held seven meetings.

2.45 A progress report was provided to HM Coroner on 10th June 2021.

2.46 The final panel meeting was held in December 2021 and final report approved by the CSP and the SSAB in Salford in April 2022 and the Adult Protection Committee in Scotland in May 2022. In October 2023 feedback was received from the Home Office Quality Assurance panel requesting amendments. The review panel was re-convened and met on 11th December 2023.

2.47 This revised report was approved by the panel and CSP and sent to the Home Office on 19th January 2024.

2.48 Delays were experienced in conducting the review due to the Covid 19 pandemic impact on services. The Home Office was notified of these delays at the time.

Equality and Diversity

2.49 The panel considered the nine characteristics set out in the Equality and Diversity Act 2010[5].

2.50 The panel noted Susan's female sex as a protected characteristic. The panel noted that females are statistically more likely to experience domestic abuse than males. The ONS (Office for National Statistics, November 2023) reports an estimated 1.4 million women (and 751,000 men) aged 16 years and over experienced domestic abuse in the last year: a prevalence rate of approximately 5.7% of women and 3.2% of men.

2.51 Further the panel noted that the ONS reports that crimes recorded by the police show the following trends: In the year ending March 2023, the victim was female in 73.5% of domestic abuse-related crimes. Between the year ending March 2020 and the year ending March 2022, 67.3% of victims of domestic homicide were female compared with 12.1% of victims of non-domestic homicide.

2.52 The panel noted Susan's ethnicity as white. The ONS report for the year ending March 2023, the Crime Survey for England and Wales (CSEW) showed that a significantly higher proportion of people aged 16 years and over in the Mixed and White ethnic groups experienced domestic abuse in the last year compared with those in the Asian or Asian British groups. Almost twice as many women in the White ethnic group experienced domestic abuse in the last year (6.0%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3.0%).

2.53 Susan had been treated over many years for anxiety and depression in both primary and secondary care and was diagnosed with recurrent depressive

[5] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity#our-duties-under-the-equality-act-2010

disorder. Susan's experience of domestic abuse may have impacted her mental health.

Dissemination of the Final Report

2.54 When finalised the review report will be shared with the following:

Susan's Family

The SCSP, SSAB and all participating agencies

All relevant officials in Scotland (to be determined)

Office of the Police and Crime Commissioner

Domestic Abuse Commissioner's Office

Greater Manchester Suicide Prevention Board

Section 3: Background Information – The Facts

3.1 Susan spent her childhood living in Salford. Susan was care experienced. She met Jake whilst she was living in a Children's Home in Salford. N.B. the review has not accessed records relating to Susan as a child.

3.2 Susan and Jake moved to Scotland when they were both around seventeen years of age. They settled there and had four children together.

What Agencies Knew – Chronology of Susan's Contact with Services

3.3 As an adult Susan had many contacts with agencies in Scotland and subsequently in Salford. The panel requested that agencies highlight those contacts which they felt were most significant and that provided insight into Susan's lived experience. Agencies were also asked to note any significant contacts shown in Susan's records in relation to contacts with Jake and with the children.

3.4 N.B. Due to the passage of time and differences in legislative requirements, it has not been possible to obtain a completely cohesive picture of Susan's contact with services in Scotland.

Events between 2015 and 27th April 2020 (Scotland)

2015

3.5 Susan was registered with GP1 who provided a summary of contacts with Susan, the majority of which related to mental health difficulties. The practice was unable to verify Susan's contact with community and specialist mental health services as notes were not available. The practice confirmed that none of Susan's children or Jake was registered with them.

3.6 GP1's records contain one reference made by Susan to verbal abuse and name calling by Jake.

3.7 On 23rd June police received a call from Susan reporting an incident at home between Susan and Jake. Police attended and noted that both had consumed alcohol, although Jake left the premises before police arrived. No crime was recorded.

2016

3.8 In early January Susan presented to Maternity Services (MSS) reporting health concerns. She was examined and discharged.

3.9 On 31st January police received a call from Susan reporting an altercation with Jake at their home. Police attended and found that Jake had already left to stay with a friend. Susan said things had been resolved. It was noted that both Susan (and reportedly Jake) had been drinking alcohol.

3.10 Throughout February and March Susan had ongoing contact with MSS. It was noted by MSS that Susan had experienced ongoing difficulties with her mental health and that Children's Services had previously been involved with the family.

3.11 Routine enquiry regarding domestic abuse took place at an appointment on 24th April, at which Susan reported that she was not experiencing domestic abuse.

3.12 Susan continued to have regular appointments with MSS throughout June to November. During this time MSS provided clinical support and liaised appropriately with other services. Child 3 was born by normal birth at full term.

3.13 Following Child 3's birth Susan reported that she was experiencing auditory and visual hallucinations. She was admitted to hospital and a psychiatric liaison visit was arranged, which Susan said she was happy with. Susan was assessed by a psychiatric nurse. A plan was put in place for Susan to be supported by the Primary Mental Health Team (PMHT).

3.14 On 14th November the PMHT conducted a psychiatric review and put in place a plan for referral to Community Mental Health Team (CMHT), part of the plan was to review medication as Susan had stopped taking her prescribed medication during pregnancy.

3.15 That same day Susan was discharged from inpatient MSS and transferred to the care of the Community Midwifery service, with whom Susan had five routine contacts over the next seven days. During these contacts Susan discussed her mental health and appropriate liaison took place between Midwifery Services, PMHT and CMHT.

2017

3.16 On 10th March Susan called police to report that she had returned home after an evening with friends when Jake had been looking after the children. A verbal argument had taken place and Jake was acting aggressively and had smashed the kitchen window. Police attended and Jake was charged with an offence of Breach of the Peace S38(1) Criminal Justice & Licensing (Scotland) Act 2010 (for which he was subsequently convicted). Police checked and recorded that the children were safe and well and had not sustained any injuries and Children's Services were notified.

3.17 On 27th October police attended two incidents involving Susan. The first was at a public house where Susan had been asked to leave and had refused. Police attended and Susan left the premises.

3.18 Shortly after this the police received a call from Susan saying that she had been attacked by Jake. Police attended the home address and spoke to Susan and Jake separately. Jake said Susan had returned home intoxicated and an argument had ensued. He said he had not assaulted Susan. On returning to speak to Susan police found her to be 'unconscious' and ambulance was called; however, Susan was resistant to being transported to hospital and became aggressive. Susan was arrested and charged with an offence of Breach of the Peace S38 (1) for which she later received a recorded police warning.

2018

3.19 In 2018 Susan registered with GP2. GP2's records show more than 150 contacts with Susan, the majority of which relate to prescribing for pain relief and anxiety.

3.20 The notes indicate GP contact with Community Mental Health Team (CMHT) and Susan being referred to Psychiatric Community Mental Health Team (PCMHT).

3.21 There are several references to suicidal ideation and references to intentional overdose. The dates recorded in the GP notes correspond with information received from mental health services.

3.22 GP2's records refer to Susan using drugs and alcohol in the past and GP2 did make enquiries about Susan's current drug and alcohol use. Susan reported using alcohol to excess (binge drinking) in one of her later contacts with the practice.

3.23 Susan's children are referred to in the notes and it appears that Susan was candid about the involvement of Children's Services, although there is no mention of any direct contact between Children's Services and GP2.

3.24 On 2nd February police attended Susan's home address following a call from 'Social Work' who had been contacted by Susan saying that she was struggling to cope with the children as Jake had left the family home. It was reported that there was no social worker available to visit, however Police conducted a home visit and noted that the two children present were in good condition, as was the home. They noted no concerns and updated Children's Services.

3.25 On 12th February Susan was brought to the hospital Emergency Department by ambulance. The Ambulance Service raised Child Protection concerns. Susan had taken a large quantity of pain relief medication, alcohol, and cocaine. When admitted Susan had a bite on her arm which she said had been done by a family member. N.B. There is no indication in the records that this was explored as a potential domestic abuse incident.

3.26 Susan was discharged home following Psychiatric assessment. It is not clear whether a plan to follow up in the community was put in place following Susan's overdose.

3.27 On 6th June police recorded an enquiry from Children's Services. Care workers had attended the home address and noted poor living conditions and that Susan had been drinking the previous evening and said she felt unable to adequately care for the children due to her mental health issues, domestic violence in her relationship with Jake and his alcohol misuse.

3.28 The children were removed under voluntary measures and placed with a member of Susan's family in Scotland. N.B. This placement broke down following allegations made by the children.

3.29 Between September and October 17th Susan had five contacts with MSS for routine ante-natal care. Medical notes indicate that MSS were continuing to liaise with psychiatric services and Children's Social Care.

3.30 On 17th October MSS were informed by Children's Social Care that the children had been temporarily removed, of which they were not previously aware.

3.31 On 18th November Susan was allocated a tenancy by Housing Services.

3.32 On 20th November MSS saw Susan at a home visit to carry out a pre-birth assessment and a referral was made to PMHT.

3.33 MSS conducted a further home visit on 29th November where Susan reported that she was struggling with low mood. They contacted CMHT and Community Psychiatric Nursing (PCMHT) regarding referral.

3.34 On 19th December MSS again contacted CMHT/PMHT as Susan had not yet received an appointment from them.

2019

3.35 MSS continued to have routine contacts with Susan over the next two months and on 1st February 2019 Susan informed them that she had received an appointment with CMHT.

3.36 On 8th February Susan reported to CSS that she had resumed her relationship with Jake but that they would not be living together.

3.37 On 12th February Susan attended an appointment with a consultant psychiatrist. She was assessed and it was recorded that there 'was no evidence of mental illness'. Susan was discharged and no follow up was indicated.

3.38 Routine appointments continued with MSS during this period, and Susan presented on several occasions with concerns about aspects of her pregnancy.

3.39 On 21st March Susan reported to MSS that she was struggling with her mental health.

3.40 A further home visit was arranged on 25th March. This was followed by Susan being admitted to hospital on 27th March due to physical issues related to her pregnancy.

3.41 On 27th March Mental Health Services received a referral from the Maternity Liaison Service. On 4th April, the referral was triaged with a note to review in the postnatal period. An alert was placed on the system so that when Susan was admitted maternity liaison would be informed.

3.42 On 8th April Susan was assessed by Maternity liaison services. Susan described some anxiety as to how she would cope in the early postnatal period with four children and a partner who reportedly had mental health problems and was binge drinking and using cocaine.

3.43 Susan and the clinician discussed options and it was decided not to prescribe medication to her at that time. It was noted by the clinician that Susan had ongoing input from social workers, health visiting and the midwife. It was therefore agreed to discharge Susan back to the care of her GP.

3.44 On 9th April MSS recorded a safeguarding concern raised by the midwife in relation to the children. It was noted that Jake had been calling the hospital and saying he couldn't cope with the children and that he wanted Susan to return home from hospital (the children had recently returned from respite care). The midwife spoke to the social worker who said they would conduct a home visit and speak to Jake.

3.45 That same day Jake visited Susan in hospital, it was recorded in notes that Susan was visibly upset. Jake had told her that he would leave her tomorrow when she came home. Susan was very upset and expressed concerns about how she would cope with the children.

3.46 On 10th April the midwife and social worker discussed a plan for returning home and engaged with PMHT regarding medication.

3.47 On 11th April Susan was discharged to the care of the Community Midwife. The following day the Community Midwife visited Susan at home and noted that Susan said her mood had improved.

3.48 On 15th April at a home visit Susan appeared to be in low mood and said that Jake wasn't helping around the house. The midwife contacted the GP for an appointment however none were available.

3.49 On 24th April CMHT received the referral and attempted to contact Susan on 29th April without success. They eventually made contact and an appointment for assessment was made.

3.50 On 9th May CMHT conducted an assessment with Susan. Susan rated her mood as 'down' and scored 3 out of 10 for mood. A care plan was agreed to support Susan with anxiety management and to monitor mood. A further appointment was made for 29th May.

3.51 On 29th May the Community Psychiatric Nurse attended Susan's home, however Susan said she had forgotten about the appointment and asked for it to be rearranged. A further appointment was made for 6th June. Susan was not at home when the CPN called for this appointment. An 'opt out' letter was put through the door to which Susan did not respond. Susan was therefore discharged from the service on 25th June.

3.52 On 31st July CMHT received a referral from Susan's GP indicating anxiety and depression as the reasons for referral. CMHT contacted Susan by letter asking her to contact the service by 16th August to 'opt in'. Susan contacted the service in August saying that she wished to receive a service but would need to be seen at home due to her level of anxiety.

3.53 Following three unsuccessful attempts to contact Susan, PCMHT arranged an appointment with her for 16th September, however Susan did not attend. PCMHT then discharged Susan back to the care of her GP.

3.54 On 13th September Susan disclosed to Children's Services that she had a significant debt of around £2,000. Support was offered from the 'Money Matters' team however Susan did not engage with the service. N.B. The review has been unable to establish any further detail regarding this debt.

3.55 On 19th November Susan presented to ED at her local hospital having taken an intentional overdose of prescribed medication. Susan was assessed and referred to PCMHT.

3.56 On 24th November Susan was assessed by the PCMHT. At this assessment it was deemed that Susan did not require referral to Psychiatry.

3.57 Susan spoke to GP2 about still feeling suicidal. The GP noted her relationship with Jake to be abusive, this was recorded by the GP as being 'argumentative not harm'. GP2 said they would refer to CMHT, however Susan left the surgery before anything could be arranged.

3.58 Susan was provided with further information on crisis services should she require emergency contact. All actions were followed up by the practitioner and Susan attended GP2 on 26th November. N.B. Brief medical notes from the GP indicate that Susan continued to feel 'suicidal' but reported that she would not 'do anything' because of the children.

3.59 On 4th December Susan attended an appointment with CMHT. At this appointment Susan disclosed domestic abuse by Jake. The plan was to offer Susan short term CPN support. Susan was advised to contact WAS (Women's Aid) for support with domestic abuse issues.

3.60 On 19th December WAS received a referral from CSS for Susan. An appointment was made for 20th December however Susan did not attend.

2020

3.61 On 20th February police in Scotland received a child concern notification which they shared with CSS relating to a previous placement of the children with a family member in Scotland.

3.62 On 25th February CSS noted that it was Susan's intention to permanently separate from Jake. She reported that she was struggling with her mental health and having difficulty coping with the children. Susan said she had an appointment with WAS regarding refuge placement.

3.63 On 27th February Susan attended an appointment with WAS who conducted a DASH risk assessment with a score of 15. The following day the WAS advocacy worker attempted to make a joint appointment with CSS however was unable to do so.

3.64 A meeting was arranged for 6th March. At that meeting Susan reported that Jake had left the family home the previous night.

3.65 On 9th March at a meeting with CSS Susan disclosed that Jake misused alcohol and cocaine and had abused her on several occasions, having once kicked her in the stomach when she was pregnant.

3.66 Susan further disclosed that she was dependent on dihydrocodeine (an opiate) which she was prescribed years ago for a back injury. She also said she had abused drugs and alcohol whilst the children were in foster care and that she wanted to seek help for her drug use.

3.67 On 10th March a child concern was reported by Police in which Child 3 who had been at home with Jake (presumably now returned to the family home), had managed to open the front door, and went wandering outside unnoticed by his father. Child 3 was found in a shop around 30 minutes later and returned to safety.

3.68 CSS initiated a Child Protection Investigation and sought for the children to be removed to a place of safety. Both Susan and Jake agreed to the children becoming accommodated on a voluntary basis (under Section 25)[6].

3.69 On 12th March Susan told CSS that she wanted to move to another part of Scotland to be closer to a family member.

3.70 On 17th March CMHT attempted to make a home visit, however there was no response from Susan. That same day CSS and WAS were in contact with each other regarding Susan moving. However, Susan changed her mind about moving and CSS began seeking accommodation for Susan in the local area. Susan had also made appointments with the drug dependency service and with WAS regarding refuge accommodation, however none was available at that time.

3.71 On 18th March Susan underwent an initial assessment with the local drug service. She was accepted by the service and was informed that due to Covid 19 initial appointments would be by telephone only.

3.72 On 19th March Susan entered a women's refuge whilst her four children remained accommodated under the voluntary arrangement.

3.73 During this time the primary school in Scotland (PSS) remained in close contact with Susan as they were concerned about her welfare and that of the children.

3.74 On 23rd March national lockdown began in England and Scotland.

3.75 On 30th March Child 3 and Child 4 joined Susan at the refuge, whilst Child 1 and Child 2 remained in the care of the local authority (under the voluntary S25 arrangement).

---

[6] In Scotland, Section 25 of the Children (Scotland) Act 1995 enables **parents, supported by social workers, to voluntarily place their child to secure their safety**, into the care of a local authority away from the parental home.

3.76 Around this time Susan registered with GP4 (Scotland) as a temporary patient and had one contact in relation to prescribed medication.

3.77 On 6th April Susan informed the refuge and CSS that she was not enjoying communal living and that she wanted her other two children back with her and to be rehoused (in Scotland).

3.78 Susan was informed that due to the current lockdown situation it was unlikely that rehousing would take place for at least three months. Susan said that if that was the case she wanted to move to England where her father and stepmother lived.

3.79 On 7th April Legal Services in Scotland received notification from Susan's solicitor that she was withdrawing her consent for the two children to remain in voluntary care.

3.80 PSS expressed serious concerns regarding the children being returned to Susan and made representation to CSS. CSS said they were concerned about Susan's ability to look after the four children however they could see no grounds for seeking an emergency child protection order.[7]

3.81 On 18th April Susan contacted the Salford Survivor Project (SSP) via their Facebook page. Susan was aware of the service through a family member who volunteered with them. Susan contacted the service to gain advice and support and told the service that she was fleeing domestic abuse by her partner. She said that whilst in the refuge she was upset that she could only have the younger two children with her and the two eldest had been placed voluntarily in care as there was not enough room in the refuge to accommodate her and four children. In addition, due to lockdown, she had not been able to see her two children who were in care.

3.82 The contact was passed to the service manager in SSP who reviewed the contact and got in touch with Susan by phone.

3.83 Between 18th April and 23rd April SSP liaised with Susan regarding her move to Salford and talked through the things that she might need to have in place when she moved. Susan said she wanted to move closer to family and SSP offered support and a housing letter if needed. Susan informed SSP that her father was collecting her and bringing her to Salford.

3.84 On 22nd April WAS contacted CSS with concerns regarding Susan's mental health. They said that she spent long periods of time away from the refuge without saying where she was going and that this was of concern as full lockdown was in place.

[7] In Scotland A child protection order (CPO) can be **issued to immediately remove a child** from circumstances that put them at risk, or to keep a child in a place of safety. Anyone can apply to the sheriff for a CPO. An exclusion order can be issued to remove a suspected abuser from the family home.

3.85 On 23rd April WAS contacted SSP regarding the availability of refuge places in the local area (Salford). SSP made a general enquiry to the Chief Officer of Salford Women's Aid. N.B. This was outside of the established referral pathways asking about the availability of refuge places. No response was received by SSP.

3.86 On 24th April CSS contacted HSCP[8] to inform them of Susan's decision to move to Salford. The usual safeguarding checks were made on the address that Susan was moving to and HSCP were satisfied that there were no significant concerns. CSS also spoke to SSP regarding support for Susan.

Events from 27th April 2020 to date of Susan's death

3.87 On 27th April 2020 Susan moved to England from Scotland. N.B. She spent a short (undetermined) time living with a family member in a neighbouring borough of Greater Manchester, and then moved to stay with her father and stepmother in Salford. Susan then applied for a tenancy in Salford.

3.88 On that day SCP made a referral to Salford Children's Services (SCS) regarding the family relocating to the area and requested that a welfare visit be undertaken. It is unclear from the records held by SCS what level of detail about the family was included in the referral.

3.89 Susan also spoke to the Primary School in Scotland on 27th April about an incident with the children's foster placement. Susan said she had been bullied in the refuge and that she had been told it could be up to a year before she could be rehoused. Susan said that she had been in touch with SSP in Salford and that they would help with housing and a deposit.

3.90 On 28th April SSP dropped off clothing, toys, and other items at Susan's father's address. They advised Susan regarding applying for housing and contacted Salford Housing Options (SHOP) and began the application process for Susan.

3.91 On 29th April housing services in Scotland contacted Susan to confirm with her that she had moved to Salford and did not require further services from them at this time.

3.92 That same day GMP received a contact from police in Scotland regarding an investigation into the allegations made about foster carers. GMP recorded this on their systems and noted the ongoing investigation.

3.93 SCS first became aware of the family on 1st May when they were referred for a welfare check by CSS. The referral was to check whether Susan knew how to access services and to ascertain the children's views, however there was no response from Susan or the referrer.

3.94 On 3rd May the Headteacher from the primary school in Scotland emailed written comments to the social worker in Scotland expressing 'disbelief' that the

[8] HSCP (Scottish Health and Social Care Partnership) is an administrative body that oversees child safeguarding in the local area.

children had been returned to Susan without an emergency child protection conference having taken place. The Headteacher said they believed there were ongoing risks to the children that had not been addressed and it was their view that the children were at imminent risk of significant harm.

3.95 The social worker responded to this indicating that meetings had been cancelled when lockdown commenced, however a restricted process of virtual meetings had been put in place. It was noted that this was not normally the process for children being discharged from care and a multi-agency meeting would usually take place.

3.96 On 4th May CSS recorded in their notes that attempts had been made to speak to SCS regarding their referral, but this had been unsuccessful. (N.B. The first time that the CSS social worker recalls being able to speak with a SCS social worker was on 11th May). During this call information was shared relating to Susan and the children. The CSS social worker was advised that the family did not meet the threshold for provision of services in Salford.

3.97 Susan had registered for housing whilst living with a family member in another GM Borough and had also contacted a social worker there, who then contacted CSS for background information. The CSS social worker explained that they had previously submitted a referral form to CSC (Salford) as they believed this was where Susan was going to live.

3.98 It was confirmed by the social worker that Susan was not at that time living in Salford and no information had been received by them from CSS.

3.99 On 4th May Susan had a telephone encounter with GP5 (Salford) requesting an emergency prescription. N.B It appears that Susan was now living with father and stepmother in Salford, however this is unconfirmed.

3.100 On 5th May GP5 received a request for medication from Susan. The GP noted that Susan was a newly registered patient fleeing domestic abuse in Scotland and that she wanted medication urgently. GP5 noted that Susan had only just registered with the practice. GP5 then contacted GP4 in Scotland to confirm her medication. GP4 confirmed that Susan had been registered with them and confirmed her medication.

3.101 GP5 received a discharge summary from GP4 confirming that Susan was currently prescribed medication for anxiety and depression. GP5 issued the same prescription to Susan. Susan was also prescribed Propranolol with accompanying instructions on dosage. GP5 attempted to contact Susan by phone but received no reply. A voicemail message was left for her.

3.102 On 7th May GP5 had a telephone encounter with Susan. Susan confirmed that she was fleeing domestic abuse in Scotland. She said she wanted to get her medication sorted as she has been without medication for 12 days. It was noted that Susan was anxious and crying, she said she was not settling well. She reported being homeless with four children and that she was living with her father and stepmother (although this is unconfirmed). She said she felt safe and

supported and that the Council will ‘sort’ housing once lockdown is over. Susan was advised that there was an ‘open door’ at the practice and that she could come in for support.

3.103 On 28th May the housing provider in Salford contacted Susan to offer her accommodation.

3.104 During this time the primary school in Scotland (PSS) remained in touch with Susan by phone having formed a good relationship with her and they remained concerned about her wellbeing and that of the children. N.B. in conversation with the Headteacher of PSS the review noted that at this time Susan had told PSS that she was becoming disillusioned with her move and that things were not working out as she had hoped.

3.105 On 10th June Susan collected keys for a property and took up the tenancy on 15th June. She said that she was happy with the property and pleased to have her own home.

3.106 On 21st June Susan presented to the Accident and Emergency Department (AED) at the local hospital reporting she had taken an intentional overdose of prescribed medication and was feeling suicidal. Susan was noted to be ‘a high risk’ adult and admitted to the ward with additional observation. Members of Susan’s family attended to support her.

3.107 Susan said that she had hoped that things would improve when she had her own home but that she was struggling to cope with the children.

3.108 Whilst at AED Susan was seen by a GMMH mental health practitioner. Susan disclosed previous domestic abuse by Jake. She also disclosed she had been abused in childhood by a family member.

3.109 A child safeguarding referral was made by GMMH noting that Susan had said she found it difficult to care for the children due to mental health issues. An adult safeguarding referral (SG1) was also made however the review could find no record that this was received by the Safeguarding Nurse.

3.110 On 22nd June SCS received the child safeguarding referral from SRFT and noted that a Children and Family Assessment should be completed.

3.111 On 22nd June GP5 received notification of Susan’s discharge from SRFT.

3.112 On 23rd June GMMH conducted a full mental health assessment during which Susan talked about historic sexual abuse, domestic abuse by Jake and a history of self-harm (attempts at taking her own life). Susan said she had attempted to leave Jake in the past but felt she had needed him. She was asked and said she did not currently have any contact with him.

3.113 That same day Susan was admitted to Salford Inpatient Services as a voluntary patient. Susan’s care plan was to receive a mental health assessment and support and referrals in relation to historic sexual assault and domestic abuse (the latter appears not to have been made due to early discharge). SCS were

informed of Susan's admission and the social worker planned for the four children to reside with Susan's father and stepmother.

3.114 On 24th June whilst at the inpatient facility it was noted that Susan appeared to have settled, although she said she was remorseful about the intentional overdose and was missing her children. The social worker made proactive contact with the ward to check on Susan and keep her informed about the welfare of the children.

3.115 That same day the social worker visited the children at the grandparents home and also visited Susan on the ward.

3.116 On 25th June, following a conversation with a support worker on the ward regarding historic sexual abuse, Susan contacted police via a 999 call and made a report of historic abuse. Police opened an investigation into the allegations and allocated this to an officer in the police division where Susan had lived at the time of the alleged offences.

3.117 That same day the social worker contacted family support to arrange for a support worker. Susan's father spoke to the social worker saying that he and Susan's stepmother were struggling to cope with the children.

3.118 On 27th June Susan spent time away from the ward and went to buy clothes for the children. When she returned, she said she had ten missed calls from Jake and that she didn't want to speak to him.

3.119 On 30th June Susan reported that she felt it would be beneficial for her to remain as an inpatient for a while longer and that she was happy with the support being provided by 'social services'.

3.120 On 2nd July Susan informed the ward that she would need to discharge herself to look after the children. Ward staff noted that Susan appeared anxious about discharge but that this was unavoidable due to family pressures regarding the children.

3.121 The social worker spoke to the grandparents and agreed a support plan. The social worker then spoke to Susan who said she felt happier that a support plan was in place.

3.122 Susan's discharge plan was discussed at the ward round, and it was agreed that discharge would include referral to home treatment and support workers via SCS. A social worker from SCS was present via telephone contact. Susan engaged in the ward round and agreed to being discharged with support in place.

3.123 The plan detailed by the social worker included an intensive visiting plan from mental health services, Home Based Treatment Team (HBTT), Outreach family support and social worker were in place. HBTT visiting 3 times a week, weekends and daily calls, family support worker visiting every other day and weekend and social worker daily contact virtual calls and visits. The family were to receive daily visits and childcare/school places were sourced.

3.124 Susan said she felt her recovery would continue in the community and felt the short crisis admission had been helpful. Susan was then discharged and returned home with the agreed plan in place. On discharge Susan was diagnosed with recurrent depressive disorder.

3.125 After returning home following discharge, Susan later presented at AED at SRFT reporting that one of the children had sustained an injury to their tongue whilst at home. Susan presented as 'acutely distressed' and was seen by a mental health nurse. She reported that she had been discharged from the mental health facility earlier that day but did not feel able to cope at home and, since discharge, had been experiencing suicidal thoughts. She said that she felt pressure whilst in the mental health facility, as her parents were looking after her four children and were struggling to cope.

3.126 Susan said she had agreed to be discharged but reported feeling anxious at the prospect of looking after the children alone. Susan described feeling overwhelmed and unsure how she would cope. She said she dispensed her discharge medication with the intention to take an overdose and end her life, however instead decided to go to AED to ask for help.

3.127 Susan reported intrusive suicidal thoughts, she stated she had felt 'better' as an inpatient. She said she was making good progress; however, she felt her discharge was premature but unavoidable. She advised that staff had been supportive and had advised her not to discharge herself if she did not feel ready. She stated she could not see a way forward.

3.128 SRFT arranged for Susan and the children to remain in hospital overnight to safeguard them. Throughout the night SRFT liaised with SCS, police, family and GMMH regarding the safety of Susan and the children.

3.129 The following day Susan was discharged from SRFT with a plan for involvement from all relevant agencies.

3.130 A message was left by SRFT AED for the duty social worker to make contact so that an update could be provided.

3.131 On 4th July SCS received the message from AED. The social worker visited Susan at home and discussed safety planning for the children, which informed subsequent S47 enquiries. At this home visit Susan was noted to be 'calmer' and reporting no thoughts of suicide. She said she had panicked about the tongue injury to one of the children. The social worker noted ongoing concerns in managing the children and the safety plan was reiterated with HBTT and family present.

3.132 At this time SCS were in the process of conducting a S17 Children and Families assessment. It was noted that concerns were escalating due to grandparents being unable to care for the children full time and that Susan had been discharged.

3.133 On 5th July Susan received her first home visit from HBTT. It was noted that Susan appeared positive about plans for the future although she reported that she

didn't feel current medication was helping with anxiety and suicidal thoughts. She was asked about self-harm and did not report any intention to harm herself. Susan said she was engaging with SCS and with mental health services and intended to continue to do so.

3.134 On the 6th and 7th of July the social worker visited Susan at home. Susan was informed that a strategy meeting was being held. Susan said that she was OK with this as she needed support.

3.135 On 7th July Salford Primary School received a contact asking whether any summer activities were available for the children. The school indicated that they would be willing to take the children onto roll to give them some stability and an introduction to the school which was excellent practice.

3.136 On 8th July HBTT conducted a home visit. Susan said she felt better but was still experiencing high levels of anxiety, although she felt better able to manage this. Susan did not express any thoughts or intention to self-harm.

3.137 On 9th July the Salford Primary School received an application under the Fair Access Policy to admit the children to the school.

3.138 That same day the social worker made a home visit. It was noted that Susan appeared much more 'upbeat'.and said she felt supported. Susan said she was aware of the forthcoming strategy meeting and of the social worker's view that there was a need to progress to Initial Child Protection Case Conference (ICPCC). Susan said she understood this. A weekend visiting plan was put in place and the children were due to start school on 13th July.

3.139 On 10th July the Section 47 enquiries concluded and ICPCC was requested as all those present at the meeting agreed that there were ongoing risks to the children.

3.140 On 12th July Child 1 and Child 2 started school at SPS. Susan brought them to school and collected them and said that she was pleased that they were in school and that she was grateful that they had a place.

3.141 That same day Susan had a home visit from the HBTT. It was noted that Susan's mental state had 'decreased' and the home was messy and chaotic. The children were present and were running around the house. Susan said she was becoming concerned about the children's behaviour and said she was struggling to cope with them and that she felt they may need to go into foster care.

3.142 Following the home visit the HBTT worker discussed their concerns with colleagues and an out of hours referral was made to SCS under the categories of 'neglect' and 'unsafe home conditions'.

3.143 The social worker contacted Susan after the weekend. Susan told the social worker that it had been a hard weekend but that she felt she had panicked when she spoke to the HBTT, and she didn't want the children to go into foster care. She felt she needed more childcare support. The family were still visiting every day and the children had now started school and nursery.

3.145 A day later Susan rang the Emergency Duty Team (EDT) saying that one of the children had bumped their head. EDT rang Susan back and noted that she was calmer. Susan’s stepmother came to stay with Susan and the children overnight and stayed until the following day.

3.146 Susan's tragic death occurred shortly after these events.

Section 4: Learning from the Review

Analysis against the key lines of enquiry

4.1 KL1 Did any agency know that Susan was subject to domestic abuse by Jake or any other person at any time during the period under review? If so, what actions were taken to safeguard Susan and were these actions robust and effective?

4.2 The review learned that all agencies who had contact with Susan in Scotland were aware that she had made disclosures of domestic abuse by her partner. The first recorded report of domestic abuse was made by Susan to police in Scotland in 2015.

4.3 Police in Scotland acted on Susan's calls in relation to domestic abuse in line with policy and practice at that time, and on one occasion Jake was charged for Breach of the Peace, the charge was later admonished (in Scottish law this refers to the lightest punishment available for an offence). However, there is no indication that Susan was offered or advised about referral to specialist domestic abuse services in these contacts.

4.4 Police contact with other agencies in Scotland appears to have related predominantly to safeguarding the children (which was good practice), however there is no indication of a safety plan for Susan or referral or liaison with specialist domestic abuse services or to services for adults at risk/vulnerable adults.

4.5 MSS conducted routine enquiry about domestic abuse with Susan when she was pregnant with Child 3 (at that time she said she was not in an abusive relationship) however there is no record that there was follow up enquiry when Susan was pregnant with Child 4.

4.6 Further there is no indication that Jake's refusal to allow Susan support when she was in hospital following the birth of Child 4, his unwillingness to look after the children, and his insistence that Susan return home from hospital (in the immediate post-natal period) resulted in action to refer Susan to specialist domestic abuse services.

4.7 CSS were aware of domestic abuse and liaised with WAS to obtain a refuge place and provided ongoing support to Susan. However, there is no indication of consideration to call a multi-agency meeting to discuss risk and safety planning for Susan, which would have presented an opportunity for agencies to work together to support Susan with disclosure and seeking help. Further there is no indication that a referral to Adult Services was considered at this time to provide help with Susan's ongoing care and support needs.

4.8 Mental Health services in Scotland made routine enquiries into domestic abuse but there is no indication that the service considered referring Susan to specialist domestic abuse services or conducting any assessment of Susan's safety via DASH risk assessment.

4.9 Susan presented at the Emergency Department in Scotland with injuries on more than one occasion, one of which was a human bite. There is no indication

that Susan was given an opportunity to talk about the circumstances of her injuries, nor is there any indication of consideration that Susan may have been a victim of domestic abuse and require assessment and referral.

4.10 Before moving from Scotland to Salford Susan proactively contacted the Salford Survivor's Project (SSP). At that time Susan was living in a women's refuge in Scotland. Actions to safeguard her as a victim of domestic abuse were initially taken by SSP who supported Susan and liaised with other agencies on her behalf.

4.11 There was good liaison between the refuge and SSP. SSP attempted to gain information about refuge availability in Salford but did not use the established pathway and did not receive a response.

4.12 Whilst living in Salford all the services Susan had contact with were aware that she had disclosed domestic abuse by Jake. They were also aware that Susan no longer lived with Jake and intended to permanently end her relationship with him.

4.13 The housing provider was aware that Susan was fleeing domestic abuse. It was noted that Jake had not moved to Salford with Susan and that he was not included on the housing application.

4.14 Susan disclosed to GP5 that she was fleeing domestic abuse and said she felt safer living in Salford. The GP noted this and offered Susan an 'open door' for support. However at that time GP5 did not seek to discuss domestic abuse with Susan nor did they offer a referral to a specialist domestic abuse service. GP5 indicated to the review that they wanted to build a relationship with Susan before talking to her about domestic abuse.

4.15 When Susan presented to SRFT on 21st June having taken an overdose of prescribed medication, she disclosed that the reason she had moved from Scotland was due to domestic abuse by her partner. She was seen by a Mental Health practitioner who noted that Susan had no current contact with Jake, it was also noted that Susan had disclosed historic abuse, and this was being investigated by GMP.

4.16 In all these contacts, although practitioners discussed domestic abuse with Susan, there is no indication that consideration was given to conducting a RIC/DASH risk assessment for Susan or of referring Susan to specialist domestic abuse services.

4.17 CSC were aware of domestic abuse as the reason for Susan fleeing Scotland, they were aware that it was Susan's intention to permanently separate from Jake however there does not appear to have been consideration of the possibility of post separation abuse/coercive and controlling behaviour by Jake.

4.18 KL2: Was Jake known to any agency as a perpetrator of domestic abuse and if so, what actions were taken to reduce the risks presented to Susan?

4.19 Susan reported domestic abuse by Jake to Police in Scotland. They responded to calls for assistance from Susan and spoke to Jake on several occasions regarding verbal altercations and disturbances at the family home, however, there is no indication that Jake was referred to any service as a perpetrator of domestic abuse. Indeed, it is recorded that Jake denied he was abusive to Susan on several occasions.

4.20 Susan had made disclosures regarding Jake being a perpetrator of domestic abuse to all the agencies with whom she had contact in Salford.

4.21 On one occasion whilst she was an inpatient in the mental health facility Susan disclosed that Jake was trying to contact her, indicating that there may have been post-separation abuse and coercive and controlling behaviour. There is no indication that any action was taken to explore this with Susan, however it was noted in the records that Susan had said she did not want to have contact with Jake.

4.22 The review has not seen any further information regarding agency involvement with Jake and therefore cannot comment further on actions to address his behaviour as a perpetrator of domestic abuse.

4.23 KL3: Did any agency know that Susan and/or Jake were experiencing difficulties in relation to drugs, alcohol, mental health, or other vulnerabilities/risk factors (this might include being vulnerably accommodated/homelessness, issues around mental capacity (executive capacity), self-neglect or self-harm?

Drugs/Alcohol

4.24 Susan disclosed that she was ‘addicted’ to prescribed drugs and sought treatment for dependency whilst she was living in Scotland. She also disclosed that she had used drugs and alcohol as a coping mechanism in her relationship with Jake. She was referred to the local drug service, however, her engagement with the service was impacted due to the imposition of lockdown in March 2020, followed by her move to Salford in April 2020.

4.25 It appears from agency records relating to Susan that several agencies in Scotland were aware that Jake used drugs and alcohol and that he also experienced mental health problems. (N.B. the review has not viewed records regarding Jake’s contact with services but has seen reference to Susan’s descriptions of Jake using drugs and experiencing mental health issues).

Mental Health/Self-Harm/Suicidality

4.26 Susan had a long history of mental health issues which she told professionals had stemmed from adverse childhood experiences (ACEs), including abuse by a family member (which was not disclosed fully to any agency until May 2020 whilst Susan was an inpatient).

4.27 Susan experienced periods of extreme low mood and anxiety and had attempted to end her life on three known occasions prior to the fatal incident. Susan also told mental health practitioners in Scotland (and later in Salford) that she had self-harmed on numerous occasions that were unknown to agencies.

4.28 Susan's engagement with mental health services in Scotland was sporadic and inconsistent. Mental health services in Scotland made efforts to engage Susan and continued to offer their services despite Susan's difficulty in engaging with them, however there is no indication that the underlying reasons for Susan's inability to sustain contact and thereby benefit from the service were ever fully explored.

4.29 The Maternity Mental Health Liaison service in Scotland played a key role in linking Susan into mental health services and showed tenacity in reviewing and re-referring Susan.

4.30 On moving to Salford Susan contacted GP5 to request prescribing of medication for anxiety and depression. GP5 responded quickly and liaised effectively with GP4 in Scotland to ensure Susan received appropriate and timely medication. GP5 also offered Susan an 'open door' to discuss mental health issues and domestic abuse, which was good practice.

4.31 Susan's presentation at AED in Salford in June 2020 after taking an intentional overdose was met with excellent practice. Susan quickly received a mental health assessment by a GMMH practitioner, following which she was referred to specialist services and was immediately admitted as a voluntary patient to a mental health unit where she remained for nine days.

4.32 GMMH made immediate contact with services in Scotland to understand Susan's history. They also liaised effectively with SRFT and with SCS in relation to Susan's ongoing care, safeguarding of the children and plans for discharge and management in the community.

4.33 Susan reported that she had found the move from Scotland destabilising to her mental health, reporting flashbacks[9] of incidents of sexual abuse in the Salford area when she was a child. Susan discussed these thoughts whilst she was an

[9] The relationship between self-harm and post-traumatic stress disorder is well documented with flashbacks being recognised as a significant factor in PTSD. https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/effects-of-trauma/
https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd-and-complex-ptsd/symptoms/#WhatAreFlashbacks

inpatient and felt supported to make a disclosure of historic sexual abuse to Greater Manchester Police.

4.34 Whilst Susan appears to have settled well into the inpatient facility, she was aware that her family were struggling to look after the children and that children's services were concerned about the safety of the children. Due to these pressures Susan asked to be discharged. A robust discharge plan was put in place that involved support from SCS and the Home Based Treatment Team (HBTT).

4.35 After Susan's discharge, mental health services and children's services had frequent contact with Susan and discussed Susan's ongoing thoughts of self-harm. HBTT conducted on-going assessment of risk with Susan and information was shared with Children's Services.

4.36 However, there is no indication that any service she had contact with recognised the potential link between Susan's self-harm and her experience of domestic abuse. Services did not recognise the potential for post-separation abuse from Jake and appear to have assumed that being separated from Jake made Susan 'safe'.

4.37 Services in Salford missed an opportunity to put in place a Section 9 Assessment[10] - A Section 9 assessment is the first formal interaction between the Local Authority and a potential service user and 'sets the trigger' for assessment, (for which Susan would have been eligible). This would have enabled Susan's complex care and support needs to have been assessed by Adult Social Care.

Accommodation

4.38 Susan was vulnerably accommodated following separation from Jake in February/March 2020. She had declared herself homeless and was seeking permanent accommodation, however she then moved into the women's refuge and subsequently decided to move from Scotland to Salford. There appears to have been good liaison between housing services and the women's refuge in Scotland.

4.39 When Susan moved to Salford she stayed with family members, briefly spending time in another borough, then moving back to her father's address. SSP acted as an advocate for Susan and helped her with completion of an application for housing which was good practice.

4.40 Susan's application for a tenancy with the housing provider was processed quickly, she was offered appropriate accommodation to meet her needs and was supported to move into a property with her children in June 2020.

4.41 KL4: Did any agency know of other factors, including adverse childhood experiences (ACEs) in relation to Susan or Jake that may have increased their risks and vulnerabilities.

[10] https://adults.ccinform.co.uk/legislation/care-act-2014/section-9-assessment-adults-needs-care-support/

4.42 Some of the agencies with whom Susan was in contact were aware that she had been subject to adverse childhood experiences.

4.43 Susan had her first child when she was a teenager, and it appears that she experienced mental health difficulties from a young age.

4.44 Whilst Susan was in contact with many agencies in both Scotland and Salford as an adult, none of those agencies took the opportunity to refer Susan for assessment as an adult with care and support needs and at risk of harm. Opportunities to use statutory referral processes (e.g. Section 42 and Section 9 of the Mental Health Act) were missed, as were opportunities to refer Susan as an Adult at Risk of Harm under the Adult Support and Protection (Scotland) Act 2007.

4.45 Such a referral may have presented an opportunity for Susan's complex needs to be assessed and might have strengthened a multi-agency approach to supporting Susan. It might also have brought a 'think family' dimension to working with Susan and her children.

Adverse Childhood Experiences

4.46 Susan told professionals in Scotland and Salford about adverse childhood experiences that impacted her adult life, particularly her mental health, however Susan did not make a full disclosure regarding incidents of historic familial sexual abuse until she was an inpatient at the mental health facility in Salford.

4.47 Susan was supported in making a disclosure of historic abuse and was enabled to contact Greater Manchester Police who immediately opened an investigation into the allegations. The GMP investigation, which was ongoing at the time of Susan's tragic death, was an example of good practice with contact being made with all relevant agencies to ensure that Susan was supported throughout the investigation.

4.48 Mental Health Services in Salford, both inpatient and home-based continued to enable Susan to discuss her adverse childhood experiences and provided opportunities for Susan to talk about her previous trauma and how this continued to impact her daily life.

4.49 However, the review found that services could strengthen practice in relation to understanding and responding to trauma[i11] where it is linked to domestic abuse in the form of coercive and controlling behaviour and to self-harm and suicidality.

4.50 KL5: Did Susan and/or Jake disclose domestic abuse to family and/or friends, if so, what action did they take? Was anyone in the local community aware of domestic abuse, if so, what actions did they take and what was the outcome?

4.51 At the time of writing Susan's family have not participated in the review other than to request a copy of the report prior to submission to Home Office.

---

11 https://www.riseuk.org.uk/get-help/about-domestic-abuse/the-affects-of-trauma

4.52 For most of the period under review Susan was resident in Scotland. The review has not requested or received any information from local community members in Scotland.

4.53 KL6: Did any agency undertake risk assessments or other actions in relation to safeguarding the children of Susan and Jake. What were these actions, who was involved and what were the outcomes?

4.54 Susan and Jake's children were known to CSS whilst they were living in Scotland and all four children had previously been placed with foster carers.

4.55 Prior to Susan moving to Salford (and whilst she was residing in a women's refuge with two of her children) the other two children had been subject to voluntary accommodation (Section 25) which had been agreed to by Susan and by Jake. Susan revoked consent for voluntary accommodation in April 2020 following which Susan moved to Salford with her four children.

4.56 PSS expressed their concern that CSS had agreed to revocation without further safeguarding processes taking place as they believed the children continued to be at risk of significant harm. The CSS response to these concerns was that they had reviewed the circumstances and judged that there was no further action that could be taken.

4.57 When she moved to Salford, Susan's children were not subject to any child protection procedures. There was a delay in the transfer of information being shared by CSS to SCS due to a lack of clarity about where Susan was living. CSS recorded that they had contacted SCS, however it appears that information was shared with the incorrect authority.

4.58 CSS then contacted SCS requesting a welfare check. This was undertaken, but as the family were not subject to child protection planning in Scotland, no further action was necessary at that time.

4.59 SCS proactively sought further information from CSS which was good practice. Following receipt of information SCS conducted a children and family assessment, and the children became 'open' to the service. Social workers continued assessment as they worked with the family throughout May and June. SCS made arrangements for the children to be looked after by their grandparents whilst Susan was in the inpatient mental health facility which was good practice, particularly given their experience of recent separation and potentially having experienced domestic abuse themselves.

4.60 The pressures on Susan's family in looking after four young children was sensitively managed by SCS and the social worker had considerable contact with the whole family to support them at this difficult time. When Susan decided she needed to take discharge from the inpatient facility an intensive family support plan was put in place which included daily contact with a social worker, access to a family support worker and school and nursery placements.

4.61 In July, following ongoing concerns regarding the safety of the children, a strategy meeting decided that the children should be subject to Initial Child Protection Case Conference. Susan remained in contact with the social worker throughout this time and said that she understood the reasons for the action taken by SCS.

4.62 Susan had expressed her fear of 'losing' her children and this was recognised by both SCS and the HBTT and discussed frequently with Susan. Records from both agencies indicate ongoing conversations with Susan regarding the safety of the children and practical offers of support in the form of nursery and school placement and family support work. It was noted by practitioners that despite Susan's fears of losing the children she appeared to be overwhelmed by anxiety and found it difficult to cope with the children, resulting in escalating risk to their wellbeing.

4.63 At this time services and Susan's family continued to provide support for Susan and the children. There was an ongoing Child and Family (C&F) assessment and daily liaison between SCS and HBTT which included dynamic assessment of risk. Ultimately it was decided that Susan's ability to provide stability for the children presented unacceptable levels of risk leading to the decision to remove the children. A longer-term plan was discussed which involved continuing to work with the family with a view to reunification in the future.

4.64 There is no explicit reference in the SCS records regarding the impact of domestic abuse on the children, however it is noted that the older children were experiencing behavioural difficulties which may have been related to experiencing domestic abuse. Given the very short period of involvement with SCS following Susan's discharge work had not yet begun to address the emotional and behavioural impact on the children and would have formed part of ongoing assessment following ICPCC.

4.65 KL7: Were protected characteristics as defined in equalities legislation considered in relation to Susan?

4.66 All agencies reported compliance with relevant legislation.

4.67 KL8: How did agencies work together in this case, was this effective (this should include working across geographic (national) boundaries.

4.68 There are examples of good practice in relation to agencies working together, however, the review found a lack of consistency in multi-agency working across all services and across geographic boundaries.

4.69 MSS were proactive in their approach to working with other agencies, particularly Children's Social Care and Mental Health services which is expected practice. However, it has not been possible to triangulate this with GP records.

4.70 Liaison took place by telephone between WAS and SSP which was good practice in the circumstances pertaining at that time.

4.71 When Susan moved to Salford the first national pandemic lockdown was in place and there is evidence that this impacted cross-boundary transfer and sharing of relevant information between CSS and SCS. This was compounded by Susan having temporarily stayed with a family member in another borough of Greater Manchester and led to confusion about where she was living.

4.72 Transfer of information between GPs (GP4 and GP5) took place by telephone which facilitated Susan receiving medication, however, GP4 had only had one contact with Susan and no other GP records were shared, resulting in a full history being unavailable to the GP.

4.73 HBTT (GMMH) and SCS worked effectively together to safeguard Susan and her children. In the weeks before Susan's tragic death there were numerous contacts between the services. This also extended to contact between the services and Susan's family. It is apparent that both services also kept Susan informed and involved in her treatment and care and decisions taken in relation to safeguarding the children.

4.74 KL9: Did Covid 19 affect working practices in any way, if so, how were these impacts mitigated? Was the impact of Covid 19 on Susan and her family taken into consideration in the way agencies worked with them?

4.75 There is considerable evidence to suggest that the Coronavirus pandemic had a significant impact on services during the period under review, and that this impacted many aspects of the case.

4.76 Susan moved from Scotland to England during the period of UK lockdown that began on 23rd March 2020. By the time she moved to England many services were not providing face-to-face appointments, however it can be seen from the chronology that, although some services were not operating on a face-to-face basis, attempts were made to provide continuity and consistency of service.

Conclusions

4.77 Susan was a mother with vulnerabilities and a long history of mental health difficulties who experienced domestic abuse from her partner. Susan had attempted to take her own life a number of times whilst living in Scotland and later when she moved to Salford. Susan said her mental health difficulties stemmed from adverse childhood experiences, and she often felt overwhelmed and anxious.

4.78 Whilst Susan was living in Scotland, actions taken by agencies to safeguard Susan as a victim of domestic abuse were often inconsistent and uncoordinated. Other than joint work and liaison between CSS and Women's Aid, and Women's Aid and SSP there is no evidence that agencies worked together to assess the impact and risk to Susan as a victim of domestic abuse by Jake nor was the impact of separation taken into consideration.

4.79 Agencies in Salford knew that Susan had been subject to domestic abuse and that she intended to permanently separate from Jake however, there appears to have been a general assumption that Susan was not at ongoing risk from Jake

as he remained in Scotland, and they were no longer living together. It is likely that contact with Jake may have continued because of shared responsibility for the children. There is no indication of agencies considering the potential for post-separation abuse (as defined in the Domestic Violence Act) and the impact that this may have on Susan's wellbeing. [12]

4.80 None of the agencies with whom Susan had contact in Salford undertook a DASH/RIC assessment which would have been good practice. There were also opportunities to refer Susan to a specialist domestic abuse service that were not taken, although the review acknowledges that it was known by agencies that Susan had been in contact with SSP.

4.81 Susan found it difficult to engage with mental health services when she lived in Scotland, however when she moved to Salford her engagement with services improved. Despite this, sadly, Susan continued to experience thoughts of self-harm, anxiety and feeling overwhelmed and unable to cope.

4.82 Susan's move from Scotland to Salford in April 2020 appears to have been motivated by a desire to build a life for herself and her children away from an abusive relationship.

4.83 Susan told professionals that she was afraid of losing her children, indeed they had been removed from her care on two previous occasions whilst living in Scotland. There was evidence of good practice in Salford with agencies supporting Susan to safeguard her children. There was also evidence of the social worker and HBTT worker having an open and honest relationship with Susan regarding statutory safeguarding requirements.

4.84 Alongside risk assessment of Susan's fluctuating mental health, there was ongoing assessment of the safeguarding needs of the children which was good practice. Susan was involved in discussions regarding the safety of the children and was kept informed of statutory measures to safeguard them, which ultimately resulted in a decision to remove the children from Susan's care. Action to safeguard children is set out in statutory guidance Working Together to Safeguard Children 2023 (previously 2018).[13]

4.85 The review found that historically services did not always respond to Susan's needs in a trauma informed way, nor was there a consistent approach to engaging Susan with understanding of how trauma impacted her day-to-day life.

4.86 Susan engaged well with services in Salford and appears to have responded positively to the ongoing support she received from SCS and inpatient and community mental health services.

---

[12] The Domestic Abuse Act 2021 identifies post separation abuse as a significant ongoing risk factor for victims.

[13] https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

4.87 Despite a high level of support and engagement with services in Salford, Susan's mental health did not appear to stabilise.

4.88 The review found that in the weeks prior to her tragic death, responses to Susan's ongoing distress were timely and well-co-ordinated, and agencies kept in frequent contact with each other to support Susan through her anxiety and thoughts of self-harm. Agencies appropriately shared information regarding Susan's risk of self-harm and worked with her to try to minimise risk.

4.89 It was not however evident that the links between domestic abuse and suicidality were made sufficiently strongly nor was there evidence that understanding of those links was embedded in practice, nor was there sufficient evidence of an understanding that Susan's separation from Jake may have increased her vulnerability to coercive and controlling behaviour and self-harm.

N.B. The review notes the links between suicidality and domestic abuse. Research by University of Warwick (2018) supports existing research in suggesting a significant association between experiencing domestic abuse and suffering negative psychological effects. It highlights the importance of professionals that engage with domestically abused clients being more aware of and responsive to their risk of suicidality. The research concluded '*Domestic abuse is still too often seen as an issue of violence alone. Yet many women in our refuges tell us that the emotional abuse, resulting trauma and mental health implications stay with them for far longer. Research in this area is limited, but the figures that do exist are harrowing. Focusing on more than 3,500 women supported by domestic abuse charity Refuge, uncovered that almost a quarter (24%) of women supported by the charity had felt suicidal at one time or another. A staggering 83% reported feelings of hopelessness and despair, key symptoms of suicidal ideation. The research also found that nearly a fifth (18%) of participants had actively planned to take their own lives, while data from charity SafeLives indicated a similar number (17%) had planned or attempted suicide. Data from research by Professor Sylvia Walby, whose research estimates that approximately one in eight of all female suicides and suicide attempts in the UK are due to domestic violence and abuse. This equates to 200 women taking their own lives and 10,000 attempting to do so due to domestic abuse every year in the UK. That's nearly 30 women attempting to complete suicide every single day.* [14]

4.90 Susan was never assessed as an adult with care and support needs which was a missed opportunity both in Scotland and in Salford. The review has established that Susan met the criteria for assessment under Section 9 of the Care Act (2014) Susan also met the criteria for Section 42 assessment under the Care Act (2014).

4.91 There is no evidence at any point in Susan's contact with services in Scotland or in Salford, of a multi-disciplinary team meeting (MDT) taking place to assess Susan's multiple complex needs ever having taken place. N.B. In Scotland this could have been done under the auspices of an Adult Support and Protection

[14] https://www.hestia.org/blog/domestic-abuse-suicide

Case Conference resulting in a Personal Protection Plan for Susan had a referral been made.

4.92 Regarding multi-agency working with the specialist domestic abuse agencies, specifically in Salford there appears to be a lack of understanding of the role and scope of services provided by SSP. It would have been good practice for agencies to question and challenge whether the project was sufficiently equipped or resourced to provide the level of specialist support needed by Susan.

4.93 Regardless that Susan was receiving support from SSP, it would have been good practice for agencies to ask Susan whether she wanted to be referred to any other specialist domestic abuse service.

4.94 The review highlights significant issues in relation to the transfer of information from agency to agency across national boundaries. The lack of robust information sharing, and transfer procedures may have been exacerbated by the Covid 19 pandemic, however, the review is not confident that there were robust processes and procedures in place (it should be noted that the transfer of cases involving children has now been addressed).

4.95 The review noted the support given to Susan by her family whilst she was living in Salford and their commitment to supporting Susan and her children.

Section 5 Recommendations

5.1 The recommendations set out below relate to agencies in Salford. N.B. The non-statutory recommendations made for agencies in Scotland are set out at Appendix 2 and have been submitted to the Adult Protection Committee (APC) for consideration. The APC has confirmed that it will establish a process to implement the recommendations.

Recommendation 1

5.2 The Chairs of the Salford Community Safety Partnership and Safeguarding Adults Board should formally write to the Home Office setting out the difficulties experienced by this review in relation to different legislative processes pertaining in the two countries.

Recommendation 2

5.3 Salford Safeguarding Adults Board should review and enhance the multi-agency policy and procedures to reflect the importance of Think Family which will enable parents with care and support to be identified under the Care Act safeguarding duties.

Recommendation 3

5.4 Salford Community Safety Partnership should seek assurance from relevant agencies involved in this review that their local policy and procedures are clear and robust to ensure a timely and effective handover of information when an adult moves from one area to another.

Recommendation 4

5.5 (a) Salford Community Safety Partnership should ensure that there is a clear expectation of collaborative working with non-commissioned services.

(b) Salford Community Safety Partnership should ensure that information regarding referral pathways is widely disseminated and understood.

Recommendation 5

5.6 (a) Salford Community Safety Partnership should ensure that services develop and adopt trauma informed approaches to mental health interventions.

(b) Salford Community Safety Partnership should ensure that all services are fully informed about the impact of domestic abuse on mental health and links to self-harm and suicide.

(c) Salford Community Safety Partnership should ensure that practitioners know about post-separation abuse and recognise it as a risk factor for victims who have separated from perpetrators and that this is reflected in practice.

(d) The GM Suicide Prevention Strategy training programme should continue to be implemented and evaluated.

Recommendation 6

5.7 Salford Community Safety Partnership should seek assurance from the Salford Safeguarding Children Partnership that all learning from the Children's Safeguarding case review has been acted on.

Appendix 1 - Glossary of Acronyms/Agencies

Due to the large number of agencies involved in the review, and in delivering services to Susan, it was agreed that an appendix of acronyms would be helpful, as below.

1. Salford

AED – Accident and Emergency Department (at SRFT)

GMP – Greater Manchester Police

GMMH – Greater Manchester Mental Health

GP5 – Salford CCG GP

HBTT – Home Based Treatment Team

NWAS – Northwest Ambulance Service

SCS – Salford Children's Services

SCSP – Salford Community Safety Partnership

SH – Salix Homes

SHOP – Salford Housing Options

SPS – Salford Primary School

SRFT – Salford Royal Foundation Trust (part of the Northern Care Alliance)

SSAB – Salford Safeguarding Adults Board

SSCP – Salford Safeguarding Children Partnership

SSP – Salford Survivor's Project

2. Scotland

APC – Adult Protection Committee

CSS – Children's Services in Scotland

CMHT – Community Mental Health Team

DASS – Drug and Alcohol Service in Scotland

ED – Hospital Emergency Department in Scotland

GP1, GP2, GP3, GP4 - General Practitioners in Scotland

HSCP – local Health and Social Care Partnership

HSS – Housing Services in Scotland

MHSS – Mental Health Services in Scotland

MSS – Maternity Services in Scotland

PCMHT – Psychiatric Community Mental Health Team

PMHT – Primary Mental Health team

Police – Police Scotland

PSS – Primary School in Scotland

WAS – Women's Aid in Scotland

Appendix 2 – Recommendations to the Adult Protection Committee Scotland

Recommendation 1

The Health and Social Care Partnership in Scotland should seek to review policies and practice in relation to referring to adult services.

Recommendation 2

The Health and Social Care Partnership, together with Information Governance and NHS agencies in Scotland should urgently review their processes and procedures to ensure that case transfer and information sharing across all agency's procedures are fit for purpose. This should include the transfer of all relevant current and historical information and should ensure that differences in policy, practice and terminology are understood when transferring cases.

Recommendation 3

(a) The Adult Protection Committee in Scotland should oversee the development and facilitation of a series of Learning Reviews to be delivered to a wide range of staff across the Health and Social Care Partnership and the NHS.

(b) Children's Services in Scotland should review their practice in relation to transfer of cases across national boundaries.

Recommendation 4

(a) The Health and Social Care Partnership Scotland should take action to ensure that disclosures of domestic abuse are recorded, responded to, and acted upon (i.e. enabling the victim an opportunity for safety assessment and follow up, including referral to specialist services).

(b) The Health and Social Care Partnership in Scotland should ensure that practitioners know about post-separation abuse and recognise it as a risk factor for victims who have separated from perpetrators.

Recommendation 5

(a) NHS agencies and Health and Social Care Partnership in Scotland should ensure that services develop and adopt trauma informed approaches to mental health interventions.

(b) Health and Social Care Partnership in Scotland should ensure that mental health services are fully informed about the impact of domestic abuse on mental health and links to self-harm and suicide.

Salford Community Safety Partnership/Salford Safeguarding Adults Board

Domestic Homicide Review (DHR)/Safeguarding Adults Review (SAR) in the Case of Susan (pseudonym) who died in July 2020

Executive Summary

April 2024

Independent Chair/Author: Maureen Noble

CONTENTS

Section 1: Overview/Review Process

1.1 This review is about Susan, a resident of Salford, who tragically died in July 2020. Susan was 26 years of age. The review panel offer condolences to Susan's family on their tragic loss.

1.2 Susan had lived in Salford for around ten weeks at the time of her death, having recently moved from Scotland where she had lived with her partner Jake since she was around 17 years of age.

1.3 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers.

1.4 Pseudonyms have been used in this Executive Summary to protect the identity of the people involved: NB Although Susan's family have not participated in the review at the time of writing pseudonyms have been confirmed with them both in writing and at the inquest.

1.5 Key People

Susan (Deceased), Ethnicity: White, Age 26

Jake (partner of Susan)

Susan and Jakes Children (referred to as Child 1, Child 2, Child 3 and Child 4)

1.6 On the date of Susan's death Greater Manchester Police were called to an address in Salford following a request for assistance by North-West Ambulance Services (NWAS) in relation to a 26-year-old female who had called for an ambulance, reporting that she had taken an overdose. Paramedics and two police constables were in attendance. Susan began to 'fit' and was transported by emergency ambulance to Salford Royal Hospital (SRFT). A short time after arrival at hospital Susan sadly died.

1.7 It was determined by police that there were no suspicious circumstances in relation to Susan's death and therefore no criminal investigation has taken place.

1.8 An inquest into Susan's death was held in June 2021 at which the coroner found that Susan had died of a self-administered drug overdose and that she had taken her own life.

1.9 This joint DHR/SAR was commissioned by the Salford Community Safety Partnership and the Salford Safeguarding Adults Board. The process began on 18th December 2020 when the CSP and SAB decided to conduct a joint DHR/SAR.

1.10 The period under review is April 2020 (when Susan moved from Scotland to Salford) to the date of Susan's death. NB Information on Susan's contact with services in Scotland is included as the panel agreed this contains important background and context.

1.11 All agencies that potentially had contact with Susan prior to the point of death were contacted and asked to confirm whether they were involved with her.

1.12 Following initial scoping for the review the following agencies were identified as having had contact with Susan and were asked to secure their records. Individual Management Reviews (IMRS) and short reports were received as set out below.

Agency/Abbreviation	Report Requested/Received	Single Agency Action Plan Yes/No
Police Scotland (Police)	IMR	No
Children's Services in Scotland (CSS)	IMR	No
Emergency Department in Scotland (EDS)	Short report and conversation with Chair	No
Drug and Alcohol Service in Scotland (DASS)	Short Report	No
GP 1 GP2 GP3 GP4	Brief Information received via questionnaire. Printout of Medical records received. Printout of Medical records received. Brief information received	No No No No
Housing Service in Scotland (HSS)	Short Report	
Maternity Services in Scotland (MSS)	Short Report	No
Mental Health Services in Scotland (MHSS)	Short Report and conversation with the Chair	No
Primary School in Scotland (PSS)	Meeting with Chair	No
Women's Aid in Scotland (WAS)	IMR	Yes
Greater Manchester Mental Health (GMMH)	IMR	Yes

Greater Manchester Police (GMP)	Short Report	Yes
Salix Homes (SH)	Short Report	No
Salford CCG (GP5)	IMR	Yes
Salford Children's Services (SCS)	IMR	No
Salford Housing Options (SHOP)	Short report	No
Salford Royal Foundation Trust (SRFT) Northern Care Alliance	IMR	Yes
Salford Primary School (SPS)	Meeting with Chair	No
Salford Survivor's Project (SSP)	IMR	Yes

1.13 In addition to receiving written agency reports the Chair held 'Teams' meetings with the Head Teacher from the primary school in Scotland (PSS) and with the Head Teacher of the primary school in Salford (SPS).

1.14 There were no conflicts or declarations of interest recorded during the review. Authors of Individual Management Reports and short reports were not directly connected to Susan.

1.15 The review panel membership is set out below:

Name	Agency/Job Role
Maureen Noble	Independent Chair and Author
Brenda Walker	Senior Officer, Adult Support and Protection, Adult Protection Committee (Scotland)
Alison Troisi	Detective Sergeant, Greater Manchester Police (GMP)
Elizabeth Walton	Assistant Director Safeguarding and Quality/ Designated Nurse Safeguarding Adults Salford CCG
Rebecca Marchmont	Named GP for Adult Safeguarding Salford CCG

Vicky O'Neill	Deputy Designated Nurse for Safeguarding Adults Salford CCG
Joanne Glynn	Safeguarding Adult Lead, Greater Manchester Mental Health (GMMH)
Dawn Redshaw	Chief Officer, Salford Women's Aid (Independent DA Advisor to the panel)
Elizabeth Stewart	Children and Families Senior Manager, Children's Services Scotland (CSS) Health and Social Care Partnership (Scotland)
Gail Winder	Assistant Director of Nursing, Safeguarding Adults, Northern Care Alliance
Eileen Conneely	Principal Manager Safeguarding, Salford Adult Care Services (ASC)
Jane Bowmer	Board Manager, Salford Safeguarding Adults Board (SAB)
Jane Anderson	Head of Housing Advice and Support, Salford Housing Options Service (SHOP)
Alison Maxwell	Head of Safeguarding, Salford Children's Services (SCS)
Helen Byrne	Tenancy Sustainment and Partnership Development Manager, Salix Homes (SH)
Roselyn Baker	Principal Policy Officer, Salford City Council (CSP Lead)

1.16 The panel met on seven (7) occasions. No panel member had had direct contact with Susan and all were senior representatives of their agency. Specialist advice was provided by a representative from a specialist domestic abuse agency. The local suicide prevention co-ordinator provided advice to the panel.

1.17 The Community Safety Partnership/Safeguarding Adults Board appointed Maureen Noble as independent Chair and Author to oversee and direct the Review, and to write the overview report.

1.18 The Chair has worked as an Independent Consultant specialising in safeguarding and domestic abuse for 11 years and has undertaken numerous Child and Adult Safeguarding reviews and Domestic Homicide Reviews. She has undertaken pro-bono work with NICE and SCIE in relation to domestic abuse.

1.19 She was previously employed by Manchester City Council as Head of Crime and Disorder. She left Manchester City Council in 2012.

1.20 During the course of the review the Chair was employed as Independent Chair for the Trafford Strategic Safeguarding Partnership. She left this role in March 2023.

1.21 Throughout the review process the Chair was independent of all agencies and individuals involved in the review and the CSP and SAB were satisfied that there were no conflicts of interest.

1.22 The first meeting of the review panel took place in February 2021.

1.23 A progress report was provided to HM Coroner on 10th June 2021.

1.24 The final panel meeting was held in December 2021 and final report approved by the CSP, SAB in Salford in April 2022 and the Adult Protection Committee in Scotland in May 2022. NB: A final draft report was submitted to the Home Office Quality Assurance panel in December 2022. In October 2023 feedback was received requesting amendments to the report. The review panel was re-convened and met on 11th December 2023. The revised report was approved by the panel and CSP and sent to the Home Office on 12th January 2024.

1.25 Delays were experienced in conducting the review due to the Covid 19 pandemic impact on services. The Home Office was notified of these delays at the time.

1.26 The following terms of reference were agreed:

1. To establish what contact agencies had with Susan; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard Susan and risk assess the perpetrator.
3. To establish whether Susan's family and/or significant others knew about domestic abuse and whether they sought or received help.
4. To establish whether there were other risk factors present in the lives of Susan and the perpetrator (e.g. mental health issues, substance misuse, adverse childhood experiences).
5. To establish whether other safeguarding issues (including safeguarding children and/or adults at risk were appropriately identified and acted upon.
6. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
7. To establish what lessons can be learned about the way in which professionals and organisations carried out their duties and responsibilities.
8. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.
9. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
10. To consider specific issues relating to diversity.

1.27 The panel considered the nine characteristics set out in the Equality and Diversity Act 2010[15].

1.28 The panel noted Susan's female sex as a protected characteristic. The panel noted that females are statistically more likely to experience domestic abuse than males.[16]

1.29 Further the panel noted that the ONS reports that crimes recorded by the police show the following trends: In the year ending March 2023, the victim was female in 73.5% of domestic abuse-related crimes. Between the year ending March 2020 and the year ending March 2022, 67.3% of victims of domestic homicide were female compared with 12.1% of victims of non-domestic homicide.

1.30 The panel noted Susan's ethnicity as white. The ONS report for the year ending March 2023, the Crime Survey for England and Wales (CSEW) showed that a significantly higher proportion of people aged 16 years and over in the Mixed and White ethnic groups experienced domestic abuse in the last year compared with those in the Asian or Asian British groups (Figure 6). Almost twice as many women in the White ethnic group experienced domestic abuse in the last year (6.0%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3.0%).

1.31 Susan had been treated over many years for anxiety and depression in both primary and secondary care and was diagnosed with recurrent depressive disorder. Susan's experience of domestic abuse may have impacted her mental health.

[15] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity#our-duties-under-the-equality-act-2010

[16] The ONS (Office for National Statistics, November 2023) reports an estimated 1.4 million women (and 751,000 men) aged 16 years and over experienced domestic abuse in the last year: a prevalence rate of approximately 5.7% of women and 3.2% of men.

Section 2: Background Information/Abridged Chronology

2.1 Susan spent her childhood living in Salford. Susan was care experienced. She met Jake whilst she was living in a Children's Home in Salford. **(**N.B. the review has not accessed records relating to Susan as a child).

2.2 Susan and Jake moved to Scotland when they were both around seventeen years of age. They settled there and had four children.

2.3 As an adult Susan had many contacts with agencies in Scotland and in Salford. This Executive Summary contains an abridged chronology of Susan's contact with services in Salford. Further information regarding Susan's contacts in Scotland can be found in the full overview report.

Events from 18th April 2020 to July 2020

2.4 On 18th April Susan contacted the Salford Survivor Project (SSP) via their Face-book page. Susan was aware of the service through a family member who volunteered with them. She asked for advice and support and told the service that she was fleeing domestic abuse by her partner and wanted to move to Salford.

2.5 On 27th April 2020 Susan moved to England from Scotland. NB: She spent a short (undetermined) time living with a family member in a neighbouring borough of Greater Manchester, and then moved to stay with her father and stepmother in Salford. Susan then applied for a tenancy in Salford.

2.6 On that day SCP made a referral to Salford Children's Services (SCS) regarding the family relocating to the area and requested that a welfare visit be undertaken. It is unclear from the records held by SCS what level of detail about the family was included in the referral.

2.7 SCS first became aware of the family on 1st May when they were referred for a welfare check by CSS. The referral was to check whether Susan knew how to access services and to ascertain the children's views, however there was no response from Susan or the referrer.

2.8 On 3rd May the Headteacher from the primary school in Scotland emailed written comments to the social worker in Scotland expressing 'disbelief' that the children had been returned to Susan without an emergency child protection conference having taken place. The Headteacher said they believed there were ongoing risks to the children that had not been addressed and it was their view that the children were at imminent risk of significant harm.

2.9 On 5th May GP5 received a request for medication from Susan. The GP noted that Susan was a newly registered patient fleeing domestic abuse in Scotland and that she wanted medication urgently. GP5 noted that Susan had only just registered with the practice. GP5 then contacted GP4 in Scotland to confirm her medication. GP4 confirmed that Susan had been registered with them and confirmed her medication.

2.10 On 7th May GP5 had a telephone encounter with Susan. Susan confirmed that she was fleeing domestic abuse in Scotland.

2.11 On 28th May the housing provider in Salford contacted Susan to offer her accommodation.

2.12 On 10th June Susan collected keys for a property and took up the tenancy on 15th June. She said that she was happy with the property and pleased to have her own home.

2.13 On 21st June Susan presented to the Accident and Emergency Department (AED) at the local hospital reporting she had taken an intentional overdose of prescribed medication and was feeling suicidal. Susan was noted to be 'a high risk' adult and admitted to the ward with additional observation. Members of Susan's family attended to support her.

2.14 Whilst at AED Susan was seen by a GMMH mental health practitioner. Susan disclosed previous domestic abuse by Jake. She also disclosed she had been abused in childhood by a family member.

2.15 A child safeguarding referral was made by GMMH noting that Susan had said she found it difficult to care for the children due to mental health issues. An adult safeguarding referral (SG1) was also made however the review could find no record that this was received by the Safeguarding Nurse.

2.16 On 23rd June GMMH conducted a full mental health assessment during which Susan talked about historic sexual abuse, domestic abuse by Jake and a history of self-harm (attempts at taking her own life). Susan said she had attempted to leave Jake in the past but felt she had needed him. She was asked and said she did not currently have any contact with him.

2.17 That same day Susan was admitted to Salford Inpatient Services as a voluntary patient. SCS were informed of Susan's admission and the social worker planned for the four children to reside with Susan's father and stepmother.

2.18 On 25th June, following a conversation with a support worker on the ward regarding historic sexual abuse, Susan contacted police via a 999 call and made a report of historic abuse. Police opened an investigation into the allegations and allocated this to an officer in the police division where Susan had lived at the time of the alleged offences.

2.19 That same day the social worker contacted family support to arrange for a support worker. Susan's father spoke to the social worker saying that he and Susan's stepmother were struggling to cope with the children.

2.20 On 27th June Susan spent time away from the ward and went to buy clothes for the children. When she returned, she said she had ten missed calls from Jake.

2.21 On 2nd July Susan informed the ward that she would need to discharge herself to look after the children. Ward staff noted that Susan appeared anxious about discharge but that this was unavoidable due to family pressures regarding the children. The social worker spoke to grandparents and agreed a support plan.

The social worker then spoke to Susan who said she felt happier that a support plan was in place.

2.22 Susan's discharge plan detailed by the social worker included an intensive visiting plan from mental health service, Home Based Treatment team (HBTT), Outreach family support and social worker were in place. HBTT visiting 3 times a week, weekends and daily calls, family support worker visiting every other day and weekend and social worker daily contact virtual/calls and visits. The family were to receive daily visits and childcare/school places were sourced. On discharge Susan was diagnosed with recurrent depressive disorder.

2.23 Later that day Susan presented to AED at SRFT reporting that one of the children had sustained an injury to their tongue whilst at home. Susan presented as 'acutely distressed' and was seen by a mental health nurse. She reported that she had been discharged from the mental health facility earlier that day but did not feel able to cope at home and, since discharge, had been experiencing suicidal thoughts. She said that she felt pressure whilst in the mental health facility, as her parents were looking after her four children and were struggling to cope.

2.24 Susan reported intrusive suicidal thoughts, she stated she had felt 'better' as an inpatient. She said she was making good progress; however, she felt her discharge was premature but unavoidable.

2.25 SRFT arranged for Susan and the children to remain in hospital overnight to safeguard them. Throughout the night SRFT liaised with SCS, police, family and GMMH regarding the safety of Susan and the children. The following day Susan was discharged from SRFT with a plan for involvement from all relevant agencies.

2.26 At this time SCS were in the process of conducting a S17 Children and Families assessment. It was noted that concerns were escalating due to grandparents being unable to care for the children full time and that Susan had been discharged.

2.27 On 5th July Susan received her first home visit from HBTT. It was noted that Susan appeared positive about plans although she reported that she didn't feel current medication was helping with anxiety and suicidal thoughts. She was asked about self-harm and did not report any intention to harm herself. Susan said she was engaging with SCS and with mental health services and intended to continue to do so.

2.28 On 9th July the social worker made a home visit. It was noted that Susan appeared much more 'upbeat'.and said she felt supported. Susan said she was aware of the forthcoming strategy meeting and of the social worker's view that there was a need to progress to Initial Child Protection Case Conference (ICPCC). Susan said she understood this. A weekend visiting plan was put in place and the children were due to start school on 13th July.

2.29 On 10th July the Section 47 enquiries concluded and ICPCC was requested as all those present at the meeting agreed that there were ongoing risks to the children.

2.30 On 12th July Child 1 and Child 2 started school at SPS. Susan brought them to school and collected them. That same day Susan had a home visit from the HBTT. It was noted that Susan's mental state had 'decreased' and the home was messy. Susan said she was becoming concerned about the children's behaviour and said she was struggling to cope with them and that she felt they may need to go into foster care.

2.31 Following the home visit the HBTT worker discussed their concerns with colleagues and an out of hours referral was made to SCS under the category of 'neglect' and 'unsafe home conditions.

2.32 The social worker contacted Susan after the weekend. Susan told the social worker that it had been a hard weekend but that she felt she had panicked when she spoke to the HBTT, and she didn't want the children to go into foster care. She felt she needed more childcare support. The family were still visiting every day and the children had now started school and nursery.

2.33 A day later Susan rang the Emergency Duty Team (EDT) saying that one of the children had bumped their head. EDT rang Susan back and noted that she was calmer. Susan's stepmother came to stay with Susan and the children overnight and stayed until the following day.

2.34 Susan's tragic death occurred shortly after these events.

Section 3 – Learning/Key Issues Arising from the Review

3.1 Susan was a mother with vulnerabilities and a long history of mental health difficulties who experienced domestic abuse from her partner. Susan had attempted to take her own life several times whilst living in Scotland and later when she moved to Salford. Susan said her mental health difficulties stemmed from adverse childhood experiences, and she often felt overwhelmed and anxious.

3.2 Agencies in Salford knew that Susan had been subject to domestic abuse and that she intended to permanently separate from Jake however, there appears to have been a general assumption that Susan was not at ongoing risk from Jake as he remained in Scotland, and they were no longer living together. It is likely that contact with Jake may have continued because of shared responsibility for the children. There is no indication of agencies considering the potential for post-separation abuse (as defined in the Domestic Violence Act) and the impact that this may have on Susan's wellbeing. [17]

3.3 None of the agencies with whom Susan had contact in Salford undertook a DASH/RIC assessment which would have been good practice. There were also opportunities to refer Susan to a specialist domestic abuse service that were not taken, although the review acknowledges that it was known by agencies that Susan had been in contact with SSP.

3.4 Susan found it difficult to engage with mental health services when she lived in Scotland, however when she moved to Salford her engagement with services improved. Despite this sadly Susan continued to experience thoughts of self-harm, anxiety and feeling overwhelmed and unable to cope.

3.5 Susan's move from Scotland to Salford in April 2020 appears to have been motivated by a desire to build a life for herself and her children away from an abusive relationship.

3.6 Susan told professionals that she was afraid of losing her children, indeed they had been removed from her care on two previous occasions whilst living in Scotland. There was evidence of good practice in Salford with agencies supporting Susan to safeguard her children. There was also evidence of the social worker and HBTT worker having an open and honest relationship with Susan regarding statutory safeguarding requirements.

3.7 Alongside risk assessment of Susan's fluctuating mental health, there was ongoing assessment of the safeguarding needs of the children which was good practice. Susan was involved in discussions regarding the safety of the children and was kept informed of statutory measures to safeguard them, which ultimately resulted in a decision to remove the children from Susan's care. Action to

[17] The Domestic Abuse Act 2021 identifies post separation abuse as a significant ongoing risk factor for victims.

safeguard children is set out in statutory guidance Working Together to Safeguard Children 2023 (previously 2018).[18]

3.8 The review found that historically services did not always respond to Susan's needs in a trauma informed way, nor was there a consistent approach to engaging Susan with understanding of how trauma impacted her day-to-day life.

3.9 Susan engaged well with services in Salford and appears to have responded positively to the ongoing support she received from SCS and inpatient and community mental health services.

3.10 Despite a high level of support and engagement with services in Salford, Susan's mental health did not appear to stabilise.

3.11 The review found that in the weeks prior to her tragic death, responses to Susan's ongoing distress were timely and well-co-ordinated, and agencies kept in frequent contact with each other to support Susan through her anxiety and thoughts of self-harm. Agencies appropriately shared information regarding Susan's risk of self-harm and worked with her to try to minimise risk.

3.12 It was not however evident that the links between domestic abuse and suicidality were made sufficiently strongly nor was there evidence that understanding of those links was embedded in practice, nor was there sufficient evidence of an understanding that Susan's separation from Jake may have increased her vulnerability to coercive and controlling behaviour and self-harm.

3.13 Susan was never assessed as an adult with care and support needs which was a missed opportunity both in Scotland and in Salford. The review has established that Susan met the criteria for assessment under Section 9 of the Care Act (2014) Susan also met the criteria for Section 42 assessment under the Care Act (2014).

3.14 There is no evidence at any point in Susan's contact with services in Scotland or in Salford, of a multi-disciplinary team meeting (MDT) taking place to assess Susan's multiple complex needs ever having taken place. N.B.: In Scotland this could have been done under the auspices of an Adult Support and Protection Case Conference resulting in a Personal Protection Plan for Susan had a referral been made.

3.15 Regarding multi-agency working with the specialist domestic abuse agencies, specifically in Salford there appears to be a lack of understanding of the role and scope of services provided by SSP. It would have been good practice for agencies to question and challenge whether the project was sufficiently equipped or resourced to provide the level of specialist support needed by Susan.

18

https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf

3.16 Regardless that Susan was receiving support from SSP, it would have been good practice for agencies to ask Susan whether she wanted to be referred to any other specialist domestic abuse service.

3.17 The review highlights significant issues in relation to the transfer of information from agency to agency across national boundaries. The lack of robust information sharing, and transfer procedures may have been exacerbated by the Covid 19 pandemic, however, the review is not confident that there were robust processes and procedures in place (it should be noted that the transfer of cases involving children has now been addressed).

3.18 The review noted the support given to Susan by her family whilst she was living in Salford and their commitment to supporting Susan and her children.

Section 4 - Recommendations from the review

4.1 The recommendations set out below relate to agencies in Salford. NB: The non-statutory recommendations made for agencies in Scotland are set out at Appendix 4 and have been submitted to the Adult Protection Committee (APC) for consideration. The APC has confirmed that it will establish a process to implement the recommendations.

Recommendation 1

4.2 The Chairs of the Salford Community Safety Partnership and Safeguarding Adults Board should formally write to the Home Office setting out the difficulties experienced by this review in relation to different legislative processes pertaining in the two countries.

Recommendation 2

4.3 Salford Safeguarding Adults Board should review and enhance the multi-agency policy and procedures to reflect the importance of Think Family which will enable parents with care and support to be identified under the Care Act safeguarding duties.

Recommendation 3

4.4 Salford Community Safety Partnership should seek assurance from relevant agencies involved in this review that their local policy and procedures are clear and robust to ensure a timely and effective handover of information when an adult moves from one area to another.

Recommendation 4

4.5 (a) Salford Community Safety Partnership should ensure that there is a clear expectation of collaborative working with non-commissioned services.

(b) Salford Community Safety Partnership should ensure that information regarding referral pathways is widely disseminated and understood.

Recommendation 5

4.6 (a) Salford Community Safety Partnership should ensure that services develop and adopt trauma informed approaches to mental health interventions.

(b) Salford Community Safety Partnership should ensure that all services are fully informed about the impact of domestic abuse on mental health and links to self-harm and suicide.

(c) Salford Community Safety Partnership should ensure that practitioners know about post-separation abuse and recognise it as a risk factor for victims who have separated from perpetrators and that this is reflected in practice.

(d) The GM Suicide Prevention Strategy training programme should continue to be implemented and evaluated.

Recommendation 6

4.7 Salford Community Safety Partnership should seek assurance from the Salford Safeguarding Children Partnership that all learning from the Children's Safeguarding case review has been acted on.

SALFORD COMMUNITY SAFETY PARTNERSHIP AND SALFORD ADULT SAFEGUARDING BOARD – MULTI AGENCY ACTION PLAN

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
1. The Chairs of the Salford Community Safety Partnership and Safeguarding Adults Board should formally write to the Home Office setting out the difficulties experienced by this review in relation to different legislative processes pertaining in the two countries.	Regional/ National	Highlight to the Home Office the challenges this review experienced due to the different legislative frameworks pertaining to the two countries.	CSP	Salford CSP reported issues to Home Office on submission of report. Home Office acknowledged the issues raised in their feedback.	Completed October 2023 Feedback received from Home Office.
2. Salford Safeguarding Adults Board should review and enhance the multi-	Local	SSAB to enhance the resources regarding Think Family to ensure that, across the	SSAB	Practitioners aware of and using Think Family practises.	Completed October 2022. GMMH and Children Services have addressed Think Family through their single agency action plans.

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
agency policy and procedures to reflect the importance of Think Family which will enable parents with care and support to be identified under the Care Act safeguarding duties.		partnership, adults who have care and support needs are recognised to have rights under the Care Act 2014.		Benefits to adults through improved systems and process for assessing and referring to services with the aim of leading to improved outcomes.	SSAB has developed Think Family Guidance and enhanced the webpage resource Think Family | Salford Safeguarding Adults Board. To strengthen the accessibility of the multi-agency safeguarding policy and procedures, SSAB has commissioned an external organisation, Tri-X to provide the multi-agency safeguarding policy and procedures for the next 3 years. The new policy and procedures went live in October 2022. Three online events held to update partners on the contents of the new policy and procedures, how to put them into practice. Ongoing work to seek assurance that partners are aware of the revised policies, have cascaded them and aligned them to their single agency policies and procedures: - Ensure key messages are cascaded across the partnership regarding Care Act duties.

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
					- Promote and cascade the multi-agency escalation policy and procedure across the partnership to ensure escalation routes are known and used.
3. Salford Community Safety Partnership should seek assurance from relevant agencies involved in this review that their local policy and procedures are clear and robust to ensure a timely and effective handover of information when an adult moves from one area to another.	Local/ National	Salford CSP to request assurance from relevant agencies involved in this review that their policy and practice in relation to cross border transfers is up to date and takes into account the learning from this review. Salford CSP and SSAB will ask Children's Services to review policies	Local Authority	Salford Children's Services to demonstrate case transfer policy is robust.	Completed March 2021. Children's Services completed a review in 2021 and one of the recommendations was to review and update the Northwest cross border procedures. This work was led by the Head of Safeguarding and Quality Assurance in liaison with regional and national peers. The revised procedures were updated in 2021 and publicised on the SSCP and GM websites (see 4.14 Children Crossing Local Authority Boundaries). The involved Local Authority in Scotland also updated their own cross border policy to align with the revised NW procedures [documentary evidence is available]. The Children and Family Service in North Ayrshire have developed a Case Transfer Protocol and it is the

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
		and practice in relation to transfer of cases in light of learning from this case and update accordingly.			intention of the Adult Protection Committee to look at this (in addition to the Social Work Scotland 'ASP Cross Boundary Cases – Good Practice Principles' National Guidance Document) and develop a Protocol for North Ayrshire Adult Services Case Transfers.
4. (a) Salford Community Safety Partnership should ensure that there is a clear expectation of collaborative working with non-commissioned services. (b) Salford Community Safety Partnership should ensure that information regarding referral pathways is widely	Local	Salford CSP will work with the lead provider of the commissioned domestic abuse victim services to develop protocols with non-commissioned services. Salford CSP will work with the commissioned domestic abuse services to ensure that referral pathways	Local Authority	Evidence of effective collaboration between commissioned and non-commissioned services. Increased awareness of commissioned specialist services. Improved referral rates into service.	At January 2024, all actions complete. Commissioned domestic abuse services – new lead provider model Safe in Salford commissioned, new service commenced April 2022. Collaborative working with non-commissioned services has been developed via a providers forum facilitated through CVS. Communications disseminated widely to promote the new service. Websites updated and cascaded. https://www.salford.gov.uk/crime-reduction-and-emergencies/domestic-abuse/

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
disseminated and understood.		are widely known and understood across all agencies.			https://safeguardingadults.salford.gov.uk/professionals/domestic-abuse/ https://safeguardingchildren.salford.gov.uk/professionals/domestic-abuse/ As part of contract, new service has developed and delivered extensive training across the partnership. Commissioners and the service meet regularly to monitor contract and drive through continuous service improvements. KPIs agreed and performance exceeding expectations. Of particular note is the development of the 'one front door' service and co-working with other agencies (e.g. mental health, housing), evidence of increased referrals both from engaged external agencies and internal to the service, demonstrable improvements to victim/survivor outcomes.
5. (a) Salford Community Safety Partnership should	Local/Regional	Salford CSP will seek assurance from		Trauma informed mental health	At January 2024, all actions complete.

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
ensure that services develop and adopt trauma informed approaches to mental health interventions. (b) Salford Community Safety Partnership should ensure that all services are fully informed about the impact of domestic abuse on mental health and links to self-harm and suicide. (c) Salford Community Safety Partnership should ensure that practitioners know about post-separation abuse and recognise it as a risk factor for		commissioned NHS Mental Health services that trauma informed approaches are embedded into mental health interventions. Salford CSP and the Integrated Care Partnership will progress the joint working on domestic abuse and suicide training offer across the partnership. SSAB / CSP to seek assurance that GMMH have embedded DA training across their workforce.		training programme established. Linkages with the Suicide Prevention Board established and strengthened CSP Mental Health Champion reports to CSP Board. Domestic abuse and suicide training offer in place.	Guidance and toolkits for practitioners published and disseminated. Think Family | Salford Safeguarding Adults Board. https://safeguardingchildren.salford.gov.uk/professionals/parental-mental-health/ The national suicide prevention strategy was launched in August 23 and a GM suicide prevention strategy is being produced at the moment. Salford has a current strategy to b refreshed alongside the GM strategy. A standing agenda item on the Salford Suicide Prevention Partnership is Learning / Themes from Serious Incidents Panel, Safeguarding Adult Reviews / Child Death Overview Panel and DHRs. A Mental Health Champions group led by the Director of Public Health has developed webpages and a training programme for the public and professionals.

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
victims who have separated from perpetrators and that this is reflected in practice. (d) The GM Suicide Prevention Strategy training programme should continue to be implemented and evaluated.		Salford CSP will liaise with Scottish counterparts for update on progress of this action.			https://www.partnersinsalford.org/salford-health-and-wellbeing-board/mental-health-and-wellbeing/ https://www.partnersinsalford.org/salford-health-and-wellbeing-board/mental-health-and-wellbeing/mental-health-training-and-courses/ the group continues to focus training to staff appropriate to their role to ensure that they feel competent and confident to have these discussions should the need arise.
6. Salford Community Safety Partnership should seek assurance from the Salford Safeguarding Children Partnership that all learning from the Children's Safeguarding case	Local	Salford CSP will ask the Salford Safeguarding Children Partnership for an update report on the case review outcomes.		Salford CSP will receive an up date and progress plan for work undertaken by the Safeguarding Children partnership.	Completed March 2021. The non-statutory case review action plan was signed off in March 2021. Five actions were identified and implemented, these are summarised below: 1. The NW cross-border procedures were reviewed, updated and published. The cross-border procedures for the Scottish local authority involved in the case

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
review has been acted on.					were also reviewed and updated to align with the NW procedures. 2. The response to concerns involving parental mental health has been strengthened at the "front door", ensuring clear timescales for information sharing to inform risk analysis and support response. The Bridge Transformation included a strategy to deliver mandatory training for social workers on the Parental Mental Health toolkit (see 5). 3. Salford Survivors (Domestic Abuse non-commissioned service) have reviewed their procedures and now consider the impact of domestic abuse on a service user's mental health as a priority, encouraging the service user to access mental health or GP services for extra support. Revised guidelines mean that where there is no involvement with mental health services or adult social care already in place,

Recommendation	Scope of Recommendation	Action Required	Lead Agency/ Board	Outcomes/Key Indicators/Date	Date Completed Outcomes Achieved
					an automatic referral to Adult Safeguarding takes place. 4. A Think Family approach proposal was developed and considered by the SSCP. The Think Family approach has since progressed and new ways of working have been implemented for example through the Family Partnership model. The Working with Families guidance has been updated, the latest version is due to be published soon. 5. A Parental Mental Health working group developed a Parental Mental Health toolkit and Think Child practice guidance. Parental Mental Health training was developed by GMMH and is now regularly delivered to multi-agency professionals.

Feedback letter
from the Home Offic