Domestic Homicide Review

Rose who died in July 2021

Independent Author – Rafik Iddin

Report completed on 12th June 2022

Amendments Provided 27th September 2023, 4th October 2023, 13th November 2023, 1st December 2023, April 2024, September 2024, December 2024 and February 2025.

Our Mum 'Rose', by her daughters:

On 13th July 2021 the fire brigade attended the address of Rose following reports of a fire. Rose was found deceased inside the property. Rose's son has subsequently been convicted of her murder.

Our Mum was not your conventional mum, at times our relationship was a difficult one but she was our mum.

Rose married for the first time when she was just 16 years old, she had two children, a girl and then a boy. Rose and her husband separated and then divorced when the oldest child was 9 but they also remained very good friends until she died.

Rose then married her second husband, and they also had two children, a girl and a boy. There was a 10-year age gap between her second child from her previous marriage and her third child. Rose and her second husband divorced a few years later when their oldest child was 3 but, again, they remained very good friends until she died.

Rose's daughters describe their relationship with their mum as a difficult one. Rose had left both sets of children with their dads and the relationship with their mum was distant. Rose was an alcoholic and had been from a very young age.

Rose had a long-term relationship following these two broken relationships lasting about 20 years; he died a year after Rose, but this relationship ended about 18 months before she died. He was also an alcoholic as were most of Rose's partners.

Rose was brought up in Manchester. Her dad died when she was very young, and her mum is still alive today. She would describe herself as the black sheep of the family, but they were all very close. She had 3 brothers and 5 sisters they all lived in a council house growing up.

She worked briefly as a barmaid. Her daughters explain that she loved socialising, she loved the pub and having fun when she was younger, as she got older she drank at home. When her oldest daughter moved to London, she would visit, she would come with us swimming with the kids. She tried to do a handstand and nearly drowned which really made everyone laugh.

Her youngest daughter also moved to London and when she had a child she would visit her. Her daughters recall that she was very good at checking on them when they had their children, she was very supportive. She was also a good Nanna to her 10 grandchildren and her great grandchildren they called her *Nanna rat lips*.

We dyed her hair once (it was the only time) and it was jet black she said that the dye burnt her head!! She looked amazing with jet black hair. Later in life she loved watching soaps and doing crossword puzzles, she loved bingo and playing cards (especially for money) and later in life she used to play online games. In the last couple of years, she didn't really like going out. She would drink cider and wine every day from when she woke up but she would often ring her daughters for a chat or to get them to check the lottery numbers.

She suffered with depression for many years. She always said she would never go on a plane and then she went to Cuba and Tunisia she loved it and told her family all about it although she did moan about the heat.

Her son was her youngest child, and the other children felt he was her favourite. She would also let him in even when he had done wrong. He would speak badly to her but he would always be forgiven.

Her children had nick names for her like black neck and cheesy t**s and she used to laugh at these.

She once had a cat who she called catsandybogglemullia bodowrthyturdy she thought this was hysterical.She would say that she was not an animal lover but loved her daughter's dog. She also had a budgie but sadly it got out of its cage and flew away.

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1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Rose (a resident of Manchester) prior her death which occurred in July 2021

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

1.3 Rose was a female of 63 years of age who was found dead following a house fire at her home during July 2021. Rose died as result of fatal injuries sustained during the fire which was proved to have been started deliberately and Rose's adult son 'Perpetrator'[1] was convicted of her murder. At the time both Perpetrator and K (his partner) had been living at Rose's home since early 2021.

1.4 In July 2021 Manchester Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) because the circumstances which led to the death of Rose gave rise to concern that she may have been suffering domestic abuse including coercive and controlling behaviour.

1.5 The review will consider agency contact/involvement with Rose which occurred between July 2019 and July 2021

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

DHR Timescales

1.7 This review began on 10th February 2022 and was concluded on 8th June 2022. The DHR was approved by the Manchester Community Safety Partnership on 18th August 2022

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms are used in the report to protect the identity of the individuals involved. At the time of her death, Rose was a White British woman of 63 years.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life, leaving devastation in its wake. Manchester Community Safety Partnership therefore wishes to express sincere condolences to the family and friends of Rose.

[1] Rose's family expressed their wish that the perpetrator be referred to as such within the report.

2.0 Terms of Reference

The general terms of reference were as follows:

2.1 Establish what lessons are to be learned from Rose's death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

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

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

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

2.6 Highlight good practice.

The case specific terms of reference are as follows and were agreed by Panel members:

2.7 Was sufficient consideration given regarding the possibility of domestic violence towards Rose from her son, particularly given the research findings regarding domestic violence towards parents and older women?

2.8 Was there sufficient professional curiosity demonstrated by agencies involved with the family and following observations, exchanges with professionals or referrals?

2.9 Was sufficient consideration given to the impact of alcohol use on family dynamics?

2.10 Was information sharing between agencies both sufficient and timely?

2.11 How well was any information from immediate and extended family members critically evaluated in the context of any safety planning and interventions for Rose?

2.12 With regard to terms of reference for time periods, these lines of enquiry are considered from July 2019, 2 years prior to Rose's death. This time period was agreed upon due to the very limited information regarding agency involvement. Any relevant historic matters prior to this date are referenced in the IMRs to provide further clarity and background information. It was also agreed that agency involvement with Perpetrator, particularly in respect of his involvement with agencies as a young person, would be considered in order to extract as much learning as possible.

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

2.14 That given the timeframe, for agencies to consider the impact that the *Covid-19* pandemic has had on service provision and agency responsiveness.

Methodology

3.1 On 17 July 2021 Greater Manchester Police referred the case to Manchester Community Safety Partnership for consideration of holding a DHR. On the 11 August 2021 representatives of the Manchester Community Safety Partnership met to consider the referral and it was agreed that the circumstances of the death met the criteria for a DHR. The Home Office was notified on the 17 August 2021.

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

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

Contributors to the DHR

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

3.4 Greater Manchester Police (GMP), Manchester Health and Care Commissioning (MHCC) (see footnote), *One Manchester* (Housing Provider) and the Northwest Ambulance Service (NWAS).

3.5 Information was also received from the Department for Work and Pensions (DWP) and Greater Manchester Mental Health Services (GMMH).

3.6 The organisation, Change, Grow, Live (CGL) was contacted by the Panel on the 26 July 2021 although none of the parties were known to the service.

3.7 Rose's two daughters (JJ and Suzi pseudonyms) and K were interviewed as part of the review process. This was particularly valuable given the limited involvement that Rose had with agencies.

3.8 Panel meetings were convened at regular intervals to both review and quality assure progress.

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

3.10 Victim Support offered specialist support to family members and standard support leaflets were sent on the 3 September 2021. While family members did not meet with the Panel during the timeframe of conduct of the review, a number of meetings with family members took place with the author on an individual basis and over an extended period of time. A Teams meeting also occurred between one of the family members, their Victim Support caseworker and members of the Panel in 2023. These processes have facilitated a number of submissions of comments and suggested amendments / additions to the Overview Report, which the Chair / Author and CSP have responded to and incorporated wherever possible in the body of the report.

The DHR Panel Members

3.11 The DHR Panel consisted of:

- Mr Rafik Iddin: Independent Chair and Author
- Ms Leanne Conroy: Policy Specialist: Community Safety Team: Manchester City Council
- Mr Ian Halliday: Policy and Performance Manager: Community Safety Team: Manchester City Council
- Ms Louise McWalters: Detective Constable: Greater Manchester Police
- Ms Pippa Nicole: Specialist Safeguarding Nurse (Children)- Manchester Health and Care Commissioning (now NHS Greater Manchester Integrated Care Team)
- Ms Sarah Khalil: Designated Nurse Adult Safeguarding- Manchester Health and Care Commissioning (now NHS Greater Manchester Integrated Care Team)
- Ms Delia Edwards: Domestic Violence and Abuse Reduction Manager: Manchester City Council
- Ms Demi Duplex: Interim Place Delivery Manager: One Manchester Housing Association
- Ms Rachel Howe: Place Delivery Manager: One Manchester Housing Association

3.12 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on 3 occasions, namely 7 July 2022, 11 May 2022 and 7 June 2022.

Author of the overview report

3.13 Mr Rafik Iddin was appointed as the independent author and chair of the DHR Panel established to oversee the review. Whilst DHR training has not yet been completed, as a date for completion of the training has not yet been provided, the independent author has extensive experience as an Assistant Director for Specialist Services and Safeguarding and has completed a number of Safeguarding Practice Reviews for both Adult and Children's Services.

Statement of independence

3.14 The author is not an employee of Manchester City Council and is not related to any member of the Council in a professional or personal capacity. The author has never been employed by any agency referenced in the review.

Parallel reviews and Coronial Processes

3.15 Criminal proceedings have concluded, and coronial processes are ongoing.

Equality and diversity

3.16 As Rose was a female of 63 years at the time of her death issues related to age and gender were given consideration as part of the review. Rose was also physically frail at that time due to issues related to health and mobility.

Dissemination

The following will receive copies of the DHR overview report:

- The Greater Manchester Deputy Mayor for Policing, Crime, Criminal Justice and Fire

- Northwest Ambulance Service
- Manchester University NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Greater Manchester Health and Social Care Commissioning
- Greater Manchester Police
- Manchester City Council Adult Social Care
- Manchester City Council Children's Social Care
- Manchester Community Safety Partnership
- Office of the Domestic Abuse Commissioner
- Greater Manchester Health and Social Care Partnership
- Manchester Safeguarding Boards
- Rose's daughters (have been provided with a draft report)
- Perpetrator's ex partner K (has been provided with a draft report)

4.0 Involvement of the family

4.1 Family members were informed of the DHR on the 3 September 2021. On this date information regarding the purpose and function of a DHR was provided to family members via Victim Support

4.2 Rose's daughters were consulted with on a number of occasions and their views have been incorporated into the report. As referenced in paragraph 3.10, whilst family members were not asked to attend panel meetings during the timeframe of conduct of the review they were met with individually as part of the review process and one further meeting was held between members of the panel, one of the daughters and her Victim Support caseworker. These meetings, and a number of subsequent submissions of comments and suggestions by the daughters, through their caseworkers, have been extremely valuable in helping to shape recommendations and actions.

4.3 Perpetrator's partner K was also engaged with during the course of producing the Overview Report, by way of meetings with the Chair / Author in 2022 and 2023. Despite a number of attempts to engage Perpetrator in the process, this was not successful.

4.4 The Community Safety Partnership and the Panel would wish to convey their appreciation to Rose's daughters and to K for their involvement, contributions, and insight.

4.5 Rose's daughters provided the pseudonyms noted within the report.

5.0 Chronology/Overview

5.1 Rose was aged 63 years at the time of her death and had, until early 2021, been living on her own in a one-bedroom bungalow in Manchester. This was a specific tenancy agreement for one person aged 55 or over. However, during early 2021 her son Perpetrator had come to live with her bringing his partner K whom he had met via a dating website. Perpetrator was 34 years of age and K was 32 years of age. No other persons were residing at Rose's address. These living arrangements had therefore been in place for a number of months and until the date of Rose's death.

5.2 During the early hours of a morning in July 2021, Greater Manchester Fire and Rescue Service were called to a fire at the address. Rose was subsequently found deceased in the living room of the home.

5.3 Neighbours reported to the emergency services hearing arguing between 23.00 hrs and midnight during the evening and a male voice could be heard *'shouting and bawling'*. Following this and during the early hours of the morning, neighbours witnessed a fire in the living room of the property. Perpetrator was seen leaving the address in a vehicle and whilst Perpetrator had requested that K get into the vehicle and accompany him, it is understood she refused. K then contacted Fire and Rescue Services and took refuge at a neighbour's address. Perpetrator was arrested the following day on suspicion of murder.

5.4 The property was made the subject of a forensic investigation, with the most likely cause of the fire being the deliberate ignition of an ignitable liquid.

5.5 A post-mortem was undertaken on the following day which concluded that the cause of death was likely to have been caused by a combination of burns and smoke inhalation.

5.6 Perpetrator was subsequently charged and convicted of Rose's murder with a minimum sentence of 21 years.

5.7 K was also arrested on suspicion of murder. However, following investigation no charges were brought against her.

5.8 Whilst agency involvement was limited, Rose had been known to health care services and had been in receipt of medication for depression. She had also been struggling with mobility and balance issues from 2019 and had subsequently suffered a fractured femur and left foot in January 2021 due to falling out of bed. The discharge letter of the 15 January 2021 also made reference to excess alcohol intake. The family are also of the opinion that Rose may have suffered from other fractures that were not reported to agencies.

5.9 A distinguishing feature of Rose's involvement with health care services was a number of appointments which were not attended. These included outpatient appointments in respect of nephrology, cancer screening programmes and orthopaedic outreach.

5.10 Rose had also been receiving support and advice regarding a request for rehousing. Following a relationship breakdown in 2019 Rose's tenancy had been changed from joint to sole tenancy.

5.11 Perpetrator had limited involvement with health care services dating back to 2010 following his involvement in a road traffic collision. It was noted at the time that Perpetrator had reported *'frightening dreams'* and *'a changed personality'* following the accident. Records note that private counselling was accessed, and a suggestion made that this be followed up with further therapy. However, it is unclear if this was progressed, due to the private nature of the arrangements and Perpetrator only became known to Greater Manchester Mental Health (GMMH) Services following the incident in July 2021.

5.12 It was also noted that Perpetrator was struggling with low mood during 2018 following a relationship breakdown. He had also reported that his mother had died of cancer. In 2020 (13 July 2020), Perpetrator reported that his father had died and that he had been *'overwhelmed with bereavement issues'.* Both of the statements regarding the death of his parents were untrue and were reported by Perpetrator to his GP.

5.13 Perpetrator has 2 children from a previous relationship.

5.14 There were also several police call outs dating back to 2003 due to verbal disputes and arguments involving Perpetrator and Rose and where alcohol use by all parties was

noted as being a distinguishing characteristic. Records note that there were 3 domestic incidents involving Rose and her son Perpetrator over a 14-year period between 2003 and 2017 and where both had been drinking. Whilst these are outside the time frame for the review these instances have been referenced, as at the time Perpetrator was a teenager, possibly a Child in Need and it was felt that further learning could be extracted from this consideration. They are also relevant as during the incident when Rose died, K had reported that Perpetrator had consumed a significant amount of alcohol and had become both verbally and physically abusive towards his mother.

6.0 Analysis

1.) Was sufficient consideration given regarding the possibility of domestic violence towards Rose from her son, particularly given the research findings regarding domestic violence towards parents and older women?

6.1 Research has indicated that one in ten domestic abuse crimes in Lancashire are committed by individuals towards their own parents with intimidating or coercive and controlling behaviour being a distinguishing characteristic. In a quarter of cases perpetrators appeared to struggle with mental health issues with behaviour consistent with depression and unstable personality disorders being noted as critical factors. These issues are compounded by the increase in the number of individuals aged 20-34 years living with their parents which has risen by a third since 1996. By March 2020 this has equated to 28% of people within this age group sharing a home with their parents, stepparents, or grandparents *(Understanding Child to Parent Domestic Abuse in Lancashire: April 2021).*

6.2 Further research has indicated that one in four victims of Adult Family Homicide (AFH) were aged 65 years or older with 78% of victims being female and 81% of suspects being male. Adult Family Homicide has also demonstrated an older victim age profile than Intimate Partner Homicide (IPH) and in cases involving older victims, suspects tended to be younger with no suspects aged over 65 years. Of the AFH deaths reviewed 71% of victims were parents, predominantly mothers and there were also a greater number of older victims of domestic homicide during the Covid 19 Pandemic. In addition, suspects of homicides involving older victims were not always known to the Police for domestic abuse and the victim often had known care or support needs (*Vulnerability, Knowledge, and Practice Programme: Domestic Homicide Project Spotlight Briefing: Older Victims: February 2022).*

6.3 Given the research findings noted above there are number of elements that merit further consideration in this case. Whilst there were 3 domestic incidents over a fourteen-year period involving Rose and Perpetrator resulting in police call outs, these were in relation to verbal arguments where both parties had been drinking. The first two incidents occurred in 2003 and 2004, within a five-month period when Perpetrator would have been 16 years old. Whilst these incidents are outside the time frame for the review and do *not* reference domestic abuse, they are pertinent, as it was noted that all parties including Rose were intoxicated. This is a feature that is examined further in the report.

6.4 During December 2020, Perpetrator's father contacted the Police and reported that both he and his son had been drinking heavily which had resulted in an argument. This resulted in Perpetrator physically assaulting his father, hitting him in the face and causing slight injuries, following which Perpetrator's father retaliated. However, Perpetrator's father indicated that he did not want to pursue a prosecution and declined further risk assessment. Whilst a crime was submitted for *Assault Occasioning Actual Bodily Harm* this was closed following review as there was insufficient evidence without the victim's support. A referral was made to STRIVE, a Volunteer Support Service who

at the time responded to non-crime domestic incidents and provided early intervention, advice, and support. However, as a crime had been recorded, this may not have been an appropriate response. The STRIVE project ceased as of March 2022.

6.5 Rose's daughters had reported that when visiting their mother; neighbours had advised that shouting and verbal arguments had been reported to the Housing Provider on at least three occasions and had indicated that on the night of Rose's death, that the screaming, shouting and arguments were much worse. Whilst this has been explored in depth with the Housing Provider and the Police, no records of any reports or referrals have been identified during the review period from either agency. Rose's daughters have been consulted regarding this issue and both were clear that neighbours had reported this to them although both daughters could not recall any further information or details such as dates. The review has been able to contact the daughter of the neighbour whom Rose's daughters reported had told them had made at least three reports to the housing authority. I have referred to the neighbour as M and her daughter as L. However, M's daughter L reported that her mother M has significant hearing issues and as she cannot hear on the phone, will not have made any phone calls. L reported that she undertakes all the phone calls for her mother and confirmed that M could not recall any instances when she had made any reports, apart from the date of the incident, when M was aware of shouting and a disturbance from next door. L confirmed that M communicates via sign language and will not have made any verbal reports as this would not have been possible. This is at odds with Rose's daughters report that neighbours had heard shouting and may indicate reluctance on M and L's part to contribute to the review, although this is speculative.

6.6 Evidence that suggested Perpetrator posed a threat to his mother has therefore been limited and whilst it is recognised that verbal arguments can be an integral component of coercive, controlling, or abusive behaviour, there is insufficient evidence to suggest that this was or had been the case. During the incidents in 2003 and 2004 the Police Officers attending had successfully de-escalated the presenting acrimonious dynamics within the family and no crimes had been reported or recorded.

6.7 Whilst Rose had presented at her GP with depression which can be an indicator of domestic abuse, there were no other signs or indicators that that Rose was a victim of abusive, coercive, or controlling behaviour or that her son or any intimate partner or extended family member were perpetrating domestic abuse. Rose was also struggling with a number of other issues such as her relationship breakdown in 2019, feeling isolated, re-housing and rent arrear issues, periods of injury, poor mobility, and sickness. All of these can be contributory factors in depression and reports indicate that Rose had received consistent care from her GP with whom it is reported that she had a positive relationship.

6.8 In terms of good practice, NHS Greater Manchester Integrated Care Team commissions the *Identification and Referral to Improve Safety* (IRIS) Service, an evidence-based training, support, and referral programme for General Practices. The training includes specifically asking older women who have adult children about domestic abuse, particularly as the national data indicates that older age groups are not being referred at the rates which domestic abuse is occurring. Whilst this point is more in relation to professional curiosity being an important part of a GP assessment, and is addressed later in the report, there was no further information which suggested that Perpetrator was a safety risk to his mother.

6.9 Similarly, *One Manchester* Housing had received no information that indicated Rose had been the victim of domestic abuse, coercive or controlling behaviour or that Perpetrator was a safety risk to his mother.

6.10 However, both of Rose's daughters reported that Perpetrator had unresolved issues which primarily related to his mother having left the family home when he was younger and which he was often reticent to talk about more openly. Perpetrator's older sister, Suzi, with whom he had stayed with when he was younger after Rose had left the family home, recalled that Perpetrator would often lose his temper and become verbally aggressive, particularly when he had been drinking. She has subsequently reported that Perpetrator had threatened to *'petrol bomb her house',* although there is no further information that indicates this was ever reported to any agency. Perpetrator's younger sister JJ also reported that Perpetrator had been threatening towards her. Adult family abuse, while increasing nationally, is still a form of abuse that is under-reported, barriers to doing so including loyalty to and fear of criminalising a son, daughter or sibling, and concern about whether agencies will be sufficiently understanding and responsive to the report. [2]

6.11 JJ reported that she had messaged her mother via social media on the night that she died and there was nothing to suggest that Perpetrator had been behaving aggressively or erratically. There was no information that gave a cause for concern and that during the exchange *'everything seemed fine'.* However, as this correspondence was via social media, JJ has subsequently raised a concern that as Perpetrator and K had access to Rose's phone she could not guarantee that it was her mother she was communicating with.

6.12 However, information provided by Perpetrator's ex-partner K suggested that whilst not being physically violent towards either his mother or herself, Perpetrator was verbally aggressive to both women. K reported that after she had moved in with Perpetrator and his mother she had started to care for Rose on an informal basis. Rose had revealed to one of her daughters, however, that such care was less than satisfactory. JJ and Suzi have raised concerns regarding the involvement of K in the review and that the relationship between Perpetrator and K *'has caused biased answers',* suggesting that K is an unreliable source of factual information. However, no further information is available from agencies which would support this view.

6.13 K reported that both Perpetrator and Rose drank substantial amounts of alcohol and that when Perpetrator had been drinking, he would often make references to his childhood and how his mother had '*chosen men over the children'.* She reported that this was a regular feature of Perpetrator's exchanges with his mother and that during these times he was verbally aggressive towards her. Despite this, K reported that at times Perpetrator was also kind and considerate towards his mother, taking her shopping or to Bingo, which were activities which Rose enjoyed.

6.14 JJ raised concerns that Perpetrator may have been violent towards his mother prior to the incident and may have assaulted her at the time of her mother's death. This issue has been revisited with both Housing and Police who have repeatedly confirmed that prior to the date of Rose's death no referrals or reports had been received in this regard from any family members or members of the public.

6.15 K did report to the review that Perpetrator had disclosed that *'he had previously had thoughts about killing his mother'*, although K reported that this statement was made to her by Perpetrator when Perpetrator was in hospital receiving treatment for burns following his mothers' death. K also reported that there was nothing that she had been aware of prior to this date which suggested that Perpetrator would have acted in the

[2] Briefing-Paper-Adult-Social-Care-Domestic-Homicide-Oversight-Mechanism-2023.pdf (domesticabusecommissioner.uk)

way that resulted in his mother's death. The accuracy of this cannot be confirmed because whilst in hospital Perpetrator was not allowed visitors.

6.16 K also reported that she had been made aware by neighbours that reports of shouting had been made to agencies but confirmed that this had not been responded to or that contact was made by agencies. As referenced, there are no reports from GMP, One Manchester Housing or the Local Authority that these concerns were raised.

6.17 The review could therefore not conclude that there was sufficient information which suggested the presence of domestic abuse, violence, coercive or controlling behaviour which agencies had been in receipt of and which was not acted upon sufficiently or in accordance with protocol, policy, and procedures. The only issue in respect of domestic abuse which may have warranted a different response was the referral made to STRIVE following Perpetrator assaulting his father following an argument and after both men had been drinking.

(2.) Was there sufficient professional curiosity demonstrated by agencies involved with the family following any observations or exchanges with professionals, or referrals?

6.18 Observations and exchanges by professional agencies with Rose and Perpetrator have already been described in detail in the report and there was limited data or information that could have warranted a more professionally curious or tenacious response from agencies. The only issue in relation to GMP involvement with Perpetrator and within the timeframe for the review was the incident in December 2020, when Perpetrator had assaulted his father following a heated argument whilst drinking. Whilst a referral was made to STRIVE this was not deemed to have been an appropriate response, given that a crime had been recorded. However, in itself, this was not sufficient enough information to suggest that Perpetrator would have been a risk to his mother.

6.19 In relation to involvement with health care services there was no information provided by Rose or her immediate or extended family members which suggested that a more professionally curious approach should have been taken. The GP observed a supportive relationship between Rose and her ex-partner who supported her attendance at appointments and Rose had advised that the relationship was a positive one. Rose was also seen privately by the GP, minimising any risk of coercion or undue influence and providing opportunity for disclosure.

6.20 It is noted that whilst the GP had not completed the IRIS training, relevant domestic abuse training had been completed. Although the GP had not specifically asked Rose about domestic abuse, Rose was presenting with depression which can be a significant indicator. It is critical for GPs to be reminded that whatever the age of a patient, depression is an indicator of domestic abuse and a professionally curious approach does need to be taken. Sensitive enquiries therefore need to be made, particularly given the additional barriers to help and support faced by older people.

6.21 During the timeframe of the review, there is no documentary evidence in the chronology of Rose missing routine GP appointments. She did not attend the scheduled nephrology appointment in August 2019 but the GP followed up and arranged for another appointment to be offered. She didn't attend the next nephrology appointment but then another follow-up was done and she eventually attended in January 2020. Also in January that year, she declined an offer of routine cancer screening. In 2021, the GP proactively referred Rose to the 'Be Well' service, then re-referred her when she did not attend that appointment, although that engagement didn't have chance to be started before she passed away. Given that it remains

unclear why Rose had not attended a more professionally curious approach needed to be taken. This finding accords with learning from other recent reviews that has resulted in agencies being increasingly aware of the need to take all reasonable steps to ascertain reasons for any non-attendance at appointments and to endeavour to resolve barriers that become apparent before arriving at decisions to close cases.

6.22 Family members have expressed concerns that given K's reported informal caring of Rose at the point of discharge from hospital, background checks need to be undertaken in relation to individuals who are caring for vulnerable adults. This issue has been explored further with Greater Manchester Integrated Care Board who has confirmed that background checks on paid carers are undertaken. Any regulated activity requires Disclosure and Barring Service (DBS) disclosure, registration with the Care Quality Commission (CQC), two references, employment history, confirmation of any training undertaken and Right to Work confirmation. However, in relation to care which is informal or provided by family or friends, this is a more complex issue. The critical issue is in relation to facilitating an environment of safe disclosure and to identify, on the basis of information and assessment, whether a patient is being adequately safeguarded. This could be addressed via the patient being asked, where safe to do so, whether they have any concerns in relation to the person who is providing care and whether this person ever makes them feel unsafe or frightened.

6.23 K has confirmed that she was providing care for Rose albeit on an informal basis and from the point at which Rose was discharged from hospital. K has also reported that she had been unaware of any missed appointments and that apart from one visit to the hospital where she had accompanied both Rose and Perpetrator, she had not taken Rose to any further appointments.

6.24 As referenced earlier both Perpetrator and K moved in to live with Rose during early 2021. JJ reported to the review that; '*there were three people living at her mother's house, a one-bedroom bungalow for only the 'over 55s' and that this had been reported to housing but that nothing was ever followed up'*. Suzi also reported to the review that; *'The neighbours told us that they had reported 3 people living there to housing on at least three occasions but that nothing was done... the neighbours also reported that there had been shouting heard a number of times from the bungalow and this had been reported to housing 'a few times' but nothing was done... the neighbours were worried about mum'.* However, no reports of either overcrowding or shouting were received by the housing provider. As referenced earlier, Rose's neighbour M was contacted via her daughter L but was unable to confirm that any reports had been made by her. Indeed, L reported that due to her mothers' significant hearing issue this would not have been possible.

6.25 However, given that it has been confirmed that K was in receipt of benefit payments such as Universal Credit and given that both Perpetrator and I's continued residence at Rose's address was breaching the terms of the tenancy agreement, it would have been possible for the Department for Work and Pensions (DWP) to have triangulated this information with One Manchester Housing.

6.26 In that respect I am of the view that a greater degree of professional curiosity could have been applied, both in respect of Rose's missed hospital appointments and the breach of the tenancy agreement, particularly as benefits were being claimed from Rose's address, where both her son Perpetrator and his partner K had been living for a number of months.

(3.) Was sufficient consideration given to the impact of alcohol use on family dynamics?

6.27 It is clear that, from the contacts that GMP had with the family over a fourteen-year period, alcohol was a contributory factor in all the incidents attended. Both JJ and Suzi described their mother as *'an alcoholic'* and reported that Perpetrator drank substantially which had started when he was 14 years old.

6.28 Whilst outside the time frame of the review there were three domestic incidents involving Rose and Perpetrator where both parties had been drinking. The first two incidents took place in 2003 and 2004 and within 5 months of each other, where it is recorded that both Rose and Perpetrator had been drinking and were described as being *'highly intoxicated'.* Given that Perpetrator would have only been 16 years old at the time and that both he and his mother had consumed an excessive amount of alcohol, a referral to Children's Social Care would have been appropriate in both these instances. It is also important to note that whilst these events took place outside the timeframe for the review they have been considered to extract as much learning as possible, particularly where this relates to the importance of early help and preventative intervention.

6.29 Whilst information from the Police IMR had initially suggested that referrals had not been made to Children's Services, further information suggested that it was not possible to verify with any degree of certainty whether this was the case due to the ages of the incidents. However, an examination of both the electronic and archived paper records could not identify any referral records. This may have provided for a more holistic assessment of the family's needs leading to an early help or support plan, particularly given the issues that Perpetrator had been struggling with and which have been described earlier. These were therefore critical junctures where a greater level of support and intervention may have been provided.

6.30 In July 2007 officers also attended a concern for welfare following a domestic incident between Perpetrator and his then partner, the mother of Perpetrator's two children. This was due to concerns that Ns partner had been drinking and that she had threatened to harm herself with a knife. N's partner left the address in a distressed state with the baby and later returned with the matter appearing to have been resolved. Whilst subsequent Police information has suggested that a referral to Children's Social Care was made at the time, no records could be identified in the Children's Social Care electronic or archived paper files which would support this. As with the incidents in 2003 and 2004, this incident lies outside the time frame of the review but is pertinent and relevant due to the presence of significant alcohol consumption as an aggravating factor.

6.31 The third domestic incident involving Perpetrator and Rose took place in 2017 when Police Officers attended in response to an abandoned 999 call. Both Perpetrator and Rose were present and whilst Rose had called from her mobile, she had no recollection of doing this when spoken to by officers. Whilst no offences were disclosed and risk assessments were completed in accordance with agency protocols, it was noted that both parties had been drinking, with Perpetrator describing his mother as *'an alcoholic'*. Again, this lies outside the timeframe for the review but is considered pertinent due to the presence of significant alcohol consumption as an aggravating factor. It must also be noted that the setting of the timeframe was consistent with Home Office guidance and practice in other reviews, although incidents during 2017 and 2003 have been referred to due to their relevance.

6.32 The only issue in relation to GMP involvement within the timeframe for the review was the incident in December 2020, when Perpetrator had assaulted his father. Perpetrator's father reported that he did not want any further contact with his son and risk assessments were completed with appropriate markers being added to the address for domestic abuse and alcohol.

6.33 Both Rose and Perpetrator were specifically questioned about alcohol consumptions as part of wider health assessments as there had been earlier concerns, prior to 2019 regarding alcohol use. However, Rose had reported during July 2019 that she 'only drank rarely', which limited the possibility of further intervention at the time. Following Rose's discharge from hospital following a fractured hip the discharge letter of the 15 January 2021 notes that excess alcohol had been a feature of Rose's medical history, and that she was being prescribed thiamine, the dosage suggesting that she was either withdrawing from alcohol or was now drinking excessively. It has also been confirmed that MFT did *not* make a referral to alcohol support services due to reduced capacity during the Covid 19 pandemic and particularly as it was a weekend.

6.34 Currently, and in terms of good practice, patients who score for increasing risk following completion of an audit *(Audit C)* will receive advice and patients who score 11-12 (out of 12) will be referred to the Alcohol Care Team (ACT) for further and more comprehensive assessment. It is likely that T having attended during the pandemic affected the likelihood of a referral to ACT at the time, although this issue has been addressed, and assurances have been provided that referral protocols are now sufficiently robust.

6.35 Similarly, earlier records from 2018 indicated that Perpetrator had previously struggled with alcohol use but that he had subsequently reported a reduction in usage. This therefore limited the possibility of further referral, support, or intervention.

6.36 Neither NWAS nor the housing provider reported any information which suggested that alcohol was a contributory factor in any exchanges or contacts with the family.

6.37 Given these issues, the importance of referrals to appropriate support services cannot be understated and whilst the Covid-19 Pandemic was impacting on capacity and the ability of agencies to respond more robustly, a greater degree of professional tenacity and follow up was required.

(4) Was information sharing between agencies both sufficient and timely?

6.38 As referenced earlier GMP had initially provided information which determined that no further support was necessary following the three domestic incidents involving T and her son. Whilst all these incidents lie outside the time frame of the review and officers successfully de-escalated the situations, the two incidents in 2003 and 2004 warranted a referral to Children's Social Care. Perpetrator would have been 16 years old at the time and both he and his mother were reported as being highly intoxicated. During the incident in 2004 Suzi, who would have been 17 years old, reported that alcohol was an ongoing issue and that their mother was *'an alcoholic'.* This may have led to an early help or support plan for the family under Children's Services Child in Need (CIN) procedures and in accordance with statutory guidance.

6.39 Following the incident in 2007 when officers attended Perpetrator's partner's address, following concerns that she was going to harm herself with a knife and had care of their baby, Police information indicated that a referral to Children's Social Care was made. However, this could not be verified in the Children's Social Care Records. It is therefore unclear whether any early help or family support under Child in Need procedures was provided.

6.40 The incident in December involving Perpetrator and his father, whilst managed appropriately by officers and which did not warrant a referral to partner agencies, did result in a referral to STRIVE which was not appropriate given that a crime had been recorded.

6.41 There were no attendances by Police Officers to Rose's home address within the timeframe of the review.

6.42 As referenced earlier, the Acute Trust informed the GP Rose's non-attendance at nephrology appointments which resulted in a re-referral and rearranged appointment. The GP also referred Rose to a *'Be Well'* service to access further support in respect of issues relating to family, lifestyle, and finance and which can contribute to a greater sense of well-being. The GP also followed up the referral to *'Be Well'* requesting that the case be re-opened as it had been closed due to *'early exit'* suggesting that T had not attended. This was good practice and reflects, at least in part, a professionally tenacious approach by the GP to ensure that Rose had further support. However, despite the GP's efforts Rose did not attend. As referenced earlier whilst the information was provided, the issue of non-attendance warranted a greater degree of professional curiosity and importantly, follow up.

(5) How well was any information from immediate and extended family members critically evaluated in the context of any safety planning and interventions for Rose?

6.43 As referenced earlier Perpetrator's sisters reported that Perpetrator drank heavily and that this had commenced from when he was a young teenager. They reported that Perpetrator had struggled with why his mother had left the family home when he was younger and expressed their worries regarding his alcohol intake and temper.

6.44 Both sisters also expressed a concern that Perpetrator and his partner K had moved in to live with their mother in her one-bedroom bungalow and that neighbour had informed them that this had been reported to the housing authority. Both expressed a concern as to why an issue of overcrowding and a breach of tenancy agreement had not been addressed and why Perpetrator and his partner had been allowed to continue living there. However, no reports regarding any concerns relating to this issue had been received by the Local Authority, the Police or the Housing Provider, *One Manchester,* from any external source.

6.45 Both sisters had reported that after their mother's death the neighbours had informed them that they often heard shouting, although this had not been reported to agencies. One sister stated; *'I am really angry with the neighbours because after mum died, they said that they could hear shouting, which was very 'heated' but didn't do anything about it.'* As referenced earlier Rose's neighbour M has been contacted via her daughter but this could not be substantiated.

6.46 Information provided to the review by K suggested that Perpetrator, whilst not physically abusive, was verbally aggressive and intimidating with both his mother and also herself. This would take place after Perpetrator and been drinking and was often related to Perpetrator's anger to why his mother had left the family home when he was younger. K confirmed that this was not reported to agencies either by herself or Rose. JJ reported that she believed Perpetrator had been violent towards his mother and has raised concerns that Rose may well have been physically assaulted just prior to her death.

6.47 The incident with Perpetrator and his father in December 2020, whilst evidence of Perpetrator's erratic and violent behaviour did not provide any conclusive information, data, or evidence that Perpetrator posed a safety risk to his mother and there are no reports from any other members of Rose's immediate or extended family prior to Rose's death that Perpetrator posed a safety risk to his mother.

6.48 Given the lack of evidence regarding any reporting by neighbours, immediate or extended family members to agencies regarding Perpetrator's behaviour or risk, it is therefore not possible to conclude that there was a lack of critical evaluation in respect of any safety planning or interventions for Rose.

(6) With regards terms of reference for time periods these lines of enquiry are considered from July 2019, 2 years prior to Rose's death. However, were there any relevant historic matters prior to this date and referenced in the IMRs which provide further clarity and background information?

6.49 As referenced earlier there were three domestic incidents in 2003, 2004 and 2017 which involved Rose and Perpetrator and where alcohol use was a predominant feature. The incidents in 2003 and 2004 did warrant a referral to Children's Social Care as at the time Perpetrator would have been 16 years of age. It is recorded that both he and his mother were heavily intoxicated and that family dynamics were characterised by verbal aggression and acrimony.

6.50 This may have provided an opportunity for a Family Support or Early Help Plan as part of the Common Assessment Framework or Child in Need provision. This is also particularly pertinent given the information which Suzi provided to the review. She described him as misusing alcohol from being a young teenager and that he had unresolved issues relating to bereavement, separation, and loss, due to his mother leaving the family home. She reported that Perpetrator had challenging and aggressive behaviours, that he had started to steal money and that his attendance at school had significantly deteriorated. There were also concerns regarding his peer associations, criminal behaviour and on one occasion she described *'finding a machete under his bed'.* This does suggest that Perpetrator was a Child in Need as defined by Section 17 of the Children Act 1989 and may have benefited from additional support. It also highlights the importance of responding to early trauma due to *Adverse Experiences in Childhood* (ACEs) and the importance of Early Help and Trauma Informed Practice. The importance of family support where there are instances of trauma for children and young people, resulting from Adverse Experiences in Childhood such as parental separation, loss, and bereavement, therefore cannot be underestimated.

6.51 Following the incident in 2007 involving Perpetrator's partner, Police information suggested that a referral to Children's Social Care was made. However, this cannot be confirmed from any Social Care records, either electronic or paper. It is therefore unclear whether any support was provided, or whether the family were subject to any safeguarding interventions. Whilst this primarily related to Perpetrator's partner threatening to self-harm, misusing alcohol, and caring for a very young child, Perpetrator would have been a very young father at the time and a support plan may have provided an opportunity for both parents to receive additional support or early help.

6.52 Whilst these incidents lie outside the timeframe of the review, they are pertinent as they underline the importance of early help, family support and timely referral.

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

6.53 The factors which are relevant in this instance are age and physical disability. As referenced earlier, research has indicated that one in four victims of Adult Family Homicide (AFH) were aged 65 years or older with 78% of victims being female and 81% of suspects being male. Of the AFH deaths reviewed 71% of victims were parents,

predominantly mothers and there were also a greater number of older victims of domestic homicide during the Covid 19 Pandemic. A further characteristic was that older victims were not always known to the Police for domestic abuse and victims often had known care or support needs (*Vulnerability, Knowledge, and Practice Programme: Domestic Homicide Project Spotlight Briefing: Older Victims: February 2022).*

6.54 As Rose was an older woman with physical mobility difficulties and care and support needs this is pertinent, although it is recorded that her ex-partner provided support at appointment attendance and that she had a positive relationship with him. It has also been suggested that K provided support for Rose, albeit on an informal basis and whilst both JJ and Suzi expressed their concerns at these arrangements, particularly with regard to K providing care for their mother, there was no further information provided to agencies and prior to Rose's death which suggested that the relationship was abusive, exploitative, or coercive.

6.55 There is no further information which suggested that Rose lacked capacity to make her own decisions or that she had been coerced or intimidated into allowing her son and his partner to reside with her.

6.56 It is noted that whilst the GP was not aware of any concerns relating to domestic abuse, Greater Manchester Integrated Care Board are addressing this issue via continuing professional development particularly in respect of the IRIS training. This training does include asking older women who have adult children about domestic abuse, particularly as the national data indicates that older age groups are not being referred at the rates which domestic abuse is occurring.

(8) That given the timeframe, for agencies to consider the impact that the Covid-19 pandemic has had on service provision and agency responsiveness.

6.57 The only contact that GMP had with the family during the review timeframe was in December 2020 which was during the Covid-19 Pandemic. Whilst officers were unable to attend immediately due to the pressing demand of other incidents, it was then confirmed that Perpetrator had left the address. A risk assessment was undertaken prior to officers attending and it has been concluded that this did not impact on the quality-of-service provision.

6.58 Whilst the Housing Provider suspended all repairs during the first 5 months of the Pandemic, support calls were undertaken to ensure that customers did not have emergency issues, and that emotional and mental wellbeing were not being adversely affected. No information was provided which indicated a safety risk to Rose or that there had been a change in living arrangements. Again, it may have been useful for the Housing Provider to have clarified with Rose whether there had been any changes in living arrangements during this time.

6.59 Rose was seen in person for some GP appointments and also received telephone support by the GP during the review period. These were opportunities to identify domestic abuse or coercive and controlling behaviour from family members, but none was reported. K had also reported that on the occasion when she had accompanied Rose and Perpetrator to the hospital both she and Perpetrator were asked to leave the room where Rose was being seen. It must be noted however that there were a greater number of older victims of domestic homicide during the Covid-19 Pandemic, which reinforces the importance of being as professionally inquisitive and curious as possible.

6.60 It is also pertinent to note that the impact of pandemic restrictions on global alcohol intake has resulted in alcohol consumption levels remaining high *post* pandemic

(Dialling Back Pandemic Drinking: Cedars- Sinai: September 2021). Given that alcohol use is an aggravating factor in incidents of domestic abuse, this underlines the importance of ongoing public awareness regarding alcohol intake levels and domestic violence.

Good practice

6.61 NHS Greater Manchester Integrated Care Team commission the *Identification and Referral to Improve Safety* (IRIS) Service, an evidence-based training, support and referral programme for General Practices. The training does include specifically asking older women who have adult children about domestic abuse, particularly as the national data indicates that older age groups are not being referred at the rates which domestic abuse is occurring. Whilst this point is more in relation to professional curiosity being an important part of a GP assessment, it must be noted that there was no information which suggested that Perpetrator was a safety risk to his mother.

6.62 It is noted that whilst the GP had not completed the IRIS training, relevant domestic abuse training had been completed.

6.63 Currently, patients who score for increasing risk following completion of an audit *(Audit C)* will receive advice and patients who score 11-12 (out of 12) will be referred to the Alcohol Care Team (ACT) for further and more comprehensive assessment.

6.64 As referenced earlier, the Acute Trust informed the GP of Rose's non-attendance at nephrology appointments which resulted in a re-referral and rearranged appointment. The GP also referred Rose to a *'Be Well'* service to access further support in respect of issues relating to family, lifestyle, and finance and which can contribute to a greater sense of well-being. The GP also followed up the referral to *'Be Well'* requesting that the case be re-opened as it had been closed due to *'early exit'* suggesting that Rose had not attended. This was good practice and reflects a professionally tenacious approach by the GP to ensure that Rose had further support.

6.65 Rose was seen in person for some GP appointments and also received telephone support by the GP during the review period. These were opportunities to identify domestic abuse or coercive and controlling behaviour from family members, but none was reported.

7.0 Conclusions and Summary

7.1 A distinguishing feature of this review has been the very limited involvement by agencies with both Rose and her son Perpetrator.

7.2 Whilst there was limited information provided to agencies during the review timeframe which may have warranted a different response a critical feature of this review has been the importance of professional curiosity and follow up and the triangulation of information. This relates to Rose's discharge home, missed hospital appointments and both K and Perpetrator residing at an address where a tenancy agreement had been breached and where benefits for K were being claimed for.

7.3 A number of key lines of enquiry have been addressed and which have considered a number of themes. These have been the possibility of domestic abuse, the prevalence of alcohol use and the quality of information sharing, the involvement of family members, the level of professional curiosity, equality and diversity and the impact of the Covid-19 pandemic.

7.4 Earlier information regarding Rose and her son has also been considered. Whilst it is acknowledged that this lies outside the timeframe for the review it has been recognised that there were a number of opportunities to consider a referral to Children's Social Care for early help or family support, as at the time Perpetrator was a young teenager and a young father.

7.5 However, assessment and referral processes have been significantly developed since the dates of these incidents via the Domestic Abuse Stalking and Honour (DASH) based assessment processes which are used by GMP. These also consider the aggravating factors of drug and alcohol use, mental health, and domestic violence to inform referrals to children and adult services. Particular focus is given to the voice of the child and/or vulnerable adults where incidents take place involving children, young people and adults who may be at risk of harm by way of complex needs and vulnerabilities.

7.6 There are however a number of recommendations which are intended to strengthen multi-agency practice, and which are drawn from the learning in this review.

8 Lessons to be Learned and Recommendations

8.1 For consideration to be given to strengthening public awareness in relation to domestic abuse, coercive or controlling behaviours and how members of the public can report any concerns.

8.2 For consideration to be given to strengthening public awareness in relation to increased alcohol consumption post pandemic and domestic abuse.

8.3 It is recommended there be a facilitated discussion with the relevant partner Housing Providers concerning any further initiative-taking measures that Housing Providers can take through their housing management processes, to ensure that vulnerable tenants are safe.

8.4 It is recommended that the CSP undertake further discussions with the DWP regarding any further checks and balances that then DWP can take to ensure that any applications for benefits are cross referenced with relevant housing providers in order to ensure that tenancy agreements are not being breached.

8.5 For referrals to the Alcohol Care Team to be made on the basis of clear evaluation and scoring.

8.6 For Greater Manchester Integrated Care Board to explore the issue of background checks for persons providing care on an informal or unregulated basis, to amend policy where appropriate and to incorporate into continuing professional development.

Rafik Iddin 12June 2022

Amended following submissions from family members:

26/9/23, 4/10/23, 13/11/23, 1/12/23, 12/12/24, 03/02/25

References:

- *(Vulnerability, Knowledge, and Practice Programme: Domestic Homicide Project Spotlight Briefing: Older Victims: February 2022).*
- *(Dialling Back Pandemic Drinking: Cedars- Sinai: September 2021)*.
- *(Understanding Child to Parent Domestic Abuse in Lancashire: April 2021).*

Glossary

- DHR- Domestic Homicide Review
- MCSP- Manchester Community Safety Partnership
- IMR- Individual Management Review
- GMP- Greater Manchester Police
- NWAS- Northwest Greater Ambulance Service
- CGL- Change Grow Live
- NHS- National Health Service
- GMMH- Greater Manchester Mental Health Services
- DWP- Department for Work and Pensions
- AFH- Adult Family Homicide
- ACT- Alcohol Care Team
- MFT- Manchester Foundation Trust
- ACE- Adverse Experiences in Childhood
- GP- General Practitioner
- IRIS- Identification and Referral to Improve Safety
- MHCC- Manchester Health and Care Commissioning *now* NHS Greater Manchester Integrated Care Board
- CQC- Care Quality Commission
- DBS- Disclosure and Barring Service

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

Appendix A

Single Agency Actions

Greater Manchester Integrated Care Board

For GPs to be professionally curious and enquire about domestic abuse whenever there are indicators such as depression or low mood, considering the wider impact to carers/children.

That the learning from this review is included within the IRIS training particularly given the prevalence of domestic abuse towards older people from family members and children and that older people may face additional barriers to accessing help and support.

For GPs to routinely enquire as to the reason for any persistent or frequent non-attendance at hospital appointments and consider the safeguarding impact to the patient by following their non-attendance / 'was not brought' policies.