

TEAM BURY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

AUGUST 2016

Victim Mrs Smith

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1. INTRODUCTION

1.1 The principal people referred to in this report are:

Mrs Smith	Victim (Former Wife of Mr A)	White British
Mr A	Perpetrator (Former Husband Mrs Smith)	White British
Daughter	Daughter of Mrs Smith and Mr A	
Son	Eldest son of Mrs Smith and Mr A	
Mr B	Partner of Mrs Smith	
Address 1	Home of Mr A	

1.2 At 16.44hrs on a day in spring 2015 GMP received a telephone call from Mr A. He said he thought he had killed Mrs Smith by stabbing her with a knife and that she was on the settee. Police officers attended address one arriving at 16.53hrs and provided first aid to Mrs Smith who had sustained stab wounds. They were assisted by a neighbour who is a doctor. Paramedics attended and pronounced Mrs Smith dead at 17.00hrs.

1.3 Mr A had a stab wound to the chest and was taken to hospital. This was self-inflicted. He was treated, released from hospital and taken into police custody. He was later charged with the murder of Mrs Smith. Mr A appeared before a Crown Court where he was acquitted of murder and convicted of the manslaughter of Mrs Smith. He received a sentence of six years imprisonment.

1.4 Very little was known to agencies about Mrs Smith or Mr A.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

- 2.1.1 Team Bury Community Safety Partnership [TBCSP] decided on 30.04.2015 that the death of Mrs Smith met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).
- 2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set as 31.12.2015.
- 2.1.3 There were no parallel reviews by other statutory agencies or bodies.

2.2 DHR Panel

- 2.2.1 David Hunter was appointed as the Independent Chair and Author on 12.06.2015. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. The first of four panel meetings was held on 30.06.2015. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone. The completion date for the report was set as 31.12.2015. There was a short delay until 16.02.2016 awaiting final comments on the overview report from panel members. While the Office of the Police and Crime Commissioner for Greater Manchester Police was not represented on the panel they have agreed to take forward actions allocated to them at paragraph 9.1 and have discussed these with the lead officer from Team Bury Community Safety Partnership.

The Panel comprised:

➤ Tim Cooke	Detective Sergeant	GMP SCR Team
➤ Paul Cooke	Adult Social Care	Bury Council
➤ Paul Cheeseman	Report Author	Independent
➤ Clare Holder	Specialist Nurse Adult Safeguarding	NHS Bury Clinical Commissioning Group
➤ David Hunter	Chair of DHR	Independent
➤ Safina Jabeen	IDVA Service	Victim Support
➤ Cindy Lowthian	Communities Manager	Bury Council
➤ Mandy Symes	Safeguarding Adults Manager	Bury Council
➤ Mr R Tonge	Greater Manchester Police	Senior Investigating Officer

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs.

- NHS Bury CCG
- NHS Chorley CCG

2.3.2 The following agencies and organisations helpfully provided information when requested by the panel;

- Greater Manchester Police (GMP)
- Bury Council Adult Social Care
- Lancashire County Council Adult Social Care
- Pennine Care NHS Foundation Trust
- The Pennine Acute Hospitals NHS Trust
- Places for People

2.4 Notifications and Involvement of Families

2.4.1 David Hunter wrote to Mrs Smith's daughter and Mrs Smith's partner Mr B to explain the DHR process and determine whether they and the family wished to contribute. Mrs Smith's daughter did not feel able to meet with David Hunter however she provided a pen picture of her parents which is included in the background (paragraphs 3.1 and 3.2). Mrs Smith's daughter was asked if she would agree to pseudonyms being used in the report to describe her parents. She said she wished to use their initials. The panel were sympathetic to this request. However, the panel were also mindful of the Statutory Guidance on conducting reviews that makes it clear reports should be anonymised¹. It was explained to her this would identify them and therefore the descriptors at paragraph 1.1 have been used. She is aware of the reviews findings.

2.4.2 The police Senior Investigating Officer spoke personally to Mr B requesting him to contribute to the DHR. However, Mr B told the police family liaison officer that he did not wish to engage in the DHR.

2.4.3 David Hunter wrote to Mr A after his trial asking him if he wished to contribute. He did not respond.

2.4.4 The panel recognised the importance of engaging with family members including the victims partner. However, Mr B told the police he did not want to engage with the review. There were no details of any other family members that might be able to contribute, and because Mr B chose not to engage he could not be asked who they might be. Consequently, contact with the family was limited to Mrs Smith's daughter.

¹ Paragraph 75: 'The contents of the overview report....must be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1988'.

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.5.2 Timeframe under Review

The DHR covers the period 01.10.2010 to the date of the homicide. The reason for this was because it represented the time when Mrs Smith and Mr A separated.

2.5.3 Case Specific Terms

The DHR Panel, in setting these terms of reference, recognised that the initial search for information on Mrs Smith and Mr A produced little detail and therefore most agencies may not have any, or very limited, material with which to address the terms of reference. Nevertheless, the DHR Panel felt it was important to pursue diligently all potential sources, in the recognition that something changed in the family dynamics which led to the death of Mrs Smith.

1. What indicators [if any] of domestic abuse between Mrs Smith and Mr A were known to your organisation and what if any risk assessments and risk management plan did you undertake?
2. What domestic abuse related services did your agency provide for Mrs Smith and Mr A and did they take account of their views and any racial, cultural, faith or other diversity issues?
3. What did your agency do to safeguard any children exposed to domestic abuse?
4. How effective was inter-agency information sharing in response to Mrs Smith's and Mr A's situation and was information shared with those agencies who needed it?
5. What did your agency do to establish the reasons for any abusive behaviour by Mr A and how did it address them?

6. Were single and multi-agency domestic abuse policies and procedures followed and did you identify any gaps in them?

3. BACKGROUND: MRS SMITH AND MR A

Note: The information in this section is drawn from the IMR, reports provided by agencies and family members.

3.1 Mrs Smith

3.1.1 The Daughter of Mrs Smith provided the following pen-picture of her mother;

"Mum worked part-time at the hospital for a number of years, she was a devoted daughter and mother and grandmother, she loved to shop for clothes, she relaxed by reading books and we used to go out with my friends every weekend to pubs and clubs before I met my husband. We then all went out for meals as family when we could. She had a distinctive laugh and always smiled. She was a sister and best friend as well as a mum to me until she moved away to Chorley to be with her new partner Mr B".

3.2 Mr A

3.2.1 Mrs Smith's daughter provided the following pen-picture of her father;

"Dad has always been a hard working father, working for the railway, also a bin man, and cleaning supervisor, he loved going fishing until his arms and hands started getting bad with shaking and being painful, he like socialising by going to the bookies not to bet a lot of money it was on dogs and horses and would only be around 20p to 50p he would spend, it got him out of the house, we loved going on holidays as a family either to Wales or Cornwall we could not afford to go abroad but we still had a great time. Dad was a brilliant father, and grandfather he loved playing and spending time with his grandchildren and I phoned him every night to make sure he was alright once mum left him to move to Chorley to be with Mr B. He was very upset about that as you can imagine but everything stayed amicable between them and I did a lot more for him like writing letters, cheques looking at cheaper insurances for him and sorting them, we got by and helped as much as we could including my brothers whom he went out with each week when he was well enough to watch them play pool".

3.3 Mrs Smith and Mr A Relationship

3.3.1 Mrs Smith and Mr A met when they were sixteen. They married, had three children and lived at address one. It is believed the couple separated for a period of time in 2007 or 2008 when Mrs Smith left Mr A. However Mrs Smith then returned to live with him.

3.3.2 In 2010 Mrs Smith met Mr B through the internet. During 2011 Mrs Smith left Mr A and went to live with Mr B in Lancashire. Divorce proceedings between Mrs Smith and Mr A were believed to have been finalised in 2012. Mr A continued to live alone at address one while the property was put up for sale.

3.3.3 Family members and neighbours had no information that there had been any violence or traces of controlling or coercive behaviour in the relationship. While their son said that Mr A was upset after the initial shock of the separation, he said his father's subsequent relationship with Mrs Smith was amicable.

4. THE FACTS BY AGENCY

4.1 Introduction

- 4.1.1 The agencies that submitted IMRs and chronologies are dealt with separately in the following narrative which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 5.
- 4.1.2 Agencies held very little information on either Mrs Smith or Mr A. Mrs Smith worked in a hospital as an administrator for a number of years. In 2011 Mrs Smith had a period of sickness from the Trust and she was referred to their occupational health department. Mrs Smith told the occupational health consultant that she was suffering from depression as a result of a “messy divorce”. The notes do not reflect any disclosures of domestic abuse and Mrs Smith said she had moved to Lancashire and was living with someone else.
- 4.1.3 Mrs Smith was offered counselling which she accepted. However, as records are not retained it is not known whether she actually attended these counselling sessions. Mrs Smith’s personal file held by the Hospital Trust contains no evidence that she had ever disclosed or presented with any signs that she may have been in a violent or controlling relationship. Mrs Smith retired from the Hospital Trust in September 2012. The panel heard it was unlikely any probing questions regarding the divorce and the possibility of domestic abuse would have been asked as a matter of routine by an Occupational Health Service, unless there was an opening or invitation.
- 4.1.4 Mrs Smith had very limited contact with Adult Social Care in both Bury and Lancashire in relation to the care of her parents. Her mother died in early 2014. Mrs Smith’s father lived with her in Lancashire following his wife’s death and Mrs Smith cared for him. There was no information from Adult Social Care that was relevant to this DHR. In relation to her health Mrs Smith only attended her Bury GP practice on one occasion during the review period for an issue unrelated to the review. She transferred from there to a GP practice in Lancashire on 27.04.2011.
- 4.1.5 Between 27.06.2011 and 13.09.2011 Mrs Smith was seen by a GP in Lancashire on four occasions for low mood. She was given support, time off work and started on a mild antidepressant. She declined counselling and her mood improved steadily. Mrs Smith was seen by a GP in 08.2012 when she was struggling with the pressures of her divorce and caring for her elderly parents. She returned a few weeks later by which time she was feeling better. The only other consultation of note is when she visited a GP on 05.12.2013 having been “sent” by her partner as she was upset about her hair thinning. No disclosure was made of any past or present domestic abuse during any of the consultations nor was there any suggestion of drug or alcohol misuse.
- 4.1.6 Mr A was a more frequent attendee at the same Bury GP practice Mrs Smith had previously attended. The focus of presentations to his GP concerned the management of his diabetes. On 10.01.2011 Mr A was screened by a nurse for depression during a routine diabetes review. He disclosed that Mrs Smith had left him following a holiday to Malta
- 4.1.7 On 08.06.2011 Mr A attended his GP practice with a sprain. The record showed at that time he had been separated from Mrs Smith for 7 months and was coming to terms with the situation. On 01.10.2013 during a routine review with a GP he disclosed he had some stress and anxiety in relation to selling his house.

- 4.1.8 On 14.03.2014 Mr A consulted his GP with physical symptoms and said he was feeling anxious. The GP issued a medical certificate for two weeks as he was deemed unfit for work. He was seen again in the practice two weeks later and said his anxiety state had increased. He was prescribed a low dose antidepressant. On 10.04.2014 Mr A was reviewed by his GP and he said his anxiety levels continued to increase which was causing him not to eat. The GP therefore reviewed his medication and changed the antidepressant.
- 4.1.9 On 17.04.2014 Mr A was reviewed by his GP as he was feeling worse and said he had high levels of anxiety. The GP continued to prescribe him the previous antidepressant medication and another medication was also prescribed on a 'use if necessary basis' as a short term measure. Mr A was given a further medical certificate as he remained stressed and anxious. This pattern of review continued.
- 4.1.10 On 02.07.2014 his GP suggested that Mr A should consider counselling and a referral was made to Improving Access to Psychological Therapies (IAPTS). This is an 'opt in service' with a two-week window for patients to take up the option. A letter was sent to Mr A by the Primary Care Team responsible for IAPTS. Mr A did not respond and his case was closed by IAPTS. However, this did not preclude him from being referred again and on 23.10.2014 his GP record shows that he was given the self-referral number for IAPTS. There is no record Mr A used it to contact the service.
- 4.1.11 The final contact that Mr A had with his GP was on 20.11.2014 when he said he was feeling better and calmer and was happy to return to work. The GP agreed and certified Mr A as fit to return to work.
- 4.1.12 Other than reporting minor crimes unrelated to this review Mrs Smith and Mr A had no contact with Greater Manchester Police (GMP) until they received an emergency call from Mr A.
- 4.1.13 About the same time that call was made, Mrs Smith and Mrs A's son arrived at address one. He visited Mr A weekly after work and to share a meal with him. Their son let himself into the house and found the body of Mrs Smith on a couch. He used the telephone to contact the police and ambulance and found the line still open from the call his father had just made.
- 4.1.14 Their son went upstairs and found Mr A. He had a chest injury and was covered in blood. A kitchen knife was on the bed and Mr A told his son 'we've had an argument'. Mr A was treated in hospital and upon his release was taken into police custody. He made no comment when he was interviewed.
- 4.1.15 During enquiries by GMP they established that Mrs Smith visited Mr A on the day of her death in order to sign legal papers concerning the sale of address one. A neighbour had been asked to be present to witness the signatures but found he was unable to make the appointed time. He therefore signed the documents in advance. GMP found no evidence this situation arose due to any manipulation by Mr A.
- 4.1.16 GMP established that Mrs Smith's visit to see Mr A alone at Address one did not appear to give her cause for concern. Mr B was aware of the visit and had no concerns for her safety either. Because Mr A chose not to answer questions it is not known what happened when Mrs Smith visited him nor why he killed her. Enquiries by GMP and by this review panel found a complete absence of any warning signs or indicators of domestic abuse or violence. Witnesses that officers from GMP saw as

part of the enquiry into this homicide expressed shock and surprise at what happened to Mrs Smith.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

5.1 What indicators [if any] of domestic abuse between Mrs Smith and Mr A were known to your organisation and what (if any) risk assessments and risk management plan did you undertake?

- 5.1.1 While Mrs Smith and Mr A were known to their GP's, very little - if any - information was held by any other agency. No agency held information there had been domestic abuse between the couple nor were they aware of any indicators of it. Consequently, there were no opportunities to assess risk nor to put a management plan in place. The GP IMR author for NHS Chorley CCG says there was no evidence of Mrs Smith being asked specific questioning around domestic abuse in any of the consultations. This would not be expected where the focus of the consultation was physical (for example when she attended with hip pain or with her asthma). However, the IMR author feels it may have been useful when Mrs Smith was discussing the difficulties around her divorce and the effect on her mood. The author states that a time of increased risk for domestic abuse victims is around the time of separation and it may be that the clinicians were not aware of this. NHS Chorley CCG have made a specific recommendation about this (see Appendix C Agency Recommendation 1).
- 5.1.2 About the time they separated in 2011 Mrs Smith had a period of sick leave. She told her occupational health consultant at the Hospital, where she worked, that she was suffering from depression which was the result of a 'messy divorce'. She did not make any disclosure to the consultant. While she accepted the offer of counselling, the records of this have not been retained. Although there was no evidence Mrs Smith disclosed domestic abuse, the panel felt it would be helpful to ensure Occupational Health Departments, both in the public and private sector in Bury, consider developing a screening tool to identify domestic abuse when employees disclose relationship difficulties, including divorce.
- 5.1.3 Mr A had frequent contact with his GP because of his diabetic condition. Following his separation from Mrs Smith he sought help from his GP for anxiety. He received medication and was offered a referral to IAPTS. He chose not to pursue this offer and instead continued to receive treatment from his GP. While his mood was low he did not make any disclosures that indicated he might have presented a risk of harm to Mrs Smith, himself or others. He did state at one point that it was caused by the sale of the house. However, this was around eighteen months before he killed Mrs Smith. It appears his condition had improved sufficiently by 20.11.2014 to allow him to return to work and there is no information he sought any further help.
- 5.1.4 A member of the panel informed the group of Resolution First Family Law, a company who provide support to lawyers on family law and domestic violence and abuse issues. The panel member asked the group to consider contacting the company in the future to ask as a protective measure if they could use this DHR as learning (i.e. giving advice to reflect the possible danger of ex partners meeting up without a third party).

5.1.5 The Chair of the DHR suggested a letter be sent to Mrs Smith's lawyer to ask if they were to reflect on the incident now would they see that Mrs Smith was putting herself into a dangerous situation by meeting Mr A on her own? After a brief discussion it was agreed a recommendation from this review should be for the CSP to engage with the local Law Society to ask if they are aware that ex partners meeting up without a third party being present is a trigger point. Members were shown a letter that was sent to local firms of solicitors in 2014 alerting them to domestic abuse (See Appendix B).

5.2. What domestic abuse related services did your agency provide for Mrs Smith and Mr A and did they take account of their views and any racial, cultural, faith or other diversity issues?

5.2.1 No agency provided any domestic abuse related services to either Mrs Smith or Mr A. They both received services from health professionals during the period under review and these contacts are discussed at paragraph 5.1. There is no indication that race, faith or diversity was an issue in this homicide. All the agencies contributing information to this DHR report having policies and procedures in place that recognise and cater for diversity.

5.3 What did your agency do to safeguard any children exposed to domestic abuse?

5.3.1 There was no evidence that any children were involved or put at risk in connection with this domestic homicide review. The three children of Mrs Smith and Mr A are all adults. All the agencies contributing information to this DHR report have policies and procedures in place that recognise and cater for child protection.

5.4 How effective was inter-agency information sharing in response to Mrs Smith's and Mr A's situation and was information shared with those agencies who needed it?

5.4.1 Because there was such limited contact with agencies by Mrs Smith and Mr A, and no traces of domestic abuse, there were no opportunities to share information. A single referral was made by Mr A's GP to the IAPTS service. There is evidence this was received by the service and that they in turn contacted Mr A with an offer to attend counselling sessions. It appears he chose not to take up this offer.

5.5 What did your agency do to establish the reasons for any abusive behaviour by Mr A and how did it address them?

5.5.1 Until the moment when he killed Mrs Smith there was no evidence known to agencies to indicate that Mr A had been abusive towards Mrs Smith. It is the collective experience of the DHR Panel this case was one of several where death occurred in the absence of any 'reported' history of domestic abuse. The Panel felt there was an opportunity for post-conviction research to be undertaken with offenders who kill without any, or minimal, forensic (reported) history of domestic abuse and recommend that the Home Office consider whether this is realistic, and if so, how it might be achieved.

5.6 Were single and multi-agency domestic abuse policies and procedures followed and did you identify any gaps in them?

- 5.6.1 There were no gaps in multi-agency policies. NHS Bury CCG made a single agency recommendation in respect of documenting referrals to services by GP although this would have had no impact on the outcome in this particular DHR case. As mentioned previously, the DHR Panel felt there was scope for occupational health departments to screen for domestic abuse when employees report relationship difficulties. This view is reflected in a recommendation.

6. LESSONS IDENTIFIED

- 6.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix B.
- 6.2 The DHR Lessons identified are listed below. Each lesson is preceded by a narrative.

1. Narrative:

Before she was killed there were no traces of domestic abuse nor indicators that Mrs Smith was at risk from Mr A. After the initial shock, their son described the separation as amicable. The couple lived apart for some time before Mrs Smith was killed and she appeared to have built a new life with Mr B.

Lesson:

While Mrs Smith did not seem to consider herself at risk and was comfortable visiting Mr A alone, it is well documented in research and known as a risk factor that the point of separation is a critical event. While the couple had physically separated some time ago, the sale of the house probably represented the last formal act in the relationship between Mrs Smith and Mr A and therefore was a point of risk.

7. CONCLUSIONS

- 7.1 The panel were concerned about the lack of information that was available regarding the relationship between Mrs Smith and Mr A. They spent time considering possible avenues where it might be found however these were not fruitful. The police investigation, which is sometimes a rich source of material not previously known to agencies, proved similarly unproductive.
- 7.2 While some domestic homicides reveal an incremental pattern of abuse the panel recognised that was not the case in respect of the death of Mrs Smith at the hands of Mr A. The couple appear to have lived a quiet life together for many years, raising three children. Their separation came as a shock to their children although it does not appear to have been precipitated by domestic abuse.
- 7.3 Both Mrs Smith and Mr A appear to have suffered from some anxiety or stress as a result of the breakdown of their relationship. That was not unusual, it was recognised by the health professionals who dealt with them and both received treatment which appeared to address their issues. While in 10.2013 Mr A spoke about the sale of the house as a cause of his anxiety there is no evidence either he or Mrs Smith made any disclosures to agencies, family or friends that might have indicated domestic abuse was present or that she was at risk from Mr A.
- 7.4 The amicable state of their relationship is borne out by the fact that, on the day of her death, neither Mrs Smith nor her new partner had any concerns about her visit to see Mr A. The presence of a third party as a signatory to the legal papers that day might have provided mitigation to the risk Mrs Smith faced. While the point of separation increases risk it does not appear that Mrs Smith knew what she would face and neither did the third party. There was no evidence that Mr A manipulated the situation to exclude the third party and thereby ensure he was alone with Mrs Smith.

8. *PREDICTABILITY/PREVENTABILITY*

- 8.1 The DHR panel have carefully considered all the information that was recorded or should have been known to agencies. There was none to suggest agencies knew, or should have known, that Mrs Smith was at risk from Mr A. The panel therefore concluded that her death was neither predictable nor preventable.

9. RECOMMENDATIONS

9.1 The DHR Recommendations appear below and in the Action Plan.

1. The Office of the Police and Crime Commissioner for Greater Manchester Police engage with the local Law Society to establish if they are aware that ex partners meeting up without a third party being present may be a trigger point for domestic violence. They should invite the Law Society to consider issuing guidance to their members on this risk.
2. Team Bury CSP to contact Resolution, a national family law organisation, and outline the learning from this domestic homicide review. They should invite Resolution to consider including appropriate guidance on how the risk to victims may be reduced in future cases in which the sale of property is an issue.
3. Team Bury CSP to contact Occupational Health departments within the borough and advise them that depression & stress could highlight DVA in a relationship and invite them to consider asking probing questions about domestic abuse in appropriate cases.

Appendix A - Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

“Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality”
2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 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
3. *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.
4. *Coercive behaviour is:* an 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.

Vulnerable Adults No Secrets

5. The broad definition of a ‘vulnerable adult’ referred to in the 1997 Consultation Paper Who decides?* issued by the Lord Chancellor’s Department, is a person:

“Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.
6. A consensus has emerged identifying the following main different forms of abuse:
 - physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
 - sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
 - psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling,

intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;

- financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

7. Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm.

Source: Section 2 No Secrets Department of Health 2000

Risk Factors

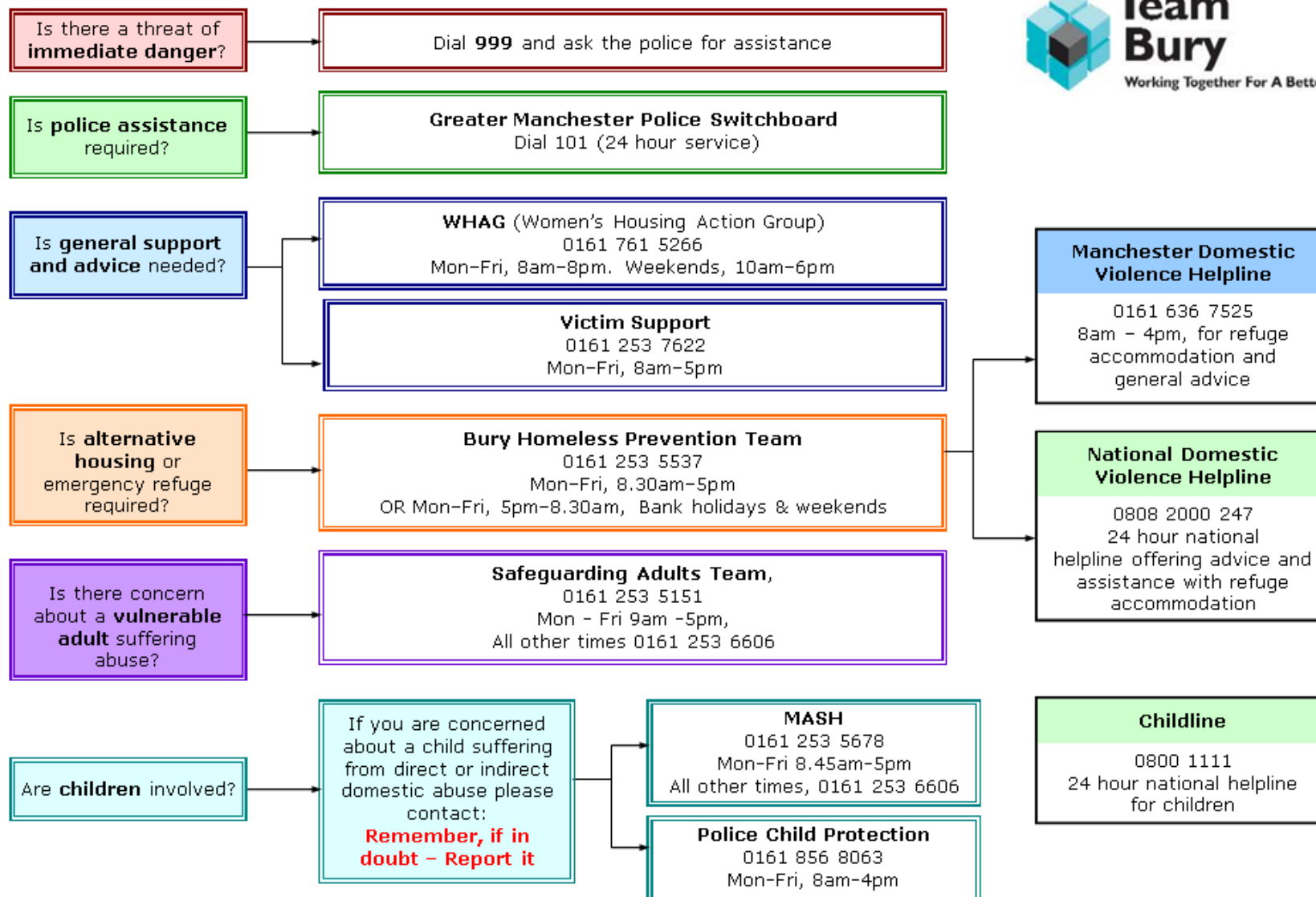
Individuals at risk for domestic violence could include those with the following risk factors:

- Planning to leave or has recently left an abusive relationship
- Previously in an abusive relationship
- Poverty or poor living situations
- Unemployed
- Physical or mental disability
- Recently separated or divorced
- Isolated socially from friends and family
- Abused as a child
- Witnessed domestic violence as a child
- Pregnancy, especially if unplanned
- Younger than 30 years
- Stalked by a partner,

The following factors may indicate an increased likelihood that a person may choose violence:

- Abuses alcohol or drugs
- Witnessed abuse as a child
- Was a victim of abuse as a child
- Abused former partner
- Unemployed or under employed/financial worries
- Abuses pets
- Criminal history including weapons
- Mental health issues/suicide attempts

How to help a person reporting Domestic Violence and Abuse



How to help a young person reporting Domestic Violence and Abuse



Is there a threat of **immediate danger**? → Dial 999 and ask the police for assistance

Is **police assistance** required? → **Greater Manchester Police Switchboard**
Dial 101 (24 hour service)

If you are concerned about a child suffering from direct or indirect domestic abuse please contact:
Remember, if in doubt – Report it

→ **MASH**
0161 253 5678
Mon-Fri, 8.45am-5pm
All other times, 0161 253 6606

→ **Police Child Protection**
0161 856 8063
Mon-Fri, 8am-4pm

For emotional support for a young person where the danger is not immediate. → **Relateen**
0845 1651830
Mon- Thurs, 9am-9pm
Fri 9am – 8pm

Childline
0800 1111
24 hour national helpline for children

National Domestic Violence Helpline
0808 2000 247
24 hour national helpline for women.

For young people: 0-18 years old
Over the age of 18 please refer to the “Adult” flowchart.

Appendix B - Letter from Team Bury



Our Ref

Your Ref

Date: 22nd August 2014

Please ask for: Jaria Hussain-Lala

Direct Line: 0161 253 5167

Direct Fax: 0161 253 5064

E-mail: j.hussain-lala@bury.gov.uk

Local Strategic Partnership

Town Hall

Knowsley Street

Dear Practice Manager,

Domestic Violence and Abuse

As the Community Safety Partnership Chair for Bury one of the work areas I have responsibility for is domestic abuse. In relation to this I am writing to practices in the local area that specialise in domestic abuse, child custody, divorce and separation to ask for their help and support in safeguarding victims, potential victims and their family.

Even if a marriage is ending amicably (no violence) women can be at risk of serious harm and injury at the point of leaving or ending a marriage. I am sure you will agree that the raising of awareness of this matter will lend a hand in safeguarding and reducing the number of domestic violence incidents. Therefore, I would be grateful if you could put the following two measures in place in your practice:

- make your clients aware of the potential risk of violence and harm to them and their children when providing advice on child contact, custody, divorce, separation & domestic violence.
- If it is safe to do so give the client a copy of the enclosed leaflets.

I thank you in advance for your co-operation in this.

If you have any questions regarding the above request please contact Jaria Hussain-Lala - Domestic Abuse Co-ordinator for Bury.

email: j.hussain-lala@bury.gov.uk

Tel: 0161 253 5167

Yours sincerely,

Chris Sykes

Chief Superintendent Bury & Rochdale Police

Appendix C - Action Plan

Panel Recommendations							
No	Scope of Recommendation	Action to Take	Lead Agency	Lead Officer	Key Milestones Achieved in Reaching Recommendation	Target Date	Date of Completion & Outcome
One	Engage with the local Law Society to establish if they are aware that ex partners meeting up without a third party being present may be a trigger point for domestic violence. They should invite the Law Society to consider issuing guidance to their members on this risk.	Contact Law Society	The Office of the Police and Crime Commissioner for GMP	L Mercer	A letter went out from Jim Battle, Deputy Police & Crime Commissioner which highlighted the issue. Subsequently a meeting took place with the Law Society where they agreed to consider issuing the guidance to members.		July 2016 Laura Mercer and Jim Battle met with the Law Society who committed to putting the recommendation into action.
Two	Contact Resolution, a national family law organisation, and outline the learning from this domestic homicide review. They should invite Resolution to consider including appropriate guidance on how the risk to victims may be reduced in future cases in which the sale of property is an issue.	Contact was made with Resolution by email	Adult Safeguarding	C Lowthian	Contact made with the organisation but as of yet no commitment to consider request.	November 2016	December 2016-10-07 Email received from Resolution confirming that they will put the recommendation to their Standards and Domestic Abuse Committees and input into any future work on safeguarding.
Three	Contact Occupational Health departments within the borough and advise them that depression & stress could highlight DVA in a relationship and invite them to consider asking probing questions about domestic abuse in appropriate cases.	Contact Society of Occupational Medicine	Adult Safeguarding	L Mercer	Letter sent to Society of Occupational Medicine.		27/05/2016 Letter received from Society of Occupational Medicine confirming that they have reminded all Practitioners about their safeguarding

							responsibilities
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Single Agency Recommendations NHS Chorley CCG						
No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Update guidance for GPs	Updating of 2010 version of "Community Practitioners, Practice Guidance. Asking about and responding to domestic violence"	Updated document ratified		Dr Linda Whitworth with help from experts in the area.	01/01/2016
2	Collate information within newsletter	Disseminate to GP practices in the CCG area (consider PanLancs)	Newsletter	Increased awareness Increased disclosures of and referrals of domestic abuse Better outcomes for victims	Dr Linda Whitworth with the CCG.	01/02/2016
3	Practice training	Individual practice involved with Mrs Smith to undertake in-house training session around domestic abuse.	Record of training session and learning from it.	As above	Dr Linda Whitworth with the practice manager and safeguarding lead.	01/02/2016

Appendix D - Letter from Home Office



Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Joyce Carroll
Bury Council
Communities and Wellbeing
Town Hall
Knowsley Street
Bury
BL9 0SW

28 July 2016

Dear Ms Carroll,

Thank you for submitting the Domestic Homicide Review report for Bury to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 22 June 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a thorough, clear and easy to follow review with good recommendations. The Panel particularly liked the pen portraits provided by the daughter which helped to humanise the subjects of the review.

There were some aspects of the report which the Panel felt could be revised, which you will wish to consider before you publish the final report:

- The Panel would like an explanation of why there was a delay in submitting the review to the Home Office;
- The Panel would like to understand why other family members and the victim's new partner were not involved in the review and why the request from the family to use real names in the report was refused;



- The Panel suggested there should be a recommendation for GPs to raise awareness of the signs of domestic abuse and their obligations to report any concerns, considering they were the primary agency contact for both the victim and perpetrator;
- Could the report clarify if the perpetrator's stab wounds were self-inflicted?
- Could you confirm if there were any parallel reviews undertaken?
- The Panel noted that there was an action given to the Police and Crime Commissioner and that they were not represented on the DHR panel. Could you clarify whether this has been discussed and agreed with them?

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would also be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners (PCCs) on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel