SAFER TRAFFORD PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Barbie'

Date of death: January 2020

OVERVIEW REPORT

After PQAA Feedback

October 2022

Chair and Author: Carol Ellwood-Clarke
Supported by: Ged McManus

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Family Tribute

'Barbie was a great Mum to her boys, auntie, sister and amazing Nanna to her baby Grandson. You could talk to her about anything. She loved life to the max and would often throw house parties. There were many good times when we went on holiday with families and friends. Barbie loved her job very much. Barbie enjoyed nights out and was always a great laugh to be with. Thank you from the bottom of our hearts and may you rest in peace always'.

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Barbie's family.

1.2 This report of a Domestic Homicide Review (DHR) examines how agencies responded to, and supported Barbie, a resident of Trafford, prior to her death in Winter 2020.

1.3 Home Office Domestic Homicide Review statutory guidance (2016)[1] states:

'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'.

1.4 In addition to agency involvement, the review will examine the past to identify any relevant background or trail of abuse, 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.

1.5 Barbie had been in a relationship with Frank for over 18 years. There had been previous reported incidents of domestic abuse within their relationship. During the two years prior to Barbie's death, the domestic abuse increased in terms of frequency and reported incidents to the police. During these two years, the case was heard at MARAC[2] on four occasions, within a six-month period. The relationship ended and Barbie moved out of the family home.

1.6 In the Winter of 2020, Barbie was admitted to hospital after being found by family in an unconscious state at her home. Upon arrival at hospital, Barbie was transferred to the cardiothoracic critical care unit, where her

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[2] Multi Agency Risk Assessment Conference

condition deteriorated: she later died. The post-mortem determined the cause of death as –

(a) multiorgan failure

(b) combined drug and alcohol toxicity

The police undertook an investigation into the circumstances surrounding Barbie's death. There have been no criminal charges in relation to Barbie's death.

1.7 In March 2020, Frank died. Frank's death occurred before the commencement of the review.

1.8 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.9 It is not the purpose of this DHR to enquire into how Barbie died. This is determined through other processes.

1.10 The inquest in relation to Barbie's death had not been heard prior to the completion of the DHR.

2. TIMESCALES

2.1 Following Barbie's death, formal notification was sent to Safer Trafford Partnership by Greater Manchester Police on 16 January 2020. A meeting was held on 4 February 2020 where it was agreed to conduct a Domestic Homicide Review. On 10 March 2020, the Home Office was notified of the decision.

2.2 Due to the Covid-19 pandemic, the DHR was suspended by Safer Trafford Partnership. Towards the end of 2020, it was agreed by Safer Trafford Partnership that the review would commence. The first meeting of the Review Panel took place on 18 January 2021. All panel meetings were held virtually due to the Covid-19 pandemic, and contact was maintained with the panel via email and telephone calls. In total, the panel met six times.

2.3 The DHR covers the period from 1 January 2018 to 11 January 2020. The start date was chosen as this was prior to an increase in reported domestic abuse within the relationship. The panel acknowledged that there had been previous domestic abuse and used this information as background and context to the review whilst focussing on more contemporary events in terms of learning. In addition, all agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.4 The Domestic Homicide Review was presented to Safer Trafford Partnership on 11 February 2022 and concluded on 25 March 2022, when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published, it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, and her partner, which were agreed by Barbie's family.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Barbie	Victim	42	White British female
Frank	Ex-partner	56	White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following Terms of Reference at its first meeting on 18 January 2021.

4.2 The DHR panel set the period of review from 1 January 2018 to 11 January 2020.

4.3 **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 inform national and local policies and procedures as appropriate;
- 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;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.
  [Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7]

4.4 **Subjects of the DHR**

Deceased: Barbie – 42yrs

Ex-partner: Frank – 56yrs (deceased)

4.5 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Barbie as a victim of domestic abuse, and what was your response?
2. What risk assessments did your agency undertake for Barbie? What was the outcome and, if you provided services, were they fit for purpose?

3. What was your agency's knowledge of any barriers faced by Barbie that might have prevented her reporting domestic abuse, and what did it do to overcome them?

4. What knowledge did your agency have that indicated Barbie could be at risk of suicide as a result of domestic abuse and any coercive and controlling behaviour?

5. What knowledge did your agency have of Barbie and Frank's physical and mental health needs, and what services did you provide?

6. What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Barbie's victimisation, and did they know what to do with it?

7. What knowledge did your agency have that indicated Frank might be a perpetrator of domestic abuse, and what was the response – including any referrals to a Multi-Agency Risk Assessment Conference (MARAC)?

8. Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

9. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Barbie and Frank?

10. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

11. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Barbie and Frank, or on your agency's ability to work effectively with other agencies?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Safer Trafford Partnership?

5. METHOD

5.1 On 4 February 2020, Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

5.2 The first meeting of the DHR panel determined the period the review would cover. The Review Panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. The Chair provided training to Individual Management Review (IMR)[3] authors to assist in the completion of the written reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified and auxiliary information sought.

5.4 The Chair liaised with the panel members, in particular the police, to identify family members or friends to help inform the DHR process. In addition, the Chair liaised with the Coroner's Office to identify family members.

5.5 On 29 February 2020, Frank died whilst an inpatient at hospital. There was no contact with Frank prior to his death. The Review Panel did not contact Frank's extended family and/or friends as details were not known. The Chair did speak with Frank's son, who made it clear that Frank's other children did not want to be involved in the review.

5.6 The Chair of the Community Safety Partnership agreed for the suspension of the DHR due to the Covid-19 pandemic. The Home Office was notified of the suspension and the review started in January 2021.

5.7 Thereafter, a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Barbie's family who were invited to make any additional contributions or corrections.

[3] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY.

6.1 The Chair wrote to Barbie's family to inform them of the review and included the Home Office Domestic Homicide Review leaflet for families, and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[4]. The Chair initially received no response to the letters that were sent, and telephone calls made.

6.2 The Chair progressed further contact with family via the Coroner's Office, but as the contact details were the same, this was again unsuccessful. The Police informed the Chair that no further details were known regarding family and friends than had been provided for the coronial case.

6.3 The Chair eventually managed to gain contact with an aunt of Barbie, who provided the Chair with information for the review. In addition to Barbie's aunt, the Chair also spoke with a cousin of Barbie's with whom she had a close relationship, and described Barbie as more like a 'sister' than a cousin. The Chair met with Barbie's aunt and cousin in person.

6.4 Barbie's aunt agreed to discuss the review with Barbie's adult children and seek clarification if they wished to contribute to the review; however, for personal reasons, she stated that it would be unlikely. The Chair agreed to respect their decision.

6.5 The Chair discussed the availability of advocacy support for the DHR with Barbie's aunt and cousin, but both stated that they did not wish to progress with the support. The Chair provided the family with a leaflet detailing advocacy support from AAFDA and agreed to refer them to the service if required. Barbie's aunt and cousin declined to attend a panel meeting.

6.6 Towards the end of the review process, the Chair was contacted by one of Barbie's children who agreed to contribute to the review. The Chair spoke to Barbie's son on several occasions and discussed the review process and findings. Barbie' son provided the Chair with additional information that has been included in the overview report. The Chair shared a copy of the draft overview report with Barbie's son. Barbie's son was informed of the availability of advocacy support; however, he declined for a referral to be made. The Chair provided Barbie's son with Home Office and AAFDA leaflets. Barbie's son confirmed that his other siblings did not want to be involved in the review process.

6.7 The Chair emailed and telephoned Barbie's employer. The Chair spoke to the manager at the Care Home where Barbie had worked. The manager

[4] https://aafda.org.uk/

had not been in that post at the time of Barbie's employment and therefore held no relevant information about Barbie. The manager agreed to speak with current employees and the Human Resources department to establish if anyone was willing and able to contribute to the review process, and if there was any relevant information held within HR records. The Chair provided the manager with Home Office leaflets for employers. Following the initial contact, the Chair spoke further with the manager and was informed that no relevant information was held within HR records.

6.8 The Chair spoke with a close work colleague of Barbie's who provided the Chair with valuable information. This has been included within the report where relevant.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Adult Social Care, Trafford Council	✓	✓	
Children's Social Care		✓	✓
Greater Manchester Mental Health NHS Foundation Trust		✓	✓
Greater Manchester Police	✓	✓	
Manchester University NHS Foundation Trust	✓	✓	
Northern Care Alliance	✓	✓	
North West Ambulance Service	✓	✓	
Trafford Clinical Commissioning Group (GP Practice)	✓	✓	
Trafford Domestic Abuse Services			✓
Victim Support	✓	✓	

7.2 The IMRs contained a declaration of independence by their authors, and the style and content of the material indicated an open and self-analytical approach, together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 Below is a summary of contributors to the review.

7.3.1 **Adult Social Care**
The teams provide social work support, assessment, care management and review for older people, adults with a physical disability and adults with a sensory impairment or loss. Community health professionals, including district nurses, also work in the Trafford Local Care Organisation and are employed by Manchester University NHS Foundation Trust.

7.3.2 **Children's Social Care**
The social care team work with children and families from 0-18 years of age. We work in a multi-disciplinary manner with our partner agencies to promote best outcomes and life chances. Social workers support families to stay together and work with other agencies to prevent family breakdown, support with parenting advice, and undertake child protection investigations. Social workers are also involved in court hearings when children cannot live with their parents (either public or private law), and in

private fostering and supporting children returning to their families, whenever possible.

7.3.3 **Greater Manchester Mental Health NHS Foundation Trust**

Greater Manchester Mental Health NHS Foundation Trust provides community-based and inpatient mental health care and treatment to a population of 1.2 million people living in Bolton, Salford, Trafford and Manchester. The Trust provides a wide range of more specialised mental health and 'outstanding' substance misuse services across Greater Manchester, the North West of England, and beyond. We provide in-reach services to prisons across the north of England, and secure mental health services for the North West of England.

7.3.4 **Greater Manchester Police**

Greater Manchester Police is the territorial police force responsible for law enforcement within the metropolitan county of Greater Manchester in North West England. GMP is the fourth largest police service in the United Kingdom, and is the second largest force in England and Wales.

7.3.5 **Manchester University NHS Foundation Trust**

The Trust formed in 2017, resulting from the merger between Central Manchester University Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust, and North Manchester General Hospital. The Trust also covers Trafford General Hospital.

7.3.6 **Northern Care Alliance**

NCA cover acute and community services in the Rochdale, Oldham, Bury and Salford areas.

7.3.7 **North West Ambulance Service**

NWAS serves more than seven million people across approximately 5,400 square miles – the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire and Glossop (Derbyshire). They receive approximately 1.3 million 999 calls and respond to over a million emergency incidents each year. NWAS makes 1.5 million patient transport journeys every year for those who require non-emergency transport to and from healthcare appointments. NWAS delivers the NHS 111 service across the region for people who need medical help or advice, handling more than 1.5 million calls every year.

7.3.8 **Trafford Clinical Commissioning Group (GP Practice)**

NHS Trafford Clinical Commissioning Group (CCG) is responsible for buying healthcare services for the people of Trafford. We are required to plan services based on the needs of our local population, secure services that meet those needs, and monitor the quality of care provided.

7.3.9 **Trafford Domestic Abuse Services**

Trafford Domestic Abuse Services (TDAS) is a registered charity. It offers support to individuals and families living or working in the Trafford area who are suffering or who have suffered domestic abuse. It provides both intervention and prevention services, and works in partnership with other voluntary organisations to support families across Greater Manchester.

7.3.10 **Victim Support**

Provides support for victims, witnesses and others affected by crime at any time: whether or not the crime has been reported to the police. Provides 1-2-1 help and support around the criminal justice system or advocacy, personal coping, and recovery measures/strategies. Provides support for victims of domestic abuse who have been assessed as standard, medium, and high-risk.

7.4 The following agencies were contacted as part of the scoping process and held no information:

- Housing
- Greater Manchester Fire and Rescue Service
- Youth Justice
- Probation
- University Academy 92
- Trafford Housing Trust

8. THE REVIEW PANEL MEMBERS

8.1 This table shows the Review Panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Sharon Boardman	Deputy Adult Safeguarding lead	Greater Manchester Mental Health[5][6]
Georgina Cartridge	Named Practitioner, Adult Safeguarding	Northern Care Alliance
Rhys Dower	Domestic Abuse Manager	Trafford Council
Andrea Edmondson	Interim Head of Clinical Safety	North West Ambulance Service
Carol Ellwood-Clarke	Independent Chair and Author	
Hannah Gaffney	Programme Manager	Public Health
Zylla Graham	Detective Inspector	Greater Manchester Police
Jen Houghton	Strategic Lead	Children's Social Care – Trafford Council
Ged McManus	Independent Reviewer	
Ann-Marie Mohieddin	Service Manager for Front Door and Safeguarding	Adult Social Care – Trafford Council
Sarah Owen	Designated Nurse, Safeguarding Adults	Trafford Clinical Commissioning Group
Anita Pluckwell	Community Team Leader	Trafford Domestic Abuse Services
Johanna Vince	Adult Safeguarding Senior Specialist Nurse	Manchester University NHS Foundation Trust

[5] GMMH commission Achieve which is the substance misuse programme in Trafford.
[6] https://www.gmmh.nhs.uk/achieve/
Greater Manchester Mental Health NHS Foundation Trust (GMMH) is proud to be the lead provider of substance misuse treatment and recovery service in the boroughs of Bolton, Bury, Salford and Trafford.
Our approach, under the name 'Achieve' will focus on delivering innovative and high performing substance misuse treatment and recovery with our partners using a proven approach that will promptly identify and support people affected by alcohol or drug misuse into appropriate treatment. We are committed to improving health and social outcomes for service users and families allowing more people to make a meaningful recovery from drug and alcohol misuse.

Jane Whittaker, Safeguarding Practitioner	Safeguarding Practitioner	North West Ambulance Service
Ruth Wilson	Area Manager	Victim Support

8.2 The Chair of Safer Trafford Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met six times and the circumstances of Barbie's death were considered in detail, with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic, panel meetings met virtually. Outside of the meetings, the Chair's queries were answered promptly via email or telephone call, and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.

9.2 Carol Ellwood-Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHRs and other safeguarding reviews. Carol retired from public service (British policing – not Greater Manchester) in 2017, after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[7].

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not Greater Manchester). He served for over thirty years in different police services in England (not Greater Manchester). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken the following types of reviews: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. In addition, they have undertaken accredited training for DHR Chairs, provided by AAFDA.

[7] https://safelives.org.uk/

10. PARALLEL REVIEWS

10.1 HM Coroner for South Manchester opened and adjourned an inquest. The Chair notified Her Majesty's Coroner that a DHR was being undertaken. An inquest had not been held at the time of the conclusion of the DHR.

10.2 The police conducted a criminal investigation into the circumstances surrounding the death of Barbie, due to concerns raised by the family. No criminal charges have been brought in relation to Barbie's death.

10.3 Greater Manchester Police referred Barbie's death to the Independent Office for Police Conduct (IOPC)[8], who determined that the mode of investigation decision was for further investigation to be undertaken at a local level. This investigation concluded in April 2020. The investigation did not identify any Police Officer or member of Police staff, had committed any criminal offence, or behaved in a way that fell below the required levels of professional standards.

10.4 The review was not aware of any other investigations that have taken place since Barbie's death.

[8] https://www.policeconduct.gov.uk/

11. EQUALITY AND DIVERSITY

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women.

A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[9]

11.3 There is nothing in agency records that indicated that any subjects of the review lacked capacity[10] in accordance with Mental Capacity Act 2005. Professionals applied the principle of Section 1 Care Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.4 Barbie and Frank were known to consume alcohol. This was documented within agencies' records and was a recurring feature during contact with the police. Neither Barbie nor Frank were known to alcohol misuse services. There was evidence that professionals had discussed with Barbie and Frank their alcohol consumption and offered to refer them to alcohol

[9] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[10] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".
Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".
Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".
Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.
Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".
Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

support services such as Achieve[11], but neither Barbie nor Frank consented for a referral to be made.

11.5 Whilst there is no evidence that Barbie and Frank were addicted to alcohol, the Equality Act 2010 (Disability) Regulations (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.6 The family told professionals that Barbie had suffered with a brain injury as a child. Information provided to the review identified that Barbie had had a benign Intracranial Hypertension and Lumber Puncture as a child. In 2011, Barbie was referred to Neurology and reviewed by a Consultant Neurologist, where she was diagnosed with chronic migraines. There was no evidence that her injury as a child impacted on her cognitive ability.

11.7 Towards the end of 2018, Barbie saw a GP in relation to anxiety and depression. Barbie was prescribed medication and attended review appointments. Barbie was prescribed Mirtazapine[12] (15mg tablets) – these were last prescribed on 19 November 2019. Barbie disclosed that her anxiety and depression was linked to work and domestic abuse. [See Section 13].

11.8 Domestic homicides and domestic abuse predominantly affects women, with women making up the majority of victims and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-

[11] https://www.gmmh.nhs.uk/achieve/
Our approach, under the name 'Achieve' will focus on delivering innovative and high performing substance misuse treatment and recovery with our partners using a proven approach that will promptly identify and support people affected by alcohol or drug misuse into appropriate treatment. We are committed to improving health and social outcomes for service users and families allowing more people to make a meaningful recovery from drug and alcohol misuse.

[12] https://www.nhs.uk/medicines/mirtazapine/

partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

11.9 Frank had high blood pressure and diabetes, which was managed through medication. Frank did not routinely take his medication as prescribed. Towards the end of 2019, Frank was seen by health professionals in relation to anxiety and depression. Frank was referred to Community Mental Health after he stated he intended to take his own life. Following an assessment, Frank was discharge back to the care of his GP. Frank was prescribed medication for his anxiety and depression. Frank was last prescribed Citalopram[13] (10mg) on 20 December 2019, and Sertraline[14] (50mg) on 8 November 2019. Neither of these medications were on repeat prescription.

11.10 All subjects of the review are white British. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

[13] https://www.nhs.uk/medicines/citalopram/

[14] https://www.nhs.uk/medicines/sertraline/

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process:

- The Family
- Safer Trafford Partnership
- Trafford Strategic Safeguarding Partnership
- All agencies that contributed to the review
- Greater Manchester Police and Crime Commissioner
- Domestic Abuse Commissioner

13. BACKGROUND, CHRONOLOGY AND OVERVIEW

This part of the report combines the Background, Chronology and Overview sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, and material gathered by the police during their investigations.

13.1 Barbie

13.1.1 Barbie was described as a 'happy go lucky' person, who loved her job caring for older people. Barbie's family informed the review that Barbie had witnessed domestic abuse between her mother and father. Barbie's uncle took his own life when she was growing up, and her aunt stated that Barbie had a difficult relationship with her mother: this meant that she would spend a lot of time with her aunt.

13.1.2 Barbie had a brother. Barbie had the strongest relationship with her cousin. Barbie's aunt described their relationship being like having two daughters instead of one. Barbie was described as being a strong woman who brought the life and soul to a party.

13.1.3 Information provided to the review stated that Barbie had suffered a brain injury as a child. As a result of the brain injury, which was reported to be a brain tumour, Barbie had a gag reflex and found it difficult to swallow.

13.1.4 Barbie was the mother to three children: all of whom were adults at the time of her death. Barbie was described as a loving and doting mother to her children. Frank was the father of the youngest child.

13.2 Frank

13.2.1 Frank had three children from a previous relationship. He had previously had a number of jobs, which included being a HGV driver and later a delivery driver. Barbie's family stated that he lost his job due to alcohol consumption. Information stated that Frank had debts of over £30,000.

13.3 Barbie and Frank's relationship

13.3.1 Barbie and Frank had been in a relationship for 18 years, of which they had been married for 11 years. The family informed the review that Barbie had brought her marriage to Frank forward so that her father, who was terminally ill, could attend. The family stated that there had always been domestic abuse in Barbie and Frank's marriage; however, Barbie had been brought up to believe that if you were married, you 'stuck with it' and therefore tolerated the abuse.

13.3.2 The extent of the abuse was not known to some of Barbie's family. Barbie's cousin told the Chair that she was aware of the abuse, and that Frank was violent towards Barbie. Barbie's cousin provided examples of the abuse, which are captured further in the report. Barbie's cousin stated that she had encouraged Barbie to leave the relationship. However, Barbie often said that as she had married Frank, that meant she took the violence in the relationship. This is covered later in Section 14.

13.4 Events prior to the Timescales of the Review

13.4.1 In February 2003, police attended a domestic incident between Frank and a previous partner, during which he was described as intimidating. The female was provided with details of support agencies. The following month, Frank assaulted a child during a domestic incident. Frank was arrested and subsequently appeared in court; he was given a Conditional Discharge for 6 months and ordered to pay £50 in compensation.

13.4.2 Between 2003 and 2013, the police attended 11 incidents of domestic abuse between Barbie and Frank. Frank was the perpetrator in nine of these incidents. The first of these assaults was in 2003, when Frank punched Barbie in the face causing an injury. In 2005, Frank punched Barbie in the face and threw her by her arm, causing bruising to Barbie's face and hip. In 2009, Barbie received a broken arm following an altercation with Frank. Barbie stated that this was not a deliberate act as she had turned away whilst he was holding her arm, causing it to twist. She maintained this account when spoken to by the police. None of the assaults resulted in criminal charges.

13.4.3 In 2007, it was reported that Barbie had taken an overdose following a domestic incident with Frank. Alcohol was recorded as a factor during all domestic abuse incidents.

13.4.4 In January 2010, Children's Social Care sent a letter to the family in relation to a domestic abuse incident that resulted in Barbie and her children leaving the home to stay with family. The letter advised that if there were further incidents of domestic abuse, then this may result in an Initial Assessment being completed. The following month, there was a further incident during which Barbie reported that she had been strangled by Frank, who had also threatened to kill her. The children were reported to have been present. Children's Social Care undertook an enquiry under Section 47 Children Act 1989, a case conference was held, and the case progressed to child protection under the category of emotional abuse. In May 2010, the case was stepped down to Child in Need (Section 17 Children Act 1989), and closed on 28 September 2010.

13.4.5 Barbie's son informed the review that, as a child, he had witnessed domestic abuse between Barbie and Frank. He described that Frank was always the perpetrator, and that the incidents would often occur whilst Barbie and Frank were consuming alcohol: usually at the weekend. By the time that he was a teenager, Barbie's son stated that he left the family home to live with other family members. The main reason for leaving was due to the domestic abuse.

13.4.6 In 2013, the police attended two incidents of domestic abuse, which were recorded as arguments between Barbie and Frank over the behaviour of one of the children. Barbie was recorded as the perpetrator in two of these incidents. The incidents were referred to Children's Social Care and shared with the child's school.

13.4.7 In June 2015, a referral was received from MARAT[15] that Frank had pushed a 14-year-old family member, causing an injury to their lip. The victim had been living with Barbie and Frank. The victim stated that they did not want to return to the home as Barbie and Frank consumed alcohol daily and that they had been slapped and punched. No further action was taken as the victim did not wish to speak to the police, and she had been moved to another placement.

13.4.8 In September 2017, Barbie attended at hospital with a facial injury. Barbie stated that she had been assaulted by Frank. It was recorded that Barbie declined a referral to Adult Social Care and MARAC. The matter was referred to MARAT. There is no record of any agency undertaking any further action in relation to this incident.

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[15] Multi Agency Risk Assessment Team which is the front door service for Children's Social Care.

Events during the Timescales of the Review.

13.5 2018

13.5.1 On 25 October, North West Ambulance Service submitted a Safeguarding Concern Notification Form after responding to an incident whereby Barbie had been found unconscious after a fall, and had sustained a facial injury. Barbie had been consuming alcohol with friends prior to the incident. Adult Social Care has no record of receiving the Safeguarding Concern Notification Form from NWAS.

13.5.2 On 2 December, Frank was arrested for an assault on Barbie during which she sustained an injury to her lip. Barbie informed the police that they both consumed alcohol daily, and that she intended to move out of the home the following day. Barbie declined to provide a statement. Body Worn Video had been used by the police during the incident. A Domestic Violence Protection Notice[16] (DVPN) was considered, but discounted due to the previous incidents between Barbie and Frank. A DASH risk assessment was completed and graded as standard. The incident was finalised, with no further action being taken.

13.5.3 On 27 December, Barbie spoke with her GP regarding anxiety and depression. During the appointment, Barbie disclosed the domestic abuse incident earlier that month. Barbie was referred to IRIS[17] and a HARK[18] questionnaire was completed. Barbie stated that she felt safe at home, and that it was the second time in their 17-year relationship that she had been assaulted. Safety education and guidance/counselling was provided to Barbie. At the end of December, the IRIS Advocate Educator, who was a trained Independent Domestic Violence Advocate (IDVA), attempted to contact Barbie. The contact was unsuccessful.

[16] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

[17] Victim Support was commissioned to deliver the IRIS programme and at this time was receiving referrals from GPs in Trafford.
[18] https://patient.info/doctor/domestic-violence-pro

13.6 2019

13.6.1 In January, further attempts were made to contact Barbie: these were unsuccessful. At the end of January, the GP was informed that the contact had been unsuccessful, and the case was closed.

13.6.2 The family informed the review that about 12 months prior to Barbie's death (beginning of 2019), she had met another man and started a relationship. The love and attention she received made her realise that she did not have to tolerate the abusive relationship with Frank, and she began making preparations to leave him. This included Barbie starting to look for somewhere else to live, and seeking advice from a solicitor. Frank was not aware of this relationship and, when Barbie eventually did tell Frank she wanted to end the relationship, he assaulted her.

13.6.3 On 3 February, police attended a domestic incident between Barbie and Frank. Frank had contacted the police and stated that, during an argument with Barbie, he had been assaulted. Barbie and Frank had both been consuming alcohol. Frank stated that he did not want to make a complaint. Barbie left the address for the night. A DASH risk assessment was completed and graded as standard.

13.6.4 On 22 February, Barbie had a review meeting with her GP. Barbie reported that she was sleeping better, and things were better at home – Frank had stopped drinking and they were communicating more. Barbie stated she had not heard from IRIS, and the GP made a further referral. Upon receipt of the referral, the IRIS Advocate Educator attempted to contact Barbie on several occasions. Contact was unsuccessful and on 12 March, an email was sent to the GP to inform them that the case had been closed.

13.6.5 On 11 May, the police received a report that Barbie had assaulted a friend. During the altercation, Frank had intervened and been assaulted. All parties had been consuming alcohol. There were no complaints of assault from Frank or the friend. Barbie left the address. Barbie and Frank stated that their relationship was over. A DASH risk assessment was completed and graded as standard and a referral was made to Strive[19]. Records held

[19] Operation Strive was launched by Greater Manchester Police in September 2016 and is a network of volunteers, PCSO's and third sector agencies who are responsible for carrying out secondary visits to standard non-crime related DV incidents, to understand and address the underlying causes and triggers and provide victims and perpetrators with the support they require by putting them in contact with the relevant partnership services for advice and support.

by Strive indicated that a referral was made to MARAT/Health, and contact made via telephone. No further information was held.

13.6.6 Two weeks later, the police received a further report of a domestic incident. The matter was reported by a family member, who stated that Frank had assaulted Barbie, as she had told Frank that she wanted to end the relationship. When the police attended the house, it was in darkness, and no one was seen. Barbie was spoken to by the police four days later and stated that she did not wish to provide a statement or take the matter further. Barbie stated that she was still living at the house with Frank, and she was sleeping on the sofa, as she had nowhere else to go. A DASH risk assessment was completed and graded as medium, which was later reduced to standard: the rationale was that the incident did not indicate any risk of harm. A referral was made to Victim Support for Barbie. A referral was also made to Achieve for Frank but, as he had not consented, the referral could not be progressed.

13.6.7 On 13 June, Frank was arrested after he had assaulted Barbie during a domestic incident. Barbie told the police that the relationship had ended 3-4 weeks earlier. Barbie did not provide a statement and she left the address to stay with friends. A DASH risk assessment was completed and graded as medium. Whilst in custody, Frank was also interviewed about the incident in May. Frank stated that he could not remember the incident. No further action was taken in relation to either assault. A DVPN was granted against Frank. A referral was made to MARAC and Victim Support, which included that Barbie was 'struggling with housing'.

13.6.8 On 16 June, Barbie was seen by Derbyshire Police, at a friend's house, after concerns had been raised regarding her mental health. Barbie stated that she had consumed a large amount of alcohol, but that she had no feelings of self-harm or suicide. A referral to Adult Social Care was not completed as Barbie did not provide her consent. Barbie told the police that she was going to reside with friends in Manchester.

13.6.9 On 17 June, a Domestic Violence Protection Order (DVPO) was granted at Salford and Manchester Magistrates Court. The order expired on 14 July 2019. Barbie and Frank were not seen by the police during the duration of this order. Later that day, an Independent Victim Advocate[20] (IVA) spoke with Barbie. Barbie stated that she did not support a prosecution against

[20] Victim Support have been delivering the Victim Assessment and Referral Service since July 2017, with a team of Independent Victim Advocates (IVAs) who undertake the majority of the victim contact.

Frank. Barbie stated that she had received a notice from the police which prohibited Frank from harming her, and evicting her from the property, but that she was unsure what the notice was. Barbie stated that she was returning to the house in the next few days, as her adult children were there.

13.6.10 The following day, the IVA had further contact with Barbie and provided her with information and safety planning advice around returning to the home. The MARAC was explained, and Barbie agreed for contact from other agencies, but requested that initial contact was made via text. Barbie stated that she was returning to work but had some concerns as she had had some time off sick recently due to the domestic abuse.

13.6.11 On 18 June, Barbie made a telephone call to the 111 service. The call was transferred to the 999 service and an ambulance was dispatched. Barbie reported that she had a headache which had worsened over a couple of days. Barbie disclosed that she was stressed due to a domestic abuse situation and police investigation, and that she was living with the perpetrator. The Health Advisor who spoke with Barbie raised a safeguarding concern without Barbie's consent, as it was felt that Barbie was at risk of significant harm. Barbie was transferred to hospital. The domestic abuse concerns were shared with staff at the hospital. A safeguarding concern was not raised as Barbie did not consent to the attending crew completing a referral.

13.6.12 On 19 June, a friend of Barbie's contacted TDAS to enquire about refuge space for Barbie, following an incident with Frank. Contact details were provided for Victim Support and the domestic violence helpline. The friend was advised that there were no spaces available at TDAS and that Barbie needed to ring the domestic violence helpline number to enquire about spaces. The friend was advised that due to data protection, Barbie would need to be present when the calls were made. Barbie's cousin told the Chair that Barbie knew her friend had made the telephone call, but Barbie did not want to leave the house and move into other accommodation.

13.6.13 The following day, the referral was reviewed within Adult Social Care. Barbie had not previously been known to Adult Social Care. A social worker contacted agencies to gather further information. These included, Community Mental Health Team, health professionals, and IDVA. The referral was deemed as high-risk due to information relating to domestic abuse and stress. A social worker spoke with Barbie the next day. Barbie stated that the relationship had ended, and she was living with family.

Barbie's housing situation was discussed, and Barbie informed the social worker that she intended to sell the house. Barbie agreed for the social worker to send her information in relation to housing options.

13.6.14 On 1 July, the IVA spoke with Barbie who stated that she was back living in the house, and that the police had served a notice (DVPO) on Frank which prevented him being at the property.

13.6.15 On 10 July, a MARAC meeting was held. This was the first of four MARACs held over the following six months. It was recorded in the MARAC minutes that Barbie had previously been referred to Victim Support and had been speaking with an IVA. The Independent Domestic Violence Advocate[21] (IDVA) updated the MARAC that they had been unable to contact Barbie and a further attempt was to be made. Further attempts at contact were made after the MARAC meeting by the IDVA, but these were unsuccessful: the case was closed, in line with policy.

13.6.16 At the end of August, Frank was seen by a GP. During the consultation, Frank stated that he had been depressed for over a year, he was going through a divorce, and had financial concerns. Frank had stopped taking his prescribed medication. Frank declined to provide further information and stated that he did not want any medication or further input at this time.

13.6.17 On 1 September, the police attended a domestic incident between Barbie and Frank. The incident was recorded as a verbal argument. Frank left the address to stay with family. Barbie and Frank told the police that they had separated four week ago, but were still living at the same address, and they were experiencing difficulties regarding the ownership of the house and the mortgage. A referral was made to MARAC, with the MARAC meeting being held on 2 October 2019. The risk level was raised to high. Victim Support attempted to contact Barbie after the MARAC referral. Contact was unsuccessful and the case was closed.

13.6.18 On 10 October, Frank contacted the police and reported that he had been assaulted by Barbie. When seen by the police, Frank refused to give any account of the circumstances. Barbie had left the address prior to the police attendance. Frank had no visible injuries. Frank refused to support

[21] IDVAs provide support to high-risk victims of domestic abuse. High-risk victims identified by Greater Manchester Police and partner agencies in Trafford were referred direct to the IDVA service on a daily basis at the time and were contacted to assess their immediate support needs before the case was heard at the MARAC meeting.

a prosecution and complete a DASH. A crime was recorded for Common Assault and filed.

13.6.19 Around three months prior to Barbie's death, the family told the Chair that Barbie and Frank went on holiday to Turkey. The holiday had been booked for some time, and it was seen as the last chance to make their relationship work. The family reported that Frank assaulted Barbie whilst they were away and, as a result of this, Barbie flew home early. After this incident, Barbie told Frank that the relationship was over. The assault was not reported to the police or other agencies, by Barbie, Frank or family following the incident in Turkey.

13.6.20 In October and November, Barbie and Frank were seen by health professionals. During these contacts, they discussed their alcohol consumption and their individual presenting mental health. There were no disclosures of domestic abuse, or records that domestic abuse was raised by health professionals.

13.6.21 On 12 November, police attended a report of a disturbance involving Barbie and Frank. During the incident, Frank picked up one of the family's dogs and stated: 'I'll snap its neck'. Barbie left the address to stay with a friend. Barbie's adult child who was present during the incident, informed the police that the arguments were getting worse between Barbie and Frank, and that alcohol was a factor for both. A DASH risk assessment was completed and graded as medium and a referral was made to MARAC.

13.6.22 Approximately five hours after this incident, during the early hours of 13 November, ambulance responded to a 999 call to Barbie. Concerns had been raised by a friend that Barbie may have been having a seizure. It was recorded that Barbie had been consuming alcohol due to moving out of her home, and years of domestic abuse. NWAS was informed of the earlier incident to which the police had attended. It was noted that Barbie had large areas of bruising to her body and legs, which she stated had been done by the dog getting excited during the arguments. Barbie consented for a safeguarding referral to be raised with Adult Social Care.

13.6.23 On 24 November, the police attended a further domestic incident. Barbie had been staying with family but had returned to the home address. Barbie and Frank had been drinking alcohol together when an argument began. Frank told the police he had sustained an injury to his hand during the argument when Barbie had thrown a glass at him. Barbie claimed the injury occurred when Frank punched a door. Barbie left the house to go to

work. A DASH risk assessment was completed and graded as medium. Frank did not support a prosecution in relation to the assault and the case was closed.

13.6.24 Four days later, a social worker spoke to Barbie in response to the safeguarding referral from 13 November. Barbie told the social worker that the house had been sold, she was residing with family, and was on the Trafford Housing list. There was no record held with Trafford Housing Trust and Trafford Housing Options List. Barbie stated that she planned to move nearer her work. Barbie stated that she did not have care and support needs, and advised that alcohol was not an issue. The social worker informed Barbie of support available through Achieve.

13.6.25 On 30 November, police received a call from Frank that Barbie had returned to the home, and he wanted her removed. When the police attended, there was no reply to knocking. Frank was then spoken to via telephone, and he requested a visit in the morning. The next day, Frank told the police he no longer required their involvement.

13.6.26 On 2 December, the social worker updated the IDVA with Barbie's contact details and information obtained during the contact on 28 November. The social worker at the Screening Team advised the IDVA that she had spoken to Barbie and Barbie declined any support from the IDVA. Barbie also said that she did not want to speak to an IDVA.

13.6.27 The same day, the police attended a further incident between Barbie and Frank. When police attended, Barbie was in bed. Frank stated that Barbie had given away one of his dogs, due to the separation. An argument had then ensued. Barbie told the police that Frank waited until she had had a drink before he started to 'goad' her. Barbie was taken to a friend's house. Barbie was recorded as the perpetrator in the incident. A DASH risk assessment was completed and graded as medium and sent for discussion at the daily risk management meeting. Frank told the police that he had tried to hang himself a few weeks ago.

13.6.28 On 6 December, the case was heard at the daily risk management meeting. The IDVA continued to have unsuccessful contact with Barbie. At that time, each agency recorded their own actions/notes from the meeting. The review has seen no further information regarding this meeting. On 11 December, the case was heard at MARAC.

13.6.29 The family stated that in the weeks prior to Christmas, Barbie had found a new flat and was making plans for a 'girls' holiday in the new year. Barbie was described as excited and had something to look forward to. The marital home was in the process of being sold and Barbie was getting ready to start a new life. Barbie's son stated that he had spoken to his mother and said that she needed to leave Frank so that she could spend time with her grandchild. Barbie was described as having a positive outlook on life.

13.6.30 On 15 December, Frank was arrested for an assault on Barbie. Frank had used a smashed bottle during the incident to assault Barbie. The police found evidence of broken glass and heavy blood stains on the carpet and furniture. The police risk assessed the incident as high. Barbie was taken to hospital via ambulance, but left prior to triage. Barbie later returned to hospital for treatment, and a DASH was completed by health professionals. A referral was made to MARAC.

13.6.31 Barbie did not provide a statement to the police. The Crown Prosecution Service did not authorise a charge and Frank was subsequently released on police bail. Upon release, Frank threatened to take his own life so was detained under Section 136 Mental Health Act 1983 and taken to hospital for assessment. Frank was assessed by an Approved Mental Health Practitioner and two doctors, and then discharged back to his GP.

13.6.32 On 19 December, Barbie was spoken to by an IDVA at Victim Support. The MARAC process was explained, and safe methods of contact agreed. During the contact, Barbie discussed that she might need support in relation to housing, and stated she would like to meet with an IDVA. An appointment was made for the following day, which Barbie attended. Barbie informed the IDVA that her priority was moving home due to the house being sold at the end of January. Support was offered to Barbie in relation to housing.

13.6.33 On 20 December, Frank saw a GP. During the consultation, Frank stated that he was homeless and currently living with family due to a domestic abuse incident. Frank disclosed suicidal thoughts, and that he felt he needed more support. Frank was prescribed medication, directed to Samaritans, Achieve, and self-referral to psychology services. The GP completed a referral to Community Mental Health Team, who conducted a telephone triage with Frank on 31 December. Frank denied any plans or intent to self-harm. The case was closed as Frank declined support.

13.7 2020

13.7.1 On 2 January, the IDVA telephoned Barbie. During that call, Barbie stated that she had been successful in obtaining new accommodation and was preparing to move. Barbie stated that she wanted the bail conditions removed from Frank so as to contact him in relation to the house sale. The IDVA emailed the police a summary of the contact with Barbie, requested an update on the investigation, and how Barbie could progress the removal of the bail conditions.

13.7.2 In January, Barbie was admitted to hospital following a suspected overdose. Later that day, a MARAC meeting was held following the incident on 15 December 2019. Barbie's condition deteriorated and she died in hospital.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Barbie as a victim of domestic abuse, and what was your response?

Adult Social Care

14.1.1 Barbie was not known to Adult Social Care until the safeguarding concerns were received from NWAS. The Screening Team within Adult Social Care had telephone contact with Barbie on two occasions. Following the first referral in June 2019, Barbie confirmed to the social worker that she was no longer in the relationship with Frank, and that she currently felt safe as she was living with family out of the area. Whilst Barbie was signposted to housing, Adult Social Care was aware of the DVPO and, therefore, it would have been appropriate for the social worker to have explored with Barbie her choice to move in with family at this stage. The referral stated that Barbie was stressed but it was not recorded if Barbie was accessing support. There was also no evidence of any discussions of risk or safety planning which could have been explored at this stage. The IMR author for Adult Social Care identified that the social worker should have discussed with Barbie her use of alcohol and agreement for signposting to support services. This area of learning has been reflected into Adult Social Care's recommendations.

14.1.2 The second referral was received in November 2019. There were detailed recordings of the social worker's contact with individual agencies, including conversations and information-sharing with the IDVA. The social worker spoke with Barbie and offered to complete a DASH, but Barbie declined. The social worker did not close the second referral until Barbie confirmed that she had received information from the social worker in relation to relevant support services.

14.1.3 The IMR author from Adult Social Care has identified a further area of learning, in relation to the documentation of actions whilst referrals are open within the Screening Team.

Children's Social Care

14.1.4 Children's Social Care was aware of domestic abuse in the relationship between Barbie and Frank due to referrals received from the police. All incidents were outside of the Terms of Reference for the review. At the beginning of 2010, an enquiry under Section 47 Children Act 1989

commenced and the case progressed to child protection under the category of emotional abuse. The case was later stepped down to Child in Need (Section 17 Children Act 1989), and subsequently closed.

Greater Manchester Police

14.1.5 The panel recognised that, in the latter two years, the volume of incidents increased in terms of frequency and violence. The panel determined that an overall analysis of the police response, under this Term of Reference, would identify learning and recommendations, rather than a review of each individual incident.

14.1.6 The police attended 23 incidents of domestic abuse during the 17-year relationship of Barbie and Frank. 12 of these incidents occurred during the timescales of this review. Frank was arrested on four separate occasions for assaulting Barbie, and following one incident, a DVPO was obtained. On each case, Barbie declined to provide a statement or support a prosecution. One incident was finalised by the Crown Prosecution Services, two were finalised by the police, and the latest incident from December 2019, was still an active investigation at the time of Barbie's death. The incidents that occurred in the presence of Barbie's children, or when the children were under the age of 18, were shared with Children's Social Care. Barbie was recorded as the perpetrator on several of the incidents: these were predominantly after the relationship had ended in the summer of 2019. Those incidents were reported to the police by Frank, who did not support a prosecution and no further action was taken.

14.1.7 The review identified opportunities for the police to instigate other safeguarding measures, and to utilise evidence gathered during their investigations to present to the Crown Prosecution Service in order that the case progressed as an evidence-led prosecution – i.e. without a statement from Barbie. This included the incident in December 2018, when Frank had assaulted Barbie causing an injury to her mouth. The officers who responded to the incident captured their contact on body worn video; this showed the injury to Barbie and her verbal account that she provided to the police.

14.1.8 Frank was arrested and later released from custody. Consideration was given to a Domestic Violence Protection Notice (DVPN)[22] upon Frank's release. A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse

[22] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence, and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim. The panel was informed that whilst consideration had been made for a DVPN by an Inspector, the rationale for the case not meeting the threshold for review by a Superintendent had not been recorded. This has been identified as an area of learning by the police, and a relevant recommendation made.

14.1.9 In May 2019, police received a report that Barbie had been assaulted by Frank. When officers attended, the house was in darkness. Barbie was not spoken to until four days later, and not seen in person until 8 days after the incident. The IMR author from the police has identified this as a missed opportunity, and determined that a more robust approach should have been taken to see Barbie at the earliest opportunity and check on her safety and welfare.

14.1.10 There was a further opportunity for the police to have considered an evidence-led prosecution in June 2019. At this time, Barbie disclosed to the police that Frank was 'extremely abusive mentally' and that there had been instances when he had been physical. The relationship had ended at this stage; however, Barbie and Frank were still living in the same house. A DVPN was issued, and the case was referred to MARAC: this was the second domestic abuse incident in three weeks.

14.1.11 The panel acknowledged the positive action that was taken by the police in December 2019. Frank was arrested, Crime Scene Investigators attended the scene and carried out a forensic examination, and body worn video was utilised and preserved. The officer continued to pursue an evidence-led prosecution. Following advice from the Crown Prosecution Service, Frank was released on bail with conditions in place to safeguard Barbie, which prevented a DVPN being instigated. This case was still an ongoing investigation at the time of Barbie's death.

14.1.12 Frank's bail conditions prevented contact with Barbie (including through social media and telephone), not to attend the home address, and not to use family to contact and engage with Barbie. The bail conditions expired on 12 January 2020. The family told the Chair that the bail conditions

were not appropriate as Frank lived with his parents during this time, and that his parent's house overlooked Barbie and Frank's house: Barbie was living at the house at this time. The review has been informed that Barbie had spoken with an IDVA to have the bail conditions removed. The reason given was to allow her to have contact with Frank in relation to the sale of the house. The IDVA passed on Barbie's request to the police. On 2 January 2020, IDVA sent e-mails to the police, querying the missing repeat MARAC referral. During this correspondence, the IDVA highlighted her concerns regarding this case, explaining that she was concerned regarding further incidents as Barbie wanted all bail conditions removed and that Barbie had stated she was not concerned by the incident or for her safety. The officer dealing with the investigation attempted to contact Barbie to discuss the bail conditions, but this was unsuccessful. The bail conditions were later cancelled by the police whilst Barbie was in hospital in a critical condition. As part of the police investigation following Barbie's death, the police recovered evidence of contact from Frank with Barbie whilst the bail conditions were in place. This was not known to agencies at the time. The family informed the Chair that Frank did not adhere to the bail conditions and that he would regularly contact Barbie via telephone and in person, including on the night prior to her hospital admission before her death.

Manchester University NHS Foundation Trust

14.1.13 Manchester University NHS Foundation Trust had no information that Barbie was a victim of domestic abuse. Frank did attend the Emergency Department and outpatient appointments with Barbie, but no concerns were raised. Information was shared by family to the Trust in January 2020, regarding domestic abuse. At this time, Barbie was heavily sedated and conversations were not possible. The Trust raised the matter within their Safeguarding Team, and sought clarification regarding contact and visitors for Barbie.

Northern Care Alliance

14.1.14 In June 2019, Barbie attended the Emergency Department with a history of throbbing frontal headaches radiating to back of head. Barbie reported multiple collapses, but no loss consciousness. Barbie informed medical staff that she was under personal stress which was linked to domestic abuse. Further information was provided in relation to a history of depression and excess consumption of alcohol. The IMR author for Northern Care Alliance identified that no further questioning took place regarding Barbie's personal circumstances, and that a significant event could have been added to the electronic system to alert for domestic abuse

for future attendances. This has been identified as an area of learning and a relevant recommendation made.

14.1.15 In December 2019, Barbie's presentation at the Emergency Department, following the assault by Frank, resulted in a DASH risk assessment being completed by health professionals, and the case referred to MARAC. During this contact, Barbie disclosed that she did not feel suicidal, and declined a referral to a Community Psychiatric Nurse. The panel acknowledged the actions of the health staff in responding to the domestic abuse.

North West Ambulance Service

14.1.16 In June 2019, Barbie had contact with the 111 service. A short while later, she was seen by an ambulance due to ongoing headaches. The Health Advisor for the initial call submitted a safeguarding concern. Barbie was taken to hospital by ambulance. Barbie disclosed to crew that she was stressed due to being in a domestic violence situation and that she was seeing a domestic abuse service. Barbie did not consent to the crew submitting a safeguarding concern. The crew shared the information with the hospital. The review identified that whilst Barbie also disclosed the domestic abuse to health professionals, they also did not submit a safeguarding concern.

14.1.17 The panel considered the different responses to the disclosures. They were informed by the NWAS panel member that Hear and Treat Staff (111 service) face the unique position of not having all the soft skills that a person who is responding face-to-face would have to engage in. Especially, in relation to gaining consent. For example, it may be that the patient is not willing to communicate as freely due to the fact that they feel unable, and fear they will be overheard. Although the call was transferred to the Paramedic Emergency Service, the 111 staff member did not have the ability to know if the patient had actually gone on to be assessed in person. For example, if the person then refuses to engage/answer the door/leaves prior to the ambulance arriving. Therefore, the Hear and Treat Staff are more likely to consider raising concerns without consent than those who are able to use all their senses at the physical scene. In addition, the panel were informed that face-to-face staff have the advantage of being able to remove the patient into the ambulance to discuss matters in private: this often means the discussion can be conducted much more freely with assurances sought that the person has access to the support of services, and the police are aware. On this occasion, the paramedics documented that Barbie reported that she had access to a local domestic abuse service, and that the police were aware of the situation. It was recorded that

Barbie did not consent to the paramedics raising a safeguarding concern notification. The domestic abuse situation was written on the Patient Report Form (PRF) that was handed into the hospital, as well as a verbal handover.

14.1.18 In November 2019, NWAS submitted a safeguarding concern after they had responded to an incident with Barbie. On this occasion, Barbie told the crew that she had been consuming alcohol due to the stress caused from her moving out of the family home following years of domestic abuse, and that there had been an altercation at the family home earlier that night, to which the police had attended. Barbie did not consent for the police to be informed, and was deemed by the paramedics to have capacity to make this decision. Barbie was seen to have large areas of bruising to her body and legs: she stated this had been caused by the dog who had become excited during the argument. Barbie declined to go to hospital. The safeguarding concern was submitted to Adult Social Care: it contained information that Barbie had stated she 'feared for her life'.

14.1.19 The police panel member informed the review that had NWAS overridden Barbie's consent, then the police would have recorded this as a crime, in accordance with National Crime Recording Standards, and the crime would have been investigated. There would have been an opportunity to have gathered witness evidence in relation to the bruising and disclosures, and the potential use of body worn video.

14.1.20 The panel determined that the information could have been shared, and acknowledged the guidance contained within the Department for Health Document – 'Responding to domestic abuse - A resource for health professionals' – which states: 'Where consent cannot be obtained or is refused, or where seeking it is likely to undermine the prevention or interruption of a crime, professionals may lawfully share information if this can be justified in the public interest, such as:

- where there is a risk of harm to the victim, any children involved or somebody else if information is not passed on as a referral
- to inform a risk assessment (where the definition of 'harm' to a child includes impairment caused by seeing or hearing the abuse of another person)
- when the courts request information about a specific case'.

The panel identified learning for agencies on the sharing of information, when consent has not been given or refused, in cases of domestic abuse and safeguarding. [Recommendation 1].

<u>Trafford Clinical Commissioning Group</u>

14.1.21 When Barbie disclosed domestic abuse to her GP, information was recorded appropriately using the HARK template, and a referral was made to IRIS. Barbie was also prescribed medication for depression. Whilst the IMR author for the CCG identified that work could have been done to identify the family structure further, and to understand more deeply the people involved, it was felt that this would have been more appropriate to be undertaken by IRIS – as it would have been outside the scope of a 10-minute GP appointment for an initial presentation.

14.1.22 At a follow-up appointment with Barbie, the GP checked regarding the outcome of the IRIS referral and made a further referral when Barbie informed her that contact had not been made. The panel was informed that IRIS was decommissioned in 2019. It was acknowledged by the panel that Primary Care may not have sufficient time during a consultation to complete a DASH risk assessment. The panel learnt that Trafford CCG have developed a toolkit to support Primary Care in assessing risk, and referring on to TDAS in cases of domestic abuse. The panel recognised this as good practice and have made a relevant recommendation for the CCG to provide evidence of the rollout and use of the toolkit. [Recommendation 2].

14.1.23 The GP was not aware of the incidents of domestic abuse that had been reported to the police. The GP was not aware that Frank was Barbie's partner and that he was registered at the same practice as Barbie. The panel was also informed that Primary Care do not share or receive information within the MARAC. This had been identified within a recent MARAC review. [See 14.7.7]. The panel agreed that this identified a significant gap within the MARAC processes and knowledge within Primary Care in relation to domestic abuse. The panel has made a relevant recommendation for the CCG to address this area of learning. [Recommendation 3].

<u>Trafford Domestic Abuse Services</u>

14.1.24 Trafford Domestic Abuse Services received a third-party report that Barbie was a victim of domestic abuse in June 2019. The caller was a friend of Barbie's who had contacted the service to enquire about refuge space. The friend stated she 'wanted to move Barbie on.' Barbie did not consent for her friend to call. There were no refuge spaces available at that time in Trafford: the friend was provided with contact numbers for other support agencies. There was no further contact with the service.

14.1.25 The panel was informed that the Domestic Abuse Adviser did not have access to 'Routes to Support'[23] at that time; however, all refuge staff now have access to the site which allows them to search for refuge availability across the United Kingdom.

Victim Support

14.1.26 Barbie was referred to Victim Support (community based domestic abuse service) by her GP in December 2018, and at a later follow-up review. Barbie was also referred to MARAC by the police on four occasions after being identified as a high-risk victim of domestic abuse:

- Referred 17 June 2019, heard 10 July 2019.
- Referred 12 September 2019, heard on 2 October 2019.
- Referred 20 November 2019, heard 11 December 2019.
- Referred 22 December 2019, heard 8 January 2020.

14.1.27 Barbie's engagement with Victim Support was variable. Often calls would not be answered, and there was, on occasions, no response to text or voicemails. In agreement with Barbie, contact was made during her working hours. The IVA would text first to advise of the times that calls would be made. The panel recognised this as good practice.

14.1.28 On 6 December, the IDVA provided information to the Daily Risk Management meeting that Barbie had not engaged with the IDVA service and, to date, they had been unable to contact her. The IDVA advised that a social worker from the Screening Team had called Barbie and she had declined IDVA support. Barbie had explained that she had no financial support and was aware of how to claim benefits. A member of the Screening Team discussed with Barbie her emotional wellbeing, during which Barbie disclosed that Frank had cancer. Barbie was advised of support available from Macmillan, GP and carers, and IDVA. Barbie, at this point, was reported to be tearful. True Colours and Back to Me[24] programmes were also discussed: these were declined by Barbie.

14.1.29 Barbie met with an IDVA on 20 December 2019; this was the first face-to-face contact. The IDVA discussed the following risk factors, safety advice, and options with Barbie:

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[23] https://routestosupport.org/
Routes to Support is a web based information system providing up to date information on domestic violence/abuse services. It aims to assist women and children facing domestic violence/abuse to find the right help by enabling front-line services to notify the refuge spaces or other services they have available.
[24] https://www.tdas.org.uk/truecolours

- Barbie was reported as not being concerned about the incident and did not wish for any safety measures to be in place. Barbie requested the IDVA to contact GMP to advise them of this. This was completed on 2 January 2020. The IDVA included, in the email, her concerns to the police regarding the removal of bail conditions.
- Barbie stated she did not feel at risk from Frank and that he was not a 'bad' person. The IDVA recorded this as an area of concern.
- Barbie declined post separation support.
- The IDVA explained options for civil orders.
- Barbie stated she wanted contact with Frank to discuss the sale of their property and sort out their belongings.
- Barbie did not want advice regarding privacy and identity.
- The IDVA also discussed Macmillan, GP, carers, and True Colours and Back to Me programmes, which had been mentioned the previous day.

The IDVA updated the MARAC and police when contact had been unsuccessful, and advised of case closures. The IDVA also updated the GP practice advising of non-engagement and failed contact attempts.

14.1.30 The panel reflected on the contact and engagement between Barbie and IDVA. The panel acknowledged the challenges that were being faced by Barbie in December 2019: her relationship had ended; she had been the victim of a serious assault; and, Frank had been released on bail with conditions not to have contact with her. These conditions were imposed to safeguarding Barbie. The panel recognised that those incidents were significant factors in Barbie's life at that time, coupled with the fact that Barbie and Frank were in the process of selling their house and trying to sort out ownership of property and contents. The panel recognised the difficulty that this situation created and the additional stress and pressure that this put on their relationship. Also, taking into account that it was Christmas and New Year, and Barbie and Frank had now separated after an 18-year relationship.

14.2 Term 2

What risk assessments did your agency undertake for Barbie? What was the outcome and, if you provided services, were they fit for purpose?

<u>Adult Social Care</u>

14.2.1 As part of the Screening Team's processes, all cases are risk assessed on the day in which they are received to determine priority of the assessment

based on the information within the referral. For this case, the determination was made that the referral was high-risk for screening due to domestic abuse. The panel agreed with this decision-making. The outcome of the screening was that both referrals were allocated to a social worker, both of whom had had contact with Barbie. [See Term 1].

Greater Manchester Police

14.2.2 The police carried out a DASH[25] risk assessment on all incidents of domestic abuse. Frank was identified as a perpetrator on four of these assessments. The DASH was risk assessed on each incident, with appropriate referrals to other agencies and MARAC. [See Term 7].

14.2.3 There were four incidents when the police completed a RARA risk assessment, as well as a DASH, in response to the domestic abuse. The RARA is a structured method of recognising and recording what action has been taken to deal with any identified risk faced by a domestic abuse victim. The risk assessment is used to compile the initial victim safety plan, and should include relationship history, circumstances of the incident, and rationale for risk setting under the following headings:

- **R**emove Risk - has suspect been arrested? Have they been remanded in custody?
- **A**void Risk - has suspect left the address? re house victim/significant witnesses or placement in refuge/shelter or other location not known to suspect.
- **R**educe Risk - joint intervention/safety planning, target hardening (fire risk assessment) bail conditions, DVPN/O, enforce breach of orders/bail, MARAC/MAPPA, Child Protection Conference, provide signposting/details to and for other agencies.
- **A**ccept the Risk - has the victim previously not engaged with services? Have they or are they intent on resuming the relationship? Do they accept if they do, the suspect poses a risk to them? MARAC/MAPPA-support and consent of victim, otherwise offender targeting, End the Fear leaflet given.

[25] Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool. The DASH risk assessment tool has been developed by ACPO, Laura Richards, in conjunction with CAADA (Coordinated Action against Domestic Abuse) to create a common tool for both police and non-police agencies when identifying and assessing victims of domestic abuse, stalking and harassment and honour based violence.

Northern Care Alliance

14.2.4 Northern Care Alliance completed two DASH risk assessments following Barbie's attendance in December 2019. These were seen by the Safeguarding Team and a referral made to MARAC. [See Term 1].

Trafford Clinical Commissioning Group

14.2.5 The GP completed a HARK assessment and made an IRIS referral on two occasions. No formal risk assessment was taken at the second presentation as it was clinically clear that Barbie had made an improvement. The HARK assessment was completed in accordance with the GP's policy.

Victim Support

14.2.6 On 18 June 2019, an IVA completed a DASH with Barbie. Information was provided to Barbie in relation to the domestic violence helpline, and that the case had been referred to MARAC. It was explained to Barbie that her case would be allocated to an IDVA for the MARAC. The IDVA service was explained to Barbie: that it was also provided by Victim Support, but a different service to multi crime. Victim Support was commissioned to deliver the Community Based Domestic Abuse Contract from 1 April 2014 to 31 March 2020. The IDVA service provided short-term support to victims that had been assessed as being at high-risk of serious harm or potential homicide. Further information on the role of commissioned services provided by Victim Support is produced at Appendix D.

14.2.7 The IDVA only had one meeting with Barbie, and two phone calls that lasted between 5 to 10 minutes. The first phone call on 19 December 2019, was a 5-minute phone call to introduce the service and explain to Barbie about the role of the IDVA and MARAC process. Victim Support's IDVA operating procedures state that a risk review should be completed during initial contact, however, this is not possible during a 5-minute call. The IDVA asked about safety but did not complete a formal review of risk using the SafeLives DASH Risk Assessment, as the time did not allow.

14.2.8 During the meeting with Barbie on 20 December 2019, the IDVA completed an ISSP, as per Victim Support policy and SafeLives best practice guidance. This meeting lasted 30 minutes and, during this time, comprehensive support and safety advice was provided to Barbie. However, the ISSP did not explore areas of mental health and alcohol use. The IDVA is no longer employed by Victim Support and has therefore not been able to contribute to the review. The recording on the Individual Safety Support Plan (ISSP) has been identified as an area of learning by Victim Support, and a relevant recommendation made.

14.3 Term 3

What was your agency's knowledge of any barriers faced by Barbie that might have prevented her reporting domestic abuse, and what did it do to overcome them?

Adult Social Care

14.3.1 Adult Social Care was aware that Barbie was not engaging with the IDVA, and that the domestic abuse continued and increased in terms of frequency and severity. Adult Social Care was also aware that Barbie was suffering from stress as a result of the domestic abuse, and that the consumption of alcohol was a recurring feature. The IMR author from Adult Social Care has determined that it was essential to consider if a Section 42 safeguarding enquiry[26] was required in relation to Barbie, due to the ongoing domestic abuse and her lack of engagement with services.

14.3.2 The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. A Section 42 safeguarding enquiry was not considered and this was identified by Adult Social Care as an area of learning. The panel was informed that Trafford Adult Social Care has completed a review of its safeguarding response that resulted in changes to its delivery of safeguarding and the development of a Safeguarding Hub. The Safeguarding Hub launched on 7 June 2021 and has created a central point of referral for all safeguarding concerns for adults, and provides a consistent approach to the application of Section 42 criteria to all referrals received by the Local Authority.

Manchester University NHS Foundation Trust

14.3.3 From reviewing the Trust's records, it has not been possible to ascertain if Barbie was seen alone at times of assessments and examinations. It was also not documented if Barbie was offered the chance to be assessed alone. This would have provided an opportunity for Barbie to disclose any concerns or domestic abuse. The Trust has identified this as an area of learning in relation to the use of their Manchester University NHS Foundation Trust Chaperone Policy.

[26] Section 42 Care Act 2014

14.4 Term 4

What knowledge did your agency have that indicated Barbie could be at risk of suicide as a result of domestic abuse and any coercive and controlling behaviour?

14.4.1 Adult Social Care had no knowledge that indicated that Barbie could be at risk of suicide as a result of domestic abuse and coercive and controlling behaviour.

14.4.2 In December 2007, the police received a call from Frank that Barbie had taken an overdose following a domestic incident. Barbie was taken to hospital. It was the practice at that time that triage staff did not make a referral for mental health when a person had been taken to hospital. The process has now changed and referrals are made to ensure the full circumstances of the person's presentation at the time would be known to partner agencies.

14.4.3 It was noted twice within Barbie's medical history that she suffered with depression – the first was during routine medical history taking, on 10 November 2019, in the MRI Emergency Department. There was no documentation to state if this was explored with Barbie. The second occasion being after admission in January 2020. This has been identified as an area of learning and a recommendation made by the Trust.

14.4.4 The panel was informed that there was a record in Barbie's medical notes, from 2001, of an overdose with paracetamol and alcohol. There is no further information held in relation to this incident. There was no information held that Barbie was at risk of suicide as a result of domestic abuse. The GP received a discharge letter from the incident in 2007, but this did not detail any link to domestic abuse.

14.4.5 In December 2018, Barbie stated that the incident of domestic abuse was only the second time in 17 years that she had been assaulted. The GP held no other information to confirm this statement from Barbie. Information gathered for the review identified that this was not an accurate account. During that contact, the GP assessed Barbie's mental state and completed the HARK assessment. Barbie's safety was also explored. In February 2019, the GP recorded an improvement in Barbie's mental state. The IMR author for the CCG has reviewed these presentations and has not identified any further opportunities that could have been taken.

14.4.6 The IMR author has reflected on how the practice undertakes medication reviews, which are shared out amongst all GPs independent of whether or

not they are responsible for the patient. This has already been highlighted to ensure that GPs do not update certain medications – particularly antidepressants and pain medications – without passing this to a GP with knowledge of the case.

14.4.7 Barbie's family had very strong views that Barbie was not at risk of suicide or had suicidal ideation at any time in her life, including following the incident with Frank in December 2019. They informed the Chair that Barbie was a strong person, who, in their opinion, would not have considered taking her own life. On the night of Barbie's death, the family stated that Frank had been to the house to collect some belongings. It is the family's view that he did not leave Barbie alive. The family described how this was Barbie's last night in their house before she moved into her new home and started a fresh life: this was something she had told family she was ready for and looking forward to doing.

14.4.8 The panel had access to Trafford Suicide and Self-Harm Prevention Strategy 2019, which is aligned with the key aim of the Trafford Health and Wellbeing Strategy to increase healthy life expectancy and reduce inequalities. The panel was also made aware of the updated work and the targeted areas within the plan for 2021/2022, which include:

- Active communications programme
- Work at locality level to ensure approaches are co-produced with communities, reflect local needs and concerns and draw on local assets.
- Train and support the workforce in feeling confident and skilled to have conversations with those at risk.
- Reduce the risk of suicide in key high-risk groups focussing on factors that have been exacerbated by Covid.
- Tailor approaches to improve mental health in specific groups.
- Work closely with Trafford VCSE to ensure services are supported in responding to the wellbeing needs of their service users.
- Support schools and organisations working with young people to promote resilience wellbeing and reduce self-harm.
- Provide better information and support to those bereaved or affected by suicide.

14.4.9 The panel considered whether the significant changes in Barbie's circumstances had made her more vulnerable to taking her own life. The panel was made aware of research indicating a significant number of

domestic abuse victims suffer from suicidal ideation. A study[27] in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. In addition, research has identified higher risk occupations, including women working in the arts and media or nursing profession and male and female carers[28]. Barbie was employed as a carer at the time of her death. The second most common form of suicide is poisoning[8]. Research has demonstrated that almost half (approximately 47% percent) of individuals who die by suicide were seen in Primary Care one month prior to their death[29].

14.4.10 The panel agreed that raising awareness of suicide risk, staff training, and access to advice may be important in reducing such risks in future. They also acknowledged the detail within Trafford Suicide and Self-Harm Prevention Strategy. The panel identified this as an area of learning and have made a relevant recommendation. [Recommendation 4].

14.5 Term 5

What knowledge did your agency have of Barbie and Frank's physical and mental health needs, and what services did you provide?

14.5.1 Adult Social Care held information that Barbie was feeling stressed, and around her alcohol use. Although Adult Social Care discussed Barbie's alcohol use with her, Barbie stated that alcohol was not a concern. Barbie told the social worker that she did not wish to receive information regarding available support services. As Barbie had capacity and did not consent for information to be shared, Adult Social Care could therefore not refer Barbie into support services. Adult Social Care did provide Barbie with information in relation to housing and domestic abuse services.

14.5.2 In June 2019, Derbyshire Police responded to a welfare call from Barbie who, following a domestic incident with Frank on 13 June, had gone to stay with a friend. Barbie told officers that she had not been taking her anti-depressant medication for a couple of weeks and this had had an adverse effect on her mental health. Barbie had consumed a large quantity of

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[27] From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse[27] [*Vanessa E. Munro & Ruth Aitken]*

[28] Suicide by occupation, England: 2011 to 2015. Office for National Statistics.
[29] Primary care contact prior to suicide in individuals with mental illness. Pearson et al., 2009. British Journal of General Practice.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2765834/pdf/bjgp59-825.pdf

alcohol at the time. Barbie declined further help or a referral, and due to no consent being provided, a safeguarding concern was not raised. The panel agreed that consent should have been overridden and a safeguarding concern raised. This would have provided an opportunity for engagement with Barbie, and further signposting to agencies.

14.5.3 In December 2019, following Frank's release from custody, he was taken to hospital under Section 136 Mental Health Act 1983, due to comments he had made in relation to taking his own life. This was appropriate action by the police. Frank was seen by Salford Mental Health Liaison Services (MHLS) on 17 December 2019, after being taken to hospital by the police under Section 136 Mental Health Act 1983. Frank reported that he had attempted to hang himself a few weeks previously, and that he was stressed around relationship difficulties with Barbie. Frank was assessed by an Approved Mental Health Practitioner and two doctors. The assessment identified no evidence of mood disorder, psychotic illness, intoxication, or delusions. Frank was discharged to the care of his GP.

14.5.4 Manchester University NHS Foundation Trust had no knowledge of Frank's mental health needs. There is no record that he was asked about his mental health during contact with the Trust. Frank's physical health needs were addressed at each presentation and followed up appropriately. The Trust's response to Barbie has been addressed at 14.4.3.

14.5.5 Northern Care Alliance responded to Barbie's physical and mental health needs during two contacts. The response to this has been addressed in Term 1 and 2.

14.5.6 Both Barbie and Frank were registered at the same GP practice. They were both separately seeing practitioners on a regular basis for a variety of physical and mental health needs. There were no links made between Barbie and Frank's relationship, as currently it is not widespread practice to 'link' households on EMIS systems. Therefore, there was never a wider discussion had between clinicians regarding the whole picture regarding Barbie and Frank jointly. The IMR author from the CCG has stated that despite the link not being in place, they did not feel that this had a negative impact on their involvement as the role of a GP is to attend to the care of the individual and respect their autonomy.

14.5.7 The panel was provided with access to a Safeguarding Assurance Toolkit that has been created for use by GP practices. The Safeguarding Traffic Light Toolkit reviews areas of safeguarding concern and relevant actions that are to be taken within the GP practice. Areas which are flagged amber or red are discussed in Multi-Disciplinary Team meetings with safeguarding leads present to ensure dynamic continued improvement of safeguarding

compliance across our service. The toolkit includes a section for the GP practice to evidence that they actively try to link family members from vulnerable families in medical records, especially if they have different surnames or live at different addresses, so they can be flagged. The panel recognised this as an area of good practice and have made a recommendation for the CCG to provide assurances to Safer Trafford Partnership on how the toolkit is being used and monitored within the CCG. [Recommendation 5].

14.5.8 The Review Panel considered whether Barbie and Frank's alcohol consumption impacted their access to support and/or if this was potentially a barrier. The Review Panel have seen no evidence that their alcohol consumption impacted their access to support. Adult Social Care discussed with Barbie her alcohol consumption; however, Barbie did not provide her consent for a referral to support services being made. [See 14.5.1]

14.5.9 Professionals discussed with Barbie and Frank their alcohol consumption and offered to refer them to alcohol support services such, but neither Barbie nor Frank consented for a referral to be made. [See 11.4]

14.6 Term 6

What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Barbie's victimisation, and did they know what to do with it?

14.6.1 Adult Social Care held information that Barbie's family and friends were aware of the domestic abuse. This information was provided to them by Barbie; however, Adult Social Care do not hold information with regards to their thoughts or awareness of the information, or if they knew what to do with that information.

14.6.2 Barbie's children had lived in the family home and had witnessed domestic abuse as children. These incidents were reported to Children's Social Care. Information provided to the review from the police stated that when the children reached maturity, they left the family home. In May 2019, Barbie contacted a family member to report that she had been assaulted by Frank. This family member reported the matter to the police. Barbie left the family home at times to live with family following incidents of domestic abuse.

14.6.3 Following Barbie's death, family members told the police that it was Barbie's intention to divorce Frank, sell the family home, and move in with family.

14.6.4 The full extent of the abuse that Barbie suffered was not known to all family members. Barbie's aunt was not aware of the level and extent of the violence, and told the Chair that had she known, she would have reported the incidents to the police. The family informed the Chair that Barbie's youngest son was aware of the abuse and witnessed incidents of violence, and this turned him against Frank. Barbie's cousin was also aware of the violence and tried to support Barbie to report the abuse and leave Frank, but Barbie would not let her contact the police. The cousin told the Chair that Barbie did not want to be on her own and was frightened that if she did report the abuse to the police and leave Frank, he would kill her: he had often made this threat towards Barbie.

14.6.5 The family stated that when Barbie did leave Frank towards the end of 2019, this was the happiest that they had seen her. They described her as 'buzzing' with excitement, and when she moved into her own property, she was 'over the moon'. Barbie's cousin stated that they had planned a holiday abroad together for later in the year, and Barbie was looking forward to having some fun.

14.6.6 Barbie's cousin told the Chair that Frank was very controlling and always told Barbie "If I can't have you no one will" and "If you leave me I'll kill you". Barbie's son told the Chair that his mother would not leave Frank due to the threats that Frank made towards her, in that she would not have any money or the house if she left the relationship. Barbie's son stated that his mother also feared the risk of being assaulted by Frank, who made threats of assault if she left the relationship. The family do not believe that Barbie's death was a suicide.

14.6.7 A work colleague of Barbie's told the Chair that Barbie was often seen at work with bruising to her face and arms. On one occasion when asked how she had received bruising to her face, Barbie stated - 'I've had an argument with a door'. The work colleague described how they questioned this with Barbie and was told by Barbie that she had been assaulted by Frank. Barbie told her work colleague that she would not report the assaults from Frank to the Police as she was frightened of Frank and what he would do to her if she contacted the Police or other agencies. The work colleague described how Barbie had appeared to be really happy in the weeks prior to her death and had told friends at work that she had a started to get her life on track and was looking forwarded to moving into her new home and started a new chapter in her life.

14.6.8 Victim Support was aware of Barbie and Frank's physical and mental health needs, as this was contained within information shared on referrals and during MARAC. Response to this has been addressed within Term 2.

14.6.9 The panel reflected that the domestic abuse was known to Barbie's family and the wider community, but the incidents were not reported to services. The panel recognised that often families and friends will not make reports due to the wishes of the those involved. The panel agreed that access to information and services should be available to help families, friends and the wider communities make informed decisions. [Recommendation 6].

14.7 Term 7

What knowledge did your agency have that indicated Frank might be a perpetrator of domestic abuse, and what was the response – including any referrals to a Multi-Agency Risk Assessment Conference (MARAC)?

14.7.1 Adult Social Care was aware that Frank was a perpetrator of abuse from the information contained within the safeguarding referrals and MARAC. Adult Social Care attended all the MARAC meetings for this case. Adult Social Care has identified learning and made recommendations in relation to the MARAC process, which includes the need for improvement of the documentation surrounding representation, and recording of the minutes within Adult Social Care. The panel was informed that MARAC meetings are now recorded and minutes are transcribed 'word for word'.

14.7.2 Frank had been in one previous relationship where he was a perpetrator of domestic abuse. Despite the extensive history of domestic abuse incidents, Frank had never been convicted of a domestic abuse offence.

14.7.3 The police referred the case to MARAC on four occasions within a six-month period. The violence within the relationship during this time was escalating. Barbie had informed professionals that she had ended the relationship and was looking to sell the house and move away. It is known that victims of domestic abuse are at an increased risk at the time of separation. Evidence from research and surveys of victims indicates that the risk of further violence and harm actually increases at the point at which a victim leaves a perpetrator.

14.7.4 The Femicide Census 2020[30] (released on 13 February 2022) identified that 41% (37 of 91) of women killed by a male partner/former partner in England, Wales and Northern Ireland in 2018 had separated or taken steps to separate from them, and that 11 of these 37 women were killed within the first month of separation and 24 were killed within the first year.

[30] https://www.femicidecensus.org/reports/

14.7.5 The panel also acknowledged that Barbie had experienced several adverse childhood experiences; and considered whether the impact of this had resulted in her enduring episodes of domestic abuse in her relationship with Frank. The Review Panel agreed with the research highlighted in this Term of Reference that a victim's reason for staying with their abusers are extremely complex, and can include adverse childhood experiences.

14.7.6 The Review Panel discussed the number of MARAC referrals that had been made within a short period of time. The Review Panel sought clarity as to whether the current MARAC policy details how repeat MARAC cases should responded to, including the consideration of referring the case to an alternative multi-agency risk management process. The Review Panel were informed that the current MARAC policy in Trafford does cover the response for repeat MARAC's within a short period of time. The Review Panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 9]

14.7.7 On 17 June 2019, a Domestic Violence Protection Order (DVPO) was granted at Salford and Manchester Magistrates Court to protect Barbie from violence, or a threat of violence, from Frank. The order expired on 14 July 2019 and stated:

This order is made to protect Barbie from violence or threat of violence because the court has found that you have been violent towards or threatened violence towards that person. This order prohibits Frank from following:- 1. From molesting Barbie. This includes molestation in general and also the following particular acts of molestation: using or threatening violence against Barbie and must not instruct or encourage or in any way suggest that any person should do so. Intimidating, harassing or pestering Barbie and must not encourage in any way suggest that any other person should do so. Contacted Barbie the person for who protection this order is made, either directly or indirectly. Not to evict/exclude Barbie from (address details removed). From coming within 300 metres from (address details removed).

14.7.8 The IMR author from the police found no record of contact with Barbie during the period of the DVPN – the Force Policy[31] (updated in Dec 2020) states that there should be contact with Victim and Perpetrator during the period of the DVPN to check compliance and provide support. There was a record of a compliance check with Frank on 27 June 2019, but there was no reply at the address. There is no record of further checks having been made. The police have identified this as an area of learning.

[31] Domestic Violence Protection Notices and Orders Procedures, December 2020

14.7.9 The panel was informed that there is currently no commissioned perpetrator provision within Trafford. At least 80% of offenders subject to Integrated Offender Management (IOM) were domestic abuse perpetrators. In 2020/2021, Trafford agreed to 'spot' purchasing work with male perpetrators of domestic abuse, which was limited in terms of available overall costs, and consisted of work totalling £47,875 for fifteen heterosexual male perpetrators. There were no referrals for female or LGBTQ+ perpetrators. The panel heard that TDAS and Talk, Listen, Change (TLC) had recently been successful in a joint bid to deliver the Make a Change Perpetrator Program (Male Adults). The confirmed date for the launch being 12 July 2021, with an additional funding application having been submitted to extend the Make a Change provision in Trafford. The panel was informed that if the additional funding was successful, it will be used to focus on 18-25 year olds, and the provision of additional counselling and behaviour change work with young people using violence in their intimate relationships and/or with their parents/carers. Whilst the panel recognised the work that was currently ongoing in relation to sourcing funding to work with perpetrators of domestic abuse, and that the higher proportion of IOM offenders are linked to domestic abuse, the panel agreed that there was still learning arising from this case. This was also around the provision of services and interventions with perpetrators of domestic abuse who are not convicted and subject to statutory intervention. The panel has identified this as an area of learning and made a relevant recommendation. [Recommendation 7].

14.7.10 The panel was informed that there had been a recent review of the MARAC processes within Trafford. A report presented to the Senior Leadership Team had identified a number of recommendations, including:

1. MARAC will continue to be held weekly.
2. Rotational chair between Police, Children and Adult's Social Care.
3. MARAC training, including LGBTQ domestic abuse training.
4. MARAC Task and Finish group relaunched.
5. All agencies will take ownership of MARAC by triaging and quality assuring all referrals, discussing high-risk DA cases within staff supervision, and ensuring knowledge is shared and kept within individual agencies.
6. GP/Primary Care and education representation.

The panel acknowledged the work that had been undertaken since the review had been commissioned, and that an action plan was in place.

Therefore, with the exception of a recommendation around Primary Care involvement, they made no further recommendations in relation to this area.

14.8 Term 8

Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

14.8.1 Adult Social Care informed Barbie of the options and choices available to her. Barbie was provided with information in relation to housing and domestic abuse services. Barbie was not provided with information in relation to alcohol, as she declined and had the capacity to make this decision. Barbie requested information be sent to her via her work address, and the social worker verified with Barbie that she had received the information before the case was closed.

14.8.2 During contact with the police, Barbie was informed about agencies that were available to her. Barbie declined to consent for referrals to be made to support agencies. Barbie was referred to Victim Support and MARAC when incidents were risk assessed as high, and in accordance with MARAC policies for repeat incidents of domestic abuse.

14.8.3 During contact with the GP, Barbie was listened to and had her feelings and wishes heard. Barbie was involved in a joint management decision, clearly outlining the factors involved in her health which were of concern, such as her mood, anxiety and alcohol use, alongside the domestic abuse.

14.8.4 On 20 December 2020, the IDVA provided options and advice to Barbie during the face-to-face appointment, these included:

- Barbie requested the IDVA contact the police to state that she was not concerned and did not want safety measures in place. This was emailed to the police.
- Barbie advised she did not feel at risk from Frank, and he was not a bad person.
- Barbie wanted to have contact with Frank to sort out the sale of their property and belongings. IDVA explored if their adult children could help facilitate these matters. Barbie explained that this was for her and Frank to sort out.
- Barbie declined advice regarding privacy and identity.

- The IDVA noted, in the safety plan, her concerns about Barbie's lack of concerns about the incident and history of abuse, and that Barbie wanted contact with Frank.
- Barbie declined post separation support.
- IDVA explained about non-molestation orders.
- IDVA explained prosecution process. IDVA offered support for the process.
- Barbie declined financial support and stated she was aware of how to claim benefits if required.
- IDVA discussed Barbie's emotional wellbeing. IDVA advised of Macmillan, GP and carer support.
- IDVA discussed True Colours and Back to Me Programmes.

14.8.5 There was a reoccurring presentation of Barbie and Frank being under the influence of alcohol during domestic incidents. Agencies identified that alcohol was a factor and discussed referrals and signposting to support agencies. Neither Barbie nor Frank accepted the offer of a referral, or made contact with those services. On the one occasion that a referral for Frank was made to Achieve, this was rejected, as he had not given his consent.

14.8.6 The panel acknowledged the challenges that agencies had when offering services to Barbie and Frank, and seeking to engage with them in response to the domestic abuse. Barbie and Frank were both deemed to have capacity to make informed decisions around their engagement with services. The panel identified learning around how services can seek engagement with clients who are deemed as being reluctant to engage or 'hard to engage'. [Recommendation 8].

14.9 Term 9

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Barbie and Frank?

14.9.1 Section 11 covers this Term of Reference.

14.9.2 There was no record held by Manchester University NHS Foundation Trust that they had documented the racial, cultural, linguistic, faith and other diversity issues during this review. This has been identified as a single agency area of learning.

14.10 Term 10

Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

14.10.1 All agencies have provided evidence to the review that they have in place domestic abuse policies and procedures.

14.10.2 Adult Social Care has identified learning in relation to the consideration of a Section 42 safeguarding enquiry. [See Term 3].

14.10.3 The police have identified learning in relation to their compliance with their policy in relation to DVPN/DVPOs. [See Term 7].

14.11 Term 11

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Barbie and Frank, or on your agency's ability to work effectively with other agencies?

14.11.1 There was a time delay following the receipt of the referral by Adult Social Care on 13 November 2019, until action on 28 November 2019. Whilst Adult Social Care has been unable to determine the exact reason for the delay, it was known that the Screening Team at that time were managing a waiting list for the service. Since this time, actions have been taken to support the management of the waiting lists. [See 14.3.2].

14.11.2 Victim Support did not always attempt contact with Barbie within 24-48 hours of receiving the referral. At the time, the community based domestic abuse service had a waiting list in place. This had been raised with Commissioners as a way of managing the demand into the service that outweighed the resources available and kept IDVAs working with safe caseload numbers. When contact was attempted, multiple attempts were made over different days via text message and phone calls. The IDVA always updated partners of the unsuccessful contact attempts, and this was shared at MARAC.

14.12 Term 12

What learning has emerged for your agency?

14.12.1 Adult Social Care

- MARAC recording.
- Training on domestic abuse – to include safety planning and consideration of Section 42 Care Act 2014.

14.12.2 Greater Manchester Police

- Evidence-led prosecutions.
- DVPN/DVPO.
- Holistic overview.

14.12.3 Manchester University NHS Foundation Trust

- Mental health enquiries during patient health assessments.
- Use of Chaperone Policy.
- Recording of racial, cultural, linguistic, faith or other diversity issues.

14.12.4 Northern Care Alliance

- Addition of the processes of domestic abuse recognition and response is required for all staff that attend the Adult Safeguarding Level 3 training.
- Significant Event addition to the Electronic Patient Records.

14.12.5 Victim Support

- Exploring vulnerabilities in ISSP.
- Timeliness of contact with victims following receipt of initial referral.
- Awareness of victim responses to domestic abuse.

14.13 Term 13

Are there any examples of outstanding or innovative practice arising from this case?

14.13.1 Whilst the review has not seen any examples of outstanding or innovative practice arising from this case, the review did acknowledge the detailed level of recording, within Adult Social Care records, by the social worker in response to the two safeguarding concerns that had been submitted for Barbie.

14.14 Term 14

Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Safer Trafford Partnership?

14.14.1 This is the first DHR since 2016 for Safer Trafford Partnership. There is no learning from this review which has appeared in previous DHRs commissioned by Safer Trafford Partnership.

15. CONCLUSIONS

15.1 Barbie and Frank had been in a long-term relationship. Barbie had been a victim of domestic abuse throughout that relationship. Incidents were reported to the police: Frank was arrested on four occasions. Frank was never convicted of domestic abuse, and undertook no work or intervention to address his offending behaviour.

15.2 Towards the summer of 2019, the relationship between Barbie and Frank broke down. Barbie made the decision to leave the relationship; however, as their home was jointly owned, Barbie and Frank remained living together. At this time, the incidents of domestic abuse increased not only in frequency but physically too. Barbie was referred to MARAC four times within six months. In July 2019, Frank was issued with a DVPO; however, when this expired, he moved back into the family home and the domestic abuse continued.

15.3 At the end of 2019, Frank assaulted Barbie with a glass bottle. Frank was arrested and released on conditional bail. At this time, Barbie had moved out of their home, which was now in the process of being sold. Barbie was moving into her own accommodation out of the area.

15.4 Barbie was referred to Victim Support but declined support until December 2019, when she sought help in relation to housing support due to the impending house sale. Barbie also sought advice on applying for the removal of Frank's bail conditions, so that she could have contact with Frank during the house sale.

15.5 In January 2020, Barbie was admitted to hospital having taken an overdose. The criminal investigation from the assault in December was still ongoing. Whilst in hospital, the bail conditions were removed from Frank. Sadly, Barbie died whilst in hospital. Frank died the following month.

15.6 The review has identified areas of learning, including the engagement with victims and perpetrators of domestic abuse, sharing information between agencies when consent has not been provided or refused, and responding to perpetrators of domestic abuse.

15.7 Barbie's family were involved in the review and provided valuable information. The panel thank them for their involvement and contribution to the review process.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies at Term 12. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action, a cross-reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Throughout this review, incidents of safeguarding were identified by professionals. Often consent was not provided by those involved. This prevented information being shared to other professionals who were involved in the case and, thereby, prevented a wider picture of the domestic abuse being known. The challenge for professionals in these circumstances is knowing when consent can be overridden, and relevant information shared.
Learning
Professionals need to be aware of how information can lawfully be shared when consent has not been obtained.

Learning 2 [Panel recommendation 2 and 3]
Narrative
The extent of the abuse and involvement of agencies in responding to that abuse was not known by Primary Care. This resulted in information to inform risk assessments not being shared. The development of a toolkit to assess risk is being progressed, which will help to identify risk and ensure referrals are made to relevant agencies.
Learning
Information-sharing between agencies can help identify victims of domestic abuse and allow for referrals to be made for support – in addition to providing professionals with all relevant information when assessing risk.

Learning 3 [Panel recommendation 4]
Narrative
This case has identified a significant change in Barbie's personal circumstances in the months prior to her death. The link between

domestic abuse and suicide was not widely known amongst professionals.
Learning
Knowledge of the link between domestic abuse and suicide will enable professionals to formulate appropriate risk assessments and risk management plans.

Learning 4 [Panel recommendation 5]
Narrative
Trafford CCG has developed a Safeguarding Assurance Toolkit to measure individual Primary Care providers' responses to safeguarding. This is a RAG related toolkit which provides Primary Care providers evidence to demonstrate their compliance to safeguarding, and action plans to address identified areas of development.
Learning
The Safeguarding Assurance Toolkit should be embedded within every Primary Care provider setting.

Learning 5 [Panel recommendation 6]
Narrative
The extent of the abuse within the relationship was not known to family members and employers. Incidents that were known, were not reported to professionals, and the family and friends supported the victim alone, without seeking support from external agencies.
Learning
Access to information on the availability of services for victims of domestic abuse, how referrals can be made to those services, including reporting concerns or incidents of abuse, can help families, friends and the wider community respond and support victims of domestic abuse.

Learning 6 [Panel recommendation 7]
Narrative
This case identified a significant volume of domestic abuse incidents over an extensive period of time and, despite agency involvement and intervention, there was no outcome through the Criminal Justice route. This resulted in no proactive work to address the offending behaviour of the perpetrator. Opportunities to respond to the offending, and work with the perpetrator, were not available.
Lesson

Working with perpetrators of domestic abuse who have not been convicted or are undertaking offender focussed work through the Criminal Justice Systems, is essential to increasing victim safety and reducing incidents of domestic abuse.

Learning 7 [Panel recommendation 8]
Narrative
This review identified the challenges that professionals face in achieving engagement with victims of domestic abuse. Especially, those who are deemed to have capacity but decline involvement with services.
Learning
Some victims of domestic abuse can find engagement with services difficult. Agencies providing services to victims of domestic abuse need to ensure that their services are accessible to these victims and that professionals are aware of the reasons why victims may choose not to engage.

Learning 8 [Panel recommendation 9]
Narrative
This review identified that the case was repeatedly referred to MARAC within a short period of time. Whilst MARAC is the conduit to review high risk cases, the volume of cases being discussed, can often result in cases being discussed for a short period of time, with no mechanism for allocated actions to be reviewed and analysed.
Learning
The use of other multi-agency risk management process allows Professionals more time to discuss the risk factors and allocate and review actions.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That all agencies involved in the review provide assurances to Trafford Safer Partnership that professionals are aware of how information can be shared when safeguarding concerns have been identified, but consent has not been obtained.
2	That Trafford CCG provides evidence and assurances to Trafford Safer Partnership on how professionals working in primary care, including GP's and Nurses are assessing risk and making referrals for victims of domestic abuse.
3	That Trafford CCG, in conjunction with Safer Trafford Partnership, ensures that information-sharing pathways are in place between GP practices and MARAC, to inform risk assessments and MARAC processes.
4	That all agencies involved in the review provide evidence to Trafford Safer Partnership that the links between domestic abuse and suicide have been provided to staff.
5	That Trafford CCG provides evidence and assurances to Trafford Safer Partnership on the implementation and compliance of the Safeguarding Assurance Toolkit within GP practices.
6	That Safer Trafford Partnership ensures that there is access to information for the community and employers on the availability of services for victims of domestic abuse, and how referrals can be made to those services, including reporting concerns or incidents of abuse.
7	That Safer Trafford Partnership ensures that the learning from this review is used to inform the ongoing work around seeking funding and the provision of services for perpetrator engagement.
8	That all agencies involved in this review provide evidence to Trafford Safer Partnership on how their service seeks to engage with individuals who are deemed as reluctant to engage, or 'hard to engage'.
9	That Safer Trafford Partnership requires that the MARAC policy is reviewed to include guidance as to how frequent repeat MARAC cases, within a six month time period, are referred to an alternative multi-agency risk management meeting for the risks to be addressed.

17.2 Single Agency Recommendations

17.2.1 Single agency recommendations are contained within the action plan at Appendix E.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

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

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. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[32]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;

[32] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the Domestic Homicide Review. It is drawn up from material provided by the agencies that contributed to the review.

Events Table	
Date	**Events – Pre TOR**
2003 - 2010	Police attended 9 x incidents of domestic abuse. Barbie was assaulted in 2 of the incidents.
03.08.07	Children's Social Care received referral for domestic incident. Recorded as verbal altercation. Alcohol a factor. No action taken.
09.01.08	Children's Social Care received referral for domestic incident. Recorded as verbal altercation. Alcohol a factor. Barbie had taken an overdose. No action taken.
19.09.09	Children's Social Care received a referral for domestic incident. Barbie sustained injuries. Frank arrested. No recorded actions by Children's Social Care.
04.01.10	Children's Social Care received referral for domestic incident. Alcohol a factor. Children's Social Care sent a letter to the family.
08.02.10	Children's Social Care received a referral for domestic incident. Alcohol a factor. Section 47 enquiry commenced. Case progressed to case conference and child protection under category of emotional abuse. In May 2010, case stepped down to Child in Need. Case closed on 28 September 2010.
14.09.13	Police attended domestic incident between Barbie and Frank. Alcohol a factor.
19.12.13	Children's Social Care received referral for domestic incident. Alcohol a factor. No action taken by Children's Social Care. The outcome was for school to take the lead.
25.09.17	Children's Social Care received referral from Wythenshawe Hospital, as Barbie had presented with a facial injury. Barbie stated that she had been hit by Frank. Barbie declined a referral to Adult Social Care and MARAC. No action was taken by Children's Social Care
Date	**Events during TOR**
25.10.18	Barbie seen by ambulance crew after being found with facial injury. Adult protection referral submitted.
02.12.18	Police attended domestic incident between Barbie and Frank. Frank arrested for assaulting Barbie. Crime finalised with no further action.
27.12.18	Barbie seen by GP. Disclosed domestic abuse. Referred to IRIS after HARK completed.
31.12.18	IDVA attempted to contact Barbie.
02.01.19	IDVA attempted to contact Barbie.
10.01.19	IDVA sent text message to Barbie.
31.01.19	IDVA emailed GP after unsuccessful contact with Barbie.

03.02.19	Police attended domestic incident between Barbie and Frank. Alcohol a factor.
22.02.19	Barbie seen by GP for review. Stated she had not heard from IRIS. Re-referred.
24.02.19	Barbie contacted 111 service for minor ailment.
25.02.19	IDVA received referral from GP.
26.02.19	IDVA attempted to contact Barbie 24 hours after the re-referral.
07.03.19	IDVA attempted to contact Barbie.
11.03.19	IDVA attempted to contact Barbie.
12.03.19	IDVA emailed GP after unsuccessful contact with Barbie.
30.04.19	Barbie seen by GP for minor ailment.
11.05.19	Police attended incident between Barbie, Frank and female. No complaints made to police. Alcohol a factor.
24.05.19	Police received report of domestic incident between Barbie and Frank. Police unable to attend. Barbie seen by police on 1 June 2019. Frank interviewed for an assault on Barbie.
13.06.19	Victim Support (Multi Crime Service) received referral from police for Barbie.
13.06.19	Police attended domestic incident between Barbie and Frank. Frank arrested for assaulting Barbie. No further action was taken. Referral made to MARAC. DVPN and DVPO authorised.
14.06.19	Victim Support IVA attempted to contact Barbie. Further referral received from police for Barbie.
15.06.19	Victim Support IVA attempted to contact Barbie.
16.06.19	Barbie seen by police.
17.06.19	DVPO granted.
17.06.19	MARAC referral received. Victim Support IVA contacted Barbie.
18.06.19	Victim Support IVA contacted Barbie.
18.06.19	Barbie contacted 111 service. Barbie transported to hospital. NWAS submitted safeguarding referral. Barbie had a CT brain scan and was discharged from hospital
19.06.19	Safeguarding referral reviewed by Adult Social Care. Social worker attempted to contact Barbie.
19.06.19	Friend of Barbie contacted TDAS.
20.06.19	Social worker contacted Barbie.
20.06.19	Victim Support IVA contacted Barbie.
28.06.19	Victim Support IVA attempted to contact Barbie.
01.07.19	Victim Support IVA contacted Barbie.
10.07.19	MARAC meeting.
15.07.19	Victim Support IDVA attempted to contact Barbie.
16.07.19	Victim Support IDVA emailed police after unsuccessful contact with Barbie.
08.08.19	Medication review updated by GP. Barbie not seen.
30.08.19	Frank seen by GP.
01.09.19	Police attended domestic incident between Barbie and Frank. Frank taken to alternative address. MARAC referral submitted.
12.09.19	MARAC referral received.

18.09.19	Frank seen by GP.
19.09.19	Barbie seen by GP.
26.09.19	Victim Support IDVA attempted to contact Barbie.
27.09.19	Victim Support IDVA attempted to contact Barbie.
02.10.19	MARAC meeting.
03.10.19	Frank seen by GP.
10.10.19	Frank reported he had been assaulted by Barbie.
16.10.19	Frank admitted to hospital and discharged home following day.
29.10.19	Frank attended Urgent Care Centre. Frank seen by GP.
08.11.19	Frank seen by GP.
10.11.19	Barbie attended Emergency Department at hospital.
12.11.19	Police attended domestic incident between Barbie and Frank. Barbie taken to alternative address.
13.11.19	Barbie seen by NWAS Paramedic Emergency Service. NWAS submitted a safeguarding concern. Adult Social Care screened the safeguarding concern.
20.11.19	MARAC referral received from police.
24.11.19	Police attended a domestic incident between Barbie and Frank.
28.11.19	Social worker contacted Barbie.
28.11.19	Victim Support IDVA attempted to contact Barbie.
30.11.19	Police received a call regarding a domestic incident between Barbie and Frank. Police did not attend. Frank spoken to by police the following day and stated that he no longer required the police. Barbie recorded as perpetrator.
02.12.19	Information-sharing between social worker and IDVA.
02.12.19	Police attended domestic incident between Frank and Barbie.
03.12.19	Social worker contacted Barbie.
04.12.19	IDVA contacted police regarding unsuccessful contact with Barbie.
06.12.19	Case heard at daily risk management meeting.
10.12.19	IDVA attempted to contact Barbie.
18.12.19	MARAC meeting.
15.12.19	Discharge summary received from Salford A+E that patient attended with lacerations to R thumb and legs. No other information on this letter. This was not sent to a clinician and simply recorded by data entry, as there was nothing in the summary notes to suggest that it needed to be reviewed or actioned by a clinician. Normal protocol followed, as workflow normally will not go to a clinician unless the letter/summary highlights any need for action or information that is pertinent. This letter did not state anything other than the fact that patient had lacerations – no further details given.
15.12.19	Police attended domestic incident between Barbie and Frank. Barbie assaulted and taken to hospital by ambulance. Frank arrested. Frank was released from custody the following day and threatened to kill himself. Frank arrested under Section 136 Mental

	Health Act 1983, taken to hospital, and seen by Mental Health Team.
17.12.19	IDVA attempted to contact Barbie.
18.12.19	Frank seen in Respiratory Clinic.
19.12.19	IDVA contacted Barbie.
20.12.19	Barbie seen by IDVA.
20.12.19	Frank seen by GP.
22.12.19	MARAC referral received.
27.12.19	GP referral received by Mental Health Team for Frank.
29.12.19	Barbie attended hospital for surgical procedure.
31.12.19	Telephone triage with Frank by Mental Health Team.
02.01.20	Email communication between IDVA and police regarding MARAC.
January 2020	Barbie transported to hospital following overdose. Admitted to hospital and transferred to Intensive Care.
08.01.20	MARAC meeting.
09.01.20	Frank seen by GP.
09.01.20	Family contact police regarding Barbie's admission to hospital. Police investigation commenced.
10.01.20	Contact with safeguarding team regarding visitation rights of Frank.
January 2020	Barbie died.

Appendix D

Victim Support – Victim Assessment and Referral Service, Greater Manchester commissioned by GMCA

Victim Support have been delivering the Victim Assessment and Referral Service since July 2017, with a staff team Independent Victim Advocates (IVAs) who undertake the majority of the victim contact. Admin staff, a Volunteer Coordinator, Team Leaders, Operations Managers and one Area Manager support the team. The service operates 9am to 7pm Monday to Friday, and 9am to 5pm on Saturdays; closed Sundays and bank holidays but there is support for victims through the VS 24/7 national Supportline.

The Victim Assessment and Referral Service is a Greater Manchester wide service and Victim Support are commissioned to provide services to Victims, Witnesses and others affected by crime who live in Greater Manchester regardless of where the crime occurred. Referrals are accepted on an explicit consent basis to the service, through the Automatic Data Transfer of cases identified by Greater Manchester Police, Professional Referrals or Self-Referrals to the service.

Self-referrals are taken over the phone, via the National VS website, via the 24hr livechat or our national Supportline available for Victims of Crime and via email.

The service is free, confidential, and independent, and can be accessed whether or not the crime has been reported to the Police. It is not a time-limited service.

The service is primarily telephone based and offers face to face discussions or appointments in exceptional circumstances.

Service users are contacted through a methodology established in an SLA with our commissioners, by letter, email, text, phone, or a mixture of these methods. Once an offer of support is made and accepted all service users are eligible to access the same level of service.

Which is; 1-2-1 telephone support from an Independent Victim Advocate (IVA) who undergo specialist training to support those affected by Crime, with relevant additional courses for supporting crimes including Domestic Abuse, Sexual Violence, Children and Young People and other areas pertaining to local need.

All service users are given an opportunity to complete an individual needs assessment with their IVA and identify further areas of need as outlined by the MOJ's/GMCA's outcomes framework.

Information and advice around the Criminal Justice System paying particular attention to the Victims Code of Conduct.

Advocacy and multi-agency working with other organisations, commonly including the Police and Housing for instance.

Support to cope and recover, through skill sets such as motivational interviewing and particular strategies, and utilising the resources developed by Victim Support.

Signposting and onwards referrals to connect service users to further support.

With respect to Domestic Abuse in the Greater Manchester context we offer support to domestic abuse cases at standard and medium risk levels, and routinely refer to MARAC for any service user identified at high risk of harm. We identify this through the DASH, where any service user accessing VS services is strongly encouraged to complete this so we can offer support based on a thorough understanding of risk. Offer information and signposting or onward referrals to local Domestic Abuse services where these are established.

Community Based Domestic Abuse Contract commissioned by Trafford Metropolitan Borough Council

Victim Support was commissioned from 01/04/2014 to 31/03/2020 to deliver the Community Based Domestic Abuse Service in Trafford; the service was commissioned by TMBC and offered an IDVA Service providing short-term support to victims that had been assessed as being at high risk of serious harm or potential homicide. A Children and Family Support Worker (part time position) who supported children and young people aged between 4-16 years old that had witnessed or had been impacted by domestic abuse. A PT Domestic Abuse Support Worker providing holistic support to victim assessed at medium and standard risk of harm. VS also delivered the IRIS programme and operated an Information and Advice Line as part of this contract.

In terms of the role of the IDVA, IDVAs provide support to high-risk victims of domestic abuse. High-risk victims identified by GMP and partner agencies in Trafford were referred direct to the IDVA service on a daily basis at the time and were contacted to assess their immediate support needs before the case was heard at the MARAC meeting.

Victims could also self-refer to the community based domestic abuse team and if after a risk assessment is completed the victim was assessed at high risk, the IDVAs continued with support and referred the victim to MARAC. If a victim, who self-refers was accessed as medium risk the victim was supported by the DA Support Worker or was referred to TDAS.

IDVAs focus on safety and risk, and are accountable for ongoing risk assessment and for developing Individualised Safety and Support Plans (ISSPs). IDVAs will implement actions arising from risk and safety planning by taking practical steps to support service users to choose suitable options and to act for themselves promote the safety of service users and their children by:

- taking action to address their immediate safety and address safeguarding
- progressing actions arising from the MARAC
- advocating for service users to access sanctions and remedies available through the criminal and civil courts
- helping them to access housing and other support organisations

- taking action to provide solutions that improve longer term safety
- are independent from other agencies and act as the voice of the service user at MARAC meetings
- accompany/advocate at meetings and appointments where needed.
- Completing regular Risk Assessments/Risk Reviews
- Once risk is reduced and support needs are met, cases will be closed with victim agreement.
- Where the victim becomes unavailable (victim may be e-mailed and text messages sent if agreed beforehand offering the service at any point in the future).
- On-ward referrals may be made to other DA services to continue with housing related support and on-going support to address the impact of DA, referrals will only be made with victim's consent and where risk has been reduced.
- Should a victim leave Trafford, for example is re-housed out of area or accesses refuge out of area, a MARAC to MARAC transfer will be made.
- If a victim accesses refuge, refuge staff will continue with support and the case will be closed to the IDVA service to prevent duplication.

Appendix E

Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That all agencies involved in the review provide assurances to Trafford Safer Partnership that professionals are aware of how information can be shared when safeguarding concerns have been identified, but consent has not been obtained.	Local	NWAS provide mandatory training on sharing of information around safeguarding. NWAS will provide regular updates to the partnership (via DHR Working Group) on percentage of staff who have completed the training, any updates made to the training, and implementation of the training.	North West Ambulance Service (NWAS) / Jane Whitaker	NWAS current L3 mandatory training covers consent and when concerns should be shared without consent. This training is delivered by the Safeguarding Team to those profiled staff on the Training Needs Analysis and was also rolled out by NWAS L&D Team to the entire patient facing workforce of the paramedic emergency Service on 2021-22 mandatory training cycle. slides taken from L3 training .docx	NWAS mandatory training Level 3 21-22.	Completed Mar22.
		Local	Probation Practitioners are	National Probation	Performance Reports are run monthly and will highlight any cases that fall	Ongoing practice expectation –	Ongoing practice expectation –

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			expected to complete, as a minimum, a known persons safeguarding check with the LA at the commencement of all community-based disposals and at least 6 weeks prior to release from custody. People on Probation are made aware of this, but their consent is not needed. Periodical checks are also completed on the gaining of any new pertinent intelligence,	Service (NPS)	into scope, new sentences and prison releases and will highlight cases were there has not been any safeguarding activity. These cases are raised with the Probation Practitioner for immediate action.	reviewed monthly	reviewed monthly.

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			commencement of new relationships (if disclosed) and requests to change address.				
		Local	Trafford Community Safety will review and update the content of the multi-agency safeguarding training, and ensure that it includes a section on professionals ability to be aware of how information can be shared when safeguarding concerns have been identified, but consent has	Trafford Community Safety / Trafford Strategic Safeguarding Partnership Rhys Dower / Laura Summers	Professionals across Trafford have access to specific safeguarding training which includes how professionals should share information, and a specific section on when and how to do this without the persons consent. Trafford Council's training department provide assurance to the partnership on agencies who have attended and the effectiveness of the implementation of this training.	TSSP Safeguarding training is delivered to multi-agency partners within Trafford. The training has been reviewed and specifically covers sharing information when consent is not obtained. This is covered in both safeguarding adults and safeguarding children's training, and in the 'Levels of	January 2023

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			not been obtained.			need workshop'. Additionally, Trafford Council will be creating videos on Levels of Need which will cover this issue. Safeguarding Children: Basic Awareness. Consent is discussed when talking about Levels of Need and making referrals. Safeguarding Children: Advanced. Similarly – discussed in context of Levels of Need document, but there is a more thorough	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
						section on how to make a referral (this is replicated from the Levels of Need training) Safeguarding Adults: Basic Awareness. Consent discussed in context of information sharing. Safeguarding Adults: Advanced. Context discussed in context of information sharing, with more detail using case study Safeguarding Adults Advanced CONSENT.p	

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
						Safeguarding Adults Basic Awareness CON Safeguarding Children Advanced C(Safeguarding Children Basic Awarer	
		Local	Mandatory Yearly top-up of Level 3 safeguarding training is provided to Paramedic emergency service staff to meet the requirements of the 3 year rolling programme of Level 3. This also includes e-learning in relation to	NWAS	NWAS provide mandatory Level 3 Safeguarding training which is delivered by the Mandatory training team each year. Staff are required to be compliant, and this is robustly monitored by the NWAS L&D Team. NWAS Publish a yearly safeguarding annual report which is circulated to all Safeguarding boards for assurance.	Yearly compliance is assured to the NWAS SLT	Complete Ongoing rolling programme.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			information sharing and IG/GDPR requirements. Level 1&2 safeguarding training is mandatory for all NWAS staff and completed as e-learning which is monitored by the NWAS L&D team.		Annual Report For Publication 2021-22.c		
		Local	Community Safety Partnership is currently reviewing its multi-agency information sharing Policy.	Trafford Community Safety Partnership / Helen Grant	Community Safety Information Sharing Protocol is currently being reviewed, draft document below. TRAFFORD%20PARTNERSHIP%20INFORM	February 2024	
2	That Trafford CCG provides evidence and assurances to Trafford Safer Partnership on	Local	Trafford CCG Safeguarding team has	Trafford Primary	The tool has been ratified at the DA steering group and a request for the Primary Care	September 2022	Complete September 2022

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	how professionals working in primary care, including GP's and Nurses are assessing risk and making referrals for victims of domestic abuse.		developed a Primary Care domestic abuse risk assessment to support GPs in identifying DVA and appropriate onward referrals to the commissioned DVA service TDAS. DA Toolkit for Trafford 2021.docx We will now gather data disclosures into GP Referrals (ICS)	Care Networks	team to upload the toolkit via F12 within EMIS records has been completed in Nov 2021. The toolkit is uploaded to F12 within the EMIS records please see attached screenshots. EMIS F12 Screenshots.docx		
3	That Trafford CCG, in conjunction with Safer Trafford Partnership, ensures that information-sharing	Local	This is an identified risk on the CCG risk register. There	PCNs due to the transition to ICS	'Review of training opportunities for GPs. Bespoke sessions on	Signed off by NHS SLT on 21st February 2023.	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	pathways are in place between GP practices and MARAC, to inform risk assessments and MARAC processes.		are a number of controls to mitigate this risk including: - Children's community health services share information in cases where there are children in the household. There is a daily risk meeting where police incidents involving vulnerable adults are considered. There is training available via TDAS and TSSP for Domestic Abuse. GPs can		Domestic Abuse delivered to GP's – completed 2021. Membership of the domestic abuse strategic Forum Completed 2021. For the Named GP and the Designated Nurses to attend the operational domestic abuse task and finish group – completed 2021. To identify previous completed work around information-sharing and work as part of the MARAC review – completed 2021. Applied to Council for 5k funding for emergency safety measures, travel costs and staff increase (unallocated GM funding). Completed by LA colleagues.	Proposed date for completion is September 2023	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			access the courses virtually. There is a list of trusted resources and online learning packages being developed and shared. There is a multi-agency review of MARAC processes. • CCG Covid-19 Response Plan developed, SLT+ leadership Team set up to support and understand additional risks and recovery plans, regular reviews at Thursday SLT		To raise the prospect of commissioning a Primary Care IDVA within the provider organisation / Primary Care networks to undertake and facilitate GP liaison for safeguarding. Currently paused, owing to spending and commissioning restrictions that have been enforced nationally during Covid. 100K has been granted for the commissioning of a Primary Care IDVA to liaise between Trafford Primary Care and MARAC. Job Descriptions have been developed but there are ongoing recruitment challenges that are being worked through. The progress of the recruitment of this role is being updated to the Domestic Abuse Board for assurance of progression.		

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			and feeding in to wider Trafford Plans. 04.10.21 UPDATE on controls: 1 page GP decision-making tool developed and shared with Practice leads. Awaiting approval from IT to add the template EMIS.				
4	That all agencies involved in the review provide evidence to Trafford Safer Partnership that the links between domestic abuse and suicide have been provided to staff.	Local	Trafford Council have reviewed and published its Suicide Prevention Strategy. Domestic Abuse forms part of the strategy. Training on the links between domestic abuse and suicide has	Trafford Safer Partnership / Trafford Suicide Prevention Board / Jilla Burgess-Allen and Lucy Webster	Domestic Abuse / Suicide Action Plan attached below. Suicide%20Preventio n%20and%20Domest	April 2023	

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			been delivered to Trafford staff. Trafford-Suicide-Prevention-Strategy-2022 A separate Domestic Abuse / Suicide Action Plan has been developed and implemented, with the following recommendations: 1. Domestic Abuse training completed by all mental health and suicide prevention support staff, to raise				

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			awareness of the link and promote signposting services. 2. Include Domestic Abuse as a specific area on any suicide prevention training 3. Ensure local suicide bereaveme nt services are trained / experience d in supporting families after the suicide of a Domestic Abuse victim				

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			and/or perpetrator 4. Revise suicide risk assessments to include questions around Domestic Abuse 5. Implement Referral pathways for DA services to ensure suicide support groups are offered 6. Referral pathways implemented for DA services to bereavement services 7. Include Domestic				

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy 8. That all agencies involved in the DHR review provide evidence to Trafford Safer Partnership that the links between domestic abuse and suicide have been provided to staff.				

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
		Local	NWAS Staff have access to the Safeguarding Policy and procedures as well as a dedicated policy in relation to domestic abuse. These policies are reviewed and updated maximum of every two years. Rolling cycle of review of documents are undertaken by NWAS Safeguarding Manager.	NWAS	Domestic abuse procedures updated and re-released January 2023. Shared to all staff groups on the Staff weekly bulletin and placed onto the Green Room for 24/7 access	January 2023	January 2023
		Local	Probation was involved in a DHR learning event that took place on the 27th June 2022	Probation Service	DHR Learning Event 27th June Agenda.pdf See agenda attached. Probation Managers from	Ongoing practice expectation – reviewed bi-monthly.	Ongoing practice expectation – reviewed bi-monthly.

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			which specifically looked at the link between DA and Suicide.		across Greater Manchester, Including Trafford were in attendance. This learning cascaded to staff, especially focussed on staff working with female offenders, many of whom are the victims of DA. This is a focus for learning and practice embedment. Currently, practice meetings with probation practitioners who hold female cases takes place bi-monthly to assist with practice development and provided and open forum for case discussions.		
5	That Trafford CCG provides evidence and assurances to Trafford Safer Partnership on the implementation and compliance of the Safeguarding Assurance Toolkit within GP practices.	Local	Continue to receive and monitor assurances via the Primary Care Safeguarding Assurance Toolkit**.**	TCCG/PCN following transition to ICS	Initial toolkit was launched in October 2019 and completion of returns and quality assurance process was delayed due to the pandemic. Despite delay, the return was completed to a satisfactory level with the majority of practices	March 2023	

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			A new template is being developed to align to GM assurances, via the GM Named GP network. Primary care in Trafford is working on publishing a standalone Domestic Abuse Policy		undergoing a quality assurance visit from the Named GP in 2020/2021. This is currently being repeated for 2022/23 with the updated toolkit as attached below which includes the DA Toolkit assurance standards. GP SAFEGUARDING ASSURANCE TOOLKIT		
6	That Safer Trafford Partnership ensures that there is access to information on the availability of services for victims of domestic abuse, and how referrals can be made to those services, including reporting concerns or incidents of abuse.	local	Weekly domestic abuse audit undertaken to ensure NWAS staff are operating within guidelines	NWAS / Jane Whitaker	NWAS shares information with CSC/ASC regarding domestic abuse utilising the ERISS Electronic System. Information is also shared on handover to hospital or Primary Care. NWAS Staff are mobile and do not work solely in any one local authority and as such they share information via the ERISS System, and this is passed to the relevant social	Robust information sharing platform is in place.	Ongoing, rolling audit programme

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					care dept linked to the patient's postcode.		
		Local	Dedicated funding to be allocated to the promotion of domestic abuse services annually. Trafford Council to complete a scoping exercise of what services are available to victims and children within Trafford. Once completion of scoping exercise, Trafford should create, share and print a Domestic abuse Support Guide. Trafford should also launch a poster campaign	Trafford Council's Community Safety Partnership	Posters were developed and distributed. Domestic Abuse Support Guide was created following the scoping exercise. The Support Guide will be printed and shared with practitioners across Trafford, to increase awareness and referrals into specialist by-and-for services.	Complete January 23	

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			and circulated posters across GP Surgeries, Stores, and coffee shops TDAS Services Poster.pdf Trafford Council have created a service directory and this is shared with the MARAC invite weekly. Community Safety have also started delivering multi-agency roundtable events every 6 months, which promote Trafford				

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			services, enable networking and partnership building, and impact on workforce development through multi-agency activities and breakout rooms.				
7	That Safer Trafford Partnership ensures that the learning from this review is used to inform the ongoing work around seeking funding and the provision of services for perpetrator engagement.	Local	Probation have a number of programmes that are designed to address DA and those offenders assessed as having offences and / or behaviour linked to DA are expected to undertake offending behaviour work to address their	Probation Service	All offending behaviour programmes have to be ratified and accredited by the MOJ – these are statutory elements of work and as such require accreditation / agreement with the MOJ in order to meet the requirements of sentence and the assessed risk linked needs of the person on probation. Probation are unable to take up programmes of work that are not ratified by the MOJ.	NA	NA

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			risks in this area. NPS will record data and share with Trafford Local Partnership Board every 6 months.				
		Regional	Trafford Council are currently commissioning two perpetrator programmes and reviewing effectiveness. These pilot projects will provide an evidence base for longer-term funding of perpetrator programs within Trafford.	Trafford Community Safety Partnership	Both programs are reviewed quarterly by community safety. £40,000 proposed to match fund the perpetrator provision for the next 12 months. An external evaluation of the program is being complete by Greater Manchester Combined Authority.	Contract end date: 1st April 2024.	
8	That all agencies involved in this review provide evidence to Trafford Safer Partnership	Local	Trafford Domestic Abuse Service (TDAS) carries out joint	Trafford Domestic Abuse Service	The program which is more commonly known as Operation Horizon has been ongoing since June 2021 to	Completed	Ongoing practice

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	on how their service seeks to engage with individuals who are deemed as reluctant to engage, or 'hard to engage'.		visits with the police to try and engage individuals who are at highest risk of domestic abuse and/or harder to reach.	(TDAS) and Greater Manchester Police (GMP)	coincide with the Euros. Due to its success, the joint partnership working has continued, and the visits are held every Thursday following the Trafford MARAC, on occasion we deliver ad hoc visits due to high risk cases which come in. The ASU now incorporate DA high risk prisoners who are dealt with by specialist DA officers, through this the unit has been able to get on board reluctant victims.		
		Local	NWAS staff follow established pathways to elicit	NWAS	NWAS staff do not hold caseloads and as such staff engage in a snapshot of the patients lives. Each presentation of the patient	Completed, as ongoing normal practice	Jan 2023

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			appropriate outcomes for the patient		is dealt with the appropriate pathway, with information sharing via the NWAS safeguarding system or to the most appropriate service such as police. Weekly audit of domestic abuse safeguarding concerns raised by NWAS staff is undertaken by the NWAS safeguarding team to ensure the police are contacted when appropriate.		
		Local	Probation can only work with those subjects to a sentence imposed by the courts. These can either be a Community Order, Suspended Sentence Order or a custodial sentence. People on Probation are required to	Probation Service	Enforcement action taken on failure to engage and address offending behaviour. 2 warnings issues on a Community Disposal can see the person on probation taken back to court for breach. Any lack of compliance with licence (released from custody) can see the person on probation recalled to custody.	Ongoing practice expectation – daily case load updates in performance reports. 6 weekly supervision with line management.	Ongoing practice expectation

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			engage with their sentence and sentence plan, which will include work to address their offending behaviour. Should a person on probation not engage with the work provided to address their offending they will be deemed as in breach of their sentence, which could see them returned to court for resentencing if subject to a community disposal or recalled to custody, if they have been		Performance reports monitor compliance, these reports are updated daily by the performance team and ae made able to probation practitioners daily in Order to monitor any issues with compliance and take action where needed. These are reliant on accurate recording by Probation Practitioners, regular supervision with a line manager, which should take place every 6 weeks is a forum to check cases are up to date in terms of recording.		

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			released on licence. Lack of engagement can be seen as not attending appointment as directed, and/or not engaging with work as directed. Therefore, attending an appointment with a DA focussed offending behaviour programme, but not engaging with the work, can see enforcement action taken.				

Adult Social Care – Trafford Council						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	MARAC Review	MARAC review is ongoing, and ASC are engaging in this process. ASC needs to ensure the outcomes of this review are embedded in practice. ASC to ensure clear documentation of MARAC meetings included the professional in attendance.	ASC are part of this MARAC review and will agree actions in the review for ASC and take these forwards. Clear process map developed to support what needs to be recorded in the system.	ASC is fully engaged in the MARAC process, resulting in better results for those heard at MARAC. ASC are co-chairs of MARAC Clearly documented information of the MARAC meeting held within the ASC system.	Ann-Marie Mohieddin Ann-Marie Mohieddin	Completed Completed
2	Training to support ASC staff in dealing with domestic abuse and considering ASC's statutory responsibility for safeguarding and safety planning.	Development and delivery of specialist training for ASC staff in relation to domestic abuse and statutory requirements. Training cascaded to staff with links	Evidence of the development of training package and roll out to staff across the service.	Better services for those who come to the attention of ASC who are experiencing domestic abuse, resulting in better outcomes for residents.	Ann-Marie Mohieddin/ Training department	Completed

Adult Social Care – Trafford Council						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		to Talk Listen and change: Domestic abuse training and services 1st Dec Make a Change are running 'Recognise, Respond, Refer' for frontline practitioners 8th Dec Trafford directory updated with resources around domestic abuse. Mandatory Domestic abuse training for all ASC staff-lunch and learns TDAS worker now located with safeguarding hub				

Adult Social Care – Trafford Council						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		part time for joint working ASC take active part in delivering round table events http://cms.intranet.trafford.gov.uk/Docs/HR/Policies/Domestic-abuse-policy.pdf Domestic abuse policy available online chapter was added to the APPP in February 2022.				

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	In responding to an incident where domestic abuse offences are disclosed or apparent, consideration at the scene should be given to an Evidence-led Prosecution	GMP DA Policy and Procedures should provide clear definitions and responsibilities for	The revised domestic abuse policy provides clear definitions and responsibilities for officers investigating	Officers investigating domestic abuse offences will have clear definitions and responsibilities to consider evidence-led	Det Supt Dodd Now - Det Supt Jude Holmes	May 2022

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	(victimless prosecution) using evidence obtained during the primary investigation. Particularly, where there is: • a history of domestic incidents • an escalation of physical abuse • a victim's previous reluctance to make a complaint.	officers investigating domestic abuse offences to consider evidence-led prosecutions where appropriate to do so. Engagement with the CPS should be sought to ensure that the CPS and GMP are aligned in the delivery and expectations of evidence-led prosecutions.	domestic abuse offences to consider evidence-led prosecutions where appropriate to do so. Resources and instruction will be made shared when the new policy goes live, including: • 7-minute briefing • Intranet page including short video from Mr Dodd • Policy available on the intranet • Separate document with practical guidance • Slide on district briefings	prosecutions where appropriate to do so. CPS and GMP will be aligned in the delivery and expectations of evidence-led prosecutions. .		

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
			• Chief cons orders GMP are currently in discussions with the CPS, who are delivering training to prosecutors on this topic. It is intended that GMP will attend this training with a view to delivering something similar to the wider GMP workforce. PPGU now schedule monthly meetings with the CPS DA Lead re ELPs to establish what advice can be given to officers to ensure best evidence is captured to secure positive charging decision in instances where an ELP is appropriate.			

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			Learning Circles are to be rolled out after being piloted across one command area. These are to include DA cases and will involve the OIC, district and cluster SLT reviewing cases to capture learning, to be fed back into the organisation learning board. November 21 Guidance shared as part of Operation Maximum around evidence-led prosecutions. ELP is also covered in the new DA Policy and it is anticipated that the DA Matters training which has been successfully funded, will further support awareness of			

Greater Manchester Police						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
			DA ELP in the organisation. Jan 22 The DA Policy is written and liaison has been undertaken with all local authorities. Jake Ashall is finalising some queries from the Directors of Adult/Child Services about the policy. Once this is completed, the policy will be sent for Chief Officer approval. Liaison with CPS continues to promote Evidence Led prosecutions where appropriate to do so. CPS have informed GMP that they have been designing a training package for prosecutors and we feel that it is important this is shared with GMP but as yet, this has not been shared. Whilst			

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			consideration should be given to an evidence led prosecution, progression to this outcome may not always be available or appropriate. The learning circles concept has now evolved and the Strategic Organisational Learning Branch have designed Evidence Led Learning. This is an internal process whereby good practice, or area's for development can be identified and learning can be discussed and shared via a formal process.			
2	The GMP Policy on DVPN/DVPOs should be clear and effective when: • considering a DVPN/O • action to be taken once DVPN/O granted.	The GMP Policy in relation to DVPOs updated (with consideration of the implementation of iOPS which	The Force Policy was updated in December 2020 and published to all officers via the intranet.	Clear process for the consideration and delivery expectations for DVPN and DVPO.	Det. Supt. Dodds DI Lindsay Booth	Completed December 2020

Greater Manchester Police						
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		replaced OPUS in July 2019). Trafford District Vulnerability Lead to provide assurance with regard to the DVPN/O process at a local level.	In December 2020, 'DA Triage Expectations' guidance (including consideration of DVPOs) was delivered by the PPGU (Det. Supt. Dodd) to Vulnerability Leads for each district for dissemination to the safeguarding teams. CPD session delivered to frontline Inspectors and MASH teams about the revised DVPN/O process. GMP - FORCE 2 police staff perform the role of DVPO officers. This has enabled a new process whereby the team now have extra flexibility to contact the victim as soon as the DVPO has			

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			been granted and offer additional support. If this contact fails, then the new process outlines the clear responsibilities for districts to make contact with the victim and conduct compliance checks within specified timeframes. A revised DVPN/DVPO policy has been signed-off and launched, alongside an accompanying training package, to reflect the changes to the process. Trafford District update: DCI Chris Mannion			

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			The district have been running a DVPO pilot since 16th November 2020, whereby: • Applications for a DVPN are reviewed by an Inspector prior to submission to the Superintendent. • Any refused applications will be documented with a full rationale and collated by the DVPN/O team. • Welfare checks are completed with the victim and overall safeguarding is managed by the MASH. • Offender compliance checks are completed by the district OMU			

Greater Manchester Police						
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			with support of response officers as required – these are captured as part of daily business on the bronze rolling log. • The district's domestic abuse coordinator is sighted on all DVPN/Os as a matter of course.			
3	Develop the application of professional judgement to support frontline officers and evaluators when recognising vulnerability, from initial risk assessments to the holistic overview of history of DA.	1. GMP to review the triage process and resourcing. - When reviewing the domestic history of a couple, consideration should have been given as to whether it is	1. December 2020, email sent by Supt. Dodd to all Districts containing the triage expectations- CP/DA and AAR ISR3 review of triage/safeguarding resourcing and training is in process. DCI Holmes (Crime Training) is reviewing	Informed decision- making in relation to risk assessments and action needed to follow up. Improved recording of rationale and progress of the action with partner agencies.	Det Supt Dodd DCI Holmes	May 2022

Greater Manchester Police						
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		appropriate to reduce the risk level. - consideration for referrals to be made to Mental Health and Alcohol Support if it is clear that until one or both of these issues are dealt with, the violence within the household will continue and will escalate. 2. Review Vulnerability training for frontline officers. - Recognising vulnerability - creation of a Care Plan where an individual is	the current vulnerability training across the Force. A funding bid is being applied for DA Matters training delivered by SafeLives. DCI Holmes is involved in the work being done around proposals for a new triage course. The content of the course has been agreed. Consideration is being made to how it would be presented and any overlaps with potential needs for ISR teams. People and Development Branch are currently leading on this with support from PPGU and ISR. The Making a Difference Toolkit has been launched on the intranet. This provides officers with a repository of partner	Ensure vulnerability is recognised, recorded, and action taken to signpost for consideration of support from partner agencies.		

Greater Manchester Police						
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		deemed to have the capacity to make the decision that they do not want help/further referrals. This will inform decision-making for future 'concerns'.	agencies available within the locality that officers can use to signpost victims to and make appropriate referrals when consent is obtained. Nov 21 - Triage Expectations document disseminated to all districts. The newly formed CPIU teams received training and the new ASU is also planned to have specific training. It also planned to complement this with an Adult Safeguarding Handbook - A practical guide to process/practices that the ASU will undertake for consistent standards. January 2022 - A meeting was held with People and			

Greater Manchester Police						
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			Development Branch regarding the commissioning of the Triage Course. Due to availability of training staff to design and deliver this course, it has not been possible for this to be delivered. As such, this has been raised as a risk on the PPD Risk Register and will be escalated to DCS Kerr, and also through the SOLB as triage continues to be a theme in several reviews that have taken place. Work has been undertaken in the interim to support officers with the triage process as per the previous updates 2. May 2020 – GMP Adults at Risk Policy and Procedure			

Greater Manchester Police						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			published with the Vulnerability Assessment Framework. Mandatory training for frontline staff followed to support this.			

Manchester University NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Doctors recording history of depression will determine if further specialist mental health assessment is necessary.	Audit of documentation to be completed to ensure that mental health assessment is indicated in the medical records. This will include advice/ services offered, as well as consideration of mental capacity. Further communications to be sent to medical colleagues to raise	Documented evidence to be recorded in the medical notes.	If self-harm or suicidal thoughts disclosed, this will trigger a referral to the Integrated Care Pathway (ICP) and a psychosocial assessment. For in-patient admissions, referral to the GMMH Mental Health Liaison Team (MHLT) should be offered if concerns raised about management of depression/anxiety.	Mental Health Safeguarding Lead Nurse – to be added to Mental Health Subgroup Action Log	December 2021 for further raising of action. December 2021 for further raising of action. Continuous ongoing action for the Organisation to achieve and maintain compliance

Manchester University NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		need for onward referral and details of discussion with the patient in the clinical records/ discharge letters to the GP.				**Update 10.02.23:** ICP is now on the MFT Hive system and GMMH docum ent their mental health assessments directly on to the HIVE system. Discharge letter is now automatically generated via HIVE and will include the presenting concerns.

Northern Care Alliance						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Response and recognition of risk of DVA and raising relevant Adult and Children's Safeguarding referrals.	Level 1&2 Children and Adults safeguarding are	Provide compliance figures to the CCG via the GM	Effective training to prompt appropriate Child and Adult's Safeguarding referrals.	Corporate Safeguarding Team	Continuous ongoing action for the Organisation to

Northern Care Alliance						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		mandatory across the organisation. Level 3 Children and Adults safeguarding training for registered professionals in line with the inter-collegiate Documents.	contractual standards. The Mandatory training figures are reported to the relevant CCG Designated Teams for our organisation. This is a part of the Greater Manchester Contractual standards that are reported into NHS England.		Clare Kelly ADNS safeguarding children and NCA Strategic lead for domestic abuse	achieve and maintain compliance of Safeguarding training. Update 21/12/22: Action complete DA is included in level 1-3 mandated safeguarding training and delivered. Level 3 is delivered in a range of platforms to increase accessibility ie: face to face, MST or new interactive e-learning programme
2	Improved recognition and response of domestic abuse, including coercion and control.	Review and update the Level 3 Adult Safeguarding training. This is to	The Domestic Abuse section of the Training that is provided.	This will improve the recognition and response of DVA, coercion and control and	Clare Kelly ADNS Safeguarding Children and	21/12/22 Action completed with update to both

Northern Care Alliance						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
		include familial domestic abuse and coercion and control. Consider evaluations of the training from the delegates.	Evaluations of the training. Intercollegiate document.pdf Assurance is also provided to the relevant CCG Designated Safeguarding teams for NHS England and the Greater Manchester Contractual Standards. Training package can be provided as evidence.	the understanding that this is now a crime.	NCA Domestic abuse strategic lead	Safeguarding children and adults training in place from November 2021

Trafford Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Ensure awareness of new referral pathways to access Trafford Domestic Abuse services is known by all GPs and secretarial/admin staff involved.	Add the Primary Care DVA risk assessment to EMIS and raise awareness through GP safeguarding lead meeting.	Screenshot of EMIS homepage. Primary Care DA risk assessment added onto the Primary Care Toolkit for assurance of the Safeguarding standards. This includes DA awareness, review of policies and toolkit awareness.	Awareness of how to refer appropriately and who to contact when dealing with domestic abuse. An increase in referrals from Primary Care into DA services and MARAC. To monitor these 6 monthly data is being provided to TDAS for assurance via EMIS the GP electronic record system. EMIS F12 Screenshots.docx referrals to TDAS or MARAC last 6m Prima	Dr Deborah Pole (Named GP Children)	January 2022
2	Ensure safeguarding tool kit completed and red/amber areas discussed at MDT meetings.	Complete the toolkit and ensure CCG have verified/ checked.	This was completed in 2021 and is again being repeated in 2022/23 with a newly developed toolkit to include the DA risk assessment tool	Assurance that Primary Care GP Practices are compliant with Safeguarding requirements and legislation across all ages. Actions provided to those Practices who are amber/red to assist in achieving standard compliance where possible.	Dr Deborah Pole (Named GP Children)	September 2021

Trafford Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
			developed with TDAS. GP SAFEGUARDING ASSURANCE TOOLKIT			

Victim Support						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Initial contact was not always attempted within 24-48 hours of receiving the referral. This was due to a resource issue at the time. There were a high volume of referrals being referred to the Domestic Abuse service at the time and consequently initial contact time frames were not always met. However, when contact was attempted, multiple attempts were made over different days via text message and phone calls. The IDVA always updated partners of the failed contacted attempts and this was shared	• Since the service was delivered, VS has new DA operating procedures that all staff follow • VS now cap the referrals within IDVA contracts to ensure safe working practices on discussion with commissioners relating to resources available	• Minutes of team meetings when discussions take place • Evidence that more of our IDVA teams have been through SafeLives training (IDVAs no longer employed by VS in Trafford but are currently in	• Improved contact rates for clients resulting in increased awareness of services available • Improvements in the ISSP for clients to include more referrals out, especially for mental health and substance misuse.	Area Manager working with Operations Manager	June 2021

Victim Support						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	at MARAC on multiple occasions.		Rochdale and Bury). Our services are accredited by SafeLives (National accreditation for governance with 5 individually accredited community services). No-longer deliver IDVA contract in Trafford. In GM, 3 IDVAs employed by VS have been through IDVA training this year and IDVA caseloads are between 20 and 30.			