Salford and Manchester Community Safety Partnerships

Domestic Homicide Review in the Case of Nikki

(Died December 2017)

Final Report

Independent Chair/Author: Maureen Noble

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1 Introduction

This Domestic Homicide Review relates to the death of Nikki, who died in December 2017. The review panel offer condolences to Nikki's family on their tragic loss.

Nikki's family were asked to propose a pseudonym for this report. They wished Nikki's name to be used in the report.

The perpetrator has been anonymised with the name Ralph.

1.1 Key People

Nikki (Victim – deceased) – Aged 30

Ralph (Perpetrator – deceased) – Aged 32

1.2 Incident Leading to the DHR

On a day in December 2017, at 10.10 hours, Greater Manchester Police (GMP) were notified by North West Ambulance Service (NWAS) of the discovery of the bodies of a deceased female and a deceased male inside a flat in Manchester. The flat was contained within a house of multiple occupancy (HMO). The owner of the HMO had telephoned NWAS to report that they had found the bodies when checking the room.

Police attended the scene and found the body of a female (later identified as Nikki) with multiple stab wounds. Lying close by was the body of a male (later identified as Ralph).

1.3 Parallel Processes

1.3.1. Police Investigation and Post Mortem

A police investigation into the circumstances surrounding the deaths has concluded, and will present its findings to the Coroner in due course. At this stage, no other persons are being sought as being connected with either death.

A Home Office post mortem established that Nikki died of multiple stab wounds. Toxicology samples taken from Nikki at post mortem found alcohol and a range of prescribed and non-prescribed drugs, consistent with therapeutic use of medication and recreational use of codeine and amphetamine.

Post mortem examined established that Ralph died of paracetamol toxicity. Toxicology samples taken from Ralph at post mortem found no alcohol present. A range of drugs were present, consistent with therapeutic use. Also found were cocaine, consistent with recreational use at 24-48 hours prior to death. Paracetamol and codeine were present, consistent with excessive use prior to death.

The indications are that Nikki was murdered by Ralph, who then took his own life.

1.3.2. Coronial Matters

At the time of writing this report no inquest has taken place in relation to the death of Nikki or Ralph. The Coroner has been updated regarding progress of the DHR.

1.4 Overview

1.4.1. Brief Background to Nikki

Nikki's relationship with Ralph began prior to the period under review. Nikki's family told the review that she was very sociable and outgoing, and that it is likely that she met Ralph at a party or club. Nikki's mother said that, at the beginning, the relationship was good, and Nikki and Ralph were happy together, and that there were no outward signs of any difficulties in the relationship.

For most of the period under review Nikki held a tenancy with a local housing provider. The tenancy began in November 2011 and ceased in May 2017, when Nikki was evicted due to rent arrears. During this period Nikki was the sole tenant of the property (although there are indications that Ralph lived at the property at times).

Throughout the duration of her tenancy the housing provider had approximately 167 contacts/attempted contacts with Nikki. The majority of these contacts were in relation to rent arrears issues. Whilst the housing provider did not receive any disclosures in relation to domestic abuse, or any reports from neighbours that Nikki may have been a victim of domestic abuse, they were aware that Nikki had vulnerabilities in relation to physical and mental health issues, and in this context they offered her further support, which was good practice. Nikki did not take up any additional support that was offered to her.

During the period under review, Nikki was registered with three General Practices (GPs) in the Salford local authority area. In this report these practices are referred to as GP1, GP2 and GP3. Nikki was also temporarily registered with a GP in another part of the UK (NB in a part of the UK that does not have DHR legislation). This GP practice is referred to in this report as GP4.

Nikki had periods of frequent contact with local GPs, although there appears to have been no particular pattern to this. Nikki experienced an ongoing medical issue for which she was prescribed pain relief. Nikki also experienced low mood and anxiety (and was referred to a counselling service). She was treated with anti-depressant medication, although she did not always take her medication.

Between 2012 and 2015 Nikki had hospital appointments for an unrelated matter which are noted but not reported on in this review.

Nikki was evicted from her tenancy in May 2017, after which she went to live with her mother. It is not clear whether, at this time, Nikki's relationship with Ralph was ongoing. Nikki told professionals that she had separated from her partner (she did not name him), however there are indications that they remained in contact with each other.

Although Nikki had said that she wished to end the relationship, Ralph continued to contact Nikki, and at one point she told a friend that he was stalking her. Nikki's mother was unhappy about Nikki's ongoing contact with Ralph at this time and spoke to Nikki about this

In November 2017, when Ralph moved to the HMO, the owner of the HMO offered Nikki a room there and Nikki began to reside there in November 2017.

Although Nikki and Ralph were living in the HMO during late November and December 2017, it appears that Nikki had begun a new relationship and that Ralph was aware of this. Police witness statements noted that Nikki and Ralph had been heard arguing by the owner of the HMO in the weeks leading up to Nikki's death.

1.4.2 Brief Background to Ralph

Prior to the period under review Ralph had lived with a previous partner and their two children in another part of Greater Manchester. Criminal records show that Ralph had been a perpetrator of domestic abuse in that relationship.

Ralph had two convictions, the sentences for which did not carry statutory supervision requirements. On 23rd October 2012 he was made subject to a 16-week custodial sentence at Manchester Magistrates Court, for the offence of Common Assault. On 14th October 2015, he was made subject to an 18 months Conditional Discharge for the offence of False Representation. During the period under review police had five separate contacts with Ralph in relation to theft of petrol from vehicles.

Throughout the period under review Ralph was registered with the same GP. He had a history of anxiety and depression and was prescribed anti-depressants and referred to a counselling service. Ralph had served in the armed forces and attributed his anxiety to his service. However, he was never diagnosed with a mental health condition.

The review has been told that Ralph talked about having connections with local organised crime networks, although his contact with offender management services suggested that Ralph was a petty offender who gained kudos from his associations with gang members.

It appears that Ralph may have spent time living with Nikki, although he also lived at his mothers' home. The review learned that Ralph also had a room kept 'open' for him at a HMO, which was owned by a family friend. Ralph was in receipt of housing benefit which was paid directly to the HMO (apparently this continued to be paid to the same HMO when Ralph was not residing there).

Ralph was supervised by the Community Rehabilitation Company (CRC) between 23rd May 2016 and 12th May 2017, while subject to an Offender Rehabilitation Act Community Order, imposed on the 17th May 2016, for the offence of Theft (siphoned petrol from vehicles) with a 16 weeks Curfew Requirement and 20 Rehabilitation Days.

In June 2017, Ralph took an intentional overdose and was admitted to hospital and received a mental health assessment. The assessment identified Ralph as being at high risk of further suicidal ideation if his frequent and heavy use of cocaine continued. Ralph was not deemed to present any risk to others.

Ralph's family said that they were aware that the relationship between Nikki and Ralph was turbulent, and that they had had an on-off relationship for some time before the incident leading to this review took place.

Ralph had confided in his sister before resuming the relationship with Nikki in late 2017 as he was unsure whether or not they should 'get back together'. Ralph's sister told the review that Ralph had been very depressed for some time but acknowledged that this was not a rationale for his alleged actions. Ralph's family were shocked at what had happened and said that there were no indications that such a tragedy would take place.

1.5 Equality and Diversity

The panel considered the seven characteristics set out in the Equality and Diversity Act 2010, and made the following observations.

The panel noted that Nikki had ongoing issues regarding anxiety and depression and that she received treatment from her general practitioners to alleviate symptoms. Nikki was referred to specialist mental health services, however she did not maintain contact with them. Nikki had an ongoing physical health issue which had been present from birth, which impacted her mobility. She was not, however, registered as a disabled person.

Ralph experienced anxiety, depression and he referred to himself as having *'post-traumatic stress disorder'*. There is no indication of a formal diagnosis of PTSD ever having been made**.** He was treated by his GP with anti-depressant medication and was referred to mental health services, however he did not maintain contact with them. Ralph presented to Accident and Emergency services on one occasion following an intentional overdose.

Neither Nikki nor Ralph were diagnosed with severe and enduring mental health conditions.

There were no other specific and equality and diversity factors noted by the panel.

1.6 Family Involvement in the Review

Nikki's family were notified in writing at the commencement of the review. Initial contact was made through the Police Family Liaison officer and an information leaflet produced by Advocacy After Fatal Domestic Abuse (AAFDA) was sent through to the family.

Nikki's mother and sister said they would be willing to contribute to the review. The Chair visited them both at mother's home in August 2018 and again in December 2018 to seek their views and to review the final draft report.

An overview of their input to the review is provided at 1.4 and their views and understanding of events are also included throughout this report. The Chair and Panel are grateful to Nikki's family for their contribution to the review.

The Chair spoke to them both regarding support available to families following a domestic homicide and offered to make contact with support services on their behalf (following this visit contact was made with a local support agency who have subsequently provided support to Nikki's family).

The Chair also spoke to Ralph's mother and sister and thanks them for their contribution to the review.

2. Conduct of the DHR

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[1]. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set in the guidance.

The Domestic Homicide Review was jointly commissioned by the Salford and Manchester Community Safety Partnerships, following a joint screening meeting in January 2018. (Nikki had recently lived in Salford and was murdered at an address in Manchester). The Home Office were notified in early February and endorsed this course of action.

The DHR has been completed in accordance with the regulations set out by the Act and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.[2]

The panel noted the revised definition of domestic abuse to ensure that all aspects of domestic abuse were addressed in the terms of reference and in the reports provided by agencies.

2.1 Terms of Reference and key lines of enquiry

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

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

[1]https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

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

2.2 Rationale for the Review and Terms of Reference

The rationale for a DHR is to ensure that the review process derives learning about the way agencies responded to the needs of the victim. It is the responsibility of the panel to ensure that the daily lived experience of the victim is reflected in its considerations and conclusions and, wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's wishes and feelings.

The review aims to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Learning from the review will help to improve services to victims of domestic abuse and a multi-agency action plan is appended clearly setting out the actions that agency should undertake to improve service delivery.

2.3 Terms of Reference:

1. To establish what contact agencies had with the victim and perpetrator; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard the victim and risk assess the perpetrator.
3. To establish whether there were other risk factors present in the lives of the victim and perpetrator (e.g. mental health issues, substance misuse, transience and vulnerability in relation to accommodation).
4. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
5. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
6. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.
7. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
8. To take into account specific issues relating to diversity.

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

1. Did your agency know that the victim was subject to domestic abuse by the perpetrator or any other party at any time during the period under review?
2. If so, what actions were taken to safeguard the victim and were these actions robust and effective?
3. Was the perpetrator known to your agency as a perpetrator of domestic abuse and if so what actions were taken to reduce the risks presented to the victim and/or others?
4. Did your agency have knowledge that the victim and/or perpetrator was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?
5. Did your agency know that the victim resided in a Home of Multiple Occupancy?
6. If so did you consider that this accommodation may be a risk factor? Please set out the reasons why.
7. Did the victim disclose domestic abuse to family and/or friends, if so what action did they take?
8. Did the perpetrator make any disclosures regarding domestic abuse to family or friends, if so what action did they take?
9. Did your agency identify any concerns in relation to safeguarding children in your contact with the victim?
10. Did your agency identify and work with any vulnerable adults associated with the victim or perpetrator? What work did you undertake and what were the outcomes?
11. What systems and processes did your agency use when working with the victim and/or perpetrator in relation to the following:
    Risk assessment
    Risk management
    Provision of services and interventions
    Service pathways (within and across agencies)
    Supervision of staff and quality assurance of decision making
    Were these systems and processes effective and of a good quality?
12. What was the level and type of multi-agency working in the case, was this effective?

Provide an analysis of what you think worked and what could be done differently from what you have learned in this case.

2.5 The DHR Panel

A DHR Review Panel was established and met on seven occasions to oversee the review. The Panel received reports from agencies and dealt with all associated matters such as

family engagement, media management and liaison with the Coroner's Office. In addition the panel liaised with local police in relation to the criminal investigation.

The Community Safety Partnerships appointed Maureen Noble as independent Chair and Author to oversee and direct the Review and to write the overview report. Maureen Noble was previously employed by Manchester City Council as Head of Crime and Disorder. Maureen left this role in September 2012. She has not been employed in any capacity by Manchester City Council since that time, and has worked as an independent consultant since leaving the authority.

A panel of senior representatives from relevant agencies was appointed as set out below.

Name	**Agency**
Maureen Noble	Independent Chair and Author
Leanne Conroy	Policy Specialist, Manchester City Council (MCC)
Ian Halliday	Domestic Violence and Abuse Manager, MCC
Roselyn Baker	Principal Policy Officer, Salford City Council
DC Suzanne Fawcett DC Alison Troisi	Greater Manchester Police
Sushma Parmar	Senior Probation Officer, National Probation Service
Tim Kyle	Head of Offender Management, National Probation Service
Elizabeth Walton	Designated Nurse Safeguarding Adults, Salford CCG
Samantha Stapleton	Interchange Manager, Cheshire and Greater Manchester CRC
Clare Kelly	Safeguarding Nurse, Northern Care Alliance
Pippa Nicolle	Named Nurse (Children), Northern Care Alliance
Mark Fitton	Community Safety Manager, City West Housing Trust
Dawn Redshaw	SIDAS (Independent Domestic Abuse Service)
Laura Forsythe	Safeguarding Nurse, Salford CCG
David Allwood	Housing Compliance and Enforcement, MCC

2.5 Sources of Information to the Review

Following initial scoping for the review the following agencies were identified as having had contact with Nikki and/or Ralph.

- General Practice (Four Practices for Nikki, One Practice for Ralph)
- City West Housing Provider (Nikki only)
- Salford Royal Foundation Trust (A&E and Acute Services)
- Greater Manchester Mental Health Trust
- North West Ambulance Service
- Community Rehabilitation Company (perpetrator only)
- National Probation Service (perpetrator only)
- Six Degrees (telephone interview)

Agencies that had significant, relevant and/or prolonged contact with Nikki and Ralph were asked to provide Individual Management Reports. Other agencies were asked to provide short reports.

There were no conflicts of interest recorded during the Review. Authors of Individual Management Reports and short reports were not directly connected to either Nikki or Ralph.

Reports were received from all agencies who had contact with Nikki and/or Ralph.

In addition to written reports, telephone conversations were held with Six Degrees (a counselling service that is offered in General Practice).

Information was requested from GP4 (who is based in another part of the UK) with whom Nikki was temporarily registered in early 2017. Several requests were made to GP4 to provide information on their contact with Nikki, however GP4 did not respond to those requests.

2.7 Disclosure

With regard to disclosure of relevant material, the panel liaised with the Senior Investigating Officer in the case to ensure that any new or additional material was made available that may be relevant to the criminal proceedings.

2.8 Additional Information Sought by the Review

The panel made enquiries regarding safeguarding in relation to Ralph's children who live in another local authority area. The panel received assurance from Children's Social Care that the children were safe and well and that there were no current safeguarding matters that the panel needed to take account of.

The panel made enquiries regarding benefits received by Ralph which were confirmed by the Benefits Agency.

The panel made enquiries regarding the status of the HMO in which Nikki and Ralph were residing in the weeks before Nikki's death. The review established that the HMO was fully licensed and legally operating.

A witness statement made by the owner of the HMO had suggested that the HMO had formal contracts for providing accommodation with two Local Authorities in the area. Further enquiries confirmed that this was not the case.

The panel reviewed witness statements made by the owner of the HMO, members of Nikki's family, members of Ralph's family and GP3. Information from witness statements was taken into consideration when compiling the final report however, the panel recognised that witness statements can be subjective and are not necessarily factual.

The panel tried to make contact with the owner of the HMO via a known contact, to invite them to participate in the review, however, at the time of writing, there has been no response

2.9 Timescale for the Review and Publication

The review commenced in May 2018. A final draft report was submitted to the Home Office for quality assurance in April 2019. Approval for publication, subject to minor changes, was received from the Home Office in November 2019.

3. Contact with Agencies – What Agencies Knew

3.1 Overview and key to agency contacts

During the period under review Nikki had a large number of contacts with agencies. As referred to earlier in this report, Nikki was registered with three separate GP practices in the local area during this period, and was also temporarily registered with GP4 when she went to live with her mother in another part of the UK between January and April 2017.

Ralph was registered with the same GP throughout the period under review.

3.2 Events in 2012

In November 2012 Ralph was sentenced for violent assault on a male unknown to him (Ralph said the motivation for the assault was in relation to victim having 'robbed' his girlfriend, presumed to be Nikki, the previous week). Ten previous offences were taken into consideration including previous domestic abuse offences.

3.3 Events in 2013

In February 2015, Nikki was seen by GP1 with Ralph for a matter unrelated to this review (NB Nikki continued to see her GP and specialist services in relation this to this matter until 2015). At this time Nikki reported that she had stopped taking anti-depressant medication.

Two months later Nikki was diagnosed with anxiety/depression by GP1 and advised to recommence medication.

In September 2013, Ralph was diagnosed with depression by his GP and anti-depressant medication was prescribed.

In December 2013, Nikki presented to GP1 saying that she was paranoid about her boyfriend, and said that she had thoughts about taking her own life.

3.4 Events in 2014

In February 2014 Ralph presented to his GP and said that he was using approximately £40 worth of cocaine on a daily basis. The GP did not refer Ralph to the drug service (the GP said this was because Ralph often refused referrals). This information was not recorded on the patient record but was reported to the review by the GP.

In March 2014 Nikki presented to GP1 asking for a 'sick note' for her employer. She said that she had stopped taking anti-depressant medication due to the unrelated matter described earlier. She was prescribed co-codamol for pain relief.

Nikki changed GP in May 2014 and was referred to psychology service (Six Degrees) by GP2. Nikki attended her first appointment with the service in August 2014.

At this appointment Nikki disclosed that she had previously been in an abusive relationship. She said that she did not use drugs or alcohol. She said that she had hit her partner about 8 weeks ago.

Nikki did not attend her next appointment with the service in September 2014. After non-attendance at two further appointments in September, Nikki was discharged from the service on 3rd October 2014.

In September 2014 Nikki told a housing officer that she was 'on suicide watch'. Support was offered in relation to debt management and housing support, however Nikki said that she did not want any support at that time.

3.5 Events in 2015

In January, Ralph presented to A&E with chest pain, he was admitted and remained in hospital for two days diagnosed with pneumonia.

In December, Ralph presented to his GP reporting depression and insomnia. He was appropriately offered support from Six Degrees but declined this. He was issued with a prescription for anti-depressant medication and was requested to attend for review in one month. He did not attend for review and there was no further contact in relation to this episode.

3.6 Events in 2016

On 26th January, Ralph was admitted to Salford Royal Foundation Trust (SRFT) with sepsis. On discharge, the summary requested that the GP refer Ralph for an x-ray in approximately six weeks' time. This referral was completed in March 2016 as requested. The GP proactively contacted Ralph by telephone on three separate occasions to ensure that Ralph collected the letter for him to attend for x-ray. There is no evidence in the records that Ralph attended for x-ray.

In March, Nikki presented to her GP reporting low mood, she said she had split up with her partner.

In May, Ralph appeared in court for an offence committed in April. The offence related to theft of petrol. Ralph was assessed by National Probation Service (NPS) as being at medium risk of re-offending and low risk of harm

At the end of May, Ralph told his offender manager that he had been thrown out of his girlfriend's accommodation (he was not asked for any further information about this and did not name Nikki). He said he had moved back to live at his mother's address.

In August, Ralph told his offender manager that he had been working away for the past few weeks and that this was going well.

On 26th October, Ralph presented to his GP with stomach problems. He was seen by a locum GP. Ralph disclosed that he had been using 'Zapain' which he had obtained from a friend to assist with poor sleep. Ralph was prescribed medication for the stomach problem and Amitriptyline[3] for poor sleep associated with depression.

In November 2016 Ralph attended his GP saying that he could not sleep. He reported that he had witnessed a shooting (in the community) and that he was having flashbacks. The GP referred him to psychology services (Improving Access to Psychological Therapies), for exploration of Post-Traumatic Stress Disorder. The referral was made on 6th December. Following triage by IAPT, a response received by the GP on the 7th December proposed that Ralph required support from the High Intensity Team and the referral was forwarded accordingly. The GP made a request for a follow up for Ralph, however Ralph did not attend this appointment and he was discharged and his GP was notified.

On 19th December, Nikki attended GP2 with facial injuries, she said that she had fallen into a glass table at home. There appears to have been no exploration of the circumstances of the injuries or enquiry regarding possible domestic abuse.

3.7 Events in 2017

During the first four months of 2017 Nikki was staying with her mother in another part of the UK. The review has learned that at this time Nikki was temporarily registered with GP4.

On 23rd January the record from Ralph's GP shows that Ralph was seen in the psychiatry clinic. On this occasion, the GP determined that Ralph was not suicidal and it appears that no further action was taken by his GP.

On 31st January Nikki telephoned GP3 to say that she was still staying with her mother in another part of the UK.

On 8th February Nikki attended GP3. She reported that she felt anxious and paranoid, and that she was under stress as she was being evicted from her rented accommodation. Nikki told GP2 that she had 'smashed up her flat'. She said that she had thoughts of self-harm but had no intention of harming herself. The GP prescribed anti-depressant medication.

Four days later on 13th February Nikki attended A&E at the local hospital following referral by GP3 regarding her 'mental state' (she said she had taken a number of tablets). Nikki reported that she felt suicidal when she presented.

Nikki was seen by a mental health practitioner who noted that Nikki 'smelled of alcohol and presented as intoxicated'.

Nikki told the mental health practitioner that she had been in an abusive relationship, and that this had ended within the last few days (she did not discuss her partner, nor was she

[3] The review has looked into NICE guidance for the prescribing of Amitriptyline.

was she asked for any further information). Nikki reported cocaine use and said that this was a factor in the abusive relationship. She said that she did not intend to resume the relationship.

The mental health practitioner made a referral to the local drug service (Achieve). The mental health practitioner did not explore the nature of the abuse reported by Nikki, nor did they conduct a risk assessment regarding Nikki's safety.

That same day, the drug service tried to contact Nikki by phone, but were unable to obtain a reply. The drug service then wrote to Nikki at her home address asking her to contact them. Nikki did not make contact with the service, the reason for this is not known to the review.

On 20th February, Ralph was arrested for an offence of theft (syphoning petrol). No further action was taken.

On 22nd February Nikki presented to GP4 whom she had seen on a previous occasion in June 2016. This was the first of eight appointments with the practice. She told the GP that she had recently stopped using cocaine (she said she had not used for two weeks). She requested Fluoxetine and asked for a medical certificate to cover her absence from work. GP4 prescribed anti-depressants, but recorded that they were cautious as they had not seen her previous medical notes (the practice requested Nikki's notes from GP2).

Nikki attended a further appointment with GP4 accompanied by her mother. She said that she needed a longer needed a medical certificate as she was unable to work.

In March Nikki attended GP4 reporting shoulder pain. Nikki told GP4 that she had had to move away from her home area because she had suffered domestic abuse. There is no indication of any exploration or follow up of this disclosure by GP4. **This cannot be corroborated as GP4 has not responded to requests to participate in the review.**

Nikki had previously been prescribed high levels of Co-codamol for pain management and she reported that she was still experiencing pain. GP4 therefore prescribed Tramadol. This was the last occasion on which Nikki presented to GP4.

As set out above in May Nikki was evicted from her tenancy due to rent arrears and returned to live with her mother. **(Note: Nikki's family said that she had told them that she was not worried about losing her tenancy and that it did not cause her any particular distress).**

Routine checks carried out by the housing provider following the property being vacated showed no signs of damage to the property.

On the 12th May, Ralph's community order ended. The offender manager undertook a spousal risk assessment in which Ralph said that he was not in a relationship.

On 2nd June, Ralph's mother called an ambulance to attend Ralph at home. She reported that she had found Ralph collapsed on the floor. An emergency ambulance transported Ralph to hospital. On the way to hospital Ralph was conscious and told paramedics that he

taken an intentional overdose and wanted to kill himself. This information was passed via the patient record, however no safeguarding alert was raised by paramedics.

That same day Ralph was seen by the mental health liaison team. He was with his partner (Nikki's mother has confirmed that it was Nikki who attended with him). He disclosed that he was a heavy and daily cocaine user. It was observed that Ralph had damage to his septum as a result of cocaine use. He also reported that he had significant debts due to drug use. The service did not make enquiries about Ralph's partner although she was present.

Ralph told the clinician that he had taken an overdose, but that he regretted it and that he was not suicidal. He said he used cocaine to deal with his emotions but did not want to make any further disclosures. He said that he was reluctant to attend drug services. The assessment concluded that Ralph had no overt cognitive impairment, no signs of depression or other overt mental health issues. The assessment of risk to self was high if cocaine use continued. He was assessed as presenting no risk to others.

Ralph was discharged to his GP on 5th June. A letter was sent to the GP to consider referral to psychology services for Cognitive Behavioural Therapy (CBT). Although Ralph had refused a referral to the drug service, the letter suggested that the GP may wish to remind Ralph that he may benefit from a referral.

The GP practice received a discharge summary on 5th June, and reviewed it the following day. The GP summary noted that actions were 'to be confirmed' on receipt of a mental health review. The GP attempted to contact Ralph on 12th June however the contact telephone number was no longer in use. There was no further contact in relation to this episode.

On 31st July, Nikki presented to GP3 saying that she was anxious and depressed. She disclosed a history of being in an abusive relationship which she said had ended five months ago. She told the GP that she was now living with her mother and that she felt safe. No further enquiry was made regarding the abuse.

On 9th October, Nikki presented to GP3 reporting anxiety, and saying that she felt paranoid about her boyfriend cheating on her (it is not known whether she was referring to Ralph). GP3 increased Nikki's dose of Fluoxetine and referred her to the counselling service Six Degrees.

Nikki did not attend the first appointment given to her by Six Degrees and on 22nd November she was discharged from the service. Following receipt of the discharge notice, Nikki contacted Six Degrees by telephone to ask for a further appointment. A new appointment was arranged for Nikki for January 2018.

On 26th November, Nikki presented to SRFT A&E in relation to an unrelated medical matter.

Note: A witness statement from owner of HMO indicates that at the end of November Ralph moved back to the HMO and that Nikki moved in shortly after him.

On 14th December, Nikki attended a mental health review with GP3. She told GP3 that she had moved out of her mother's home due to stress, and that she was now living in a 'Mental

Health Home' in another area. She told GP3 that she had increased her alcohol consumption as she had been stressed. GP3 suggested that Nikki may want to consider moving to a practice closer to her new address.

On 22nd December, police were called by NWAS to the HMO where the bodies of Nikki and Ralph had been found by the owner.

4. Lessons Learned

4.1 Addressing the terms of reference

TOR 1: Did any agency know that Nikki was subject to domestic abuse by Ralph or any other party at any time during in the period under review?

Nikki disclosed domestic abuse to GP2 on two occasions, one of these disclosures related to a previous partner (before she met Ralph). In 2014 Nikki told GP2 that she was in an abusive relationship and that she had split up with her partner. She also disclosed to the GP that she had 'hit' her partner. There were no targeted enquiries made by the GP in relation to Nikki's disclosures that she had been subjected to abuse, or that she had hit her partner. It would have been good practice for GP2 to pursue further enquiry with Nikki.

On three occasions Nikki presented to GP2 with injuries (in March, October and December 2016). She did not give any indication that these injuries were associated with domestic abuse, however, GP2 did not make any enquiries regarding domestic abuse. There was no attempt at targeted enquiry or discussion regarding Nikki's safety and whether she wanted to make a disclosure, which would have been good practice.

On each occasion the GP did not pursue any further enquiries with Nikki regarding her relationship and whether there was ongoing abuse, nor did they offer to refer Nikki to a specialist domestic abuse service or offer any other form of support in relation to domestic abuse. The GP did not link any of Nikki's presentations with injuries to potential domestic abuse. Good practice in the future would be for GP's to make enquiries regarding domestic abuse to facilitate disclosure, and to provide signposting and referral to specialist domestic abuse services. This will be facilitated by the further roll-out of the IRIS programme in Salford, and is reflected in the CCG action plan.

In February 2017 Nikki disclosed domestic abuse during a mental health assessment following presentation at A&E. Nikki said that she had been in an abusive relationship and had now separated from the perpetrator. This disclosure was taken at face value by practitioners and no further enquiry was made into whether Nikki remained at risk of domestic abuse from her partner. **The risks associated with separation from an abusive partner were not recognised or addressed by the mental health practitioner.** (These risks are well documented and evidenced by a range of research e.g. https://www.reducingtherisk.org.uk/cms/content/identifying-risk-indicators).

No support or referral to specialist domestic abuse services was offered to Nikki. This was a missed opportunity to explore Nikki's previous vulnerability to domestic abuse and any current risks, including the risk posed by her recent separation from Ralph.

When Nikki presented to GP4 in February 2017 she disclosed that she had been in an abusive relationship and had moved away from her home area because of this. The review has been unable to ascertain whether GP4 took any action to explore this disclosure further or to refer Nikki to a specialist service.

In November 2017 Nikki disclosed to GP3 that she had been in an abusive relationship which had ended five months previously. No further enquiry was made by the GP in relation to this disclosure. This was a missed opportunity to explore any current risks and to offer support to Nikki (as above in relation to separation).

Nikki experienced difficulty with rent arrears. Nikki did not disclose or discuss economic abuse with any agency. There were, however, some potential indicators of economic abuse in her relationship with Ralph. It is known to the review that Ralph was selling drugs and that he was also a frequent user of drugs. Nikki also talked to her family about not being allowed out of the house and occasions on which she was not able to go to work. It would be good practice for agencies to be aware of the potential for economic abuse in relationships and to explore these, particularly when there are other known vulnerabilities (see Footnote 5).

TOR 2: If so, what actions were taken to safeguard the victim and were these actions robust and effective?

There were several missed opportunities to safeguard Nikki following the disclosures referred to above.

TOR 3: Was Ralph known to any agency as a perpetrator of domestic abuse and, if, so what actions were taken to reduce the risks presented to the victim and/or others?

During the review period Ralph was not known to any agency as a perpetrator of domestic abuse, however, he had previously been known to offender management services as a domestic abuse offender. There is no indication that this information was shared with other agencies at that time.

In May 2017 the CRC undertook a spousal risk assessment with Ralph at which he said that he was not in a relationship. There is no requirement for self-report information to be corroborated by the service and this is therefore expected practice.

TOR 4: Did any agency have knowledge that the victim and/or perpetrator was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors?

Nikki was known by her GP to experience anxiety and depression and was prescribed anti-depressant medication. Nikki was also referred to psychology services (Six Degrees) on two separate occasions.

Nikki disclosed to mental health services that she used cocaine. Nikki's family confirmed that she used drugs (cannabis and cocaine) and that her drug use intensified when she was in a relationship with Ralph. Nikki had told her family that her drug use was particularly chaotic when Ralph was living at her rented property and that her house was 'like a crack den'. She told her family that she wanted to stop using drugs, and in order to do this she needed to stay away from Ralph.

At consultations with GP1 and GP3 Nikki said that she drank alcohol to cope with pain and also when she was under stress. When Nikki presented to A&E following a GP referral it was noted that she appeared to be intoxicated. There is no indication that either GP offered assessment of any risks associated with Nikki's alcohol use, which would have been good practice.

Although Nikki's drug use was known by her family and Nikki was referred to drug services, the review cannot speculate as to why Nikki did not take up the referral. The review notes that the relationship between domestic abuse, alcohol and drug misuse and mental health (the 'toxic trio')[4] are well documented and professionals should continue to explore these potential risk factors when working with victims of domestic abuse.

Ralph was treated by his GP for anxiety and depression and was referred to psychology services (Six Degrees) in relation to post-traumatic stress disorder (PTSD) **NB: There does not appear to have ever been a formal diagnosis of PTSD**. Ralph told his GP that he had been in the armed forces and also said that he had witnessed a friend being shot (in the community) and that these maybe reasons for his anxiety, however, there is no evidence of a clear diagnosis or cause for these symptoms.

Ralph spoke to his GP regarding suicidal ideation and, in June 2017 he took an intentional overdose which resulted in him being admitted to hospital for observation and mental health assessment. On discharge he reported that he did not have thoughts of self-harm, however he was deemed to be at high risk of a recurrence of suicidal ideation if he continued to use cocaine on a heavy and frequent basis.

Ralph was known to use drugs, and disclosed to his GP and to A&E (during a mental health assessment) that he was a frequent and heavy user of cocaine. Ralph said that he used drugs to cope with his emotions, although he was unwilling to discuss this any further. He said that he did not want to attend drug services, but did want to stop using drugs.

[4] http://safelives.org.uk/sites/default/files/resources/Risk%2C%20threat%20and%20toxic%20trio.pdf

It would have been good practice for Ralph's GP to monitor Ralph's drug use and to encourage him to seek support from drug services, although Ralph had told his GP that he did not want to attend services.

TOR 5: Did any agency know that the victim resided in a Home of Multiple Occupancy?

Nikki told GP3 that she was living in a 'mental health home' at a consultation in November 2017. No further enquiry was made regarding the nature of the accommodation. This may have assisted the GP in understanding more about Nikki's vulnerabilities, particularly as she had recently been treated for anxiety and depression.

TOR 6: If so was it considered that this accommodation may be a risk factor? Please set out the reasons why?

As agencies were not aware that Nikki was residing in a HMO, no risk assessments were undertaken.

TOR 7: Did Nikki disclose domestic abuse to family and/or friends, if so what action did they take?

Nikki told her family on a number of occasions that Ralph had assaulted her, but that she did not want to involve the police. Nikki also told her family that Ralph was controlling and manipulative. She said that Ralph would provide her with drugs as a means of keeping her under his control, and that this was particularly the case when he was living at her rented property (although he was not declared as a tenant and the housing provider was not aware that he was residing there).

Nikki's mother told the review that Nikki had told her that Ralph was dealing drugs, and that he kept drugs under the floorboards of Nikki's property. Nikki said to her mother that she was sometimes locked in the house whilst he was out dealing drugs, and that she would 'help herself' to drugs on these occasions.

Nikki's family said that the relationship with Ralph was on and off, but that Nikki always seemed to be drawn back to him, and that she said she loved him and felt that he needed her, which is why she returned to the relationship with him.

Both Nikki's mother and sister said they had tried to encourage Nikki to leave Ralph. They spoke to Nikki about getting help from a domestic abuse service, however she said she did not want to do this. She said she felt that Ralph cared about her and that, although the relationship was volatile, they loved each other.

In the early part of 2017, Nikki went to stay with her mother in another part of the UK. At this time Nikki's mother was aware that Nikki was still in touch with Ralph by phone, and on one occasion he turned up at the address. This caused tensions in the relationship between

Nikki and her mother, however mother continued to support Nikki, despite not agreeing with her choices regarding the relationship with Ralph.

Later in 2017 Nikki told her family that she wanted to separate from Ralph. She told a friend that he was 'stalking' her. At this time Nikki was staying with her mother. It appears that Nikki may have resumed her relationship with Ralph, and that she may have begun to use drugs. At this time Nikki moved out of her mother's house and went to stay at the HMO where Ralph was also staying.

Nikki remained in contact with her mother by text until shortly before her death.

TOR 8: Did Ralph make any disclosures regarding domestic abuse to family or friends, if so what action did they taken?

Ralph's family were aware that his relationship with Nikki was volatile. It is not evident that Ralph made any disclosures regarding domestic abuse to either family or friends.

TOR 9: Did any agency identify any concerns in relation to safeguarding children in their contact with the victim?

Ralph had children to a previous partner. The review made enquiries regarding the safety of the children and was satisfied that they were safe.

TOR 10: Did any agency identify and work with any vulnerable adults associated with the victim or alleged perpetrator? What work did you undertake and what were the outcomes?

No other vulnerable adults were identified during the review process.

TOR 11: What systems and processes did agencies use when working with the victim and/or perpetrator in relation to risk assessment and risk management, provision of services and interventions, single and multi-agency service pathways and supervision/quality assurance of decision making. Were these systems of a good quality?

Nikki received a mental health assessment when she was referred to A&E by her GP in February 2017. During the assessment Nikki made a disclosure regarding domestic abuse, however this was not acted upon by the service. Nikki said that she had left the relationship and this was construed as Nikki now being 'safe'.

There is no evidence of management supervision or quality assurance of decision making in relation to this assessment. A single agency action is identified in this regard.

No further risk assessments or risk management work was undertaken in relation to Nikki.

Ralph was subject to risk assessment and risk management in relation to his offending. The assessments were supervised by managers, however opportunities were missed to question

decisions made by offender managers supervising Ralph. This is identified as learning in the single agency action plan.

Ralph also received assessment of his mental health following overdose. He was assessed as being at risk of further suicidal ideation if he continued to use drugs. However, Ralph was reluctant to seek specialist help and support in relation to drug use.

TOR 11: What was the level and type of multi-agency working in the case, was this effective?

GP1 and GP3 appear to have made appropriate referrals to mental health services in relation to Nikki.

Ralph's GP appropriately referred him to mental health services.

Neither Nikki nor Ralph maintained contact with mental health services therefore opportunities for ongoing multi-agency working between mental health and other services were not present.

There is no evidence of multi-agency working in relation to domestic abuse, despite Nikki having made disclosures to more than one agency. Opportunities to explore domestic abuse with Nikki were not taken and there is no evidence of consideration being given to referring Nikki to specialist domestic abuse services by any agency.

Mental Health services referred Nikki to drug services, however Nikki did not follow up the referral. The review has not been able to establish why Nikki did not take up the service, however, given her other vulnerabilities, it would have been good practice to discuss the referral with Nikki and offer her a further opportunity to engage with services.

4.2 Analysis of Practice

4.2.1. City West – Housing Provider

City West demonstrated good practice in supporting Nikki as a tenant with known vulnerabilities. Tenancy support was offered but declined by Nikki and a 'Vulnerable Person' alert was added to the IT system.

With hindsight there may have been opportunities to explore Nikki's disclosures about her physical and mental health in more detail, however the review does not construe the absence of such exploration as poor practice.

The review concludes that there may have been scope for City West to make routine enquiry regarding domestic abuse, however Nikki did not make disclosures of domestic abuse upon which to make targeted enquiries. The review notes work undertaken by the Domestic Abuse Housing Alliance and research by Gentoo which indicates that rent arrears are a possible indicator of domestic abuse[5]. This research will be shared with local housing providers as a model of good practice.

[5] http://www.safelives.org.uk/sites/default/files/resources/Safe%20at%20Home%20Report.pdf

4.2.2. Community Rehabilitation Company (CRC) and National Probation Service (NPS)

The Initial assessments completed within OASyS (the national offender assessment system), assessed Ralph as being low risk of harm in all categories (i.e. Children, Public, Known Adult, Staff and Prisoners).

Ralph disclosed within the first few weeks of the sentence that he had left his accommodation due to a relationship break up. It would have been good practice for the Case Manager to this explore further.

As Ralph was assessed as low risk of harm, a formal risk management plan was not produced. This is not an error, it is within the system of assessment that the CRC and NPS currently use. However, risk was to be managed via the completion of the Entitlement Programme (an offender programme), and via appointments with his Responsible Officer and referral to community partnerships as required. It was therefore accepted practice that a risk management plan was not produced.

As Ralph presented with historic Domestic Abuse (2008), liaison with Greater Manchester Police Domestic Violence Unit would have been expected, but was not undertaken in this case. Actions to address this are contained in the single agency action plan to ensure that future practice is strengthened.

Neither of the Case Managers who worked with Ralph recorded the name of the partner whom Ralph stated that he resided with at the beginning of his sentence. It would have been good practice to do this and would have afforded an opportunity to discuss Ralph's relationship further.

4.2.3. General Practice – Nikki

GP1

- There were no direct disclosures of domestic abuse to GP Practice 1. However Nikki did say that she was 'paranoid' about her boyfriend. It would have been good practice in future to explore this further.
- The presentation with hand pain in December 2013 could have been an opportunity to identify early health indicators of domestic abuse.
- GP1 had not received IRIS training at this point, however the GP could have sought guidance in relation to domestic abuse from other professional sources.

GP2

- In August 2014, when Nikki attended her first and only appointment with Six Degrees, the practitioner entered information directly onto the GP electronic patient record, as Nikki was seen at GP2. Nikki disclosed to the Six Degree's practitioner that she had previously been in a violent relationship. As the disclosure of domestic abuse was historical at this time there was no further exploration of domestic abuse and no DASH risk assessment carried out.
- It appears there was no communication between Six Degrees and GP2 outside of the electronic entry. Therefore, there is no reference of the Six Degrees practitioner

informing GP 2 of the disclosure of historic domestic abuse. This was a missed opportunity to share information between Six Degrees and the GP in relation to a domestic abuse disclosure.

- There was never a domestic abuse 'read code'[6] applied to Nikki's records. Two 'read codes' suitable were available at this time, 'victim of domestic abuse' and 'history of domestic abuse'. Therefore domestic abuse was not flagged on the GP system for future appointments or to subsequent GP Practices. It would be good practice in future to enter 'read codes', this will be reinforced through IRIS training.
- It also appears that there was no further discussion with the practice by the Six Degrees practitioner surrounding Nikki's subsequent three non-attendances with their service. Nikki had scored highly for both depression and anxiety during her August appointment and guidance suggests that follow up contact should be made following non-attendance. Future good practice would be to initiate a further discussion regarding non-attendance, although the review recognises that it can be difficult to engage service users once they have left the service.
- In November 2014 Nikki registered with a new GP. The notes from this appointment are very brief and it does not appear her mood was assessed or reasons for Six Degrees non-attendance were explored. Had the appropriate 'read codes' been applied, this may have prompted further enquiries from the GP.

GP3

- On registration with GP3, no 'read codes' for domestic abuse had been added to Nikki's electronic records, which may have prompted further questioning during her initial consultations. As it was, awareness of any history of domestic abuse would have been reliant on GP3 completing a full review of Nikki's records.
- A direct disclosure of domestic abuse was made in July 2017 when Nikki reported being in an abusive relationship, which had ended five months prior to the consultation. No further enquiry was made in relation to domestic abuse, which would have been expected practice.
- During the consultation, the GP identified that Nikki was currently staying with her mother (assumed to be a place of safety) and confirmed that Nikki was no longer in a relationship with Ralph. On this occasion the GP made a further referral to Six Degrees. No further enquiry was made by the GP regarding domestic abuse, which would have been good practice.
- The GP in this instance was aware through domestic abuse training, about the increased risk to victims following separation from a violent relationship. It would have been good practice to discuss this with Nikki, and to offer an opportunity of referral to specialist domestic abuse service.
- Had 'read codes' been applied following previous disclosures to Six Degrees/GP2, this may have prompted a different response/ assessment of risk by GP3. This was the third occasion where domestic abuse 'read codes' were not applied to the electronic records.

GP4

[6] https://digital.nhs.uk/services/terminology-and-classifications/read-codes

- Nikki made a disclosure of domestic abuse to GP4 when she presented in February 2017. She also disclosed that she was coming off drugs and that she had a history of depression and anxiety. There is no indication that GP4 assessed or acted on Nikki's disclosure and the associated vulnerability factors (the Toxic Trio).

Summary

Opportunities were missed to make routine and targeted enquiry into possible domestic abuse.

4.2.4. General Practice - Nikki

- The CCG single agency action plan includes action to strengthen GP practice in relation to domestic abuse through implementation of the IRIS programme. The aim is that the planned completion of the IRIS training programme, coupled with prompts from the GP system (via application of 'read codes') will enhance practitioners knowledge around early identification, identification of health indicators and referral of domestic abuse within Primary Care.
- Ongoing work in relation to improving the use of 'read codes' is taking place within the CCG.

4.2.5. General Practice – Ralph

- Ralph was not known as a perpetrator of domestic abuse by his GP and there were no indicators that would have led the GP to make a targeted enquiry.
- The GP made appropriate referrals in relation to mental health however, Ralph did not maintain engagement with mental health services.
- Ralph's GP spoke to Ralph about attending drug services, but did not pursue this with him as Ralph said that he would not attend.
- The review identified numerous gaps in record keeping by the GP. This issue is identified for action in the CCG single agency action plan.

4.2.6. Greater Manchester Mental Health Trust – Nikki

Nikki disclosed domestic abuse at the mental health assessment in February 2017. She said that her relationship had ended, and this was taken at face value**.** There appears to have been no consideration of significant risk factors. The assumption appeared to be that the relationship was over and Nikki was therefore no longer at risk of domestic abuse. This was over-optimistic and unrealistic. The relationship had only ended the day before and the likelihood of further contact was potentially high. There was no consideration of the possibility of coercive and controlling behaviour being a significant factor in Nikki maintaining her relationship with Ralph. This was a missed opportunity to explore the nature of the relationship and any ongoing risks to Nikki.

An appropriate and timely referral was made to the substance misuse service immediately after Nikki was seen by the mental health liaison team. However Nikki did not respond to contact from the service.

It would have been good practice for GMMH to have undertaken a further risk assessment including completion of a RIC (risk indicator checklist) to establish the nature and severity of the domestic abuse, the pattern of the relationship, the risk of Nikki returning and future risk. It would also have been good practice to explore the influence of coercive and controlling behaviour in the relationship and for the practitioner to have spoken to Nikki about referral to specialist domestic abuse services.

The GMMH single agency action plan identifies actions to address learning in this regard.

4.2.7. Greater Manchester Mental Health Trust – Ralph

- Ralph had one contact with GMMH in June 2017. His mental health was assessed after being admitted to an acute ward following an overdose of medication. He was appropriately referred back to his GP within 3 days, with a recommendation that a psychology referral would be helpful, and also to consider a referral to the Achieve substance misuse service when Ralph was ready to engage.

- At this assessment Ralph did not disclose domestic abuse in his relationship. He described it as "on and off" and said that they had argued recently. The notes state that his partner was also present during the assessment (although details of the partner – now known to be Nikki - are not recorded). From an adult safeguarding perspective, it would have been good practice to make further enquiry about the person attending with Ralph and to have recorded this.

4.2.8. Greater Manchester Police (GMP) – Ralph

- Ralph came to police attention in relation to his repeat offending of syphoning fuel from trucks and appropriate action was taken in relation to his offending. There was no other police involvement with Ralph during the period under review.

4.2.9. North West Ambulance Service (NWAS) – Ralph

- Ralph disclosed suicidal ideation and problems at home to NWAS staff in June 2017. This was not further explored at the time, due to the pressing need to seek medical treatment being a priority. This information was passed on to the hospital at the time through a verbal handover and written documentation on a Patient Report Form, however no specific safeguarding alert was raised. It would be good practice in future to ensure that the receiving agency was alerted to potential safeguarding issues.

4.2.10. Salford Royal Foundation Trust – Nikki

- Nikki attended A&E in February following a mental health referral by her GP (she said she had 'taken tablets'). She stated that she had separated from an abusive boyfriend and that both had been using illicit drugs, which was fuelling their behaviours with one another. Nikki said that she was paranoid and feeling out of control, describing her flat as being like a 'crack den'.

- As Nikki was referred for a mental health assessment she was not triaged in the same way she would have been if she had self-referred. In these circumstances basic observations were undertaken and the Mental Health Liaison team were informed that a patient had arrived for assessment.[7]
- The records do not indicate that Nikki was asked in more detail about her ex-partner or that her disclosure of an abusive relationship was explored any further. It was not known if, at that time, the Mental Health Liaison team routinely enquired about domestic abuse or undertook DASH assessments with patients who disclosed domestic abuse.

The GMMH single agency action plan identifies actions to address learning in this regard.

4.2.11. Salford Royal Foundation Trust – Ralph

- As set out above, when Ralph presented on 2nd June 2017 his girlfriend (Nikki) was reported to be present, however no details were taken. As referred to earlier in this report, Nikki's mother subsequently confirmed that Nikki was present with Ralph.

- Ralph was discharged later that day with follow up from the Community Mental Health Team which was appropriate.

4.2.12 Six Degrees

- The service highlighted that the application of 'read codes' to GP notes has been an ongoing issue. Since IRIS training has been in place there has been better communication, however not all GP's are IRIS trained and work needs to continue to ensure that disclosures and identifiers are noted on the system.

- The service has identified that advice and support in relation to domestic abuse should be offered at all contacts.

The service has provided a single agency action plan to address learning.

4.3 Summary of Single Agency Learning

4.3.1. City West Housing

- City West have not identified any specific learning emerging from their involvement with Nikki.

- [7] The Mental Health Liaison team are employed by Greater Manchester Mental Health (GMMH), previously Greater Manchester West (GMW). GMMH are commissioned by SRFT to provide mental health services for inpatients and unscheduled care.

4.3.2. Community Rehabilitation Company (CRC)

- Neither practitioner who worked with Ralph attempted to obtain a Police Domestic Abuse call out report. While the index offence was not domestic abuse linked, and the evidence available at the time of the start of the sentence indicated that there had not been any domestic abuse concerns since 2008, the disclosed relationship problems relayed at the beginning of the sentence should have prompted the request for a call out report. As noted above, it is expected good practice that the CRC will obtain call outs on all cases.

- Once Ralph disclosed that he had contact with his two children, the practitioner should have made a referral to Children's Services, to identify if they were known to Children Services. This did not occur for the length of the sentence and therefore fell short of expected practice. Both practitioners who worked with Ralph stated that they are aware of expected practice and therefore should have followed the practice instruction.

- Clearer contact recording is a learning point for both practitioners in CRC who worked with Ralph, both failed to record the name of Ralph's partner / ex-partner. Both are aware of the importance of sound recording and evidence gathering.

4.3.3. General Practice (GP1, GP2, GP3) – NB this does not include GP4 as the practice is outside of the English Healthcare System

- The requirement and significance of 'read code' application as an opportunity to safeguard victims (past and present) requires strengthening within Primary Care services and those services with access to GP electronic records (Six Degrees).

- The opportunities to utilise existing screening tools to provide an objective measure of assessment of depression in conjunction with a selective questioning approach should be considered by GP Practices as an opportunity for best practice.

- The adoption of IRIS[8] within Salford GP Practices will provide greater opportunities for Practice staff to identify health indicators of domestic abuse and enable an opportunity for early intervention and support for victims of abuse.

- The significance of recording details of those attending consultations with an adult, including greater exploration of names of significant others referred to during a consultation (including current and previous partners), is highlighted by this review. NB: it should be noted that it is not entirely clear how open Nikki was in respect of her relationships following review of the electronic records and corresponding interviews with interacting GP's.

[8] http://www.irisdomesticviolence.org.uk/iris/

- Nikki was noted by her GPs not to talk very much in consultations. An opportunity, particularly in single handed practices where the continuity of one GP is limited, to gain a close and trusting relationship with the patient can often be challenging. This becomes increasingly difficult in patients with a more sporadic attendance record.

4.3.4. GMMH

- Nikki may not have been placed at increased risk of harm because a DASH (RIC)[9] assessment was not offered or completed, however there was a missed opportunity to discuss potential risks with Nikki.

- GMMH should ensure that all staff who work in the Mental Health Liaison Team are up to date with safeguarding training and attend the newly developed domestic violence and abuse training course.

- Any immediate lessons learnt should be disseminated to A&E staff regarding assessment of risk of domestic violence and abuse when partners have recently separated. This should include consideration of the influence of coercive and controlling behaviour.

4.3.5. NWAS

- There is no evidence that domestic abuse was considered by the NWAS crew during their contact with Ralph in June 2017, although a disclosure around 'domestic problems' was made. This was an emergency situation due to the toxicity of the overdose and Ralph's medical needs were given priority. However, a safeguarding concern could have been considered by the NWAS attending crew.

- Ralph was taken to hospital and NWAS crew expected that a mental health assessment would take place following immediate medical treatment. It was the view of the attending practitioners that presentation of Ralph's needs on that occasion appeared to be of a mental health nature, rather than a safeguarding concern.

4.3.6. SRFT

- The approach to disclosures of domestic abuse across all agencies needs to be strengthened and clarified.

- SRFT safeguarding services do not link in with GMMH safeguarding services in terms of policy and procedure for the recognition and response to domestic abuse and are therefore not clear on the expectations of that service in the completion of DASH assessments within SRFT inpatient services. It would be best practice to clarify these relationships and expectations.

[9] http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face

5. Conclusions and Recommendations

5.1 Summary of Key Learning from the review

The review has established that Nikki made disclosures of domestic abuse to General Practice (including a GP outside of England with whom she was temporarily registered). She also made a disclosure to Mental Health Services and to the Six Degrees support service. None of these services offered risk assessment, safety planning or referral to specialist services. There is learning in the review for all services who were aware of domestic abuse and did not take action to safeguard Nikki.

Nikki did not refer specifically to Ralph as the perpetrator of the abuse towards her, although she did talk about historic abuse and abuse from a recent partner from whom she had now separated. No further enquiry was made regarding her relationship with Ralph, and whether this presented ongoing risk to Nikki. There is learning for all services regarding further enquiry into historic domestic abuse and the risks presented by separation from an abusive partner.

This appears to have led to assumptions being made by services that, because Nikki reported that she had separated from Ralph, she would be 'safe'. No account was taken of possible coercive and controlling behaviour by Ralph, and Nikki's declarations that she was safe were not explored and were taken at face value. There is learning for all services regarding exploration of the nature of relationships and the influence of coercion and control by perpetrators.

Professionals did not take into account that separation can increase risk for victims. This is an area of practice that could be strengthened.

Nikki was offered support to address mental health issues, however for reasons unknown to the review, she did not fully engage with services. Links were not made between mental health, domestic abuse and alcohol misuse. The importance of services understanding and exploring the relationship between domestic abuse and other risk factors is highlighted (the toxic trio), and practice could be strengthened in this area.

The review does not make a multi-agency recommendation in relation to this conclusion as single agency action plans, and work that is already in progress, identify where practice could be strengthened. The CSPs will oversee the implementation of single agency action plans as required by the Guidance.

The review found that agency records were not consistent, particularly in relation to recording information about specific reports of domestic abuse, further enquiry regarding current risk factors (e.g. ongoing relationship with the perpetrator). The review also found that opportunities to link Nikki and Ralph, when they were seen together by professionals, were not recorded thoroughly, which led to potential missed opportunities to explore the nature of their relationship.

Nikki changed GP three times in the period under review (she also temporarily registered with a GP outside England). The system for applying 'read codes' in General Practice, which would have acted as a trigger to GPs to raise domestic abuse with Nikki, was not used. This meant that, as Nikki moved from one practice to another, information regarding disclosure of domestic abuse did not follow her. It would be good practice to implement local and national guidance in this regard, and a single agency action is made for the CCG to ensure that practice is strengthened.

Nikki's family were concerned about the potential for domestic abuse in all its forms in the relationship between Nikki and Ralph. They spoke to her about this but felt that Nikki minimised the physical abuse, saying that she did not want to leave Ralph or seek support from specialist services. The family were aware of coercive and controlling behaviour and felt that, in the early part of the relationship, and felt that Nikki appeared to accept this as being a normal part of her relationship. In the latter part of the relationship Nikki said that Ralph was 'stalking' her, but she did not want her family to intervene, and they did not feel that they could go against her wishes, other than to continue to advise her to separate from Ralph.

This highlights the difficulties faced by families where coercive and controlling behaviour, and levels of physical violence, have become normalised within relationships. The review concludes that support for families should enable them to challenge the normalisation of abusive behaviours, whilst also ensuring that fears about the impact that this may have on victims are addressed.

The review panel felt that it was important to note that the themes raised by the DHR were similar to other DHRs in both CSP areas (and nationally).

The panel observed that ongoing public awareness of domestic abuse for victims, families and the wider community, and a stronger emphasis on prevention and early intervention, starting in schools and focusing on both victims and perpetrators, should be given a high profile both locally and nationally.

The panel did not feel it appropriate to make a specific recommendation about how this could be achieved, but felt that concerted campaigns and proactive dissemination of learning from other DHRs may help to raise awareness.

5.2 Recommendations

Recommendation 1

Salford CSP should seek assurance from its member organisations that they have procedures and governance in place to ensure that all contacts with service users are recorded and acted upon as necessary (i.e. if the service user is considered to be at risk). This should include assurance that professionals ask questions regarding other persons who are present at contacts and that responses are recorded and actioned as necessary.

Recommendation 2

Manchester and Salford CSPs should task their respective domestic abuse working groups with reviewing, and where appropriate, revising guidance, literature and approaches to supporting families and friends of domestic abuse victims and perpetrators, in line with the findings of this review.

Appendix 1

Methodology by which DHR was completed

The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

Individual Management Reviews (IMR) were completed by

- City West Housing Trust
- Greater Manchester Police
- Salford Clinical Commissioning Group
- Cheshire and Greater Manchester Community Rehabilitation Company (CRC)
- National Probation Service
- Manchester City Councils Housing Compliance and Enforcement Team
- Greater Manchester Mental Health NHS Foundation Trust
- North West Ambulance Service
- Northern Care Alliance NHS Group (NCA)

The authors of the IMRs had had no prior involvement in the case.

The DHR was overseen by an independently chaired Panel which ultimately approved the DHR overview report and submitted it to Manchester and Salford Community Safety Partnerships.

Dissemination

It is intended that a copy of the DHR overview report will be shared with the following:

City West Housing Group
North West Ambulance Service
Greater Manchester Mental Health NHS Foundation Trust
Manchester Health and Care Commissioning
Greater Manchester Police
Salford Clinical Commissioning Group
Cheshire and Greater Manchester Community Rehabilitation Company (CRC)
National Probation Service
Northern Care Alliance NHS Group (NCA)
Manchester City Council Housing Compliance and Enforcement Team
Manchester City Council Adult Social Care
Salford Community Safety Partnership
Manchester Community Safety Partnership
Manchester Safeguarding Board
Salford Safeguarding Board
Salford Women's Aid (SIDAS)
The victim's family
The perpetrator's family.