Salford Community Safety Partnership

Domestic Homicide Review

Overview Report

‘Bailey’

Died August 2022

Name of Chair and Author Removed

Date 18 April 2024

1 Introduction

1.1 This Domestic Homicide Review (DHR) report examines agency responses and support given to Bailey, a resident of Salford, prior to her death. The panel would like to offer their condolences to Bailey's family on their tragic loss.

1.2 Bailey had been in a long-term relationship with her boyfriend since she was 15[1] years old and was subjected to domestic abuse from him. That relationship ended around March 2021 after he was recalled to prison (albeit he was not arrested and returned until July 2021). After that relationship had ended, she continued to receive threats and intimidation from him, despite him being in prison. Bailey did not report this to any agency.

1.3 Around October 2021, Bailey formed a relationship with Sam.

1.4 In April 2022, Bailey reported domestic abuse from Sam to the police (although she did not name him) and was provided with support from several agencies to leave the area and obtain accommodation away from him.

1.5 Bailey lived alone at the time of her death in refuge accommodation provided by Manchester Women's Aid. Sam lived alone at a flat in Manchester.

1.6 Bailey had no children and was 22 years old when she was murdered by Sam at his flat. Sam was 44 years old.

1.7 In addition to agency involvement, this review also examines the past to identify any relevant background or trail of abuse before the homicide, 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.

1.8 The review considers agencies' contact and involvement with Bailey and Sam from 1 November 2018 until her death in August 2022. This time period was chosen as it covers the period when Bailey was still in a relationship with her former partner and also a period when Sam was released from prison and was in relationships with other women. The panel felt that this period ensured that relevant interactions with support agencies were captured.

[1] It has not been possible to definitively establish whether Bailey formed this relationship when she was 14 or 15 years old. Throughout the report, the age provided by the reporting person / agency has been used.

1.9 The intention of the review is to ensure that 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.

1.10 **Note:**
It is not the purpose of this DHR to enquire into how Bailey died. The Coroner's Office has informed the Lead Officer that the Coroner's case was suspended permanently after the criminal trial. Family were informed in April 2024. The Coroner will be sent a copy of this final report.

2 Timescales

2.1 This review began on 18 April 2023.

More detailed information on timescales and decision-making is shown at paragraph 5.2.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.

3.2 Pseudonyms were agreed by Bailey's mum to protect the identities of the subjects of this review.

4 Terms of Reference

4.1 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

Apply these lessons to service responses including changes to 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)

4.2 **Timeframe Under Review**

The DHR covers the period from 1 November 2018 until Bailey's death in August 2022.

4.3 **Case Specific Terms**

Subjects of the DHR

Victim: Bailey, aged 22 years

Perpetrator: Sam, aged 44 years

Despite the relationship ending more than 12 months prior to Bailey's death, the panel considered whether her former partner should also be made a subject of this review. The relationship was undoubtedly abusive and the panel felt that Bailey's experiences from it must have impacted her ability to consider future abuse and understand how to seek help. The panel agreed that on balance, it would not be proportionate to include him as a subject of the review. However, that relationship remains very relevant and as such the panel felt it appropriate to include details within the report in order to ensure that Bailey's circumstances could be considered with appropriate context.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Bailey and how did your agency assess the level of risk presented by the alleged perpetrators to Bailey and/or others. Which risk assessment model did you use?

2. Did your agency consider that Bailey may be being exploited or could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert or hold a strategy meeting?

3. What consideration did your agency give to any mental health issues or use of controlled drugs by Bailey or Sam when identifying, assessing and managing risks around domestic abuse?

4. What services did your agency provide for Bailey and Sam. Were they timely, proportionate and 'fit for purpose' in terms of addressing domestic abuse in addition to risks posed by organised criminality.

5. Was your agency aware that Bailey and Sam were in a relationship and if not, could more have been done by any agency to establish that fact?

6. How did your agency ascertain the wishes and feelings of Bailey and Sam in relation to alleged offending and were their views taken into account when providing services or support?

7. How effective was inter-agency information sharing and co-operation in response to incidents involving Bailey and Sam? Was information shared with those agencies who needed it? Was any information not shared, due to concerns around sensitivity, confidentiality, risk, data protection or any other reason?

8. Was there sufficient focus on reducing the impact of perpetrators alleged abusive behaviour towards Bailey by applying an appropriate mix of sanctions (arrest/charge) and other interventions?

9. Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice and were any gaps identified?

10. What knowledge did family, friends and employers have that Bailey was in an abusive relationship and did they know what to do with that knowledge?

11. Were there any examples of outstanding or innovative practice?

12. What training did your agency provide to staff around domestic abuse? Had staff who interacted with Bailey and Sam completed the training and when?

13. What learning did your agency identify in this case?

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

5 Methodology

5.1 On 23 August 2022, Greater Manchester Police (GMP) notified Salford Community Safety Partnership of the circumstances surrounding Bailey's death and asked that consideration be given to conducting a domestic homicide review.

5.2 On 20 January 2023, following a screening process, Salford Community Safety Partnership held a meeting to consider multi-agency information held in relation to Bailey's death. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review [paragraph 13 Statutory Home Office Guidance][2] and recommended one should be conducted. The Home Office was informed on 23 February 2023.

5.3 The first meeting of the DHR panel took place on 18 April 2023, via Microsoft Teams video conferencing. All subsequent meetings also took place via Microsoft Teams. The panel met five times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 24 November 2023, after which amendments were made to the report which were agreed by the panel.

5.4 The panel were mindful of the timescales suggested within the Section 5 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016. Towards the end of the review, further information was received from Bailey's family, employer and Children's Social Care, which required further consideration and analysis by the panel. The overview report was not therefore completed with six months.

5.5 The report was then shared with Bailey's mum who gave feedback and identified areas of factual inaccuracy. The report was appropriately amended.

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[2] Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

6 Involvement of Family, Friends, Work Colleagues and Wider Community

6.1 Family

6.1.1 The DHR Chair wrote to Bailey's mum and dad separately, inviting them to contribute to the review.

6.1.2 Bailey's mum had been in regular contact with the Probation Service and through that relationship she was asked if she would contribute to the review. Bailey's mum met with the Chair and provided valuable background information. Her contribution is referenced appropriately throughout the report.

Bailey's dad did not respond.

6.1.3 The Chair wrote to Bailey's sibling who did not respond. It was explained by their mum that they found the process too upsetting and did not feel able to contribute.

6.1.4 Bailey's mum, dad and sibling were provided with the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)[3] leaflet.

6.2 The Perpetrator

6.2.1 The Chair wrote to Sam and asked if he was prepared to contribute to the review. He did not respond. Probation Service also made an approach to Sam in prison, on behalf of the Chair. Sam made it clear that he did not wish to be involved in the review.

6.3 Friends

6.3.1 The Chair established the identity of Bailey's close friend. Although they indicated through a third party that they would be prepared to contribute to the review, they did not reply to an email or several telephone messages. The panel agreed that this suggested that they did not wish to contribute and agreed to respect their privacy.

6.4 Employer

6.4.1 The Chair spoke with Bailey's first line supervisor for her last job. Their contribution is referenced appropriately within the report. It was also established that the employer may consider learning opportunities within their own organisation in respect of the identification of, and support for, staff who may be victims of domestic

[3] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

abuse. The Chair and other panel members engaged with senior members of the management team and Human Resources.

7 Contributors to the Review/ Agencies Submitting IMRs[4]

7.1.1	**Agency**	**Contribution**
	Greater Manchester Police (GMP)	IMR
	Salford Children's Services	IMR
	Wigan Children's Social Care	IMR
	North West Ambulance Service	IMR
	Northern Care Alliance	IMR
	Pankhurst Trust (incorporating Manchester Women's Aid)	IMR
	NHS Greater Manchester (Wigan Locality)	IMR
	NHS Greater Manchester (Bury Locality)	IMR
	NHS Greater Manchester (Salford Locality)	IMR
	NHS Greater Manchester (Manchester Locality)	Short Report
	Housing Options, Salford City Council	IMR
	Greater Manchester Mental Health NHS Foundation Trust (GMMH)	IMR
	Safe in Salford	IMR
	Greater Manchester Probation Service	IMR
	Greater Manchester Fire and Rescue Service	Short Report
	Irwell Valley (Housing)	Short Report

[4] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Bailey and/or the perpetrator.

7.1.2 In addition to the IMRs, each agency provided a chronology of interaction with Bailey and Sam, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of Bailey or Sam, nor had any involvement in the provision of services to them.

7.1.3 Not all IMRs were requested when the review initially commenced. As more information was received and considered by the panel, it became clear that other agencies were required to provide further information.

7.1.4 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Bailey and Sam and any other action taken.

7.1.5 It should also provide an analysis of events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.1.6 The IMRs in this case focussed on the issues facing Bailey and where appropriate, interactions with Sam. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.2 Information About Agencies Contributing to the Review

7.2.1 Greater Manchester Police (GMP):

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.

7.2.2 Salford Children's Services:

Salford City Council services related to the health and social care of children and young people.

7.2.3 Wigan Children's Social Care:

Wigan Council services related to the health and social care of children and young people.

7.2.4 North West Ambulance Service (NWAS):

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 make 1.5 million patient transport journeys every year for those who require non-emergency transport to and from healthcare appointments. NWAS deliver the NHS 111 service across the region for people who need medical help or advice, handling more than 1.5 million calls every year.

7.2.5 Northern Care Alliance (NCA):

The Northern Care Alliance NHS Foundation Trust brings together staff and services from Salford Royal NHS Foundation Trust and Pennine Acute Hospitals NHS Trust. The NCA Group provides a range of integrated health and social care services to patients and service users at their home, in their community or in one of four hospitals - Salford Royal, The Royal Oldham Hospital, Fairfield General Hospital in Bury and Rochdale Infirmary. Our aim is to deliver consistently high standards of care to them all.

7.2.6 Pankhurst Trust (incorporating Manchester Women's Aid):

Manchester Women's Aid provides support services to those suffering from domestic violence and abuse through community outreach, group work sessions, children's play, safe homes and educational resources.

7.2.7 NHS Greater Manchester (Wigan, Bury, Salford and Manchester localities):

NHS Greater Manchester is the Integrated Care Board for Greater Manchester and is responsible for commissioning health services across the ten localities. At the time of the report the locality ICB safeguarding team is supporting primary care in contributing to the DHR process.

7.2.8 Housing Options, Salford City Council:

Salford City Council housing service offers advice and assistance on housing and housing related issues.

7.2.9 Greater Manchester Mental Health NHS Foundation Trust (GMMH):

GMMH is a specialist mental health provider, providing inpatient and community-based mental health care for people living in Bolton, the city of Manchester, Salford, Trafford and Wigan, and a wide range of specialist mental health and addiction

services across Greater Manchester. GMMH also provide Health and Justice Services in a number of custodial settings.

7.2.10 Safe in Salford (SIS):

Domestic Abuse Support in Salford providing a Crisis Service (Independent Domestic Violence Advocates, or IDVAs) for victims, advice and support service for victims, specialist support for GPs (known as IRIS), children and young people's support – Harbour, and behaviour support programmes for perpetrators.

7.2.11 Greater Manchester Probation Service:

The Probation Service (formally the National Probation Service) for England and Wales is a statutory criminal justice service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties.

7.2.12 Greater Manchester Fire and Rescue Service (GMFRS):

GMFRS is one of the largest fire and rescue services in England, covering an area of 493 square miles and serving a population of 2.87 million residents.

7.2.13 Irwell Valley (Housing):

Irwell Valley are a not-for-profit housing association providing affordable homes and services to more than 20,000 people across Greater Manchester.

8 The Review Panel Members (Role and Agency / Organisation)

8.1

- Independent Chair and Author
- Lead Officer, Salford City Council
- Detective Inspector, Serious Case Review Team, Greater Manchester Police
- Assistant Chief Officer, PDU Lead Salford, National Probation Service
- Specialist Safeguarding Families Nurse, NHS Greater Manchester Integrated Care
- Named Nurse, Safeguarding Children, GMMH
- Deputy Adult Safeguarding Lead, GMMH
- Service Manager, Safe in Salford Partnership (IDVA Service)

- Domestic Abuse Specialist Nurse, Northern Care Alliance

8.2 The DHR Chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

8.3 The panel were mindful of the requirement for all panel members to be named within this report as set out in Section 31 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

Through this review process, lengthy discussion took place between panel members in relation to previous and current information and police intelligence. Throughout the review, sensitive intelligence has been received by several agencies which suggests that associates of Bailey's former partner and associates of Sam are in dispute, linked to her death. Several threat to life incidents have been managed by Greater Manchester Police. The future threat is unclear and prevents an effective and credible assessment of risk, including to the panel members for this review.

The DHR Chair made a decision that panel member names would not be included within the report. The panel supported that decision. A copy of the overview report and executive summary which also includes panel member names is stored securely by Salford Community Safety Partnership, but will not be disseminated without the authority of the Partnership Chairs.

9 Author and Chair 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. In this case, the chair and author were the same person.

Following a career in policing [not Greater Manchester Police], they are now an independent practitioner who consults within mental health services, education and children's social care. They are an Associate Trainer for the College of Policing, an Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services and an Independent Member of the Parole Board. They have completed accredited training for DHR chairs provided by AAFDA and have chaired and written previous DHRs. They have no previous or current links with Salford City Council or any of its partner agencies.

10 Parallel Reviews

10.1 The coroner has been made aware of the death and at the time of writing, the inquest remains suspended, pending the outcome of this review.

10.2 The management of Sam by the Greater Manchester Probation Service has been the subject of a Serious Further Offence (SFO) Review, which was submitted to His Majesty's Prisons and Probation Service, (HMPPS) in March 2023. This reviewed the most recent period of supervision, from September 2021 until August 2022.

10.3 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected 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** [for example a woman who is pregnant and for 26 weeks after giving birth].
- **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** [for example born male or female].
- **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].

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.

11.2 Bailey had engaged with Child and Adolescent Mental Health Services (CAMHS) since the age of 9. She was diagnosed as being Bipolar Affective Disorder Type 2[5] and displayed some emotionally unstable personality disorder traits.

11.3 During the timeframe of this review, Bailey accessed mental health support through GMMH, although there were periods where she was discharged due to non-

[5] Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration. These shifts can make it difficult to carry out day-to-day tasks. **Bipolar II disorder** is defined by a pattern of depressive episodes and hypomanic episodes. The hypomanic episodes are less severe than the manic episodes in bipolar I disorder (https://www.nimh.nih.gov/health/topics/bipolar-disorder)

attendance at appointments. She was prescribed medication for her mental health conditions.

11.4 Despite Bailey's long standing poor mental health, the panel did not consider that she was disabled within the meaning of Section 6 of the Equality Act 2010. Neither did they consider that her health would have met the criteria for a care needs assessment under the Care Act 2014.

11.5 The panel also discussed information around Bailey's use of illegal drugs. Although the review established that Bailey may have used controlled drugs and was alleged to have been involved in the supply of them, there was no suggestion that any use impacted her day to day ability to function or her ability to care for herself.

11.6 Bailey and Sam were both white British and were living in urban areas which are predominantly white British demographic. 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.

11.7 Domestic homicides and domestic abuse predominantly affect 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, according to the Office for National Statistics homicide report 2021/22[6], there were 134 domestic homicides in the year ending March 2022.

Of the 134 domestic homicides: 78 victims were killed by a partner or ex-partner, 40 were killed by a parent, son, or daughter, and 16 were killed by another family member.

Almost half (46%) of adult female homicide victims were killed in a domestic homicide (84). Of the 84 female victims, 81 were killed by a male suspect. Males were much less likely to be the victim of a domestic homicide, with only 11% (50) of male homicides being domestic related in the latest year.

12 Dissemination

12.1 Bailey's family
Home Office
Salford Community Safety Partnership
Greater Manchester Police and Crime Commissioner

6 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-relationship-between-victims-and-suspects

Domestic Abuse Commissioner
All agencies contributing to this review

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies, and material gathered by the police during their investigation following Bailey's death. The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1 Relevant History

13.1.1 Bailey disclosed a long history of poor mental health to healthcare professionals. She had been supported by CAMHS from the age of nine after she witnessed domestic abuse between her parents, who then separated. The separation was not amicable and family explained that Bailey found it difficult to cope with the circumstances.

13.1.2 Bailey remained living with her mum and younger sibling.

13.1.3 As a young teenager, Bailey struggled with her body image. She would often starve herself to lose weight and family believe that when she was around 13, she may have been bulimic. Bailey's mum facilitated her ongoing support from CAMHS and observed that Bailey seemed to like meeting with them and was keen to continue.

13.1.4 When Bailey was 14, Children's Social Care were contacted by her school health service who stated that they were concerned about reports that she had been involved in sexual relationships with several males aged between 14 and 17. They had also been informed that Bailey was using illegal drugs and alcohol. School stated that they were concerned about Bailey's mental health, including reports of her self-harming. Concerns were also raised that Bailey may be subject to controlling and coercive behaviour from her father.

Although Children's Social Care recorded that it discussed these concerns with Bailey's mum, she disagrees. Her mum did challenge Bailey regarding her use of drugs around the same time, but this was not in the context of any disclosures from either her school or Children's Social Care.

13.1.5 When Bailey was 15, during an appointment with her GP, she disclosed that she had previously deliberately self-harmed and was depressed. She reported that she did not have a good relationship with her mum, who did not believe her poor mental health to be genuine. Despite being 15 years old at the time, she asked her GP to address any letters to her rather than her mum as she felt her mum would not inform

her of contact. Bailey's GP made a referral to CAMHS but she did not attend and was discharged from the service as neither her nor her mum provided consent for appointments with them to take place.

13.1.6 Around 2 months before Bailey's 16th birthday, she met her boyfriend at a children's disco. Bailey did not tell her mum that she had met him for another 3 months, when she admitted that her boyfriend was 18 years old and should not have been at the disco where they met. Within days of meeting him, Bailey was wearing expensive new clothes, which were bought by him. Bailey's mum described how her relationship with her boyfriend intensified within days. He would ring her mobile phone regularly to check up on her whereabouts. Within a few months of the relationship forming, Bailey went on holiday with a friend. On the day of her return, the windows of her mum's house and all the windows of her car were smashed during the night. A couple of years later, Bailey's mum's house and car windows were again smashed and Bailey told her that her boyfriend was responsible. Bailey also told her mum that it had been her boyfriend who had arranged for the windows to be smashed previously because, while she was away, she had missed a number of telephone calls from him and this had made him angry.

13.1.7 Bailey remained in a relationship with her boyfriend and her family observed that she would often have expensive clothing and other items bought by him and would spend much of her time away overnight with him. Bailey's family informed police that they were concerned about her relationship with him and explained that he was controlling and exerted influence over most aspects of her life. The description of her partners behaviour would now likely constitute an offence of coercion and control[7].

13.1.8 Bailey's boyfriend was well known to Police. He was a member of an organised crime group and police intelligence confirms that despite being 16, Bailey was seen in his company at wine bars and on other occasions when he was involved in criminality. Bailey's boyfriend had an extensive criminal history, including domestic abuse offences. Bailey was provided with information about his previous offending by means of the Domestic Violence Disclosure Scheme (DVDS[8]) and police placed a marker on Bailey's address indicating that she may be at risk of Child Sexual Exploitation.

13.1.9 At the same time, Children's Social Care completed a Child and Family Assessment which explored Bailey's relationship with her boyfriend. That assessment concluded

[7] 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).

[8] Domestic Violence Disclosure Scheme (DVDS) also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

that she was a victim of domestic abuse. She described coercive and controlling behaviour from her boyfriend and physical abuse.

13.1.10 Bailey also informed CAMHS that her boyfriend was a gang member and said that she spent time living with him in hostels or his friends' houses, until he was sent to prison for firearms offences. She was still 16 years old and visited her boyfriend in prison every two weeks. Even after her boyfriend had been incarcerated, Bailey still spent most of her time staying at his father's address, telling family that she needed to look after his brothers and dogs.

13.1.11 Bailey remained in a relationship with that boyfriend until around March 2021 when, following a period of living in the community, he was recalled to prison. Although Bailey was in a relationship with him for around six years, family estimate that, during that time, he was out of prison for no more than 12 months and never on her birthday. Bailey was impressed by his wealth and appeared to be under his complete control.

13.1.12 Although Bailey would not admit to her family that she was a victim of domestic abuse, they believed that she was. Bailey's mum saw photos of her on her phone with black eyes. Bailey's family suspected that she may be laundering money for her boyfriend and his criminal associates. They described her as immature and vulnerable.

13.1.13 Bailey had a diagnosis of Bipolar Affective Disorder Type 2 and some emotionally unstable personality disorder traits. She described herself as having impulsive behaviour and gave healthcare professionals an example of spending £30,000 that she had saved over the space of four months.

13.1.14 Bailey told healthcare professionals that she did not have a good relationship with her family and they had not been part of her life due to her relationship with her boyfriend, who she remained with, despite frequent abuse from him. She also described that she did not have many friends and struggled to form friendships with people.

13.1.15 Although Bailey was in a relationship with her boyfriend for many years and throughout that time he was criminally active, she had no criminal convictions.

13.1.16 Bailey was arrested in March 2021 on suspicion of money laundering and possession of controlled drugs and at the time of her death, she was still under investigation in relation to those offences. She was arrested with her boyfriend who was subsequently recalled to prison and was still in custody at the time of her death. Although the panel have been unable to confirm, it appears that Bailey ended the relationship with her boyfriend at that point.

13.1.17 Bailey was described by her family as a bright child. She enjoyed her years in primary school but secondary school was more of a challenge for her. She did not receive a place at her first choice secondary school and went to another where she did not know anybody. She successfully studied for her GCSEs and then secured a full-time place at a private dance school located outside of Manchester. For the first two terms, Bailey would usually be dropped off at the train station in the morning by her mum, but after that she was usually dropped off by her boyfriend as she was spending most of her time with him. When she was dropped off by him, Bailey would often still be in her 'going out' clothes from the night before and was sometimes still under the influence of alcohol.

13.1.18 Bailey's attendance at dance school became sporadic and therefore her mum stopped paying the fees after the first year. Bailey then secured a job in telephone sales and performed very well, earning a good salary.

13.1.19 In May 2019, Bailey started work as a sales executive for a large electrical retailer. In March 2021, Bailey did not attend work for several weeks and her employment was terminated. She did not secure another job and was reliant on state benefits.

13.1.20 Sam has an extensive criminal history with almost 100 convictions for offences including drugs, firearms, violence and domestic abuse. He has been subject to MARAC with previous partners.

13.1.21 Police hold a large volume of intelligence regarding Sam, including his involvement in organised crime. Much of the intelligence is sensitive and the panel were not provided with full details. The Chair and police panel member spoke privately and although the specific details of the intelligence were not provided, the Chair was satisfied that the panel could conduct this review effectively without it. No intelligence was withheld which would have impacted on the review.

13.1.22 Sometime around October 2021, Bailey formed a relationship with Sam. The panel were unable to establish the circumstances of them meeting and no agency was aware that Bailey and Sam were in a relationship with each other.

13.1.23 Bailey first reported domestic abuse from Sam in April 2022 and provided police and other agencies with a different name for him. Although it was not known at the time, it is now known that the boyfriend was actually Sam. This has been confirmed by police during the investigation into Bailey's death.

13.1.24 On 16 August 2022, North West Ambulance Service was called to an address in Manchester where they discovered Bailey with an arterial wound to her groin. Sam was also present. Bailey was conveyed to hospital where she underwent

emergency surgery. Bailey remained in a critical condition and passed away later in August 2022.

13.1.25 A Home Office Post Mortem was conducted and the cause of death was confirmed as a stab wound to the groin.

13.1.26 Sam was initially arrested on suspicion of wounding with intent but later for murder. He was charged and on 9 March 2023 was convicted of murder, wounding with intent and coercive and controlling behaviour. He was sentenced to life with a minimum term of 23 years.

13.1.27 At the time of her death, Bailey was living alone in refuge accommodation in Manchester, provided by Manchester Women's Aid after being supported by agencies to leave Sam following domestic abuse.

13.2 **Events within Timeframe of Review**

13.2.1 The following paragraphs summarise domestic abuse and safeguarding issues affecting both Bailey and Sam within the timeframe of review, which the panel felt were most relevant.

13.2.2 On 17 August 2018, Sam was released from prison with a condition to reside at approved premises.

13.2.3 On 21 August 2018, police attended a report of a disturbance at a private residence in Manchester. A third party had seen and heard Sam being verbally and physically abusive towards his partner. When police arrived, Sam's partner denied that there had been a disturbance and stated they were unhappy at police involvement. A DASH[9] assessment resulted in the risk being categorised as high and a MARAC referral was made. Sam was arrested for assault and recalled to prison due to being on licence.

13.2.4 On 8 November 2018, the Probation Service reviewed risks in respect of Sam. He had not been charged with any offences following the incident on 21 August 2018. Re-release was supported.

[9] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009-2023) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009. The DASH is a multi-agency tool used by most agencies with a focus on keeping victims and their children safe and ensuring perpetrators are proactively identified and managed. Half the questions focus on coercive control and there is a focus on stalking and so-called honour based abuse.

13.2.5 On 8 January 2019, Probation Service withdrew support of Sam's re-release following receipt of intelligence (not made available to the DHR panel).

13.2.6 On 15 April 2019, Sam provided Probation Service with a new address for his release from prison. The address was that of a female friend, although enquiries were not made to establish the relationship between her and Sam. The address was accepted as appropriate. It was later ascertained that the female was Sam's partner.

13.2.7 On 8 May 2019, Sam was released from prison to an approved address. A condition of his release was that he must notify Probation Service of any developing personal relationships with women, whether intimate or not.

13.2.8 On 13 May 2019, Sam attended a GP appointment and reported anxiety, depression, low mood, panic attacks, poor sleep and suicidal thoughts. He reported 'recurrent thoughts'. He declined anti-depressant medication but was prescribed medication to help him sleep.

13.2.9 On 16 May 2019, Sam provided Probation Service with a negative alcohol test but admitted failing to take prescribed medication and failing to attend sessions in respect of drug and alcohol use.

13.2.10 On 17 May 2019, Sam was issued with a not fit for work note due to anxiety and depression.

13.2.11 On 23 May 2019, Sam failed to return to his approved premises and Probation Service made a decision to recall him to prison. His whereabouts were unknown.

13.2.12 On 18 August 2019, Sam's former partner reported that he had broken into her home and stolen her car. The DASH assessment was high risk and a MARAC referral was made.

13.2.13 On 22 August 2019, Sam was arrested and charged with handling stolen goods and disqualified driving. He was technically bailed to return to a police station but was recalled to prison.

13.2.14 On 4 November 2019, Bailey presented to her GP as a new patient and requested an urgent appointment to discuss medication for long term poor mental health. She disclosed a long history of mental health issues and explained that she had been under CAMHS from the age of nine when her parents separated. Bailey was prescribed medication and referred to GMMH.

13.2.15 On 18 November 2019, GMMH received the referral from Bailey's GP. A routine duty assessment was booked for 23 January 2020.

13.2.16 On 12 December 2019, police received intelligence that, although still in prison, Sam had been sending messages to his former partner requesting that she meet with him on his release, which was imminent. He stated that if she did not agree to meet him, he would find her.

13.2.17 On 16 December 2019, Sam was released from prison. Licence conditions included living at approved premises and disclosing any developing relationships.

13.2.18 On 25 December 2019, Sam was admitted to hospital due to a leg injury. Whilst in hospital, hospital staff reported that he was visited by a girlfriend on 28 and 29 December.

13.2.19 On 31 December 2019, Probation Service initiated Sam's recall to prison for breach of his licence conditions. He failed to return to his approved premises after being discharged from hospital.

13.2.20 On 9 January 2020, Probation Service conducted a risk assessment which identified Sam's history of offending, emotional mismanagement and substance misuse. The assessment outlined that the Domestic Violence Disclosure Scheme should be considered if there was any suggestion of Sam forming a relationship with a partner.

13.2.21 On 22 February 2020, police arrested Sam for driving whilst disqualified on 28 January 2020. He was recalled to prison.

13.2.22 On 6 March 2020, Sam's application for re-release was not supported by the Probation Service due to no approved premises being available.

13.2.23 On 18 May 2020, Sam was released from prison with conditions to reside at approved premises and advise the Probation Service of any developing relationships.

13.2.24 On 13 July 2020, Police executed a search warrant at an address in Stockport. Sam was present with a female [now referred to as his partner]. Both denied that they were in a relationship. His partner was asked to consider receiving information regarding Sam through the Domestic Violence Disclosure Scheme (DVDS) but she declined, insisting that she was not in a relationship with him.

13.2.25 On 18 July 2020, Sam's prison sentence expired therefore he was no longer subject to licence conditions.

13.2.26 On 13 August 2020, Police were called to a disturbance at the home of Sam's partner. She had visible injuries but would not tell Police how she had received

them. Children had been present during the incident. Sam was identified as the aggressor and was heard to say, '*whoever calls the police will have their windows smashed*.'

The DASH assessment was high risk. A MARAC referral was made and Sam's partner was provided with information about Sam's offending history by means of a DVDS. She stated that she would no longer allow Sam into her address.

13.2.27 On 18 September 2020, Bailey discussed her fertility with her GP. She described having unprotected sex with her partner for six years and not becoming pregnant. She was referred for a gynaecology appointment.

13.2.28 On 18 October 2020, Police attended a third party report of Sam and his partner arguing in the street. The DASH assessment was high and a referral was made to MARAC .

13.2.29 On 4 November 2020, a strategy meeting was held to discuss the complexities of information sharing between agencies in respect of Sam. Probation Service, Police and Children's Social Care attended . Actions were set to establish whether Sam was in a relationship with his partner or any other female.

13.2.30 On 26 November 2020, Bailey contacted GMMH and asked for an appointment to discuss her medication as her anxiety was affecting her work. She was prescribed Promethazine.

13.2.31 On 31 December 2020, Sam was arrested following an incident where some family members of his partner were injured after being run over by a vehicle. Sam was charged with causing serious injury by dangerous driving and other motoring offences.

13.2.32 On 30 January 2021, Sam's partner's family were the victims of a shooting outside their home address. The suspect was Sam, who was arrested on 6 February 2021. He received a four week custodial sentence for breach of court order but charges relating to the shooting were not pursued due to insufficient evidence.

13.2.33 On 4 February 2021, Children's Social Care made a high risk referral to MARAC following the incidents where Sam was alleged to have targeted his partner's family. The case was heard at MARAC on 16 February 2021.

13.2.34 On 7 February 2021, anonymous information was submitted to Crimestoppers which suggested that Bailey was involved in the supply of controlled drugs.

13.2.35 On 8 February 2021, Bailey had a telephone consultation with her GP and requested a not fit for work note. The GP reviewed her Bipolar 2 disorder and noted that she reported low mood. Bailey stated that she worked in sales and her employer had noticed a drop in performance and advised her to take sick leave. Bailey also stated that she had no support network and felt that the enforced covid lockdown was contributing to her poor mental health.

13.2.36 On 9 March 2021, via the GP administrative team, Bailey requested and received a new not fit for work note.

13.2.37 On 16 March 2021, Bailey did not attend her gynaecology appointment.

13.2.38 On 17 March 2021, police reported seeing Bailey and her long-term partner together in a vehicle linked to the supply of controlled drugs.

13.2.39 On 19 March 2021, police executed a search warrant at Bailey's address. Although Bailey and her partner were not present, drugs and a significant quantity of cash were recovered. Later that day, Bailey and her partner returned to the address. They were searched and further drugs and cash were recovered, some being secreted within Bailey's clothing. Both were arrested and Bailey's partner informed police that the drugs and cash belonged to Bailey.

13.2.40 On 21 March 2021, police received further information which suggested that Bailey was involved in the supply of controlled drugs.

13.2.41 Following his arrest, Bailey's partner was recalled to prison on 23 March 2021. He was not physically returned to prison until 15 July 2021, following his arrest in Milan and extradition back to the UK.

13.2.42 On 29 March 2021 – an off duty PC contacted police to request a welfare visit for Bailey. They had been contacted by Bailey's supervisor at work. They were concerned for Bailey as she had not been in work for two weeks due to being unfit for work. Prior to this, Bailey had been seen with bruises to her face, claiming that she had walked into a door. Bailey's supervisor stated that there were rumours that Bailey was considering travelling to Turkey with her partner.

13.2.43 Following this information, police made enquiries with one of Bailey's parents. They stated that they had been contacted by Bailey two days previously and she had appeared to be fine. They did however state that they believed Bailey was a victim of criminal exploitation and despite being the victim of regular abuse from her partner, she continued to return to him. They stated that her partner had spent several periods of time in prison. Bailey's parent stated that they disapproved of her relationship with her partner and due to this, their own relationship had broken down.

13.2.44 Police were unable to locate Bailey and began a missing person investigation. Police established that Bailey was still using a vehicle and bank cards and were able to speak with her by telephone, but she said that she would not meet with them. Police stopped her vehicle on 11 April 2021 and Bailey refused to disclose where she had been or where she was living. She stated that she had not seen her partner for several weeks.

13.2.45 On 27 April 2021, Bailey had a telephone appointment with the gynaecology department. She stated that she was keen to conceive with her partner, whom she had been in a relationship with for seven years.

13.2.46 On 7 May 2021, Bailey had a telephone consultation with her GP to request a not fit for work note. The GP recorded that she had not attended her last appointment with GMMH. The note was issued.

13.2.47 On 27 May 2021, police received information from HM Passport Office that Bailey and her partner had been issued with passports.

13.2.48 On 8 June 2021, GMMH discharged Bailey from their care. This was due to her not attending several appointments and not responding to letters or phone calls.

13.2.49 On 30 June 2021, Bailey had a telephone appointment with the fertility clinic. She shared the name of her previous partner and stated that he had been involved in three previous pregnancies with different partners, all of which ended in terminations. The clinic requested that Bailey or her partner collect a pack from reception for the purpose of semen analysis.

13.2.50 On 10 August 2021, Bailey was issued a not fit for work note by her GP.

13.2.51 On 29 August 2021, Sam was released from prison with a condition to live at approved premises.

13.2.52 On 29 October 2021, Bailey contacted her GP and requested a not fit for work note backdated to August 2021. The GP did not issue the note due to her not engaging with GMMH, not currently receiving medication and not recently being reviewed.

13.2.53 On 5 November 2021, Bailey had a telephone consultation with her GP and was issued with a not fit for work note backdated to when she called on 29 October 2021. A review took place of her Bipolar Affective Disorder.

Bailey explained that the reason she did not respond to calls from GMMH was that her phone had been seized by police. She informed the GP that she lived alone as her boyfriend was in and out of prison.

Bailey asked for another referral to GMMH which was made by her GP but not accepted by them. She was referred to 'Living Well' (a service which offers holistic support for people struggling with their mental health and connects them with support such as employment, finance and housing, available through the GP).

13.2.54 On 2 November 2021, Bailey had a telephone appointment with the fertility clinic. During that appointment, she was again requested to collect, or have her partner collect, a pack from reception for semen analysis.

13.2.55 On 22 December 2021, Bailey was discharged from Living Well after she declined any support to obtain employment. An assessment was offered in relation to psychological therapy, social inclusion and employment support, however, this was declined by Bailey, who asked for medication only. A medication review was discussed with the Community Mental Health Team who offered an out-patient appointment.

13.2.56 On 26 January and 8 February 2022, Bailey was issued with not fit for work notes following telephone consultations with her GP.

13.2.57 On 10 February 2022, Sam's prison sentence expired, meaning he was no longer subject to licence conditions but was subject to post sentence supervision. He attended appointments with his Probation Officer in February and March 2022.

13.2.58 On 15 February 2022, Sam provided Probation Service with a positive drugs test, revealing he had used cocaine. A formal written warning was issued.

13.2.59 On 28 February 2022, Bailey contacted her GP by telephone and reported that her boyfriend had beaten her up the previous week. She stated that she could not open her jaw properly.

Bailey's GP advised her to attend A & E. She stated that she was going to attend the previous week but thought they would ask her lots of questions.

13.2.60 In March 2022, Sam failed to attend several appointments with his Probation Practitioner.

13.2.61 On 4 March 2022, Bailey's GP attempted to contact her by telephone to follow up her appointment on 28 February. She did not answer and the GP left a voicemail message. The GP telephoned Bailey again on 9 March and she stated that she felt vulnerable and was a victim of physical abuse from her boyfriend. She stated that she had no friends or family and could not move anywhere as she had two dogs.

Bailey stated that she was concerned that when her ex-boyfriend is released from prison soon, there may be 'clashes'.

The GP issued a not fit for work note and advised that she needed a medication review. The GP recorded that Bailey needed a referral for safeguarding / domestic abuse.

13.2.62 On 16 March 2022, Bailey's GP sent an email to GMMH to chase her referral. She was subsequently offered an outpatient appointment on 10 May 2022.

13.2.63 In March and April 2022, police received information that Sam was in violent dispute with several unidentified people. The reports suggested links between Sam and organised criminality.

13.2.64 On 6 April 2022, GMFRS attended a report of a fire at the flat below Bailey's home address. They saw that water appeared to be leaking from Bailey's flat into the one they had attended, causing a small electrical fire. Firefighters did not get a response to knocking at Bailey's door so forced entry and isolated a minor water leak before securing the premises and leaving a note for the occupant to contact them.

13.2.65 On 7 April 2022, GMFRS returned to Baileys address to check on the welfare of two dogs which had been in cages at her address the day before. Again there was no response to knocking so the firefighters entered with keys. The dogs were again present in cages, so the RSPCA were called. After the dogs had been exercised, the firefighters locked the address.

Later the same day, Bailey attended the fire station to collect her keys. The Watch Manager had intended speaking to Bailey about the welfare of the dogs, but realised that she was distressed and had a black eye. She explained that she had left her address in a rush after having an argument with her boyfriend, during which he had smashed up her car. She admitted that he had caused her black eye but when the manager suggested contacting the police, she said that would make matters worse and left the station quickly.

The Watch Manager reported the matter to the police and made a safeguarding referral to the local authority.

13.2.66 Over the next three days, police attempted to locate Bailey and speak with her about the incident reported by GMFRS, leaving notes for her to make contact.

13.2.67 On 11 April 2022, Probation Service initiated breach action against Sam for failing to live at his approved address after police informed them of intelligence in relation to a

threat to life notice issued to him at an alternative address. The breach was listed to be heard at Manchester & Salford Magistrates Court on 6 May 2022.

13.2.68 On 12 April 2022, Bailey made contact with the police and met with them outside her home address. She refused them access to her address and declined to provide either a statement or the name of the person who had assaulted her. She told officers that if she was seen talking to them, she would be dead. She stated that she wasn't safe in Salford and needed to leave the area.

Police officers completed a care plan to offer support to Bailey although she did not consent for police to share any of her information.

13.2.69 On 13 April 2022, Bailey rang the police and reported being assaulted by her boyfriend. She provided his name (now known to be false) and stated that he was 35 years old. She informed police that she had been in a relationship with her boyfriend for six months but they did not live together. Bailey explained that she had been the victim of numerous assaults by her boyfriend over a period of several weeks.

13.2.70 Bailey declined to provide a witness statement regarding the assaults by her boyfriend. Police recorded crimes of assault occasioning actual bodily harm and controlling and coercive behaviour but filed them no further action due to a lack of evidence to support a prosecution.

A DAB[10] and DASH were completed and the risk was assessed as medium. Referrals were made to Safe in Salford for IDVA support and a recommendation was made that Bailey be rehoused away from the area.

13.2.71 Police discussed a DVDS disclosure with Bailey, but she declined. A referral was made to MARAC.

13.2.72 Police took Bailey to a refuge out of the area and facilitated support from Manchester Women's Aid, Refuge and Adult Intervention Team.

[10] 'DAB' refers to a Greater Manchester Police Domestic Abuse Report, an electronically held report on GMP's Integrated Operational Policing System which records circumstances and associated actions identified in response to suspected incidents of domestic abuse. The record is automatically queued for triage by an Adult Support Unit or MASH Officer and risk assessed, with appropriate recording of crime, investigation, and onward referrals to partner agencies managed through the report. Closure of all DAB reports within GMP is overseen by a Multi-Agency Safeguarding Hub supervisor to ensure risk assessment, referrals and action management has been appropriate.

13.2.73 On 14 April 2022, Salford Housing Options arranged temporary accommodation for Bailey for that night before identifying a temporary hotel for her the following day. Bailey was referred to Manchester Women's Aid by her IDVA.

13.2.74 On 19 April 2022, Safe in Salford received a referral for Bailey and an IDVA identified her case as high risk. They noted that Bailey had received appropriate support and had been transferred to South Manchester MARAC.

13.2.75 Also on 19 April 2022, Bailey contacted Manchester Women's Aid and asked for support in finding refuge accommodation. She explained that the last incident of domestic abuse from her boyfriend was on 7 April 2022, when she had been punched by him, causing bruising to her arm and face. She also provided them with an incorrect name for her boyfriend and stated that she was unable to provide his address.

13.2.76 On 21 April 2022, Bailey moved out of the temporary hotel arranged by Salford Housing Options and into a refuge arranged by Manchester Women's Aid.

13.2.77 On 21 April 2022, Manchester Women's Aid contacted GMMH and informed them that Bailey had left Salford due to domestic abuse and was now housed by them in Manchester. They explained that Bailey did not have medication and needed a prescription.

13.2.78 On 25 April 2022, due to Bailey now residing in another area, her MARAC referral was transferred to South Manchester.

13.2.79 On 26 April 2022, Bailey had a face to face appointment with GMMH in Salford. She asked if future appointments could be completed by telephone as she was anxious coming into the Salford area.

13.2.80 On 29 April 2022, Manchester Women's Aid allocated Bailey a support worker who facilitated a telephone appointment with GMMH who were unable to prescribe Bailey with Bipolar medication until she had been assessed. Another telephone appointment was made for 10 May 2022, during which the Community Mental Health Team informed Bailey that they would not prescribe medication until she had an ECG and blood tests.

13.2.81 On 17 May 2022, Bailey's case was heard at South Manchester MARAC.

13.2.82 On 22 May 2022, Sam rang 111 and requested an ambulance due to him feeling dizzy and vomiting. A short time later, Bailey again rang 111 and asked for an estimated time of arrival for the ambulance. Sam was taken to hospital.

13.2.83 On 23 May 2022, Sam again rang 111 reporting chest and upper back pain. Paramedics attended although Sam refused any treatment.

13.2.84 On 27 June 2022, Bailey gave notice on her privately rented apartment in Salford. She had been awarded priority banding for rehousing in Manchester and the Manchester Women's Aid support worker started to assist her with viewing suitable properties.

13.2.85 On 7 July 2022, Bailey did not attend her appointment with the Community Mental Health Team clinic.

13.2.86 On 20 July 2022, Bailey attended a face to face appointment with a Manchester GP. She discussed her history of domestic abuse and stated that she was still living in a refuge. The GP offered Bailey a referral to IRIS (domestic abuse service in Manchester for Primary Care referrals) but she declined.

13.2.87 On 10 August 2022, Bailey contacted GMMH and stated that she had lost her prescription. She was issued with a new prescription and asked to collect it that day from Salford.

13.2.88 On 16 August 2022, North West Ambulance were called to an address in Manchester where Bailey was present with a serious stab injury to her groin. Police also attended and observed that in addition to the stab wound, Bailey had visible bruising and appeared to have been assaulted. Sam was also present and was initially arrested on suspicion of wounding but later for controlling and coercive behaviour and attempted murder.

13.2.89 Bailey's injuries proved to be fatal and she passed away in hospital later in August 2022. Sam was arrested on suspicion of murder.

13.2.90 Following Bailey's death, Sam was charged and convicted of her murder. He was sentenced to life with a minimum term of 23 years.

14 Analysis

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Bailey and how did your agency assess the level of risk presented by the alleged perpetrators to Bailey and/or others. Which risk assessment model did you use?

14.1.1 GMP held intelligence which suggested that throughout Bailey's relationship with her previous boyfriend, both were involved in criminality and Bailey was supplying drugs from his address. In March 2021, Bailey and her boyfriend were arrested for drugs offences. Bailey was found to have drugs and cash secreted within her clothing and, when interviewed, her boyfriend stated that drugs recovered from his vehicle belonged to Bailey. He denied any involvement in drugs supply. Bailey's boyfriend was recalled to prison and both were released under investigation.

14.1.2 Police were in possession of historic information from Bailey's mum that she suspected Bailey was a victim of criminal exploitation, but the investigating officers did not consider that on this occasion. No discussion took place to explore the relationship Bailey had with her partner and despite him apparently laying all blame on her for the drugs found within his vehicle, police did not consider that she may have been involved unwillingly.

The panel discussed the thoroughness of the police investigation and agreed that it lacked professional curiosity and was a missed opportunity to support Bailey with safeguarding options. The panel saw no evidence that police considered that Bailey may be a victim of exploitation by her partner.

This is a learning point which leads to a single agency recommendation for GMP.

14.1.3 The panel discussed whether in view of previous police intelligence which suggested that Bailey may have been at risk of exploitation, 'markers' should have been placed on her GMP intelligence record to reflect this. The panel learned that in 2019, GMP changed I.T. systems and many records had to be manually updated. As such, it is not possible to establish whether Bailey's previous intelligence record had such markers but at the time of her death it did not.

The panel felt that had such markers been attached to Bailey's record at the time of her arrest, it may have prompted the investigating officers to consider her as a victim.

This is a learning point which leads to a single agency recommendation for GMP.

14.1.4 Also in March 2021, Bailey's employer reported concerns to GMP. They had not seen Bailey for around two weeks and they suspected that she was in an abusive relationship. She had recently been seen with facial injuries and had informed

colleagues that they were caused by her boyfriend. A missing from home investigation was instigated by GMP and Bailey was located and spoken to by officers two days later. She refused to meet with officers, but she was stopped driving a vehicle 11 days later, providing an opportunity for officers to establish the circumstances of her being reported missing.

14.1.5 The information provided by Bailey's work colleagues that she was a victim of domestic abuse was not considered by the officers who spoke with her.

Although GMP located Bailey and established that she was not 'missing', No risk assessment or DAB was recorded, despite Bailey's colleagues reporting visible injuries and her disclosures regarding being assaulted.

The panel felt that police failed to respond appropriately to a report of domestic abuse and as such, an opportunity to address risk and support Bailey was missed.

This is a learning point which leads to a single agency recommendation for GMP.

14.1.6 When Bailey attended the fire station on 7 April 2022 to recover her flat keys, GMFRS staff saw that she had a black eye and was visibly distressed. They demonstrated good professional curiosity and were able to discuss the cause with her. Bailey disclosed that she had been assaulted by her boyfriend and although staff attempted to persuade her to report the matter to the police, Bailey appeared scared to do so, saying that it *"would make matters worse".*

GMFRS staff rightly identified that although Bailey had not given her or her boyfriend's details, they should still seek to address the risk to her. They reported the matter to GMP and submitted a safeguarding referral to the local authority the same day.

14.1.7 GMP made attempts to contact Bailey but took five days to do so, by which point she had no visible injuries. Bailey made it clear that she did not feel able to provide any further details to officers and feared for her safety if she had been seen talking to them. Officers were still concerned about her safety and began to complete a care plan to ensure further support was offered to her.

14.1.8 That care plan was never completed as the following day, 13 April 2022, Bailey recontacted GMP and reported that she had again been assaulted by her boyfriend. She provided an incorrect name for him. Officers tried to identify Bailey's boyfriend based on the information she provided, but were unable to do so and felt that she was withholding information from them. It is now known that the boyfriend was Sam.

14.1.9 Bailey disclosed that the assault by Sam was not an isolated incident and she had been assaulted by him many times over several weeks. She described being

knocked unconscious by him and being hit so hard that she believed that Sam had perforated her ear drum. Officers established that Sam controlled her finances by not letting her work and being reliant on him to pay for everything. She also reported that he would drive past her house and she felt this was him controlling her.

14.1.10 Despite Bailey not identifying her boyfriend or feeling able to provide a statement, GMP still recognised that she was at risk and recorded crimes of section 47 assault and coercive and controlling behaviour. They completed a DASH assessment which was graded as medium risk and made a referral to MARAC. That same day, GMP supported Bailey by referring her to Salford Housing Options, instigating her being provided alternative accommodation, a hostel out of the area.

14.1.11 GMP completed a care plan which included the allocation of two officers from the Adult Support Unit to coordinate attempts to record and further the criminal investigation for assault, support Bailey with her housing needs with a move away from Salford by taking her to a local refuge, a referral to 'Safe In Salford' and also to MARAC where subsequent actions included coordination of Mental Health Care with a referral to the Community Mental Health Team.

14.1.12 GMP considered offering Bailey an opportunity to learn more about Sam's previous history of domestic abuse through a DVDS, but as she had not identified him to officers, they were unable to do so (or establish the extent of his offending).

14.1.13 The Probation Service managed Sam during the period of review. Sam was assessed by them as posing a high risk of serious harm to the public. Probation Service also saw evidence of abusive behaviour from Sam within relationships and therefore conducted a Spousal Assault Risk Assessment (SARA) on eight occasions during this review period. On each occasion, the completed SARA assessment identified a high risk of further violence to a partner from Sam.

14.1.14 Bailey was registered with a GP practice in Salford from 31 October 2019 until April 2022. Throughout that time, Bailey presented with physical health complaints which could have been indicators for domestic abuse, as outlined by the NICE Domestic Abuse Quality Standard 2016.

14.1.15 From February 2021, Bailey was frequently issued with not fit for work notes by her GP, due to her poor mental health. During consultations with Bailey for those health complaints, the potential for domestic abuse was not considered by staff and the panel agreed with the practice that opportunities were missed to identify that Bailey was a victim of domestic abuse.

14.1.16 Bailey disclosed domestic abuse to her GP during an appointment in February 2022. She informed the GP that she suffered *'intermittent physical abuse, felt vulnerable, stuck and had no friends or family.'* Bailey also informed her GP that

she was concerned about her ex-boyfriend who was due to be released from prison.

Despite her disclosures and concerns, the GP practice did not make any referrals for support for Bailey and did not assess risks to her from either the boyfriend who had subjected her to abuse or her ex-boyfriend who was due to be released from prison. This is despite the GP notes stating, *'she needs referral for safeguarding / domestic abuse.'*

The panel acknowledged that this disclosure was made a month before Bailey first reported domestic abuse to police. The failure of the GP to take further action was a missed opportunity to support Bailey and instigate interventions from other professionals. The panel agreed that there should have been a safeguarding referral made by the GP. This delay may have made it more difficult for Bailey to ask for help.

This is a learning point which leads to a single agency recommendation for that General Practice.

14.1.17 In March 2021, Bailey was referred to a gynaecology consultant after reporting to her GP that she and her boyfriend had been trying to conceive and had been unable to do so. She reported that she had been having unprotected sex with him for the past seven years. Over the next three months, Bailey met and spoke with gynaecology staff on several occasions as advice was provided on how to improve her chances of conceiving.

Despite the fact that Bailey informed staff that she had been in a sexual relationship with her boyfriend since the age of 14 (and stated that he was 17 at the time), there was a lack of professional curiosity around the circumstances.

14.1.18 The panel agreed that this was a missed opportunity to explore Bailey's relationship with her partner to not only consider abuse or exploitation in the past, but also her current vulnerability. Northern Care Alliance explained that since this time, additional training has been provided within early pregnancy and fertility clinics, where routine inquiry has been introduced.

This is a learning point which leads to a single agency recommendation for NCA.

14.1.19 The panel acknowledged that the lack of domestic abuse screening during routine medical appointments with GP's and hospital staff has been highlighted during previous DHR's, although application continues to be inconsistent.

This is a learning point which leads to panel recommendation 2.

14.1.20 Bailey registered with a GP practice in Manchester after moving to the refuge in April 2022. The practice considered a clinic letter from GMMH and had two

consultations with her. Although both the clinic letter and conversations with Bailey made it clear that she was a victim of domestic abuse, neither the letter or the conversations with Bailey contained the finer details of the type, severity or frequency of abuse which Bailey had suffered. The practice has reflected on this and believes that the fact that Bailey was already living in a refuge arranged by Manchester Women's Aid, may have provided staff with reassurance that she was receiving appropriate support for domestic abuse. The practice identified that this presumption suggests a gap in knowledge of what support is offered within a refuge environment and have identified learning which is included in a single agency action plan.

The panel agreed that staff could have been more professionally curious and this may have established more facts around the abuse Bailey had suffered. Despite this, the practice did still provide Bailey with contact numbers for mental health crisis support and did offer to refer her to IRIS (domestic abuse service).

14.1.21 Safe in Salford received a referral from GMP on 19 April 2022 and although the DASH assessment was graded as medium risk, they identified the risk to Bailey as high. They recontacted GMP and asked that the DASH assessment be amended to high risk. That was done the same day and the MARAC date was listed for 27 April 2022.

Salford hold a weekly MARAC and 27 April was the first realistic opportunity to consider Bailey's case, although action was immediately taken to safeguard her by moving her away from the area and offering IDVA support. The panel agreed that the date of the proposed MARAC was appropriate, as was the initial action taken to support Bailey and reduce imminent risk.

14.1.22 Safe in Salford (SIS) referred Bailey to Manchester Women's Aid on 19 April 2022. Staff discussed the abuse she had been subjected to and established that she had been a victim of physical and emotional abuse and coercive and controlling behaviour from Sam (although she still did not name him). Bailey explained that Sam constantly texted and called her when they were not together and she feared what he might do to her.

Staff completed a DASH assessment which was medium risk.

14.1.23 The panel considered whether there was evidence that Sam had subjected Bailey to coercion and control and in doing so referred to the Crown Prosecution Service's policy guidance:

14.1.24 The Crown Prosecution Service's policy guidance on coercive control states:[11]

[11] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

‘Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can 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 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
- 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
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage

- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.1.25 Considering the Crown Prosecution Service's guidance, the panel felt that the physical and emotional abuse along with physical monitoring, preventing Bailey from working and making her financially reliant on him were all clear indicators that she was being subjected to coercive and controlling behaviour by Sam.

14.2 **Did your agency consider that Bailey may be being exploited or could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert or hold a strategy meeting?**

14.2.1 The Care Act 2014 section 42 states:

'…where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and

(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.'

14.2.2 From 2016, GMP was aware that Bailey was in a relationship with her former boyfriend and that the relationship had started when Bailey was 14 years old. Bailey's family told GMP that they were concerned that her boyfriend controlled most aspects of her life and would 'shower her with designer gifts'.

14.2.3 Bailey's family told GMP that despite her age, she would disappear with her boyfriend for several days at a time and stayed in hotels with him. They reported that Bailey's physical appearance and accent changed dramatically.

14.2.4 GMP was aware that Bailey's boyfriend was involved in serious and organised crime and when her family reported the concerns, he was wanted by police for firearms offences. GMP assessed that Bailey was at risk of child sexual exploitation and made safeguarding referrals to Children's Social Care who worked

with Bailey and her mum to try and rebuild their relationship which had by that stage broken down due to her remaining in a relationship with her boyfriend.

14.2.5 GMP made Bailey aware of her boyfriend's offending history by means of a DVDS, but were of the opinion that Bailey did not appear shocked or concerned about his offending and was dismissive of any risk to her. She remained in a relationship with him and regularly visited him in prison.

14.2.6 GMP holds intelligence which suggests that in 2021, Bailey was involved in the supply of controlled drugs with her former boyfriend. Both were arrested by GMP in March 2021 and she was found to be in possession of both controlled drugs and cash. When interviewed, Bailey's boyfriend stated that drugs and cash found within his vehicle belonged to her.

14.2.7 GMP outlined to the panel that the investigation into these offences was not good enough. It lacked strategic direction and was not supervised effectively. This resulted in key lines of enquiry not being explored and interviews with both Bailey and her boyfriend being conducted in a superficial manner. The investigation was not complete at the time of Bailey's death.

14.2.8 The panel were informed that despite GMP being in possession of information suggesting that Bailey had been at risk of criminal and sexual exploitation since the age of 14, this was not considered during the investigation into her possession of drugs and cash. The fact that she may have been a victim of exploitation was not considered by the investigating officers and therefore, when Bailey was released on bail, an opportunity was missed to assess whether she may be an adult at risk within the terms of the Care Act 2014.

The panel felt that this was a missed opportunity to support Bailey in both an exploitative and domestic abuse context.

This is a learning point which leads to a single agency recommendation for GMP

14.2.9 When Bailey reported domestic abuse by Sam in April 2022, GMP took positive action to safeguard her. She was moved to safe accommodation and referred to MARAC. Although at that stage GMP did not consider it necessary to refer Bailey to Adult Social Care to consider an assessment under the Care Act 2014, it did expect that to be considered within the MARAC process.

14.2.10 Bailey had frequent appointments with her GP until April 2022 when she changed practice after moving away from Salford. The GP practice knew Bailey's history and was aware of several risk factors which may have suggested that she was at risk of exploitation or was an adult at risk. Some of those risk factors were Bailey's

experience of childhood trauma, the breakdown of her relationship with her parents, poor mental health and unhealthy relationships as a child.

14.2.11 GP records do not suggest that any consideration was given to Bailey being at increased risk of domestic abuse, exploitation or could have been an adult at risk.

The panel felt that the type and number of risk factors presented by Bailey should have prompted her GP to consider that she could be at risk and this should have been explored further by the GP.

This is a learning point which leads to a single agency recommendation for that General Practice.

14.2.12 After registering with a different GP practice in Manchester in April 2022, Bailey had two consultations with staff and disclosed historic domestic abuse. The panel again acknowledged that staff could have been more professionally curious and could have explored Bailey's circumstances in the present, rather than assuming that this was being done as part of support within the specialist refuge.

14.2.13 When Bailey attended the fire station to collect her keys in April 2022, the Watch Manager was professionally curious and proactive, making a safeguarding referral and contacting GMP the same day. The panel thought that this was a good example of an agency taking prompt and effective action to address safeguarding risks.

14.2.14 During the period of review, GMMH engaged with Bailey frequently as they assessed and treated her mental health. During consultations, Bailey disclosed that she was a victim of domestic abuse. Staff did not explore the abuse with her or seek to provide support. Consultations were focussed on assessment of her mental health and prescription of medication.

Records do not suggest that any discussion took place to understand the root cause of Bailey's mental health at that time. No safeguarding referrals were made.

14.2.15 On several occasions, Bailey failed to attend appointments with GMMH and on one occasion this resulted in her being discharged from their care. GMMH did not make enquiries with other agencies to establish why Bailey had not attended. The panel felt that the missed appointments may have been an indicator that Bailey was an adult at risk, a victim of domestic abuse or exploitation, but this was not discussed with Bailey.

The panel felt that the fact Bailey had suffered with poor mental health for many years and her teenage history was well known to staff, this may have resulted in

them not exploring what was causing or worsening Bailey's mental health at that time.

This is a learning point which leads to a single agency recommendation for GMMH.

14.2.16 In 2021, Bailey had several consultations with gynaecology specialists, as she was keen to conceive with her boyfriend. From the onset, Bailey made it clear that she had been having unprotected sex with her boyfriend since the age of 14 when she was below the age of consent.

Gynaecology specialists did not consider that this may have been an indicator that Bailey was previously being sexually exploited when she was 14 or that it may indicate that she may still be at risk of exploitation or domestic abuse at that point.

14.2.17 Although Bailey provided her boyfriend's personal details to staff in the fertility clinic, there was no requirement for him to be seen or spoken to by them and semen samples for analysis could have been provided by Bailey personally.

The panel felt that the process on this occasion lacked professional curiosity and was a missed opportunity to identify exploitation or domestic abuse at a critical time for Bailey, when there was an opportunity for her to put distance between her and the abuser; he was out of the country avoiding being recalled to prison.

14.2.18 At the time of Bailey's appointments, many agencies were slowly returning to normal practice after Covid-19 lockdown restrictions. The gynaecology department were still carrying out most appointments by telephone and the panel were conscious that this may have impacted on the ability of professionals to assess patients fully. The NCA panel member explained that even if the appointment had been face to face, there would still not have been any requirement for Bailey's boyfriend to attend with her or deliver his own semen sample for analysis. It was explained that as a result of this review, staff within the fertility clinic will now ask patients '*can I speak with your partner'*. This has been introduced along with routine enquiry in respect of domestic abuse within the fertility clinic and is contained within the single agency action plan.

This is a learning point which leads to panel recommendation 2.

14.2.19 Fertility clinic staff established that Bailey's boyfriend had been involved in three previous terminated pregnancies with different partners.

The panel agreed that this suggested he had been involved in other intimate relationships with other women whilst he had been Bailey's boyfriend. The panel agreed that the fact he had been involved in three previous terminations and was now supporting Bailey to conceive should have aroused some suspicion in staff

and triggered a more curious approach to establish more about Bailey's current circumstances.

14.2.20 The panel discussed links between terminated pregnancies and domestic abuse and agreed that this should have been a red flag. Research by BMC Medicine in 2014 suggests:

'Intimate partner violence is common among women having abortions, with between 6% and 22% reporting recent violence from an intimate partner. Concern about violence is a reason some pregnant women decide to terminate their pregnancies.'[12]

14.2.21 In April 2022, when SIS received a referral from GMP, it processed that referral the same day, upgraded the risk to high and quickly established that a priority was to arrange accommodation for Bailey outside of the Salford area. The panel agreed that this initial action was appropriate and addressed the immediacy of risk of Bailey being located by Sam and being subjected to further domestic abuse.

14.2.22 SIS arranged for Bailey's case to be heard at MARAC within 8 days. The panel agreed that this was a reasonable timescale and the fact that Salford holds weekly MARACs was good practice.

14.2.23 Due to Bailey being re-housed out of the area, her case was removed from the Salford MARAC list and relisted in South Manchester on 17 May 2022.

Although the panel acknowledged that this added a delay of a further 20 days for Bailey's case to be heard, it was agreed that appropriate steps had already been taken to safeguard her and provide appropriate support.

14.3 **What consideration did your agency give to any mental health issues or use of controlled drugs by Bailey or Sam when identifying, assessing and managing risks around domestic abuse?**

14.3.1 GMP held information which suggested that Bailey suffered with poor mental health and when she was arrested in March 2021, recorded that she was Bipolar, suffered with anxiety and had previously considered self-harm.

[12] https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-014-0144-z#:~:text=Intimate%20partner%20violence%20is%20common,decide%20to%20terminate%20their%20pregnancies.

GMP also held information which suggested that Bailey used illegal drugs.

14.3.2 Although GMP held information which suggested that Sam had a close association with illegal drugs and also used steroids, it was unaware that he and Bailey were in a relationship until they were called to the incident in August 2022 which led to Bailey's death.

14.3.3 During the period of review, Probation Service monitored Sam closely. Its assessment was that an increased use of cocaine and steroids would likely increase the risk of him becoming violent and this would specifically lead to an increased risk of domestic abuse, should he form a relationship with someone. To manage this, Sam was made subject to licence conditions including drug testing, engagement with substance misuse services and a requirement to notify Probation Service of any relationship with a female.

Sam did test positive for cocaine on one occasion and admitted to using steroids.

14.3.4 Sam did not always adhere to those conditions and the Probation Service took appropriate action where necessary, including recalling him to prison. Sam was described by the Probation Service as being *'skilled in avoidance and manipulation tactics'* and this sometimes caused a delay in staff enforcing breaches of conditions. However, throughout this period, Sam did not inform them that he was in a relationship and so the links between domestic abuse and substance misuse were never made.

14.3.5 In May 2019, Sam informed his GP that he was suffering with depression, low mood, anxiety and had a panic attack. He stated that this was due to him living in a hostel having recently been released from prison. He was prescribed medication and also offered a referral for specialist support, although he declined.

The panel agreed that Sam's presentation included indicators for domestic abuse himself and he could have been asked further questions to establish whether he was a victim of domestic abuse. This did not happen, nor was he asked about any relationships.

14.3.6 When Bailey registered with her Salford GP in 2019, she disclosed a long standing history of poor mental health, beginning when she was a young child. In February 2020, Bailey was diagnosed with Bipolar Affective Disorder Type 2 and traits of Emotionally Unstable Personality Disorder. The panel considered whether events around this time may have triggered a deterioration in Bailey's mental health but learned that, sometimes, mental illness of this type can appear suddenly and without warning. It is not always triggered by any specific event.

14.3.7 Bailey disclosed domestic abuse to her GP in February 2022. There is no evidence of a formal DASH risk assessment completed by the GP and therefore

information in respect of previous mental health conditions or substance misuse were not identified at that time.

14.3.8 As outlined at section 14.2.14, whilst providing mental health services, GMMH did not explore domestic abuse with Bailey or establish any factors that were exacerbating her illness at that time. The panel agreed that this was a missed opportunity.

14.3.9 When Bailey reported domestic abuse in April 2022, the IDVA conducted an initial screening of her case and appropriately explored her mental health and use of illegal drugs. Bailey did not disclose drug use but did outline her mental health history, enabling SIS to appropriately manage risks and understand the impact of her mental health on her current circumstances as a victim of domestic abuse.

14.3.10 When Bailey was moved out of the Salford area and found accommodation by Manchester Women's Aid, she informed her support workers of her mental health history and current requirements in terms of medication.

Bailey was well supported by her Adult Intervention Worker who provided her with weekly support sessions and also attended her accommodation weekly to assess any use of alcohol or illegal drug use (there was never any sign of either).

Manchester Women's Aid considered mental health and potential drug use to manage risks to Bailey, attempting to ensure that there was no need for her to return to Salford. However, GMMH did not transfer Bailey's prescription to a Manchester pharmacy, meaning that she needed to travel to Salford to collect essential medication, despite the area being unsafe for her due to the threat from Sam.

The panel thought that this must have caused Bailey fear and anxiety and could have been easily avoided.

14.4 **What services did your agency provide for Bailey and Sam. Were they timely, proportionate and 'fit for purpose' in terms of addressing domestic abuse in addition to risks posed by organised criminality.**

14.4.1 GMP had minimal contact with Bailey during the timeframe of review. Prior to that period, GMP was aware of her relationship with her previous boyfriend and took action to safeguard her by means of a DVDS disclosure and referral to children's social care. GMP held information which suggested that Bailey had previously been at risk of child sexual exploitation.

14.4.2 GMP held information which suggested that Bailey remained in a relationship with her previous boyfriend, despite him being in prison. Information suggested that Bailey lived with her previous boyfriend's family and was aware of and sometimes involved in criminality and in March 2021 she was arrested with him whilst in possession of illegal drugs and cash. Shortly after their arrest, Bailey's employer reported to GMP that they believed she was in an abusive relationship and had been seen with visible injuries. They had not seen her for two weeks and reported her missing.

14.4.3 GMP conducted an inadequate investigation into Bailey and her ex-boyfriend's possession of drugs and cash, and at the time of her death, Bailey was still under investigation. Considering the amount of information held by GMP in respect of Bailey's previous mental health and safeguarding history (including that she had previously been considered to be at risk of child sexual exploitation from the same ex-boyfriend), the panel felt that the investigating officers may not have given appropriate consideration to the fact that Bailey may have been a victim of exploitation.

This is a learning point which leads to panel recommendation 1.

14.4.4 Around two weeks after Bailey had been recorded as a missing person, GMP saw and spoke with her. Bailey did not wish to discuss where she had been or who she had been with and was angry that police asked her questions. The circumstances leading to Bailey being recorded as a missing person were centred around her employer's concerns that she was a victim of domestic abuse from the same ex-boyfriend. Despite this, GMP did not ask her about the third party reports that she had been assaulted by her ex-boyfriend. Officers did not explore domestic abuse and did not record the incident as domestic abuse. No DASH assessment was conducted.

The panel felt that the GMP response to finalising the missing person investigation fell below what should be expected. GMP missed an opportunity to investigate domestic abuse, safeguard Bailey and provide her with support.

14.4.5 On 7 April 2022, GMFRS took positive action and reported concerns for Bailey after seeing her with a black eye and observing her reluctance to report matters to the police. Although they did not know her name or the name of the perpetrator, GMFRS still made an appropriate safeguarding referral and reported matters to GMP.

14.4.6 GMP created an incident log to respond to the report by GMFRS. That log was assessed and graded by several members of GMP staff including supervisors but was not made a priority. As such, officers did not see or speak with Bailey until 12 April (five days later). Bailey did not confirm that an assault had taken place and

made it clear to officers that she was scared, saying *'If I'm seen talking to you, I'm dead'.*

The officers did not record a crime and GMP informed the panel that in these circumstances, one should have been recorded. They did however record a Care Plan to coordinate referrals to partner agencies and strategise support requirements.

The panel agreed that GMP should have made greater effort to make contact with Bailey sooner. The report of concern came from a professional third party and justified a greater degree of urgency to establish that Bailey was safe. The panel felt that she deserved better service than a five day response.

GMP have provided reassurances that this specific incident has been identified during this DHR process and staff involved in the management have already been provided with feedback to reinforce the expected standards of assessment, management and review of domestic abuse incidents. Given that reassurance, the panel have not made recommendations around this issue.

14.4.7 On 13 April 2022, Bailey contacted GMP and reported that she had been assaulted by her boyfriend Sam (she still provided an incorrect name for him) on several occasions over a period of weeks. She stated that the relationship had ended and the perpetrator was not there with her at the time. Bailey asked if she could speak to the same officer who had attended her address the previous day but was informed that this was not possible.

GMP assessed the incident as low risk and did not allocate resources immediately.

14.4.8 Almost seven hours later, Bailey recontacted GMP and asked when officers would arrive. She said that she was scared. Control room staff told Bailey that they still did not have anyone available to respond and she should remain inside with the doors and windows locked. She was advised to ring 999 if the perpetrator reattended.

Around twenty hours later, officers arrived at Bailey's address. They saw that she had visible injuries to her arm and face and she reported serious and prolonged assaults by Sam, some rendering her unconscious. Bailey provided the incorrect name for Sam and insufficient information to identify him. Officers suspected that she was intentionally providing misleading information to prevent them from establishing the true identity of her boyfriend.

When considering how GMP prioritise the allocation of resources to live incidents, the panel agreed that the amount of time it took for GMP to respond to Bailey was reasonable. She made it clear that the perpetrator had left and was not an immediate threat to her. However, the panel also felt that as a repeat victim who

had reported domestic abuse the previous day, Bailey deserved better. It was acknowledged that the delay may have given Bailey more time to think about her situation and this may have affected her decision not to reveal Sam's true identity.

14.4.9 Officers completed a DASH and assessed the risk to Bailey as medium. GMP recorded crimes of section 47 assault and controlling and coercive behaviour but filed the crimes as no further action due to being unable to identify the perpetrator (the evidential threshold was not met). GMP provided support for Bailey by moving her away from Salford to remove her from the threat of further abuse and referred her to MARAC.

The panel discussed at length what more could have been done by GMP to correctly identify the perpetrator as Sam. The GMP panel member explained that the circumstances would not have met the threshold for covert enquiries to be made and the panel understood this. However, the panel saw no evidence that the investigating officers made any enquiries beyond asking Bailey the identity of the perpetrator. Some panel members felt that more could have been done to identify Sam, such as house to house enquiries, checks of CCTV, checks of automatic number plate recognition systems in the area and speaking with the reporting person from the missing from home investigation in March 2021.

14.4.10 GMP holds extensive information in relation to Sam and his involvement in serious and organised crime, including extreme violence and the criminal use of firearms.

During the period of review, GMP responded to reports of domestic abuse by Sam against two previous partners. The incidents included physical assaults, threats and burglary. GMP took positive action which resulted in high risk DASH assessments, MARAC referrals, criminal prosecutions and Sam being recalled to prison on two occasions.

14.4.11 Sam was also accused of and arrested for causing serious injury by dangerous driving and attempted murder. In both cases, the family of Sam's partner had been targeted by him following altercations between them over his relationship with her.

14.4.12 Due to Sam's criminal activity and profile, he was often the subject of serious threats and during the period of review he was issued with three Threat to Life Notices (TTL)[13]

14.4.13 The panel were informed by GMP that previous violent incidents involving Sam had been dealt with positively and effectively by them.

[13] Threats to Life is described as an incident whereby someone's life is in real and immediate danger and placing an obligation on police to take reasonable steps to protect that person (GMP guidance).

When Bailey was the victim of domestic abuse in April 2022, GMP did not know that the perpetrator was Sam. The panel felt that Sam's criminal profile, history of abuse and use of violence was so extreme that it must have been a significant contributory factor in Bailey feeling that she was unable to identify him. She must have been extremely scared of what would happen to her or her family if she reported abuse.

14.4.14 During supervision by the Probation Service, several sentence plans were developed with Sam to explore his attitudes, behaviours and emotional regulation, specifically in respect of relationships. Abstinence from drug misuse, recognising the impact of violence upon others and understanding the risks of his lifestyle and associates were also consistent themes developed within sentence plan objectives that were developed upon each of his releases from custody.

Whilst the Probation Service was able to instigate intervention to explore his current lifestyle choices, these were not frequent or structured and were on Sam's terms. The panel acknowledged that the management of Sam's sentence plans was challenging for the Probation Service due to his manipulative and controlling manner and that his recalls to prison also resulted in a loss of momentum in managing risk in the community.

14.4.15 Until June 2021, Bailey had been managed by GMMH under a Care Programme approach (CPA). She was discharged due to not attending her appointments and when re-referred by her GP in November 2021, she was managed under standard care (meaning she was subject to annual review).

GMMH informed the panel that Bailey made contact with them *'as and when she needed prescriptions'* and identified that there had been a lack of professional curiosity around Bailey's behaviour and ad-hoc engagement with them.

The panel agreed that more could have been done to understand Bailey's situation and support her in terms of domestic abuse and exposure to criminality.

14.4.16 During the period of review, Bailey attended hospital appointments on 11 occasions. Three appointments were by telephone in relation to gynaecology consultations, during which there was no consideration given to the fact that Bailey may have been a victim of either domestic abuse or sexual exploitation.

Other appointments were related to various issues including a dog bite, throat examinations, knee pain and acid reflux. Bailey was not asked routine safeguarding questions on any occasion.

The panel noted that some of those appointments were at significant points within the period of review i.e. when Bailey may have been a victim of abuse from her

previous boyfriend and also around the time that she started a relationship with Sam.

The panel felt that these were missed opportunities to explore Bailey's vulnerabilities in a secure, clinical environment.

14.4.17 Northern Care Alliance explained that although staff have been encouraged to use routine enquiry questions during appointments to consider domestic abuse, this does not always happen. The panel felt that this was an area of development for them and other agencies and is a learning point which leads to panel recommendation 2.

14.4.18 On 28 February 2022, Bailey rang her GP and reported that she had been assaulted by her boyfriend. This was the first occasion that she made any disclosure in respect of abuse from Sam. The GP advised her to attend A & E and arranged a follow up telephone call for 4 March 2022. Bailey did not answer the call and the GP called again on 9 March 2022, this time establishing further details regarding the abuse Bailey had received. The GP noted that *'she needs referral for safeguarding / domestic abuse'*, but made no referral. It was not until 7 April 2022, that other agencies were made aware that Bailey was a victim of domestic abuse, when GMFRS reported concerns.

Bailey was not asked the name of the perpetrator on any occasion. The panel again thought it was unlikely that she would have named Sam, but felt that she still should have been asked. This may have been one of the first occasions when Bailey was attacked by Sam and at this early stage, there may have been a greater chance of Bailey feeling able to disclose the identity of the perpetrator, before their relationship became more established and she became more fearful of him.

The panel agreed that a safeguarding referral should have been made on 28 February 2022.

14.4.19 During the two consultations which Bailey had with her GP in Manchester, she was offered referrals to specialist domestic abuse services who could provide advice by telephone (IRIS Service). These referrals were offered in response to Bailey disclosing historic domestic abuse to her GP, although she declined the opportunity to speak with them.

14.5 **Was your agency aware that Bailey and Sam were in a relationship and if not, could more have been done by any agency to establish that fact?**

14.5.1 No agency was aware that Bailey and Sam were in a relationship until the fatal incident in August 2022.

14.5.2 As outlined throughout this report, when Bailey reported domestic abuse in April 2022 she provided GMP with an incorrect name for the perpetrator.

GMP held information in respect of someone with the same name and in an attempt to confirm the identity of the perpetrator, showed Bailey photographs of that individual. Bailey stated that that person was not her boyfriend.

GMP requested access to Bailey's mobile phone in order to establish a telephone number for the perpetrator which may help to identify him. Bailey stated that she had erased all data from her phone and did not provide consent for GMP to examine it.

14.5.3 GMP officers formed the opinion that Bailey was withholding information and providing misleading information to prevent them from identifying her boyfriend. She did not feel able to provide a statement or support a prosecution.

14.5.4 As outlined in 14.4.9, some panel members felt that more could have been done to identify Sam as the perpetrator. The panel saw no evidence that Bailey was informed that should she agree to provide a statement, she would be entitled to special measures[14] at court or, if the degree of threat justified it, potentially even support from the UK Protected Persons Service to keep her safe.

14.5.5 Although the exact date is unknown, considering all available evidence, the panel estimate that Sam and Bailey started their relationship around October 2021 and at that time, Sam was subject to post sentence supervision by the Probation Service. As part of that supervision, Probation Service liaised regularly with GMP in an attempt to establish whether or not Sam had formed any new relationships as failing to notify them would have breached conditions and could have resulted in either recall or return to court.

14.5.6 Probation Service had access to and checked GMP intelligence in respect of executive action involving Sam, CPS documents and police checks of various addresses linked to Sam. Nothing within any of that material suggested that he was in a relationship with anyone or linked to Bailey in any way.

14.5.7 Probation Service informed the panel that on 1 April 2022, as a result of Sam failing to attend appointments with them, a management decision was made to conduct a visit to Sam's approved address (his father's address). Sam did not answer telephone calls from them, therefore this did not happen.

[14] There are a range of special measures available, for example giving evidence from behind a screen, in private (that is without the public being in court) or via a live link so that victims do not have to face the accused. The use of video links allows victims and witnesses to take part in criminal proceedings without having to meet the accused face-to-face, thereby reducing unnecessary stress.

The IMR author informed the panel that this visit should have taken place unannounced and if this had happened, it may have established that Sam was not living where he should and may have resulted in further enquiries being made to locate him. Although this may have resulted in an enhanced intelligence picture in respect of Sam's lifestyle and adherence to sentence plan conditions, the panel did not feel that it would likely have established that he was in a relationship with Bailey.

14.5.8 Probation Service also informed the panel that in May 2022, Sam provided them with a copy of a bank statement to prove residence at his approved address.

That statement included a single transaction of £3.49 from Bailey. The panel considered whether this transfer could have been identified as being an indication that Sam was in a relationship with Bailey and agreed that this would have been very difficult to establish.

Probation Service informed the panel that they felt that the member of staff who reviewed the bank statement could have been more curious as to who the transaction was from. The likelihood of him revealing who Bailey was would have been remote, but he should have been asked, nonetheless.

14.5.9 After forming her relationship with Sam, Bailey had appointments with her GP, gynaecology specialists, GMMH and physiotherapists (regarding knee pain). On no occasion was she asked if she was in a relationship with anyone.

The panel felt that considering Bailey's reluctance to identify Sam to the police, it was unlikely that she would have informed other professionals that she was in a relationship with Sam, but she could have been asked.

14.6 **How did your agency ascertain the wishes and feelings of Bailey and Sam in relation to alleged offending and were their views taken into account when providing services or support?**

14.6.1 During the period of review, Sam was known to be in two other relationships, prior to forming one with Bailey. Sam was abusive in both and police were called to several incidents where Sam was heard or seen by third parties to be violent towards his partners.

Neither partner felt able to report abuse to the police or support prosecutions. On one occasion, police arrested Sam and instigated an evidence led prosecution.

14.6.2 Sam is recorded on GMP systems as a high risk domestic abuse perpetrator. That same level of risk is agreed by the Probation Service.

The panel felt that if GMP had been aware that Sam was the perpetrator when Bailey reported abuse in April 2022, positive action would likely have been taken, regardless of whether Bailey felt able to support a prosecution or not.

14.6.3 Sam did not wish to disclose or discuss relationships when engaging with the Probation Service.

There was a significant history through his case records of Sam failing to disclose relationships and he avoided any engagement around his behaviour, including interventions in respect of domestic abuse.

14.6.4 The panel acknowledged that Bailey was a highly vulnerable individual. She had a long history or poor mental health from a very early age. As a child, she experienced trauma in the form of witnessing domestic abuse between her parents. She was supported by mental health services throughout her childhood and adult life and reported being in a sexual relationship with her former boyfriend from the age of 14. That partner subjected her to domestic abuse and his actions would now meet the definition of coercive and controlling behaviour. That same relationship also placed Bailey at risk of sexual exploitation and criminal exploitation.

14.6.5 The panel were aware that there are a number of barriers to victims reporting domestic abuse. The Victim Support 'Surviving Justice' 2017 report contains the following information:

Barriers to reporting as cited by Victim Support caseworkers

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%

Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.6.6 The panel felt that it was likely that Bailey had normalised abuse within her relationship with her former boyfriend and Sam and that she was also too scared to fully report matters to professionals who could have helped her.

14.6.7 When Bailey did report abuse from Sam in April 2022, she made it clear that she was scared of further abuse and felt that moving away from Salford would take her away from that risk. Agencies did support her with that and collectively provided a prompt and effective response by moving her out of the area.

14.6.8 However, the panel felt that there were barriers preventing Bailey from fully disclosing the circumstances of the abuse from Sam, including his true identity. As such, the level of risk was never fully assessed and was not managed effectively.

The panel agreed that agencies never truly established what Bailey's wishes or feelings were and therefore were never able to effectively support her or withdraw her from a cycle of abuse.

14.7 **How effective was inter-agency information sharing and co-operation in response to incidents involving Bailey and Sam? Was information shared with those agencies who needed it? Was any information not shared, due to concerns around sensitivity, confidentiality, risk, data protection or any other reason?**

14.7.1 No agency was aware that Bailey and Sam were in a relationship and, as such, there was no opportunity for specific information to be shared.

14.7.2 However, it is now known that Sam was the perpetrator when Bailey reported abuse in 2022. As outlined previously, when Bailey first reported that abuse to her GP in February 2022, this information was not shared with other agencies.

14.7.3 In April 2022, when GMFRS suspected that Bailey was a victim of abuse, reports were made to GMP and the local authority the same day. Although GMP took longer to investigate those reports than they should, it did share all relevant information with other agencies who were able to support Bailey with a move away from the area.

14.7.4 Although the immediate risk to Bailey appeared to have been reduced by moving her away from Salford, the panel felt that, initially, there was a lack of clarity around who 'owned' the ongoing risk. There was an assumption on the part of Bailey's GP that protective measures were all being managed by Manchester Women's Aid and this resulted in a lack of professional curiosity during consultations with Bailey.

14.7.5 Additionally, there appeared to be a lack of clarity around the current level of risk and how that should be managed. Bailey's GP made efforts to ensure that she received support from GMMH, but the issue of her prescribed medication was not effectively managed, meaning Bailey had to return to Salford, where she was at greater risk.

The panel felt that following her move out of the area, agencies did not effectively share knowledge and this resulted in confusion. Professionals' meetings would have been useful and would also have provided GMP with an opportunity to inform agencies that Bailey felt unable to disclose the true identity of the perpetrator. This may have encouraged greater professional curiosity by all agencies, which may have helped to identify the perpetrator as Sam.

14.7.6 There is no suggestion that any information was not shared due to concerns around sensitivity, confidentiality, risk or data protection.

14.8 **Was there sufficient focus on reducing the impact of perpetrators alleged abusive behaviour towards Bailey by applying an appropriate mix of sanctions (arrest/charge) and other interventions?**

14.8.1 In March 2021, when Bailey's employer reported concerns that she may be a victim of domestic abuse from her former boyfriend, GMP did not take appropriate action. As outlined previously, when she was located, Bailey was not asked about domestic abuse, meaning no consideration was given to taking positive action to investigate alleged criminal offences or protect Bailey.

14.8.2 When Bailey reported abuse in April 2022, GMP were not able to establish the perpetrator was Sam therefore no action could be taken against him.

14.8.3 The Probation Service were unaware that Sam was in a relationship with Bailey.

Until 10 February 2022, Sam had a licence condition to disclose any developing relationships. He did not disclose any during this period or the period after the condition expired.

Upon his licence expiry, there remained a requirement for Sam to reside only at an address approved by his Probation Practitioner and permission was required before he stayed at any other address. Sam did not request to reside at any alternative property other than at his father's address.

14.8.4 On 11 April 2022, when information was received to suggest that Sam was not residing at his approved address, breach action was instigated but later withdrawn by the Probation Enforcement Team as there was insufficient evidence to support the breach. The Probation Service IMR author outlined that whilst it can be difficult to prove a breach of this nature, more should have been done to pursue the breach rather than withdraw it. This was reflected within its own review.

14.8.5 Probation Service informed the panel that the opportunity to place Sam on a formal Domestic Abuse programme was not appropriate during his most recent periods of supervision. This was due to his denial and reluctance to recognise any abusive behaviours within his relationships. The limited time left on his licence also made that option unfeasible.

14.9 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed? Are the procedures embedded in practice and were any gaps identified?**

14.9.1 During the period of review, Sam was in relationships with two other partners prior to forming a relationship with Bailey. GMP investigated allegations of abuse by Sam against both those partners and made six referrals to MARAC.

14.9.2 When Bailey reported abuse in April 2022, immediate action was taken to protect her by moving her away from Salford and into temporary accommodation. Although the police DASH assessment was medium, a referral was still made to

the SIS service and an IDVA was allocated to the case. The IDVA screened the case immediately and increased the grading to high risk, listing the case for hearing at MARAC eight days later. The panel agreed that this was the appropriate hearing and acknowledged the good practice of weekly MARAC meetings in Salford.

14.9.3 Due to Bailey being moved from Salford to Manchester, her case was transferred to South Manchester MARAC and relisted with them for 17 May 2022.

The panel agreed that although the move resulted in an additional 21 days before Bailey's case was heard, her support continued to be appropriate. Salford services implemented safeguarding measures immediately and did not close their case until Bailey was engaging with Manchester.

14.9.4 Prior to the period of review, Sam had been subject to MAPPA arrangements. In February 2021, the Probation Service contacted the MAPPA Support Unit to consider whether Sam should again be subject to MAPPA arrangements. Given there was already effective liaison in place between Police and Probation, this was not considered to be necessary.

14.9.5 In its own SFO (Serious Further Offence) review, the Probation Service identified missed opportunities in terms of accessing and sharing information with other agencies. Enquiries made to assess Sam's compliance with licence conditions could have been expanded to include housing services, children's services and substance misuse services.

The panel agreed that if this had been done, it may have identified further breaches in his licence conditions and potentially resulted in his recall.

14.10 **What knowledge did family, friends and employers have that Bailey was in an abusive relationship and did they know what to do with that knowledge?**

14.10.1 Historically, Bailey's mum suspected that she was in an abusive relationship with her previous boyfriend. She outlined her concerns to GMP and Children's Services. Her mum told officers that she believed Bailey's boyfriend exerted control over her and exploited her sexually. The GMP panel member explained that although the concerns were discussed with Bailey's family and Children's Social Care, clear offences were never identified therefore no investigation took place. Professionals agreed that the issue of the DVDS and her boyfriend's imprisonment reduced the risks appropriately.

14.10.2 Although Bailey's mum reported concerns in an attempt to support and safeguard her, this caused tension between them to the point of their relationship breaking down. Bailey's mum was frustrated that, despite the obvious risks to her from her boyfriend, she remained in a relationship with him, even when he was in prison.

14.10.3 Bailey's mum stated that at the age of 16, Bailey was brainwashed by her boyfriend, who controlled most aspects of her life and subjected her to physical abuse. Her family tried to persuade her to leave her boyfriend, but Bailey stated that she wanted to be with him.

14.10.4 Bailey's work supervisor was aware that she was in an abusive relationship and tried to offer her support and encouragement to leave her boyfriend. Bailey explained to her supervisor that she had *been 'groomed into a criminal gang from the age of around 15'* and described the gang members as being high profile in Manchester. Her supervisor explained that although her boyfriend *was 'in and out of prison'*, Bailey remained close to other members of the same gang when he wasn't around.

14.10.5 In April 2021, Bailey's employer contacted GMP and reported concerns for her safety. Several weeks earlier, Bailey had been seen with facial injuries and disclosed to colleagues that she had been assaulted by her boyfriend. Since that time, Bailey had been absent from work due to sickness but had maintained contact with her manager. That contact had now ceased and Bailey's manager had not heard from her for around 2 weeks.

As outlined previously, Police instigated a missing person investigation and located her, establishing that she was not missing.

14.10.6 Bailey did not return to her job despite her manager trying to make contact with her outside of work and after a series of letters and warnings were issued, her employment was terminated.

14.10.7 The DHR Chair spoke with Bailey's supervisor and met with a senior member of the management team and a representative from Human Resources within the organisation. The meetings were productive, with the organisation explaining that at the time that Bailey was employed by them, they did not have any processes in place to effectively identify members of staff who may be victims of domestic abuse.

They explained that since that time, they have increased strategic oversight of this area and recognise their duty to support their staff appropriately. Examples were given of how an increased awareness of domestic abuse had resulted in some supervisors identifying members of staff who were victims of domestic abuse,

encouraging them to use support services and thereby more effectively managing welfare within the workplace.

The organisation was also provided support by the DHR panel in terms of learning material.

The panel agreed that the employer should be offered further support to make improvements and this is a learning point which leads to panel recommendation 3.

The panel also agreed that this review should encourage all public sector agencies to refresh their own workplace policies for safeguarding and this is a learning point which leads to panel recommendation 4.

14.10.8 After Bailey and her boyfriend ended their relationship, her friend noticed that she began to make more effort to look after herself and seemed happier, but she still did not have any contact with her mum.

14.10.9 Bailey's friend recalls that sometime after her boyfriend was imprisoned, she met Sam. Bailey described Sam as being a 'bigger fish' in the criminal underworld.

14.10.10 In April 2022, Bailey rang her mum for the first time in around a year. She explained that she had been beaten up and was waiting to be placed into a women's refuge. Although Bailey's mum knew that the perpetrator was not her previous boyfriend (she knew that he was still in prison), Bailey did not want to give any more details about the incident. Bailey's relationship with her mum started to improve and they would occasionally meet for coffee at lunch time and kept in touch almost daily by text. They enjoyed spending time together.

14.10.11 There was an occasion where Bailey's mum could not get hold of her for three or four days and when she did, Bailey said that she was on holiday with her friend in Wales. She then admitted that she wasn't in Wales, but was actually in Cyprus with him. Bailey's mum suggested to her that the relationship sounded more than friendship, but Bailey did not confirm that to be the case. Bailey's mum asked her directly if her friend was the person who had beaten her up, resulting in her being in the hostel. Bailey said not.

14.10.12 Over the coming months, Bailey confirmed to her mum that her friend was Sam and gave her limited further information, without going into any detail. Bailey's mum explained that they both wanted to continue to stay in touch with each other, so she decided that she would respect Bailey's privacy and not try to find out more.

14.10.13 Bailey's mum recalls one occasion a couple of months after she'd first learned about Sam, where Bailey told her that she'd had an argument with him and returned to the hostel. She said that he had rung her 30 times in one day and as

such, she had blocked him. Bailey never talked about anything that happened after that incident.

14.11 **Were there any examples of outstanding or innovative practice?**

14.11.1 The panel did not identify examples of outstanding or innovative practice but did want to highlight good work by GMFRS.

Although there is a clear expectation that all professionals should take appropriate steps to address any suspicions that a person may be a victim of domestic abuse, this does not always happen; there are examples of this being the case within this review.

When Bailey attended the fire station to collect her keys on 7 April 2022, GMFRS staff were inquisitive and tried to discuss the cause of her obvious facial injuries. Despite Bailey refusing to elaborate, they still correctly identified that she was a victim of domestic abuse and needed help; they not only reported the matter to the police but also submitted a safeguarding referral the same day.

14.12 **What training did your agency provide to staff around domestic abuse? Had staff who interacted with Bailey and Sam completed the training and when?**

This area of analysis was intended to establish exactly what training had been received by professionals who engaged with Bailey and Sam. Although agencies were able to explain what training was available and 'should' be completed, few were able to provide this information in granular detail and this leads to panel recommendation 5.

14.12.1 **GMP:**

All frontline staff have attended DA Matters and Think Victim 2 training between April 2022 and April 2023. That training includes themes around risk assessment, management, onward partnership referral and safeguarding actions and is introduced through emotive case studies including requirements for investigations and evidence-led prosecution pathways.

New recruits receive training which includes:

- The definition of domestic abuse
- Controlling and coercive behaviour and the dynamics of an abusive relationship
- The stages of coercive control
- The power and control wheel
- The importance of positive action
- Victim blaming
- Non-fatal strangulation
- Voice of the child

- Adverse childhood experiences
- Op Encompass
- The DASH
- Toxic trio
- RARA
- Perpetrator behaviour
- Use of language
- Knowledge of key support agencies and partners
- Force policies and procedures

14.12.2 **Salford Children's Services**:

The panel acknowledged that Salford Children's Services had no interaction with Bailey or Sam during the period of review. No information was provided by them in relation to staff training.

14.12.3 **Wigan Children's Social Care:**

The panel acknowledged that the agency's interaction with Bailey was prior to the time frame for this review and training delivery has evolved since that time.

14.12.4 **North West Ambulance Service**:

NWAS did not have any contact with Bailey prior to the critical incident and so did not have any opportunity to explore issues or experiences around their experience of domestic violence or abuse.

All patient facing clinicians within NWAS receive safeguarding training to level 3. The content is written by the Safeguarding Team in line with the intercollegiate document. The training package is updated annually and includes scenarios to encourage discussions and is delivered by the learning and development team.

Educating staff around the wider elements of domestic abuse and the emotional and psychological effects that control and coercive behaviours have on victims has been a focus for the Safeguarding Team.

The aim has been to ensure staff utilise professional curiosity with every patient, and especially when faced with a patient who may be in mental health crisis, to explore the reasoning behind the presentation and provide a safe and supportive environment to ease any disclosures that the patient is willing to make.

NWAS Safeguarding Practitioners further complete a weekly audit of domestic abuse concerns which assists in understanding the geographical areas covered by NWAS and gives further assurance that training around the subject of domestic abuse has been understood, and that domestic abuse is adequately identified by staff and explored with professional curiosity.

14.12.5 **Northern Care Alliance:**

Prior to and during the period of this review all medical and nursing staff working in Emergency Departments across the Northern Care Alliance were mandated to attend Levels 1- 3 Safeguarding Children's training which was inclusive of the recognition and response to domestic abuse and the impact on children and young people. This training includes reference to the method and completion of DASH assessments.

At this time only Levels 1 and 2 Safeguarding Adult training were mandated in the Salford Care organisation. Level 3 Safeguarding Adult training was mandated for all medical and nursing staff in September 2019, and is also inclusive of recognition of domestic abuse, in line with Adult Safeguarding: '*Roles and Competencies for Health Care Staff (2018)',* known as the intercollegiate document.

In addition, during the period of this review, targeted standalone domestic abuse training for health care staff was provided in each Emergency Department across the new Northern Care Alliance.

In November 2021 the whole cohort of staff requiring level 3 Safeguarding Children and Adults training was reviewed and updated to provide Alliance wide consistency of provision following the formal integration of Salford Royal Hospital NHS Trust and Pennine Acute Hospital Trust forming the Northern Care Alliance. This review considerably increased the numbers of qualified and Registered staff required to undertake level 3 training.

14.12.6 **Pankhurst Trust (incorporating Manchester Women's Aid):**

Bailey's support worker had been working for Manchester Women's Aid for 6 years and had completed all domestic abuse training, including sessions on completing the DASH, safety planning, support plans and managing risk. The same training is provided to all the staff working with people experiencing domestic abuse.

14.12.7 **NHS Greater Manchester (Wigan Locality):**

Astley General Practice staff complete standard safeguarding training and as such their knowledge of domestic abuse reflects what is taught on Level 2 safeguarding training.

14.12.8 **NHS Greater Manchester (Bury Locality):**

All clinical staff within GP Practices are expected to undertake level 3 safeguarding training. The Rock Healthcare have engaged in the safeguarding assurance process for 2022/23. The following information was provided by Rock Healthcare regarding line of enquiry for domestic abuse in 2022/23:

- There is a Domestic Abuse flowchart detailing what steps to take.
- Domestic abuse is detailed in the Safeguarding Policy.
- An alert is added to the patient record, which advises all staff and other agencies that we refer to if a patient is a victim of abuse.
- Domestic abuse is coded in the patient record.

14.12.9 **NHS Greater Manchester (Salford Locality):**

Medical records suggest that Bailey's consultations were mainly with registrars, regular GP's and locum GP's. Training records suggest that most consultations were undertaken with staff who had no IRIS training at the time the consultation took place. Therefore, this identifies a gap in GP knowledge and may offer some insight into why domestic abuse pathways were not followed. On the occasions when Bailey's consultations took place with a clinician who had received IRIS training it is unclear what the barriers were to following the domestic abuse and safeguarding pathways.

There is an expectation that in any given year GP practices as a whole achieve 85% compliance as per the Salford Standard which runs April – April. In April 2022 training data suggests that the practice was 83% compliant with IRIS training. Due to the timeframe when IRIS training was embedded into practice, those practitioners who had undertaken the initial training would have been due to complete their 3-yearly refresher training in 2021-22. However, practices were under significant pressure due to resource and capacity as a result of Covid-19 which consequently resulted in a reduction in expected training compliance data at the time across the Salford footprint.

14.12.10 **NHS Greater Manchester (Manchester Locality):**

Primary Care staff in Manchester all complete IRIS/domestic abuse training with Manchester Women's Aid. The Manchester GP Practice last completed this in June 2022 and for those staff who may have missed the training all sources of information are available on the Practice's intranet and IRIS are able to provide 'mop-up' training. It is unclear if the Physician Associate and FY2 Trainee Doctor had completed this training as neither were or are employed directly by the Practice and both maintain their own training portfolio via their own employers.

Manchester Women's Aid have confirmed that Physician Associates are able to access IRIS training via their GP Practice.

The Physician Associates employer (South Manchester GP Federation) has confirmed that Physician Associates are required to have completed online level 1 domestic abuse training however, they access IRIS training via the GP Practice.

Therefore, the gap identified is that GP Practices need to seek assurance that all of their members of staff(including allied health professionals) whether employed directly by the Practice or employed by an external agency have undertaken IRIS training. Thus, patients will receive the same consistent response from all members of the primary care team.

14.12.11 **Housing Options, Salford City Council:**

Staff receive training on the homelessness legislation in relation to domestic abuse and attend the multi-agency training on DASH/MARAC and Introduction to Domestic Abuse. The Housing Options Advisor who had contact with Bailey had completed the DASH/MARAC training in July 2019 and also homelessness legislation in relation to vulnerability which included domestic abuse in July 2019. They had not attended the Introduction to Domestic Abuse course.

14.12.12 **Greater Manchester Mental Health NHS Foundation Trust (GMMH):**

Staff receive the following training:

Safeguarding level 1 – on induction to the trust
Safeguarding level 2 – eLearning
Safeguarding adults at risk of abuse and neglect level 3 mandatory training

14.12.13 **Safe in Salford:**

The duty IDVA who dealt with BAILEY is a qualified IDVA and solicitor. They had a Salford Women's Aid induction and SIS induction which included all relevant training. Their SIS induction took place in April 2022.

14.12.14 **Greater Manchester Probation Service:**

All Probation Practitioners are required to undertake Domestic Abuse training prior to supervising any case that has evidence of abusive behaviours within relationships. Sam's case was allocated to a qualified Probation Officer to manage given the complexities, level of risk and potential for domestic abuse.

The Mandatory Domestic Abuse training is currently an online package of training that should be repeated every three years. Consequently, training records from the

earlier part of this review (2018 – 2020) have been updated with the most recent dates that the training has been completed. Training includes:

- Child protection and safeguarding, eLearning, 1 hour, repeated every three years
- Domestic abuse awareness, eLearning, 1 hour, repeated every three years
- Adult safeguarding, eLearning, 1 hour, repeated every three years

Training records have been reviewed for the key Probation Practitioners in this case and identify that their training is completed in line with expectations:

Probation Practitioner 1 (Case Manager 2021 – 2022) completed October 2020
Probation Practitioner 2 (Case Manager 2020 – 2021) completed August 2021
Probation Practitioner 3 (Case Manager pre 2020) completed December 2021

14.12.15 **Greater Manchester Fire and Rescue Service:**

Regular training on domestic abuse is carried out with all firefighters and support staff by our training section. Added to this staff can enrol for training on domestic abuse offered by external partners, and particularly Salford City Council.

14.12.16 **Irwell Valley (Housing):**

All staff undertake Safeguarding and Domestic Violence training.

14.13 **What learning did your agency identify in this case?**

Taken directly from IMRs:

14.13.1 **Greater Manchester Police (GMP):**

This was a complex case and there have been issues with officers failing to identify risk and safeguarding.

Following the report in March 2021 when Bailey was reported missing following her disclosure of domestic abuse to work colleagues, it appears officers became focused on dealing with this matter as a missing person and seemed to have not considered safeguarding or domestic abuse and as such there was a missed opportunity to safeguard Bailey and take more positive action.

GMP have clear policies and procedures in place (Think Victim and Think Victim 2) and have recently reviewed and updated their Domestic Abuse Policy and Procedures to provide greater clarity to police officers on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigation. This policy sets out expectations on how GMP tackles domestic abuse at every level. In November 2022, the force launched 'DA Matters training' which was completed in March 2023. The aim is to create long term sustainable improvements and consistency in the response to domestic abuse. It tackles all issues relating to domestic abuse and also covers issues of coercive control, victim blaming and recognition of manipulation used by perpetrators. The training was mandatory for all public facing roles within GMP.

In March 2021 Bailey and her previous boyfriend were arrested for drugs offences and a crime report was submitted, however, there were few updates on the crime or meaningful supervisory reviews.

It is imperative that supervisors manage their team's workloads appropriately and that individual officers fully understand their responsibilities surrounding crime progression.

GMP have clear policies and procedures in place and the PIP 1 and PIP 2 investigation and review Policy and Procedures were recirculated in September 2023.

In April 2022 following a report by the Fire Service of a female attending the fire station with injuries a log was opened by the police, however, the log appears not to have been managed in accordance with policies and procedures.

A review has now been carried out on this log resulting in several members of staff requiring feedback and they will be given the opportunity to review how they dealt with the log and reflect on how they could have improved the level of service they provided. If necessary, the members of staff will be given further learning regarding the policies and procedures involved with this type of log.

Officers attended numerous domestic incidents during the timeframe of this review involving Sam and Bailey and their previous partners, however on a number of occasions when offences had been committed, the victim did not support a prosecution. Consideration should have been given in these cases to evidence based prosecutions which allows prosecutors in domestic abuse cases to prosecute offenders in the absence of support from a victim.

Following Bailey's arrest for drug offences in March 2021, there appears to have been no consideration of conducting an intelligence interview with her with a view

to obtaining information regarding criminality. This should be considered by all officers conducting suspect interviews as part of their interview planning.

14.13.2 **Salford Children's Services:**

Salford Children's Services had limited input with Sam and Bailey, there are some records in respect of Bailey when she was younger, and Sam in respect of a previous partner however no assessment was undertaken in respect of their relationship.

14.13.3 **Wigan Children's Social Care:**

The panel acknowledged that the agency's interaction with Bailey was prior to the time frame for this review and its response to domestic abuse and exploitation has evolved since that time.

14.13.4 **North West Ambulance Service:**

No learning was identified by NWAS.

14.13.5 **Northern Care Alliance:**

There is no evidence in the records that links the two parties together prior to the circumstances relating to this review. However there are areas of learning relating to the improvement of professional curiosity, this relates specifically to the contact with Bailey and her known partner as part of fertility investigations.

The records do not contain any evidence of further enquiry or professional curiosity that the period that Bailey and her partner reference that they were actively trying to conceive included a period when Bailey would be estimated to be 14 years old.

It is imperative that health professionals know how to enquire about concerns and feel confident that it is a legitimate and important part of their role to do so.

14.13.6 **Pankhurst Trust (incorporating Manchester Women's Aid):**

The need for regular review of case notes and safety plans is essential and line managers conduct 6-8 weekly case reviews with the keyworkers to promote reflective learning. Regular supervision and clinical supervision are also essential for client safeguarding as well as staff wellbeing and understanding.

14.13.7 **NHS Greater Manchester (Wigan Locality):**

The domestic homicide took place long after Bailey attended Astley General Practice and the practice could not have predicted that such a terrible event would

occur. However, moving forward, similar cases where children witness domestic violence and are supported for the same, should act as a prompt to explore further when they disclose that they are in a relationship themselves to ensure that they are safe.

14.13.8 **NHS Greater Manchester (Bury Locality):**

The records have been reviewed retrospectively and it would be easy to see where consultations could have been viewed differently given the subsequent circumstances. However, each contact Sam had with the GP practice took place in isolation from previous consultation and there does not appear to be any connection identified, such as the latter consultations regarding lower back pain, and follow up regarding non-attendance at A&E. No alerts were evident on the records. When Sam reported mental health concerns, the GP plan was to review in four weeks. However, the records indicate a review did not take place. Consideration needs to be given of how follow up is guaranteed for mental health patients.

14.13.9 **NHS Greater Manchester (Salford Locality):**

Recognition of early childhood experiences and the impact this can have on an individual's ability to protect themselves and how this can lead to increased vulnerabilities in adulthood especially domestic abuse.

Primary care needs to continue to enhance knowledge and skills around domestic abuse in relation to identifying health indicators, having a low threshold for making selective enquiries and making appropriate referrals to support services such as IRIS, safeguarding and to MARAC in response to high risk domestic abuse disclosures.

There may be barriers to the effectiveness of IRIS training compliance versus transfer to practice.

Primary care to continue to enhance the considerations given to individuals with a pre-existing mental health diagnosis who present with mental health symptoms in relation to a domestic violence indicator.

Greater professional curiosity around social dynamics - Hidden Males and importance of understanding role of Male within the relationship.

14.13.10 **NHS Greater Manchester (Manchester Locality):**

Primary Care to clearly document in records that they have asked about current relationship status and any current concerns for victims of domestic abuse. If there are current concerns offer IRIS referral and if declined then as per Primary Care domestic abuse policy - Primary Care to carry out risk assessment for MARAC criteria if individuals decline IRIS service.

Primary Care read codes/flags in respect to domestic abuse and safeguarding may not automatically transfer from GP Practice to GP Practice even when notes are sent electronically. However, the Safeguarding Lead GP does not believe that, had any safeguarding/domestic abuse read codes and/or flags been on Bailey's records, this would have made any difference to the x2 consultations as both clinicians did ask about domestic abuse and the FY2 Trainee Doctor did offer an IRIS referral.

All GP Practices need to seek assurance that all of their members of staff (including allied health professionals) whether employed directly by the Practice or employed by an external agency have undertaken IRIS training. Thus, patients will receive the same consistent best practice response from all members of the primary care team.

14.13.11 **Housing Options, Salford City Council:**

No learning was identified.

14.13.12 **Greater Manchester Mental Health NHS Foundation Trust (GMMH):**

There was no Professional curiosity, focus was on Bailey's mental health and medication and there was no holistic approach to her care. Lack of multi-agency communication/meetings. There was no clear risk assessment when Bailey could not attend the area due to violence. Bailey was on standard care; it would have been good practice to consider to increase her to CPA (Care Programme Approach) for coordination when staff were aware of the domestic abuse.

14.13.13 **Safe in Salford:**

No learning was identified.

14.13.14 **Greater Manchester Probation Service:**

Sam is a complex case that required a strong and robust plan and approach to supervision. Multi-agency working was essential in monitoring and managing presenting risks given there was a continued reluctance from Sam to share information about his current circumstances and whereabouts, relationships or associates. Through this review and the internal review completed upon the commission of the SFO, the following learning has been identified:

Regional learning:

- There were barriers to gaining timely responses to requests for information through **Domestic Abuse Checks.** There were times within this review where information was not shared and times where information was not obtained in a timely manner that enabled a prompt response to indications of relationships and therefore increasing risks. Work is already underway and led by the Public Protection Team to ensure Probation Practitioners are able to access this information more promptly and monitoring of the progression of this plan to its implementation is an action that has been identified within this and the SFO report.

- **Monitoring and review of Management Oversight actions** – not all actions set following management consultations were completed thoroughly and in a timely way and this appears to have prevented verification or gathering of information linked to risk, particularly in respect of gaining assurances of where Sam was residing. There is a process now in place to monitor the completion of actions set during management consultations. An action has also been identified to seek assurances that this process is used and is successful in monitoring the timely completion of actions set.

Individual Learning:

There are general themes for individual learning around Safeguarding Practices, clarity in respect of case recording and a need for a greater use of professional curiosity. A consequence of not updating assessments, recording decisions clearly or asking questions meant that there were some gaps in fully undertaking assessments and developing appropriate risk management plans for all those identified as being at risk from Sam. The consequences of this were seen more recently when enforcement action was not as robustly undertaken as the nature of the case warranted. Consequently, actions have been set to seek assurances of individual practitioners practice in this regard.

Sam was subject to a licence period between 28 September 2021 and 10 February 2022. During that period, the Probation service is able to recall an offender to custody in light of breach of conditions. Any breach of conditions within this period and consequent recall would see an automatic release date of 10 February 2022. On 10 February 2022, Sam moved into Post Sentence Supervision Licence which has a far more limited approach to enforcement. There are fewer licence conditions that offer an enforcement pathway and any breach would need to go before the Court to determine the legitimacy of the breach. The maximum sentence for this

breach would be 14 days in custody. At which point, the offender would need to be released.

Enforcement of this case was not as robust as the presenting risk warranted. Had action been taken to breach Sam at times of positive drug tests or recall him at times of avoidance of appointments, then there may have been the opportunity of disrupting those behaviours linked to risk. Enforcement action should have been pursued at times of non-compliance.

There was limited evidence of Sentence Plan delivery, particularly around substance misuse and domestic abuse behaviours. A learning point has been developed to seek assurances of sentence delivery in line with risk management and sentence plans.

Drug testing was not undertaken in line with expected practice and this impacted upon formal enforcement action being pursued. Action is already underway to seek assurances that drug testing is completed in line with frequency set within management oversight sessions and / or risk management plans.

14.13.15 **Greater Manchester Fire and Rescue Service:**

Continue to report and act upon concerns raised about domestic abuse.

14.13.16 **Irwell Valley (Housing):**

No learning was identified.

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

14.14.1 Agencies followed their own processes and protocols when supporting Bailey and Sam but did not identify any needs or issues requiring specific attention.

15 CONCLUSIONS

15.1 Bailey suffered with poor mental health since the age of around nine and received support from several agencies at various times of her childhood and adult life. As an adult, her engagement with mental healthcare professionals was intermittent, resulting in an inconsistent level of care.

15.2 As a child, Bailey was affected by the separation of her parents and the domestic abuse which she saw first-hand.

15.3 As a teenager, Bailey was involved in unhealthy relationships and from the age of around 15 was coerced into a relationship with a violent criminal who was controlling and physically abusive. That relationship continued for around six years, much of which her boyfriend spent in prison. The panel agreed that the hold he had over her was so strong that, despite her boyfriend's incarceration, she remained under his control and still associated predominantly with his family and fellow gang members rather than her own family.

15.4 By early 2021, Bailey was involved in some of her boyfriend's criminal activity, resulting in her arrest. At the same time, Bailey stopped going to work, resulting in her employment being terminated. The panel agreed that her arrest and interactions with police presented opportunities for agencies to intervene and provide an exit route from what was a violent, unhealthy and corrosive relationship. Despite GMP having information that Bailey may have previously been a victim of exploitation as a child, the panel saw no evidence that the investigating officers considered that she may be a victim of exploitation on this occasion. The investigation into her possession of drugs and money was inadequate and had not been concluded at the time of her death some 17 months later.

15.5 During the same key period, Bailey had several appointments with professionals in respect of her mental and general health, along with fertility and gynaecological matters. Despite the presence of several indicators suggesting that Bailey could be a victim of domestic abuse, no healthcare professional asked her about it.

15.6 Panel discussions considered the level of professional curiosity used by staff from all agencies who engaged with Bailey around the time of her arrest in 2021 and in the 17 months that followed. The panel agreed that on almost every occasion, more should have been done to establish that Bailey was a victim. Healthcare professionals often refer to using 'routine enquiry' when engaging with patients.

The panel acknowledged recommendation 6 of the NICE guidelines, which says that health and social care service managers and professionals should:

'Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.'[15]

The panel did not see evidence of this during appointments with Bailey.

15.7 Although the panel have little information about Bailey's lifestyle after her arrest, it appears that she did find a way to escape the relationship with her boyfriend, his

[15] NICE, Domestic violence and abuse: multi-agency working. Public health guideline (PH50), recommendations, 26 February 2014

family and his criminal associates. Sadly, by the end of 2021, she had begun a relationship with an equally violent and abusive individual, Sam.

15.8 The panel were unable to establish the circumstances in which they met. What is clear is that Sam and Bailey's previous boyfriend knew of each other through criminal activity.

15.9 The panel agreed that aspects of Sam's management by the Probation Service could have been better. It could have been more intrusive around his compliance with licence conditions, particularly around its monitoring of his living arrangements. A more robust and effective approach may have resulted in his recall to prison and Bailey's family feel let down by this.

15.10 The panel agreed that the circumstances leading to Bailey's tragic death were generally unclear and often confusing. The extent of criminality and level of violence used by both Sam and Bailey's former boyfriend were significant and that is the environment in which Bailey found herself from the age of around 15, as a victim.

15.11 Despite the complexities of this review, and the several examples of agencies not being as inquisitive as they should, the panel agreed that tragically no agency was aware that Bailey and Sam were in a relationship until after her death.

15.12 Bailey's mum takes great solace from the fact that even when Bailey was being taken to hospital after being fatally stabbed by Sam, she still did not name him. This gives her mum hope that Bailey did not realise that she was going to die.

16 Learning

This multi-agency learning arises following debate within the DHR panel.

16.1 Narrative

The links between domestic abuse and exploitation were not recognised by agencies during the timeframe of the review.

Learning

Further work is needed by agencies to enable their staff to recognise that victims can be subjected to both domestic abuse and exploitation at the same time.

Recommendation 1 applies.

16.2 Narrative

The panel did not see evidence that, during appointments, professionals considered that Bailey may be a victim of domestic abuse.

Learning

Knowledge of and consistent application of 'routine enquiry' questions would more effectively identify victims of domestic abuse.

Recommendation 2 applies.

16.3 **Narrative**

Bailey's employer did not have an effective process in place to identify domestic abuse amongst its staff or address concerns that employees may be victims of domestic abuse.

Learning

A clear workplace safeguarding policy, including for domestic abuse will enable the employer to address its duty of care to its employees and support victims effectively. The panel also agreed that this review should encourage all public sector agencies to refresh their own workplace policies for safeguarding.

Recommendation 3 and 4 apply.

16.4 **Narrative**

Agencies were unable to provide assurances that staff who interacted with Bailey and Sam had received domestic abuse training.

Learning

An effective process to check that all staff have received domestic abuse training will ensure that all staff have the knowledge to identify and address abuse and appropriately manage risk.

Recommendation 5 applies.

17 RECOMMENDATIONS

17.1 DHR Panel

17.1.1 All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that domestic abuse staff training includes all forms of criminal and sexual exploitation.

17.1.2 All relevant healthcare agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has a clear organisational policy outlining when routine enquiry questions should be asked during interactions with patients.

17.1.3 Salford Community Safety Partnership should offer Bailey's former employer support as they design and implement a safeguarding and domestic abuse policy. This should include signposting to credible learning and development resources.

17.1.4 All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has reviewed and refreshed its own workplace policy for safeguarding and highlight any changes in respect of domestic abuse.

17.1.5 All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has an effective policy in place to ensure that all staff have received domestic abuse training appropriate to their role.

Action Plan

Appendix A

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1	All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that domestic abuse staff training includes all forms of criminal and sexual exploitation.	CSP to require all agencies to provide details of staff training pertaining to criminal and sexual exploitation issues.	Agency responses.	Assurance that training across the partnership includes relevant content. Staff better able to recognise all forms of criminal and sexual exploitation.	SSAB Business Manager
2	All relevant healthcare agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has a clear organisational policy outlining when routine enquiry questions should be asked during interactions with patients.	Healthcare agencies to provide CSP with relevant policy documents	Agency records: • Policy documents • Staff training records • Audits of case records	Staff confident to conduct routine enquiry. Evidence of better outcomes for patients.	Panel members representing health organisations.

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
3	Salford Community Safety Partnership should offer Bailey's former employer support as they design and implement a safeguarding and domestic abuse policy. This should include signposting to credible learning and development resources.	CSP to provide introduction to commissioned service (Safe in Salford) to employer. Service to assist employer with learning and development resources.	Feedback from service and employer: • Implemented policy guidance. • Training programmes completed.	Employer confident in their staff safeguarding and domestic abuse competency.	SSAB Business Manager
4	All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has reviewed and refreshed its own workplace policy for safeguarding and highlight any changes in respect of domestic abuse.	CSP to require all agencies to provide details of up to date/refreshed safeguarding and domestic abuse policies.	Agency workplace policies. Evidence of dissemination of good practice.	Agencies confident in their staff safeguarding and domestic abuse competency.	SSAB Business Manager
5	All agencies involved in the review should provide the Salford Community Safety	CSP to require all agencies to provide details of up to date	Audit of staff training programmes – reach and take up.	Agencies confident that their domestic abuse staff training	All panel members.

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	Partnership with assurance that it has an effective policy in place to ensure that all staff have received domestic abuse training appropriate to their role.	and appropriate training programmes.		programmes are comprehensive. Staff confident in tackling domestic abuse issues.	

End of Overview Report ‘Bailey’