Salford Community Safety Partnership

Domestic Homicide Review in the Case of Siobhan

(Died June 2019, aged 27 years)

Period Reviewed: January 2009 to June 2019

Final Report

Independent Chair/Author: Maureen Noble

June 2021

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1. Introduction

This Domestic Homicide Review relates to the death of Siobhan, who died in June 2019. Siobhan was 27 years of age. The review panel offer condolences to Siobhan's family on their tragic loss.

The victim and assumed perpetrator are referred to by pseudonyms throughout this report. The name used for the victim has been chosen by her family. The assumed perpetrator is referred to as 'George' throughout this report. This name was randomly chosen by the DHR Chair.

The period reviewed is from January 2009 when it was first known and reported by Siobhan's mother that George had been abusive to Siobhan, until the date of Siobhan's death in June 2019. The panel chose this time period for review to ensure that the all relevant historic information was included in the review.

1.1 Key People

Siobhan (Victim – deceased)

George (Assumed Perpetrator – deceased aged 31 years)

Child 1 – Oldest Child of Siobhan and George

Child 2 – Youngest Child of Siobhan and George

1.2 Locations

Address 1 – Address where the fatal incident occurred, home of Siobhan, Child 1 and Child 2

Address 2 – Property where the tenancy was terminated due to rent arrears (February 2017)

1.3 Incident Leading to the DHR

On a day in June 2019 at 02.09 hours police received an emergency call from Siobhan's grandfather. He reported that he had received a call from George asking him to go to Address 1 to collect the children. George said that he had killed Siobhan.

At 02.16 hours police received a second call, this was from Siobhan's father. He said he was at Address 1 and that Siobhan was dead in bed and had multiple stab wounds to her upper body.

Police officers attended Address 1 with North West Ambulance Service.

At 02.18 hours George was found hanging in the garage at Address 1. He was cut down and officers commenced resuscitation. When paramedics arrived, George was taken to the local hospital in a critical condition.

It was confirmed by paramedics at the scene that Siobhan had died as a result of her injuries.

Both Child 1 and Child 2 were present at the address. It was unclear whether they had witnessed the incident.

Two days later George died in hospital as a result of his injuries.

1.4 Parallel Processes

1.4.1. Police Investigation

Following Siobhan's death a police investigation commenced, which has now concluded. The findings of the investigation will be presented to the Coroner in due course. At this stage, no other persons are being sought as being connected with either the death of Siobhan or the death of George.

Police have informed the DHR panel that the indications are that Siobhan was murdered by George, who then attempted to take his own life by hanging. George survived this attempt, however he later died in hospital as a result of his injuries.

1.4.2. Post Mortem

A Home Office post mortem established that Siobhan died of multiple stab wounds. The DHR panel has not seen toxicology reports in relation to either Siobhan or George.

1.4.3. Coronial Matters

At the time of writing this report no inquest has taken place in relation to the deaths of either Siobhan or George.

The Coroner has been updated regarding progress of the DHR and the final report has been submitted to the Coroner.

1.4.4. Referral to Independent Office of Police Complaints (IOPC)

Greater Manchester Police (GMP) made a referral to the IOPC. The DHR was made an interested party in the IOPC investigation, and terms of reference for the two processes were shared.

At the time of writing the IOPC report is unpublished. The DHR Chair has viewed a copy of the unpublished report. There are no recommendations contained in the IOPC report.

1.4.5. Pen Picture of Siobhan

Siobhan was described by her family as a lovely young woman who had everything to live for. She adored her two children and was close to her immediate and extended family.

Siobhan had a history of anxiety and depression and had been referred to Child and Adolescent Mental Health Services (CAMHS) as a young person. This review has not reviewed records of her contact with these services, but is aware from General Practitioner (GP) records that Siobhan reported adverse childhood experiences[1]. Adverse Childhood Experiences are factors within a child's life which may result in wellbeing or mental health issues in later life, including maternal alcohol issues, incidents of domestic abuse and being a young carer (Siobhan referred to these issues in 2012 when seen by the perinatal mental health team, and again in 2016 when she received psychological therapy). Siobhan's vulnerabilities in relation to ongoing mental health issues were evident in her medical records throughout the period under review.

Siobhan also experienced a traumatic event at around 15 years of age which impacted her emotional health.

It appears that Siobhan's relationship with George began around 2008/09. Around this time George was subject to a community order for common assault (this offence did not relate to Siobhan).

Siobhan and George set up home together, living in rented accommodation. Their first child (Child 1) was born in October 2011. Siobhan experienced post-natal depression (post-natal depression is a recognised medical condition which can affect women after childbirth)[2], following the birth of Child 1 and was treated by her GP. She was also referred to the specialist perinatal mental health team by her GP.

In October 2012 Siobhan was assaulted by George in an incident which resulted in Siobhan presenting to A&E with a broken nose. George was charged with assault, although Siobhan said that she did not wish to press charges against him. He was prosecuted without witness involvement and was made subject to a 12 month community order for the offence of common assault.

The relationship between Siobhan and George was said by Siobhan's family to be 'on and off' and that they began to notice that Siobhan was increasingly unhappy in the relationship. Siobhan's family said that throughout the relationship the couple spent periods of time living apart, however they always got back together. They said that Siobhan made allowances for George, as he experienced low mood, depression and thoughts of self-harm.

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1 http://www.safelives.org.uk/practice_blog/living-domestic-abuse-ace-adverse-childhood-experience

2 https://maternalmentalhealthalliance.org/wp-content/uploads/Louise-Howard-MMHA-DV-and-other-social-determinants.pdf

Child 2 was born in January 2015. Siobhan again experienced post-natal depression following the birth. Siobhan saw her GP who prescribed anti-depressant medication and referred Siobhan to Greater Manchester Mental Health Services (GMMH) perinatal mental health services. At the initial screening for counselling Siobhan disclosed historic domestic abuse by George. In later sessions with the therapist Siobhan also disclosed ongoing controlling and coercive behaviour by George.

In addition to ongoing episodes of mental ill health, Siobhan also experienced a number of recurring physical health difficulties, these appear to have largely been related to physical health issues, for which Siobhan presented and received treatment from her GP and specialist services.

Siobhan and George continued their relationship, and although they lived separately sometimes, these separations were not permanent. Siobhan's family said that she wanted the children to continue to have a relationship with their father, and this kept the couple in contact with each other even when they were not living together.

In the months leading up to the fatal incident, Siobhan had begun a new relationship and had told George that she did not intend to resume her relationship with him. (George reported to his GP in May 2019 that he had separated permanently from his partner).

Siobhan's family told the review that, in the weeks before her death, George had harassed Siobhan and would not leave her alone. They said that he was jealous and controlling and that he was using drugs heavily and frequently. **(NB this was not reported to agencies at the time and was not known by agencies involved in this review).**

George was aware of Siobhan's new relationship, although she had been very careful not to disclose it on social media, partly because of her concerns about how George would react. Siobhan was also mindful of the impact on the children and wanted to ensure that they had time to adjust to her having a new partner.

Siobhan's family told the review that she just wanted to get on with her life and settle down with her new partner and her children.

1.4.6. Pen Picture of George

The review has used agency records to construct a pen picture of George. (George's family were made aware of the review, however the DHR panel decided not to invite them to participate as there were conflicting views between the families which had the potential to cause further distress).

From agency records it appears that George had a history of aggression and violence, having been involved in offending behaviour in his youth. The review has noted this as important historical context but has not analysed these events as they fall outside of the period under review.

In 2008 George received a community sentence for an assault committed against his father, this was said to have resulted from an altercation.

George began his relationship with Siobhan sometime in 2008/09. Siobhan's family said that they felt he had always been a difficult character and that he was controlling and jealous of Siobhan from the start of their relationship.

George had a job, although he had periods of unemployment (due to redundancy). He appears to have jointly supported the family financially together with Siobhan. The review established that there were some financial difficulties in relation to rent arrears.

George reported to his GP that he had ongoing issues in relation to mental health. He experienced episodes of anxiety, low mood and depression and reported to his GP and psychological services that he experienced thoughts of self-harm. He described himself as having 'suicidal' thoughts on more than one occasion, although the review could find no evidence that he acted, or intended to act, upon these thoughts, until after the fatal assault upon Siobhan.

During the period under review George told his GP and Psychological services that he had problems with drugs and alcohol, for which he received and requested treatment. According to Siobhan's family, George's drug use appears to have increased in the weeks/months before Siobhan was murdered.

George was observed by the children's primary school to be involved in their care. School noted that, although they did not always know when the couple were together, there was an arrangement where George collected the children from school on one day per week.

1.5. Equality and Diversity

The panel considered the nine characteristics set out in the Equality and Diversity Act 2010[3] and made the following observations.

The panel noted Siobhan's gender as a protected characteristic in relation to disproportionate representation of female victims and male perpetrators.

The panel noted that Siobhan had been treated by her GP for anxiety and depression. Siobhan was also referred to psychological services and specialist mental health services in relation to anxiety and depression. On two occasions during the period under review Siobhan was pregnant and gave birth.

[3] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity#our-duties-under-the-equality-act-2010

George experienced anxiety and depression and was treated by his GP in primary care, and referred to specialist psychological and mental health services, where he received cognitive behavioural therapy.

Neither Siobhan nor George were ever diagnosed with severe and enduring mental health conditions.

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

1.6. Family Involvement in the Review

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

The family were already in contact with the local Victim Support Service and received support from a Domestic Homicide Victim Support worker.

The Chair/Author met with Siobhan's family on two occasions. At the first meeting the family were provided with information about the DHR process and provided with contacts for the Chair/Author. At this meeting the family reported that they had some concerns about the impact of events upon Child 1 and Child 2, the Chair/Author reported these concerns to the lead commissioner who passed them on to Children's Services for action.

The first meeting was held at the home of Siobhan's paternal grandparents. Seven family members were present.

The family raised the following points about the relationship between Siobhan and George.

- George had always been a difficult character and the family believe he had been abusive towards Siobhan from early in their relationship
- It was mentioned by grandmother that Child 1 had told an agency that 'she didn't like it when daddy hit her'
- The relationship had been on/off for many years. Other than for a brief time at the start of the relationship, they had separate tenancies in separate accommodation and, in the last few years they did not 'live' together although George 'stayed' at the family home.
- Siobhan's family had told Siobhan many times to separate from George. They felt that she did not do this because she was scared of what he would do, but

also that she protected him because he was the children's father. They said 'you can't understand someone's logic in these circumstances', but they always were there to support her in her choices.

- It appears that over the last couple of years they felt that Siobhan and George were not in a relationship, despite him seeing Siobhan and the children. The family may have felt that this lowered the risk to her.
- They said that, despite his behaviour and temperament, they (and Siobhan) would never have believed that he could do something like this.
- He was known to them to be a heavy drug user and they said that his drug use had increased in recent years. However, they felt strongly that no one should assume that it was his use of drugs that had led to the murder – they said drugs do not make you kill someone!
- They described George as a person who was self-oriented and narcissistic (these terms were used by the family) and someone who did not take responsibility for his actions.
- They noted that following the incident in 2012 he did not comply fully with the NPS and that the 'anger management' courses that he took did not make any difference to his behaviour.
- They could not understand why Siobhan had not wanted him prosecuted at this time – perhaps she thought he would change? However, after reading the DHR report, Siobhan's family felt that the review had provided more insight into how controlling George had been (e.g. they had not previously been aware that George had been financially abusive), and how his behaviour would have impacted Siobhan. They felt this explained Siobhan's retractions. They also felt that Siobhan's attempts to break away from George must have taken enormous strength, and that agencies who were aware of domestic abuse in the relationship had not fully recognised this.
- During the months before Siobhan's death they said that George had begun to behave more bizarrely – he would go into the house in the evening/night and just stand at the bottom of Siobhan's bed staring at her – intimidating her. Note: Police membership of the review panel said that they had not been aware of this, or they would have followed it up.
- They said that he called her names frequently and tried to make her feel small. They also said that he was extremely controlling and used intimidation to stop her from doing things. She had lost her confidence until she met a new partner.
- We talked briefly about the new relationship. Siobhan had been very careful not to say too much to George about this, although he did know that Siobhan intended to form a permanent relationship with her new partner and that she did not want to return to a relationship with George. They said that Siobhan had not yet fully discussed the relationship with the children as she wanted to give them time to adjust. She was considering their feelings about when it was best for them.

- George was jealous and they feel this fuelled his anger towards Siobhan and her new partner, and George had made threats to the new partner and to Siobhan's family.
- On the night of the incident they said that George would have known that both Siobhan and the children would be in bed when he went to the house, so they felt he must have known what he intended to do.
- The family felt that police did not provide enough support to Siobhan in relation to obtaining a non-molestation order. They said that Siobhan needing help completing the forms but that they were told this was not available due to a lack of resources.
- The family told the review that some police officers who visited them were not trained in domestic abuse and felt the point should be made that officers having the right skill set is necessary for families and victims
- They were very concerned that the children had both been found to have bruising to the front of their legs when they were examined after the incident?
- Siobhan's family said they felt agencies in general could have been more supportive of her.
- We agreed that we would meet again in January when a first draft report was available and we could then talk more about events.

The Chair/Author met with Siobhan's family again in February 2020 to discuss the findings and recommendations of the review. At this meeting the family confirmed that the review had addressed their questions and reported that they were awaiting further information about the Inquest and the IOPC investigation.

The family also confirmed that Siobhan had not been in contact with a specialist domestic abuse service and that they had all thought that, once Siobhan separated from George on a permanent basis, she would be able to get on with her life.

The family wanted time to consider whether they wished the report to use a pseudonym for Siobhan. This will be reflected in the final report following Home Office approval.

2. Conduct of the Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[4]. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

This Domestic Homicide Review was commissioned by the Salford Community Safety Partnership, following a screening meeting held in July 2019. The Home Office were notified and endorsed this course of action.

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

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.[5]

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

2.1 Terms of Reference and key lines of enquiry

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

- Establish what lessons are to be learned from a domestic homicide, regarding the way in which professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Use learning from the DHR to prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children;
- Draw up and implement a co-ordinated multi-agency action plan that ensures that learning in relation to domestic abuse is acted upon at local, regional and national level;
- Contribute to a better understanding of the nature of domestic violence and abuse;

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

- Highlight good practice.

2.2 Rationale for the Review and Terms of Reference

The rationale for a DHR is to ensure that the review process derives learning about the way agencies responded to the needs of the victim.

It is the responsibility of the panel to ensure that the daily lived experience of the victim is reflected in its considerations and conclusions.

Wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's wishes and feelings.

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

Learning from the review will help to improve services to victims of domestic abuse. A multi-agency action plan is appended that sets out the actions that agencies should undertake to improve services to victims.

2.3 Terms of Reference:

1. To establish what contact agencies had with the victim and perpetrator; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard the victim and risk assess the perpetrator.
3. To establish whether the victim's family and/or significant others knew about domestic abuse and whether they sought or received help.
4. To establish whether there were other risk factors present in the lives of the victim and perpetrator (e.g. mental health issues, substance misuse, adverse childhood experiences).
5. To establish whether other safeguarding issues (including safeguarding children and/or adults at risk were appropriately identified and acted upon.
6. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
7. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
8. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.

9. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
10. To take into account specific issues relating to diversity.

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

KL1: Did your agency know that the victim was subject to domestic abuse by the perpetrator or any other party at any time during in the period under review? If so, what actions were taken to safeguard the victim and were these actions robust and effective?

KL2: Was George known to agencies as a perpetrator of domestic abuse? If so, what actions were taken to reduce the risks presented to Siobhan and/or others?

KL3: Did agencies have knowledge that Siobhan and/or George was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors? Were agencies aware of any factors in relation to adverse childhood experiences that may have impacted the Siobhan or George?

KL4: Were agencies aware of coercive and controlling behaviour in relation to Siobhan by George perpetrator? How was this assessed and what was the outcome?

KL5: Were Siobhan's family aware that she was a victim of domestic abuse? If so, did they take any action (did the family seek or receive support from any agency in relation to domestic abuse)? Did Siobhan's family identify any barriers to accessing services? Was anyone in the local community aware of domestic abuse, if so, what actions did they take and what was the outcome?

KL6: Did agencies identify any concerns in relation to safeguarding children in their contact with the victim or perpetrator?

KL7: Were matters of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim or perpetrator?

KL8: What systems and processes (assessment, referrals, and case closures) were used in the case? Were these appropriate and effective? What might you change as a result of learning from the case?

KL9: What was the level and type of multi-agency working in the case, was this effective?

2.5 The DHR Panel

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

family engagement, media management and liaison with the Coroner's Office. In addition, the panel liaised with the police Senior Investigating Officer in relation to disclosure of relevant material.

The Community Safety Partnership appointed Maureen Noble as independent Chair and Author to oversee and direct the Review, and to write the overview report. Maureen Noble was previously employed by Manchester City Council as Head of Crime and Disorder. Maureen left this role in September 2012. She has not been employed in any capacity by Manchester City Council since that time, and has worked as an independent consultant since leaving the authority. Maureen has extensive knowledge and experience in conducting DHRs and undertakes pro-bono work with NICE in relation to domestic abuse.

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

Name	**Agency**
Maureen Noble	Independent Chair and Author
DC Suzanne Fawcett	Greater Manchester Police
Jane Anderson	Service Manager, Housing Choice and Support, Salford City Council
Manjit Byrne	Head of Cluster: Salford & Trafford, National Probation Service
Luke Kiernan	Interchange Manager, Cheshire and Greater Manchester Community Rehabilitation Company
Emma Ford	Head of Safeguarding, Children's Services, Salford City Council
Sharon Bailey	Deputy Adult Safeguarding Lead, Greater Manchester Mental Health
Andrea Patel	Designated Nurse Safeguarding Children & Looked After Children, NHS Salford Clinical Commissioning Group
Dawn Redshaw	Chief Officer, Salford Women's Aid
Mark Fitton	Community Safety Manger, ForHousing
Jane McKenzie	Domestic Abuse Lead, Northern Care Alliance
Pippa Nicolle	Named Nurse (children) Northern Care Alliance
Roselyn Baker	Principal Policy Officer, Salford City Council

2.6 Sources of Information to the Review

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

- NHS Clinical Commissioning Group (CCG) – GPs for Siobhan and George (IMR)
- ForHousing – Housing Provider Siobhan and George (IMR)

- Salford Housing Options (SHOP) – Housing Provider Siobhan and George (IMR)
- Salford Royal Foundation Trust (SRFT) - A&E, Acute and 0-19 Services – Siobhan (IMR)
- Greater Manchester Mental Health Trust (GMMH) – Mental Health Services and Peri-natal Mental Health Services (IMR)
- Greater Manchester Police (GMP) – Siobhan and George (IMR)
- North West Ambulance Service (NWAS) – Siobhan (Short Report)
- Community Rehabilitation Company (CRC) – George (Combined IMR)
- National Probation Service (NPS) George (Combined IMR)
- Bolton NHS FT (BNHSFT) – Maternity and Midwifery Services, A&E and Acute – Siobhan (IMR)
- Primary School for Child 1 and Child 2 (Short report)
- Salford Children's Services (CSC) (IMR)
- Six Degrees and Improving Access to Psychological Therapies Service/IAPT (Psychological Services) – Siobhan and George (Short Report)
- Victim Support (VS) (Short Report)

The Independent Chair/Author met with the Head Teacher of Child 1 and Child 2's primary school who then provided a short report to the review.

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

In addition to written reports, telephone conversations were held with Six Degrees Psychological Service.

2.7 Disclosure

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

2.8 Timescales for the Review

The review commenced in August 2019 with the final report being submitted to the Home Office in August 2020.

3. What Agencies Knew

3.1 Overview and key to agency contacts

As set out earlier in this report, the review covers the period January 2009 to the date of Siobhan's death in June 2019. During this period Siobhan and George had a large number of contacts with agencies. The review panel agreed that a condensed chronology should be prepared that highlighted the most significant contacts with agencies for analysis. Events contained in the condensed chronology are set out and analysed below.

It should be noted that, whilst Siobhan was a resident of the Salford local authority area throughout the period reviewed, Siobhan used A&E services and Maternity and Midwifery services (including community midwifery) in the neighbouring local authority area of Bolton. These services are separately identified throughout this report.

It should be noted that Siobhan and George were registered with separate GP practices (Child 1 and Child 2 were registered with the same practice as Siobhan).

Neither of the GP practices was aware that Siobhan and George were in a relationship together, and they were not linked on health systems, although there was one occasion in which George was present at a GP appointment with Siobhan.

George was also present at some maternity, midwifery and health visitor appointments with Siobhan.

3.2 Relevant Background Agency Contact Prior to 2009

George was supervised on a 12 month Community Order with 100 hours Unpaid Work requirement between 12th June 2008 and 12th May 2009. This was in relation to the offence of Common Assault (3 offences). These offences were not related to Siobhan.

George's compliance with this order was poor and he was breached on two occasions in October and December 2008.

It is recorded that he referred to his girlfriend during a programme session on 20th May 2008, however the girlfriend's name is not stated. It is recorded that George made "inappropriate comments about women" during a session in May 2008. He was also removed from the programme session on 16th June 2008 due to disruptive behaviour.

A post-programme review meeting was held on 4th September 2008. It is recorded that areas for further work included addressing his distortions in thinking, his alcohol use and the influence of others on his behaviour.

3.3 Events in 2009

George was further breached against the order on 27th March 2009 due to non-compliance with appointments. On 15th April 2009 he received a 28 day extension of the suspended sentence and a five day residency requirement at sentencing. The Community Order and Suspended Sentence Order terminated on 12th May 2009 and 26th May 2009 respectively.

In August 2009 Siobhan's mother reported to police that George had grabbed Siobhan by the throat, that he had been intoxicated at the time and that he had previously been violent to Siobhan.

Police attended the address and spoke to George and Siobhan. Siobhan said that it had been a verbal argument and that she did not wish to pursue the matter. Siobhan said that there had been no previous violence by George. Siobhan said that she and George were soon to be moving into a new flat. The attending officer noted this.

In September 2009, Siobhan presented to the Housing Options (SHOP) service requesting help with rehousing. She reported that she had been living with her grandparents but had moved out. George was included on the housing application. Siobhan then withdrew her application as George had secured a property and Siobhan was going to live with him.

3.4 Events in 2010

In February 2010 Siobhan presented to her GP with abdominal pain, a recent ultrasound scan showed a possible miscarriage. The GP appropriately followed up with clinical care.

In August Siobhan presented to her GP accompanied by George. Siobhan requested investigations to establish if there were any clinical reasons that she had been unable to conceive.

In November Siobhan contacted police saying that George was banging on the door and making threats. She said that George had been violent to her previously and that he was intoxicated.

Siobhan reported that she was at George's address (at this time the couple appear to have been living separately). Police attended and removed Siobhan from the address. A risk assessment (using a system that pre-dated DASH) was undertaken and a risk of 'standard' was placed on the incident. Siobhan was contacted by police with information regarding local domestic abuse services.

Four days after this incident Siobhan saw her GP and asked for support with mental health issues. She reported that she was experiencing low mood but didn't know why. She told the GP that she had previously experienced bullying and post-traumatic stress disorder (whilst at school). Siobhan requested a referral to Psychological Services.

The following day Siobhan presented to the GP accompanied by her grandmother. A depression questionnaire was conducted on which Siobhan scored highly, indicating depression. Anti-depressant medication was indicated and prescribed in line with NICE guidance (this guidance relates to the treatment and care of people presenting to general practice with symptoms of depression) [6].

A month after starting anti-depressants Siobhan's medication was changed as the initial medication did not suit her.

3.5 Events in 2011

In January Siobhan contacted her GP to say that she was feeling better but that she had not yet received an appointment for psychological services. The GP appropriately followed this up.

In February Siobhan attended her GP and reported that she was pregnant with Child 1. She was advised to contact midwifery services in line with the local protocol. (It appears that Siobhan and George were now living together).

Four days later Siobhan presented to Royal Bolton Hospital with abdominal pain, however Siobhan discharged herself before she could be seen. Siobhan's GP was notified and Siobhan was contacted to advise on what to do if she had further difficulties, and the offer of GP contact if she became concerned. This was good practice.

Two days later Siobhan contacted the Out of Hours medical service reporting that she had chest pain. On investigation this was suspected to be reflux and Siobhan was advised to contact her GP.

In March Siobhan's GP practice noted that Siobhan had been offered an appointment with the psychological service (which was provided through the GP practice).

In late April Siobhan consulted her GP saying that she could not sleep at night due to noise from neighbours and that this was increasing her anxiety. The GP wrote a supporting letter to housing on Siobhan's behalf.

In June Siobhan presented to SRFT Emergency Department reporting genito-urinary problems. Antibiotics were prescribed.

In August Siobhan presented to SRFT with abdominal pain, she was admitted overnight and received an appointment for an ultrasound scan the following day.

In late October Child 1 was born by normal delivery and both Siobhan and Child 1 were discharged two days later.

On 8th November Siobhan presented to her GP saying that she was experiencing low mood, had been tearful and that she felt guilty for 'not coping'. Siobhan reported to

[6] https://www.nice.org.uk/guidance/cg90

the GP that she had a supportive partner at home who could help her. The GP prescribed anti-depressant medication and a short course of sleeping tablets with a planned period of review, and a referral was made by the GP to GMMH perinatal mental health service.

On 18th November the Health Visitor conducted a birth visit in line with the national Healthy Child Programme (a national programme of services offered to all children) [7]. Child 1 was assessed as developing well. The HV focused on Siobhan's mental health as she had reported experiencing post-natal depression.

Siobhan was not asked questions about domestic abuse at this visit, the reason given being that George was present. (NB At this time the HV service were not aware of the report of domestic abuse reported to police in November 2010).

In December the Health Visitor conducted the required 6-8 week home visit. At this visit Siobhan was asked questions about domestic abuse. Siobhan reported that there had been two episodes of physical violence by George about two years ago.

Siobhan said that this had been alcohol fuelled and that she had banned George from drinking, and there had been no further incidents (she did not refer to the incident in November 2010). The HV noted that Siobhan had been referred to the perinatal mental health service.

Siobhan saw the perinatal mental health worker on 12th December and discussed bonding with Child 1. Siobhan talked about childhood issues and problems in her relationship with George.

The plan was to offer Siobhan cognitive behavioural therapy (CBT), which began on 22nd December.

3.6 Events in 2012

Siobhan attended a second session of CBT with GMMH in early January. The issues raised by Siobhan about her relationship with George were not explored at this session.

Siobhan attended a further session the following week, again there is no indication that relationship issues were discussed, although Siobhan had raised these at her first session.

On 23rd February a three-month home visit was undertaken to Child 1 by the HV Staff Nurse. Domestic abuse questions were asked and Siobhan disclosed that George had gone out last weekend with her consent, but that it caused arguments when he goes out. Siobhan did not disclose any current domestic abuse but said that there had been a couple of incidents of violence around two years ago.

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[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf

Siobhan said that she rarely left the house and that she didn't want to attend the children's centre as she found it difficult to meet new people. The HV was concerned about maternal mental health and followed this up, however there was no exploration of indicators of potential escalating risk in relation to isolation and low self-esteem.

On 29th February Siobhan did not attend her final CBT appointment. Siobhan was sent an 'opt in' but as Siobhan had not responded to the letter she was discharged from the service.

At the end of March, HV made a home visit to Siobhan and Child 1 and offered Siobhan mental health support. It was noted that Siobhan looked and felt well and Siobhan said that the relationship with George had improved. Siobhan said there were no domestic abuse issues and that George had said he would be willing to attend the 'Relate' service.

On 25th April HV made a home visit at which Siobhan reported that George had been made redundant. There is no indication that HV considered a potential escalation of domestic abuse risk in relation to loss of employment (this may have been because Siobhan had not identified any current domestic abuse in other contacts).

On 29th May Siobhan attended Bolton NHS FT A&E department with a corneal abrasion to her right eye. This was treated and Siobhan was referred to the outpatient clinic. There is no indication of whether targeted enquiry was made in relation to this injury given Siobhan's history of domestic abuse. It is not clear whether this is due to a lack of recording or access to historical records. The review therefore makes the assumption that no targeted enquiry was made.

On 31st May HV conducted a further home visit to support with emotional health . Both Siobhan and George were present and HV noted that George was still unemployed. There is no indication of discussion in relation to domestic abuse at this meeting.

In July HV conducted a further home visit. HV noted that George now had a new job and Siobhan said that things at home were much better, and that George had really bonded with Child 1. Siobhan said that she would contact HV if she felt she needed support at any point in the future.

On 14th October a friend of Siobhan's contacted police to report that George had assaulted Siobhan whilst at a friend's house.

Police spoke to Siobhan and George. Both said they had been drinking at a friend's house when Siobhan had tried to leave due to George 'being very drunk'. An argument ensued and Siobhan stated that the next thing she remembered was coming round on the floor choking on her own blood.

George claimed that Siobhan had walked into a wall. The friend stated that after this incident Siobhan had said that George had drunk a full bottle of vodka and that

during the assault she had fallen to the floor where he had continued to punch her and stamp on her.

A DASH risk assessment recorded the incident as standard risk, however on review by a Specialist Officer this was raised to Medium risk. The officer at the time recorded that a discussion took place with Children's Social Care (CSC) regarding the incident, however no referral was made to CSC as Child 1 was not present at the incident, having stayed with grandparents.

Specialist Officers from GMP made contact with Siobhan who stated that George had never done anything like this before and it was a 'silly mistake', however on the initial crime report Siobhan stated that George was aggressive when he consumed alcohol.

That same day at 03.20 hours Siobhan presented to Bolton A&E by ambulance reporting an assault by her partner. Siobhan reported she had been punched in the face. Siobhan was referred to the ENT clinic and was assessed. Siobhan received injuries of a laceration to her nose requiring stitches, a broken nose and a chipped tooth. There is no indication that Siobhan was asked questions about domestic abuse or offered referral to specialist domestic abuse services. It would not have been routine practice in the service at this time for Siobhan to be offered any specific domestic abuse assessment (e.g. RIC).

George was arrested and given bail conditions not to contact Siobhan, however Siobhan asked for these to be removed as she said she wanted to return to the relationship. Siobhan provided a retraction statement and declined the offer of any further support. (NB police pursued a prosecution without witness statement and George was convicted despite Siobhan withdrawing her support).

On 23rd October Siobhan was reviewed in the ENT clinic, at this time she said that she could not properly remember what had happened as she had been intoxicated.

On 15th November George appeared in court in relation to the assault on Siobhan. The hearing was adjourned for a pre-sentence report.

On 29th November George was interviewed in respect to a Pre-Sentence Report. He was subsequently sentenced and was supervised on a 15 month Suspended Sentence Order with IDAP and Supervision requirements between 6th December 2012 and 5th March 2014. (NB It was recorded that George complied well with this order and did not have any breaches).

3.7 Events in 2013

On 23rd December George attended his GP reporting low mood and chest pains. He said he had been feeling unwell for some weeks. It was noted in the GP records that it had been 26 months since George had last sought a GP consultation. George said that he sometimes felt like he wanted to harm himself, however he reported no active plans to self-harm. The GP conducted a PHQ9 (an inventory of depression) which showed George to have a high score indicating depression (he scored 23 out

of a possible score of 27). An appointment was made for George to see the Primary Care IAPT service. George was commenced on anti-depressant medication.

George completed the NPS IDAP (a perpetrator programme focusing on addressing behaviour in relation to domestic abuse) on 8th August 2013.

3.8 Events in 2014

On 13th January George saw his GP who repeated the PHQ9 questionnaire. George had a score of 11/27. He reported feeling much better and not having chest pains. It was planned that George continue with anti-depressant medication and would be reviewed in one month's time.

On 14th January Siobhan attended an appointment at Bolton NHS FT Maternity Service. No concerns were identified.

On 29th January George attended his first session with the Primary Care IAPT service. He reported feeling low, angry and frustrated before coming to the appointment, he reported he was taking anti-depressant medication and also reported a history of violence and domestic abuse.

On 26th February George attended a further appointment with Primary Care IAPT service at which he reported increased stress, the notes do not state a reason for this, but George was appropriately stepped up to Step 3 as he was deemed to require more intensive support to address longer term issues.

On 5th March the Suspended Sentence Order terminated as planned.

On 16th April the GP received notification from GMMH that George had not responded to requests to contact them for an appointment and had therefore been discharged from the service.

George attended two further sessions with the Primary Care IAPT service at which he reported improvements in his mood. He was asked about suicidal thoughts and said these were 'fleeting', but that he had no thoughts to self-harm.

On 12th May Siobhan was briefly admitted to Bolton NHS FT with abdominal pain and was discharged the same day. At this time Siobhan was pregnant with Child 2.

On 21st May George did not attend his planned appointment with the Primary Care IAPT service. His key worker contacted GMMH and learned that he had not taken up the offer of services with them and had been discharged. It is unclear whether the GP was notified of George's lack of engagement.

On 20th June Siobhan attended ante-natal clinic for a routine appointment, she was accompanied by George. At this appointment no questions were asked regarding domestic abuse. (NB is it is noted by the review that the records now contained information regarding the assault by George in 2012).

On 7th July, ForHousing received a letter from Siobhan in which she said that she had not been a joint tenant with George for the past month, and that this was due to a breakdown in their relationship

Between 23rd July and 3rd September Siobhan attended three routine ante-natal appointments. At the appointment on 3rd September it was noted that Siobhan was seen alone. She was asked about domestic abuse and said she had no concerns. She also informed the service that she was now living at a new address.

Siobhan attended two further routine ante-natal appointments in October and December, at which no concerns were identified.

3.9 Events in 2015

In January Child 2 was born by normal delivery. Both Siobhan and Child 2 were well and discharge took place as planned.

At a GP consultation on 20th January Siobhan told the GP that she was experiencing post-natal depression and was not coping well with looking after Child 2. She said that her partner was helping her. Siobhan said that she was experiencing low mood and did not want to leave the house. Anti-depressant medication was commenced. The GP wrote to HV to inform them of Siobhan's presenting symptoms and requested surveillance by HV. Siobhan was also referred to GMMH perinatal mental health service. This was good practice.

GMMH noted receipt of referral from Siobhan's GP and a letter was sent to Siobhan informing her that the service no longer offered perinatal health services and offering Siobhan an appointment on 6th February with their psychological services.

Siobhan again presented to her GP on 26th January, she was accompanied by George at this appointment. Siobhan reported that she felt more anxious and generally unwell. She reported some improvement in mood and that she did not have thoughts of self-harm. However, she felt the anti-depressant medication did not suit her, and it was agreed to change to a different anti-depressant.

On 30th January HV conducted a home visit to Siobhan and Child 2. Child 2 was noted to have a medical need for which a referral was made. There were no other concerns about Child 2. HV noted Siobhan's anxiety and depression and that this was being managed by the GP.

HV also made routine enquiry regarding domestic abuse, about which Siobhan said she had no concerns. Siobhan said that she was planning to go back to live with maternal grandmother for support when George went back to work. It is not clear whether George was present at this visit.

On 10th February Siobhan attended an initial screening/assessment appointment with GMMH at which she disclosed historic domestic abuse by George and that she felt that George had been coercive in relation to her pregnancy.

At this session Siobhan disclosed that she had experienced a traumatic event in 2006. There is no evidence of trauma informed practice (practice which recognises the impact of previous trauma on individual's presenting conditions and needs), exploration of the issues raised or assessment of risk, nor was there any consideration of making a referral to specialist domestic abuse services.

That same day Child 2 and Siobhan were discharged from the Bolton Community Midwife service.

On 12th February SRFT HV made a home visit. Siobhan reported that she and Child 2 were well and had been living at the family home address, not with maternal grandmother as had been previously planned.

A further home visit by the HV took place on 5th March to conduct the 6-8 week assessment of Child 2. It was noted Siobhan was struggling with low mood and that she was awaiting a counselling appointment. HV offered support and encouraged Siobhan to attend Sure Start. George was present at the visit and HV recorded that she was unable to ask domestic abuse questions for this reason.

On 26th March George attended a GP consultation at which he requested anti-depressant medication. George reported that he had stopped taking the medication previously prescribed. The GP undertook anxiety and depression screening. George disclosed that his symptoms were causing problems with his partner who had recently had a child. There is no indication that the GP made further enquiry regarding the nature of the problems or the impact on partner or the children.

Between 31st March and 14th April Siobhan attended three appointments with a therapist at GMMH. At the third session Siobhan disclosed details of her own adverse childhood experiences which included maternal alcohol issues, domestic abuse and being a young carer. There is no indication that any of these sessions explored adverse childhood experiences, trauma or domestic abuse.

At a home visit by the HV on 22nd April Siobhan said that she was feeling much better and that George was helping with Child 2.

That same day Siobhan attended an appointment with the therapist at GMMH at which she disclosed controlling and coercive behavior by George. Siobhan was given information about support available from the 'Women's Centre'. There is no indication of exploration of risks to Siobhan or the children or any consideration of referral to specialist domestic abuse services.

At a therapy session with GMMH on 12th May Siobhan reported an improved relationship with George and described him as her best friend. Siobhan reported that her mood had improved. This appears to have been taken at face value, with no exploration of previous reports of coercive and controlling behavior.

On 25th June Siobhan's GP received notification from GMMH that Siobhan was being discharged from the service. They reported that Siobhan had attended eight of

twelve planned sessions. The discharge report said that no safeguarding or risk issues had been disclosed during therapy.

On 15th December George attended a GP consultation at which he disclosed that he was experiencing low mood. He reported that he had been drinking every night for the past eight weeks and was trying to reduce this. He said he did not use illicit substances. Anti-depressant medication was commenced. There appears to have been no exploration around the impact of George's behaviour upon his family.

3.10 Events in 2016

At a home visit by HV on 5th January, it was noted that Siobhan 'looked well'. George was present at the visit and it is recorded that domestic abuse questions were not asked due to his presence.

On 2nd February George attended a consultation with his GP. George reported low mood with associated symptoms of blunting of affect, loss of confidence, poor self-esteem, loneliness, increased periods of tearfulness, guilt, loss of concentration, loss of interest. George reported suicidal ideation but said that the children were a protective factor.

George reported a recent relationship breakdown one week previous and that he was living away and sleeping on a sofa. George said that he was also having problems at work and was facing disciplinary action at work due to his attitude. George also reported financial problems.
Hamilton Scales for anxiety and depression was undertaken and scored 16/21 for anxiety and 17/21 for depression.

George disclosed alcohol use of 32 units weekly and a history of use of illicit substances including cannabis and cocaine. The treatment plan was to continue anti-depressants and the dose was increased. He was given the telephone number of Primary Care Psychology services to self-refer. He was given a note to take two weeks off work.

On 17th February George attended an initial appointment with Six Degrees. The assessment noted that George had a long history of low mood and anxiety, more recently triggered by the break-up of his relationship with his girlfriend with whom he had two children.

He described daily thoughts of wanting to end his life but denied any current thoughts or plans. He stated that he would never act on these thoughts and identified his two children as a reason to continue.

George said he drank 14 units per day of alcohol (a much higher level than previously disclosed), used cannabis daily and weekend use of cocaine. George requested referral to the Drug and Alcohol Team. He described a long-standing issue with anger when he has been drinking.

On 17th March, the service contacted George by phone. He reported he was engaged with the Drug and Alcohol team and would like to continue sessions with psychological services. He was offered an appointment in April 2016, and informed that a new worker would take over the clinic in May 2016. George stated he would prefer to wait until May to see a consistent practitioner.

On 2nd August, ForHousing issued a notice to seek possession to Siobhan and George due to rent arrears. A previous change of tenancy request had not been actioned as it had not been signed and no manager was available to authorise approval.

On 5th September Siobhan attended a consultation with her GP at which she discussed problems with a contraception implant. She said that at this time she was not in a sexual relationship.

On 7th September anti-depressant medication was indicated and prescribed. The GP discussed removal of the implant and a review of Siobhan's anxiety and depression and Siobhan was advised to return if anxiety and depression did not improve following removal.

At a further appointment with the GP on 13th September anti-depressant medication was reviewed and it was agreed that Siobhan would stay on the same medication.

At a consultation with his GP on 16th September George reported ongoing low mood and experiencing thoughts of self-harm/suicide, although he had no plans to act on these. George reported that he was working and that this was stressful. Anti-depressant medication was prescribed with a review planned for two weeks' time and a self-referral to Primary Care Psychology services was advised.

George was reviewed by the GP on 30th September when an improvement in symptoms was noted, George was to continue on anti-depressant medication.

Between 17th and 26th October George attended three counselling sessions with Six Degrees at which he discussed fleeting thoughts of self-harm and referred to his children as protective factors.

3.11 Events in 2017

On 24th February, following a number of interactions with Siobhan and George, ForHousing terminated the tenancy. George gave a forwarding address in Bolton where he said he would be living with his new partner.

On 1st May police received a call from Siobhan's mother saying that George had turned up at their home and had refused to leave. Siobhan reported that she believed George to be drinking and using cocaine.

She said she had told him that the relationship was over, but he refused to believe this. A DASH risk assessment was undertaken and assessed as 'standard'. The DASH assessment recorded that debt issues were identified, Siobhan said she had taken out a loan to assist George with debt.

The attending officer spoke to Child 1 who said that they 'don't like it when mum and dad shout at each other'. A referral was made to Children's Services and a 'Strive'[8] referral was made (Strive is a local process to review 'standard' risk domestic abuse incidents and to offer support). Siobhan was contacted by Strive and told them that the situation had calmed down and that George had not made any further contact.

On 12th May Siobhan attended a GP consultation, it was noted by the GP that it had been eight months since her last consultation. Siobhan reported some physical health issues and that she was feeling stressed, but that this may be due to applying for a new job. A referral was made for an unrelated physical health issue and the GP gave Siobhan information on the Primary Care Psychology service and informed her that she could make a self-referral.

Siobhan had a further GP appointment on 24th May at which the GP reviewed results of blood tests and put in a place a treatment plan for the physical health issues identified.

At a further GP appointment on 30th May Siobhan reported worsening of symptoms of anxiety (which could have been related to a medical condition) and reported almost daily panic attacks. Additional medication was prescribed.

3.12 Events in 2018

On 29th March NWAS received a call for an emergency ambulance in relation to Siobhan experiencing ongoing abdominal pain. Triage was undertaken and it was determined that Siobhan did not require an emergency ambulance.

On 30th March Siobhan presented to Bolton NHS FT A&E with abdominal pain. Siobhan was assessed and discharged. During assessment Siobhan described the relationship with her partner (George) as being on/off but did not make any disclosures regarding domestic abuse.

On 22nd April police received a call from Siobhan's sister in which she reported that threats had been made to her and her family by George. Siobhan's sister expressed concern for Siobhan in relation to George making threats to her in front of the children. Siobhan was spoken to by police who said that she felt events had been 'over dramatised'. The incident was not recorded as a domestic abuse report and was closed.

On 8th May George attended a GP consultation at which he reported low mood. He said that he lived with his partner and two children

On 18th May Siobhan presented to her GP reporting symptoms of low mood and anxiety, this was her first presentation in relation to mental health since May 2017. Siobhan requested an increase of anti-depressant medication. She told the GP that

[8] https://talklistenchange.org.uk/news/145-working-to-end-domestic-abuse-our-huge-contract-win-to-deliver-services-across-greater-manchester

she had an on/off relationship with her partner and was feeling low. Blood tests were taken to measure thyroid levels and Siobhan was given information regarding self-referral to counselling services and medication was increased with a plan for review.

On 4th September Siobhan presented to her GP reporting that she was experiencing anxiety (flashbacks) about an incident in which Child 1 had been injured in an accident on an escalator (there was no implication of abuse in this incident). She said that she had recently started a new job, but had lost the job due to taking time off when Child 1 was injured. She said that she felt anxious and overprotective towards the children. Siobhan was given a four week 'fit note' and advised to self-refer to counselling services.

On 17th October Siobhan presented to her GP with symptoms of lower abdominal pain. She requested investigations as she had experienced similar difficulties a number of years ago. She reported that she was in a stable relationship at that time (it is not noted whether this was George).

3.13 Events in 2019

On 15th May George presented to his GP reporting intermittent feelings of depression which had lasted for several weeks. The GP noted that this was George's first consultation in over 12 months. He said he had recently split up with his partner. He said that he was working and was enjoying his job, although it was stressful. George said he had no thoughts of self-harm/suicide and that anti-depressants had been helpful in the past. The GP prescribed anti-depressants and advised George to look out for 'red flags' in relation to thoughts of self-harm. There was a plan to review in one month.

On 25th May Siobhan telephoned police to report that George was being abusive to her when he was collecting the children (she said that the relationship had ended). She told police that George had threatened to 'put her head on a stick'. Siobhan stated that George was due to drop the children home later that day. She stated at this time that she was scared of him and what he will do, believing that he was a danger to her but not to the children.

That same evening Siobhan's father called police to report the matter, however the call handler refused to take details from him. He called back at 21.23 p.m. when the call handler noted that he was 'rude' and may have been intoxicated, again the call handler refused to discuss the matter with him.

Siobhan was recalled at 21.42, there was no reply to the call and a message was left apologising for the delay in contacting her. This was followed by a rapid text sent at 23.44.

On 25th May Victim Support received an electronic referral to their service, they tried to make contact with Siobhan by phone but could not obtain a reply. Siobhan did not

make contact with the service therefore they were unable to provide a service to her.

On 26th May at 09.27 hours an attempt was made to call Siobhan, however there was no answer. Siobhan then called back at 09.39 to say that she was not available until 19.00-22.00.

The incident was not serviced by police until 28th May at which point Siobhan said she did not want to make a statement or for George to be spoken to as he had not been in contact since she told him she intended contacting the Police. A Domestic Violence Prevention Notice (DVPN) could have been considered. It appears that this was not given consideration, possibly because the FWIN and PPI were assessed as standard. As a consequence, the incident did not reach triage process where DVPN/DVPO would have been considered.

NB: Siobhan's family said they felt that the gravity of the situation when victims call in distress doesn't always seem to be recognised and that this would impact the confidence of victims to make reports.

A DASH risk assessment was completed and was recorded as standard risk. An Operation Encompass[9] (Operation Encompass is an initiative designed to inform schools and other key agencies where children are living in a household where a domestic abuse incident has taken place). referral was made via the electronic system. NB It was the beginning of the school holidays which delayed the notification being picked up by the Primary School.

On 30th May Siobhan presented to her GP requesting oral contraception. Although not recorded in GP records, the GP recalled that Siobhan said she was now in a relationship with a new partner.

On 5th June the events described at 1.3 of this report took place which resulted in the death of Siobhan.

[9] https://www.operationencompass.org/

4. Learning from the Review

4.1 Learning in relation to key lines of enquiry

4.1.1. KL1

Did your agency know that the victim was subject to domestic abuse by the perpetrator or any other party at any time during in the period under review? If so, what actions were taken to safeguard the victim and were these actions robust and effective?

During the period under review Siobhan made disclosures of domestic abuse to some of the agencies that she had contact with.

The first recorded report of domestic abuse to police was by Siobhan's mother in 2009. This was followed by a report from Siobhan in November 2010, when she said that George had been violent to her in the past. A risk assessment of 'standard' was placed on the incident. Siobhan was contacted with information regarding local domestic abuse services, which was good practice.

Following the birth of Child 1 in 2011, there was an opportunity to enquire about domestic abuse at the birth visit by HV, when Siobhan reported that she was experiencing post-natal depression. However, George was present and the HV was therefore unable to ask about domestic abuse in a safe way. NB: At this time the HV service were not aware of the previous report of domestic abuse reported to police.

At a follow up visit in December questions were asked about domestic abuse and Siobhan reported episodes of physical violence two years ago. The primary focus of this visit was on Siobhan's mental health.

When Siobhan saw the mental health worker at GMMH in December of that year she discussed issues in her relationship with George. This resulted in a referral for CBT which began on 22nd December. Siobhan disclosed historic domestic abuse and vulnerabilities at this and future sessions, however there was no exploration of domestic abuse or referral to specialist domestic abuse services.

When the three month home visit was undertaken to Child 1 by the HV, domestic abuse questions were asked and Siobhan disclosed that George had gone out and had been drinking and that this could cause tensions. Siobhan did not disclose any current domestic abuse but said that there had been a couple of incidents of violence around two years ago. At that visit Siobhan said that she rarely leaves the house and that she didn't want to attend the children's centre as she finds it difficult to meet new people.

The next domestic abuse incident reported to police was by a friend of Siobhan on 14th October 2012 when Siobhan sustained a broken nose in an assault by George.

Initially this incident was recorded as standard risk and was upgraded to medium risk when reviewed by Public Protection Unit (PPU). The review panel concluded that this incident could have been assessed as high risk, which would have led to a referral to

MARAC and would have afforded an opportunity to identify the risk posed to Siobhan by George, to share information with other agencies and to offer specialist support to Siobhan.

The review noted that police pursued prosecution of George despite Siobhan not wishing to support this. As a result, George received a 15 month suspended sentence. However, the outcome of the prosecution and sentence did not result in engagement in a support service with Siobhan, although attempts were made to contact her.

At the time of this incident Siobhan presented to Bolton A&E by ambulance and reported that she had been assaulted by her partner. Siobhan had a broken nose and other injuries to her face. Siobhan was referred to the ENT clinic. There is no indication in the records that Siobhan was asked questions about domestic abuse. It is noted by the review that this would not have been expected practice at that time.

When she was pregnant with Child 2, there was a further opportunity to enquire about domestic abuse when Siobhan attended ante-natal clinic at Bolton NHSFT for a routine appointment, at the time she was accompanied by George. At this appointment there is no indication in the records that questions were asked regarding domestic abuse, although Siobhan's records contained information regarding the previous domestic abuse incident in October 2012 together with information that Siobhan experienced anxiety and depression.

In January 2015 following the birth of Child 2, HV noted Siobhan's anxiety and depression and that this was being managed by the GP. The HV also made routine enquiry regarding domestic abuse, about which Siobhan said she had no concerns. Siobhan said that she was planning to go back to live with maternal grandmother for support when George went back to work. It is not clear whether George was present at this visit.

In February of that year Siobhan attended an initial screening/assessment appointment with GMMH at which she disclosed historic domestic abuse by George, including coercion and control in relation to her second pregnancy. Siobhan disclosed that she had experienced a traumatic event in 2006. There is no evidence of exploration of the issues raised or assessment of risk to Siobhan, nor is there any attempt to refer to specialist services for domestic abuse or the trauma she had experienced in 2006.

A further home visit by the HV took place on 5th March at which George was present. HV recorded that they were unable to ask about domestic abuse because of this. At a further home visit in January George was present at the visit and it was recorded that domestic abuse questions were not asked for this reason.

On 1st May 2017 police received a call from Siobhan's mother saying that George had threatened Siobhan. A DASH risk assessment was undertaken in which debt issues were identified, Siobhan said she had taken out a loan to assist George with debt.

The DASH was set as standard risk. The attending officer spoke to Child 1 and recorded that Child 1 said she doesn't like it when mum and dad shout at each other.

It was good practice for the attending officer to seek the views of the child and to discuss this with Children's Services.

Given the history of domestic abuse it would have been good practice to review the risk rating of standard, as there was a potential indicator (i.e. debt) that George was coercive and controlling in his relationship with Siobhan.

Children's Services did not fully take into account the history of domestic abuse based on information from the incident in May 2017 and the case was closed with no further action.

On 28th April 2018 police received a call from Siobhan's sister reporting threats made by George's sister to herself and her family. Siobhan's sister expressed concern for Siobhan in relation to George making threats to her in front of the children. Siobhan was spoken to by police and said that she did not have any current concerns and that events had been 'over dramatised'.

When the incident of 25th May 2019 was reported to police a crime was recorded of Malicious Communications and flagged as a Domestic Abuse Crime, the incident was open and closed as a Domestic Abuse Incident. NB this incident is being investigated by the IOPC and has been reviewed by GMP's Professionals Standards Branch (PSB).

This also presented a second opportunity to consider DVPN/DVPO. A supervision review of the crime *may have considered* a DVPN, however the action for a review by a supervising officer was not responded to prior to the tragic deaths and it is unlikely it would have got through the DVPN and court process in time.

The GMP Policy and procedure in relation to DVPO is currently being reviewed and re-written.

It is the view of the panel that this incident could have been assessed as high risk, as George had said he would "put Siobhan's head on a stick" and that this could have been perceived as a threat to kill. Had the incident been assessed as high risk a referral to MARAC would have taken place. By the time of Siobhan's murder police had not followed up the incident with George.

In summary Siobhan made a number of disclosures of previous domestic abuse to A&E, Health Visiting Services, Counselling and Mental Health Services and to Police. There were only two documented occasions on which Siobhan was provided with information about domestic abuse services, and no evidence to suggest that any service considered making a referral to specialist services on behalf of Siobhan.

In addition, there were missed opportunities to make targeted enquiry with Siobhan regarding domestic abuse, based on her presenting mental and physical health issues.

4.1.2. KL2

Was George known to agencies as a perpetrator of domestic abuse? If so, what actions were taken to reduce the risks presented to Siobhan and/or others?

George was known to be a perpetrator of domestic abuse in his contact with the National Probation Service in 2008/2009 and 2010. The offences in question did not relate to Siobhan and therefore no attempts were made to contact her with regard to safety planning.

At the time of the incident in October 2012 when George assaulted Siobhan and broke her nose, he was identified as the perpetrator by Greater Manchester Police, by the Courts and by the Community Rehabilitation Company. Siobhan also disclosed that it was George who had caused the injury with which she presented to Bolton NHS Foundation Trust A&E. Whilst George was successfully prosecuted for the assault, other than attempts by the Women's Safety Service (contracted by CRC) to contact Siobhan, there were no other risk assessments or safety planning put in place for Siobhan. There was no indication that any agency involved considered referring Siobhan to specialist domestic abuse services.

Siobhan also disclosed that she had been a victim of domestic abuse in the past at the hands of George during therapy sessions with GMMH. There was no attempt to gather further information regarding George as the perpetrator of this abuse, nor was there any consideration of referring Siobhan to a specialist domestic abuse service.

In relation to the assault in 2012, police officers undertook a DASH risk assessment with Siobhan which was marked as standard risk, this was however increased to medium risk after management supervision. Given the severity of Siobhan's injuries the DHR panel considered that the risk could have been assessed as high and a referral could have been made to MARAC. This was a missed opportunity to safeguard Siobhan.

Police demonstrated good practice when they brought a prosecution against George, although Siobhan had said that she did not wish to prosecute and refused to make a statement.

When Siobhan disclosed to the therapist at GMMH that she had been a victim of domestic abuse by George no further information was explored and no further action was taken. This was a missed opportunity to explore current risks with Siobhan and to discuss and make a referral to specialist domestic abuse services and to share information with other services (with Siobhan's consent).

George spoke to Primary Care Psychology services about his anger and depression and linked these to difficulties in his relationship. This was not explored further with George and this was a missed opportunity to identify George as a perpetrator of domestic abuse and to consider assessing risk and sharing information.

4.1.3 KL3

Did agencies have knowledge that Siobhan and/or George was experiencing difficulties in relation to drugs, alcohol, mental health or other vulnerabilities/risk factors? Were agencies aware of any factors in relation to adverse childhood experiences that may have impacted the Siobhan or George?

Siobhan

There is no indication that Siobhan had problems in relation to drugs or alcohol in her contacts with agencies or according to her family.

Siobhan presented to her GP frequently and from an early age reported mental ill health, including anxiety and depression. Siobhan was later (2017) diagnosed with an ongoing medical condition for which she was treated, however some of the symptoms of this condition could also have been a result of mental health issues. There is no indication throughout Siobhan's contact with her GP that the possibility that her mental health presentations may have been linked to domestic abuse was considered.

Siobhan experienced post-natal depression after the birth of both her children, for which she was treated with anti-depressant medication by her GP and supported by the Health Visitor. There was no exploration of whether domestic abuse was a factor in Siobhan's presenting issues in both episodes. Although practice was different at this time, there were opportunities to identify links between Siobhan's post-natal depression and domestic abuse as a potential underlying factor.

Siobhan was advised by her GP to seek support from the Primary Care Psychology service which was good practice.

Siobhan was also referred to specialist perinatal mental health service (GMMH) for cognitive behavioural therapy. There is no indication that any of these sessions explored adverse childhood experiences or domestic abuse. At the third session Siobhan disclosed details of her own adverse childhood experiences which included maternal alcohol issues, domestic abuse and being a young carer. She also disclosed a traumatic event that had taken place when she was around 16 years of age. There is no indication that the service explored Siobhan's disclosures, nor of any attempt to refer Siobhan to specialist services, or conduct a risk assessment or safety planning for Siobhan.

Siobhan attended the majority of her CBT sessions with GMMH, however she was discharged from the service when she did not attend her final appointment. Discharge under these circumstances is expected practice, however there was no apparent consideration of whether Siobhan remained at risk of domestic abuse when she was discharged from the service, and no communication with Siobhan's GP regarding Siobhan's disclosures of domestic abuse by George.

In summary there a number of contacts, throughout the period reviewed, where Siobhan presented with mental health issues that, on further exploration, may have been related to domestic abuse.

Siobhan received appropriate clinical treatment for presenting mental health issues, however, opportunities were missed to establish whether domestic abuse may have contributed to Siobhan's mental health issues.

George

George presented to his GP on many occasions reporting mental health problems, including anxiety, depression and thoughts of self-harm and suicide. George was referred to the Six Degrees counselling service on two occasions which was expected practice.

As well as presenting with mental health problems, George also disclosed drug and alcohol issues to his GP and to the Primary Care Psychology service, by whom he was referred to the Drug and Alcohol service, which he attended, although engagement does not appear to have been sustained.

On 29th January 2014 George attended his first session with Six Degrees. He reported feeling low, angry and frustrated before coming to the appointment, he reported he was taking anti-depressant medication and also reported a history of violence and domestic abuse. This does not appear to have been explored by the practitioner, nor is there any indication of the practitioner exploring risk to current partner. It is not documented whether, at initial assessment, George was asked about whether he had any dependents. George said that he had fleeting thoughts of taking his own life however he said he did not have specific plans to harm himself.

On 26th March 2015 George attended a GP consultation at which he requested anti-depressant medication. George reported that he had stopped taking medication previously prescribed. The GP undertook Hamilton Anxiety and depression screening. George disclosed that his symptoms were causing problems with his partner who had recently had a child. Family circumstances and impacts were not explored by the GP.

On 15th December 2015 George had a GP consultation at which he disclosed that he was experiencing low mood. He reported that he had been drinking every night for the past eight weeks. Anti-depressant medication was commenced. There appears to have been no professional curiosity around the impact of George's behavior upon his family.

Throughout 2016 to 2019 George continued to present to his GP and counselling services reporting anxiety, depression and thoughts of self-harm. Appropriate treatment interventions were delivered, however, there is no indication that any agency attempted to identify the underlying causes of George's mental health issues,

nor is there any indication that his violent and aggressive behaviour was explored in relation to the impact that this may have had upon his family.

In summary George's mental health, including thoughts of self-harm, was reported on many occasions. Agencies responded with appropriate treatment and care, however no links were made to George as a possible perpetrator of domestic abuse.

4.1.4. KL4

Were agencies aware of coercive and controlling behaviour in relation to Siobhan by George perpetrator? How was this assessed and what was the outcome?

Siobhan disclosed to the HV, following the birth of Child 2, that she felt isolated and was losing confidence. She also disclosed 'problems' in her relationship with George. At that time the risk and recognition questions asked by the service were not specific in relation to coercion and control and the impact that this may have had on Siobhan.

Siobhan made disclosures about George's coercive and controlling behaviour during her therapy sessions at GMMH. Siobhan was given information by the therapist about the 'Women's Centre' however there is no indication of any attempt by the therapist to explore the impact of George's coercive and controlling behaviour on Siobhan, or to recognise this as a risk factor in relation to domestic abuse and risks to the children.

Police contacts with Siobhan in relation to domestic abuse refer on one occasion to a potential indicator of coercion and control (possible financial abuse in relation to debt)

In summary, none of the agencies who were aware of domestic abuse explored the impact of coercion and control on Siobhan, nor did they advocate, seek or refer Siobhan to specialist domestic abuse services who would have been able to support Siobhan to address these factors in her relationship.

4.1.5. KL5

Were Siobhan's family aware that she was a victim of domestic abuse? If so, did they take any action (did the family seek or receive support from any agency in relation to domestic abuse)? Did Siobhan's family identify any barriers to accessing services? Was anyone in the local community aware of domestic abuse, if so, what actions did they take and what was the outcome?

Siobhan's mother made two contacts with police regarding domestic abuse incidents in 2009 and again in 2017. Siobhan's father also contacted police regarding George threatening Siobhan in 2019 (however the call handler refused to speak to him on this occasion).

Siobhan's family said that they were aware that both physical abuse and coercive

and controlling behaviour had been used by George. They told the review that George was a difficult person and that he was self-oriented.

Family members had tried to encourage Siobhan to permanently separate from George and said that she had indeed separated from him on a number of occasions, however these separations did not last. However, Siobhan finally decided that she was going to end the relationship permanently in 2018, and that this is when George became more aggressive and his use of drugs increased. They observed that he had become more threatening and intimidating towards Siobhan, however they did not report this to police as they believed that George would eventually accept the relationship was over and would leave Siobhan alone.

Following the incident on 25th May, Siobhan's father attempted to report this by telephone on two occasions, however the call taker refused to speak to him and a log was not created. Usual practice would be that, following the call, the incident would be passed to the Radio Operator who would review the grading and if they are unable to effectively resource the incident should flag this with Supervision to consider the risk and deployment options. On this occasion, when the incident was reported by Siobhan, Police attendance was delayed immediately at the request of Siobhan as she was due to go to work. The FWIN was then endorsed regularly indicating the lack of available resources leading to further delays and also delays due to Siobhan's availability.

Incidents are graded and regularly assessed to identify Threat, Harm and Risk and resourced accordingly.

The panel's view is that this should have been treated as a third party report of Domestic Abuse – it is clear from the review that Siobhan's family appear to have concerns regarding the relationship and knowledge of this may have assisted in a more thorough risk assessment.

The actions of the call handler did not comply with GMPs Third Party Reporting Policy and represent a missed opportunity to offer safeguarding advice and add further information to the incident log. GMP has made a single agency recommendation in this regard. When a call from a victim or a third party reporting Domestic Abuse is received the call handler should be able to identify the fact that it is domestic related and ensure that it is graded appropriately, they should offer immediate safeguarding advice and ensure they obtain sufficient information to pass on to the Radio Operator and Attending Officer to enable an early assessment of risk.

The family did not make contact with specialist domestic abuse services. They said that they encouraged Siobhan to separate from George however they did not feel that professional help was necessary. They reflected that, had Siobhan been offered a referral to domestic abuse services, she may have taken this up, but they could not be sure.

The family did not feel there were any specific barriers to them in relation to accessing services or information in relation to domestic abuse.

There is no indication that anyone in the local community was aware of domestic abuse in the relationship between Siobhan and George.

4.1.6. KL6

Did agencies identify any concerns in relation to safeguarding children in their contact with the victim or perpetrator?

There were two occasions on which police spoke to Children's Social Care regarding safeguarding Siobhan and George's children. In 2012 the incident was discussed with CSC. On the second occasion in 2017 a referral was made which was investigated by CSC and closed.

The review has identified that professional curiosity into the impact on the children of domestic abuse (where this was known) and of episodes of parental mental ill health could be strengthened. This matter does not appear as a recommendation but it is noted in a number of single agency action plans.

4.1.7. KL7

Were matters of race, culture, religion and any other diversity issues considered by agencies when dealing with the victim or perpetrator?

All agencies followed policy and guidance in relation to equality and diversity.

There were no specific matters of diversity for agencies to take into consideration.

4.1.8. KL8

What systems and processes (assessment, referrals, and case closures) were used in the case? Were these appropriate and effective? What might you change as a result of learning from the case?

During the period reviewed three DASH risk assessments were undertaken. The 3 DASH risk assessments were completed in 2012 (standard increased to medium), 2017 (standard) and 2019 (standard). The incidents in 2009 and 2010 were recorded as verbal altercations.

The incident graded as medium in October 2012 could have been graded high risk (see 5.1.4).

The GPs of both Siobhan and George appropriately undertook mental health assessment and reviews, however, as has been observed earlier in this report, assessment with Siobhan did not include questions regarding domestic abuse as a potential causal factor (although this would not have been expected practice at that time).

The HV service assessed the family as requiring universal plus level of service and additional support around maternal mental health.

The SRFT 0-19 HV assessment process for mental health is in-line with the NICE Quality Standards (QS115) Antenatal & Postnatal mental health. The Whooley Question tool[10] was used (this is a 2 question tool that health professionals can use without formal psychiatric training as part of a general discussion regarding mental health). Siobhan was asked those questions following the birth of Child 1 and Child 2 – followed on by the use of Edinburgh post-natal depression scale[11] where the scores were in line with how Siobhan had also described her mental health as in low mood. Maternal mental health is one of the high impact areas for health visiting and as such it is reasonable for the HV at that time to hold high importance to it.

4.1.9. KL9

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

There is little evidence of multi-agency working in relation to safety planning for Siobhan. This is in part due to domestic abuse incidents not being graded as high risk, and information not being shared amongst agencies (which would have led to a referral to MARAC). The review considers that the incident that took place in October 2012 could have been graded high risk.

Inter-agency working took place in relation to Siobhan's pregnancy with information being shared between in relation to the provision of Health Visiting and Community Midwifery services. However, the review believes that communication between Bolton NHS FT and SRFT could have been strengthened based on historical events.

There is evidence of multi-agency working within the parameters of health, with liaison between HV and GP to support Siobhan with her mental health that appears to be effective. Again, there is some evidence of inter-agency working between Six Degrees and GMMH and between GMMH and the relevant GP, however this is restricted to updating information on attendance and the outcomes of initial assessment.

However, the records do not show the sharing of information from other agencies around domestic abuse until the GMP domestic abuse history document was sent in May 2017 outlining previous domestic abuse incidents.

4.2. Summary of Single Agency Learning

Agencies involved in the DHR were asked to identify learning, and to complete single agency action plans to address specific areas of practice or systems that required improvement. A summary of key learning is provided below and more detailed single agency actions plans are provided at Appendix 2.

[10] https://whooleyquestions.ucsf.edu/

[11] http://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf

In addition to the single agency plans, the panel made suggestions throughout the review where it was felt that practices could be reviewed that did not require inclusion in the single agency plan and these have been referred to in this report.

4.2.1. Bolton NHSFT

Bolton NHS FT did not identify any actions for inclusion in a single agency action plan, however the following learning was noted.

The attendance at A&E on 14th October 2012 following the assault to Siobhan is significant, and it is the only identified episode of domestic abuse recorded in the hospital notes. The A&E records do not include the name of the perpetrator or specific actions taken in relation to domestic abuse during this attendance. This does not necessarily mean no action was taken but if it was it is not recorded. The review concludes that without recorded evidence it must be assumed that no enquiry or action was taken in relation to Siobhan's disclosure that George had assaulted her.

Clinical care and follow up was provided to the A&E attendance in 2012 related directly to an assault. Limited record keeping does not indicate signposting to support services or discussions about safety planning took place. As above, the review must assume that signposting and safety planning did not take place.

Contact with midwives during the pregnancy for Child 2 shows routine enquiry about domestic abuse, personal safety and support within relationships and wider family. There are no concerns identified and only one reference to a historical incident (presumed to be from 2012). The review has noted that there was inconsistency in relation to targeted enquiry based on the presence of George at visits and a single agency recommendation is made in this regard.

4.2.2. CRC

CRC provided a single agency action plan which notes that the IDAP programme has now been replaced by the Building Better Relationships programme. CRC noted that although George was deemed to have successfully completed the programme, it is not possible to say that it influenced or changed his behaviour – indeed the indications are that it had little or no positive impact on him in the long term.

CRC identified an issue in relation to record keeping and have a made a single agency recommendation in this regard within the attached single agency action plan.

The review identified a potential safety risk to victims who are sent an 'information pack' through the post by the Women's Safety Service. This has been raised with the panel representative from CRC who will take it forward within the service.

The DHR panel has raised the question of whether a national review/evaluation of behaviour management programmes for domestic abuse offenders would be of value. A recommendation is made in this regard. (Recommendation 4).

4.2.3. Salford CCG

The CCG has provided a detailed single agency action plan which is attached. The single agency action plan identifies learning in the following areas:

For those tertiary services who record directly onto GP electronic records, effective liaison with key personnel from the medical practice needs to be enhanced to improve information sharing and enable more effective and robust safeguarding processes within Primary Care. The Primary Care response to disclosures of both current and particularly historical domestic abuse requires greater emphasis in clinical practice.

The Primary Care response to consideration of compromised parenting capacity and the recording of professional curiosity needs a greater emphasis within clinical practice. It is acknowledged that it can create significant difficulties for Primary Care when family members are registered at different medical practices. GP practice 2 would have been unable to see any issues affecting the children or the victim that would have helped understand the family dynamics more clearly.

To manage risks effectively around domestic abuse consent from the victim and their understanding around actions being taken are essential so they are aware of the risks and support can be put in place around management of their safety. The challenge for Primary Care generally is that all patients have the ability to access their own electronic records so any disclosures from external agencies or directly from the victim or children cannot be stored on the perpetrator's records. This can be extremely problematic when victims and perpetrators are registered separately. Wider consideration of how organisations manage disclosures of domestic abuse by perpetrators should be factored into learning, including the challenge of when agencies have no contact with the victim.

4.2.4. ForHousing and Salford Housing Options

ForHousing and Salford Housing Options did not identify any actions to include in a single agency action plan. However, the services will ensure that opportunities to identify domestic abuse (particularly in relation to debt management) are taken. The service will remind staff of the agency policies in relation to domestic abuse and refer them to the guidance from the Domestic Abuse Housing Alliance[12].

4.2.5. GMMH

GMMH have provided a detailed agency action plan which is shown at Appendix 2. Key learning identified by the agency is as follows:

A key focus for GMMH is to continue to promote awareness and understanding of the safeguards in relation to Domestic Violence and Abuse (DVA). GMMH recognises and acknowledges:

There were missed opportunities by practitioners in relation to robust safeguarding and the recognition of domestic abuse in all its forms:

[12] https://www.dahalliance.org.uk/

- Emotional/ Psychological
- Physical
- Coercion & Control

As professionals we must practice:

- 'Professional Curiosity', which is the capacity and communication skill to explore and understand what is happening and why rather than making assumptions or accepting things at face value.
- 'Respectful Uncertainty' and apply critical evaluation to information and maintain an open mind. Develop and maintain a critical mind-set and work in a reflective way.
- 'Safe Uncertainty', focus on safety but consider changing information, different perspectives and acknowledge that certainty may not be achievable.

There was a need for improved communication and sharing of information between both internal partners within the Trust and external agencies.

There was a need for practitioners to follow GMMH Safeguarding Policies and Local Multi-agency Safeguarding policies and procedures at every opportunity provided, which includes a 'Think Family' approach.

There was a need for risk management plans to have included a focus on the escalation and sharing of risk when safeguarding concerns were identified. For example: Completion of RIC/ DASH tools and criteria for referrals to MARAC. Pre-sentencing consultation with Criminal Justice Liaison Service.

With every DNA or cancellation staff must consider the implications on the safeguarding of children or adults and when there are such concerns, liaison needs to take place with Safeguarding Children and Safeguarding Adult Leads.

Safeguarding is a fundamental part of patient safety and safeguarding is an essential and integral component of good managerial and clinical supervision for all staff. GMMH needs to ensure supervision supports practitioners to reflect critically on the impact of their decisions on the child/ adult and/ or their family.

4.2.6. GMP

GMP has provided a single agency action plan which is shown at Appendix 2. In addition to the action identified in the plan there is identified learning in these areas.

Following the attendance at the 25th May 2019 incident the officer completed a DASH risk assessment alongside a RARA risk assessment (Remove Avoid Reduce Accept). Voice of the Child was considered. Although the officer does not believe that the children were present when he attended, he did take details and make a referral via Operation Encompass. Clarification with the officer indicates that the process for Operation Encompass referrals involves emailing the individual school

along with Salford GMP Encompass Team and the relevant local authority area team. The emails are sent during weekends and school holidays.

The incident was graded as a standard risk, i.e. that there were no indicators of serious harm. This was based on the responses to DASH questions and the fact that Siobhan had stated that she had put measures in place to reduce contact between her and George.

There is no acknowledgement of any increased risk due to the recent separation, however this would not necessarily have been known by the Attending Officer who was not a Specialist Domestic Abuse Officer. As this incident was graded as Standard Risk this would not have been reviewed by a Specialist Officer and can be finalised by the Attending Officer or their Supervisor.

There has been little contact with Siobhan, George and their children within the Review Period. The final contact with Siobhan in May 2019 resulted in a risk assessed as Standard and a crime report being submitted. It is apparent from details on the FWIN that Siobhan's father had attempted to report his concerns however had been advised that Siobhan had to report the issues. This would be contrary to GMP Policy which permits third party reports of Domestic Abuse.

There is a possibility that had her father been spoken to and the details of his concerns recorded this may have influenced the risk assessment process.

Similarly had Police attendance not been delayed this too may have changed the way in which Siobhan reported her concerns – at the time of ringing she clearly felt that there was a genuine threat from George however after the passage of time the lack of contact from George may have influenced the way that Siobhan minimised the threat when she eventually spoke with an officer.

4.2.7. NPS

During the supervision period in 2009, there is evidence of some good and pro-active practice. Case recording is of good quality and clear actions being taken and followed up. Multi-agency working was used well and to good effect to help to support George in securing housing and employment. There was a tendency to focus on compliance issues rather than to take a holistic view of George's presenting problems. Specifically, it is apparent there may have been a missed opportunity to explore and address potential mental health difficulties. Learning from the case, the NPS would benefit from ensuring offender managers have the skills and knowledge to identify mental health issues and understand how these link to both compliance and risk of reoffending. The NPS should ensure Offender Managers have access to specialist advice and that there are appropriate referral pathways in place to address individual needs in regard to mental health.

The review evidences there are appropriate processes in place to identify domestic abuse perpetrators at their earliest point of contact with the NPS. The Offender Manager identified the domestic abuse and flagged the case file appropriately. The

Effective Practice Framework is utilised effectively in Court and appropriate sentences recommended.

On receiving the sentence, the initial case work was completed swiftly and appropriately. OM3 ensured George could commence the IDAP group at the earliest opportunity. The subsequent quality of case management however suggests that, following these initial stages, there is a risk of drifting during the period where an offender is engaged with a programme requirement. There are clear shortfalls in terms of the multi-agency information sharing and liaison resulting in the NPS having an incomplete understanding of the risks and protective factors within this case.

There is further learning in terms of the NPS response to child safeguarding in cases of domestic abuse. The review raises questions as to OMs understanding of relevant policy and legislation in respect to statutory duties around child safeguarding. The clear lack of consideration for the impact of the offending on Child 1, or the need to work in partnership with Children's Services is a key concern. The NPS should look at ways to increase OMs knowledge and skills in identifying, risk assessing and responding to child safeguarding issues. There should be effective procedures in place for management oversight of child safeguarding issues to support OMs.

The review has found that case recording is inadequate in this case. The NPS needs to ensure OMs are aware of the importance of accurate case recording and that relevant practice guidance is being utilised by all OMs.

4.2.8. NWAS

NWAS has not identified any new learning from the case and did not provide a single agency action plan.

4.2.9. Salford Children's Services

Salford Children's Services has provided a single agency action plan identifying the need for increased awareness and training in relation to domestic abuse.

It should be noted that the agency has recently been involved in a review of Operation Encompass and will implement practice recommendations from that review. The recommendations are attached at Appendix 3.

4.2.10. Primary Care Psychology Service (Six Degrees)

The service has provided a detailed agency action plan which is shown at Appendix 2.

Much of the learning identified by the service relates to improvements in internal information gathering, including strengthening initial assessment around risk management and information sharing. Several of the actions identified have already been reviewed and implemented.

The agency also noted the need to strengthen awareness and assessment procedures in relation to safeguarding children.

4.2.11. SRFT

SRFT has provided a detailed agency action plan which is shown at Appendix 2.

What has been learned is that a review of DASH knowledge and completion by community paediatric staff and in particular 0-19 service is required as the numbers may not reflect the proportionality of those patients who are asked the domestic abuse routine enquiry questions.

Use of routine enquiry questions was not consistent (not applied when George was present). The perpetrator George was known to SRFT 0-19 team as a possible perpetrator of domestic abuse from when Siobhan made the disclosure at the 6-8 week follow up visit following the birth of Child 1 – 13/12/11. George did not make a disclosure to SRFT staff.

SRFT has identified a deed to strengthen opportunities and actions in relation to disclosure. Use of the DASH/RIC may have resulted in further discussion with Siobhan and offers of support.

What has been learned is the importance of clear documentation that encompasses the wider nature of domestic related relationship issues. This is parallel to the skills and knowledge of staff in assessing risk at the time, taking into consideration previous history and making a conclusion based in the limited allocated contact time.

Furthermore, the focus on the strain of becoming new parents is acknowledged in terms of parenting capacity, family support and emotional health but does not appear to have been identified as a potential risk for domestic abuse. This identifies learning regarding whether staff have the skills and knowledge to complete DASH, to advice on safety planning and to identify the risks such as pregnancy and new parents.

What could have been done differently is the recognition of the links between emotional health and domestic abuse and in the identification of the 'trio of vulnerabilities' that increase safeguarding risk.

The combination of Siobhan's emotional health and a history of domestic abuse is likely to have been a barrier for Siobhan seeking further support from the 0-19 service, however SRFT records acknowledge that they are aware but the focus appears to be regarding Siobhan emotional health and not the wider potential implications of domestic abuse.

4.2.12 Victim Support

Victim Support provided a single agency action plan.

5. Conclusions and Recommendations

Siobhan was a young woman with a number of vulnerabilities, particularly in relation to mental health. She had experienced mental health difficulties from adolescence into adulthood, and was frequently seen in primary care. She was also appropriately referred to specialist mental health services.

Siobhan experienced ongoing domestic abuse from George which was known to a number, but not all, of the agencies with whom Siobhan had contact. It appears that the abuse began early in their relationship and took the form of coercive and controlling behaviour, intimidation and verbal abuse, probable financial abuse, physical violence and threats, and a perceived threat to kill which was made shortly before Siobhan's murder.

As is the case for many victims of domestic abuse, Siobhan sometimes 'minimised' George's abusive behaviour. This may have been related to control, fear and worry about the impact of disclosure and coercion by the perpetrator.

It is clear from speaking to Siobhan's family that she wanted to protect her children, which may have been a factor in her decisions not to pursue complaints against George.

The review has identified several themes for learning which are set out below, some of which appear in other local and national DHRs. Their familiarity does not make these issues any less important.

Some of the learning from this review does not result in multi-agency recommendations as Salford CSP already have actions in place to address identified learning from other reviews. However, the review recommends that the Salford CSP Domestic Abuse Action plan is reviewed and updated with the learning from this review.

Key learning is set out below, alongside recommendations where these are proposed.

5.1 Conclusions

5.1.1 Conclusion 1

Routine and Targeted Enquiry and Referral to Specialist Domestic Abuse Services for victims

The review has highlighted that in the period under review, there were a number of missed opportunities to make routine and targeted enquiries about domestic abuse with Siobhan. (NB practice has now changed and routine and targeted enquiries are embedded into practice). These opportunities were missed in a range of settings including the GP practices, Bolton NHS FT services, GMMH, Six Degrees and SRFT.

The lack of referral to specialist domestic abuse services for Siobhan stands out as a significant gap in this review. The importance of providing opportunities for the range of support and interventions that specialist services can provide needs to be

highlighted to agencies across the CSP area and a recommendation (Recommendation 1) is made in this regard.

5.1.2 Conclusion 2

Recognising and Responding to indicators of risk

Siobhan had frequent contacts with a number of services, most particularly her GP. Siobhan reported on numerous occasions that she was experiencing anxiety, depression, and panic, feelings of isolation, relationship difficulties and post-natal depression.

Throughout the period reviewed, Siobhan presented to General Practice on numerous occasions with risk indicators of domestic abuse including anxiety and depression (dating back to her adolescence), post-natal depression[13] and genito-urinary issues[14] both within and outside pregnancy. The review could see no indication that Siobhan's general practice or other health agencies explored a potential connection between these presentations and the possibility that Siobhan was a victim of domestic abuse.

It is important that general practitioners, and other agencies, are able to make the connection between presenting conditions (e.g. mental health, health and sexual health issues) and domestic abuse, to enable them to implement targeted enquiry and appropriate referral. These points are linked to conclusion 1 and recommendation 1.

5.1.3 Conclusion 3

Understanding other key risk factors – coercion and control and increased risk at separation

There were a number of occasions on which Siobhan disclosed coercive and controlling behaviour by George, and other indicators (Siobhan may have taken out a loan to pay George's debts and that Siobhan retracted reports of domestic abuse on more than one occasion).

The review indicates that practitioners across agencies did not give full consideration to the impact on Siobhan of coercive and controlling behaviour. Referral to specialist domestic abuse services would have provided Siobhan with a safe and supportive environment within which to disclose and discuss George's coercive and controlling behaviour.

There is learning regarding coercive and controlling behaviour by perpetrators and how this is balanced against victim retractions or what is sometimes referred to as 'minimising' behaviour. Agencies should focus on empowering victims to understand

[13] http://www.safelives.org.uk/policy_blog/i-kept-hoping-someone-would-ask%E2%80%A6

[14] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

the impact of abuse and assist them in building resilience. Siobhan's family highlighted that it must have taken enormous strength for Siobhan to try to break away from George and that she needed more support from agencies to help her to do this.

The majority of professionals involved in working with Siobhan were aware that her relationship with George was what she described as 'on/off'. Professional understanding in relation to the increased risk to victims of domestic abuse leading up to and at the point of separation is not evident throughout the period under review. It is unclear whether Siobhan recognised the risks associated with separation. Siobhan's family told the review that Siobhan would not have imagined that George could have 'done what he did'.

In summary, understanding key risk factors associated with perpetrator behaviour is not evident in the case and should be strengthened. A recommendation is made in this regard (Recommendation 2).

5.1.4 Conclusion 4

Risk Assessment

The DHR has highlighted a number of issues in relation to the completion of DASH risk assessments, particularly in relation to the overall level of risk assigned to the incident. The current system of risk assessment relies heavily on the identification of significant risk factors to formulate the judgement about whether a case meets the threshold (high risk) for referral to MARAC.

It is the view of the panel that the domestic abuse incident in 2012 in which Siobhan was assaulted by George and her nose broken could have been graded high risk by the officer conducting the risk assessment due to the severity of the injury. The panel accepts that there is a degree of discretion associated with any risk assessment, and Siobhan's retraction was taken into consideration when grading the risk to her. However it is the view of the panel that Siobhan's retraction does not detract from the severity of the assault and the injury, and the role of coercion and control as a factor in the retraction should have been taken into consideration.

Paradoxically police went ahead with a prosecution of George without Siobhan supporting this. This indicates to the review that the severity of the incident was recognised, however the route for bringing George to account was geared to bringing him to justice, rather than safeguarding Siobhan. These outcomes should not be mutually exclusive.

Following the incident that took place at the end of May 2019 a crime was recorded for Malicious Communications due to texts and messages received by Siobhan from George. This has been reviewed by the Deputy Force Crime Registrar who agreed with the crime submission, however requested a further crime for Section 4 Aggravated Harassment be submitted to comply with National Crime Recording Standards.

It should be noted that the Salford Local Authority area is currently involved in piloting a new approach to DASH risk assessment. The review therefore makes a recommendation in this regard (Recommendation 3).

5.1.5 Conclusion 5

Accurate and Timely Recording and sharing of Information

There are several examples in the review of practitioners not recording information, this took place in a number of agencies. The most significant example relates to George's contact with NPS during 2012-2014. NPS has provided assurance that practice has changed in relation to record keeping, and has also submitted a detailed single agency action plan to support changed practice in the service.

There are a number of examples of information not having been shared in a timely way or at a time when agencies may have been unable to receive it. The two most significant examples are the sharing of information regarding the assault on Siobhan in October 2012 not reaching her health records in a timely manner. Secondly, the notification via Operation Encompass in May 2019 took place during the first week of school holidays. As it happened the email was picked up by the Primary School Head Teacher, although it may easily have been 'stuck' in the system waiting for schools to return.

5.1.6 Conclusion 6

Links Between Mental Health, Substance Misuse and Domestic Abuse

The toxic trio of substances, mental health and domestic abuse are present – because George did not make disclosures that he was a perpetrator of domestic abuse, links were not made by professionals in relation to his mental health and drug use. Routine and targeted enquiry with potential perpetrators and victims could have assisted with this, however, risk assessments were not such as to facilitate information sharing.

George's mental health was not explored within the context of his parenting i.e. safeguarding issues in relation to disclosures of suicidal ideation. Stronger links need to be made to establish whether children (or partners) may be at risk.

As referenced throughout this report Siobhan experienced ongoing mental health difficulties which were not linked by any agency to have a potential connection to domestic abuse.

5.1.7 Conclusion 7

Strengthening Focus on Safeguarding Children

Although appropriate action was taken by GMP to refer and consult in relation to the safety of the children, other agencies did not take a proactive approach. This does not only relate to those agencies who were aware of domestic abuse, but also to

those agencies who were aware of both Siobhan and George's mental health difficulties.

Despite the volatility and risk factors in their relationship, both Siobhan and George were actively involved in parenting their children, which inevitably brought them into contact with each other.

Recognition of potential safeguarding issues and preventative work in the context of 'Thinking Family' may be of benefit within the local partnership.

A number of single agency action plans focus on this aspect of learning.

The review supports the Recommendation in the recent Government Bill on Domestic Abuse and commends this to the local partnership.

Children who have experienced domestic abuse risk suffering a range of long term negative consequences as a result of their experiences and must be able to access the necessary support and health services to help them recover. Children in refuge and other temporary accommodation, and those who have moved home repeatedly to flee domestic abuse, are particularly vulnerable and risk becoming invisible to professionals in the education, health and social care sectors. (*Paragraph 84)*

5.1.8 Conclusion 8

Interagency Working and a proactive 'whole system' response to domestic abuse

The DHR panel noted the similarity between this and other local and national reviews in relation to agencies working together in a proactive way to encourage safe disclosure, respond to the needs of victims, support families and children, and to develop a workforce that is proactive and responsive to domestic abuse. The panel also noted that the demand for a range of services is increasing, whilst capacity in services is reducing, placing pressure on individual agencies and the whole safeguarding system.

5.2 Recommendations

Recommendation 1

The CSP should ensure that agencies are (a) aware of the local specialist domestic abuse service, (b) know how to make referrals to the service and (c) provide comprehensive support and referral as necessary to victims of domestic abuse.

Recommendation 2

The CSP should undertake a programme of work, as part of the development of the local domestic abuse strategy, to raise awareness of perpetrator behaviour and its impact on victims.

Recommendation 3

The CSP should monitor and report learning from the current pilot in relation to DASH risk assessment and results should be fed into local practice.

Recommendation 4

The CSP should write to the Ministry of Justice to seek assurance that reviews into the effectiveness of domestic abuse offender behaviour programmes are in place to ensure that resources are effectively targeted and positive outcomes can be demonstrated.

Recommendation 5

The Safeguarding Children Partnership should ensure that understanding the impact of domestic abuse and parental mental ill health are given full consideration when practitioners engage with families at any stage of contact.

Appendix 1

Methodology by which DHR was completed

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

Reports were provided by the agencies set out at 2.6 in the main report.

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

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

Dissemination

It is intended that a copy of the DHR overview report will be shared with all of the above agencies and to the following:

Salford Community Safety Partnership
Salford Safeguarding Adults and Children's Partnerships
Salford Women's Aid (SIDASS)
The victim's family

Appendix 2

Family Tributes

From Siobhan's Dad

I am not using my daughter's real name to protect her confidentiality, but this tribute is to her and everyone who knew her will recognise it?

The 24th December 1991 was one of the happiest days of my life when my first born child came into the world, my beautiful princess. She was absolutely perfect, a bundle of joy and happiness who lit up a room and always had a smile on her face. As she grew she always made everyone smile as she was just a happy, smiling, fun baby and toddler. She loved life, her mum and dad, nana's and grandad's, brother and sister, auntie's and uncles, nephews, nieces and cousins but she had a special bond with her sister Shannon and they were inseparable and like a little comedy duo.

As the years went by we had numerous family holidays which Siobhan loved, especially Turkey, and because she was blonde all the locals loved her, as did everyone as her personality was infectious.

Siobhan became interested in swimming at an early age and started training with Salford, eventually being picked for the squad. Her love of swimming had her training 5 days a week, even at 5am in a morning before school, but nothing fazed her and she was always up with a smile, trained then off to school. At school she was a very popular pupil and extremely academic. Her swimming never stopped her gaining good grades at school and her schooling never stopped her swimming. She would go on to win dozens of medals and compete in numerous galas around the North of England. She was on the brink of being picked for the Great Britain squad but pick up a bad knee injury which ended her swimming career. She was so upset but picked herself up and got on with her life.
She had a huge group of friends and was never without them, they were always there for her no matter what.

As Siobhan grew in to a beautiful young woman she had always wanted her own family as she loved children so when she was pregnant with her first child she was ecstatic and the mother in her came out and she doted on her daughter and did anything and everything for her. No child could have wished for a better mother. Along with being a mother Siobhan worked to support her family and was still the beautiful loving daughter i love and miss to this day and always will.

Siobhan then had her second child and she was just as ecstatic. It was her perfect family and she did anything and everything for him as well, nothing was too much for her.

She was just an amazing person, not only my daughter but best friend, along with my other children, a warm hearted, loving, caring, thoughtful, selfless person who would help anyone and give you her last penny. I never heard anyone say a bad word about

her and the love people had for her was shown at her funeral when their was standing room only in the church, which held approximately 400. She was loved by so many.

June 5th 2019 was the day my world came crashing down when I found my beautiful princess brutally and cowardly taken from me, her children, her siblings, her grandparents, extended family and friends. She never deserved to have her young life ended after 10 years in an abusive, coercive, controlling relationship. She had finally found the courage to end the relationship, only to continually be harassed and threatened with her life up to the early hours of June 5th 2019 when my first born, my beautiful princess was taken from me by the angels.

I miss Siobhan every single minute of the day and night and my life can never be and will never be the same again. I love you Siobhan and miss you, always and forever, and will never ever forget you. You are in my every thought and in my heart. I wish I could see you one last time, hug you and tell you how much i love you and how sorry I am that I didn't protect you from harm. Sleep tight my beautiful princess and we will meet again one day, then I can be with you for eternity. Love you and miss you. Your heartbroken dad xxxxx

From Siobhan's Sister

My sister was the most wonderful soul, she was family oriented, a selfless person who did anything for anyone, an amazing mother and sister.

Losing her was like losing a part of my heart. A massive hole is missing that will never be filled. They say time is a healer, but nothing will ever heal the heartbreak I feel missing my big sister. She wasn't just a sister, she was my right arm, my shoulder to cry on, my everything. We did everything together, and I constantly miss all the memories we didn't get to make.

She will always have a special place in my heart. She was my first friend, my forever friend. I will always cherish the 24 years I spent with her. I will love her for eternity and even after that. Until we meet again one day, rest peacefully my beautiful.

Your little sister xxxxxxxxxx