Salford Community Safety Partnership (CSP)

Domestic Homicide Review (DHR) Relating to Debbie (Pseudonym)

Died August 2021

Final Report Version 3

Resubmitted 18th July 2025

Independent Chair/Author: Maureen Noble – Retired January 2024

Contents

Please note that this report uses a 'simple'[1] numbered footnote referencing style that enables readers to explore further information should they wish to do so. Where the panel have deemed it necessary to include further detailed information this is included either as a footnote or in the body of the text

Section 1: Overview

1.1 This report is about Debbie who sadly died in August 2021. The review panel offers condolences to Debbie's family and friends on their loss.

1.2 The report examines agency responses and support given to Debbie, a resident of Salford, prior to the point of her death.

1.3 The Chairs of Salford Community Safety Partnership (CSP) agreed to conduct a Domestic Homicide Review following screening with reference to section 18 of the statutory guidance that 'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'. In this case, Debbie had made an online report of domestic abuse to police in July 2021, including a request for disclosure of any relevant previous reports in relation to Jack (not his real name) under the Domestic Violence Disclosure Scheme (DVDS)[2] sometimes known as Clare's Law. Debbie had recently ended her relationship with Jack.

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[1] https://design102.blog.gov.uk/2021/05/28/document-references-and-footnotes-how-do-you-write-yours/

[2] NB: DVDS is a police policy giving people the right to know if their current or ex-partner has any previous history of violence or abuse to enable them to make an informed decision about whether to continue in a relationship with the subject based on information which may be shared with them about the subject's past offending behaviour. Consideration must also be given as to whether the subject should be told that information about him/her may be disclosed to the person at risk. Such a decision must be based on an assessment of risk of harm to the person at risk if the subject were to be informed. For more information a link to Clare's Law and to the most recent DVDS statutory guidance is provided below.[2]
[2] https://assets.publishing.service.gov.uk/media/6489ab97103ca6000c039ea0/Domestic_Violence_Disclosure_Scheme.pdf. https://clares-law.com/what-is-clares-law/

1.4 In addition to agency involvement the review will also examine the past to identify any relevant background; whether support was accessed within the community, and whether there were any barriers to accessing support.

1.5 Confidentiality - The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers.

1.6 **Key People:**

- Debbie (Deceased) Ethnicity White British Aged 43
- Jack (Debbie's ex-partner)

Circumstances Leading to the Review

1.7 On a date in August 2021 police attended Debbie's address following a report that Debbie had been found hanging from a ligature in her bedroom.

1.8 On arrival at the address police officers found that Debbie had been cut down from the ligature. Jack and Debbie's father were also present at the scene. Jack reported to officers that he had been trying to contact Debbie without success and had become concerned as this was unusual. Jack said he rang his father and asked him to accompany him to Debbie's home. Jack said he entered the house and found Debbie hanging from a ligature behind her bedroom door. Debbie's father arrived and found Jack outside. When Debbie's father entered the house he found Debbie's body and contacted police.

1.9 It was noted at the time by attending police officers that Debbie appeared to have hanged herself with a dressing gown tie.

1.10 A diary/notebook was recovered by police at the scene. This was later examined by police and was found to contain entries made in June 2021 by Debbie that related to her relationship with Jack, and to thoughts of self-harm/suicide.

1.11 Police have undertaken a special procedure investigation into Debbie's death, concluding that there is no evidence of suspicious circumstances, criminality, or third-party involvement. On this basis the case was referred to His Majesty's Coroner for Coronial proceedings.

1.12 Following Debbie's death police received a complaint from a member of Debbie's family. During the course of this review two investigations into the complaint have taken place. As a result of the complaint Police made a referral to the Independent Office of Police Conduct (IOPC). IOPC returned the referral to Greater Manchester Police (GMP) requesting that GMP undertake an internal investigation. The investigation has now concluded.

Section 2 Methodology

Decision to conduct a DHR

2.1 Salford CSP received notification of a requirement for screening for DHR on 8th September 2021. Due to the COVID-19 pandemic there was a delay in screening the DHR referral.

2.2 On 20th February 2022 the Chairs of the CSP agreed that a Domestic Homicide Review should take place and the CSP began a commissioning process. Debbie's family were first contacted at this time.

2.3 Due to ongoing police enquiries, in January 2023, the CSP decided that the DHR should be paused pending the findings of GMPs investigation. Home Office were notified of this decision in writing. Debbie's father was informed of this decision in writing in March 2023. No acknowledgement of this correspondence was received from Debbie's father.

2.4 An Inquest due to take place in February 2023 was stood down. In June 2024 Salford CSP was notified that the case had been referred to the Chief Coroner and that they had directed that the case be transferred from Manchester West to Inner North London Coroner. The CSP has been informed that the Chief Coroner made this decision based on the circumstances that the Manchester West Senior Coroner recused himself to avoid a perception of bias arising out of a connection between the Greater Manchester Police and a family member.

2.5 The Manchester West Area Coroner then ceased his involvement because of ill health and the Investigation was allocated to an Assistant Coroner. The Chief Coroner then transferred the case outside Manchester, to avoid any perception of conflict given the jurisdiction of GMP and the concerns the Applicant (Debbie's aunt) raised.

2.6 The DHR was re-opened in October 2023 and concluded in March 2024. Debbie's father and Debbie's aunt were contacted by the CSP Lead Officer (this term refers to a Senior Policy Officer who has lead responsibility for Domestic Abuse at Salford City Council and oversaw the DHR process) to offer them a further opportunity to discuss the conclusions and recommendations of the review prior to submission to the Home Office.

2.7 Debbie's father spoke with the Lead Officer in March 2024 and explained that he wanted to bring this to a conclusion and had no further comment. Debbie's aunt met with the Lead Officer in April 2024 and requested time to review the report with her AAFDA representative. A panel meeting received her feedback in September 2024 and feedback was provided at this time. More information about family involvement is set out below.

2.8 After submission of this report in October 2024, an Inquest was held at St Pancras Coroner's Court on the fifth of December 2024. Conclusion of the Coroner as to the death is recorded as suicide.

Timescales

2.9 The period covered by this review is 1st January 2018 to the date of Debbie's death in August 2021. This timeframe was chosen to reflect Debbie's contact with relevant agencies. As is usual the review does not focus on events that took place after Debbie's death.

Impact of Covid-19 Pandemic on the Review

2.10 The review was conducted 'virtually', and all meetings and conversations were conducted by Microsoft Teams or by telephone, other than one meeting in person with Debbie's aunt (see below).

Equality and Diversity

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

2.12 The panel noted Debbie's female sex as a protected characteristic. The panel noted that females are statistically more likely to experience domestic abuse than males. The ONS (Office for National Statistics, November 2023) reports an estimated 1.4 million women (and 751,000 men) aged 16 years and over experienced domestic abuse in the last year: a prevalence rate of approximately 5.7% of women and 3.2% of men.

2.13 Further the panel noted that the ONS reports that crimes recorded by the police show the following trends: In the year ending March 2023, the victim was female in 73.5% of domestic abuse-related crimes. Between the year ending March 2020 and the year ending March 2022, 67.3% of victims of domestic homicide were female compared with 12.1% of victims of non-domestic homicide.

2.14 The panel noted that, whilst Debbie was not diagnosed with severe and enduring mental illness, she had been treated for anxiety and depression by her GP. She was also referred to a specialist service to explore possible symptoms of ADHD[4] (unfortunately Debbie died before this referral was responded to). Debbie made entries into a diary/notebook (recovered from the scene of her death by police) in which Debbie wrote that she was experiencing thoughts of self-harm and suicide.

2.15 Evidence suggests that there are strong links between domestic abuse, mental health and suicide and that experiencing domestic abuse can increase vulnerability to suicidal thoughts and actions. According to research conducted by the Chairty Refuge around 3 women a week die by suicide as a result of domestic abuse.[5]

The third annual report from the national Domestic Homicide Project,[6] which works across England and Wales, was published in March 2024. The report identifies:

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[3] Equality and diversity - Department of Health and Social Care - GOV.UK
[4] ADHD stands for Attention Deficit Hyperactivity Disorder
[5] Facts and Statistics - Refuge
[6] Domestic Homicide Project - VKPP Work

- that a total of 93 domestic abuse related deaths recorded between April 2022 to March 2023 were by suicide.
- the majority of victims were female aged 25 to 54 years old, and the majority of perpetrators were male and of the same age bracket.
- victims and perpetrators of ethnic minority heritages remain slightly over-represented compared with the general population.
- more victims of domestic abuse killed themselves, than were murdered by their abuser.

2.16 The panel noted Debbie's ethnicity as white. The ONS report for the year ending March 2023, the Crime Survey for England and Wales (CSEW) showed that a significantly higher proportion of people aged 16 years and over in the Mixed and White ethnic groups experienced domestic abuse in the last year compared with those in the Asian or Asian British groups. Almost twice as many women in the White ethnic group experienced domestic abuse in the last year (6.0%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3.0%).

2.17 The panel noted Debbie's age as a specific equality and diversity factor. Debbie was 43 years of age at the time of her death. Evidence tells us that Domestic abuse affects women of all ages

Whilst the ONS Crime Survey for England and Wales (CSEW) 2024[7] noted that there was no statistically significant change in the prevalence of domestic abuse experienced by adults aged 16 to 59 years in the last year (5.4%), compared with year ending (YE) March 2023, the survey conducted in March 2019 showed that women aged 20 to 24 years were significantly more likely to be victims of any domestic abuse in the last year than women aged 25 years and over (Figure 4).

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

Terms of Reference

2.19 The following terms of reference were agreed at the first DHR panel meeting.

1. To establish what contact agencies had with Debbie; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about disclosures of domestic abuse and what actions they took to safeguard Debbie and risk assess the alleged perpetrator.
3. To establish whether Debbie's family and/or significant others knew about disclosures of domestic abuse and whether they sought or received help.

[7] Domestic abuse in England and Wales overview - Office for National Statistics

4. To establish whether there were other risk factors present (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 consider specific issues relating to diversity.

2.20 Key Lines of Enquiry (specific questions asked of agencies)

KL1 Did any agency know that Debbie may be subject to domestic abuse in any form at any time during the period under review?

KL2 If so, what action did agencies take to safeguard Debbie as a victim of domestic abuse?

KL3 How did agencies work individually and collectively to safeguard Debbie?

KL4 Did any agency have information that Jack may have been a perpetrator of domestic abuse?

KL5 Were family and/or friends aware that Debbie may have been a victim of domestic abuse? If so, what action did they take? Did family/friends identify or experience any barriers to supporting Debbie in relation to safeguarding her from possible domestic abuse?

KL6 Did any agency know whether Debbie may have experienced any difficulties in relation to physical health, substance misuse, accommodation, economic abuse or possible criminal exploitation, and how did agencies respond to this?

KL7 Did any agency know that Debbie may have experienced difficulties in relation to mental health, self-harm and/or suicidal ideation?

KL8 Was any agency aware of any matter regarding safeguarding children that need to be considered by the review?

KL9 Did Covid-19 affect working practices in any way, if so, how were these impacts mitigated?

2.21 The review was conducted in accordance with the regulations set out in the Domestic Violence Crime and Victims Act (2004)[8] 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.

2.22 Home Office guidance (2016) states:[9]Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Domestic Homicide Reviews are not about who is culpable.

2.23 As set out in Home Office guidance DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

Purpose of a DHR

2.24 The over-arching purpose of a DHR is to:

- Establish what lessons are to be learned 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.
- Highlight good practice.

Involvement of Family, Friends, and Significant others

2.25 At the first meeting of the DHR the panel discussed the involvement of Debbie's family and friends. The panel compiled a picture of key

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[8] https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

relationships from material used to scope the DHR and also discussed early information from agency records to identify family, friends and members of the community who may be able to provide insight into Debbie's lived experience.

Debbie's Father

2.26 Debbie's father was notified in writing at the commencement of the review in April 2022 and was provided with information on DHRs and support available to families (leaflets produced by Home Office and the organisation Advocacy After Fatal Domestic Abuse (AAFDA) who provide support to families, were included with the letter).

2.27 Debbie's father telephoned the Lead Officer at the CSP and provided background information and said he would like to speak to the Chair of the review. Contact was made by the Chair who held a telephone meeting with Debbie's father in June 2022.

2.28 At the telephone meeting between Debbie's father and the Chair, Debbie's father spoke about Debbie's life and her relationship with Jack. The Chair made notes about his thoughts and views which were shared with the DHR panel.

2.29 The Chair then contacted Debbie's father in August 2022 by email to update on progress of the review and to seek a further meeting. No reply was received to this email.

2.30 The Chair contacted Debbie's father again on 6th December 2022 by email and on 7th December 2022 by text to update him and discuss the content of a draft report that had been requested by HM Coroner. Debbie's father responded to the Chair on 7th December by text. He said he did not want any further contact from the Chair 'under any circumstances'. Father suggested that his witness statement be used in the DHR report to reflect his views. The review asked for a view on this from the Coroner's office, however no response was received.

2.31 Following this exchange with the Chair, Debbie's father has been kept informed of progress by the CSP Lead Officer.

2.32 In March 2024 Debbie's father was contacted in writing to inform him that the report was nearing completion and to provide him with an opportunity to read and discuss the report. Debbie's father contacted the Lead Officer and agreed to speak via telephone. During a lengthy call, Debbie's father informed them that he did not wish to see the report or to have any involvement in the DHR. He told the Lead Officer that he was not being represented by any other family member and did not support ongoing complaints regarding any aspect of enquiries into Debbie's death from

other family members. In this conversation father was informed on the pseudonym suggested by the panel.

2.33 Following feedback from the Home Office, the Lead Officer contacted Debbie's father again in April 2025. He responded and, during a telephone conversation with the Lead Officer, he confirmed that he did not want to read the DHR report. He said that Debbie's death had been traumatic for her family and that he wanted to move on.

2.34 He did at this point feel more able to share his thoughts with the Lead Officer and said that he wished to include a tribute to Debbie in the final report. He had discussed this with Debbie's child (Child 1) with whom he said he had become very close since Debbie's tragic death and that she was happy with the content. He asked that the following be included in this report:

'In the few years since 'Debbie's' tragic suicide I have become quite close to my grandchild (Debbie's child) and that's been comforting and healing for both of us. I'd just like to say that Debbie was a 'super' clever girl and also 'sassy' and popular. Sometimes I think with qualities like these there can also be a downside like mild depression etc. I've got good memories though and also my lovely grandchild'.

Debbie's Birth Mother

2.35 Debbie's birth mother was first referenced in a meeting between the Chair and Debbie's aunt in November 2022. Debbie's aunt said that she was in communication with other members of Debbie's family, including Debbie's birth mother who was terminally ill and has since sadly passed away. The Chair asked if Debbie's birth mother may wish to contribute to the review. Debbie's aunt said she would ask her.

2.36 The Chair suggested that they should contact the Lead Officer of the review if they wished to participate. Debbie's birth mother was not contacted directly by the Chair or the Lead Officer of the review. The panel acknowledges that additional efforts should have been made to ascertain whether she felt able or unable to contribute to the review.

Child 1

2.37 Child 1 was a minor during the period of the DHR.

2.38 The review established that Child 1 had lived with their father since their parents had separated, although they had spent a short time living with Debbie immediately after the separation. Child 1 continued to spend time with Debbie but did not return to live with her.

2.39 The Chair contacted Child 1's school and spoke to the Safeguarding Lead who confirmed that there had been no safeguarding concerns at any time in relation to Child 1. The school were aware of the separation of

Child 1's parents and that Child 1 had experienced some difficulties at this time.

2.40 The review made enquiries with Child 1's GP to ensure that there were no safeguarding concerns relating to Child 1. No further records in relation to Child 1 were accessed.

2.41 The panel felt strongly that the review should not include any further information relating to Child 1 and should adopt the principles set out in Working Together to Safeguard Children that a sensitive approach should be taken, recognising that Child 1 would have experienced significant trauma in relation to the death of their mother. Therefore, the panel agreed there would be no further analysis of, or reference to, contacts with Child 1 in the review.

2.42 In April 2025 Debbie's father confirmed that he had spoken to Child 1 about the review and asked if she was comfortable with it. Child 1 confirmed that she did not want any involvement in the review but that she was comfortable with the tribute provide by Debbie's father.

Debbie's Aunt

2.43 Debbie's aunt was contacted at the start of the review and responded saying she wished to meet with the Chair. A meeting was arranged with Debbie's aunt which took place on 10th November 2022 at a community venue in Salford. The Chair was accompanied by a member of the specialist domestic abuse service in Salford. Debbie's aunt was accompanied by a member of her family for part of the meeting.

2.44 At the meeting the Chair made brief notes to provide feedback to the DHR panel. The Chair provided an overview of the DHR process and invited Debbie's aunt to raise anything that she thought would be relevant to the review.

2.45 Debbie's aunt told the review that she had not seen Debbie for several years prior to her death but they remained in contact with each other and wider family members via phone, text and social media.

2.46 She said that following Debbie's death she had spoken to friends of Debbie who told her that Debbie had told them, both by text and in conversation, that Jack was abusive to her.

2.47 Debbie's aunt said she had also read copies of Debbie's journals and diaries in which Debbie referred to the relationship with Jack as being abusive. NB: The Chair and lead commissioner had already had sight of these text messages and Debbie's diary and had made enquiries to confirm that no agency involved in the review had knowledge of these

text messages or of Debbie's diary prior to Debbie's death. The panel therefore deemed that, whilst providing valuable insight into Debbie's lived experience, agencies could not have known about any of the events referred to in the messages and diary. It was therefore agreed by the panel that agency learning could not be derived from this material, however the panel noted the content and context of the material in relation to Debbie's lived experience at that time. It was not possible to triangulate Debbie's thoughts and feelings as none of those with whom Debbie was corresponding contributed to the review.

2.48 Debbie's aunt told the review that she had viewed police body worn footage which showed a neighbour saying that she had witnessed Debbie in a state of distress following an alleged incident with Jack.

2.49 Debbie's aunt told the review that she had concerns about the police investigation and had made a complaint to police regarding their interactions with Debbie and that this was ongoing.

2.50 Debbie's aunt suggested that the review should view body worn footage from the scene of death. The Chair said they would make further enquiries about viewing this. NB: The Chair raised this with the DHR panel at a meeting on 18th November 2022. The panel decided that footage related to the scene of the death was not within the parameters of the DHR. The footage was therefore not requested by the panel.

2.51 In April 2024 Debbie's aunt was provided with a copy of the draft DHR report and invited to comment and suggest anything she felt could be expanded upon or amended. Debbie's aunt was supported in this process by an advocate from AAFDA (Advocacy After Fatal Domestic Abuse) who liaised with the Lead Officer on behalf of Debbie's aunt.

2.52 On 1st July 2024 AAFDA submitted a document to the Lead Officer containing a number of points and questions raised by Debbie's aunt.

2.53 A Review Panel to consider Debbie's aunt's comments was convened and took place on 2nd September 2024 (there was a delay in bringing the panel together due to school summer holidays). As requested the Lead Officer sent feedback from this meeting to Debbie's aunt via AAFDA on 19th September 2024.

2.54 Following the feedback from the panel Debbie's aunt contacted the Lead Officer by email to say that she was not happy with the panel's response and wanted the review to be done again. Her comments were considered by the CSP who advised Debbie's aunt that the process was complete and there would be no further feedback to her before submission of this report. The Lead Officer spoke to the Team Leader at AAFDA regarding the CSP decision. The Team Leader said she would advise Debbie's aunt of the CSP decision.

2.55 Debbie's aunt contacted the Lead Officer by email on 27th March 2025 saying that she had been in touch with the Home Office and suggesting that they agreed with her concerns regarding the review. Feedback subsequently received from the Home Office on 28th March suggested that 'relations had broken down' with Debbie's aunt and further suggested that the review panel make contact with her. The panel met on 29th April 2025 to address this and other queries posed by the Home Office.

2.56 The panel concluded the following:

- The panel recognised that Debbie's aunt had provided helpful background information regarding Debbie and had been very willing to share important information with the review. The panel also acknowledged the traumatic circumstances of the review and the impact on Debbie's aunt and other family members.

- The panel noted that Debbie's aunt had been involved in the review from the outset and the panel believed that all reasonable requests made by her had been considered and acted upon. The panel acknowledged that neither Debbie's aunt nor any other family member had been invited to the panel meetings but reflected on the general practice that the panel will always consider if a family member should be invited to meet with the panel but that this would be the exception. In this review, as in others, the panel decided that it would be more appropriate for the Independent Chair/Author to be the link, this being less intimidating and more personal for family members supported by their advocates.

- The panel reviewed the communications between Debbie's aunt and the Lead Officer over the last three years. Debbie's aunt does not consider that the DHR's conclusions are consistent with her view of the circumstances. The panel has, on a number of occasions, discussed Debbie's aunt's views and conclusions. However, these focus on cause and circumstances around the death which is a matter for police and coronial processes and outside the remit of the DHR, which seeks learning regarding the way in which professionals and organisations work individually and together to safeguard victims.

- The panel noted that other family members had indicated to the Lead Officer that they were not in agreement with Debbie's aunt's position and that this had deterred some family members from participating in the review.

  It was agreed that a further offer should be made to Debbie's aunt by email inviting her to provide a testimonial for inclusion in the report prior to resubmission to the Home Office and that the report would be shared with her on resubmission.

Debbie's Ex Partner (Father of Child 1)

2.57 A letter was sent inviting Debbie's ex-partner to participate in the review. No response was received.

Jack

2.58 A letter was sent to Jack inviting him to participate in the review, no response was received.

Friends and Community

2.59 Two of Debbie's friends (one of whom was a work colleague) were invited by letter (and email) to contribute to the review. Neither responded to this invitation.

2.60 Following feedback from the Home Office regarding the involvement of Debbie's work colleague, the panel addressed this at the reconvened meeting on 29th April. The panel's view was that all reasonable efforts had been made to engage the work colleague, unfortunately without success. The panel did not feel it would be appropriate to attempt to contact this individual again.

2.61 Following information from Debbie's aunt regarding a neighbour witnessing an altercation between Debbie and Jack, the review made enquiries with the housing provider and confirmed that this incident had not been reported to them. NB: On further enquiry the review found that police had first been informed of this incident by Debbie's neighbour during the police investigation after Debbie's death.

2.62 Following Home Office feedback the panel re-addressed the matter of the neighbour witnessing domestic abuse. The panel again discussed the neighbour having been spoken to by police as part of their review and the neighbour declining to provide a statement. The panel agreed that the Lead Officer should write to the neighbour by recorded delivery letter offering an opportunity to participate in the review. The neighbour has not responded to this letter.

Debbie's Employer

2.63 The panel agreed that Debbie's employer should be asked to contribute to the review as they had contacted GMP after Debbie's death as a member of their staff had informed them about Debbie's allegations of abuse by Jack.

2.64 Following an introductory email from the Lead Officer, Debbie's employer telephoned them on 5th December 2022.

2.65 Debbie's employer said that Debbie had never spoken to them directly about abuse and that they only became aware of Debbie's allegations

after her death. They confirmed that they had contacted police after Debbie's death.

2.66 Debbie's employer confirmed that they had discussed career development with Debbie and had identified an opportunity for a three-month placement to another part of the country which could commence in December 2021.

2.67 Debbie's employer confirmed that there was no discussion about abuse or disclosure made by Debbie in this conversation. The employer said that to their knowledge, the discussion about a placement was not linked to Debbie requesting a move because of domestic abuse.

The DHR Panel

2.68 A DHR panel of senior representatives from relevant agencies was established and in total met nine times:

- 8th April 2022
- 27th May 2022
- 22nd July 2022
- 26th August 2022
- 27th September 2022
- 18th November 2022
- 9th January 2023
- Review paused in January 2023 to allow for complaints against Greater Manchester Police to be investigated and concluded.
- 21st November 2023
- Report finalised March 2024, Independent Chair/Author retires. Report shared with family for comment.
- 2nd September 2024, to consider feedback from family members.
- Report submitted to Home Office on 8th October 2024
- 29th April 2025 to consider feedback from the Home Office QA panel

2.69 There were no conflicts of interest and none of the panel members had any previous direct contact with Debbie or her family. 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.

Agency and Job Role of panel members
Independent Chair and Author
Lead Officer, Salford City Council
Service Manager, Safe in Salford Domestic Abuse Service (DA specialist adviser)
Specialist Nurse, Safeguarding Families, NHS Greater Manchester (Salford)
Designated Nurse Safeguarding Children and Cared for Children, NHS Greater Manchester (Salford)
Community Safety Manager, ForHousing
Safeguarding Nurse leads, Northern Care Alliance NHS Foundation Trust

Agency and Job Role of panel members
Detective Constable, Serious Case Review Team, Greater Manchester Police
Strategy Manager Public Health (suicide prevention specialist adviser)

2.70 The Community Safety Partnership appointed Maureen Noble as Independent Chair and Author to oversee the Review and to write the overview report on 1st March 2022.

2.71 The Chair has worked as an Independent Consultant specialising in safeguarding and domestic abuse for 11 years and has undertaken numerous Child and Adult Safeguarding reviews and Domestic Homicide Reviews. She has undertaken pro-bono work with NICE and SCIE in relation to domestic abuse.

2.72 She was previously employed by Manchester City Council as Head of Crime and Disorder. She left Manchester City Council in 2012.

2.73 Until March 2023 the Chair was employed as Independent Chair for the Trafford Strategic Safeguarding Partnership.

2.74 Throughout the review process the Chair was independent of all agencies and individuals involved in the review.

2.75 The Chair retired in January 2024 prior to the completion of the review. From this point the CSP Lead Officer assumed the role of Chair to the panel.

Agencies Submitting Information to the Review

2.76 Following initial scoping for the review the following agencies were identified as having had contact with Debbie and were asked to secure their records. Individual Management Reviews (IMRS) and short reports were received as set out below.

Agency/Abbreviation	Report Requested/Received	Single Agency Action Plan Yes/No
General Practitioner Represented by NHS Greater Manchester (Salford)	IMR Received	Yes
Salford Royal NHS Foundation Trust (Northern Care Alliance)	IMR Received	Yes
ForHousing	IMR Received	No actions identified
Greater Manchester Police	IMR Received IMR Revised November 2023	Yes

Agency/Abbreviation	Report Requested/Received	Single Agency Action Plan Yes/No
Northwest Ambulance Service	Short Report	No actions identified

Other Information Provided to the Review

2.77 The Chair and Lead Officer had sight of witness statements and received a summary relating to the complaint made to police by Debbie's aunt.

2.78 The Chair attended a Pre-Inquest Review meeting with HM Coroner in August 2022. The DHR continued to co-operate with HM Coroner in relation to inquest. The Review was not invited to contribute to the Inquest held in London in December 2024 but on request we have received the Record of Inquest.

2.79 The Chair and Lead Officer had sight of Debbie's diary/journal (see above).

2.80 In addition to Salford Royal Foundation Trust (SRFT) the review made enquires with two other local hospital trusts in locations close to Debbie's home (and a location where she had previously lived) to establish whether Debbie had ever attended their A&E departments in relation to domestic abuse or other health matters. Confirmation was received that Debbie had never done so.

2.81 Enquiries were made regarding criminal antecedents in relation to Jack. The review found that domestic abuse incidents had been reported in the past but there were no domestic abuse crimes. These incidents were not related to Debbie and took place outside of the timeframe of this review. The panel therefore concluded that these antecedents should not be referred to further in this report.

2.82 It is known that there are links between self-harm/suicide and domestic abuse, the Chair therefore invited input to the review from the local Suicide Prevention Committee. The coordinator was co-opted to the panel and attended all meetings. The co-ordinator provided input into forming the conclusions and recommendations of the review.

2.83 The review was provided with updates regarding complaints made to GMP and IOPC. NB: The IOPC involvement was in relation to police handling of Debbie's aunt's complaint. These complaints do not fall within the purview of the DHR. Other than a revised IMR provided by GMP in November 2023 no information from these complaints is contained in this report.

2.84 Single agency action plans are attached at Appendix 1. Not all agencies involved in the review identified learning.

2.85 There were no conflicts of interest recorded during the Review. Authors of Individual Management Review reports and short reports were not directly connected to Debbie or Jack.

2.86 Disclosure was not applicable as there was no criminal investigation in the case.

2.87 When finalised the review report will be shared with the following:

Members of Debbie's family

The Community Safety Partnership Board

Relevant safeguarding agencies in Salford

Greater Manchester Suicide Prevention Board

Office of the Police and Crime Commissioner

HM Coroner

Section 3: Background and Chronology

Background

3.1 Debbie was described by those who knew her as a lively, bubbly and very intelligent person. She was said to do everything 'to the max' and was strong minded and determined.

3.2 Debbie had a wide social network and enjoyed spending time with friends and family.

3.3 Debbie had one child (referred to in this report as Child 1) with whom she had a loving relationship. Debbie's relationship with Child 1's father sadly broke down and, after a period of living with Debbie, Child 1 decided to live with their father. Debbie maintained contact with Child 1 and they spent time together and were supported in maintaining their close relationship by Debbie's father and step-mother.

3.4 Debbie's career was very important to her. She had returned to education as an adult and achieved a higher educational qualification. She was said to be determined to achieve success in her career and progressed quickly to a senior role in which she was said to excel. Her employer reported that she was respected by colleagues and a valued employee.

3.5 Debbie appears to have known Jack through family connections for some time before beginning a relationship with him. The review does not know exactly when their relationship began, but the family believe it to be early 2020 and it is on police record that it was ongoing in October 2020.

3.6 Jack had in the past been a friend of Debbie's father although their friendship had ended some years ago. At the time of Debbie and Jack's

relationship it appears that Jack was also in a relationship with another person with whom he shared children.

3.7 During her relationship with Jack, Debbie made notes in a diary/notebook which was recovered from the scene of her death by police. The contents of this diary was not seen by any agency prior to Debbie's death and could not have been known by any agency, nor were any of these thoughts disclosed in any of the few interactions with agencies that Debbie had.

3.8 Following feedback from the Home Office, the DHR panel revisited their decision regarding the inclusion of excerpts from Debbie's diary to ensure that her voice was heard through her recorded experiences, thoughts and feelings. The panel confirmed its decision to preserve Debbie's privacy and agreed that the diaries contained deeply personal events and reflections from Debbie, many of which were not related to her relationship with Jack. The panel did not agree that these entries should be included in this report.

3.9 The panel asked the independent panel representative from the local domestic abuse service to review the entries relating to Jack and to Debbie's emotional health and wellbeing.

3.10 The following is a reflection of the diary/notebook compiled by the panel member and agreed for inclusion in this report by the panel. To clarify, this is a notepad and is not a diary in the sense that it is completed on a daily basis. It is more of a notepad of private thoughts and journalling and included 'to do' lists. There are some entries that are dated.

3.11 The panel discussed thoroughly how best to convey Debbie's lived experience and still preserve her privacy and dignity. This notepad diary is Debbie's private thoughts and introspections and we do not feel it is appropriate to publish this information in its entirety.

3.12 We have decided to summarise some parts; to try and be Debbie's voice and ensure we acknowledge her lived experience of domestic abuse. It is important to highlight that we do believe Debbie's accounts of what she was experiencing.

3.13 Debbie describes being in turmoil about her relationship with Jack and that it had ended and she wanted to move on with her life.

3.14 Debbie described an abusive relationship. In one entry she says that Jack had attacked her the previous Tuesday and "thrown her around the room". The entry said Jack had chased and threatened her dog as the dog had tried to defend Debbie. A neighbour having to knock on during this was mentioned and the panel did contact the neighbour to discuss potential learning but the neighbour did not respond.

3.15 One of Debbie's entries says "He is always bruising me". She writes about "wanting to die" and she describes her relationship with Jack as

"Toxic" and lists a number of reasons to die. She does list her relationship difficulties as one of those reasons.

3.16 Debbie's notepad diary clearly highlights some of Debbie's lived experience of physical and psychological abuse. She has described being physically attacked and being bruised. She described "head games", Jack being "nasty" and "moody", "lying to her" and being "unpredictable".

3.17 Debbie's diary highlights that she was struggling with her self-worth, a known impact of domestic abuse, which can lead to anxiety, depression, post-traumatic stress disorder and suicidal thoughts or attempts and substance misuse.

Chronology

2018

3.18 On 6th March Debbie had a medication review with her GP. She reported that she felt the reviews were taking place too often and that she was comfortable with current prescribing for anxiety and depression.

3.19 On 28th June a further medication review took place with the GP. Debbie reported that since being prescribed medication difficulties with alcohol consumption had reduced.

3.20 On 12th November a further medication review took place. Debbie said she was still waiting for an appointment regarding her concerns previously discussed with the GP that she may have ADHD (Attention Deficit Hyperactivity Disorder). The GP followed this up the same day (NB: the first referral had taken place in November 2017).

3.21 The GP enquired about Debbie's mental health, alcohol consumption and relationships. Debbie said she did not have any thoughts of self-harm. She confirmed that she was not in a relationship at that time. She also expressed some concerns about Child 1.

2019

3.22 The GP followed up the ADHD referral again in January 2019 when it was confirmed the consultant was on leave and there was a 3-month waiting list. The GP emailed the secretary to mark the referral as urgent.

3.23 A voicemail was left for Debbie to contact the surgery. There are no further records regarding the outcome of this referral.

3.24 On 31st May Debbie made a call to North-West Ambulance Service reporting that she was experiencing abdominal pain. She was provided with a telephone assessment by a clinician. Debbie said the pain had subsided and said she did not want a referral to an out of hours GP but would follow up with her own GP.

2020

3.25 In January Debbie reported an incident of criminal damage to GMP and ForHousing. Debbie reported that she had found a small hole in one of her windows, possibly made by a pellet gun during a non-specified time period. GMP investigated the incident, and no offender could be identified. On that basis the crime was filed with no further action.

3.26 ForHousing secured the locks and replaced the broken window. NB: The review asked the ForHousing panel representative to confirm whether this type of anti-social behaviour may be more prevalent in the area in which Debbie lived – they reported that this was unlikely.

3.27 On 6th April Debbie rang 999 reporting that she was experiencing chest pain. Debbie received a telephone assessment by a clinician from NWAS and was referred to her GP. Advice was given regarding action to take if the pain worsened.

3.28 In August Debbie had a telephone encounter with her GP for a review of medication. Debbie reported that she was 'fine' with her current dose of anti-depressant medication and felt anxious at the thought of the dose reducing. It was agreed that Debbie should be kept at the current dose.

3.29 In October Debbie had an encounter with her GP in which she said that the split with her partner (partner unspecified) had been unpleasant and that she had subsequently experienced panic attacks. There is no indication that the GP explored potential safeguarding or domestic abuse issues during this encounter.

3.30 In November Debbie had a further encounter with her GP following a change in medication, which she said had been helpful. However, Debbie reported that she was not sleeping well and was prescribed a short course of sleeping tablets.

2021

3.31 On 11th January Debbie presented to the A&E Department at Salford Royal Hospital (SRFT) reporting that she had been experiencing chest pain for the past two days. She was examined at 02.17 hours on 12th January by a clinician who noted that she had bruising to her arms. Debbie said this was due to 'martial arts.'

3.32 On 12th January Debbie had a telephone encounter with an Advanced Nurse Practitioner at her GP practice, reporting upper abdominal pain. Debbie was prescribed medication for indigestion. The GP Practice requested an ultra-sound scan; however the scan did not take place prior to Debbie's tragic death although the referral had been made by the GP. The panel noted that national lockdown did not extend wait times and there is no evidence to indicate a delay in referral due to the GP contact being via telephone.

3.33 In June the GP contacted Debbie to ask her to attend for routine blood tests, however these did not take place prior to her tragic death.

3.34 On 12th July Debbie contacted police via an on-line referral system. She reported that she was experiencing domestic abuse from her partner and wanted to request a disclosure under Clare's Law/DVDS (Domestic Violence Disclosure Scheme).

3.35 In the on-line referral Debbie reported that her partner (presumed to be Jack) had assaulted her in the past and that she was beginning to realise he was a 'bully' and was controlling. She reported that she had found out that he had been abusive towards an ex-partner.

3.36 The online form was reviewed and noted as being 'low risk' and suitable for a 'domestic abuse appointment'. NB: In line with policy, a separate incident log was created for the DVDS request. An email was sent to the PPIU (Public Protection Investigation Unit) supervisors requesting allocation to an officer. The DVDS email was missed therefore the domestic abuse record (DAB) was not created at the initial point. It was only when the corresponding log was actioned, and the officer went to visit Debbie, that the request for a DVDS was discussed with her.

3.37 At 9.30 hours on 12th July a police officer spoke to Debbie on the phone. Debbie said that she was no longer in a relationship with Jack but that he kept trying to get back with her. She said that during the relationship Jack had broken her fingers and her ribs.

3.38 She said she was happy with having a domestic abuse appointment which was booked for 19.00 hours on 13th July at the local police station. The officer completed a THRIVE[10] assessment.

3.39 The officer then updated the police log with the date and time of the domestic abuse appointment.

3.40 On 13th July the police log was updated that staff would be unable to service this appointment due to it coinciding with another appointment and low staffing levels. The log was then delayed due to resourcing issues, and there was a gap between 13-19th July where there were no entries on the log. It is not evident how or if the change of appointment was relayed to Debbie, there is no evidence present within her phone records to show a change of appointment, nor whether the appointment happened.

3.41 The log was picked up again on 19th July and was eventually allocated on 21st July when an officer visited Debbie at home**.

3.42 On 20th July GMP received a referral from the NSPCC (National Society for the Prevention of Cruelty to Children) regarding an email notification of concern for the children of Jack's ex-partner. The online referral had been sent to the NSPCC by Debbie where she expressed concern regarding domestic abuse and alcohol use between Jack and his ex-partner.

3.43 On 21st July a GMP officer visited Debbie at home in relation to the on-line report she made on 12th July. At the visit Debbie stated that Jack had

[10] THRIVE is a risk assessment tool used by Greater Manchester Police

assaulted her whilst they were in a relationship (and that the relationship was now over).

3.44 The written record of the conversation with the officer states that Debbie was 'vague on details'. Debbie stated that Jack had grabbed her hand about 6 weeks ago and squeezed her fingers causing pain.

3.45 She also said that in October 2020 Jack had squeezed her waist causing pain to her ribs. She believed her ribs and fingers to be broken due to the pain however she said she did not seek medical treatment for either alleged assault.

3.46 The police log states that Debbie said she did not want a crime to be progressed and that she would not support a prosecution as this may cause further problems. The review learned that body-worn camera footage of this encounter with Debbie has been lost due to a 'system-error'. The review sought further information from GMP who confirmed that the footage was no longer available due to a system over-write facility which deleted the footage after 28 days as it was saved with a domestic abuse marker and not an evidential marker. NB: A single agency action has been identified by GMP regarding preservation of evidence.

3.47 Debbie was informed by the attending officer that other decision-making officers would be responsible for providing any information under Clare's Law/DVDS. However, the officer expressed the view that Debbie may not be entitled to any information as she was no longer in a relationship with Jack. The officer's rationale for this assumption was incorrect and GMP have since completed training for staff responsible for DVDS disclosures.

3.48 Debbie's risk was assessed as medium (the rationale for this rating was as she lived alone and was no longer in a relationship with the alleged perpetrator). Debbie said she did not want to complete a full DASH[11] risk assessment.

3.49 She was advised to contact the police if Jack contacted her again. She was also advised about orders she could apply for to provide safety and about other agencies she could contact for advice and she said that she would ring 999 if Jack turned up at the address.

3.50 Following this visit the officer returned to the police station and created a DAB record that same day.

3.51 On the morning of 22nd July, the DAB was picked up by the triage officer because it was marked as a medium-risk DAB requiring triage.

[11] https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

3.52 The triage officer performed the background checks and identified there was an open police log from the NSPCC requesting the children of Jack's ex-partner be visited by police due to concerns raised by Debbie.

3.53 On 22nd July it was documented that a referral had been made to Children's Social Care in line with policy regarding the NSPCC safeguarding report.

3.54 The triage officer then tried to telephone Debbie but did not get a reply. Had the triage officer spoken to Debbie the risk assessment may or may not have changed, and DVDS could have been discussed.

3.55 A crime of Section 39 assault was recorded (relating to the previously reported injuries to rib and fingers) which was subsequently filed as Debbie said she did not wish to proceed with a prosecution. The crime report investigation was not progressed further because, according to the police record 'there are no further lines of enquiry; there are no CCTV/witnesses to the incidents, (Debbie) has not disclosed these incidents with any other parties, and no medical records to confirm what injuries the victim sustained'.

3.56 The crime was reviewed by a Detective Inspector who endorsed the crime with a rationale for the closure of the crime report that the victim did not support a prosecution and therefore it would not be in the public's interest to pursue the matter.

3.57 On 29th July GMP safeguarding team made unsuccessful attempts to contact Debbie by phone.

3.58 On 30th July an officer attended the children's address in relation to the NSPCC report, however the children's mother was not present. A family member was spoken to. NB: No further contact was made until 15th August when mother was seen and reported the children to be safe and well.

3.59 In early August GMP received a call from Debbie's father saying that he had found Debbie hanging, that she had been cut down and that she was unresponsive and cold. Police attended the scene and spoke to Jack and Debbie's father. Officers reviewed the scene and found no evidence of third-party involvement. A referral was made to the coroner.

3.60 Two days later GMP attempted to contact Debbie by phone, the officer making the call was unaware of Debbie's death.

Section 4: Analysis

Analysis of the key lines of enquiry

4.1 *KL1 Did any agency know that Debbie may be subject to domestic abuse in any form (including economic/financial abuse) at any time during the period under review?*

4.2 *KL2 What action did agencies take to safeguard Debbie as a potential victim of domestic abuse?*

4.3 With the exception of Greater Manchester Police none of the agencies who were involved with Debbie during the period under review received any disclosure or information that Debbie was subject to domestic abuse in any form.

GMP

4.4 The online referral made by Debbie was rated low risk and suitable for a domestic abuse appointment (an appointment with a police officer to discuss and further assess) in line with policy. The appointment made for Debbie to attend the police station was delayed due to service pressures, and whilst Debbie was spoken to on 13th July, it was 21st July before she was visited at home.

4.5 In the same referral Debbie requested disclosure of any history of domestic abuse relating to Jack under the DVDS legislation.

4.6 Although a log was created for this request it was not actioned until 21st July when the visiting officer informed Debbie that she was not eligible for DVDS as she was separated from Jack. This decision had not been triaged and was the belief of the attending officer.

4.7 This was not in line with police policy at that time for two reasons, firstly the DVDS request had not been triaged or reviewed by an officer and there had been no discussion regarding the application, secondly there was no policy stating that disclosure could not be made if the person seeking disclosure was no longer in a relationship.

4.8 The officer asked for further details in relation to the allegations of assault. Debbie did not want to provide additional details saying that the stomach/ rib injury had occurred in October 2020 and the 'broken' fingers about 6 weeks prior to her call. Debbie stated that she did not wish to proceed with a complaint, however the crime was recorded.

4.9 The domestic abuse record was reviewed by a safeguarding officer who considered the history of both parties, both in relation to domestic abuse and crime to inform them as to whether the assessment of risk was accurate. Efforts were made to contact Debbie to assess whether any further support was required.

4.10 Consideration was given to an evidence-led prosecution however the reviewing Inspector applied the National Decision model[12] and deemed that it would not pass the evidential threshold test and was not in the public interest.

4.11 The time between Debbie's initial request for DVDS and the response from GMP was initially delayed by nine days, however the DVDS process was being progressed within the recommended 35 days. What is unclear

[12] The National Decision Model is the primary decision-making model for police in England and Wales. Individuals, supervisors and others use it to assess potential decisions or decisions that have already been made.

is whether the decision maker was aware of the basic eligibility of an individual to receive a disclosure under the DVDS scheme when a relationship has ended, with the recorded rationale referring to the ended relationship as the basis for the non-disclosure. This rationale was found to be too cursory and has led to a further requirement for assessment of organisational learning.

GP

4.12 Debbie's contacts with her GP during the period under review highlight good practice in relation to medication management and review. Based on Debbie's presenting difficulties (which included anxiety and depression, alcohol issues and relationship difficulties), the GP might have exercised greater professional curiosity and made selective enquiry into the possibility of domestic abuse.

4.13 The review noted that historically the GP record included A&E information of a potential overdose episode in 2004. It was noted that the GP asked Debbie about self-harm at other encounters and documented no risk, which was good practice.

4.14 KL3 How did agencies work individually and collectively to safeguard Debbie?

4.15 Primary and secondary care health services appropriately shared information and worked together in relation to Debbie's presenting health needs.

4.16 Debbie was not assessed to be a high-risk victim of domestic abuse and therefore did not enter the MARAC system.

4.17 There were no other encounters in which services were required to work together to safeguard Debbie.

4.18 *KL4 Did any agency know that Jack may have been a perpetrator of domestic abuse.*

4.19 Previous partners of Jack had reported domestic abuse incidents to police that took place outside of the timeframe of this review. No domestic abuse related assault crimes were recorded against Jack.

4.20 No other agency was aware of the relationship between Debbie and Jack nor that Jack may have been a perpetrator of domestic abuse.

4.21 *KL5 Were family and/or friends aware that Debbie may have been victim of domestic abuse? If so, what action did they take? Did family/friends identify or experience any barriers to supporting Debbie in relation to safeguarding her from possible domestic abuse?*

4.22 During the period covered by this review there is no contemporaneous information available regarding family or friends' knowledge of domestic abuse or actions taken to support Debbie.

4.23 The Chair and the Lead Officer saw some of the text messages and Debbie's diary/journal. Whilst these provide insight into Debbie's lived experience, they were unknown to any agency at the time and were not analysed for learning. The panel agreed that the diaries contained deeply personal events and reflections from Debbie, as referenced in paragraph 3.10, it was a notepad and is not a diary in the sense that it is completed on a daily basis. It is more of a notepad of private thoughts and journalling and included 'to do' lists, many of which were not related to her relationship with Jack and it was agreed that these entries should not be included in this report. However, the entries have been reviewed and key themes relevant to domestic abuse have been noted to better understand Debbie's experience.

4.24 *KL6 Did any agency know whether Debbie may have experienced difficulties in relation to physical health, substance misuse, accommodation, economic abuse or possible criminal exploitation, and how did agencies respond to this?*

4.25 Debbie contacted agencies on several occasions regarding her physical health. She also spoke to her GP about managing alcohol use.

4.26 The review has identified one opportunity where selective enquiry might have enabled disclosure of domestic abuse by Debbie when she presented to the Accident and Emergency Department at Salford Royal Foundation Trust (SRFT) in January 2021. Debbie was asked about bruising to her upper arms and said this was due to 'martial arts'.

4.27 Debbie's response was taken at face value and no further questions were asked. There was no routine or selective[13] enquiry as to whether Debbie was experiencing domestic abuse which was not in line with SRFT policy at that time.

4.28 Debbie contacted NWAS (Northwest Ambulance Service) on two occasions reporting physical symptoms (chest and abdominal pain). On both occasions Debbie received telephone triage and was referred to her GP for further treatment and advice.

4.29 Debbie also consulted her GP regarding physical symptoms of chest pain and abdominal pain. Debbie was given advice on what to do if symptoms recurred or worsened. Debbie was subsequently referred for an ultrasound scan in January 2021 however this did not take place before her death.

4.30 None of the agencies involved in the review had any information suggesting that Debbie experienced financial abuse or criminal exploitation.

4.31 There is no information to suggest that Debbie was homeless or vulnerably accommodated during the period under review.

[13] Routine and selective enquiry are terms used in health settings to describe circumstances in which domestic abuse enquiry would be made.

4.32 *KL7 Did any agency know that Debbie may have experienced difficulties in relation to mental health, self-harm and/or suicidal ideation?*

4.33 Debbie had regular encounters with her GP in relation to ongoing anxiety and depression, for which she was treated in primary care.

4.34 The GP records indicate appropriate management of Debbie's presenting mental health issues through medication review and telephone encounters. Debbie complied with her treatment (it was recorded that Debbie was 'fine' with GP management), and the GP continued to prescribe whilst conducting regular medication reviews, which is good practice. The GP might have considered referring Debbie for specialist psychological support.

4.35 The review noted a potential overdose episode in 2004 which appears to have led Debbie's GP to make opportunistic enquiry with Debbie. This was good practice. The GP recorded that Debbie said she did not experience thoughts of self-harm when she was asked.

4.36 Greater professional curiosity around Debbie's presentations with abdominal pain and chest pain might have led to selective enquiry regarding domestic abuse, particularly in the context of anxiety and depression and excessive alcohol use.

4.37 No other agency with whom Debbie had contact was aware of mental health issues, self-harm or suicidal ideation.

4.38 *KL8 Was any agency aware of any matter regarding safeguarding children that needed to be considered by the review?*

4.39 The review established with all relevant agencies that there had been no safeguarding concerns in relation to Child 1.

4.40 Debbie made a report of concern to the NSPCC for the welfare of Jack's children who lived with their mother. The NSPCC referred this report to GMP in line with their safeguarding policy. However, there was a delay of over ten days between the initial contact and an officer attending the address in response to the NSPCC referral.

4.41 There were no safeguarding issues arising from this referral, however the response was too slow, and contact should have been made with the family sooner. Although not specifically related to this issue guidance contained in Working Together to Safeguard Children (2023) encourages swift action in response to safeguarding referrals.[14]

4.42 *KL9 Did Covid-19 affect working practices in any way, if so, how were these impacts mitigated?*

[14] Working together to safeguard children - GOV.UK

4.43 Due to national lockdown resulting from the Covid pandemic many GP appointments were conducted via the telephone. It is not possible for the review to comment on the impact this may have had on Debbie.

4.44 No other agency reported specific issues, however, all agencies noted the pressure on services during the pandemic coupled with significant adjustments to usual practice and service delivery.

4.45 Published research suggests that there was an increase in domestic violence and abuse reports during the pandemic. A report from UK Research and Innovation found that between April and June 2020 of the COVID-19 pandemic there was a 65% increase in calls to the national domestic abuse helpline compared to the first three months of that year.[15]

Lessons to be Learnt

Responding to Domestic Abuse

4.46 Debbie made an allegation of domestic abuse to police about Jack in July 2021 via an on-line contact form. She also asked for disclosure of any previous history of domestic abuse relating to Jack (DVDS).

4.47 The request for disclosure was not processed in line with GMP policy or the national guidance in place at the time and resulted in Debbie not being afforded disclosure of Jack's previous offences.

4.48 Decision making regarding whether to make a disclosure to Debbie appears to have been based on misinterpretation of the policy with an individual officer, without triage or further discussion. Although the triage officer did try to contact Debbie to discuss the DVDS on three separate occasions by phone (one of which was after Debbie's tragic death), none resulted in contact with Debbie.

4.49 In addition to a missed opportunity for disclosure this also highlights a gap in understanding in relation to the potential for post-separation abuse[16].

4.50 The policy in relation to DVDS within GMP has now been updated to reflect learning from this and other DHRs.

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[15] https://www.ukri.org/who-we-are/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/

[16] What is post separation abuse. It is not always the case that leaving an abusive partner will increase a woman's safety and research has established that, in many cases, domestic abuse from an intimate partner does not end upon separation. Post-separation can actually see an escalation of abuse with women reporting continued threats and intimidation when leaving their abusive partner. This abuse ranges from harassment type behaviour to physical abuse with a heightened risk of homicide.

4.51 This has highlighted that Multi-Agency Safeguarding Hub (MASH) officers across the Force may have a lack of understanding about the ability to disclose under DVDS when a relationship has ended.

4.52 There has been no specific training for DVDS for MASH officers – this is a gap that has been identified as an organisational area for improvement, and the Public Protection Governance Unit (PPGU) have taken up a piece of work with People & Development to make sure there will be an appropriate training package in place for roll-out as soon as possible.

4.53 Revisions have been made to the policy/flowchart to ensure that there is further clarity regarding the eligibility to disclose after a relationship has ended, but only where the decision to disclose is proportionate and necessary.

4.54 Debbie reported injuries to police for which she said she had not sought treatment. It is known that victims do not seek always medical help, and may disclose injuries some time after they have occurred. This re-emphasises the importance of ensuring that opportunities to make selective enquiry should be taken whenever they present.

Routine and Selective Enquiry

4.55 GP Practices undertake IRIS[17] training to support them in making selective enquiry in respect of domestic abuse. Based on the presence of health indicators, assessment could have been strengthened by direct enquiry around domestic abuse being made.

4.56 The IRIS Project was already embedded at this time and the GP Practice were making regular referrals. It is therefore unclear what the barriers were to making selective enquiry in this case although it is acknowledged consultations were taking place on the telephone with potential impact on non-verbal communication. Face to face consultation may have provided opportunity for increased professional curiosity however this was hampered by practice during the Covid-19 pandemic.

4.57 With regard to selective enquiry in secondary care (SRFT AED) this should have taken place and practice was not in line with organisational policy at that time.

Responding to Vulnerability/Trauma Informed Practice

4.58 Debbie experienced vulnerabilities including mental ill health and substance use, and she reported domestic abuse to GMP. The presence of these three factors is referred to as the trio of vulnerabilities.[18]

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[17] IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial.

[18] The term trio of vulnerabilities is used by the NHS to describe the presence of domestic abuse, mental ill health and substances in a person's life – previously referred to as 'the toxic trio'.

4.59 As Debbie had self-reported a history of difficulty with managing alcohol consumption and current anxiety this might have been an opportunity for the GP to review whether Debbie wished to be referred to psychology services. There is no indication in the records that the GP considered this.

4.60 Debbie was not referred to specialist alcohol services and there is no indication that Debbie sought specialist support for alcohol issues outside of disclosure to her GP.[19]

4.61 Responses to Debbie's vulnerabilities would have been strengthened by trauma informed approaches including routine and selective enquiry, a demonstrable understanding of the potential for post-separation abuse and referral to specialist services.

4.62 Debbie was perceived as a strong and resilient character. The review acknowledges the dilemma faced by professionals when assessing vulnerabilities in people who present as resilient, however a stronger focus on professional curiosity and trauma informed practice is to be encouraged.

Self-Harm and Suicidality

4.63 The review learned that Debbie was asked about self-harm (probably due to a self-harm incident having taken place in 2004) by her GP. On each occasion Debbie said that she did not have thoughts of harming herself.

4.64 The review notes there are links between domestic abuse and suicidality. Research commissioned by the charity Agenda Alliance concluded that women experiencing domestic abuse (or intimate partner violence) are three times more likely to experience suicidal thoughts. (Agenda Alliance 2023).

4.65 A 2018 study by the University of Warwick, focusing on more than 3,500 women supported by domestic abuse charity Refuge, uncovered that almost a quarter (24%) of women supported by the charity had felt suicidal at one time or another. A staggering 83% reported feelings of hopelessness and despair, key symptoms of suicidal ideation. (source https://www.hestia.org/blog/domestic-abuse-suicide.6

4.66 The diary/notepad found at the scene of Debbie's death illustrates that Debbie was experiencing emotional distress in relation to her relationship with Jack. The entries made by Debbie clearly detail abuse from Jack and Debbie's thoughts of self-harm and suicide. The panel concluded that as none of the agencies with whom Debbie had contact with had sight of the diary/notepad or its content prior to Debbie's death, the main learning we can obtain from the diary is to ensure that we acknowledge Debbie's

[19] Alcohol and mental health are closely linked. Drinking too much can affect your well-being. Some people may drink to try to relieve the symptoms of mental ill-health. https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health

'Lived Experience' and raise awareness of the devastating impact of Domestic Abuse on Mental health and Wellbeing.

4.67 The local Suicide Prevention Strategy action plan recognises domestic abuse as a potential factor in self-harm and suicide and a local training programme is in place. The review recommends that learning from this case is fed into the development of the Greater Manchester Suicide Prevention strategy.

Help and Support for Victims, Families and Friends

4.68 There is no indication that Debbie made contact with specialist domestic abuse services. The panel observed that there are many sources of help available to victims both locally and nationally, however Debbie may not have felt she needed to access them, or may have been reluctant to do so for reasons unknown to the review.

4.69 The review believes that sources of help and support to victims of domestic abuse should be widely publicised and easily available.[20],[21]

4.70 Although there is insufficient contemporaneous information to draw conclusions regarding the role of family and friends in this case, the review notes the importance of providing family and friends of victims of domestic abuse with opportunities to access support and engage with services.

4.71 The review has recommended that the local Domestic Abuse Board should revisit guidance to families and communities and make any necessary amendments based on the findings of this review.

The Role of Employers

4.72 Debbie did not make any disclosures of domestic abuse to her employer although it appears she did speak to a work colleague about her relationship with Jack.

4.73 The review notes that Employers have a duty of care in relation to domestic abuse [22]as set out in the Domestic Abuse Act (2021).

4.754 The local partnership should publicise and raise awareness of organisations such as the Employer's Initiative on Domestic Abuse who provide valuable guidance on policy and best practice. The domestic abuse charity Hestia also provide a help-line for employers (0203

[20] https://www.gov.uk/guidance/domestic-abuse-how-to-get-help
[21] https://www.salfordfoundation.org.uk/safeinsalford/
[22] https://safelives.org.uk/sites/default/files/resources/DV%20Employer's%20guidance%20FINAL%20Update%203%20-%20SafeLives%20rebranded.pdf

8793695 or email Adviceline.EB@hestia.org between 9am-5pm Monday to Friday for support) [23],[24]

The Impact of the Covid-19 Pandemic

4.75 The pandemic limited opportunities to see Debbie face to face which significantly impacted the ability of services to assess her presenting issues.

4.76 It is acknowledged that systems and services were under extreme pressure during the pandemic.

4.77 The personal impact that the pandemic had on Debbie's mental health is unknown. The impact of self-isolation particularly in the context of a potentially abusive relationship is not known in this case, however research conducted by MIND (Mental Health Charity) into the effects of the pandemic on mental health suggests significant increases in anxiety and depression across the population as a whole and within known vulnerable groups.[25]

4.78 It is unknown whether the impact of Covid-19 affected the assessment of Debbie whilst in the Emergency Department. There were geographical changes made to the department as a direct result of Covid with clinicians and nurses in PPE (Personal Protective Equipment).

Wider Learning

4.79 The panel noted that the learning from this review mirrored many other DHRs both locally and nationally. It was felt that systemic change has not embedded in relation to implementing learning from DHRs leading to continuous improvement in practice.

Single Agency Learning

4.80 The panel is satisfied that the single agency action plans attached to this report address learning identified by individual agencies.

[23] https://www.eida.org.uk/news/new-domestic-abuse-statutory-guidance-highlights-employers-duty-care

[24] https://www.hestia.org/respond-to-abuse

[25] https://www.mind.org.uk/about-us/our-policy-work/coronavirus-research/#:~:text=We%20found%3A,health%20worse%20during%20the%20pandemic.

Section 5 Multi Agency Recommendations

5.1 The recommendations set out below are drawn directly from learning emerging from this review.

NB: The panel noted that there are overlaps in learning with other recent DHRs in Salford. To avoid duplication of work already in place, this review recommends follow up action in relation to recommendations 1, 2 and 4.

Recommendation 1

5.2 The CSP should ask all partner agencies for confirmation that their policies and operating models promote a culture of professional curiosity that adopts a person-centred approach that recognises the trauma experienced by victims of domestic abuse.

Recommendation 2

5.3 The CSP should ask all partner agencies to confirm their approach to raising awareness of post-separation abuse and associated risks (as set out in previous DHRs).

Recommendation 3

5.4 The CSP and local Suicide Prevention Strategy Team should ensure that the links between domestic abuse and suicide are clearly articulated in local strategy, policy and practice.

Recommendation 4

5.5 The CSP should write to all relevant agencies to remind them of their duties and responsibilities in relation to routine and selective enquiry into domestic abuse (as set out in previous DHRs).

Recommendation 5

5.6 The CSP should publicise relevant guidance to employers regarding their duty of care to employees in relation to domestic abuse.

Recommendation 6

5.7 The CSP should review current campaigns and guidance to ensure that support services for victims and families are well publicised and accessible.

Glossary of Terms

AAFDA	Advocacy After Fatal Domestic Abuse charity
CSP	Salford Community Safety Partnership
DAB	Domestic abuse record
DVDS	Domestic Violence Disclosure Scheme
GMP	Greater Manchester Police
IMRS	Individual Management Reviews
IOPC	Independent Office of Police Conduct
MASH	Multi-Agency Safeguarding Hub
MIND	Mental Health Charity
NSPCC	National Society for the Prevention of Cruelty to Children
NWAS	Northwest Ambulance Service
ONS	Office for National Statistics
PPE	Personal Protective Equipment
PPGU	GMP Public Protection Governance Unit
PPIU	GMP Public Protection Investigation Unit
SRFT	Salford Royal Foundation Trust Hospital

Appendix 2 Multi Agency Action Plan

DHR Panel Recommendations

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
1	The CSP should ask all partner agencies for confirmation that their policies and operating models promote a culture of professional curiosity that adopts a person-centred approach that recognises the trauma experienced by victims of domestic abuse.	Tackling Domestic Abuse Board (TDAB) to ask all partner agencies for confirmation that their policies and operating models meet this recommendation.	Individual agency responses.	Agencies better able to demonstrate professional curiosity in practice.	Tackling Domestic Abuse Board (TDAB)
2	The CSP should ask all partner agencies to confirm their approach to raising awareness of post-separation abuse and associated risks (as set out in previous DHRs).	CSP to ask all partner agencies for confirmation that their policies and operating models meet this recommendation.	Individual agency responses.	Agencies better able to demonstrate understanding of post – separation abuse and associated risks.	Tackling Domestic Abuse Board (TDAB)
3	The CSP and local Suicide Prevention Strategy Team should ensure that the links between domestic abuse	Learning from this case is fed into the business of the local	Minutes of the Salford Suicide	links between domestic abuse and suicide are clearly	Public Health Team

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	and suicide are clearly articulated in local strategy, policy and practice.	suicide prevention partnership board. Salford Suicide Prevention Strategy refresh to prioritise the links between domestic abuse and suicide.	Prevention Partnership. Refreshed Salford Suicide Prevention Strategy.	articulated in local strategy, policy and practice.	
4	The CSP should write to all relevant agencies to remind them of their duties and responsibilities in relation to routine and selective enquiry into domestic abuse (as set out in previous DHRs).	CSP to ask all partner agencies for confirmation that their policies and operating models meet this recommendation.	Individual agency responses.	Agencies better able to demonstrate effective use of routine and selective enquiry in practice that evidence improved outcomes for customers, clients and patients.	Tackling Domestic Abuse Board (TDAB)
5	The CSP should publicise relevant guidance to employers regarding their duty of care to employees in relation to domestic abuse.	Identified as action in TDAB plan. Partner agencies to demonstrate effective workplace policies to safeguard staff.	Agency workplace policies and implementation plans.	Agencies can demonstrate effective workplace policies and support for staff.	Tackling Domestic Abuse Board (TDAB)
6	The CSP should review current campaigns and guidance to ensure that support services for victims	Joint Safeguarding Comms Group to review reach and accessibility of	CSP Comms plan -evidence of delivery.	More victims accessing services.	Tackling Domestic Abuse Board (TDAB)

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer
	and families are well publicised and accessible.	information about da specialist services.	Joint Comms delivery plan - evidence of delivery. Safe in Salford performance reports.	Better outcomes for victims accessing services.	