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**Salford City Council**

Salford Community Safety Partnership

Domestic Homicide Review

Overview Report

'Dylan'

Died August 2022

Chair and Author: Dan Bettison

Date 2 January 2025

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### Introduction

- 1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Dylan, a resident of Salford, prior to his death. The panel would like to offer their condolences to Dylan's family on their tragic loss.
- 1.2 Dylan was married and had two adult children. Around 10 years prior to his death, Dylan told his wife and siblings that he was gay. He continued to live with his wife for several more years before he moved into his own home in Salford.
- 1.3 Around the end of 2019, Dylan met Ollie online, they began a relationship with each other and Ollie moved into Dylan's house. Ollie was 24 years younger than Dylan. Some of Dylan's family and friends were aware that he was a victim of domestic abuse from Ollie.
- 1.4 In June 2022, Dylan made contact with a domestic abuse charity based outside of Salford. Over a period of several weeks, Dylan disclosed and discussed domestic abuse from his partner. He did not provide his address and would not identify Ollie.
- 1.5 In July 2022, Dylan reported domestic abuse to Greater Manchester Police. He did not identify Ollie and did not wish to support a prosecution.
- 1.6 In August 2022, Dylan left his flat and sought help and advice from family members as how best to end the relationship with Ollie and be able to return home. Later that month, Dylan took his own life in a hotel room close to where he worked.
- 1.7 In addition to agency involvement, this review also examines the past to identify any relevant background or trail of abuse before Dylan's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.
- 1.8 The review considers agencies contact and involvement with Dylan and Ollie from 1 March 2019 until Dylan's death in August 2022. This time period was chosen as it includes a period of time before Dylan met Ollie. The panel felt that this period ensured that relevant interactions with support agencies were captured.
- 1.9 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

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- 1.10 **Note:**  
It is not the purpose of this DHR to enquire into how Dylan died; that is a matter that has already been investigated by the police and coroner.

### 2 Timescales

- 2.1 This review began on 7 December 2023.  
More detailed information on timescales and decision-making is shown at paragraph 5.2.

### 3 Confidentiality

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

- 3.2 Pseudonyms were agreed by Dylan's family to protect the identities of the subjects of this review.

### 4 Terms of Reference

- 4.1 The purpose of a DHR is to:

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

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

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

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4.2

### Timeframe Under Review

The DHR covers the period from 1 March 2019 until Dylan's death in August 2022.

4.3

### Case Specific Terms

#### **Subjects of the DHR**

Victim: Dylan, aged 58 years

Perpetrator: Ollie, aged 34 years

#### **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Dylan and how did your agency assess the level of risk presented by the alleged perpetrator. Which risk assessment model did you use and were multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed if appropriate?
2. What consideration did your agency give to any mental health issues when identifying, assessing and managing risks around domestic abuse?
3. What services did your agency provide for Dylan and Ollie. Were they timely, proportionate and 'fit for purpose'.
4. Did your agency consider that Dylan may be being exploited or could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert or hold a strategy meeting?
5. How did your agency ascertain the wishes and feelings of Dylan and Ollie in relation to alleged offending and were their views taken into account when providing services or support?
6. How effective was inter-agency information sharing and co-operation in response to incidents involving Dylan and Ollie or disclosures made by them? Was information shared with those agencies who needed it? Was any information not shared, due to concerns around sensitivity, confidentiality, risk, data protection or any other reason?
7. What knowledge did family, friends and employers have that Dylan was in an abusive relationship and did they know what to do with that knowledge?
8. Were there any examples of outstanding or innovative practice?
9. What training did your agency provide to staff around domestic abuse. Had staff who interacted with Dylan and Ollie completed the training and when?
10. What learning did your agency identify in this case?

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11. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues when completing assessments and providing services to Dylan and Ollie (including sexuality and age)?

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### Methodology

- 5.1 On 13 June 2023, Advocacy After Fatal Domestic Abuse (AAFDA)<sup>1</sup> wrote to Salford Community Safety Partnership and asked that consideration be given to commissioning a Domestic Homicide Review into the circumstances surrounding Dylan's death. AAFDA had supported Dylan's sibling and wife during the Coroner's inquest and requested the review on behalf of his sibling.
- 5.2 On 2 October 2023, Salford Community Safety Partnership held a meeting to consider multi-agency information held in relation to Dylan's death. It agreed that the circumstances of the case met the criteria for a Domestic Homicide Review [paragraph 13 Statutory Home Office Guidance]<sup>2</sup> and recommended one should be conducted. The Home Office was informed on 20 October 2023.
- 5.3 The first meeting of the DHR panel took place on 7 December 2023, via Microsoft Teams video conferencing. All subsequent meetings also took place via Microsoft Teams. The panel met four times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 17 June 2024, after which amendments were made to the report which were agreed by the panel.
- 5.4 The panel were mindful of the timescales suggested within Section 5 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016. Towards the end of the review, additional engagement was necessary with both Manchester University and LGBTQ+ foundation, prior to the final report being completed and agreed by panel members. The overview report was not therefore completed with six months.

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<sup>1</sup> Advocacy After Fatal Domestic Abuse (AAFDA) [www.aafda.org.uk](http://www.aafda.org.uk)

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

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- 5.5 The report was shared with Dylan's family who provided feedback. They requested some amendments be made to correct factual inaccuracies but overall felt that the report was *'balanced and brings together the key strands'*
- 6
- Involvement of Family, Friends, Work Colleagues and Wider Community
- 6.1.1 The DHR Chair wrote to Dylan's wife, one of his children and his siblings separately, inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the AAFDA leaflet.
- 6.1.2 The Chair wrote to one of Dylan's friends and also his supervisor from work.
- 6.1.3 Some family and friends (including his work supervisor) wished to contribute to the review and provided valuable background information, which is referenced appropriately throughout the report. Some family and friends wished to provide background information but did not want other members of the family to know this. The panel agreed to maintain confidentiality between members of the family and therefore, throughout the report any contributions are referenced as coming from 'family and friends', rather than identifying exactly who.
- 6.1.4 Family and friends explained that following Dylan's death, the relationship between some family members had become strained. The panel agreed that it should not involve itself in the disagreements and should maintain an independent approach within the parameters of the review objectives.
- 6.1.5 The panel agreed that Dylan's mother and one of his children should not be contacted as part of the review. Both are in poor health and family members requested that they not be contacted as this would likely impact on their health further. Neither had extensive knowledge of Dylan and Ollie's relationship. The panel respected their wishes.
- 6.1.6 During the review, the Panel Chair was contacted by AAFDA who requested an update. Although the review was originally requested by AAFDA, family informed the Chair that they were no longer in contact with them and some family did not wish to be. As such, AAFDA were not provided with any update. However, prior to the overview report being agreed by the panel, AAFDA again requested an update on behalf of some family members. Although it was established that support was still not being provided by them, some family members requested that AAFDA be provided with the final draft, which the Chair agreed to do.
- 6.2
- The Perpetrator

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- 6.2.1 The panel had lengthy discussion around whether or not to contact Ollie. It was mindful that Ollie had not been investigated in respect of Dylan's death, but at the time of the review was still under investigation by Greater Manchester Police for controlling and coercive behaviour towards Dylan prior to his death.
- 6.2.2 Although Dylan took his own life and that individual physical act was not directly linked to Ollie, the panel felt that there was still evidence that Dylan had been a victim of domestic abuse from Ollie and as such felt it appropriate to refer to Ollie as the perpetrator.
- 6.2.3 Some panel members felt that Ollie should be contacted by the Chair in order to gain a balanced overview of his relationship with Dylan. Some panel members felt that Ollie should not be contacted due to his mental health.
- 6.2.4 The panel sought advice from the clinical lead from mental health services and this included an update on Ollie's current behaviour and his mental health following Dylan's death. The Panel agreed that the likelihood of Ollie engaging with the review was slim and that even if he did engage, his input would likely be unreliable. The panel also felt that any approach to Ollie could significantly affect his current mental health and thereby increase risks towards the panel members, Dylan's family and Ollie himself.  
This opinion was formed with access to detailed information in respect of Ollie's current mental health diagnosis and his behaviour towards professionals over the previous months, including his arrest for a violent offence.
- 6.2.5 The Chair wrote to Ollie's University and held a meeting with its safeguarding lead. Although the University did respond to a request for information, the content was minimal and provided no information of particular relevance.

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### Contributors to the Review/ Agencies Submitting IMRs<sup>3</sup>

7.1.1	<b>Agency</b>	<b>Contribution</b>
	Fortalice	IMR
	Greater Manchester Police (GMP)	IMR
	Greater Manchester Mental Health Trust (GMMH)	IMR
	Northern Care Alliance (NCA) Salford Care	IMR

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<sup>3</sup> Individual Management Reviews (IMR's) are detailed written reports from agencies on their involvement with Dylan and/or the perpetrator.

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### Organisation

NHS Greater Manchester (Salford Locality)	IMR on behalf of Dylan's GP
North West Ambulance Service	Short Report
Spire	Short Report
Doctor Care Anywhere	Short Report

- 7.1.2 In addition to the IMRs, each agency provided a chronology of interaction with Dylan and the perpetrator, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of Dylan or the perpetrator, nor had any involvement in the provision of services to them.
- 7.1.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to Dylan and Ollie and any other action taken.
- 7.1.4 It should also provide an analysis of events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.
- 7.1.5 The IMRs in this case focussed on the issues facing Dylan and where appropriate, interactions with Ollie. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency and by the Panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

### 7.2

#### Information About Agencies Contributing to the Review

#### 7.2.1

##### Fortalice:

Fortalice are a Bolton based charity providing frontline services for people who are, or have been, affected by domestic abuse and violence. Our support includes refuge

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accommodation, local community services, education and accredited training for professionals.

In our refuges we offer wraparound support to the women and children who stay with us. In the community, we provide individual and group work for adults and young people, healthy relationships courses in schools and an IDVA and ISVA service. Our team work with Bolton GPs to raise awareness of domestic violence and encourage referrals.

### **7.2.2 Greater Manchester Police (GMP):**

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

### **7.2.3 Greater Manchester Mental Health (GMMH):**

GMMH is a specialist mental health provider, providing inpatient and community-based mental health care for people living in Bolton, the city of Manchester, Salford, Trafford and Wigan, and a wide range of specialist mental health and addiction services across Greater Manchester. GMMH also provide Health and Justice Services in a number of custodial settings.

### **7.2.4 Northern Care Alliance (NCA) Salford Care Organisation:**

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

### **7.2.5 NHS Greater Manchester (Salford Locality):**

NHS Greater Manchester is the Integrated Care Board for Greater Manchester, and has statutory duties to ensure the health providers they commission discharge effective safeguarding duties across Greater Manchester.

### **7.2.6 North West Ambulance Service (NWAS):**

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

### 7.2.7 **Spire Healthcare**

Spire Healthcare group is a national provider of private healthcare in the United Kingdom.

### 7.2.8 **Doctor Care Anywhere**

Doctor Care Anywhere group is a private provider of online healthcare services.

7.2.9 Primary Care medical records reveal that Ollie was referred by his GP to primary care psychology services (Six Degrees). Within a day of the referral, Six Degrees referred Ollie to the high intensity team at GMMH. The Chair considered that relevant information and discussion would have been better captured by the GP and GMMH and therefore decided that Six Degrees were not required to participate in the review.

## 8 **The Review Panel Members**

- 8.1
- Chair and Author
  - Lead Officer, Salford City Council
  - Detective Inspector, Serious Case Review Team, GMP
  - Safeguarding Adult Lead
  - GMMH
  - Specialist Safeguarding Families Nurse, NHS Greater Manchester Integrated Care
  - Interim Named Nurse For Safeguarding Children, Salford Care Organisation Northern Care Alliance NHS Foundation Trust
  - Director of Operations for TDAS part of the Safe in Salford Partnership/ Domestic Abuse Specialist Adviser.

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- Head of Safeguarding and Designated Nurse, Safeguarding Children and Cared for Children (Salford), NHS Greater Manchester Integrated Care
- Domestic Abuse and Sexual Violence Programme Manager, LGBT Foundation
- Public Health Principal Manager
- (Advisor on suicide prevention issues)

8.2 The panel felt that it did not have an adequate understanding of the gay community generally. It was also mindful of the fact that Dylan had disclosed his sexuality in later life, having been married to his wife for many years and having children with her. It was agreed that specialist advice should be sought and the panel approached several gay groups and charities in the Manchester and Salford areas. Some felt unable to support the panel, but Tyler Andrew, LGBT Foundation did agree to provide specialist advice and agreed to be a panel member.

8.3 LGBT Foundation are a national charity with LGBTQ+ health and wellbeing at the heart of its work. It seeks to celebrate and empower diverse communities to realise their full potential.

8.4 It should be noted that agencies and charities used several different acronyms when referring to members of gay and trans communities. This was also the case within research material considered by the panel. This report therefore adopts terminology used by different authors; such as LGB, LGBQ+, LGBTQ+ and trans.

8.5 The panel also felt that it was important to understand what was known and being done within the area in relation to suicide prevention strategies and approached Nicola Prescott who agreed to join the panel.

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

9

### **Author and Chair of the Overview Report**

9.1

Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review chairs and authors. In this case, the chair and author were the same person.

9.2

Dan Bettison was chosen as the independent chair and author of the review. Following a career in policing, [not GMP] he is now an independent practitioner who consults within mental health services, education and children's social care. He is

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an Associate Trainer for the College of Policing, an Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services and an Independent Member of the Parole Board. He has completed accredited training for DHR chairs provided by AAFDA and has chaired and written previous DHRs.

### 10 **Parallel Reviews**

10.1 An inquest was held on 21 February 2023.

The Coroner concluded that Dylan died by suicide, the medical cause being asphyxia.

10.2 No agency has undertaken any form of internal review separate to the DHR process.

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

### 11 **Equality and Diversity**

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

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of his life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected

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characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].

- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

Section 6 of the Act defines ‘disability’ as:

- (1) A person (P) has a disability if:
  - (a) P has a physical or mental impairment, and
  - (b) the impairment has a substantial and long-term adverse effect on P’s ability to carry out normal day-to-day activities.

11.2 Ollie had engaged with mental health services since September 2021. He had been assessed several times and referred back to his GP for ongoing support. He was not diagnosed with any specific mental health condition, although he was prescribed medication for depression.

11.3 Despite Ollie’s poor mental health, the panel did not consider that he was disabled within the meaning of Section 6 of the Equality Act 2010. Neither did it consider that his health would have met the criteria for a care needs assessment under the Care Act 2014.

11.4 Ollie was Iranian and his first language was not English, although the panel could not establish what language he spoke.

During appointments with physiotherapists, professionals recorded that they had used his friend as an interpreter. There is no evidence of an interpreter being used during Ollie’s appointments with the GP, hospital or GMMH, or when interviewed by

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GMP.

The panel agreed that if there were concerns that Ollie did not understand English, then an interpretation service should have been used. The panel noted that mental health services engaged with Ollie more than any other agency and never considered it necessary to use an interpreter. Professionals were of the opinion that Ollie could speak and understand English.

11.5 Dylan had attended the emergency department reporting suicidal ideation. GP records following this attendance do not make it clear whether an adult social care referral was considered for him. Dylan informed his GP that he was working and had support from his family and others. The panel agreed that he did not require support from Adult Social Care.

11.6 Dylan and Ollie were both gay. The LGBTQ panel member advised that LGBTQ+ communities often face additional barriers, risks and psychosocial stressors including:

- Higher risks of domestic abuse and sexual violence
- Experiences of hate crimes and discrimination
- Higher prevalence of poor mental health, substance misuse and social isolation
- Lack of safe spaces and service provision.

11.7 The panel were keen to establish what domestic abuse looked like in the Greater Manchester area, rather than acknowledging national statistics. Current LGBT Foundation data reveals that 28% of trans people and 25% of LGB+ people have reported experiencing violent and/or threatening behaviour from a partner or ex-partner in the last year, a similar rate as experienced by heterosexual women. Based on Census 2021 data, for those living in a couple or family household, approximately 1,600 Trans and 8,700 LGB+ Greater Manchester residents could therefore be at risk of domestic abuse.

11.8 SafeLives 2016 – 2019 Spotlight Series reported:

- 28% of LGBT+ victims of domestic abuse have attempted suicide compared to 15% of victims who don't identify as LGBT+
- LGBT+ victims of domestic abuse are more than twice as likely to have self-harmed (32% vs 14%)
- 15% of LGBT+ victims have been abused by multiple perpetrators

The panel agreed that some professionals did not identify indicators of domestic abuse when engaging with Dylan and Ollie, despite both revealing that they were in a same sex relationship. The panel felt that both therefore received an inadequate service around potential domestic abuse and this could have been because Dylan

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and Ollie were gay. There was a lack of professional curiosity by some professionals.

### 12 **Dissemination**

- 12.1 Dylan's family
- Home Office
- Salford Community Safety Partnership
- Greater Manchester Police and Crime Commissioner
- Domestic Abuse Commissioner
- All agencies contributing to this review

### 13 **Background, Overview and Chronology**

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

#### 13.1 **Relevant History**

##### **Dylan:**

- 13.1.1 Dylan was brought up in the Wirral in the North West of England. He had an older and younger sibling.
- 13.1.2 Dylan excelled at school and achieved high grades in 4 'A' Level subjects. He was described by family and friends as an academic and a 'grade A student.' From the age of 13 or 14 Dylan was an organist at the church attached to his private school; he was so talented that he was also asked to play at other churches in the area. He was paid to do this.
- 13.1.3 Dylan attended Christchurch College, University of Oxford where he studied modern languages. He was also an organ scholar there. Whilst at University, Dylan spent a year in Italy before returning to the UK; living in London where he taught for a year before beginning a career in the TV and media industry as a sound engineer.
- 13.1.4 Although Dylan excelled academically, family and friends stated that he always seemed to resent that part of his life and seemed insistent that, in the future, he would not wish to raise his own children the same way.

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- 13.1.5 Around 1989, Dylan met his wife at the recording company where they both worked. They were married in 1993. They had two children together who were born 2 years apart in the mid 1990's.
- 13.1.6 Dylan and his wife later moved to Yorkshire, where Dylan had secured work as a sound engineer, working on high profile TV programmes.
- 13.1.7 In 2012, Dylan told his wife that he was gay. He did not tell many people other than his siblings and a few very close friends. He told family and friends that he wanted to be happy with a man.
- 13.1.8 Dylan and his wife continued to live together, by that time on the Wirral but then around 2015, Dylan moved out. He purchased a house in Salford where he lived alone but then rented that property out, when he returned to live and work in London. Around this time, Dylan also told his children that he was gay. Dylan returned to Salford in 2018, living in his house in Salford.
- 13.1.9 Dylan and his wife remained very close. They were best friends.
- 13.1.10 Dylan was described as highly intelligent, caring and always wanted to help people. He was a perfectionist and had low self-esteem.
- 13.1.11 Most of Dylan's family and friends described Dylan as a private person rarely wishing to share his personal business with others. He would go to his mum and talk to her if he was worried about something. In later life, when he was with Ollie, this was not possible as she became unwell and suffered with Alzheimer's.

### **Ollie:**

- 13.1.12 Ollie arrived in the UK in 2015 and claimed asylum after leaving Iran. His asylum claim was based on identifying as a gay man, which is illegal in Iran, and having been arrested one month earlier for having sex in a public place.
- 13.1.13 Ollie told Home Office staff that he had been in several relationships with men in Iran. Within 10 weeks of arriving in the UK, Ollie claimed to have formed a relationship with a man who confirmed the relationship to Home Office staff.
- 13.1.14 After arrival in the UK, the Home Office provided Ollie with Asylum Support accommodation in Liverpool. In 2016, he was moved to dispersal accommodation in Oldham and in 2019, he moved to the Stockport area. The panel were unable to establish what previous connection Ollie had with the Greater Manchester area, if any.

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- 13.1.15 Ollie was granted refugee status in February 2016 as the Home Office accepted that he was a gay man and at real risk of persecution from the Iranian authorities due to his sexual orientation. He was granted permission to stay in the UK until February 2021. In January 2021, Ollie applied for indefinite permission to stay in the UK, which was granted in March 2021.
- 13.1.16 In November 2018, Ollie was arrested on suspicion of assault after he was accused of slapping a previous partner's face during an argument. His partner did not support a prosecution and Ollie was released with no further action being taken. A DASH<sup>4</sup> was completed by GMP and the risk was assessed as medium.

### **Dylan and Ollie's Relationship:**

- 13.1.17 Sometime around October or November 2019, Dylan met Ollie online. They spent time together in the Lake District and then almost immediately afterwards Ollie moved into Dylan's house and began paying him £200 per month for rent. This money was paid back to Ollie each month by Dylan withdrawing cash.
- 13.1.18 Ollie was studying at University. Dylan's family and friends believe that he was paying Dylan the rent in order that he could claim benefits.
- 13.1.19 In January 2021, Ollie informed the Home Office that his current address was that owned by Dylan, although he did not tell them that he was in a relationship with him.
- 13.1.20 Family and friends described that Ollie controlled Dylan and had a hold over him. Dylan's eldest child also lived in Dylan's house for around 2 years and witnessed Ollie being verbally and emotionally abusive towards Dylan. Dylan made his child promise that he would not tell his wife about the abuse. He described Ollie's behaviour as explosive. Family members also stated that Ollie did not like them coming to the house to see Dylan. On one occasion, he confronted one family member in a calm, quiet and condescending manner and made it clear that they should stop coming to the house. Dylan was present and was visibly shaking and scared of Ollie, who after saying this, walked over to Dylan and kissed him, whilst smiling at Dylan's family.
- 13.1.21 In the early hours of 6 August 2022, Dylan left his home and went to stay with his wife. The next day, he went to live with one of his siblings. He confided in them and made it clear that he had been physically and emotionally abused by Ollie for most

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<sup>4</sup> The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009-2023) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009. The DASH is a multi-agency tool used by most agencies with a focus on keeping victims and their children safe and ensuring perpetrators are proactively identified and managed. Half the questions focus on coercive control and there is a focus on stalking and so-called honour based abuse.

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of their relationship. He worried how to get Ollie out of his house but felt guilty about making him potentially homeless. He also informed his sibling that Ollie had threatened to report him to the police and his own employer for him being complicit in Ollie fraudulently claiming benefit by living at his address. Dylan was very worried about this but even more worried that Ollie had threatened to kill his wife and children, if he ever left him. Dylan had made an appointment with a solicitor for advice on managing his separation from Ollie and removing him from his house, but he took his own life prior to attending that appointment.

- 13.1.22 On a date later in August 2022, GMP and NWAS were called to a hotel in Salford, where Dylan had taken his own life.
- 13.1.23 In February 2023, an inquest was held into Dylan's death. The coroner concluded that Dylan's death was suicide, the cause being asphyxia.
- 13.1.24 Following the inquest, Dylan's family made a complaint to GMP on behalf of Dylan, asking that Ollie be investigated for controlling and coercive behaviour. This investigation was commenced by GMP and remains ongoing in consultation with the Crown Prosecution Service at the time of publication of this Review.

### 13.2 **Events within Timeframe of Review**

- 13.2.1 The following paragraphs summarise domestic abuse and safeguarding issues affecting both Dylan and Ollie within the timeframe of review, which the panel felt were most relevant.
- 13.2.2 On 14 February 2020, Dylan attended a GP appointment where physical and sexual health discussions took place. He informed the GP that he had a long term partner and was not concerned about sexually transmitted diseases.
- 13.2.3 On 2 April 2020, Ollie attended the emergency department reporting an injury to his shoulder. He informed staff that he lived with a friend and was asked routine enquiry safeguarding questions which did not identify anything which concerned staff. Medical records state that Ollie attended in company with his partner, but no name is recorded.  
During triage, staff recorded that he sustained the injury after falling in the shower. During a further medical assessment, staff recorded that he sustained the injury whilst exercising at home.
- 13.2.4 On 3 April 2020, staff from the fracture clinic rang Ollie twice to discuss ongoing treatment needs. Ollie did not answer the calls and as such, he was sent written advice.

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- 13.2.5 On 3 April 2020, physiotherapy department sent a letter to Ollie's GP, explaining that they had spoken to him by telephone 'with the help of a friend'.
- 13.2.6 On 6 April 2020, physiotherapy department contacted Ollie by telephone to conduct a follow up appointment with him. Ollie asked that the physiotherapist speak with his friend who he resides with due to a language barrier. The friend was believed to be Dylan, although he was not positively identified.
- 13.2.7 On 2 December 2020, Dylan attended a GP appointment where he reported abdominal bloating and a change in bowel habits. He stated that it was not affecting his work but said that he had some stresses in his private life. He made an appointment with a private healthcare provider, Doctor Care Anywhere, who referred Dylan for further investigations for his bowel concerns to another private health provider, Spire.
- 13.2.8 On 17 December 2020, Dylan attended an appointment with Spire Healthcare (private healthcare provider). Ongoing bowel issues were discussed and a colonoscopy was conducted.
- 13.2.9 On 27 July 2021, Ollie had a consultation with his GP who recorded "*Mental health review multiple mental health problems struggling, home sick, anger.*"
- 13.2.10 On 29 July 2021, Ollie had a follow up consultation with his GP who recorded that he reported anxiety, anger, admitted to auditory and visual hallucinations and a long standing deep depression. The GP prescribed medication and made a referral to psychiatry.
- 13.2.11 On 16 September 2021, Ollie's GP referred him to the psychiatry department.
- 13.2.12 On 17 September 2021, GMMH received the GP referral, and allocated Ollie's case to the Early Intervention Team for assessment of psychotic symptoms. The case was referred for further discussion at a multi-disciplinary team meeting on 20 September 2021.
- 13.2.13 On 20 September 2021, following discussion at a multi-disciplinary team (MDT) meeting, staff telephoned Ollie. He was suspicious of the call but did engage with the member of staff. Ollie reported that he lived alone, had no family in the UK, his mood was low, he was hearing voices and was convinced that a friend was poisoning his drink.  
Ollie named Dylan as his carer, but did not positively identify him.

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- 13.2.14 On 21 September 2021, Ollie's case was discussed in MDT with information from above. Ollie again named Dylan as his carer but was not willing to share Dylan's information before speaking to him
- 13.2.15 On 29 September 2021, GMMH made an appointment with Ollie for an initial assessment. Ollie cancelled that appointment due to 'privacy issues at home'. He agreed to attend an appointment on 7 October 2021.
- 13.2.16 On 7 October 2021, Ollie attended an appointment with GMMH. He expressed unusual beliefs about his unnamed boyfriend and their relationship based on reality and not delusional thoughts. He reported hearing male voices twice a week. Ollie stated that he became angry over irrelevant matters and 'lashed out physically'. Ollie was referred back to his GP for a medical review and Primary Care Psychology for therapy.
- 13.2.17 On 12 October 2021, Ollie was contacted by GMMH. 'Call to Ollie to update him on the outcome of the assessment. Ollie expressed emotion and disappointment at this outcome but was informed of the plan to refer to PCP (Primary Care Psychology) and he seemed happy with the outcome and thanked the practitioner.'
- 13.2.18 On 23 November 2021, Ollie attended a GP consultation where he reported anxiety and depression. He stated that he had taken Sertraline for 4 weeks but that had not helped him. The GP recorded that he had been referred to psychiatry but they had told him to speak with the GP regarding his medication. The GP recorded that Ollie stated he had joined a gym and he had been accused of having sex in the shower which had made him more depressed and he had been unable to attend university. Ollie informed the GP that he was 'getting a solicitor'.
- 13.2.19 On 25 November 2021, Ollie attended a follow up GP consultation where he reported feeling angry, agitated and frustrated as he was a refugee. Ollie again talked about the incident at the gym where he had been accused of having sex in the shower. He stated that he felt that people did not like him and that he was targeted.  
The GP advised Ollie to restart on Sertraline medication and continue with the course to ensure it had full effect. Medication was prescribed in December 2021, January 2022, March 2022, May 2022 and June 2022.  
The GP referred Ollie to Salford IAPT psychology services (Six Degrees).
- 13.2.20 On 5 January 2022, Dylan attended a consultation with a private healthcare provider regarding shoulder pain. He was referred for physiotherapy. The consultation notes stated that there was 'no indication of any safeguarding concerns'.

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- 13.2.21 On 23 March 2022, Dylan attended a GP consultation. He reported pain in his shoulder for 2/3 months and other physical symptoms over the previous year.
- 13.2.22 On 10 May 2022, Ollie's GP received a letter dated 13/4/22 from Salford psychological services to say that he had been discharged as he had not opted into the service.
- 13.2.23 On 20 June 2022, Dylan telephoned Fortalice (Domestic Abuse Charity based in Bolton) and asked for support.  
Dylan disclosed domestic abuse from Ollie including threats that he would burn his house down. He would not disclose Ollie's full name or their address. When he was informed that the charity provided services for residents of Bolton, he provided a partial Bolton postcode.  
The staff member agreed to continue support by telephone but Dylan insisted that this was preceded by email contact.  
Dylan declined any referrals for services (including IDVA<sup>5</sup>) or to report the abuse to the police. He also declined to participate in the DASH RIC<sup>6</sup> assessment.
- 13.2.24 On 21 June 2022, Dylan emailed Fortalice and asked if the ISVA<sup>7</sup> was available for a chat. The ISVA replied and arranged to call Dylan that afternoon.  
Dylan discussed a recent incident but still declined to make any reports to the police, stating he did not want his family to know. Dylan declined all suggestions made by the ISVA regarding ending the relationship, which Dylan stated he wanted to do. Discussion took place regarding Clare's Law<sup>8</sup>, but Dylan also declined this.  
The ISVA recorded that there was further discussion regarding safety planning, but Dylan stated that he did not feel unsafe, he was more concerned about his family finding out if he ended the relationship with Ollie.
- 13.2.25 On 27 June 2022, Dylan emailed Fortalice and asked the ISVA if she was available to talk.  
Dylan stated he felt the risk to him was minimised as Ollie had Covid and felt that he may be catastrophising. Dylan was referred to Fortalice's Advice Team.

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<sup>5</sup> The main purpose of an independent domestic violence advisor (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members to secure their safety and the safety of their children.

<sup>6</sup> Checklist for use by IDVA's and other non-police agencies for identification of risks when domestic abuse, 'honour' based violence and/or stalking are disclosed  
<https://safelives.org.uk>

<sup>7</sup> Independent Sexual Violence Advisor

<sup>8</sup> [Clare's Law](#), also known as the Domestic Violence Disclosure Scheme (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.

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- 13.2.26 On 29 June 2022, Dylan emailed Fortalice for further advice. The ISVA who Dylan had been speaking with was not available.
- 13.2.27 On 30 June 2022, Dylan telephoned Fortalice several times, asking to speak with the ISVA who he had been speaking with. She was not available.
- 13.2.28 On 1 July 2022, the ISVA emailed Dylan to explain her role and the role of the Fortalice Advice Team who could offer more extensive support to him. A phone call was arranged for later that day to discuss further.  
The ISVA phoned Dylan, who explained he was being supported by his boss who was aware of some of his situation.  
Dylan was provided legal advice regarding how to remove Ollie from his home. Dylan again declined further support services. He was advised to speak to his GP about depression and anxiety and said that he would consider this.
- 13.2.29 On 7 July 2022, Ollie attended at his GP practice and requested a letter that he was expecting to be available to him. He was rude to staff and was issued with a zero tolerance letter, removing him from access to the practice for 8 days.
- 13.2.30 On 17 July 2022, Dylan attended the emergency department requesting mental health support. He disclosed that he had been searching the internet for ways to end his life. He was reluctant to talk about the trigger and stated it was due to difficult home circumstances since 'coming out 10 years ago'. He explained that he lived with his ex-partner with whom he had no children.  
Dylan left the emergency department before being seen by GMMH so was therefore contacted by telephone by them. GMMH recorded that Dylan was not showing overt signs of distress and felt that he needed practical support. Dylan denied thoughts of self-harm and agreed to see his GP but was reluctant for a letter to be sent as he didn't want a letter arriving at his home address.  
GMMH provided Dylan with helpline numbers and agreed to ask his GP to telephone him.
- 13.2.31 On 17 July 2022, Dylan's GP received correspondence from GMMH, asking them to arrange to see him following his attendance at the emergency department. This was tasked to a GP the following day.  
The GP contacted Dylan by telephone on 27 July 2022 and made an appointment with him for 8 August 2022.
- 13.2.32 On 18 July 2022, Dylan called Fortalice. A Project Worker discussed legal options with him but he did not wish to follow that advice. The Project Worker suggested counselling but Dylan stated, "he has had loads of it." Dylan stated that he would consider their discussion and would make contact when he was ready.

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- 13.2.33 On 25 July 2022, Fortalice attempted to ring Dylan but his phone number was not in use. An email was sent to him and he replied with a telephone call. The ISVA again discussed safety planning and support options with Dylan but he did not wish to report his situation to the police or consider any legal options.
- 13.2.34 On 26 July 2022, Dylan emailed Fortalice and stated that he was staying with a friend and had not told Ollie where this was. The ISVA telephoned Dylan who stated that Ollie was making threats to tell Dylan's family about their relationship. He stated that he had made similar threats in the past and never carried them out. Dylan was again advised to report matters to the police and seek the advice of a solicitor.
- 13.2.35 On 26 July 2022, Dylan contacted GMP and made a number of allegations against an un-named person. These included assault, damage to his phone and threats against people and property. GMP tried to arrange an appointment for Dylan to see them, which resulted in him attending the police station on 1 August 2022.
- 13.2.36 On 27 July 2022, Dylan emailed Fortalice and informed them that he had contacted the police after the previous day's conversation but asked them not to take further action. Fortalice emailed Dylan back and provided reassurance that he had done the right thing by reporting to the police. He was provided additional 24-hour support lines.
- 13.2.37 On 28 July 2022, Fortalice rang Dylan's number several times but his phone was engaged.
- 13.2.38 On 29 July 2022, Dylan telephoned Fortalice and stated that the police had asked him to attend the station to give a statement on 1 August 2022. Dylan informed Fortalice that he was concerned that he would be accused of benefit fraud as Ollie stated on a claim that Dylan was his landlord, not that they were in a relationship.
- 13.2.39 On 1 August 2022, Dylan attended the police station and alleged that an unnamed partner had spat at him, grabbed his arms causing bruising and damaged his mobile phone. Police submitted a DASH risk assessment (graded as medium). Another officer followed up the allegation and spoke with Dylan by telephone. He declined any referrals and was not supportive of further police action, declining to provide Ollie's details. He assured officers that he was safe and there had been no incidents for some time, therefore the crimes and investigation were filed, and no further action taken.

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- 13.2.40 On 2 August 2022, Dylan emailed Fortalice and stated that he had shared details of his situation with his wife as well as the police, but he was becoming more depressed.  
Fortalice emailed Dylan and provided reassurance that it was positive that Dylan had shared this detail with his wife and the police. The staff member stated that she would request he be called by a colleague as she was going on annual leave. She provided support lines available 24-hours for Dylan to contact.  
Fortalice emailed their Adult Services Team, requesting they contact Dylan.
- 13.2.41 On 5 August 2022, a Project Worker from Fortalice emailed Dylan. She explained that she was now available for him in terms of support. Dylan rang back and explained that he'd had further contact with the police. He stated that things were much calmer with Ollie.
- 13.2.42 On 9 August 2022, Dylan had a telephone consultation with his GP.  
The GP recorded that Dylan reported low mood secondary to domestic abuse and had been struggling for a long time. He reported that he cohabited with a younger man who was a refugee and they had known each other for three years, living together for two years. Dylan confirmed that they were in a relationship.  
Dylan stated that his ex-partner was controlling, had anger management issues and was insecure, particularly in respect of his wife. He stated that he had tried to end the relationship but that had made things more difficult. He stated that he had been logging incidents with the police and was speaking to a support worker at a refuge. He stated that he had accessed counselling.  
Dylan stated that he had moved out to stay at his brother's address but this wasn't a long-term solution. He reported that he felt safe as he was away from his partner.  
Dylan was keen for confidentiality and for only limited people to be involved due to concerns around escalation if his partner found out.  
Dylan stated that he felt there was a risk for himself and other people who get involved.  
Dylan informed the GP that he was separated from his wife but they had a good relationship. They had 2 children and the younger child had mental health issues and he was concerned that his situation was not helping this.  
Dylan stated that his wife, brother, and colleagues were aware of what had been going on and were supportive and sympathetic. He stated that he felt that he was losing his family and explained that his older son had stated that he won't visit him until things are sorted.  
The GP recorded that Dylan reported no thoughts of self-harm and enjoyed being around people and found this supportive.  
The GP recorded that they discussed options with Dylan, including IRIS/ men's advice line and a social worker and suggested a follow up appointment in 2 weeks or sooner if struggling.

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The GP explained that Dylan should call 999 if felt at risk or was unable to keep himself safe and emphasised that A&E was a point of safety for him.

- 13.2.43 On 10 August 2022, Fortalice telephoned Dylan. He explained that he had been speaking to his wife and the police. He also stated he had attended Salford A&E and been referred to his GP but did not disclose why and would not disclose his GP details.  
Safety planning and legal options were explored a number of times but Dylan declined.  
Dylan stated that he was staying with his brother after an incident that was unpleasant but did not wish to discuss this further.
- 13.2.44 On 18 August 2022, Fortalice telephoned Dylan. Who stated that he was still staying with his brother and Ollie was still residing at Dylan's property. He stated that he was still scared of Ollie, but he had not carried out any of his previous threats.  
Dylan explained that he felt guilty over the current situation and did not want to be the cause of Ollie's deportation or other immigration issues.  
Safety planning and support options were reiterated and a further call was arranged for 23 August 2022.
- 13.2.45 On 22 August 2022, Ollie registered at a new GP practice.
- 13.2.46 On 23 August 2022, Dylan had a telephone consultation with his GP to follow up his previous appointment.  
Dylan stated that he did not feel the GP could help with his situation.  
Dylan explained that he continued to live with his brother while his ex-partner remained in his house. He stated that he was having no further contact with his ex-partner currently but was struggling to decide when and how to make contact to get him to leave the property. He described feeling guilty about asking him to leave and potentially making him homeless.  
Dylan stated that he had support from his family but they were disappointed that he had not fully cut ties with this ex-partner. The GP recorded that Dylan expressed a lot of guilt about the impact it is having on them.  
Dylan stated that he had 2 counselling sessions with no benefit and did not currently wish to revisit this. He stated that he had a support worker via a women's refuge in Bolton.  
He stated that he had engaged with IRIS and spoken to a support worker but found them too "hard-line" and not especially supportive.  
Dylan explained that he planned to see a solicitor for advice the following week.  
Dylan described feeling hopeless for the future and stated "*I just don't see a way out of this*".  
He described waking at 4am with night terrors and feeling constantly anxious.

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Dylan informed his GP that he enjoyed his work and did not need time off but felt that he was not working at his usual standard.

Dylan informed his GP that he had called Samaritans at the weekend as he was thinking and googling about suicide methods. He stated that he had no current intent to act on these thoughts but the ideas had concerned him.

Medication was discussed but Dylan felt it would not change his situation and he was not optimistic that it would work.

The GP discussed a follow up appointment with Dylan and asked that it be done face to face. Dylan declined this as he stated that he was too anxious to return to the local area, and was worried about seeing his ex-partner. A telephone follow up appointment was arranged for one week later.

- 13.2.47 On a date later in August 2022, Dylan was found deceased in a private room at a Hotel in Salford. A police investigation ruled out any third-party involvement and Dylan appeared to have taken his own life.
- 13.2.48 Following the Coroner's inquest into Dylan's death, family members asked GMP to investigate alleged controlling and coercive behaviour by Ollie. He was interviewed by GMP on 15<sup>th</sup> December 2022 and at the time of writing this report, the case remains with the Crown Prosecution Service for assessment as to whether Ollie should be charged with any offences.

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### 14 Analysis

#### 14.1 **What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Dylan and how did your agency assess the level of risk presented by the alleged perpetrator. Which risk assessment model did you use and were multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed if appropriate?**

14.1.1 Ollie attended the emergency department in April 2020, reporting pain in his shoulder. Records show that he was asked routine enquiry questions in an attempt to identify any safeguarding concerns (e.g. has the patient ever been hurt or felt frightened by someone they know?). Ollie stated that he was not experiencing any domestic abuse.

Records show that Ollie attended with his 'partner', although it is not recorded who that is. It is also unclear whether or not he was alone when he was asked the routine enquiry questions.

The panel agreed that this was evidence of inadequate recording and as such it could not be confident that domestic abuse had been adequately explored.

14.1.2 Ollie failed to attend some appointments following his emergency department attendance. He did later engage with a telephone follow up appointment with the physiotherapy team, although communication took place through a friend due to Ollie not understanding English. It is not clear if during those telephone appointments, routine enquiry questions were asked of Ollie and if they were, whether this was through his friend also. Neither is it clear whether or not Dylan was the friend.

NCA Interpretation and Translation policy states that a qualified registered interpreter should always be offered to patients when English is not the patient's first language. If a patient expressly desires a family member or friend to act as their interpreter, then informed consent in their own language through an independent interpreter must be gained and recorded in their notes.

Again, during telephone appointments it is not clear who the 'friend' was and therefore the effectiveness of questioning or assessment is unknown.

The panel were provided with sufficient evidence to suggest that Ollie understood English and did not actually need an interpreter. However, policy was not followed and this is addressed by means of a single agency action plan.

14.1.3 The panel agreed that missing appointments could also be considered an indicator of domestic abuse and this was not considered by the physiotherapy team. This is a learning point which leads to panel recommendation 1

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- 14.1.4 When GMMH conducted assessments of Ollie in September and October 2021, it did not explore comments made by him that ‘a friend was poisoning his drink’. Neither did it explore his relationship with Dylan, who he referred to as his carer. When Ollie cancelled an appointment due to ‘privacy issues at home’, they did not explore those reasons further.
- 14.1.5 Ollie also reported hearing male voices twice a week and stated that he became angry over irrelevant matters and ‘lashed out physically’ at his partner, about whom he also had ‘some thoughts’. Staff assessed the thoughts as being real and not delusional. Despite this, the assessment did not explore the thoughts further or any risks to Dylan as his partner.
- The panel agreed that consultations with Ollie were focussed on his clinical assessment only and did not appropriately consider his personal circumstances (including a potentially abusive domestic relationship) which may have contributed towards his condition at the time and which may have increased the risk of domestic abuse towards Dylan. The panel felt that staff should have demonstrated greater professional curiosity.
- This is a learning point for GMMH which leads to a single agency recommendation.
- 14.1.6 Dylan’s only direct contact with NCA was when he attended the emergency department in July 2022. He was reluctant to engage with the triage nurse but stated that he felt suicidal due to “difficult home circumstances” since coming out 10 years earlier. He stated that he was currently living with his partner.
- Dylan did not want to discuss this further with the triage nurse and he was referred to the mental health team (GMMH).
- 14.1.7 Although Dylan left the department prior to being seen by GMMH staff, they did speak with him by telephone.
- As with the emergency department triage staff, Dylan again stated that he was experiencing “difficult home circumstances “ and stated that he did not want any written communication going to his home address.
- Although the telephone assessment was brief, it did not consider domestic abuse and no routine enquiry questions were asked, despite Dylan raising obvious concerns about his domestic circumstances. Dylan’s home circumstances were not explored further and there was no disclosure of abuse by him.
- The panel acknowledged that suicidal ideation is considered a health indicator for domestic abuse and thought that despite Dylan not wishing to discuss his circumstances further, he should have been asked specifically about that risk. That may have influenced the extent of their assessment of risk.
- Again, this is a learning point for GMMH which leads to a single agency recommendation.

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- 14.1.8 Dylan contacted Fortalice for support on 20 June 2022. An Independent Sexual Violence Advisor (ISVA) answered his telephone call and provided initial support and guidance to him. From that date, contact between Dylan and Fortalice was frequent by both telephone and email.
- During the initial and subsequent contacts with Dylan, Fortalice recorded that he reported coercive and controlling behaviour by Ollie including emotional abuse and one incident where Ollie grabbed his arms when trying to get his phone, resulting in bruising.
- Dylan described an incident when Ollie asked to sleep in Dylan's bed and he said no. He did not suggest that that the request to sleep in his bed was of a sexual nature. That resulted in an argument during which he threw a plant pot and smashed Dylan's phone.
- Dylan described the emotional abuse as 'taunting' and name calling towards both him and his family. He explained that Ollie was jealous of his relationship with his family and as such, he adapted his behaviour to avoid conflict.
- Fortalice attempted on many occasions to gain consent from Dylan to complete a risk assessment which may have resulted in a referral to MARAC.
- Dylan was informed of all options available to him, including legal options. Dylan continued to decline any referrals for support and initially refused to report the abuse from Ollie to police.
- 14.1.9 Fortalice explained to the panel that the ISVA who answered Dylan's first call would not have been the person who would have maintained contact with him. He would have been allocated another member of the team. However, Dylan did seek out that specific ISVA on most occasions. Despite it not being their core role, the ISVA continued to seek consent from Dylan for them to complete a risk assessment and consider referrals to other legal and support services. They also continued to provide him with safety planning advice.
- Dylan refused to provide Ollie's surname, the address where they lived together or his employer or GP details.
- The panel felt that little more could have been done by Fortalice in terms of assessing the risks to Dylan from Ollie.
- 14.1.10 On 17 July 2022, Dylan's GP received correspondence from GMMH, asking them to arrange to see him following his attendance at the emergency department. This was tasked to a GP the following day.
- The GP contacted Dylan by telephone on 27 July 2022 and made an appointment with him for 9 August 2022. The panel agreed that an appointment within 12 days of the telephone call was reasonable and would likely have been chosen based on availability and Dylan's choice of date.
- 14.1.11 In August 2022 Dylan had two contacts with his GP in relation to low mood secondary to domestic abuse including control and coercion. The GP explored

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support options with Dylan who appeared to have been proactive in seeking out support independently prior to the GP contact which included; independent specialist domestic abuse service, police, solicitor and mental health services, which could have afforded the GP a false sense of security that appropriate advice and support was being accessed by Dylan.

- 14.1.12 The GP did provide further advice around support options including IRIS, a men's advice line, and social care. Safety planning was also completed including reminding Dylan that he should contact 999 if he felt unable to keep himself safe. Further follow up consultations were also scheduled. Practice could have been strengthened if the sharing of information with other agencies had taken place including; completion of a DASH and referral to MARAC (if the threshold was met), consideration of a referral to adult social care or mental health services. The panel agreed that the consultations with Dylan were thorough and extracted a great deal of information about the domestic abuse he was suffering. However, the panel felt that the information obtained was not appropriately assessed and, as such, not acted upon. This is a learning point which leads to a single agency recommendation for Primary Care.
- 14.1.13 Dylan rang GMP on 26 July 2022 and reported being the victim of domestic abuse from his partner, who he did not name. He stated that he had bruising from abuse by his partner. Dylan asked GMP not to come to his address or telephone him outside of office hours. He stated that he had reported the abuse for 'recording purposes only' and did not wish to see the police. GMP made follow up calls to Dylan and arranged for him to attend a police station on 1 August 2022. When Dylan attended that appointment, he maintained the stance that he did not wish to take any action against his partner and refused to name him. He stated that he had moved out of his house and was living with a friend for a short while. He stated that his relationship with Ollie was coming to an end in an agreeable manner. Dylan had no obvious injuries.
- 14.1.14 The officer conducted a thorough assessment of Dylan's situation and established that he had received bruising when Ollie had tried to take his phone from him, he had been spat at, Ollie checked his phone and accused him of flirting with other people. The officer recorded a crime of assault occasioning actual bodily harm and completed a DASH risk assessment with a grading of medium risk. The panel agreed with that assessment. The information was passed to the Safeguarding

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Team, who also made further contact with Dylan and confirmed the risk assessment as appropriate. All referrals were declined by Dylan.

No crime of coercion and control was recorded by GMP and the panel were satisfied that the assault crime was the priority offence and the investigation was centred on it, whilst still considering the wider circumstances.

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

14.1.16 The Crown Prosecution Service's policy guidance on coercive control states:<sup>9</sup>

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances

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<sup>9</sup> [www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship](http://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)

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- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

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

14.1.17 Considering the Crown Prosecution Service's guidance, the panel felt that although all of the following behaviours were not apparent until after Dylan's death, they provided evidence that he was being subjected to coercive and controlling behaviour by Ollie:

- Isolating a person from their friends and family
- Monitoring their time
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim

## **Official Sensitive**

- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Threats to hurt or kill
- Assault
- Criminal damage (such as destruction of household goods)
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Reputational damage

## Official Sensitive

### 14.2 **What consideration did your agency give to any mental health issues when identifying, assessing and managing risks around domestic abuse?**

14.2.1 After Dylan had attended the emergency department in July 2022, disclosing that he was feeling suicidal, he was discharged to his GP following a telephone assessment which was undertaken by the mental health liaison team after Dylan left the department prior to being seen by them. This appears to have been an acute mental health episode. The GP practice contacted Dylan to arrange a follow up assessment, and on the 9<sup>th</sup> and 23<sup>rd</sup> of August 2022 Dylan had consultations with a GP where his mental health was discussed. On both occasions the GPs offered Dylan support, psychological support (counselling) and medication, which Dylan stated he would consider. Further plans were made for a subsequent follow up appointment, but Dylan died before that date. Dylan disclosed coercion and control to his GP and highlighted that he was receiving specialist support from a domestic abuse service in Bolton. Dylan didn't feel IRIS were able to help him.

Advice was sought from the suicide prevention representative on the panel. It was informed that national suicide rates for LGBTQ+ communities are not available in the UK, as sexual orientation and gender identity are not currently recorded on death certificates. However, a growing amount of global evidence points to a higher risk of suicidal behaviour and self-harm for LGBTQ+ people. The panel acknowledged that the extent and credibility of that evidence is not clear, but did consider it relevant, when considering other risk factors and domestic abuse indicators for Dylan.

In October 2024, another Salford DHR made a recommendation that the CSP and Salford Suicide Prevention Partnership should ensure that the links between domestic abuse and suicide are clearly articulated in local strategy, policy and practice. The Office for Health Improvement and Disparities (OHID) will further consolidate this by assessing whether the training currently being offered by the partnership effectively reflects the local strategic objectives, addresses known vulnerabilities including those impacting on LGBTQ+ communities and establish the extent of partnership agency implementation of the training." This is a learning point which leads to a single agency recommendation for the local OHID.

Dylan's GP was aware that Dylan had been a victim of domestic abuse from his partner and that his mental health had deteriorated to the point of feeling suicidal, but did not appear to identify the link between the two.

The panel felt that the absence of any formal domestic abuse risk assessment contributed towards this and, as such, there were missed opportunities to discuss specific support for Dylan from other domestic abuse services, who may have been better placed to support Dylan.

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

14.2.2 Ollie's contacts with the GP service were predominantly in relation to his mental health and resulted in referrals being completed to psychiatry and psychology services and medication being regularly issued. There is no indication that domestic abuse was considered within the context of those consultations.

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- 14.2.3 As outlined at 14.1.6, when Dylan attended the emergency department in July 2022 and reported feeling suicidal, domestic abuse was not considered by the mental health triage team who spoke with him after he left the hospital.

This was despite Dylan raising obvious links between his mental health and domestic circumstances. The panel felt that this was a missed opportunity to explore what was contributing to Dylan's acute mental health episode and may have identified him as a victim of domestic abuse. The panel agreed that the assessment of Dylan fell below what should be expected, despite him clearly saying that his domestic circumstances had contributed to him feeling suicidal.

- 14.2.4 GMMH did not consider domestic abuse when assessing Ollie in October 2021 despite him saying that he had been aggressive and lashed out at his partner.

The panel felt that during engagement with both Dylan and Ollie, GMMH staff did not demonstrate an effective understanding of the links between mental health and domestic abuse. Neither did they use sufficient professional curiosity to understand the wider needs of or risks to both patients.

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

- 14.2.5 Throughout engagement with Dylan, Fortalice identified that he was suffering with poor mental health directly linked to his domestic circumstances. Repeated attempts were made by them to encourage Dylan to seek support from his GP, but he refused.

- 14.2.6 When Dylan reported domestic abuse to GMP, consideration was given to mental health during the DASH assessment. Dylan advised the officer that he had a GP appointment booked to discuss this and declined any additional referrals.

- 14.3 **What services did your agency provide for Dylan and Ollie. Were they timely, proportionate and 'fit for purpose'.**

- 14.3.1 Ollie reported mental health problems to his GP in July 2021 and was prescribed medication. The GP noted that he should be referred to psychiatry and the GP records highlight that the referral was completed almost two months later. Ollie was not seen by GMMH until October 2021, three months after he initially raised concerns with his GP.

The panel explored the delay in the referral to psychiatry and established that, at the time, the GP Practice was transitioning record management systems and experienced limited access to previous patient records. It was also acknowledged that the COVID 19 pandemic placed additional pressure on service providers and this likely contributed to the delay. Considering the observations made by GMMH after assessment however, the panel agreed that the delay did not adversely affect Ollie's mental health.

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- 14.3.2 After Dylan attended the emergency department in July 2022, GMMH referred him to his GP for support. From receiving that referral, to making contact with Dylan, it took 10 days. On review of medical records there is no clear explanation for the delay.

When Dylan was contacted by the GP Practice this was not for a consultation but to make an appointment for one in the future. An appointment was made for 9 August 2022 – 23 days after the original referral from GMMH.

The panel agreed that the detail obtained by the GP during that appointment was detailed and this could have been known to agencies earlier had it not taken so long for the appointment to be arranged.

- 14.3.3 When Ollie attended the emergency department in 2020 with shoulder pain, he was seen promptly and referred for follow up appointments with both consultants and physiotherapists.

There were inconsistencies in what staff recorded as the cause of the injury, with the emergency department staff recording a fall in the shower and physiotherapy staff recording an injury caused whilst exercising at home. This inconsistency was not identified by professionals, most likely because agencies have separate recording systems.

Ollie was asked safeguarding questions at the emergency department but it is not clear if he was alone when asked those as he was accompanied by a friend.

The panel felt that through several appointments with professionals, opportunities were missed to identify Dylan as Ollie's friend or partner. Throughout the timeframe of review, there are numerous examples of Ollie being in company with a friend, but no agency identified who that was (although GMMH did record that Ollie named Dylan as his carer without providing identifiable information). The panel felt that if agencies had policies in place to record the name of the person accompanying a patient, this would have resulted in discussion with both Ollie and Dylan and may have presented opportunities for potential domestic abuse to be identified.

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

- 14.3.4 During a later telephone appointment with Ollie, he asked the physiotherapist to speak to him through his friend as English was not his first language. It is not known if that friend was Dylan.

- 14.3.5 When Ollie attended the GP practice on the 7 July 2022 to collect an x-ray request form, he was verbally abusive to staff, made racist comments and was physically intimidating. Staff felt threatened.

An eight day removal from the practice was enforced as per the primary medical services policy. The panel agreed that this was an appropriate response from the GP practice and

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acknowledged this was further evidence that Ollie also displayed aggressive and confrontational behaviour outside of the domestic environment.

- 14.3.6 When Dylan contacted Fortalice for support on 20 June 2022. An ISVA answered his initial telephone call and provided initial support and guidance to him. From that date, contact between Dylan and Fortalice was frequent by both telephone and email, although Dylan did gravitate towards trying to contact the ISVA whom he had initially spoken with. Fortalice explained to Dylan that a project worker would be his point of contact, although Dylan would still ring the ISVA. Fortalice tried to complete a DASH risk assessment with Dylan, but he refused to take part in the assessment. Fortalice managed this well and if calls or emails from Dylan were missed as he had contacted the wrong person, they sent internal messages to the project worker, ensuring that someone returned Dylan's calls promptly.
- 14.3.7 It is not known why Dylan chose to contact Fortalice rather than a Salford based domestic abuse charity. The panel surmised that it may have been due to Dylan's wishes to not pursue a prosecution or name Ollie. He refused to provide his address, his GP or employer details and provided a Bolton part-postcode. The panel agreed that although Dylan did not wish to seek further support and declined assessments and referrals by Fortalice staff, he must have felt comfortable talking to them. He eventually did report domestic abuse to the police.
- The panel saw evidence that Fortalice tried to support Dylan. They were a reassurance and comfort for him.

When Dylan attended the emergency department in July 2022, he was referred to GMMH within 10 minutes of arrival. Although he left hospital, within an hour, GMMH did make an assessment of Dylan during a telephone conversation and made a referral to his GP the same day.

- 14.3.8 On 18 August 2022, Fortalice contacted Dylan by telephone and he updated them that he was staying at his sibling's address. They agreed to ring him on a later date, but did not do so, due to a lack of capacity. When they did attempt contact with Dylan by email, he had died.
- 14.3.9 GMP could not establish the personal details for Ollie based on the information provided by Dylan. Dylan did not wish to speak to GMP again after his initial telephone call, but officers still made follow up calls to him, resulting in him attending the police station. Dylan did not wish to elaborate further or pursue a prosecution against Ollie. The investigating officer recorded appropriate crimes and referred the case to a Safeguarding Unit who again assessed the circumstances of Dylan's case. That unit also contacted Dylan, who refused to provide Ollie's details and stated that he did not want the police to take any action against him.
- Dylan was offered referrals to support services and a fire risk assessment, both of which he declined as he stated that he felt safe where he was staying.

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The domestic abuse report was therefore closed, and the crimes were filed with no suspect details and no further action being taken, in line with Dylan's wishes.

- 14.4 **Did your agency consider that Dylan may be being exploited or could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert or hold a strategy meeting?**
- 14.4.1 No agency who contributed to this review considered that Dylan was being exploited or was an adult at risk.
- 14.4.2 Dylan told Fortalice that he was working, had his own property, managed his own money and had capacity to make decisions and manage his day to day activities.
- 14.5 **How did your agency ascertain the wishes and feelings of Dylan and Ollie in relation to alleged offending and were their views taken into account when providing services or support?**
- 14.5.1 GP records document that when Dylan disclosed low mood and domestic abuse, he was offered referrals to and information about services available to victims of domestic abuse. He declined that support.
- 14.5.2 Ollie informed GMMH that he had unusual thoughts about his partner (he did not name Dylan) and physically lashed out at him. There was no further exploration around what Ollie meant by this or what risk it presented to Dylan. During his only interaction with GMMH, Dylan stated that his current mental health was linked to his domestic circumstances. This was not explored either, leaving GMMH with a lack of understanding about the context in which both Ollie and Dylan had presented to them. It was therefore unable to ascertain the wishes of either party whilst providing services to them.
- 14.5.3 Despite several conversations with Fortalice, Dylan consistently refused any form of referral for further support and declined to report any alleged offending to police until 26 July 2022.
- 14.5.4 GMP could not establish the personal details for Ollie based on the information provided by Dylan. As such, they never spoke with him. Dylan was very clear when speaking with officers that he did not wish police to investigate or prosecute Ollie and officers acted in accordance with those wishes.
- 14.5.5 The panel were aware that there are a number of barriers to victims reporting domestic abuse. The Victim Support 'Surviving Justice' 2017 report contains the following information:

### **Barriers to reporting as cited by Victim Support caseworkers**

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Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

### 14.5.6

The panel felt that there were several barriers preventing Dylan from fully disclosing the circumstances of the domestic abuse from Ollie, including his identity.

Information has been received from family and friends following Dylan's death which has helped the panel understand the reasons why Dylan could not disclose the abuse from Ollie, but those barriers were not all clear to agencies at the time they were engaging with him.

The panel felt that significant barriers to Dylan reporting were fear of Ollie and that he would be in more danger, concern about his wife and children and the dangers posed to them, a misunderstanding and normalisation of the abuse, wanting to protect Ollie from prosecution or from being homeless and embarrassment that he may have been complicit in Ollie making fraudulent benefit claims.

The LGBTQ Foundation panel member explained that victims of domestic abuse often struggle to access the right services and support. Common barriers for LGBTQ+ victims include:

- Fear of not being believed (particularly for lesbian and bi women and trans/non-binary communities).

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- Fear of experiencing homophobic, biphobic, and transphobic abuse, hate crimes and discrimination in mainstream support services
- Services available not providing what they need and not understanding their identities (particularly for trans and non-binary people)

14.5.7 Dylan chose to contact Fortalice, rather than local support services. He did not provide them with any identifiable information about him or Ollie. The panel agreed that due to the barriers outlined above, this suggested that Dylan felt unable to seek any support locally until he later disclosed abuse to his GP and GMP.

14.5.8 The level of risk was therefore never truly established by any agency and as such, Dylan's wishes or feelings were never understood.

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- 14.6 **How effective was inter-agency information sharing and co-operation in response to incidents involving Dylan and Ollie? Was information shared with those agencies who needed it? Was any information not shared, due to concerns around sensitivity, confidentiality, risk, data protection or any other reason?**
- 14.6.1 No agency was aware that Dylan and Ollie were in a relationship and as such, there was no opportunity for specific information about their relationship to be shared.
- 14.6.2 Dylan provided a significant amount of detail within GP appointments in August 2022 but this was not shared with any other agency. If the GP had conducted an assessment of risk using the DASH risk assessment, they would have considered Dylan's full circumstances and may have instigated the sharing of information with other agencies. The panel did however discuss that this would only likely have happened if Dylan had provided consent for the information to be shared at MARAC as the risk would likely have been assessed as low or medium. The panel felt that considering that Dylan had not wished to consent to any information being shared by any agency, the likelihood of him agreeing to a MARAC referral was minimal.
- 14.6.3 Dylan accessed private health care providers which complicates information sharing further. There were, however, no safeguarding concerns identified by the private healthcare providers during consultations with Dylan – although there is evidence of appropriate safeguarding enquiry. Evidence of appropriate information sharing was evident by the private health provider to his NHS GP, although this related to clinical matters only.
- 14.6.4 Although NCA and GMMH did share information about both Dylan and Ollie, GMMH did not explore the potential for domestic abuse being present and as such only clinical information was present.
- 14.6.5 Fortalice had more engagement with Dylan than any other agency, yet he did not wish to provide any personal information which would identify his address or Ollie. Fortalice asked on several occasions if Dylan would consent to referrals to other agencies who may be able to help him, but he did not want this to happen.
- 14.6.6 GMP conducted a DASH assessment following Dylan's disclosures of domestic abuse which was graded as medium and as such did not meet the threshold for a MARAC referral. Dylan also made it clear that he did not consent to information being shared with other agencies.
- 14.6.7 There is no suggestion that any information was not shared due to concerns around sensitivity, confidentiality, risk or data protection.
- 14.7 **What knowledge did family, friends and employers have that Dylan was in an abusive relationship and did they know what to do with that knowledge?**

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- 14.7.1 Dylan's family and friends describe him as being a very private person, who rarely shared details of his private life.
- 14.7.2 Dylan's wife and children knew that his relationship with Ollie was abusive. One of his children lived with them for around 2 years and regularly witnessed Ollie being verbally abusive towards Dylan, who pleaded with them not to tell his wife. Ollie was also verbally abusive towards Dylan's child and their partner, who subsequently moved out of the address due to Ollie's behaviour.
- 14.7.3 Family and friends describe how Ollie seemed to have control over most aspects of Dylan's life. Ollie disliked Dylan's wife and children and was angry that Dylan was still close to them. He was particularly angry that Dylan would help his wife financially. Ollie asked Dylan's wife not to come to Dylan's house anymore and also refused to allow one of his children to live with them for a short time, while they were at a university nearby. This upset Dylan greatly, but he did as Ollie instructed. This made Dylan's contact with his family more difficult and often it had to be without Ollie's knowledge.
- 14.7.4 Dylan's family and friends recall occasions where they saw Ollie shouting and screaming at Dylan and telling him that he should be around the house for him, rather than spending time away from the house after he had finished work. Ollie was once seen to spit on Dylan and call him a dog.
- 14.7.5 Dylan cared greatly for his wife and children and did not want them to worry about him. He therefore led two separate lives; one with Ollie and one with his family.
- 14.7.6 Dylan's dad died in 2021 and although he did not bring Ollie to the funeral, he did bring a large bouquet of flowers and made a point of telling family that they were from Ollie. Family now think that this was an example of Ollie wanting to have control of, or involvement in, all aspects of Dylan's life.
- 14.7.7 In spring 2022, Dylan's family and friends recall that he was obviously physically and mentally unwell. He was not himself and admitted that he was finding it difficult to balance what Ollie demanded of him, with his desire to see his own family. He explained that he found it difficult that one of his children was living close by in poor quality accommodation when he could be living with him but couldn't as Ollie did not like him. He said that this was tearing him apart.
- 14.7.8 Around June 2022, family and friends recall that Dylan was again looking unwell and was clearly struggling mentally. He told them that he was worried about his child's imminent graduation ceremony as Ollie had made it clear that he expected to go, despite not even liking them. He did not want Ollie to go with him as he knew that it would spoil the day and upset his family, but he did not feel that he could stop him attending.

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- 14.7.9 Although some of Dylan's family and friends did not see Dylan being physically abused by Ollie, they suspected that he was. They did however think that Dylan was being controlled by Ollie, who they described as being manipulative.
- 14.7.10 Some of Dylan's family and friends did know that Dylan was being physically abused by Ollie. He told them that they argued a lot, it would become violent and Ollie would hit him. He said that he was scared of Ollie and that he had threatened to report Dylan to the police over some benefits that Ollie had been fraudulently claiming with help from Dylan. Dylan was very worried about this and was upset at the thought of his family and employers knowing that he may have done something wrong. Dylan said that he could not see a way out of his current situation and often said that the only way out would be to kill himself. They did not believe that he would do this and were reassured by the fact that Dylan had said that he was receiving support from a domestic abuse charity and had contacted the police. He said that he knew he needed to leave Ollie, but could not bring himself to do so.
- 14.7.11 Some of Dylan's family and friends met Ollie occasionally. When they did, he was polite and pleasant in their company, but Dylan told them that he wasn't like that when they were alone. They described that Ollie had a hold over Dylan and he did not want him to have other friends as he was jealous. Despite this stance with Dylan, Ollie did have his own friends. He would sometimes stay with other men in London and formed sexual relationships with some of them, who also gave him money.
- 14.7.12 In July 2022, Dylan left his house to stay with a friend. He went back to his house and tried to resolve matters with Ollie, but then on 6 August 2022 he left again and went to stay with his wife and then a sibling, telling his sibling the full extent of the abuse he had been subjected to by Ollie.
- 14.7.13 Dylan had bruises on his arms which were so obvious that he wore a jumper, despite the hot weather. He described being regularly assaulted by Ollie and had video recordings of the abuse he had suffered, some being recorded by Ollie himself as he subjected Dylan to verbal abuse. Dylan explained that he had tried to leave Ollie but he had threatened to kill his wife and children if he ever did.
- 14.7.14 Dylan explained that Ollie would ring him regularly throughout the day and would also walk him to and from his workplace.
- 14.7.15 Dylan told his sibling that he had reported the abuse to police but did not wish to take the matter any further. On one occasion, Dylan's sibling was present when he received a call from the police about the report he had made. He again insisted that he did not wish to take matters any further and he had left the house, so he was safe.

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- 14.7.16 Dylan was worried about how he would be able to get Ollie to leave his house. He had made his mind up that the relationship was over, but he still worried about Ollie and was concerned that he did not have anywhere else to live.
- 14.7.17 Dylan explained that Ollie was still studying at university and that he may now struggle as it was Dylan who had been completing all of his coursework for him. Dylan was also worried that he may get into trouble over the benefits and student loans that Ollie had been claiming whilst living with him. He had been searching the internet to learn more about money laundering regulations. Dylan's family and friends all agreed that if Dylan had done something wrong, it must have been through fear of Ollie. He was a law abiding person with strong moral standing. He was a victim.
- 14.7.18 After Dylan had left the house, Ollie did not make any contact with him other than once during the first week, when he asked Dylan for money. Dylan told his sibling that there was evidence of abuse from Ollie on his computer at home. He wanted to go back to get it, but was too scared to go.
- 14.7.19 Dylan made an appointment to meet with a solicitor for advice around making Ollie leave his house. He chose a solicitor based in Manchester as he was worried that if he had used a solicitor from Merseyside, Ollie might think that Dylan's wife was involved. Dylan passed away prior to the date of that appointment.

### 14.8 **Were there any examples of outstanding or innovative practice?**

- 14.8.1 The panel did not identify any examples of outstanding or innovative practice.

### 14.9 **What training did your agency provide to staff around domestic abuse. Had staff who interacted with Dylan and Ollie completed the training and when?**

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

### 14.9.2 **Primary Care in Salford:**

All Salford GP staff attend specialist domestic abuse training by specialist services delivering training (specific for GPs). There is an expectation that in any given year, GP practices achieve 80% compliance as per the Salford Standard which runs April – April. NHS GM records suggest that in July 2022, IRIS training compliance for the GP practice was 50%. However by year end of 2023-24, compliance was 87%.

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### 14.9.3 **NCA:**

All medical and nursing staff within the Emergency Department receive mandatory safeguarding training which emphasises that safeguarding is everyone's responsibility (RCN 2018), and the content of this training also contains domestic abuse awareness (including various categories within the definition of abuse).

All trained staff have level one to three safeguarding children and adults on their training matrix as mandatory training. Adult and Children's level three training is delivered separately and as part of this training domestic abuse indicators are discussed for both. This includes training for staff on how to respond if they receive a domestic abuse disclosure. Domestic abuse is purposefully included in both training to ensure all staff have a think family response to domestic abuse.

The domestic abuse leads now completes training to all new staff as part of staff induction within the department. The domestic abuse leads have developed a specific domestic abuse intranet site which all staff can access. This site includes information on domestic abuse, policies and guidance documents, previous DHRs, NCA DASH checklist and guidance on completing a DASH and the contact numbers for adult and children safeguarding teams within the NCA and also the domestic abuse leads. NCA staff also have the option to access domestic abuse training via Salford Community Safety and Safeguarding partnership offers.

### 14.9.4 **GMMH:**

There is Domestic Violence training available on the Learning Hub for all staff. All patient facing staff have to complete Safeguarding Training as indicated in the Intercollegiate Document for Safeguarding Adults. There is Level 1 and 2 training online and then face to face Level 3 training that needs to be completed every 3 years. Domestic Violence is within the training.

Previously, specific Domestic Violence training was provided by the Trust but due to low attendance a decision was made to incorporate Domestic Violence into the Level 3 Safeguarding training. As per the Intercollegiate Document for Safeguarding Adult training, all staff in patient facing roles need to complete Level 3 Safeguarding Training on a three yearly basis and this is mandatory across the Trust.

### 14.9.5 **NWAS:**

NWAS front-line clinical staff have Safeguarding Training at L3 in line with the expectations of The Intercollegiate Document's for both Adults and Children, this includes awareness of domestic violence and abuse, including coercive and controlling behaviour. NWAS operates over the whole geography of the North West of England and has a robust safeguarding information sharing system which allows reporting of safeguarding concerns 24 hours a day, 7 days a week, which enables staff to be able to

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report safeguarding concerns electronically in a timely and detailed fashion to our partners in Adult Social Care and Children's Social Care.

This L3 training is provided to NWAS staff as part of the mandatory training profiles for each staff member and compliance is overseen and monitored by the NWAS Learning and Development Team.

### 14.9.6 **Fortalice:**

The ISVA is a qualified IDVA and ISVA. All our staff undertake core domestic abuse training on an annual basis and additional specialist training is ongoing.

### 14.9.7 **GMP:**

All GMP officers are given domestic abuse training. The officer who dealt with Dylan when he reported abuse would have had domestic abuse training as part of their initial training. At the time of the incident, the officer was very young in service, so the training was recent. This initial training was followed up with the new Domestic Abuse Matters Training, which was delivered in 2022. It is not known if the officer had received this training prior to dealing with Dylan.

DA Matters mandatory training was launched in November 2022 and has now been delivered to all officers in public facing roles across 2023; for all new officers this training forms part of their induction. The Training reinforces the agreed definitions around DA, including the risk assessment tools, processes and partner agency sharing requirements contained within the revised Domestic Abuse Policy.

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

#### 14.10

Taken directly from IMRs:

#### 14.10.1 **Primary Care in Salford:**

Missed opportunities in identifying health indicators of domestic abuse in Men.

Missed opportunities to complete a DASH assessment and signpost to male specific domestic abuse services.

Missed opportunity to link Ollie and Dylan as partners co-habiting on the GP records and see both males in the context of a relationship.

#### 14.10.2 **NCA:**

The NCA records do not include any disclosures of domestic abuse, however there are areas of learning relating to the improvement of professional curiosity, from review of the records there are gaps in information relating to the adult's ethnicity, language spoken and relationship status.

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There also needs to be a more consistent application of the use of interpreters to communicate with patients when English is not their first language.

### 14.10.3 **GMMH:**

There was no learning identified in the 3DR completed after Dylan's death. After further discussion with the manager of MHLT in Salford, learning was identified. The learning would be about concerned curiosity in relation to the statement made by Dylan about his difficult home circumstances and how the circumstances impacted on his mental health and his thoughts of self-harm. This could have been further explored with Dylan to ascertain if there were any other issues in his life that may have needed further exploration and offer of support/advice.

There was no mention of Ollie in the 3DR as they were not aware of their relationship at the time of writing. There could have been further exploration of Ollie's anger and lashing out behaviour as he had indicated he was in a relationship. He revealed that he was in a same sex relationship. There was a potential of unconscious bias around same sex relationships/male victims of domestic violence that needs exploration and learning.

### 14.10.4 **Fortalice:**

Discussions have taken place as to if anything further could have been done to support Dylan and as information was withheld and he would not give his consent, we have concluded that as we saw other agencies becoming involved, he was developing a broader network of support which we had hoped in the longer term would be positive for him.

### 14.10.5 **NWAS:**

No learning was identified.

### 14.10.6 **GMP:**

No learning was identified in this case. Officers acted in accordance with policy and guidelines.

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### 14.11 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues when completing assessments and providing services to Dylan and Ollie (including sexuality and age)?**

14.11.1 When Ollie attended the emergency department on 2 April 2020, staff recorded that he spoke English. This contradicts what is recorded by the physiotherapist on the 6 April 2020, when Ollie asked staff to speak to his friend due to a language barrier. There is no record of what language Ollie spoke, or who the friend was.

14.11.2 The panel discussed at length whether the lack of an interpreter during other consultations undermined the effectiveness of assessments and interviews with other agencies. The Chair spoke directly with mental health professionals involved in Ollie's care and they confirmed that his understanding of English appeared good. GMP also confirmed that during interviews with Ollie, no interpreter was needed. His legal representative was present.

The panel agreed that it was unlikely that Ollie had needed an interpreter during consultations. However, this is a still learning point which leads to panel recommendation 3.

14.11.3 As outlined throughout this report, some professionals did not identify indicators of domestic abuse when engaging with Dylan and Ollie, despite both revealing that they were in a same sex relationship and despite them disclosing obvious indicators that domestic abuse may have been present for them.

The panel felt that agencies failed to take account of the fact they were gay and did not adequately explore domestic abuse during consultations, suggesting a lack of understanding of domestic abuse within LGBTQ+ relationships.

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

## 15 **CONCLUSIONS**

15.1 The referral for this DHR was not submitted by GMP following Dylan's death. It took a request from AAFDA on behalf of Dylan's family to instigate this review. The panel felt that the referral should have been made much earlier and by GMP.

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

15.2 In September and October 2021, Ollie was assessed by GMMH following a referral from his GP. Although Ollie did appear to be exhibiting some signs of psychosis, he did not meet the threshold for specialist treatment and was referred back to primary care for low level psychological talking treatment.

15.3 There were several indicators that Ollie may be in a relationship with another person and that they may be at risk of abuse. Ollie talked about feeling angry, lashing out at his

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partner and having 'thoughts' about them. He said that he suspected his 'friend' may be poisoning his drink. He also cancelled an appointment due to 'privacy issues at home'.

Within GMMH assessments, Ollie named Dylan as his carer. The GMMH staff who assessed Ollie did not explore any of these issues and therefore did not consider that Ollie may be a perpetrator of domestic abuse. Neither did staff explore his relationship with Dylan; noting that he was Ollie's carer (without providing identifiable information).

- 15.4 When Dylan attended the emergency department in July 2022 and disclosed that he felt suicidal, staff made a referral to GMMH. Dylan stated that he was experiencing "difficult home circumstances " and stated that he did not want any written communication going to his home address.  
Although timely, the telephone assessment was brief and did not consider domestic abuse. No routine enquiry questions were asked, despite Dylan raising obvious concerns about his domestic circumstances
- 15.5 The panel felt that GMMH staff could have done more during consultations with both Ollie and Dylan. They should have been more professionally curious.
- 15.6 In June 2022, Dylan sought advice from Fortalice and over the following two months, he communicated with them by telephone and email regularly. Fortalice tried to support Dylan but its impact was limited due to him feeling unable to provide them with any detail which could identify him or Ollie.
- 15.7 Fortalice is based in a different area to where Dylan lived and the panel felt that one reason why he approached them may have been to maintain confidentiality. Dylan was very concerned about his family or employer becoming aware of the extent of his problems with Ollie.
- 15.8 Another reason could be that he did not know where he could go to seek advice. Dylan told friends and family that he met Ollie online and, as such, it is likely that he was comfortable using social media and this may have been a safe space for him to explore his sexuality.  
The panel felt that if there had been accessible online support for members of the LGBTQ+ community, Dylan may have been more likely to access that support from people who better understood his lived experiences, rather than an out of area 'women's refuge' (as described by Dylan during a GP appointment).  
This is a learning point which leads to panel recommendation 4.
- 15.9 When Dylan did report domestic abuse to GMP in July 2022, he still did not name Ollie as the perpetrator. GMP followed this up with Dylan and tried to support him as best it could but Dylan felt unable to accept help or support. A family member witnessed Dylan receiving a call from GMP, during which he insisted that he did not wish to support a prosecution.

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- 15.10 When Dylan disclosed domestic abuse to his GP in August 2022, several support options were suggested to him. Dylan did not wish to access any of that support and he informed the GP that he was already receiving support from other agencies. The panel felt that this may have given the GP a false sense that everything that could be done was being done. A DASH risk assessment would have better considered Dylan's full circumstances and may have instigated the sharing of information with other agencies.
- 15.11 The 2021 Census data shows that 5.6% of Salford's population identify as gay, bisexual or other sexual orientation (excluding heterosexual). This is higher than the regional or national rate of 3.2 % each. The panel felt that this higher rate necessitated a prompt and proactive campaign to increase awareness amongst professionals working in Salford.
- 15.12 The panel felt that all agencies involved in Dylan and Ollie's care, would benefit from a greater understanding of domestic abuse within same sex relationships and within the LGBTQ+ community generally. The panel also agreed that domestic abuse and sexual violence should be identified in relationships regardless of how individuals identify themselves. People no longer always identify as either heterosexual or gay, therefore the importance of identifying domestic abuse indicators is essential.  
This is a learning point which leads to panel recommendation number 1
- 15.13 Dylan loved his wife and children dearly and after revealing that he was gay, remained very close to them. The threats that Ollie made towards his family worried Dylan greatly.
- 15.14 Dylan was also extremely worried that he may have committed criminal offences by allowing Ollie to live with him and claim student and housing benefits at the same time. The panel saw no evidence that Dylan had committed any offences, but the fact that he felt that he may have worried him significantly. Dylan was a very well respected professional person within his area of work. He was held in high regard nationally and the threats made by Ollie that he would discredit him by revealing his involvement in criminal offences were unbearable for Dylan.
- 15.15 Dylan did find the courage to leave Ollie and was being supported by friends and family to manage the separation. He was due to see a solicitor for legal advice. Family and friends were confident that he was being appropriately supported. Tragically, Dylan took his own life before that appointment.
- 15.16 At the time of writing, GMP were still conducting an investigation into allegations of controlling and coercive behaviour by Ollie against Dylan over several months prior to his death (reported by Dylan's family). Some family have provided GMP with digital media which is said to contain evidence of abuse. The Crown Prosecution Service has

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yet to make a charging decision and the digital media has yet to be examined and as such, Ollie remains a suspect.

### 16 **Learning**

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

#### 16.1 **Narrative**

During consultations with both Dylan and Ollie, agencies did not identify recognised indicators of domestic abuse. Some agencies did not explore potential domestic abuse with Ollie or Dylan and therefore missed opportunities to identify potential abuse or make assessments of risk.

#### **Learning**

Increased awareness of domestic abuse indicators will enable professionals to better identify and support victims. Further work is needed by agencies involved in the review to enable their staff to recognise all aspects of domestic abuse, regardless of how a person identifies themselves.

**Recommendation 1 applies.**

#### 16.2 **Narrative**

During consultations with Ollie, he was often accompanied by Dylan, yet agencies did not record his identity.

#### **Learning**

Organisational policy requiring professionals to record the identity of third parties during consultations would present opportunities for a more effective assessment of potential domestic abuse.

**Recommendation 2 applies.**

#### 16.3 **Narrative**

Agencies did not always demonstrate effective procedures for managing communication with service users who did not speak English.

#### **Learning**

Effective and consistent arrangements for interpreter services will enable professionals to conduct thorough assessments to identify potential domestic abuse.

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### **Panel recommendation 3 applies.**

#### 16.4 **Narrative**

Specialist domestic abuse advice may not be readily available or accessible to members of the LGBTQ+ community.

#### **Learning**

Increased awareness of what advice and support is available, will encourage members of the LGBTQ+ community to access support for domestic abuse.

### **Panel recommendation 4 applies.**

#### 16.5 **Narrative**

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

#### **Learning**

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

### **Recommendation 5 applies.**

**RECOMMENDATIONS**

17

**17.1 DHR Panel**

- 17.1.1 All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that domestic abuse staff training includes all recognised indicators of domestic abuse and highlights the prevalence of domestic abuse for LGBTQ+ victims.
- 17.1.2 All agencies should provide the Salford Community Safety Partnership with assurance that organisational policy exists which requires professionals to record the identity of third parties during consultations.
- 17.1.3 All agencies should provide the Salford Community Safety Partnership with assurance that effective arrangements for interpreter services are in place and that staff will not rely on family or friends to interpret for each other.
- 17.1.4 The Salford Community Safety Partnership should review current specialist domestic abuse service provision for members of the LGBTQ+ community and develop a plan to improve awareness and accessibility; including increased visibility on-line and social media platforms.
- 17.1.5 All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has an effective policy in place to ensure that all staff have received appropriate domestic abuse training.

**17.2 Single Agency Recommendations**

- 17.2.1 All single agency recommendations are shown in the action plan at appendix 'A'

DHR Panel Recommendations						
Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that domestic abuse staff training includes all recognised indicators of domestic abuse and highlights the prevalence of domestic abuse for LGBTQ+ victims.	CSP to require all agencies to provide details of staff training pertaining to domestic abuse and the focus therein on issues and barriers for LGBTQ+ victims.	Central training offer materials. Agency responses.	Assurance that training across the partnership includes relevant content. Staff better able to recognise all forms of domestic abuse and issues and barriers for LGBTQ+ victims.	Roselyn Baker	The partnership Workforce Development Group takes strategic lead for the partnership training offer which is delivered by our commissioned da services and includes content regarding all exploitation types. The Tackling Domestic Abuse Board is reviewing all agency standalone training offers, which are subject to review February 2025.

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<b>DHR Panel Recommendations</b>						
<b>N°:</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcomes</b>	<b>Lead Officer</b>	<b>Date</b>
2	All agencies should provide the Salford Community Safety Partnership with assurance that organisational policy exists which requires professionals to record the identity of third parties during consultations.	CSP to require all agencies to provide details of relevant Organisational policy.	Agency records.	Staff confident to identify and record third party presence. Evidence of better outcomes for patients.	Relevant Panel members.	All relevant agencies are required to provide this assurance which is subject to review February 2025.
3	All agencies should provide the Salford Community Safety Partnership with assurance that effective arrangements for interpreter services are in place and that staff will not rely on family or friends to interpret for each other.	CSP to require all agencies to provide details of policies regarding interpretation services.	Agency records.	Evidence of better outcomes for patients.	Relevant Panel members.	All relevant agencies are required to provide this assurance which is subject to review February 2025.
4	The Salford Community Safety Partnership should review current specialist domestic abuse service provision for members of the	CSP to review specialist provision arrangements with Safe in Salford service.	Safe in Salford report to commissioners. CSP Comms Plan.	Better reach and effective service provision for LGBTQ+ community.	Roselyn Baker/Claire Baddley.  Vicky Pemberton.	Specialist service data and process review by end February 2025.

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<b>DHR Panel Recommendations</b>						
<b>Nº:</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcomes</b>	<b>Lead Officer</b>	<b>Date</b>
	LGBTQ+ community and develop a plan to improve awareness and accessibility; including increased visibility on-line and social media platforms.	Review CSP comms plan to focus on LGBTQ+ community focused comms messages. Safeguarding comms group to assist with social media input with, e.g. LGBT Foundation who have some influence with relevant social media platforms.				Comms work underway and will culminate with The Pink Picnic in September 2025.
5	All agencies involved in the review should provide the Salford Community Safety Partnership with assurance that it has an effective policy in place to ensure that all staff have received appropriate domestic abuse training.	CSP to require all agencies to provide details of up to date and appropriate training programmes.	Audit of staff training programmes – reach and take up.	Agencies confident that their domestic abuse staff training programmes are comprehensive. Staff confident in tackling domestic abuse issues.	All panel members.	The partnership Workforce Development Group Training monitors attendance figures which include breakdown by agency. However, staff turnover means that further assurance will be required on a regular basis and this is subject to

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<b>DHR Panel Recommendations</b>						
<b>N°:</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcomes</b>	<b>Lead Officer</b>	<b>Date</b>
						review February 2025.

End of Overview Report 'Dylan'