Chorley and South Ribble Community Safety Partnership
(C&SR CSP)

Domestic Homicide Review in relation to Gemma (died May 2017 aged 30 years)

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

Period Reviewed
1st January 2011 to Date of Death

Final Overview Report
(August 2021)

Independent Chair: Maureen Noble
Independent Author: John Doyle

Contents Page

Section 1 – Background 3-9

Section 2 – Conduct of the DHR 9-21

The timescale of the Review
The Review Process
The Terms of Reference
Methodology
Involvement of Family and Friends
Contributors to the Review and the DHR Panel

Section 3 – The Facts 21-29

Key incidents: the chronology
What the agencies knew and how and why events occurred
Addressing the Key Lines of Enquiry

Section 4 – Learning from the DHR 29-43

Learning against practice
Learning against the terms of reference

Section 5 – Lessons Learnt 44-49

Summary
Conclusions and recommendations

Appendices

Appendix 1 Single Agency Action Plans
Appendix 2 Multi-Agency Action Plan
Appendix 3: The Home Office Definition of Domestic Violence
Appendix 4: Glossary of Terms

Section 1 - Background

1.1 Introduction

1.2 This report is about Gemma, who was murdered by her partner Robert in May 2017. Gemma was 30 years old at the time of her death. The review believes that Gemma had only formed a relationship with Robert in the six weeks before her murder.

1.3 Gemma's family requested that her real name be used in this report. The perpetrator is referred to as Robert throughout this report which is a pseudonym agreed by the Domestic Homicide Review (DHR) panel.

1.4 The review panel offer their sincere condolences to the family and friends of Gemma and would like to extend thanks to Gemma's family and to those services who participated in the Review and assisted the Panel with the review.

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

1.6 Following the publication of the associated Home Office Action Plan in March 2012, guidance on the conduct and completion of DHRs has been updated. It is under this guidance that the Chorley and South Ribble Community Safety Partnership commissioned this DHR.

1.7 Circumstances leading to the Domestic Homicide Review

1.8 The events leading to the decision to carry out this DHR are as follows:

1.9 At the time of her death Gemma lived in a property registered with the Local Authority as a House of Multiple Occupation (HMO). This HMO is long established, with several long-term residents.

1.10 Gemma was last seen by another resident of the HMO the day before she was murdered. Witness statements made during the process of investigation suggest that late in the evening on the day before the murder occurred, other tenants living in the same accommodation could hear arguing between Robert and Gemma.

1.11 On the day she was murdered, it was noticed that Gemma did not attend breakfast as she would routinely do. Consequently, other residents expressed concerns as to her whereabouts and the Lancashire Constabulary (LC) were notified. Officers attended the premises and Gemma was found deceased in her room. Evidence gathered at the scene suggested that Robert may have

been the last person to see Gemma alive. Police began a search for Robert, and he was later found in a churchyard and subsequently arrested but made no admission to the offence.

1.12 A post-mortem took place that established that Gemma had injuries consistent with assault. The cause of death was recorded as asphyxiation.

1.13 Robert was charged with Gemma's murder and was remanded in custody. Robert submitted a guilty plea following the charge of murder and received a life sentence (with a minimum tariff of 17 years).

1.14 Overview of Key People

1.15 Gemma

1.16 The picture gathered by the review of Gemma's life during the period under review, is of an adult who had many vulnerabilities that stemmed from a childhood during which she experienced traumatic abuse.[1] (NB Trauma and traumatic abuse is described by the mental health charity MIND as 'Going through stressful, frightening, or distressing events is sometimes called trauma). The impact of childhood trauma is referred to throughout this report as Gemma's family, and the DHR panel concluded that Gemma's childhood experiences had a significant impact upon her daily lived experience and decisions in adult life.

1.17 The panel agreed that it is particularly important that Gemma is not viewed solely as a victim of her circumstances and is clearly seen as an individual who was a mother, a daughter, and a sister. Sadly, during the period under review, Gemma was in the grip of chaotic drug misuse and her lifestyle had a profound influence on her relationships and life choices. The review panel would wish readers to bear this in mind when considering Gemma's actions and choices.

1.18 Members of Gemma's family who participated in the review provided insight into Gemma's lived experience. As referenced above, Gemma experienced traumatic abuse as a child. This was a significant factor in Gemma's vulnerabilities in later life.[2] The national charity National Association for People Abused in Childhood (NAPAC) recognise that childhood abuse in all forms significantly impacts the lives of victims, as children and into adulthood.

1.19 Gemma's family said that she was unable to cope with what had happened to her and began using drugs to deal with her feelings.

[1] https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/about-trauma/
[2] https://napac.org.uk/

1.20 Gemma became pregnant with Child 1 in her early twenties. Her relationship with the father of Child 1 broke down and Child 1's father was granted custody of Child 1.

1.21 Gemma then met her long-term partner and became pregnant with Child 2. The relationship was problematic from the outset. Both Gemma and her partner were dependent on drugs and lived near other drug users. Additionally, members of her partner's family were involved in drug use and drug dealing and Gemma's family said they were a negative influence on Gemma.

1.22 Child 2 became 'Looked After' in April 2012 and was permanently removed from Gemma's care later that year. As was noted by Gemma's family, the removal of Child 2 had a profound effect on Gemma and contributed to an escalation in her drug use and a deterioration in her mental health, from which she never fully recovered. This made it difficult for Gemma to maintain engagement with supportive services, although she did make efforts throughout the period under review to address her vulnerabilities.

1.23 NB Gemma's family confirmed that the relationship between Gemma and Robert had begun only six weeks prior to Gemma's death, although they thought that Gemma and Robert may previously have met due to their contact with a local service. The family said that they did not know Robert, nor did they know that, prior to her death, Gemma had commenced a relationship with him. They later learned, through letters written by Gemma that she had quickly 'fallen in love' with Robert and felt that she wanted to be with him forever.

1.24 Robert

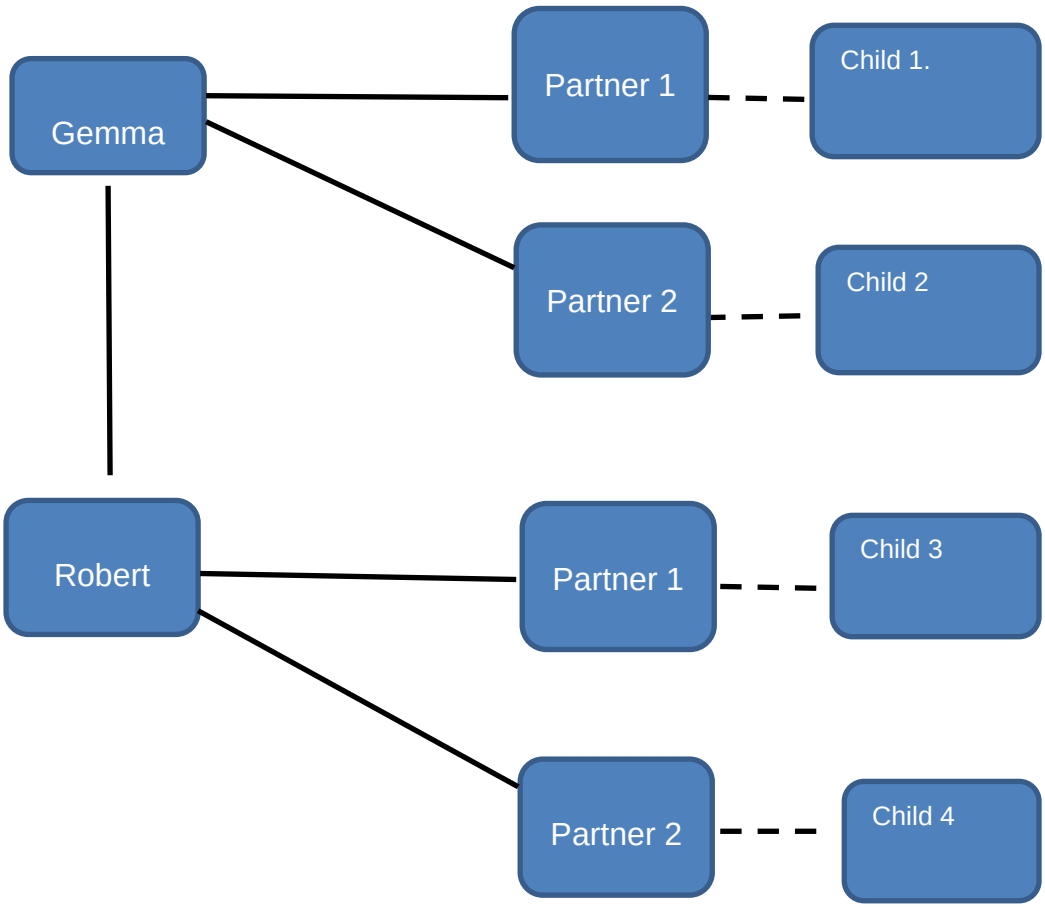
1.25 Robert had a traumatic and troubled early life. When Robert was aged eleven, he was diagnosed with epilepsy. Shortly after this, Robert took an overdose of diazepam. He later told professionals that the overdose was linked to abuse in his childhood.

1.26 Before moving to the local area, Robert had a long-term relationship and had a child with his partner. (Robert also has a child from another relationship). The long-term relationship broke down and he moved to the local area some years ago, where he became known and established as a member of the local drug using community. This brought him into contact with the police on several occasions.

1.27 During the period under review, Robert had contact with the local drug treatment service and, although he had periods of abstinence and relative stability, he appeared to relapse into dependent chaotic drug misuse during this period.

1.28 Relationships

Set out below is a genogram that describes the connection between the subjects of this review



1.29 The views of Gemma's family

1.30 When the Chair of the panel met with Gemma's family, they said that the processes around Gemma's death had been difficult. They welcomed the support of the Family Liaison Officer (FLO). They had, however, found they had to seek information from agencies rather than this being offered to them.

1.31 They had recently received a letter from the Coroner regarding an inquest taking place into Gemma's death 'when the criminal proceedings' had been completed. This had given them cause for concern as the criminal proceedings had been completed some time ago. (NB: The review panel has confirmed that no inquest took place).

1.32 The family also had concerns about the way that they were informed of Gemma's death. This was via a telephone call from the Family Liaison Officer to their workplace during which the family was informed that Gemma had died

in suspicious circumstances. The Chair stated that they would raise this with the members of the panel because, although it is not causally related to the review, it is important that best practice is followed in future.

1.33 In relation to Gemma and the points concerning agency involvement, the family expressed significant concerns around the accommodation in which Gemma lived. They had visited the property after Gemma's death and found the standards to be extremely poor. A close family member is aware of the regulations regarding Homes of Multiple Occupancy, and they felt that there were clear signs of the property not being fit for purpose.

1.34 The family also expressed concerns around vulnerable people being accommodated in the same premises without, apparently, any service interventions to support them.

1.35 They were realistic about the nature of the problems experienced by Gemma and that it was not easy to engage her in services. However, they felt that the review should highlight the fact that accommodating vulnerable people, particularly those with drug and alcohol dependencies, in the same premises without supervision or support would lead to further problems, and result in an inability to break away from problematic lifestyles.

1.36 As referenced above the family did not know Robert, nor did they know that Gemma was in a relationship with him, until they found letters in a 'book of memories' that they found in Gemma's room after her death. They felt that Robert had sought Gemma out because she had access to drugs. They read in Gemma's letters that she had 'fallen in love' with Robert and had said in her letters that she loved him and wanted to stay with him forever.

1.37 They were of the view that Gemma may have known Robert vaguely for some time, but that the relationship had only begun in the six weeks or so prior to Gemma's death.

1.38 The family spoke about Gemma's vulnerabilities with honesty and sensitivity. They felt that her drug dependency had taken over her life and had led to the breakdown of her relationship with the Father of Child 1 and the Father of Child 2 and to her children being removed from her care. They spoke about the relationship with Child 2's father being problematic and that this had an extremely negative influence on Gemma's life.

1.39 Gemma's sister expressed the view that Gemma's drug use was associated with the abuse she experienced in childhood and, although it was destructive, it served as a coping mechanism for things that had happened to Gemma in the past.

1.40 The family felt that the key to helping someone like Gemma lay in perseverance from agencies as it was highly unlikely that such deep rooted and complex issues could be resolved through short term interventions. They knew that Gemma did not remain in contact with services for long enough to

gain any therapeutic benefit from them and recognised the difficulty that services have in continuing to be made available in these circumstances

1.41 The family said that Gemma was a person who needed someone to lean on and depend on and that, even though Gemma's relationship with her first partner had been difficult (and involved drug misuse and drug dealing), Gemma had felt safe with him and that the break-down of that relationship caused Gemma to slip further into drug dependence and a chaotic lifestyle. The family stated that Gemma had 'chosen' him above her children, to some extent, and had been unable to break her addiction even in the face of the children being removed.

1.42 The family expressed concern that, when Child 2 was removed and placed in their care, there was little support available for Gemma. The family explained to social care staff at the time that it would be difficult for them and Gemma to maintain their previous relationship (Gemma had stayed with family prior to Child 2's removal). The family felt that there should be support available to people with vulnerabilities in circumstances where children are removed. The Chair agreed that this was an area that the members of the panel and the report should reflect upon.

1.43 Gemma's family reflected on the exceedingly difficult decision to become the legal guardian for Child 2. However, they recognised that there was a need to be realistic about how much Child 2 needed stability and care. At the time when Child 2 was placed in their care, the family said that Child 2 was in a poor state of health and that they agreed that Child 2 needed to be removed from Gemma's care, although they recognised how difficult this would be for Gemma. The family said that when Child 2 came to live with them, Child 2 was unsettled and disturbed, and afraid of certain things because of what they had seen and experienced. The family stated that Child 2 was terribly upset by seeing a dog bed as they recalled that this was where people who came to their house used to sleep.

1.44 They said that Gemma had been encouraged by social care to have a drug test, although Gemma never did this. They thought that a test was offered by the GP, but it was not clear who was offering the test.

1.45 In relation to what might have made a difference to Gemma, the family stated that living in an environment where there was little or no opportunity to avoid other drug users daily, without any support, intervention or supervision made recovery from addiction almost impossible for Gemma.

1.46 The family stated that having a support worker at the time that Child 2 was removed may have been helpful to Gemma. Additionally, the family said that they wished Gemma could have maintained contact with support services, and that services could have recognised that Gemma's issues were deep rooted and would take time to resolve.

1.47 As stated elsewhere in this report, Gemma's family were asked to review the revised report and gave their approval to the content.

Section 2 - Conduct of the DHR

2.1 The timescale of the Review

2.2 At the initial meeting of the DHR Panel, it was agreed that the timeframe for the Domestic Homicide Review should cover the period from the 1st of January 2011 to the date of Gemma's death. This was year that Gemma first had contact with Child Protection Services and in which Robert first presented to local drug services.

2.3 As is usual, participating agencies were reminded that if issues arose that were pertinent to the discussions of the Panel that fell outside this time frame, then they should be submitted to provide context for the case.

2.4 Proposed timetable for completion

2.5 The Review began with an initial meeting of the Panel held on the 15th of August 2017 at which the Panel agreed to hold a minimum of five meetings during the review period. The panel agreed a draft timetable with agreed dates and expected actions.

2.6 A submission was made to the Home Office in September 2017 to request an extension to the target date for the completion of the Overview Report. This request was made to accommodate the submission of further information to the review and to enable the criminal proceedings to be completed. The Home Office responded positively to the request for extension. The expected end date was scheduled to be April 2018.

2.7 The final report was shared with Gemma's family in May 2018 with the panel signing off the report for submission to the Home Office in June 2018. However, it appears that due to staff changes and an administrative error in the commissioning body, the final report was never submitted.

2.8 This error came to light in October 2020. A local authority officer contacted the DHR Chair and enquired about the process of submission. The Chair advised that the Home Office should be notified immediately, and the report was sent to them in November 2020.

2.9 On 31st March 2021, a response was received from the Home Office acknowledging the delay and requesting clarification and amendments to the report.

2.10 Gemma's family were notified of the error and kept up to date regarding resubmission. They viewed the final report prior to submission to the Home Office.

2.11 The DHR panel was reconvened on 29th April 2021 and approved this revised report, which was duly submitted and approved (insert date when known).

At the panel meeting on 29th April 2021 agencies who had submitted single agency action plans to the review confirmed that all actions had been completed within the initial timescales.

A revised multi-agency action plan was approved which is attached at Appendix Two of this report.

2.12 Statement of Confidentiality

2.13 The members of the Panel were cognisant of the protocol concerning confidentiality: i.e., that the information provided for the purpose of conducting a Domestic Homicide Review is strictly confidential and shall not be shared, except for the purpose of the review. Information was available only to participating officers/professionals and their line managers until the report was approved for publication by the Home Office Quality Assurance Group

2.14 The Review Process

2.15 The purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence, abuse 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: and
- Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

2.16 The rationale for the review process is to ensure agencies respond appropriately to victims of domestic violence and abuse by putting in place appropriate support mechanisms, procedures, resources, and interventions with an aim to avoid future incidents of domestic homicide and violence[3].

2.17 This Review has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004), and in line with

[3] Further information is also available at: https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this Report at Appendix 3.

2.18 The Terms of Reference

2.19 The Panel approved these specific terms of reference at its initial meeting in April 2017 and agreed to keep them under review. This was to ensure that they could be amended to capture the implications of any additional information submitted as a part of the Review process. It was agreed that the Review would:

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

2.20 The Panel also agreed the following key lines of enquiry:

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

- Was the perpetrator known to any agency as a perpetrator of domestic abuse and if so, what actions were taken to reduce the risks presented to the victim and/or others?
- Did any agency have knowledge that the victim and/or perpetrator was experiencing difficulties in relation to drugs, alcohol, mental health, or other vulnerabilities/risk factors (in this case the Panel agreed to consider the issue of accommodation, particularly houses of multiple occupation)
- Did the victim disclose domestic abuse to family and/or friends, if so, what action did they take?
- Did the perpetrator make any disclosures regarding domestic abuse to family or friends, if so, what action did they taken?
- Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?

2.21 Methodology

2.22 Individual Management Reviews and Chronology

2.23 At its first meeting, the DHR Panel approved the use of the Individual Management Review (IMR) template and integrated chronology template issued by the office of the Lancashire Police and Crime Commissioner (PCC). The Chair of the Panel contacted each participating agency, as appropriate, and invited them to make their submissions in accordance with the timetable established by the Panel. The level of compliance with this request was excellent. The template and guidance for both the IMR and the integrated chronology were clear – they were to be used to determine the nature and frequency of contact each participating agency had with Gemma and with Robert.

2.24 Involvement of Family and Friends

2.25 As set out above the review panel considered the involvement of family and friends of the victim. The Chair of the Panel sent notifications describing the purpose of the DHR to Gemma's family, inviting them to participate – if they wished to do so. The Chair provided information produced by the Home Office explaining the DHR process. The Chair also provided information and contact details for the independent organisation, Advocacy After Fatal Domestic Abuse (AAFDA). The Chair spoke to the family about seeking specialist support, however they did not wish to avail themselves of these services.

2.26 As is usual, no set timeline was established for the participation of the family – the Panel and the Chair considered it more appropriate to allow sufficient time for family members and friends to consider the request.

2.27 Gemma's sister and her partner, agreed to participate in the review and met with the Chair on the 1st of March 2018. The Chair maintained contact with the family from that point to the completion of the review to maintain a

line of communication so that updates on the progress made to complete the review and feedback could be facilitated.

2.28 The perpetrator was informed of the DHR and was invited to contribute if they wished to do so. As the perpetrator is serving a custodial sentence in a high security prison, it was suggested by the Offender Manager that a video link interview be established. A time was set for the Chair to speak to the perpetrator; However, the interview was cancelled at short notice. A second appointment was made by the Chair for 8th March 2018. However, there was no response to this appointment. The panel discussed whether to attempt to arrange further appointments and decided that no further contact should be attempted. This was discussed with Gemma's family who had no objection to the perpetrator not being spoken to.

2.29 The Panel considered whether to speak to people residing the HMO at the time of Gemma's death. However, the panel concluded that witness statements made by residents, which were viewed by the Chair, contained limited information regarding Gemma, other than confirming her connection to Robert and her whereabouts in the period immediately before her murder. The panel also noted that the residents at that time in the HMO were adults at risk, with their own vulnerabilities and concluded it would not be in the best interests of these residents to involve them in the review.

2.30 This decision was ratified at the reconvened panel meeting on 29th April.

2.31 No other family or friends came forward to participate in the review.

2.32 Contributors to the Review

2.33 NB The Chair of the Panel and the Author of the Overview Report provided guidance for the IMR authors on writing an IMR, in line with Home Office guidance (Home Office 2016). The IMR Authors were not directly involved with Gemma or Robert. IMR reports were quality assured by a senior accountable manager countersigning the report. Agencies were asked to address contacts with both Gemma and Robert. IMR Authors were invited to present their IMRs to the DHR Panel.

2.34 The contributors to the Review are described in the table below:

Organisation / Author	Nature of the submission	Completed and submitted by
Lancashire County Council: Children's Social Care (CSC)	IMR and notes of child protection proceedings	Rose Howley. The author had no direct involvement with the subjects of the case. The IMR was quality assured and approved by a Senior Manager within the service.

Organisation / Author	Nature of the submission	Completed and submitted by
Lancashire County Council: Adult Social Care Service (ASC)	Short Management Report (with supplementary written information)	Pauline Bartholomew. The author is the manager for a team of Social Workers (Safeguarding Enquiry Service, Central Lancashire) and had no direct involvement with the subjects of the case. The report was quality assured and approved by a Senior Manager within the service, Randip Bhogal (Patient Safety and Safeguarding Service)
Lancashire Teaching Hospital NHS Foundation Trust (LTHFT)	IMR	Paul Corry. Adult Safeguarding Practitioner working within the Safeguarding Team at LTHFT. The author was not involved with Robert or Gemma. The IMR was quality assured by a senior manager in the Trust (Julie Seed).
Chorley Community Housing (CCH)	Short Management Report	Debbie Parkinson. The author is responsible for managing a team of Tenancy Enforcement and Support Officers who deal with reports of anti-social behaviour, domestic abuse, safeguarding concerns and tenancy fraud. The author is a staff member of Chorley Community Housing and had no direct contact with the subjects of this case.
Cotswold House (CSH)	Individual Management Review	Lorraine McIntyre. Cotswold Supported Housing is the homeless accommodation service managed by Chorley Borough Council. The Author is the Manager of the service and has 24+ years of experience of working in a supported housing environment including Domestic Abuse Refuges. The author is independent of the case, was not a witness in the case and had no direct contact with the subjects of the case.
Discover Drug and Alcohol Services (Discover)	Individual Management Review	Margaret O'Neill. The author is the Team Manager responsible for the day-to-day management

Organisation / Author	Nature of the submission	Completed and submitted by
		of service delivery of drug and alcohol services within Chorley, South Ribble and West Lancashire. In her role as Team Manager, Ms O'Neill was aware that Gemma and Robert were receiving support from the Service she managed. Ms O'Neill knew of Gemma and Robert in this context only and had no knowledge of their life outside of the service and Ms O'Neill had no direct clinical contact with them. As the Author, Ms O'Neill was acting independently and the IMR was quality assured and ratified by a Senior Manager from the host Trust (Dr Karen Clancy)
Greater Manchester Police Service (GMP)	Short Management Report	DC Simon Hurdley. The author is responsible for the review of single agency involvement, practices and analysis relating to Child Serious Case Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews. The author is a staff member of Greater Manchester Police, Serious Case Review Team and had no direct contact with the subjects of the case. The short report was quality assured by a senior manager in the service (DI Carol Hobson).
CCG/ GP	IMR	Dr Linda Whitworth. The author is a local GP as well as working for the Clinical Commissioning Group (CCG) as GP Lead for Safeguarding. The author is entirely independent of the case and independent of the management of the decision making within the case.
Lancashire Care Foundation Trust (LCFT)	IMR	Lorraine Chadwick (Lead Nurse for the Mental Health Network in Central and West Lancashire) and Cherry Collison (Safeguarding Lead for LCFT –

Organisation / Author	Nature of the submission	Completed and submitted by
		providing scrutiny and oversight to the IMR). The authors have had no operational involvement nor been involved in any management decisions in respect of this case and are therefore able to bring independence to the information gathered and shared.
Lancashire Constabulary (LC)	IMR	Damian McAlister. The author is a Review Officer. The author has no operational involvement in the investigation or in the decision making or management of the case. The IMR was quality assured and approved by a Detective Inspector (Stephen Ryder).
Clare House (Women's Refuge)	Short Management Report	Liz Stanton. The author is the Refuge Manager for Progress Housing Group. Liz is responsible for the running of the Chorley and South Ribble Women's Refuge and its additional outreach services. The IMR was quality assured by a senior manager in Progress House (Annette Stevens)
North West Ambulance Service (NWAS)	IMR	Sarah Harris. Safeguarding Practitioner (Cumbria and Lancashire area) for North West Ambulance Service NHS Trust. The author is a registered nurse with 15 years' experience working for the NHS in an Emergency Department. The author has had no operational involvement in this case and brings independence to this review by being more than two lines removed from the management of the decision making in this case The IMR was quality assured by a senior manager in the service (Deborah Bullock, Head of Clinical Safety).
Victim Support (VS)	Short submission	Bridget Cheney and Dee Conlon provided an account of the calls

Organisation / Author	Nature of the submission	Completed and submitted by
		made to the perpetrator following notification to them by the Constabulary following the assault on the perpetrator. The attempts at contact, though frequent, were not successful.

2.35 Copies of IMRs were circulated to all the Panel members for analysis and scrutiny, prior to the meetings of the Panel and Panel members were able to cross-reference significant events and highlight any missing information for further investigation.

2.36 DHR Panel Members

2.37 Panel members were appointed based on their seniority within relevant and appropriate agencies and their ability to direct resources to the review and to oversee the implementation of the review findings and recommendations. Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were also invited to support the panel.

2.38 The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

2.39 The views and conclusions contained within this overview report are based on findings from both documentary reviews and personal records and transcripts and have been formed to the best of the Review Panel's knowledge and belief.

2.40 The members of the Panel are described in the table below (NB some job titles have changed since the review was finalised in 2018).

Panel member	Name	Organisation
Chair	Maureen Noble	Independent
Review and Investigating Officer	Damian McAllister	Lancashire Constabulary
Administrator	Alison Stringfellow	Chorley Borough Council
Head of Early Intervention and Support	Louise Elo	Chorley Borough Council
Service Manager	Liz Stanton	Clare House
Community Safety Managers	Rachel Austen Irene Elwell	Chorley City Council

Designated Professional for Safeguarding and Mental Capacity Act	Lorraine Elliott	Clinical Commissioning Group
Service Manager	Rose Howley	Lancashire Children's Social Care Service
Service Manager	Bridget Cheney Dee Conlon	Victim Support
Service Manager	Margaret O'Neil	DISCOVER Drug and Alcohol Service
Service Manager	Debbie Parkinson Paul Dewhurst	Chorley Community Housing
Safeguarding Manager	Sarah Harris	North West Ambulance Service
Safeguarding Manager	Paul Corry	Lancashire Teaching Hospitals NHS Trust
Associate Director Safeguarding and Lead Professional for Safeguarding Adults and Mental Capacity Act (MCA)	Bridget Welch Cherry Collison	Lancashire Care NHS Foundation Trust
In attendance		
Author	John Doyle	Independent
Administrative Assistant	Alison Stringfellow	Chorley Borough Council.

2.41 DHR Chair and Author

2.42 The Commissioning Authority (Chorley Borough Council) appointed an independent Chair, Maureen Noble, to oversee and direct the Review, in accordance with the Home Office Guidance. The Chair has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews.

2.43 The Chair has completed the relevant Home Office Domestic Abuse Training modules. The Chair had no prior contact with the subjects of this case, no connection with the community safety partnership and no personal contact with any of the agencies involved in the Review prior to the incident occurring.

2.44 In turn, an independent author, John Doyle was appointed to write the overview report. John has extensive experience in public health, health

protection and NHS management and had no connection with the case, no connection with the community safety partnership and no connection with any of the agencies involved in the review.

2.45 The author has undertaken the online Home Office Domestic Abuse Training Modules and has worked as author of several domestic homicide reviews.

2.46 Parallel Processes

2.47 Setting aside the criminal proceedings, there were no pertinent parallel processes necessary for the Panel to consider.

2.48 The Chair of the Panel communicated with the Office of the Coroner and informed them that the DHR was taking place and the expected time frame of the Review.

2.49 No Coroner's Inquest has taken place.

2.50 Equality and Diversity

2.51 The review panel were committed to the ethos of equality, openness, and transparency. The review panel considered all equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to the victim, perpetrator, and family members.

2.52 There is no evidence that Gemma or Robert were directly discriminated against by any agency based on the nine protected characteristics described by the Equality Act 2010 *i.e., Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.*

2.53 The Chair of the Panel was not required to challenge any member of the Panel on the grounds of diversity or sensitivity to equality legislation throughout the process of completing the Review.

2.54 The Panel noted that whilst none of the agencies contacted in relation to this Review identified any specific diversity issues concerning Gemma or Robert, this did not mean to suggest that these agencies were unaware of Disability discrimination as it pertains to the Equality Act 2010.

2.55 As already noted, and considered in detail through this Review, Gemma lived with several longstanding mental health difficulties, coupled with a history of substance misuse, and significant 'Adverse Childhood Experiences' (ACE).

2.56 The Panel discussed the issue of Adverse Childhood Experiences (ACEs) and noted that the term 'ACEs' was first employed in 1998 by a

landmark population study[4] and referred to 10 categories of abuse, neglect and family dysfunction in childhood used to predict a variety of poor adult outcomes. Since the original study was published, there has been widespread debate regarding the approaches used to prevent ACEs.

2.57 It is also important to note that there are other negative child circumstances, beyond the original 10 listed in the 1998 study, that can predict negative adult health outcomes (e.g., low birth weight, childhood disability, bullying and social discrimination). The Panel also noted that the link between ACEs and poor adult outcomes is not deterministic.

2.58 Under the terms of the Equality Act[5] a disability means a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities.

2.59 A person is covered by the terms of the Equality Act if they have a progressive condition and/or if they have had a disability in the past. For example, if a person had a mental health condition in the past, which lasted for over 12 months, they are still protected from discrimination because of that disability.

2.60 It is important to note that discrimination does not have to be intentional to be unlawful.

2.61 Gemma (and Robert), clearly, would have been covered by the terms of the Equality Act because of the conditions they were both living with. The Panel, however, did not identify that Gemma or Robert were discriminated against by any of the services in contact with them. In reaching this conclusion, the Panel noted that Gemma and Robert had engagement with several services throughout the scope of the Review.

2.62 The panel noted sex as a protected characteristic in relation to Gemma, and were cognisant of the disproportionate prevalence of women as victims of domestic abuse.

2.63 Dissemination of the Overview Report

2.64 The dissemination of the final Overview Report and Executive Summary will be undertaken in accordance with the procedure approved by the commissioning authority and the Home Office. The Overview Report and Executive Summary will be circulated to:

- The Chorley and South Ribble Community Safety Partnership
- The family of Gemma
- The Office of the Coroner
- The Office of the Police and Crime Commissioner for Lancashire
- All agencies involved in the review

[4] See Felitti et al., 1998
[5] https://www.equalityhumanrights.com/en/equality-act/equality-act-2010

Section Three – The Facts

3.1 Both Gemma and Robert had many contacts with agencies during the period under review. The panel selected key contacts from the chronology as set out below (NB specific dates of contacts were not always provided by some agencies).

3.2 Chronology of Key Contacts

2011

3.3 In February Robert was referred to drug treatment services. They recorded no heroin use and low risk. There was no identification of vulnerability to self or others. They recorded Robert was using illicit buprenorphine originally prescribed as pain relief for a broken arm.

3.4 On 21st of July an anonymous referral was made to Children's Social Care (CSC), concerning Gemma, alleging drug misuse, poor home conditions, and a baby crying. A Core Assessment was completed, and a referral was made to the children's centre for support. CSC informed the father and Gemma that if any further concerns or information is received that raises concerns regarding their ability to meet Child 2's needs and safety, CSC would need to consider an initial child protection conference.

3.5 On 22nd of July Robert was offered an interview at Cotswold Supported Housing and he was accepted for accommodation

3.6 On 1st of September Child 1's father (Gemma's previous partner) told the CSC that he was using a large amount of alcohol and non-prescription drugs daily. He was the sole carer for Child 1. CSC noted that Child 1 had little contact with Gemma.

3.7 On 21st of September Robert registered with a new GP

3.8 On 28th of September Robert failed to attend a referral to the community mental health team.

3.9 On 30th of September a drugs warrant was executed at the home address of Gemma, and Child 2 was present. Gemma's current partner was found in one of the bedrooms with another person preparing heroin to be sold.

3.10 On 6th of October concerns were raised regarding Child 2's poor diet and poor hygiene. An initial Child Protection Conference was convened.

3.11 On 7th October there was a Strategy discussion regarding Child 2. Gemma informed CSC that her relationship had ended. Gemma stated that she could not cope with his drug dealing and drug use and stated she was

frightened that Child 2 would be taken away; Gemma said she was upset by Police referrals

3.12 On 27th October a S.47[6] enquiry commenced. The following day Gemma informed CSC that her relationship with her partner had re-commenced, she said that she receives support and care from him and no one else

3.13 On 7th November a Child Protection Plan and Core Assessment meeting took place under the category of neglect. All agencies in contact with the family were involved in the meeting.

3.14 Two further meetings took place with CSC in December in relation to ongoing concerns.

3.15 On 19th of December Robert reported an episode of depression and his GP made an urgent referral to the local mental health team.

2012

3.16 On 31st of January LC made a submission to the CSC citing concerns regarding Gemma and her partner.

3.17 8th of February Robert had received an offer of an appointment from the Lancashire Care Foundation NHS Trust (LCFT), but he did not attend. Details were sent for another appointment.

3.18 In March, the drug service noted that Robert's mental health was characterised as: 'low mood and self-harming'. Robert's GP commenced a prescription of venlafaxine. The drug service noted that Robert's Benzodiazepine use had risen alongside occasional illicit use of methadone.

3.19 On 5th of April, following the granting of an Interim Care Order, Child 2 became 'Looked After'. Child 2 was placed in the care of extended family members, subject to further assessments. A Special Guardianship Order was then granted in favour of the members of the extended family. Gemma reported to her GP that her child had been taken into care and reported a depressed mood. Gemma was referred to counselling and commenced a prescription of antidepressants.

3.20 On 17th April A Childcare plan review took place. The following were present at the meeting:

- Housing services
- Health Visitor
- V1 and JM
- Children's Social Care Service (CSC)

[6] Under section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action

- Child and Parenting Support Service (CAPSS) from Lancashire County Council
- Aunt and Uncle of Child 2

A comprehensive placement plan was agreed which included

- Support from Aunt and Uncle for Gemma and her partner to remain together
- Weekly CSC visits
- Weekly support for Gemma
- Support from the Health Visitor
- Fortnightly visit to baby clinic
- Local Authority applied for nursery provision (15 hours per week)
- Courses and support from the Children's Centre
- Child 2 to be registered at a GP and Dental Practice
  Gemma and Aunt provided with a list of key contacts to seek advice
- Gemma to seek appointment with GP for mental health support (appointment scheduled for 30/04/2012)
- Gemma was encouraged to visit well women clinic
- Gemma's partner was encouraged to re-engage with the drug treatment service
- Aunt and Uncle have support from CSC

3.22 In April Robert reported that he had been receiving care from the mental health team and his mood had lifted since commencing medication. His anti-depressant medication was increased to 150mg daily and Robert reported a good response to this dose a short time afterwards

3.23 On 18th of June Robert received a letter from the Lancashire Care Foundation NHS Trust (LCFT) offering an appointment for October. (Robert did not attend). The LCFT Practitioner sent Robert a letter asking if he wished to continue counselling. This event noted that if no reply was received by the 07/11/2012, Robert would be discharged, and his GP would be informed.

2013

3.24 On 1st of February the case regarding Child 2 was closed by the Lancashire Children's Social Care Services (CSC), in agreement with the appointed Special Guardians (a close family member).

3.25 On 14th of February Robert attended the A&E service following a fall and a seizure. Robert reported that he had split from his girlfriend and relapsed into heroin use, with cocaine and benzodiazepines.

3.26 On 11th of August Robert attended the A&E service following an alleged assault. Dental and jaw injuries and concussion were recorded. Hospital letters were sent to Robert's GP including reference to a previous fracture of his arm that was not healing, and he was referred to victim support. An investigation commenced but remains undetected. Victim Support services attempted to contact Robert on several occasions but without success.

3.27 On 24th of August Lancashire Police received a telephone call from Gemma to say that her boyfriend was being assaulted. The Police attended the address and Gemma stated that she was also assaulted during the incident after unknown males forced their way into Gemma's home address. The crime report states that the officers believed this may have been related to a 'drugs feud'.

3.28 In September, Gemma attended a drug treatment assessment. It was recorded that Gemma had reduced her heroin use and reported no alcohol use. Gemma reported a low mood, but no suicidal thoughts. Gemma informed the service that Child 2 had been removed from her care eighteen months ago and that Child 1 was living with their paternal grandmother. The service noted that Gemma was living with her partner, who was also in the treatment service.

3.29 In October, Gemma attended the drug service and reported no heroin use but her screening reported a positive result for buprenorphine and opiates. Gemma was attending several support groups.

3.30 In November, Gemma spoke to her keyworker at the drug service and stated that she was fed up with how her partner treated her and that she wanted to end the relationship. The key worker suggested a referral to the domestic violence and abuse service. Gemma declined the offer. Gemma attended her GP for a review of her depression and reported flashbacks of childhood abuse. A referral was made by the GP into the mental health services at LCFT. This resulted in an offer of counselling support. Any appointments missed by Gemma were re-booked.

3.31 During the period October to December, Robert reported to the drug service that he had increased his use of illicit drugs. The drug services noted that Robert had poor engagement with the service and recorded that he said this was due to the emotional shock from the recent assault.

3.32 In December, Gemma attended the counselling services offered by LCFT and commented that she had a supportive partner and so would speak to him for support. Gemma reported that she was still using heroin but that things were more settled at home.

2014

3.33 On 3rd of March Gemma reported to her GP that she was having convulsions. A referral was made to the neurology service. Gemma was subsequently discharged back to her GP because the service was unable to contact her to make an appointment. This was later resolved, and the appointment was re-instated.

3.34 On 11th of March concerns were recorded by the Discover drug and alcohol service concerning Gemma's self-care. She was supported to contact the mental health team to organise an appointment for the 2nd or April.

3.35 On 2nd of April Gemma attended one to one counselling support from LCFT. No safeguarding issues were flagged, and another appointment was scheduled.

3.36 In July, the local women's refuge discussed housing options with Gemma.

3.37 On 17th of July Gemma's GP referred her into the Psychological Wellbeing Service in relation to anxiety and depression.

3.38 In August, Gemma reported to her GP that she was continuing to have fits and reported she was not receiving mail from the drug treatment service or the Community Mental Health Team. The address was checked and amended. LCFT recorded that Gemma had dropped out of active treatment.

3.39 In September, Robert commenced preparation for an episode of in-patient detoxification treatment for his drug misuse.

3.40 In October, Gemma did not attend her appointment with her drug treatment case manager.

3.41 In November, Gemma reported a low mood to her GP and the GP amended Gemma's prescription. Gemma was advised to self-refer to the mental health service. Gemma stated that she wished to move away from her current accommodation. Gemma reported that her occasional drug use was triggered by anxiety and depression. Gemma stated that she was discharged from the mental health service because of two missed appointments.

3.42 In December, Gemma's GP received several letters from several services reporting recurrent non-attendance. A re-referral to the neurology service had been done in September but Gemma did not attend. Gemma also missed her mental health team appointments, her drug team appointments, her respiratory clinic appointments, and her GP appointments.

2015

3.43 In January, Gemma attended a re-arranged appointment with the drug service, and it was recorded that she had lapsed back into heroin use. Gemma stated that she was determined to stop using illicit drugs and wanted to re-engage in the support groups provided by the service.

3.44 In February to March (3 weeks), Robert completed a programme of detoxification treatment as an in-patient. However, Robert was discharged early due to a positive swab result of un-prescribed diazepam. Robert presented to the drug treatment service and was reported as re-engaging well with the group programme.

3.45 In June and July, Gemma attended the mental health service at LCFT and reported on-going illicit drug use, and on-going seizures. Gemma informed the LCFT case manager that she had been low in mood.

3.46 It was recorded by the drug service that Robert had a lapse into heroin and buprenorphine use. Robert stated that he had stopped and re-started anti-depressants and epileptic medication. Robert was given support in accessing treatment for Hepatitis C infection.

3.47 On 4th of October Lancashire Constabulary received intelligence that Gemma and her current partner were supplying cocaine and heroin.

3.48 On 11th of November Gemma was re-referred to the mental health team and subsequently had a telephone assessment during which she said her partner was loving and supportive – the outcome was that she was told to self-refer to “Minds-matter” (a service provided by LCFT) and the relevant crisis telephone numbers were given. LCFT offered Gemma an appointment to consider issues relating to depression and anxiety and Gemma verbally accepted the appointment date.

3.49 In November, the drug treatment service reported that Robert had no illicit drug use for approximately six months.

3.50 In December, Gemma self-referred for further Cognitive Behavioural Therapy (CBT). LCFT completed a telephone assessment and advised Gemma once again to self-refer to Minds Matter (and an information pack was sent to Gemma in relation to Minds Matter). Gemma agreed to undertake this in line with her risk management plan.

3.51 On 29th of December Robert did not attend his GP surgery appointments 3 times within 3 months. A letter was sent to Robert, as per practice policy, and he was removed from the GP list due to a “breakdown of the doctor-patient relationship”

2016

3.52 On 25th of January Gemma was arrested for an alleged assault and was interviewed. Gemma admitted the offence and she was given a conditional caution.

3.53 In February. Robert informed the Discover Drug and Alcohol Treatment service that he had separated from his partner.

3.54 In February and March, the drug treatment service reported that Gemma was attending support groups and appeared more positive. Gemma was awaiting an appointment for Cognitive Behavioural Therapy.

3.55 On 3rd of May, Lancashire Police receive intelligence that Gemma and Robert were supplying heroin.

3.56 On 8th of June, Lancashire Police received intelligence that Gemma and Robert were supplying heroin and ‘crack cocaine’.

3.57 On 13th of July, NWAS recorded a 999 call for Robert. He said he was feeling depressed over a breakup with his partner and admitted to crushing and injecting three clonazepam tablets into his groin in a deliberate suicide attempt. Robert was transported to the local Emergency Department. A letter was sent to his GP to inform them of the assessment that had been undertaken. The practitioner at the Emergency Department considered the risk and safeguarding issues and offered support for a counselling referral but Robert declined the offer, and he was discharged.

3.58 In September, Gemma attended the drug service and reported a reduction in heroin use and appeared brighter in mood. The service discussed options for detoxification and rehabilitation, but Gemma declined the offer because she wanted to stabilise on her own, despite advice that specialist support was available from the drug treatment service.

3.59 On 20th of October, Gemma attended the drug service and reported a low mood and self-harm (she was making cuts to her arms). Gemma's partner had found her and taken her to seek medical treatment. The drug service offered support and Gemma stated that she was involved with the mental health team but did not know her worker's name. The service discussed the aims of reducing illicit use and re-engaging with the treatment service support groups. Gemma stated that she felt unable to re-engage due to her depression.

3.60 In November, Robert had plans in place for a detoxification scheduled to commence on the 9th of December 2016 followed by a rehabilitation placement. During the execution of a drugs warrant at Robert's home address, he informed an officer that he had been stabbed in the shoulder by a carving fork during a 'drugs taxing' incident. Robert would not provide any further detail about the alleged assault and therefore the investigation could not be progressed.

3.61 On 28th of November, information was received by the Lancashire Constabulary concerning a 52-year-old man who was being financially abused by several people. Gemma was implicated in the allegation and she was served with a notice to cease and desist.

3.62 On 8th of December, Robert presented to the drug service in a dishevelled state. The in-patient detoxification service had attempted to contact Robert but without success.

3.63 On 14th of December, Robert presented to the drug service with no appointment and reported that he had been smuggling heroin and one wrap had exploded inside him. Robert also stated his snake had bitten him. Robert's arm was very swollen, red, and solid to the touch. Robert was advised to seek urgent medical attention.

3.64 On 15th of December, Lancashire Teaching Hospital NHS Trust reported that Robert was brought in by ambulance due to a prolonged assault by 4 other people. He had multiple small lacerations to the head, tenderness to the

lower jaw as well as a three-day old snake bite to his right wrist. Robert declined to provide any further details to the Police and this investigation could not be progressed.

2017

3.65 On 3rd of January, Robert reported to the police that whilst he was at his home address a brick was thrown at the window causing it to shatter. He stated it was dark therefore he was unable to describe the offender. He stated that it may have been in relation to a drug related debt that a woman he has been associating with had accrued.

3.66 On 19th of January, the drug treatment service attempted to contact Gemma via telephone – but they did not receive an answer. The service contacted the appropriate dispensing Pharmacy as Gemma had been out of treatment for three days. The service advised the pharmacy that if Gemma re-presented to them to direct her to the drug treatment service.

3.67 On 20th of January and 1st of February, the Lancashire Constabulary noted that Gemma and the mother of her current partner were dealing heroin and crack from their home address.

3.68 On 1st of February, the multi-disciplinary team at the drug treatment service discussed Gemma's case because Gemma had dropped out of prescribed treatment. Letters were sent to attempt to re-engage Gemma in service. Gemma was not considered appropriate for the out-reach service. Following a failure to engage with the service, the team agreed to discharge Gemma and Gemma's GP was informed.

3.69 That same day Robert undertook an assessment for detoxification. Robert stated that he was considering relocating to Scotland as soon as the treatment had been completed (he had a child living there).

3.70 Three days later, Gemma contacted the police to state that a group of males had attended her address and smashed a window. Police officers attended but neither Gemma nor her current partner would provide statements

3.71 On 17th of February, the drug service recorded that Robert had not collected buprenorphine for last three days. The Pharmacy was advised to tell Robert to attend the drug service as soon as possible. Funding for the detoxification was withdrawn to re-establish Robert's position and readiness.

3.72 On 7th of March, the Lancashire Constabulary received intelligence that Gemma and her current partner were dealing heroin and on the 24th, the Police received intelligence stating that Gemma and her current partner had separated but they were continuing to deal heroin

3.73 On 10th of March, a warrant under the Misuse of Drugs Act was executed at the home address of Robert. 15 wraps of what was believed to be heroin

were recovered and Robert was arrested for possession with intent to supply. Robert attended the drug treatment service without an appointment as he had received a letter from his keyworker. Robert stated he wished to obtain a prescription as he was using heroin and crack cocaine again. Robert was low in mood with suicidal thoughts. Mental health advice was given by the drug treatment service. The drug services recorded that Robert had been seen begging and sleeping rough in some local woods. He said he had been advised to contact the manager at a local House of Multiple Occupation for accommodation.

3.74 On 13th of April, a member of the public called for an ambulance because Robert was having a fit on the street outside of the property where he was living at the time. The crew attended and took Robert on board the ambulance for assessment. They advised that he should attend hospital, but Robert declined. Robert told the paramedic that he had taken heroin and cocaine earlier in the morning. (NB it was at this incident that the first reference was made to Gemma and Robert being known to one another).

3.75 Robert was left with Gemma at the residence where they were living and advised to call 999 if any further seizure activity occurred. The North West Ambulance Service (NWAS) submitted a Safeguarding Alert into the Lancashire Adult Social Care Service.

3.76 On 4th of May, the drug service reported that they had received no contact from Robert since his last presentation in March and therefore it was decided to discharge him from the group programme.

3.77 On 19th of May, the drug services noted that they had received no contact from Robert and hence he was discharged from the service and his case was closed.

3.78 The murder took place some days later.

Section 4 – Learning from the DHR

4.1 Learning from Agency Practice

4.2 The Panel was aware that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the “right thing”. It would be unwise not to recognise that a DHR will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid hindsight bias and has viewed the case and its circumstances, as the individuals would have seen them at the time at which they occurred.

4.3 All the agencies involved in this review provided candid accounts of their involvement to identify necessary lessons learnt. Analysis of agency practice

is set out below (NB as agency involvement covered different time periods, the analysis is presented in alphabetical order).

4.4 Adult Social Care

4.5 Gemma was not known to the Adult Social Care (ASC) service in Lancashire.

4.6 Robert was recorded on the Lancashire County Council Adult Safeguarding system as NWAS had raised a Safeguarding Alert on the 13th of April 2017. This was, in the view of NWAS, a suggestion of emotional and psychological abuse. The alert stated that the Police and other agencies were aware. It also stated that no one at the property wished to make a complaint in relation to the allegations made.

4.7 The safeguarding alert raised by NWAS was subsequently closed by the Multi Agency Safeguarding Hub (MASH) on the basis that Robert was not considered eligible for care and support, and he presented as being capable of protecting himself.

4.8 It would have been good practice to establish, via a capacity assessment, whether Robert reached the threshold for care and support, but there is no evidence that a capacity assessment took place.

4.9 Children's Social Care

4.10 Children's Social Care (CSC) first became involved with Gemma in 2009 due to concerns about her parenting of and ability to protect Child 1. This involvement was brief as Gemma felt that at this time that Child 1's needs would be best met by their father. The Father of Child 1 reported that he was concerned about Gemma's ability to care for Child 1 and that Child 1 would remain in his care.

4.11 CSC did have extensive involvement with Gemma between October 2011 and February 2013. At this time, Gemma was in a relationship. Concerns were recorded regarding parental substance misuse and mental health concerns which were having an impact on the care that they were able to provide. There were also concerns regarding child neglect which led to a Child Protection plan and, as positive improvements were not seen, the case progressed to care proceedings and the child was removed from their care.

4.12 During this period there was multi-agency involvement and multi-agency meetings, and no concerns were raised regarding domestic abuse in any form. The plan of support offered to Gemma was robust, but she did not fully engage and so it was not effective.

4.13 Although Gemma's case was closed to the Lancashire CSC in February 2013, as care proceedings had concluded and Child 2 was safeguarded, Gemma was still able to access support in relation to substance misuse and mental health from universal services.

4.14 Lancashire CSC did not have any involvement with Gemma or Robert during their relationship as they did not have any children residing in their care.

4.15 The actions taken by Lancashire CSC to safeguard Child 1 and Child 2 were robust, and the review saw evidence of strong multi-agency working to support Gemma during the period leading up to the removal of Child 2. The placement plan included support for Gemma, however, it appears that Gemma was unable to sustain engagement with the plan.

4.16 Chorley Borough Council Housing Options and Cotswold Supported Housing

4.17 Robert presented as homeless to the Chorley Borough Council (CBC) Housing Options service on the 22nd of July 2011. The reason for homelessness was described by Robert as a relationship breakdown with his wife.

4.18 Robert moved into suitable temporary accommodation with Cotswold Supported Housing (CSH) on the 22nd of July 2011 and vacated the accommodation on the 5th of December 2011. This was due to him being re-housed to an alternative tenancy. However, Robert approached Housing Options again on the 19th of March 2014 stating that he was being harassed at his flat and wanted advice regarding re-housing. Robert re-applied to the social housing list (Select Move) and received medical priority (due to his epilepsy).

4.19 Robert was re-housed via Select Move to a Chorley Community Housing (CCH) social tenancy on the 9th of February 2015. Robert was a CCH tenant until the 7th of May 2017. CCH had little contact with Robert following his initial interview in 2015, with only a handful of telephone calls where Robert reported issues with a missing key fob.

4.20 Chorley Community Housing (CCH) had no contact with Gemma and were not aware of Robert's relationship status.

4.21 Chorley Borough Council (CBC) provided appropriate levels of support to Robert and liaised with support services on his behalf. Robert did not sustain his tenancy with them, possibly due to his involvement with local criminal gangs. These matters were not disclosed to CBC.

4.22 Cotswold Supported Housing (CSH)

4.23 CSH first became involved with Gemma when she moved into the facility with her child. The Chorley Borough Council Housing Options team referred details of Gemma to CSH, and she was referred with her previous partner. Due to the risk assessments carried out, Gemma's partner at the time was deemed too high risk for the service and Gemma moved in with her child on the 30th of October 2011. Gemma remained there until the 20th of December 2012.

4.24 During her stay it was noted that some agencies (CSC and the Health Visitor) raised concerns regarding Gemma's mental health and that she appeared to be low or depressed. CSH were aware that Gemma was asked to see her GP and that she made several GP appointments but did not attend.

4.25 By October 2012, Gemma had effectively disengaged from the service and spent most of her time away from the scheme, returning late at night when support staff had left. Gemma left the premises early in the morning.

4.26 Cotswold Supported Housing (CSH) made efforts to support Gemma and liaised with other services on her behalf. It should be noted that during the period of Gemma's tenancy with CSH, Child 2 was removed from her care. There is evidence that CSH were involved in child protection meetings with the Lancashire CSC and other agencies, and it appears that they continued to try to support Gemma until she left the service in December 2012.

4.27 Chorley Borough Council Housing Team referred Robert to Cotswold Supported Housing (CSH) on the 22nd of July 2011. Robert was Interviewed and moved into CSH on the same day. In the interview Robert alleged to be a victim of domestic abuse and named his ex-partner as the perpetrator. Robert moved out of CSH on the 5th of December 2011 to his own tenancy.

4.28 The review saw evidence that Robert was supported in his tenancy, however he left to move to his own tenancy for reasons he did not disclose.

4.29 Discover Drug and Alcohol Service

4.30 Both Gemma and Robert had previous contact with Discover, and in Robert's case this was over several years. His engagement with the service was variable, however he did appear to sustain relatively long periods of treatment, but then relapsed into more chaotic use.

4.31 Neither Gemma nor Robert were in treatment in the weeks prior to Gemma's murder as they had both been discharged.

4.32 The review noted that liaison between mental health services and drug treatment services when the service user is engaging with both services simultaneously could have been improved. The review noted that there are various models of treatment for service users with dual mental health and substance misuse problems, which are elsewhere in this report. NB It should be noted that at the time of writing this report Discover is no longer the drug service provider in the local area.

4.33 Greater Manchester Police

4.34 Greater Manchester Police had limited contact with Robert (and none with Gemma) during the period under review. In 2012 there were several Criminal Records Bureau (CRB) applications in relation to Robert concerning him seeking employment with an addiction charity known as Addiction

Dependency Solutions in Greater Manchester. The panel did not receive any information to confirm if this employment was ever taken up by Robert.

4.35 Lancashire Care Foundation NHS Trust (LCFT)

4.36 Gemma had contact with LCFT three times in the period from 2011. It was reported that she requested support with her emotional wellbeing and was referred into Lancashire Care Foundation Trust (LCFT) Mental Health services by her GP due to concerns in relation to anxiety, depression and stress assessed at a mild to moderate level.

4.37 Records indicated that 5 scheduled counselling appointments were offered over the period 14th of December 2013 to the 22nd of April 2014 of which Gemma accessed three sessions.

4.38 Records over this period indicate that Gemma reported to be using drugs, but that support was being provided by Discover. It is noted throughout the contact records that routine enquiry was undertaken in relation to Gemma's close relationships, and records noted no safeguarding or domestic abuse issues.

4.39 As Gemma did not attend the last counselling appointment, on the 22nd of April 2014, she was discharged and no further follow up was required. This was communicated to her GP.

4.40 Lancashire Care NHS Foundation Trust were not made aware of concerns in relation to safeguarding issues or domestic abuse at points of engagement and review, despite evidence of enquiries being made with Gemma. Case notes do not document who Gemma was in a relationship/s with over the periods of involvement (November 2013 to December 2015). However, there is no indication of concern identified in relation to domestic abuse at any time.

4.41 There is evidence of a lack of engagement from Robert and to a lesser extent, Gemma.

4.42 Regarding Robert, the specific offer of counselling was not taken up and the rationale given was that he was anxious that this would set him back (due to revisiting childhood trauma) and he may return to using substances. It is noted, however, that throughout his records with LCFT, Robert was accessing support from Discover.

4.43 It should be noted that LCFT have a recording system in place to support practitioners in recording routine enquiry in relation to domestic abuse and this is embedded within its electronic care recording systems.

4.44 The review has established that there were other risk factors present in the lives of both the Gemma and Robert. Gemma identified as having anxiety and depression and needs relating to her substance misuse. Robert identified as having substance misuse and self-harm issues.

4.45 Lessons can be learned from the case about the way in which professionals carry out their duties and responsibilities in relation to strengthening and evidencing that routine enquiry is embedded in practice.

4.46 Work to strengthen the engagement of service users with complex needs is recognised as an area for development, however, as documented in other areas of this report, there is a finite resource available to offer to service users who do not maintain engagement with services.

4.47 Lancashire Teaching Hospital NHS Trust (LTHT)

4.48 There were 7 contacts with Gemma during the scope of the Review. These contacts were non-complex in their nature and the consultations did not highlight any concerns regarding any form of domestic abuse. The last contact with Gemma was on the 15th of November 2016 at a general thoracic clinic. This consultation was not completed (it should have included spirometry and chest x-ray) due to Gemma's anxiety on the day. Gemma 'did not attend' any subsequent appointments made for this clinic.

4.49 Robert had a total of 15 A&E attendances between the 1st of January 2011 and the date of Gemma's murder. Most attendances resulted in Robert being discharged and placed in the care of his GP for follow up treatment, if this was required. Within Robert's clinical narrative, he was known to have Hepatitis C, epilepsy, asthma, he reported self-harm, depression and he was a drug user engaged with the local drug treatment service.

4.50 Of these contacts, two were significant. Firstly, Robert was brought in by ambulance to A&E on the 12th of July 2016 with an intentional overdose of clonazepam. He was discharged on the same day. There is no documentation that there was any Mental Health follow-up made following his discharge.

4.51 The second significant admission to A&E was on the 15th of December 2016 when Robert was brought in by ambulance due to a prolonged assault by 4 others. Within the clinical records it states that Robert was assaulted in a house over a two-hour period and was punched and kicked in his head and body. No police referrals were made by A&E and there is no record that Robert wished to make a complaint to the police.

4.52 There were concerns regarding Robert's drug misuse and mental health which could have been explored further and further details of his condition passed onto his GP for review when he visited A&E.

4.53 The NHS Trust provide telephone numbers to relevant patients such as Robert following mental health related visits to emergency services. This could have included details of the local Crisis Team and/or the Samaritans.

4.54 Passing on such information should be recorded on the patient notes (and included in discharge letters). There is a need to show that there is

some recognition of external support for patients who experience Mental Health problems when they are discharged into the community.

4.55 The accurate recording of Mental Health referrals, assessment and intervention needs to be included within the patient's notes. However, no Mental Health input or referral was documented within Roberts notes or discharge letter. Whilst Robert's record stated that a more detailed report will be sent to the GP following "from the speciality" the Panel could not access this report or who the speciality was.

4.56 Lancashire Constabulary

4.57 Both Gemma and Robert had several contacts with police in the local area.

4.58 Police records noted that in 2013, Gemma's partner (not Robert) was assaulted but neither Gemma nor her partner would provide any further details and so the investigation could not reach a point of prosecution. The Lancashire Constabulary recorded that the crime may have been in relation to a 'drugs feud' but this could not be verified

4.59 The intelligence gathered by the Lancashire Constabulary suggested that Gemma was involved in the use and supply of drugs and it was considered that the relationship between Gemma and Robert may have been based on Gemma's ability to supply drugs.

4.60 The Lancashire Constabulary noted that the relationship between Gemma and Robert developed between three and eight weeks prior to Gemma's murder and that, as far as the Lancashire Constabulary was aware, Gemma and Robert never lived together as a couple but resided in the same House of Multiple Occupation (HMO). The investigation into Gemma's death did not discover any allegation or anecdotal suggestion of domestic abuse between Gemma and Robert.

4.61 The intelligence resulted in the execution of two separate warrants at the home addresses of Gemma and one warrant executed was under the Misuse of Drugs Act.

4.62 Gemma was also arrested for theft from a local supermarket and was implicated in the financial abuse of a man who was also living in the same property as Gemma. The victim in this case was subject to a Vulnerable Adult Protecting Vulnerable People (PVP) notification (graded as medium risk) and all the information collated was shared via the Multi-Agency Safeguarding Hub (MASH).

4.63 Lancashire Constabulary's involvement with both Gemma and Robert was largely related to their involvement in drug use and drug dealing. However, police also appropriately raised concerns regarding Child 2 leading to the initiation of child protection proceedings.

4.64 The review saw no evidence of the use of drug testing as a means of referring either Gemma or Robert to services, which would have been good practice.

4.65 North West Ambulance Service (NWAS)

4.66 According to the records, NWAS first encountered Robert on the 12th of July 2016 when a call was received from a neighbour of Robert who had called for an ambulance at Robert's request. Robert was complaining of feeling unwell.

4.67 On the arrival of the ambulance Robert was found to have a high temperature and the crew thought he was possibly suffering from sepsis. Robert also thought that he may have suffered from a seizure. Robert was transported to the nearest Emergency Department, as per Trust protocol.

4.68 Then, on the 14th of July 2016, Robert called 999 stating that he had injected Clonazepam tablets into his leg and that he had done this intentionally, to take his own life. Again, Robert was transported to hospital.

4.69 On the 13th of April 2017, a neighbour of Robert contacted 999 because Robert had a fit in the street outside his home address. When NWAS arrived, Gemma was at the scene. Robert declined transportation to hospital and was deemed by the crew to have mental capacity. Robert agreed to stay with Gemma for the rest of the day and dial 999 if he suffered from any further fits.

4.70 On this occasion the North West Ambulance Service Emergency Crew raised a safeguarding concern with the Lancashire Adult Social Care service.

4.71 Primary Care

4.72 Gemma accessed her GP surgery, and the records show excellent continuity of care and thorough consultations. The GP referred appropriately to the mental health services and others.

4.73 However, letters from some of the services into which Gemma was referred, indicated, at various points, several non-attendances. This included neurology, the mental health team, the drug team, and respiratory clinic appointments. She also did not attend some GP appointments.

4.74 Whilst it may have been her choice to not attend, her capacity to make these decisions was not assessed. Given her use of drugs and mental health difficulties her mental capacity to make informed choices could have been impaired. In this situation every effort should have been made to assess and document her mental capacity.

4.75 In August 2016, Gemma reported that she was doing well, was no longer taking heroin and was under the care of the drug treatment service. However, the GP received a letter from the drug team in February 2017 stating that Gemma had fallen out of treatment. Nevertheless, Gemma continued to

collect her medication from the GP surgery but was not seen by a GP in the Practice following receipt of the letter. It would have been good practice for the GP to review Gemma's drug use and mental health at this point.

4.76 Robert was registered at GP Surgery outside of the local area from 2011 until 2015. There is evidence of safe prescribing with checking of letters, thoughts about interactions and appropriate monitoring and medication reviews.

4.77 Robert initially attended and received on-going support with his depression and epilepsy. Between 2013 and 2015 there were letters reporting non-attendance at orthopaedic, neurology and Hepatitis C clinics. In the view of the author of the CCG submission, Robert met the criteria of a 'vulnerable adult' (in need of additional support) at this point but was not identified as an adult at risk by the practice.

4.78 From September to December 2015 Robert did not attend 3 appointments at the surgery (though he did attend at least one appointment in this period), and he was removed from the list as per the practice policy.

4.79 Robert subsequently registered at another GP surgery in February 2016. After his new patient check by the Practice Nurse (which was thorough) he was never seen again at the surgery. His medication was added to the screen inaccurately and the practice continued to prescribe his medication without any review. The clonazepam prescription (for his epilepsy) was amended correctly when requested by the specialist and the venlafaxine dose (for his depression) was halved with no reason in September 2016 and was not corrected, even when the error was queried by Robert 5 months later. An overdose of prescribed medication (clonazepam) was not acted upon and he was not reviewed at the surgery for his epilepsy or mental health despite letters suggesting a very vulnerable and unwell individual.

4.80 A letter received by the practice on the 10th of August 2016 from the drug team mentioned an overdose of his prescribed clonazepam 3 weeks previously. This letter was not acted upon and no warning was put on his medication screen, he was not invited in for a review and there is no evidence of the GP and drug team working together.

4.81 Hospital letters indicate a chaotic, unwell individual with uncontrolled epilepsy, mental health problems including an overdose and untreated serious health problems (hepatitis C and a non-healing fracture of his arm). He was not identified as an adult at risk by the practice and his self-neglect was never questioned[7].

[7] ***Self-neglect***
This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support. (Care Act 2014).

4.82 If Robert understood the risks and consequences of not attending appointments and using illicit drugs this would have been considered as an 'unwise decision' under the mental capacity act and appropriate risk management measures could have been considered

4.83 There is no indication that Robert's GP considered undertaking an assessment of Robert's capacity (under the Mental Capacity Act) which may have assisted in identifying appropriate referral pathways for his treatment and care.

4.84 Women's Refuge

4.85 The refuge received a referral from Discover (the drug treatment service) for Gemma on the 16th of December 2013. Following this referral, the Refuge then initiated several attempts to contact Gemma. The Refuge then arranged to meet Gemma on the 9th of January 2014.

4.86 Gemma said she was not currently looking for work and asked the refuge to get her an appointment with a solicitor because she wanted contact with her children. When the refuge asked Gemma about her health, she said she was taking medication for depression, as prescribed by her GP.

4.87 The refuge gave Gemma the Samaritans telephone number so that she could talk to them, should she feel the need. Gemma said she wanted to move from her current address, with her boyfriend, as she felt it was the accommodation that made him abusive towards her. Gemma said the abuse occurred when her partner got drunk and was nasty to her, but he was not physically violent. Gemma also said that she wanted to be free of drugs but did not think she could do this if she remained living where she was.

4.88 The refuge agreed to see what Gemma's housing options were, to contact a solicitor and to check out courses for her at the local College. Gemma then stopped engaging with the Refuge and with the drug service. The refuge checked with the drug service several times to see if Gemma had been back in contact with them, were told that she had not, and the Refuge never met Gemma again.

4.89 The refuge offered support to Gemma at their initial contact with her. However, she did not maintain contact with them. In fact, they only met Gemma once and, despite efforts to keep in contact with Gemma through the drug service, the contact lapsed.

4.90 Learning Against the Key Lines of Enquiry

4.91 Did any agency know that Gemma was being subject to domestic abuse by Robert at any time during in the period under review?

4.92 Gemma disclosed historic domestic abuse by a previous partner to the women's refuge in December 2013.

4.93 CSC were aware of historic allegations of domestic abuse related to Gemma's previous partner; however, this was outside of the timeframe of this review.

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

4.95 During their initial assessment, the refuge discussed Gemma's needs and then attempted to meet her again to make progress with their plan. However, Gemma disengaged from the service.

4.96 Did the victim disclose domestic abuse to family and/or friends, if so, what actions did they take?

4.97 Gemma's family were unaware of her relationship with Robert or of any domestic abuse that may have taken place within the relationship

4.98 *Did the perpetrator make any disclosures regarding domestic abuse to family or friends, if so, what action did they taken?*

4.99 None of the agencies involved in the review had any record of Robert as a perpetrator of domestic abuse.

4.100 Robert reported that he had been a victim of domestic abuse in a previous relationship, however this took place outside of the timeframe of this review.

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

4.102 Within the scope of this review, Robert was not known as a perpetrator of domestic abuse by any of the participating agencies.

4.103 Are there any matters relating to safeguarding vulnerable adults and/or children that the review should take account of?

4.104 Lancashire police reported concerns about Child 2 due to Gemma's drug use during 2011 and 2012. These were recorded by way of Vulnerable Child reports.

4.105 CSH were aware of safeguarding issues concerning Child 2 and were aware that Child 2 was subject to a Child protection plan. CSH attended all 4.106 the Child Protection meetings and case conferences and provided reports when requested.

4.107 Information concerning the safeguarding of Gemma's children was not shared with the LCFT mental health service by any other agency. LCFT were aware that the Children born to Robert were not in his care and were not aware of the reasons why.

4.108 NWAS raised an adult safeguarding concern with the Lancashire Adult Social Care service in relation to Robert following Robert enduring an epileptic fit outside the property where he lived.

4.109 The submission to the panel by the GP stated that, in their professional view, both Gemma and Robert met the criteria as set out in The Care Act as being vulnerable adults/adults at risk during the period under review

4.110 Lancashire CSC had a significant level of involvement regarding Gemma's second child, Child 2. This included Child 2 being subject to a Child Protection Plan and, ultimately, being subject to a Guardianship Order whereby the Maternal Aunt and her partner became the guardians for Child 2.

4.111 Did any agency have knowledge that the victim and/or perpetrator was experiencing difficulties in relation to drugs, alcohol, mental health, or other vulnerabilities/risk factors including transient lifestyles and vulnerability of accommodation (including HMO accommodation)

4.112 Drug Misuse

4.113 Both Gemma and Robert used and supplied drugs. This appeared to result in Gemma and Robert being involved in incidents of violence. All incidents were investigated but were not progressed because neither Gemma nor Robert would make statements and consequently the Police could not meet the prosecution threshold.

4.114 Though Robert had 21 convictions on the Police National Computer, many of which involved drugs, his offending was not considered to represent someone who was committing crime solely to fund a habitual addiction to illicit drugs. Robert did not disclose any mental health difficulties to staff whilst in contact with them.

4.115 Gemma was referred to a refuge by the Discover Drug and Alcohol Service. Gemma was, at the time of the referral, taking subutex[8] as a part of her treatment. The refuge was also aware that she suffered from anxiety and depression and was at the time awaiting a psychological assessment.

[8] Subutex is an opioid medication used to treat opioid addiction

4.116 In the view of the refuge, the accommodation where Gemma was living – a local House of Multiple Occupation (HMO) – was unsuitable for her needs, and they called Chorley Borough Council's Housing Options service to consider the issue of re-housing Gemma. The Council stated that the HMO was registered with them and so complied with all necessary legislation and therefore they were not able to immediately help Gemma until Gemma had addressed her rent arrears. The refuge established a payment plan for Gemma. The refuge did not know if Gemma ever paid any of this payment plan because they never met Gemma again.

4.117 Gemma was a client with the local Discover Drug and Alcohol Recovery Service. However, Gemma was discharged (in February 2017) due to a period of non-engagement.

4.118 Gemma was attending services for opioid dependency and reported underlying mental health issues throughout the scope of this review (up until the point of being discharged following a period of non-engagement).

4.119 Gemma reported to the service that she sporadically attended appointments with mental health services. Her engagement with Discover was irregular at times with no significant periods of stability.

4.120 Robert was a client of the local Discover Drug and Alcohol Recovery Service. Robert was discharged from the service, due to a period of non-engagement, in May 2017.

4.121 Robert was in treatment with Discover services (from February 2011) for opioid dependency and showed periods during his six-year treatment episode as stable and progressing well with his treatment and long-term goals. In late 2016, Robert alleged an incident of serious assault against him. Following this assault, his commitment to his treatment appeared to deteriorate significantly.

4.122 Within the Lancashire Care Foundation NHS Trust (LCFT) records of the contact with Gemma in 2015, there was a history of substance misuse and engagement with the drug treatment centre. There were no comments recorded regarding the stability or quality of Gemma's housing (this was unknown to the service). Gemma had intermittent contact with several services (Minds Matter, Psychological Wellbeing Service and Cognitive Behavioural Therapy Services)

4.123 The LCFT Single Point of access offered an appointment to Robert at the request of his GP for the Primary Care Mental Health Team (PCMHT) on the 27th of September 2011 but Robert did not attend. He was sent a letter to invite him to contact the service again within 14 days, but he was discharged when he did not engage with the service. The PCMHT wrote to his GP to advise them of this.

4.124 Mental Health

4.125 Gemma attended her GP for support with depression and was referred to the mental health team. However, due to inconsistent engagement, Gemma did not receive sustained mental health support.

4.126 The panel discussed the issue of vulnerability, following opinions shared with them by the GP. In the view of the GP, Gemma met the criteria of a 'vulnerable adult' as described by the Care Act 2014, which states that the safeguarding duty applies to an adult who:

- *Has needs for care and support (whether the local authority is meeting any of those needs)*
- *Is experiencing, or at risk of, abuse or neglect*
- *As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect*

4.127 The referral system is complex and difficult to navigate for many patients. If Gemma had been identified as an adult at risk (a vulnerable adult) and the records coded as such it is possible that the outcomes of her referrals may have been different in that services may have tried harder to engage her. Her recurrent missed appointments, mental health issues and drug misuse all put her at risk.

4.128 The Improving Access Psychological Therapies (IAPT) service reviewed Robert following a referral from his GP in August 2012 and recorded that 'thoughts of his girlfriend keep him safe'. He was seen in October 2012 for one session but then did not attend the next one. He completed an exit questionnaire and stated that he had decided to stop the counselling as it might cause a relapse and he may return to drug use to cope. He also declined any other support from the mental health services.

4.128 Robert exhibited low level mental health issues throughout his treatment. He was assessed by the mental health team following a hospital admission in July 2016 and discharged. He was made aware by his case manager of how to access mental health treatment in an emergency should the need arise. A review of risks was undertaken at regular intervals throughout Robert's treatment and after his assault.

4.129 Records show that Robert took an intentional overdose in July 2016 and was assessed by the mental health liaison practitioner within the Emergency Department. A full health and social care needs assessment was completed at this time. The assessment concluded by saying Robert denied any suicidal thoughts or feelings of hopelessness, he could keep himself safe he had no thoughts to self-harm and had no thoughts to harm others. He had no paranoid ideation therefore the practitioner identified no concerns about his mental health state. The practitioner contacted the Discover Drug and Alcohol Treatment Service and updated them verbally and sent a comprehensive letter to the GP informing them of the assessment that had been undertaken.

4.130 When NWAS attended to Robert when he had a seizure outside of his property (in April 2017), he disclosed to the paramedic and emergency medical technician that he had used cocaine and heroin. Robert also disclosed that he had concerns regarding the landlord of the property he and Gemma were living in. Robert made allegations in relation to financial abuse. These concerns were passed by NWAS to the Lancashire Adult Social Care Service. Robert did not give consent for this referral, but it was felt by NWAS that the information should be shared in the wider public interest as Robert alleged that other vulnerable residents at the property were also being financially abused.

4.131 Robert attended his GP for support with depression and was referred to the mental health team. Robert did not engage with the service to any significant extent. Robert did engage with the drug and alcohol treatment service.

4.132 Robert was removed from the list of his first GP (within the timeframe of this review) because of several missed appointments, as per the practice policy. The question of why he was not accessing his appointments was not asked, nor was it considered as to whether he was able to understand the risks and consequences of his actions. In the absence of violent behaviour and the presence of vulnerabilities the panel concluded that the decision to remove Robert from the practice list was questionable, citing GMC Guidance on Good Medical Practice (2013):

> *"62. You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient."*

4.133 Other Risk Factors

As cited in other areas of this report both Gemma and Robert had experienced trauma and abuse in their childhoods. It is not clear how much of this was known to agencies however there is learning in relation to exercising professional curiosity, as well as robust assessment tools, when seeking engage people with multiple complex needs.

4.134 Both Gemma and Robert experienced periods of vulnerable accommodation and spent some time living in a HMO.

4.135 In relation to accommodating vulnerable people with complex needs (and where domestic abuse may be a factor) there are several models that would be helpful to the local partnership in delivering services to people with multiple complex needs. The panel would commend work undertaken in the 'whole housing approach' guidance and toolkit developed by DHA Alliance.[9]

[9] https://www.dahalliance.org.uk/what-we-do/whole-housing-approach/whole-housing-toolkit/

Section 5 – Lessons Learnt, Conclusions and Recommendations

5.1 Summary of Learning

5.2 The review learned that Gemma and Robert are likely to have met when Robert took up residence at an HMO in the local area. The review believes that this took place 3-8 weeks before the homicide. It may be that they knew each other prior to this, as both were involved in drug misuse and related activity in the local area and were both clients of the local drug treatment service.

5.3 The review heard from Gemma's family that letters found after Gemma's death suggested that she had become besotted with Robert and thought that she would "be with him forever".

5.4 Both Gemma and Robert presented with familiar patterns of drug misuse, interspersed with periods of relative stability (referred to by some as the 'Revolving Door Syndrome'). As well as experiencing difficulties associated with chaotic drug use and dependency, both Gemma and Robert had histories of trauma, abuse and adverse childhood experiences which exacerbated their dependencies and mental health difficulties.

5.5 The review learned that Gemma experienced several vulnerabilities in her adult life including on-going anxiety and depression; on-going substance misuse; periods of unstable accommodation and possible exposure to risk factors associated with drug dealing and drug use. In addition to this, one of Gemma's children was removed permanently from her care. As documented earlier Gemma had experienced abuse in her childhood that continued to cause her distress in adulthood.

5.6 Gemma had historically reported domestic abuse by a previous partner and had been assessed by a women's refuge for support. However, she did not stay in contact with the refuge long enough to benefit from the service and continued to live with her partner.

5.7 During the period under review Robert presented with several risks and vulnerabilities.

5.8 Robert experienced chronic episodes of drug dependence and had done so over many years. He presented with mental health difficulties and had been diagnosed with epilepsy for which he received medication. It appears that Robert may have had difficulty in managing his epilepsy due to other lifestyle factors.

5.9 Robert appears to have developed connections with local criminal networks and there are some indications that this may have led to transience in relation to his accommodation, and to him being seriously assaulted on at least one occasion.

5.10 Both Gemma and Robert were registered with local drug services. They were not known to the drug service as being in a relationship and presented there at different times and with different issues.

5.11 Although Gemma and Robert were both regular and problematic users of drugs, the panel learned from the submissions made that neither would have stood out as being at particular risk of harm (over and above that known to be associated with problematic drug use) and neither would have stood out to services as having specific additional risk factors or support needs. The specialist drug service reported that many of their service users have a similar profile and lifestyle to Gemma and Robert.

5.12 Neither Gemma nor Robert was assessed under the Care Act as being 'in need of additional support'. The panel discussed this aspect of the review and noted that Gemma and Robert formed part of a group of people who could potentially 'slip through the net' of services due to the chaotic nature of their lifestyles and presentation – the impact of their vulnerability being attributed solely to their drug use.

5.13 Whilst Gemma did engage with some services, engagement was sporadic and unpredictable. This led to Gemma never receiving a full assessment of her mental health needs. The review has concluded that this lack of assessment was understandable given Gemma's difficulty in engaging with services.

5.14 Robert was known to have attempted suicide in July 2016. There was no follow up to this incident of self-harm by any service, nor is there any evidence that Robert received a discharge assessment to determine current levels of risk to himself or to others.

5.15 Robert showed some progress in relation to stabilising his drug use and had begun to work as a volunteer in the local service. However, following an alleged assault, Robert returned to a chaotic lifestyle and resumed a pattern of problematic drug use. It appears that Robert did not make a formal complaint to police about the assault and therefore there was no police follow up.

5.16 At the time of Gemma's death, both Gemma and Robert were living in a House of Multiple Occupation (HMO). The premises have a local reputation for accommodating people with multiple complex needs who find it difficult to find accommodation in any other sector.

5.17 This environment was viewed by the panel and by Gemma's family as one in which it would be difficult to escape the negative aspects of a transient lifestyle within which the use of substances featured heavily and one in which people with on-going vulnerabilities and risks would find it difficult to change deeply embedded problematic behaviours.

5.18 Gemma had been subjected to domestic abuse by a previous partner and had, on one occasion, sought support from a local refuge, but had not

been able to sustain contact with them, and therefore did not benefit from support or interventions to address domestic abuse. Lancashire CSC were aware that Gemma's relationship with her partner was abusive, and they did provide support to Gemma.

Gemma did not make further disclosures of domestic abuse to any of the services she was in contact with. However, it is the view of the panel that Gemma may have 'normalised' or minimised the domestic abuse that she experienced in her relationship, and that she may have experienced ongoing abuse without reporting this to any agency. Greater professional curiosity in relation to domestic abuse might have resulted in Gemma disclosing or following up offers of support and services.

5.19 Conclusions and Recommendations

5.20 Since the completion of the review in 2018 policy and practice in the local area has developed. The recommendations set out below were relevant at the time of the completion of the review and address current policy and practice. These recommendations and the appended multi-agency action plan were ratified as the extraordinary panel meeting that took place on 29th April 2021.

5.22 The panel noted that policy and practice in the following areas is in place:

- A self-neglect framework is now in place that guides multi-agency working and responses to some of the issues raised in this review. Further information can be found at: https://www.lancashiresafeguarding.org.uk/media/1458/Multi-Agency-Self-Neglect-Framework-Final-March-2019.pdf
- Practice in Children's Social Care has developed in relation to working in multi-disciplinary teams to offer support to children and families presenting with complex needs
- A Violence Reduction Network is in place at countywide level. The network adopts a trauma informed approach to working with people who experience violence. Further information can be found at https://www.lancsvrn.co.uk/

5.23 Thematic learning from the review and associated recommendations are set out below:

5.24 Conclusion 1 - Risk Factors Associated with Accommodation

5.25 Living in a House of Multiple Occupation (HMO) with other vulnerable people increased Gemma's risks in relation to chaotic drug misuse and mental health difficulties. Her difficulty in engaging with services would have been exacerbated by these factors. The HMO had no therapeutic input despite many of its residents having complex needs.

5.26 Recommendation 1

5.27 (1.1) Chorley and South Ribble Community Safety Partnership (CSP) should be assured that the learning from this review is incorporated into the work currently being undertaken to ensure compliance with regulations to improve the conditions for residents accommodated in homes of multiple occupancy (HMOs).

5.28 (1.2) The Chorley and South Ribble CSP should review the success of providing drug and alcohol support services in HMOs and explore whether this type of provision can be provided in the future.

5.29 Conclusion 2 - Adults with complex needs who have difficulty in engaging with services

5.30 As outlined in the summary, both Gemma and Robert had a range of complex needs. Their vulnerabilities and risks were exacerbated by drug misuse which contributed to chaotic daily lives and an inability to sustain contact or engage with helping agencies.

5.31 The drug treatment service informed the panel that neither Gemma nor Robert 'stood out' from others with similar complexities. It was recognised that it is difficult for services to sustain engagement with individuals such as Gemma and Robert as compliance cannot be enforced.

5.32 Gemma was referred to, and offered appointments with, a range of services. However, the review learned that despite some periods of relative stability and attempts to engage with services, Gemma found it difficult to maintain contact with services because of her chaotic lifestyle. This resulted in services being unable to establish a therapeutic relationship with Gemma.

5.33 Neither Gemma nor Robert gained therapeutic benefit from the services they used due to the difficulty in maintaining contact with them.

5.34 When applying a logical analysis to the availability of services for vulnerable people, the review could not find any evidence that either Gemma or Robert was unfairly or unjustly excluded from services.

5.35 The review noted that there are a range of models available to services to encourage engagement by people with complex needs and chaotic lifestyles. Key to the success of these services is the principle of 'no wrong door' where people with drug dependencies and co-occurring mental and physical health issues can access services through a range of entry points. The review commends the work of Public Health England's guide to

local commissioners set out in 'Better Care for People with co-occurring mental health and alcohol/drug use conditions.[10]

5.36 What is apparent from the review is the very real challenge that services face in meeting the needs of service users with chaotic lifestyles who continue to engage in deeply embedded harmful behaviours that prevent them from engaging or benefitting from interventions. This review cannot provide solutions to this problem but feels that it is an important point to note.

5.37 Recommendation 2

5.38 (2.1) The Chorley and South Ribble CSP should receive assurance that the requirements of the Care Act 2014 in relation to the assessment of people with complex care and support needs are understood by agencies and are being implemented.

5.39 (2.2) The Chorley and South Ribble CSP should receive assurance that specialist substance misuse services are able to link into appropriate care and support services across the partnership area.

5.40 (2.3) The Lancashire Care Foundation NHS Trust (LCFT – now known as the Lancashire and South Cumbria NHS Foundation NHS Trust) should provide assurance to the Community Safety Partnership that clinical guidance in relation to the management of self-harm and suicide is followed in primary and secondary care.

5.41 Conclusion 3 - Adverse Childhood Experiences and Childhood Trauma

5.42 Gemma experienced trauma as a child, having been subjected to abuse by an adult. The impact of trauma upon Gemma's adult life was clear to her family and they felt strongly that this abuse led to Gemma's problems in adult life.

5.43 At the time of this review practice in relation to childhood trauma was under-developed. It is not clear to the review to what extent Gemma discussed her childhood experiences with professionals, however the review concludes that greater professional curiosity coupled with a greater understanding of the impact of childhood trauma would have been of benefit to Gemma.

5.44 Robert also experienced trauma as a child and began using drugs at an early age.

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

5.45 Similarly, it is not clear to what extent Robert disclosed the impact of trauma upon his adult life. Again, developing practice in this important area is recommended.

5.46 Recommendation 3

5.47 The Chorley and South Ribble CSP should work with the local safeguarding partnership to ensure that developing awareness of childhood trauma and its impact in adult life is understood and that models of good practice are adopted in local services.

5.48 Conclusion 4 - Impact of the removal of children

5.49 The review recognises the actions to safeguard Gemma's children were appropriate and necessary. However, there is no doubt that the removal of her children contributed to the deterioration in Gemma's mental health and to her difficulty in breaking the cycle of drug addiction which had become a feature in her daily life.

5.50 The review has seen records from the Lancashire Children's Social Care (CSC) Service that indicate a high level of engagement and support being offered to Gemma, and significant efforts to work in a multi-agency way to safeguard Child 2 and offer support to Gemma.

5.51 The review believes that recent developments in practice associated with supporting parents (particularly those with existing and historic vulnerabilities) in coping with the removal of children would have assisted Gemma at the time. However, the review recognises that this is a developing area of practice and that professional practice at the time of the events described in this review was in its infancy, however, the review would commend work in this important area and therefore makes a recommendation in this regard.

5.52 Recommendation 4

5.53 Lancashire Children's Services and the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) should use learning from this review to develop practice in relation to supporting vulnerable parents when children are removed from their care.

5.54 Conclusion 5

The review concludes that, whilst Gemma made only one disclosure regarding domestic abuse by her previous partner, opportunities may have been missed by professionals to make further enquiries regarding domestic abuse. The review believes that the CSP should satisfy itself that all professionals are supported and trained to enable them to understand and respond to the dynamics associated with domestic abuse. All professionals should be able to identify all forms of domestic abuse, to assist victims in

relation to disclosure, and to ensure that support and services are available to victims.

5.55 Recommendation 5

The Community Safety Partnership should be assured that the local response to domestic abuse includes sufficient training and support to professionals across all agencies that enables the application of professional curiosity in relation to all aspects of domestic abuse and the ability to identify, assess and refer to specialist services.

Appendix 1 Single Agency Action Plans (NB All single agency action plans have been completed)

Actions were identified by the following agencies:

Clinical Commissioning Group
Lancashire Care Foundation Trust
Discover Drug Service
Lancashire Teaching Hospitals NHS Trust

1. **CCG**

SINGLE AGENCY RECOMMENDATIONS FOR ACTION

Name of Agency: Primary Care	IMR Report Writer: Dr Linda Whitworth
Dates as given in Terms of Reference: 1/1/11to 21-24/5/17	
Name(s) (or initials) of Victim(s): Gemma	Ethnic Origin: White British

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Raise awareness regarding self-neglect and the identification and coding of adults at risk. Challenge the attitudes that drug users can sometimes be seen as "difficult" rather than vulnerable.	Write and circulate a newsletter plus the document below to clinicians. http://www.lancashiresafeguarding.org.uk/media/31672/-LSAB-Guidance-for-Safeguarding-Concerns-Final-April-2017.pdf	The newsletter	Increased awareness amongst primary care of the issues in this case with better outcomes for adults at risk.	Dr Whitworth	01/01/2018
2.	Raise awareness regarding how dealing with incoming mail, referral processes	Include these topics in safeguarding champion forum meetings.	Agendas for meetings and feedback	Increased awareness amongst primary care of the issues in this case with better	CCG safeguarding team	01/04/18

	and DNAs may need to be different for adults at risk.			outcomes for adults at risk.		
3.	Medication and mail policies to be reviewed and case review completed regarding errors made	Internal review by Eaves Lane Surgery with supervision from CCG safeguarding team.	Notes from meeting with evidence of reflection. (not appropriate to attach here but review has been fully completed)	Increased safety for patients.	Eaves Lane Surgery	01/11/18

2. LCFT
SINGLE AGENCY RECOMMENDATIONS FOR ACTION

Name of Agency: Lancashire Care Foundation Trust	IMR Report Writer: Lorraine Chadwick, Cherry Collison
Dates as given in Terms of Reference: 01.01.2011 - current	
Name(s) (or initials) of Victim(s): Gemma and Robert	Ethnic Origin:

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	1	All staff to implement the SG006A policy	Team manager will provide assurance report at governance meetings	Staff will be offering routine enquiry at every contact where appropriate and recording in ECR	Service managers	End of Q4
2	1	Annual audit of compliance with	Audit report	Assurance that routine enquiry is	Audit team	End of 2018

		recording routine enquiry on to the patient record on eCR		embedded in practice and recorded on eCR		
3	2	The findings of the review will be disseminated to inform continued improvement of practice.	LCFT Safeguarding Domestic Abuse Portfolio Group will take the following actions: - • Training updated as required • Lessons learned are disseminated across the networks • Recommendations and action plans reviewed regularly by the team • Blue Light 54 is reissued to remind staff of their responsibilities in respect of urgent referrals.	An improvement in practice and implementation of routine enquiry	Associate director of nursing (safeguarding)	End of 2018

3 DISCOVER

SINGLE AGENCY RECOMMENDATIONS FOR ACTION

Name of Agency: Discover Drug and Alcohol Recovery Service	IMR Report Writer: Mags O' Neill
Dates as given in Terms of Reference:	
Name(s) (or initials) of Victim(s): GL	Ethnic Origin: English

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Following significant incidents relating to assault for consideration of vulnerable adults' referral to support service users.	To discuss with safeguarding leads within Substance Misuse Services appropriateness of referrals to vulnerable adult teams following service user assault	"No decision about me without me" principles. Multi agency meetings	Agreed pathways of identification of when to refer service users to vulnerable teams for support	Discover Substance Misuse safeguarding lead	December 2017
2.	Requirement for improvement in liaison with mental health services where Service user is engaging with both services.	Progress with current partnership working practices to improve liaison between front line staff working with service users in substance misuse services and mental health.	Recommendations from the dual diagnosis partnership	Robust pathways for communication in the care delivery of clients with a dual diagnosis.	Discover Substance Misuse dual diagnosis lead	March 2018

3.	Consider retention and discharge processes especially where service users are living in unsuitable accommodation.	To review current practices to appraise if current pathways are considering the needs of service users who are living in chaotic environments	Local policies and procedures.	Agreed pathways to maximize engagement with service users often difficult to engage and maintain in services.	Locality managers for Discover Drug and Alcohol Recovery Service.	December 2017.

4. LANCASHIRE TEACHING HOSPITALS
SINGLE AGENCY RECOMMENDATIONS FOR ACTION

Name of Agency: LTHTR	IMR Report Writer: Paul Corry
Dates as given in Terms of Reference:	
Name(s) (or initials) of Victim(s): Robert & Gemma	Ethnic Origin: White British

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.	Accurate recording of Mental Health referrals, assessment, and interventions.	Forward recommendation to Matron and Ward Manager of A&E	Email Matron and Ward Manager	Accurate documentation which shows what safeguarding and support mechanisms have been put in place to mitigate risks for vulnerable patients	Paul Corry, Matron and Ward Manager	19.10.17

2.	LTHTR to provide telephone numbers to the patient such as the Crisis Team and/ or the Samaritans and thus record that this has been completed.	Forward recommendation to Matron and Ward Manager of A&E	Email Matron and Ward Manager	This shows that there is some recognition of external support for patients who experience Mental Health problems when they are discharged into the community.	Paul Corry, Matron and Ward Manager	19.10.17
3.	Consider police referrals and record patient's consent	Forward recommendation to Matron and Ward Manager of A&E	Email Matron and Ward Manager	Appropriate information sharing with relevant agencies	Paul Corry, Matron and Ward Manager	19.10.17

APPENDIX 2 - MULTI AGENCY ACTION PLAN (UPDATED MAY 2021)

Nº:	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target date to complete
1.1	C&SR CSP should be assured that the learning from this review is incorporated into the work currently being undertaken to ensure compliance with regulations to improve the conditions for residents accommodated in homes of multiple occupancy (HMOs).	C&SR CSP to request details of any problematic HMO's or any concerns or complaints of breaches of compliance with regulations from Env Health Teams	Documented review	Assurance that problematic HMO's are being highlighted	Chorley Council EHO	End Sept 21
		Request C&SR CSP are consulted on any future relevant HMO complaints/concerns	Documented review and create action plan	Confirmation that complaints and concerns are being raised and actioned	Chorley Council EHO	End Sept 21
		Review each referral and how the CSP can provide input incorporating the below recommendations	Future complaints referraled to CSP to be documented and included on OWG minutes	C&SR CSP involved in developments and work around problematic HMO's	Chorley Council EHO	End Sept 21

1.2	The C&SR CSP should review the success of providing drug and alcohol support services in HMOs and explore whether this type of provision can be provided in the future.	Review of substance misuse service input to HMOs and action plan	Review documentation available Action plan in place to look at findings and move forward this provision in the future	Recommendations from the review implemented providing assurance	Chorley Council and CGL Drug Services	End Sept 21
2.1	The C&SR CSP should receive assurance that the requirements of the Care Act 2014 in relation to the assessment of people with complex care and support needs are understood by	C&SR CSP to share the findings of this review with all partners and request written assurance that they are Care Act compliant. C&SR CSP to circulate update to all partners regarding Care Act compliance	Evidence of communication/ require. Minutes of CSP meeting. Evidence of communication/CSP minutes.	Statement of Care Act compliance.	Chorley Council, Adult Social Care (Safeguarding) Chorley Council via CSP	End Sept 21

	agencies and are being implemented.	and request specific actions, to be agreed with partnership if any gaps exist				
2.2	The C&SR CSP should receive assurance that specialist substance misuse services are able to link into appropriate care and support services across the partnership area.	CGL (commissioned service) to review links with providers and report to CSP.	Report to C&SR CSP regarding links with support services that identifies gaps/work in place to address gaps.	Statement of links between specialist substance misuse services and other support services. Action plan to address gaps.	CGL Commissioned Service	End Sept 2021
2.3	LCFT should provide assurance to the C&SR CSP that clinical guidance in relation to the management of self-harm and suicide is followed in primary and secondary care.	LCFT to provide policy on self-harm and suicide to C&SR CSP. Tested against learning from this review LCFT to draw up an action plan to address any gaps.	Report to C&SR CSP meeting from CCG including up to date policy. Action plan (if deemed to be necessary)	Updated policy and procedures in relation to managing self-harm and suicide in primary and secondary care.	LCFT	End Sept 2021

3.	The C&SR CSP should work with Lancashire Children's Safeguarding Assurance Partnership and Lancashire Safeguarding Adults Board to ensure that developing awareness of childhood trauma and its impact in adult life is understood and that models of good practice are adopted in local services.	C&SR CSP to circulate the findings of this review in writing to Chair(s) of the local safeguarding children partnership seeking current position in relation to development of trauma informed practice. Safeguarding partnerships to respond with update and any necessary action plan.	Communication from C&SR CSP to partners. Action plan (if deemed to be necessary)	Clarity of current position in relation to development trauma informed practice. Evidence of current policy and practice to be available to all partners.	Chorley Council and LSACP	End Sept 2021
4	Children's Services and the Lancashire Children's Safeguarding Assurance Partnership should use learning from this review to	CSC and LSCP to review current policy and practice in relation to children who are removed	Evidence of discussion with CSC/LSCP leads.	Assurance regarding current policy and practice on supporting vulnerable parents.	CSC and LSCP	End Sept 2021

	develop practice in relation to supporting vulnerable parents when children are removed from their care.	CSC and LSCP to share up to date policy and practice with partners and identify any areas to be strengthened	Minutes of LSCP meeting showing review and any actions required.			
5.	The Community Safety Partnership should be assured that the local response to domestic abuse includes sufficient training and support to professionals across all agencies that enables the application of professional curiosity in relation to all aspects of domestic abuse and the ability to identify, assess and refer to specialist services.	C&SR CSP to check with all agencies involved they have access to and staff attend appropriate domestic abuse training.	Evidence of discussions with agencies	Professionals accessing appropriate training through their agencies and having the professional curiosity	CSP	End Sept 2021

Appendix 3

The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

“Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

“Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

This definition, which is not a legal definition, includes so-called 'honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

a. a person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

b. Where a victim lived in different households at different time, “the same household as the victim” refers to the household in which the victim was living at the time of the act that caused the victim’s death.

Appendix 4

Glossary of Terms

A&E – Accident and Emergency Service
CSC – Children Social Care (Services)
CSP – Community Safety Partnership
DHR – Domestic Homicide Reviews
GP – General Practice
HO – Home Office
IDVA – Independent Domestic Violence Advocate
IMRs – Individual Management Reviews
LCFT – Lancashire Care Foundation NHS Trust
MARAC – Multi Agency Risk Assessment Conference
MASH – Multi-Agency Safeguarding Hub
NWAS – North West Ambulance Service
PPU – Public Protection Unit
PVP – Protecting Vulnerable People
RIC – Risk Identification Checklist (part of the CAADA process)
S47 – Section 47 of the Children Act 1989
SPoA – Single Point of Access