Chorley and South Ribble Community Safety Partnership

Domestic Homicide Review in relation to Gemma (Died May 2017, Aged 30)

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

Period Reviewed
1st January 2011 to Date of Death 2017

Executive Summary
(August 2021)

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Independent Chair: Maureen Noble
Independent Author: John Doyle

CONTENTS PAGE

Section		Title	Page
Section 1	-	Background	1-3
Section 2	-	Conduct of the DHR	3-6
Section 3	-	The Facts – What Agencies Knew	6-11
Section 4	-	Lessons Learnt	11-14
Section 5	-	Conclusions and Recommendations	14-17

NB : The format of this Executive Summary mirrors that of the full overview report for ease of cross referencing.

Executive Summary Confidential

Section 1 – Background

1.1 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.

1.2 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 DHR panel.

1.3 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.

1.4 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.

1.5 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.

1.6 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.

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

1.8 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).

1.9 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 difficult childhood, during which she experienced traumatic abuse. The panel agreed that it is especially 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

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would wish readers to bear this in mind when considering Gemma's actions and choices.

Section 2 - The Review Process

2.1 The review was commissioned by the Chorley and South Ribble Community Safety Partnership and has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004) and with the revised guidance issued by the Home Office to support the implementation of the Act.

2.2 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. 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.

2.3 The review panel considered the involvement of family and friends of the victim and the Chair of the Panel sent notifications describing the purpose of the DHR to the family of Gemma, inviting them to participate. The family were provided with information regarding DHRs and of available support services. Gemma's sister and her partner, agreed to participate in the review and met with the Chair of the panel on the 1st of March 2018. The Chair maintained contact with the family to keep them appraised of progress and seek their views. The family has approved publication of the final overview report.

2.4 The perpetrator in this case was also informed of the DHR process 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. However, it was not possible to interview the perpetrator due the interview being cancelled. A further appointment was made but no response was received. The panel decided that no further attempts at contact be made and therefore the perpetrator has not been involved in this review.

2.5 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. 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.

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2.6 The contributors to the review:

Organisation / Author	Notes and Nature of the submission
Lancashire County Council: Children's Social Care	IMR and notes of child protection proceedings concerning the children of the subjects of this case
Lancashire County Council: Adult Social Care Service	Short Management Report (with supplementary written information) concerning records of the victim and perpetrator
Lancashire Teaching Hospital NHS Foundation Trust	IMR in relation to both the victim and the perpetrator
Chorley Community Housing	Short Management Report concerning the victim and the perpetrator
Cotswold House	Individual Management Review concerning the victim and the perpetrator
Discover Drug and Alcohol Services	Individual Management Review concerning the contact with the victim and with the perpetrator
Greater Manchester Police Service	Short Management Report concerning historical records of their contact with the perpetrator
Clinical Commissioning Group and GP	IMR for both the victim and the perpetrator
Lancashire Care Foundation NHS Trust	IMR for both the victim and the perpetrator
Lancashire Constabulary	IMR for both the victim and the perpetrator
Women's Refuge	Short Management Report concerning the victim
North West Ambulance Service	IMR concerning the victim and the perpetrator
Victim Support	Short submission concerning their attempts to contact the perpetrator

2.7 The Review Panel Members:

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	Women's Refuge
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

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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.

2.8 The Author of the Overview Report

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

2.10 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. The author has completed other DHRs and has participated in online training provided by the Home Office.

2.11 Terms of Reference for the Review

1. To establish what contact agencies had with the victim and perpetrator; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard the victim and risk assess the perpetrator.
3. To establish whether there were other risk factor present in the lives of the victim and perpetrator (for example, mental health issues,

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substance misuse, transience, and vulnerability in relation to housing and accommodation)
4. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways
5. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
6. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
7. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
8. To consider specific issues relating to diversity.

2.12 The following key lines of enquiry were agreed by the panel:

- 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?

2.13 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. The panel's discussions in relation to specific aspects of equality and diversity are available in the full overview report.

2.14 The timescale for the review was impacted by criminal proceedings which resulted in delays to the production of a final report.

2.15 The final report was not submitted to the Home Office until November 2020 due to an administrative error. The Home Office requested amendments

Executive Summary Confidential

to the report. These were undertaken and a revised report was submitted in May 2021.

2.16 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

Section 3 Summary Chronology

3.1 Set out below is an abridged chronology of key agency contacts and events. A more detailed chronology is contained within the full overview report.

2011

3.2 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.

3.3 On 21st of July an anonymous referral was made to Lancashire Children's Social Care (CSC) Service, 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. The CSC informed the father and Gemma that if any further concerns or information was received that raised concerns regarding their ability to meet Child 2's needs and safety, then the Children's Social Care Service would need to consider an initial child protection conference.

3.4 In October, concerns were raised regarding Child 2's poor diet and poor hygiene. An initial Child Protection Conference was convened and in November, a Child Protection Plan was instigated under the category of neglect

2012

3.5 In January, a 6-month child protection review took place with Gemma and the CSC produced an action plan. The Lancashire Constabulary made a submission to the CSC citing concerns regarding Gemma and her partner.

3.6 Robert received an offer of an appointment from the Lancashire Care Foundation NHS Trust (LCFT), but he did not attend. In March, the drug

Executive Summary Confidential

service noted that Robert's mental health was: 'low mood and self-harming' and Robert's GP commenced a prescription of venlafaxine. The drug service noted that Robert's Benzodiazepines use had risen alongside occasional illicit use of methadone.

3.7 In April, Child 2 became a Child Looked After following the granting of an Interim Care Order and 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 extended family members. 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.

3.8 Robert received a letter from LCFT offering an appointment for October. Robert did not attend.

2013

3.9 In February, the case regarding Child 2 was closed by the Lancashire Children's Social Care services, in agreement with the appointed Special Guardians (a close family member).

3.10 Robert attended the A&E service following a fall and a seizure. In May, Robert was preparing for in-patient detoxification.

3.11 In August, Lancashire Constabulary 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.

3.12 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. 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.

3.13 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 however Gemma declined this. 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 Lancashire Care Foundation NHS Trust (LCFT). This resulted in an offer of counselling support. Missed appointments were re-booked and Gemma attended several sessions.

3.14 Robert reported to the drug service that he had increased his use of illicit drugs.

Executive Summary Confidential

2014

3.15 In July the local women's refuge discussed housing options with Gemma. Gemma's General Practitioner (GP) referred her into the Psychological Wellbeing Service in relation to anxiety and depression.

3.16 In August, Gemma reported to her GP that she was having 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. Gemma reported experiencing panic attacks.

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

3.18 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.

2015

3.19 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 use illicit drugs and wanted to re-engage in the support groups provided by the service.

3.20 In February, Robert completed an episode of detoxification treatment as an in-patient. However, Robert was discharged early due to a positive swab result He re-presented to the drug treatment service and was reported as re-engaging well with the group programme.

3.21 In June and July, Gemma attended the mental health service at Lancashire Care Foundation NHS Trust (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. It was recorded by the drug service that Robert had a lapse into heroin and buprenorphine use.

3.22 In September, Gemma had three fits in one day and was admitted to hospital however she self-discharged. Gemma reported threats being made to her by another resident at her current tenancy and the Police were involved in the situation.

3.23 Following three missed GP appointments in three months a letter was sent to Robert and he was removed from the GP list as per practice policy.

3.24 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

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sent to Gemma in relation to Minds Matter). Gemma agreed to undertake this in line with her risk management plan.

2016

3.25 In 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.

3.26 In July, the North West Ambulance Service (NWAS) recorded a 999 call for Robert. 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.

3.27 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, however Gemma said she wanted to stabilise on her own, although advice that specialist support was available from the drug treatment service was provided to her.

3.28 In October, Gemma attended the drug service and reported a low mood and self-harm. 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. Gemma stated that she felt unable to re-engage due to her depression.

3.29 In November, Robert had plans in place for detoxification scheduled for 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.

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

3.31 On the 15th of December, the Lancashire Teaching Hospital NHS Trust (LTHT) 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.

Executive Summary Confidential

2017

3.32 In January, the drug treatment service attempted to contact Gemma via telephone – but they did not receive an answer.

3.33 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.

3.34 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.

3.35 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). Funding for the detoxification was withdrawn to re-establish Robert's position and readiness.

3.36 In 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. He said he had been advised to contact the manager at a local House of Multiple Occupation (HMO) for accommodation.

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

3.38 In 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.

3.39 Some days later Gemma was murdered by Robert.

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Section 4 – Key issues arising from the Review

4.1 A detailed analysis of agency learning and the conclusions and recommendations of the DHR panel can be found in the full overview report. Set out below is a summary of the key learning arising from the DHR

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

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

4.4 Lancashire Children's Social Care (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. The Women's Refuge were aware that Gemma had reported domestic abuse with a previous partner.

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

4.6 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.

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

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

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

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

4.11 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.

4.12 *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?*

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

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

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

4.16 Cotswold Supported Housing (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 the Child Protection meetings and case conferences and provided reports when requested.

4.17 Information concerning the safeguarding of Gemma's children was not shared with the Lancashire Care Foundation NHS Trust (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.

4.18 The North West Ambulance Service (NWAS) raised an adult safeguarding concern with the Lancashire Adult Social Care (ASC) service in relation to Robert following Robert enduring an epileptic fit outside the property where he lived.

4.19 The submission to the panel by the General Practitioner (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

4.20 Lancashire Children's Social Care (CSC) Service 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.

4.21 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)

4.22 Drug Misuse

4.23 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.

4.24 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.

4.25 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).

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4.26 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.

4.27 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.

4.28 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.

4.29 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.

4.30 Gemma attended her General Practitioner (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.

4.31 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.

4.32 The LCFT Single Point of Access (SPoA) 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 the GP to advise them of this.

4.33 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.

4.34 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.

4.35 When the North West Ambulance Service (NWAS) attended to Robert when he had a seizure outside of his property (in April 2017), he disclosed to the paramedic that he had taken heroin and cocaine earlier in the morning. It was at this incident that the first reference was made to Gemma and Robert being known to one another.

Executive Summary Confidential

4.36 As explored in the full overview 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.

4.37 Both Gemma and Robert experienced periods of vulnerable accommodation and spent some time living in a House of Multiple Occupation (HMO).

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Section 5 - Conclusions and Recommendations from the Review

5.1 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.

5.2 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/

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

5.4 Conclusion 1 - Risk Factors Associated with Accommodation

5.5 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.

5.6 Recommendation 1

5.7 (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).

5.8 (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.

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

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5.10 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.

5.11 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.

5.12 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.

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

5.14 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.

5.15 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.[1]

5.16 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.

5.17 Recommendation 2

5.18 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.

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

5.19 (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.

5.20 (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.

5.21 Conclusion 3 - Adverse Childhood Experiences and Childhood Trauma

5.22 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.

5.23 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.

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

5.25 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.

5.26 Recommendation 3

5.27 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.

5.28 Conclusion 4 - Impact of the removal of children

5.29 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.

5.30 The review has seen records from the Lancashire Children's Social Care (CSC) Service that indicate a high level of engagement and support

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being offered to Gemma, and significant efforts to work in a multi-agency way to safeguard Child 2 and offer support to Gemma.

5.31 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.

5.32 Recommendation 4

5.33 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.

5.34 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 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.

5.35 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.

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