Derby & Derbyshire Safer Communities

Op Domino

Overview Report into the death of Harriet in March 2023

Parminder Sahota
Independent Chair and Author
Date Completed: March 2025

Contents

Preface

Harriet's father, Geoff, and brother Jonathan have requested that their real names be used. All other names mentioned will be pseudonyms. The identities of the independent author and the review panel have been disclosed.

The independent author and review panel sincerely offer condolences to all affected by Harriet's death. They also thank Harriet's family for their engagement.

The main objective of a Domestic Abuse Related Review (DARDR) is to facilitate the understanding gained from the death of a person involved in a relationship where domestic abuse was identified. To effectively integrate these lessons, professionals must analyse each case to identify key changes needed to reduce domestic abuse-related deaths.

Harriet was thirty-three when she died. She was described by those close to her as kind, compassionate, and creative, with a lifelong love of music, dance, and time spent with friends. She trained in hairdressing and was known for her warmth and willingness to help others, often offering support to those around her.

Harriet also faced significant challenges. She lived with mental ill-health, experienced repeated bereavement, and was a victim of domestic abuse in several relationships. Despite these difficulties, she expressed hope for stability and was valued by the people in her life.

This review seeks to reflect who Harriet was, recognise the complexity of her experiences, and ensure that learning from her life and death leads to improved protection and responses for others. The author thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

Harriet was a beautiful, amazing, and caring person.
Steven.

1.1 Introduction

1.1.1 The report was written following the tragic death of Harriet, thirty-three, in March 2023. Greater Manchester Police (GMP) referred Harriet to the Tameside (Greater Manchester) Community Safety Partnership (TCSP) in March 2023.

1.1.2 Harriet's death occurred in Tameside, although she was a resident of Derbyshire. Therefore, Derbyshire County Council (DCC) discussed the case at their Domestic Abuse Homicide Review (DHR) meeting in June 2023. Following the consideration of information from Tameside, the DCC review panel agreed that the criteria for a DHR had been met.

1.1.3 In 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004[1] introduced DHRs.

A domestic homicide review involves a thorough examination of the factors and conditions leading to the death of an individual aged 16 or older, particularly when such death is associated with violence, abuse, or neglect.

1.1.4 The Victims and Prisoners Act 2024 highlighted the importance of establishing and conducting reviews related to deaths caused by domestic abuse, renaming DHRs to Domestic Abuse-Related Death Reviews[2] (DARDR).

In this section, "domestic abuse-related death review" means a review of the circumstances of the death of a person which is held—
(a)where the death has or appears to have resulted from domestic abuse towards the person within the meaning of the Domestic Abuse Act 2021, and
(b)with a view to identifying the lessons to be learned from the death.'

1.1.5 The DHR statutory guidance[3] still governs the review, and the panel has agreed to refer to the review as a DARDR.

1.1.6 The review aimed to assess the agency's responses and support provided to Harriet from **September 2021 to March 2023**. Additionally, the review focused on identifying relevant background or history of abuse, the acquisition of community support, and any obstacles Harriet faced in accessing support.

1.1.7 Harriet was in an intimate relationship with Ian from September 2021 to January 2022. Their relationship was marked by domestic abuse and resulted in Ian's arrest, bail, remand, and a custodial sentence for assault.

[1] https://www.legislation.gov.uk/ukpga/2004/28/section/9
[2] https://www.legislation.gov.uk/ukpga/2024/21/section/19/enacted#p02111
[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.1.8 Harriet was referred to Bridges, a domestic abuse service in Tameside, between December 2012 and December 2016, following domestic abuse relationships with "A" (2012 & 2015), "B" (2016), and "C" (2016). GMP attended to domestic abuse incidents concerning "C", " D" (2020), "E" (2021) and "F" (2021).

1.1.9 To facilitate learning and ensure that all facets of agency support were identified, they were asked to provide relevant information within the specified timeframe.

1.1.10 Harriet disclosed to GMP in January 2023 that she was in an exclusively sexual relationship with Ken. GMP and Derbyshire Police received assault allegations from both Harriet and Ken.

1.1.11 GMP discovered Harriet unconscious and not breathing in a private residence in Tameside. Ken was arrested on suspicion of murder, and after a criminal investigation, he was released with no further action (NFA).

1.1.12 The post-mortem outcome was "inconclusive", and a subsequent post-mortem determined the cause of death:

1. Hypoxic-Ischaemic Encephalopathy[4] and Aspiration Pneumonia[5]
2. Cardio-Respiratory Arrest[6]
3. Hanging

1.1.13 The DARDR is not intended to replace the criminal or coroner's courts or to resemble a disciplinary proceeding.

1.1.14 At the time of the review, the coroner's inquest was scheduled for Spring 2025.

1.2 Case Summary

1.2.1 In March 2023, Ken's neighbour contacted GMP to report that Ken had assaulted Harriet and thrown her down the stairs of his flat.

1.2.2 GMP forced entry to the flat and discovered Harriet unconscious and not breathing on the stairs. Cardiopulmonary resuscitation (CPR) was administered until the paramedics arrived.

1.2.3 Ken subsequently contacted GMP to report that his ex-partner, Harriet, had stolen money from him to buy drugs. He stated she had allegedly jumped and fallen down the stairs and had bitten and scratched him as he attempted to leave the flat. He claimed that her injuries were self-inflicted.

[4] A brain injury occurs when the brain does not receive enough oxygen or blood flow
[5] A lung infection resulting from inhaling bacterial-rich fluids
[6] Loss of sufficient respiratory and cardiac function

1.2.4 Ken was arrested on suspicion of attempted murder after returning to the address with his father. He reported that Harriet threw herself down the stairs.

1.2.5 The Criminal Investigation Department[7] (CID) began enquiries with Ken's neighbours.

1.2.6 On the day of Harriet's death, a neighbour reported that they had observed Ken outside his front door and Harriet standing in the doorway of Ken's flat. According to the neighbour, Harriet disclosed that she was suicidal and wanted to end her life. Ken closed the door and locked it with his key. The neighbour reported hearing Harriet pleading with Ken to allow her to leave.

1.2.7 The neighbour spoke with Harriet through the window. Harriet once more disclosed that she was suicidal. The neighbour reported that the situation had stabilised and was quiet.

1.2.8 The neighbour reported that the argument resumed in the afternoon, and they heard Ken and Harriet shouting and Harriet screaming: *"You're killing me"*. The neighbour heard a succession of loud bangs coming from the stairwell. They suspected that someone had been thrown or fallen from the stairs three to four times. Subsequently, the neighbour contacted GMP.

1.2.9 Another neighbour reported hearing a female screaming and shouting at Ken's address. They were aware that Ken was also present at the address. The neighbour suspected that items were being thrown inside the address for approximately five minutes before the activity ceased.

1.2.10 The neighbour stated this behaviour had occurred previously and consistently occurred when Ken had company, although they were uncertain if it was the same female.

1.2.11 Harriet and Ken had had two previous contacts with GMP. The initial contact occurred in October 2022, during which Harriet was identified as the perpetrator and Ken as the victim. A Domestic Violence Protection Order[8] (DVPO) was issued to protect Ken.

1.2.12 The subsequent GMP contact occurred in January 2023. Ken was identified as the perpetrator, and Harriet as the victim.

1.2.13 In February 2023, the Multi-Agency Risk Assessment Conference[9] (MARAC) was informed of Ken's domestic abuse disclosure to his mental health worker; he was identified as the victim, and Harriet as the alleged perpetrator.

[7] CID deals with investigations into serious crimes
[8] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010
[9] https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/

1.3 Background Information about Harriet

1.3.1 Harriet was thirty-three years old at the time of her death; she was single and had no children.

1.3.2 Harriet had four siblings; one died in a motorbike accident, and two died by suicide (September 2021 and January 2023). She is survived by one brother who lives locally and works for the armed forces.

1.3.3 Harriet was passionate about dancing. During her childhood, she developed her piano skills and attended ballet classes. She listened to music of all genres and attended concerts. She would listen to rap music after her brother died in a motorbike accident, as it was his favourite genre and enabled her to maintain a sense of connection with him.

1.3.4 Steven, Harriet's mother, reported that Harriet witnessed the domestic abuse she was subjected to by her husband, Geoff, Harriet's father. Steven asserted that the abuse had strained her relationship with Harriet, reporting that Geoff would talk negatively about her to Harriet.

1.3.5 Both Geoff and Jonathan disputed this assertion, with Geoff stating that he was, in fact, a victim of domestic abuse perpetrated by Steven. (This information was received following Home Office approval, as previous attempts to contact Geoff or Jonathan during the DARDR process were unsuccessful.)

1.3.6 After completing her secondary education, Harriet pursued a career in hairdressing and secured a position at a local salon. Harriet was out of work at the time of her death, and the author was unable to determine when she last held employment.

1.3.7 Harriet was diagnosed with a Personality Disorder[10] and was formally admitted to a mental health unit under the Mental Health Act 1983[11] (MHA) in 2015.

1.3.8 Harriet met Ken while they were inpatients in the mental health unit in 2015. They communicated intermittently and initiated a sexual relationship in the months leading up to her death.

1.3.9 In February 2021, Harriet was admitted to a general hospital for an overdose. She received a mental health assessment and was subsequently discharged to her GP.

[10] https://www.nhs.uk/mental-health/conditions/personality-disorder/#:~:text=Symptoms%20of%20a%20personality%20disorder,disorder%20will%20have%20different%20symptoms.
[11] https://www.legislation.gov.uk/ukpga/1983/20/contents

1.3.10 Harriet was not receiving secondary mental health services[12] at the time of her death.

1.3 Timescales

1.4.1 The Statutory Guidance outlines the requirements for reviewing Chairs and Authors in sections 36 through 39. In this review, the responsibilities of the Chair and Author were merged.

1.4.2 The independent author was commissioned on 27 October 2023.

1.4.3 The commencement of the review was postponed due to the criminal investigation.

1.4.4 The first panel meeting on 2 July 2024 examined agencies' information to establish a review period.

1.4.5 The subsequent meetings discussed the agencies' chronologies and reports, the terms of reference (TOR) and the determination that eight reports would be required.

1.4.6 The overview report was reviewed and finalised in additional meetings.

1.4.7 The Derbyshire Domestic & Sexual Abuse Partnership Board approved the finalised report on 15 April 2025.

1.5 Confidentiality

1.5.1 The review is confidential until the Home Office Quality Assurance Panel approves the release of the overview report.

1.5.2 In November 2023, the coroner requested the initial draft to determine the individuals and agencies necessary to attend the inquest. The panel-approved report was sent to the coroner in January 2025 to prevent any additional delays in the inquest. It was emphasised that the report must not be shared and is intended solely for the coroner's use.

1.5.3 The contributing officers, professionals, and line managers were permitted access to confidential information.

1.5.4 The review has been appropriately anonymised following the Statutory Guidance. Steven chose her pseudonym, and Ken's father chose his. Additionally, the date of death has been removed to protect anonymity.

[12] Specialised care for people with complex or long-term mental health conditions that primary care services (GP) cannot meet.

1.5.6 The following are the selected terms and pseudonyms:

- The victim: Harriet
- Harriet's mother: Steven
- Harriet's father: Geoff
- Harriet's brother: Jonathan
- Recent Ex-Partner: Ken
- Ex-Partner: Ian

1.6 Terms of Reference

1.6.1 The review intends to identify the lessons learned from Harriet's tragic death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.

1.6.2 The DARDR panel agreed to address the following themes as part of the TOR:

1. Trauma
2. Substance/Alcohol Misuse in the Context of Domestic Abuse
3. Mental Health and Self-Harm in the Context of Domestic Abuse
4. Access to Services
5. Poverty and Domestic Abuse
6. Learning

1.6.3 The author shared the TOR with Steven's advocate on August 8, 2024; the revised TOR was sent to the advocate on December 6, 2024. No amendments were requested.

1.7 Methodology

1.7.1 The Statutory Guidance outlines the procedure for conducting the review. The primary objective of the review is to establish a coordinated multi-agency approach that ensures the effective identification and response to domestic abuse as soon as possible.

1.7.2 The DARDR panel comprised agencies from Derbyshire and a representative from GMP. Harriet resided in Derbyshire before her death and had contact with GMP.

1.7.3 At the first review panel meeting, panellists shared their agency engagements for Harriet, Ken and Ian.

1.7.4 Adult Social Care (ASC), Department for Work and Pensions (DWP) and Harriet's GP practice provided additional information to enhance the panel's understanding of Harriet's financial and personal challenges.

1.7.5 Crossroads (domestic abuse service based in Derbyshire) shared the minutes of the high-risk perpetrator panel regarding Ian.

1.7.6 The coroner shared the disclosure bundle with the author, which contained the following:

1.	Statement from Harriet's father, Geoff.	2	Statement from Harriet's mother, Steven. The author met with Steven, as detailed in Section 1.8.
3	Statement from Ken's father. The author spoke with Ken's father, as detailed in Section 1.8.	4	Statement from Ken's mother.
5	Statements from Harriet's friends X6.	6	Statement from Ken's family acquaintance and Harriet's friend.
7	Statements from Ken's Neighbours (X3).	8	Statement from a local shop owner: The above is included in Section 8.
9	Statements from GMP X9: The key events encompass information regarding the contacts before Harriet died.	10	Record of Police Interviews: Ken X2. The key events include the first interview and the second, which concerns Harriet's death.
11	Streamlined Forensic Reports: Ken X3 concerning Harriet's death	12	Photographs of the location and items where Harriet was discovered deceased.
13	GP Practice letter re: Harriet is included in the key events.	14	Statements from Pennine Care NHS Foundation Trust re: Harriet X2 included in the key events.
15	Statement from Tameside General Hospital regarding Harriet's death.	16	Streamlined Forensic Reports: Harriet X2, concerning Harriet's death.
17	Forensic Pathologist		

1.7.9 The review's approach required agencies to submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or submit a summary report.

1.7.10 Upon receiving the chronologies, the author agreed with the DARDR panel to amend the TOR to incorporate Harriet's previous relationship with Ian. Consequently, the advocate was sent the revised TOR.

1.7.11 IMR/summary authors may be the same as panel members and must be independent of victim and perpetrator care. In addition, the authors must discuss

their agency and interactions with the victim or perpetrator, respond to the TOR and summarise relevant contacts before the review period.

1.7.12 The reports were presented to the panel, and all panel members had access to all IMRs/summaries to analyse and comment on the support provided, as well as provide feedback on areas for improvement and good practice.

1.7.13 The IMR/summary authors and panel members identified their agency's learning and provided recommendations as applicable.

1.7.14 The chronologies, reports, and contact with Harriet's family influenced the recommendations in this review.

1.7.15 The panel met a total of five times.

1.8 Involvement of Family and Friends

1.8.1 It is essential to involve families in the review, as they can serve as advocates for the victim and provide information that agencies may lack.[13]

1.8.2 The family and other relevant individuals are crucial in spotlighting the victim and giving them a voice. They can also provide information regarding the victim's identity, aspirations, and dreams, as well as the support they believe the victim should have received or the support they feel would facilitate an improved response to domestic abuse victims.

1.8.3 The author and the DARDR panel recognised the contribution that Harriet's family and friends would make to the review process, ensuring that her perspective was duly considered.

1.8.4 **On 5 July 2024, Jonathan, Harriet's brother**, was notified by email of the review by GMP and invited to participate. No response was received.

1.8.5 **On 5 July 2024, GMP hand-delivered letters to Harriet's parents regarding the review**. The letter included information from the Home Office[14] regarding the purpose of the review and an advocacy service: Advocacy After Fatal Domestic Abuse[15] (AAFDA). No response was received from Harriet's father.

1.8.6 **On 23 July 2024, GMP initiated additional communication with Jonathan via email**; however, no response was received.

---

[13] Rowlands, J. & Cook, E. (2022). Navigating Family Involvement in Domestic Violence Fatality Review: Conceptualising Prospects for Systems and Relational Repair. Journal of Family Violence, 37(4), pp. 559-572. https://doi.org/10.1007/s10896-021-00309-x

[14] https://www.gov.uk/government/publications/domestic-homicide-review-leaflet-for-family#:~:text=Details,relevant%20information%20leaflet%20is%20delivered.

[15] https://aafda.org.uk/resource-categories/leaflets

1.8.7 **On 7 August 2024, an AAFDA Advocate contacted the author to confirm that** they would facilitate communication for Harriet's mother, Steven.

1.8.8 The author and advocate acknowledged various factors that impeded Steven's direct participation in the review. As a result, Steven consented to the advocate receiving the TOR, and they agreed to discuss these with her.

1.8.9 The advocate requested a meeting with Steven after the pre-inquest hearings in November and December 2024.

1.8.10 The panel acknowledged that Steven had reported Harriet to Derbyshire Police for harassment and threatening behaviour. This could limit the review's ability to represent Harriet accurately.

1.8.11 **On 14 January 2025, the author met with Steven, her advocate and Crossroads staff**.

1.8.12 Steven reported that Harriet was a lovable child and would contact her daily. However, Steven believed that Harriet's disengagement with her was precipitated by Steven's abusive and acrimonious relationship with Geoff.

1.8.13 Steven reported the deaths of her children; Harriet's siblings impacted Harriet. She and Steven often visited their graves to comfort each other. Steven was unaware that Harriet had sought professional help following the deaths.

1.8.14 Steven was unaware of Harriet's intimate relationships and became aware of Ken after her death. According to Harriet's friend, they told Steven that Ken wanted Harriet to announce their relationship on social media. Steven did not think they were dating.

1.8.15 Steven discussed Harriet's friends, with whom she maintains regular communication. She mentioned a friend who held Harriet in high regard, and Harriet intended to spend the day with him on the day of her death.

1.8.16 Steven acknowledged that Harriet's interpretation of relationships may have been significantly influenced by her witnessing domestic abuse between her and Geoff. Steven stated she consistently tried to safeguard her children from the violence. Nevertheless, it frequently transpired in their presence.

1.8.17 Steven spoke fondly of Harriet, whom she described as compassionate and passionate about her family. Steven agreed to consult with Harriet's friends and her grandmother, Steven's mother, to determine whether they would be willing to participate in the review. The author gave Steven her contact details to share with Harriet's friends and grandmother.

1.8.18 **On 8 November 2024, the author emailed Jonathan** with information from the Home Office and AAFDA. The review's objectives were emphasised, and it was explained how his contribution could benefit the panel by accurately representing Harriet's perspective and enabling the panel to gain valuable lessons. No response was received.

1.8.19 The following is a summary of the statements received by the coroner. It is crucial to note that consent was not obtained because attempts to contact the individuals were unsuccessful. However, the panel acknowledged that the absence of information regarding Harriet would make her voice inaudible without the following information.

1.8.20 **Harriet's father, Geoff: Dated May 2023**

1.8.21 Geoff acknowledged that Ken was on bail but was uninformed of the conditions.

1.8.22 Ken had sent Geoff four messages via social media following Harriet's death. Ken informed Geoff that he loved Harriet. Geoff did not respond to these messages.

1.8.23 **Ken's mother: Dated March 2023.**

1.8.24 She confirmed that Ken and Harriet met in a mental health ward eight years ago and had a brief relationship.

1.8.25 The chronology includes contact information that is relevant to the review.

1.8.26 **Harriet's Friend 1: dated March 2023.**

1.8.27 Friend 1 had known Harriet since 2015 and had met Harriet while she was an inpatient in a mental health ward.

1.8.28 Friend 1 reported that Harriet would accompany them for tea and spend time with them.

1.8.29 Friend 1 recalled that on Christmas 2022, Harriet was arguing with Ken over the phone. Upon her return from the phone call, she appeared agitated.

1.8.30 **Ken's Family Acquaintance and Harriet's Friend 2: Dated March 2023.**

1.8.31 The acquaintance had known Ken's family when they were ten; they confirmed that they were not Ken's friends.

1.8.32 They had known Harriet since they were fifteen, but did not see her again until March 2023. Friend 2 described Harriet as exceedingly attractive during her youth.

1.8.33 Friend 2 was aware that Harriet had used Class-A drugs and had experienced personal tragedies, such as the suicide of her siblings.

1.8.34 Friend 2 was also aware of Harriet's relationship with Ian, who had assaulted her. They were unaware of Harriet's relationship with Ken.

1.8.35 **Harriet's Friend 3: Dated May 2023.**

1.8.36 Friend 3 met Harriet approximately twelve to thirteen years ago. They characterised Harriet as a reserved individual who suffered from severe anxiety and was averse to involving others in her issues.

1.8.37 Friend 3 knew Harriet had been in a relationship with Ken for twelve months; however, they had not met Ken. They reported that Harriet would characterise Ken as violent towards her, and the relationship was volatile.

1.8.38 According to Friend 3, they were concerned about Harriet and would contact them regularly. Friend 3 reported that Harriet informed them that Ken would evict her from the house in the early hours and would tell others that she was a drug addict and that he was controlling towards her.

1.8.39 **Harriet's Friend 4: Dated March 2023.**

1.8.40 Friend 4 had known Harriet since the early 1990s; they attended the karate club together.

1.8.41 Friend 4 had a conversation with Harriet in early March 2023, asking her if she had a boyfriend:

"Oh, don't get me started on my boyfriend. I have one stalking me now; he keeps popping out of the woodwork everywhere I go. Do you know what he has said to me? He said he would put me in the same grave as my sister. How sad is it for someone to say something like that?"

1.8.42 Harriet was advised by Friend 4 to avoid individuals of that nature and strive for happiness.

1.8.43 **Friend 5: Dated March 2023.**

1.8.44 Friend 5 had known Harriet for approximately two years. Harriet helped and supported Friend 5 with shopping, walking their dog, and tidying their flat.

1.8.45 Friend 5 was aware that Harriet had been in an abusive relationship with Ian, who had been released from prison after a serious assault on Harriet.

1.8.46 According to Friend 5, Harriet had been in an intermittent relationship with Ken for eight years. Harriet disclosed to Friend 5 that she had met Ken while they were inpatients in a mental health ward.

1.8.47 Friend 5 reported that Harriet would contact them when she encountered issues or a disagreement with Ken. Friend 5 reported having overheard Ken shouting and abusing Harriet on the phone.

1.8.48 According to Friend 5, Ken had threatened Harriet and had his hands around her throat. Ken would discuss the prospect of marriage and having children when they parted ways.

1.8.49 Friend 5 stated that Harriet had shown them an article about gaslighting and felt Ken was doing this to her.

1.8.50 **Friend 6: Dated 18 May 2023.**

1.8.51 Friend 6 stated that Harriet was unhappy living with her strict parents and always lived in the shadow of her siblings.

1.8.52 Friend 6 reported that Harriet had informed her that she had been the victim of bullying and assault at school, which had led to the placement of a metal plate in her jaw.

1.8.53 Harriet's GP practice did not have documentation regarding the presence of a plate in her jaw.

1.8.54 Friend 6 stated that Harriet completed a hair and cosmetics course after leaving school, but did not pursue this further.

1.8.55 Friend 6 reported that Harriet had spoken to her about her abusive relationship with Ian, who had pushed her down the stairs and shattered a mirror over her head. Friend 6 reported that Harriet was pregnant at the time and had always aspired to become a mother. Because of the assault, she lost the baby and experienced three miscarriages.

1.8.56 Harriet's GP practice recorded one miscarriage in 2020.

1.8.57 Friend 6 reported that Harriet had informed them that Ian was possessive and controlling and that she had intended to end the relationship. However, Ian continued to stalk her, and Harriet became terrified of him. Ian assaulted Harriet: he dragged her out of a restaurant where she had been with friends, fractured both of

her wrists after damaging her eye socket, and her face was full of cuts and bruises. Ian was on bail at the time.

1.8.58 In January 2022, GMP was informed of the above incident. According to the initial crime details, the offender was Harriet's partner, Ian. The offender had assaulted Harriet by rotating her shoulder and striking her in the head upon their return to the room after a night out. Harriet was suspected of having sustained a fractured wrist, dislocated shoulder, broken finger, and fractured eye socket. Additionally, there was visible swelling and a laceration to her left eye.

1.8.59 Harriet attended a medical examination at Tameside Hospital a few days later. Harriet sustained a broken little finger on her left hand, a fractured bone in her right hand, a broken right wrist, broken ribs, and bruising to her face and body. At the time of this offence, Ian was not on bail.

1.8.60 Friend 6 reported that Harriet suffered from nightmares and flashbacks because of the assault in January 2022.

1.8.61 Friend 6 stated that Harriet had tried to turn her life around; she had stopped substance use and reduced her alcohol intake.

1.8.62 In November 2022, Friend 6 discovered that Harriet had met a new boyfriend, Ken. Harriet informed Friend 6 that she was not in a relationship with him and that they met a few years ago while in a mental health ward. Ken had recently found her on social media and contacted her there.

1.8.63 **The author contacted Ken's father on 10 January 2025.**

1.8.64 Ken's father reported that Harriet had been intermittently present in Ken's life since 2015. He recalled visiting Ken's home numerous times to ask Harriet to leave. Ken's calls to him to ask that Harriet leave were consistent, with Ken contacting him in the event of any difficulties. GMP documented one instance in which Ken's father attended to request that Harriet vacate the residence.

1.8.65 Ken's father stated that he and Ken's mother had contacted GMP numerous times to request support for Ken, but it was not provided.

1.8.66 Ken's father believed Harriet could have benefited from mental health support, and he had contacted the police, hoping she would receive assistance.

1.8.67 Families and others should be provided with consistent updates regarding the review process. The author kept the advocate informed of the review's progress.

1.8.68 Families and other individuals must be permitted time to review the final report and feedback. They must also be allowed to review the report and engage in a face-to-face discussion (if they wish) to discuss their feedback. This discussion should include instances of disagreement and negative feedback, which must be considered and incorporated into the review.

1.8.69 The report was sent to the advocate to discuss with Steven on 28 February 2025. Steven requested amendments to ensure factual accuracy concerning the deaths of her children. No further comments were received.

1.8.70 Following the Home Office's approval, the reviewer was contacted by Geoff and Jonathan, who raised concerns about their lack of involvement in the review process and the way Harriet was portrayed in the report.

1.8.71 They also challenged Steven's assertion that she was a victim of domestic abuse by Geoff. It was agreed that their comments would be formally recorded as an addendum to the report and shared with the Home Office to ensure transparency.

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Summary/Other
Bridges Domestic Abuse Service Tameside. Offers refuge provision and specialist services in Tameside for adults and their children who are at risk of domestic abuse, as well as those who are the perpetrators of such abuse.	Chronology and Summary
Crossroads Crossroads Derbyshire is the Derbyshire County Council-commissioned provider of Domestic Abuse Services throughout Derbyshire, working with Elm and Nottingham Community Housing Association (NCHA) WISH[16].	Chronology, Summary and Minutes of the High-Risk Perpetrator Panel regarding Ian.
Department of Work and Pensions (DWP)	Chronology, Summary and welfare right support/application/appeals
Derbyshire Community Health Services NHS Foundation Trust (DCHS) Specialist community health services in the country	Chronology

[16] https://www.ncha.org.uk/care-and-support/services-and-care-homes/all-care-homes-and-services/ncha-derbyshire-wish/

Derbyshire County Council: High Peak North Adult Social Work Team. Adult Social Care and Health (ASCH)	Chronology and Derbyshire Discretionary Fund (DDF) applications
Derbyshire Fire and Rescue Service (DFRS)	Chronology
Derbyshire Police (Police)	Chronology and IMR
Elm Foundation The Elm Foundation is a charitable organisation that offers services to women, men, and children who have been or are currently experiencing domestic abuse. They operate the Derbyshire Domestic Abuse Helpline.	Chronology and Summary
Glow Deliver independent domestic violence advisor services throughout Derbyshire. A High-Risk Domestic Abuse Service	Chronology and Summary
GP Practice	Chronology, Summary and Three Documents Related to Harriet's Presentation Concerning Bereavement, Depression and Domestic Abuse.
Greater Manchester Police (GMP)	Chronology and IMR
North West Ambulance Service NHS Trust (NWAS)	Chronology
Pennine Care NHS Foundation Trust (FT) Provider of mental health, learning disability, and autism services to people across Greater Manchester and beyond.	Chronology

1.10 The Review Panel Members

1.10.1 Section 9 of the 2004 Act[17] emphasises the same agencies that represent Community Safety Partnerships (CSPs)[18] as the DARDR panel members.

1.10.2 The DARDR panel comprised the following independent members:

Panel Member	Job Title		Organisation
Alison Boyce	Domestic Abuse Manager	DCC Lead on this DARDR	Derbyshire County Council (DCC)
Jonathan Pope	Domestic Abuse Lead, Public Protection	Panel Member	Derbyshire Constabulary

[17] https://www.legislation.gov.uk/ukpga/2004/28/section/9
[18] https://www.gov.uk/government/publications/community-safety-partnerships/community-safety-partnerships#:~:text=Community%20Safety%20Partnerships%20(CSPs)%20were,antisocial%20behaviour%20in%20their%20communities.

DC Debra Makin	Serious Case Review Team	Panel Member	Greater Manchester Police
Julia Ashbrook	Senior Community Safety Officer	DCC Liaison Officer	Derbyshire County Council
Jonathan Lawtonedge	Named Professional for Safeguarding Adults	Panel Member	Pennine Care NHS FT
David Smith	Community Safety Manager	Panel Member	High Peak Borough Council
Jennifer Calverley	Chief Executive	Expert Panel Member	The Elm Foundation
Kerry Glennie	Head of Operations	Expert Panel Member	Crossroads Derbyshire
Liz Smith	Service Manager, High Peak Social Work Team	Panel Member	Derbyshire County Council Adult Social Care
Lisa Wright	Operational Manager	Expert Panel Member	Bridges/Jigsaw Homes
Lucy Willis	Head of Domestic Violence and Abuse Services	Expert Panel Member	Glow
Michelle Grant	Designated Lead Nurse – Safeguarding Adults	Panel Member	NHS Derby and Derbyshire Integrated Care Board (DDICB)
Sharon Ingram	Business Services Officer	Admin	Derbyshire County Council
Victoria Clarke Gillian Quayle	Lead for Substance Misuse Health Improvement Practitioner: Substance Use	Expert Panel Members	Public Health

1.10.2 The Statutory Guidance states:

> "*Consideration should also be given to whether either the victim or the perpetrator was an 'Adult at Risk' – a person who is or may need community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of himself or herself, or is unable to protect himself or herself against significant harm or exploitation.*
>
> *If this is the case, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists, such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005."*

1.10.3 The independent author is a specialist practitioner in community mental health nursing and a best interest assessor[19]. Furthermore, Pennine Care NHS Foundation Trust provided the panel with its local expertise in mental health care.

1.10.4 Public health reviewed the report. They are fundamentally concerned with preserving life, particularly that of the most vulnerable, marginalised, excluded, or susceptible, to preventable mortality and illness. One area in which public health can and should excel is the development of an approach to suicide reduction and prevention.

1.11 Chair and Author of the Overview Report

1.11.1 The Statutory Guidance outlines the necessary skills and expertise required to chair a review effectively. According to the Guidance, the chair must be independent of the family, friends, and agencies involved in the review.

1.11.2 The chair is expected to have a comprehensive understanding of domestic abuse and its associated issues. They must be aware of the research, guidance, and legislation applicable to both adults and children, as well as the various laws in place to safeguard both groups. These are typically illustrated by the chairs' professional experience and/or previous reviews on safeguarding and domestic abuse.

1.11.3 The Home Office anticipates that all chairs will have completed the DHR training provided by AAFDA. The training equips chairs with the necessary skills and knowledge to conduct reviews and emphasises the importance of ensuring ongoing development.

1.11.4 Parminder Sahota is an experienced independent chair and author with over eleven years of expertise in safeguarding and domestic abuse. In 2021 and 2024, she completed the DHR Chair training from AAFDA, solidifying her position as a qualified professional.

1.11.5 Parminder has dedicated over 20 years to the NHS as a mental health nurse, focusing on crisis work and providing care and treatment to adults diagnosed with personality disorders. She was the Director of Safeguarding Children and Adults, the Domestic Abuse Lead, and the Prevent (counterterrorism) Lead for an NHS Trust.

1.11.6 Parminder had no prior contact with Harriet's family or friends and is independent of the agencies and partnerships involved.

1.12 Parallel Reviews

[19] https://www.legislation.gov.uk/ukpga/2005/9/schedule/A1/part/4/crossheading/best-interests-assessment#:~:text=38A%20best%20interests%20assessment,meets%20the%20best%20interests%20requirement.&text=(2)The%20assessor%20must%20consult,relevant%20hospital%20or%20care%20home.

1.12.1 The coroner's inquest is scheduled for Spring 2025.

1.12.2 The Crown Court Unit, Crown Prosecution Service (CPS), North West, reviewed the death. The criminal case was closed due to insufficient evidence to charge Ken with any offences.

1.12.3 Steven requested a formal review of the CPS's decision not to pursue a prosecution for the death of Harriet under the Victims' Right to Review Scheme.[20]

1.12.4 A specialist prosecutor reviewed the police's case documents and deemed the decision not to prosecute appropriate. Steven received a letter that provided a detailed explanation of the reasoning behind it.

1.13 Equality, Diversity and Inclusion

1.13.1 The Statutory Guidance states that equality and diversity issues must be considered and incorporated into the scope and process of the review. The independent author and panel considered all protected characteristics under the Equality Act (2010), which legally safeguards individuals from discrimination.

1.13.2 Harriet was of white British descent and was thirty-three at the time of her death. The characteristics relevant to this review are disability and sex.

Disability

1.13.3 Harriet had a diagnosis of Personality Disorder. Characteristics of this disorder include a disturbed thinking style, impulsive behaviour, and difficulties managing mood. People with borderline personality disorder may also have intense but unstable relationships.[21]

1.13.4 In 2016, Harriet was diagnosed with anxiety and depression and was prescribed medication to treat the symptoms of these conditions. Research has highlighted that domestic abuse significantly affects mental health, potentially resulting in suicidal thoughts, feelings of hopelessness, anxiety, or self-harm.[22]

1.13.5 There is a correlation between domestic abuse and depression, with estimates indicating that three women each week take their own lives due to the impact of domestic abuse.[23] The findings presented by Hestia provide substantial evidence for this assertion. [24]

[20] https://www.cps.gov.uk/legal-guidance/victims-right-review-scheme
[21] https://www.nhs.uk/mental-health/conditions/personality-disorder/
[22] https://www.womensaid.org.uk/information-support/the-survivors-handbook/domestic-abuse-and-your-mental-health/
[23] https://refuge.org.uk/what-is-domestic-abuse/the-facts/
[24] https://www.hestia.org/blog/domestic-abuse-suicide

1.13.6 A study conducted by the University of Warwick and Refuge[25] yielded essential insights into the prevalence of suicidal ideation among victims of domestic abuse. Their analysis identified several risk factors, including depression, psychological distress, feelings of despair and hopelessness, substance abuse issues, childlessness, and a history of cumulative abuse, especially of a sexual nature. Kent and Medway have established a documented relationship between suicide and domestic abuse.[26]

1.13.7 The insights highlight the risk factors for Harriet: She was a repeat victim of domestic abuse, was diagnosed with depression, had endured trauma from past domestic abuse relationships, and faced the deaths of her siblings by suicide. Additionally, she struggled with substance misuse and did not have children.

1.13.8 Women's Aid[27] reported that 35.1% of 31,396 service users expressed feelings of depression or suicidal ideation, highlighting the ongoing necessity for mental health support.

1.13.9 Safe Lives[28] reported the following

- *Disabled women are significantly more likely to experience domestic abuse than disabled men, and experience more frequent and more severe domestic abuse than disabled men.*
- *Disabled people encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers. Abuse can also happen when someone withholds, destroys or manipulates medical equipment, access to communication, medication, personal care, meals and transportation.*
- *Not only do disabled people experience higher rates of domestic abuse, but they also experience more barriers to accessing support, such as health and social care services and domestic abuse services.*

1.13.10 The research demonstrates the necessity for services that provide care and support to individuals with disabilities to be aware of the potential barriers to accessing support and the increased risks of harm they may face. This would enable professionals to make appropriate enquiries and provide safe environments for disclosures of domestic abuse.

Sex

[25] https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf
[26] https://www.local.gov.uk/case-studies/kent-and-medway-highlighting-relationship-between-domestic-abuse-and-suicide
[27] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf
[28] https://safelives.org.uk/news-views/disability-and-domestic-violence/?gad_source=1&gclid=CjwKCAjwpbi4BhByEiwAMC8Jncf4UrXnLPjnmXuAxZr2Mw_7Kcau1bbVnVShWnA86JpELRXuMbcN0xoCURwQAvD_BwE

1.13.11 The Crime Survey for England and Wales estimated that 1.4 million women and 751,000 men aged sixteen and older encountered abuse for the year ending March 2023, as reported by the National Office of Statistics.[29]

1.13.12 Women's aid[30] emphasised that domestic abuse is a crime that is influenced by gender; while men can also be victims, women are more frequently subjected to repeated and severe forms of abuse. Women's Aid[31] emphasised that 94.3% of domestic abuse perpetrators are men.

1.13.13 The National Centre for Domestic Violence[32] observed that women exhibited a higher likelihood of sustaining physical injuries or being murdered, encountering sexual violence, and facing repeated instances of victimisation. Furthermore, it was observed that a significant proportion of the victims, precisely two out of every three, were female.

1.13.14 GMP had responded to domestic abuse incidents perpetrated by Harriet's previous partners before her relationship with Ian. Ian had inflicted Harriet with numerous injuries, including fractures.

1.13.15 Women's Aid further highlighted that male violence against women and children represents a broader societal concern intensified by domestic abuse committed by men towards women. This outcome can be attributed to disparities in women's societal status.

1.13.16 Through a partnership with Women's Aid and the University of Bristol, their research[33] revealed that sexism and misogyny are factors that predispose abusive partners to engage in coercive and controlling behaviours. Misogyny and sexism justify men's abusive behaviour in intimate relationships and create barriers that prevent female survivors from accessing the support they need to leave.

1.13.17 The review has made a recommendation to increase public awareness of healthy relationships and to increase awareness of the gendered nature of domestic abuse to cultivate a culture of respect.

1.13.18 According to an analysis of DHRs[34] many suicide victims resulting from domestic abuse were women. Furthermore, the individuals accused of the offences were predominantly male or former partners. A notable 94% of the reviews indicated the presence of mental health difficulties.

[29] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023#sex
[30] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[31] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf
[32] https://www.ncdv.org.uk/domestic-abuse-statistics-uk/
[33] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[34] http://wrap.warwick.ac.uk/174206/1/WRAP-learning-legacies-analysis-domestic-homicide-reviews-cases-domestic-abuse-suicide-2023.pdf

1.13.19 As evidenced by the data[35] domestic abuse is characterised as a gendered crime; while men can be victims, women are statistically more likely to experience repeated and severe forms of abuse.

1.13.20 The data and research emphasise the need for agencies to recognise domestic abuse as a gendered crime and to implement measures that encourage disclosures of domestic abuse.

Inclusion

1.13.21 Harriet's various challenges can be comprehensively analysed through an intersectional perspective.

1.13.22 Womankind[36] defines intersectionality as:

'Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression, and we must consider everything and anything that can marginalise people – gender, race, class, sexual orientation, physical disability, and so on.'

1.13.23 An intersectional approach emphasises that societal issues cannot be confined to a single aspect, such as race or gender; instead, it is essential to consider the entirety of an individual's identity.

1.13.24 The additional factors unique to Harriet were:

- Family dynamics
- Familial suicide
- Financial concerns
- Repeat victimisation of domestic abuse
- Substance misuse

1.13.25 These will be examined in the TOR.

1.14 Dissemination

1.14.1 The report will be extensively disseminated after the Home Office grants permission to publish, including, but not limited to:

- Members of the Derby & Derbyshire Safer Communities
- Agencies represented
- Derbyshire and Greater Manchester Safeguarding Adult Board

[35] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[36] https://www.womankind.org.uk/intersectionality-101-what-is-it-and-why-is-it-important/

- Domestic Abuse Commissioner
- Local Police and Crime Commissioner for Derbyshire and Greater Manchester
- Tameside Community Safety Partnership
- A copy of the report will also be published on the Safer Derbyshire Website.

2.1 The Facts

2.1.1 Harriet was the victim of domestic abuse in her previous intimate relationships.

2.1.2 GMP recorded Harriet and Ian as being in an intimate relationship in September 2021. Harriet contacted GMP to report that the relationship was abusive in January 2022.

2.1.3 In January 2022, GMP arrested Ian for a Section 18 assault (Offences against the Person Act 1861, Grievous Bodily Harm (GBH) with intent[37] against Harriet. Derbyshire Police referred Harriet to MARAC as a victim of domestic abuse perpetrated by Ian.

2.1.4 In November 2022, Ian entered a guilty plea; he received a restraining order and a custodial sentence.

2.1.5 In February 2023, Glow, a high-risk IDVA service, informed Harriet of Ian's release, which had occurred seventeen days prior.

2.1.6 Steven reported Harriet to Derbyshire Police for harassment and threats in March 2022, July 2022, and January 2023. Derbyshire Police referred Steven to the MARAC in January 2023 as a victim of domestic abuse perpetrated by Harriet.

2.1.7 GMP became aware of Ken in June 2022. Ken's mother was concerned about his well-being. She reported that Harriet had taken control of his property without his consent, and Ken's father attended the property to request her departure. GMP reported no offences and informed Ken's care team of the incident.

2.1.9 In July 2022, Ken reported a physical assault committed by Harriet to Derbyshire Police. The police attempted to obtain further information to no avail, and subsequently, no further action was taken. The call operator and police could not establish the relationship between Ken and Harriet. Therefore, it was not documented as domestic abuse.

2.1.10 In September 2022, Harriet contacted GMP and NWAS and reported that Ken had taken an overdose of medication. She stated she had been at his property to

[37] A serious physical injury caused intentionally or recklessly by one person to another

perform cleaning duties, and he became *"nasty",* prompting her to leave. Domestic abuse was not recorded as the relationship status was unknown.

2.1.11 In October 2022, Ken contacted GMP to report that Harriet had physically assaulted him. Harriet contacted GMP the same day and made counter-allegations. A Domestic Abuse, Stalking and Honour-Based Violence[38] (DASH) was completed for Ken.

2.1.12 Ken submitted another report to GMP in October 2022, stating that Harriet had committed criminal damage.

2.1.13 Harriet contacted GMP in January 2023 to report that Ken had assaulted her. She disclosed that the relationship was exclusively sexual.

2.1.14 Ken was referred to MARAC by Pennine Care NHS FT in February 2023 as a victim of domestic abuse from Harriet. The case was discussed at the Manchester MARAC in March 2023.

2.1.15 In March 2023, Ken's neighbour contacted GMP due to concerns regarding Harriet's safety. The police discovered Harriet at Ken's address, unconscious and not breathing.

2.2 Key Events

2.2.1 The following are the significant events that occurred within the specified timeframe. They illustrate Harriet's history and help the panel gain a comprehensive understanding of her life.

November 2012

2.2.2 Employment Support Allowance[39] (ESA) was granted until Harriet's death.

December 2012

2.2.3 MARAC referral by GMP: Harriet was recorded as a high-risk victim of domestic abuse from "A". A Bridges (refuge & specialist domestic abuse service) Independent Domestic Violence Advisor[40] (IDVA) was assigned to Harriet. Harriet disclosed that she had been in a relationship with A for a few weeks and was anticipating temporary or emergency accommodation information.

January 2013

2.2.4 A joint visit with the IDVA and Derbyshire Police to see Harriet at her parents' home. A referral to a refuge was accepted, and Harriet moved in.

July 2013

[38] https://safelives.org.uk/resources-library/dash-risk-checklist/
[39] https://www.gov.uk/employment-support-allowance/what-youll-get
[40] https://support.jigsawhomes.org.uk/information-article/bridges-partnership-domestic-abuse/

2.2.5 Harriet was admitted to Pennine Care NHS FT, mental health unit, with low mood.

May 2014

2.2.6 Bridges closed Harriet's service as she had not responded to them.

January 2015

2.2.7 Personal Independence Payment[41] (PIP) was awarded until Harriet's death.

2.2.8 The IDVA contacted Harriet to schedule an initial visit after her self-referral, identifying her as a victim of domestic abuse. Harriet received a home visit and reported that she was experiencing ongoing harassment from "A" and was experiencing difficulties with her mental health because of her brother's death.

February 2015

2.2.9 Home visit by the IDVA and the sanctuary scheme (aims to help at-risk households stay safely in their homes by providing extra protection and security)[42] was completed on the property. Harriet was referred for bereavement counselling.

May 2015

2.2.10 Harriet was admitted to the Pennine Care NHS FT mental health unit. She was diagnosed with a Personality Disorder.

2.2.11 The IDVA conducted a home visit. "B" was accused of domestic abuse by Harriet, and she also expressed suicidal thoughts. A refuge was extended to her; however, she declined. Harriet was observed to be intoxicated.

December 2016

2.2.12 GMP responded to domestic abuse incidents. "C" was arrested, and Harriet was relocated to a refuge.

June 2017

2.2.13 ASC received concerns from Harriet's friend through an online submission. They expressed concern regarding their inability to reach Harriet and that Harriet's father had reported her missing after not seeing her for a week. They informed ASC that she had been hospitalised and had been attacked at her home, necessitating her relocation.

2.2.14 The friend was also worried that individuals may have possessed her phone and supplied her with drugs. They believed that accommodation requirements should be prioritised.

[41] https://www.gov.uk/pip
[42] https://www.gov.uk/government/publications/sanctuary-schemes-for-households-at-risk-of-domestic-violence-guide-for-agencies

2.2.15 ASC called the friend, and they advised that Harriet was safe and well at the property. Harriet was reported to have a support worker, and no social care needs were identified.

June 2018

2.2.16 Harriet was listed as the perpetrator in the High Peak (Derbyshire) MARAC case. A domestic incident occurred between her and a male. Harriet was reported to have assaulted the male with scissors and a knife after drinking excessive alcohol. Both were taken to the hospital by police with minor injuries.

July 2020

2.2.17 Harriet reported a verbal argument with GMP with "D".

January 2021

2.2.18 Harriet called 999 and was found intoxicated outside a Manchester hotel by GMP officers. Upset, she declined to talk to officers, mentioning her brother's death and her post-traumatic stress disorder (PTSD). Officers learned she had not seen her brother since November 2020 due to her PTSD and cocaine issues. She refused police or ambulance transport to the hospital.

2.2.19 The officers determined that she did not qualify under Section 136 (MHA). Police can relocate individuals showing symptoms of a mental disorder to secure locations for immediate care[43]), and her brother took her home. Her risk was assessed as medium (a possible but minimal risk of harm to the subject or the public was identified), and a care plan was submitted. Derbyshire Police received information to explore referrals to partner agencies, as Harriet had lived there.

February 2021

2.2.20 Harriet attended the hospital after an overdose. The Mental Health Liaison Team (MHLT) planned to inform her GP about her assessment. She was advised to reduce her alcohol and cannabis use and consider self-referring to Change Grow Live (CGL, drug and alcohol service) for support.

2.2.21 Harriet reported that the mirtazapine (antidepressant) was no longer effective, and she was encouraged to discuss her medications with her GP. The MHLT discussed the effects of substances on her prescribed medications and provided a 24-hour support line number. Harriet requested that X continue weekly support and that X be informed about today's presentation. MHLT advised Harriet to explore the Anthony Seddon Trust[44] for support. Harriet agreed to attend the emergency department (ED) or contact emergency services.

May 2021

[43] https://www.legislation.gov.uk/ukpga/1983/20/section/136
[44] https://tasfund.org.uk/

2.2.22 Intimate relationship with "E" Harriet called GMP. She appeared distressed and told the phone operator that "E" had threatened her and her neighbour. Harriet declined to advance the report and stated that she was away. Since Harriet lived in Derbyshire, the log was sent to Derbyshire Police to resolve the matter. GMP assessed the risk as low. (A possible but minimal risk of injury to the subject or the public is assessed.)

2.2.23 Abandoned 999 call to GMP by Harriet. Harriet was recorded screaming and appeared out of breath. The initial THRIVE[45] risk assessment was high risk. (The likelihood of serious harm to the subject or the public is high.) An officer encountered her on the street and transported her to her home. The officer reported that Harriet did not threaten to harm herself or others.

2.2.24 Harriet made a further call to GMP, talking about "biohazard" and "rise orders" given by a man to his dog, which she believed were orders to hurt her. Due to concerns for Harriet's mental health, the details were passed to the NWAS, who attended the address but could not gain entry. The occupant at the address informed NWAS that no one else lived there. Attempts were then made to locate Harriet's address. GMP did not submit a care plan.

2.2.25 GMP contacted Derbyshire Police to conduct address checks for Harriet. Harriet informed Derbyshire Police officers that she was staying with a friend at an address in Manchester and declined to disclose the address. She was unharmed and did not necessitate an ambulance.

2.2.26 The GMP IMR author stated that a care plan should have been submitted in this case, and the neglect was inconsistent with the policy. A care plan must be submitted every time GMP responds to an individual with mental health-related concerns. Regardless of whether the individual exhibiting mental health issues is transferred by NWAS, conveyed to a health setting (Section 136: MHA Suite/ED), or neither.

2.2.27 The care plan documents the occurrence and activities precisely. The information must be collected at the time of the occurrence to assess the risk to the individual and others and to make informed judgments about additional measures. After reviewing it, the District Safeguarding Team may refer the matter to other relevant agencies.

2.2.28 GMP implemented a mandatory requirement in August 2024 that the Force Contact, Crime and Operations (FCCO) document must include the specific location of a vulnerable individual when necessary, utilising What3Words (The what3words app

[45] THRIVE (Threat, harm, risk, investigation, vulnerability, and engagement) used to assess the right initial police response to a call for service. It allows a judgement to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of the decision.

enables the emergency services to find someone easily[46]). This is designed to assist partner agencies, such as NWAS and mental health teams, in identifying individuals and providing follow-up care. It also ensures that GMP can use this information to locate an individual if any subsequent concerns are raised, thereby preserving life and limb.

July 2021

2.2.29 Derbyshire Police contacted GMP regarding a domestic incident between Harriet and "F" in their jurisdiction. A request was submitted to GMP to conduct a check on "F" at his Manchester address. Derbyshire Police was notified that the request was returned because officers were unavailable.

2.2.30 **The key events below are associated with the approved timeframe.**

September 2021

2.2.31 GMP recorded an intimate relationship with Ian and Harriet.

December 2021

2.2.32 Derbyshire Police responded to an incident of criminal damage; Harriet's partner smashed the television against the wall. An incident, DASH, and a Public Protection Notice[47] (PPN) were completed. Harriet did not wish to provide information for the assessment, and the PPN contained only a few details.

2.2.33 The suspect left before Derbyshire Police arrived, and the duration of the relationship was unclear, with a minimal history. Harriet mentioned in the call that she might end up deceased, likely referencing her sister's suicide. No signs of physical assault or injury were found, so no serious harm/risks were identified.

2.2.34 Derbyshire Police referred Harriet to the Domestic Abuse Helpline (Elm Foundation). Harriet was distressed about her sister's death and expressed concerns about the police's investigation. She believed that her sister had been murdered.

January 2022

2.2.35 GMP recorded a domestic abuse incident involving Harriet and Ian after they returned to a hotel from drinking. A dispute escalated, leading to Ian assaulting Harriet and causing her multiple injuries. Initially classified as grade 2, with a priority response within 1 hour, the incident was later upgraded to grade 1, requiring an emergency response within 15 minutes.

[46] https://www.gmp.police.uk/news/greater-manchester/news/news/2023/february/greater-manchester-police-encourage-members-of-the-public-to-download-what3words-before-embarking-on-motor-vehicle-journeys/

[47] A PPN is an information-sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response.

2.2.36 A domestic abuse event (DAB[48]) was established, and the risk was initially assessed as a medium of further harm. The risk was raised to high due to the severity of the assault and Harriet's previous unreported assaults in Derbyshire and the South of England. After spending time together post-separation, Ian assaulted Harriet out of jealousy over a friend's call.

2.2.37 A high-risk MARAC referral was sent to Derbyshire Police following a DAB submission. (Risk levels: High Risk: 14+ - Identifiable indicators suggest a potential for serious harm, with possible immediate and severe consequences.) Medium Risk: 10-13- Certain indicators can identify the risk of serious harm. While the perpetrator can cause serious harm, this is unlikely unless there is a significant change in circumstances, like relationship breakdowns or substance misuse. Standard Risk: 0-9 - The current evidence does not suggest a likelihood of serious harm.)

2.2.38 GMP arrested Ian. During the interview, Ian responded “no comment” to all questions. GMP granted Ian bail so they could acquire additional evidence, including medical records, CCTV footage, and statements from the hotel staff. His bail conditions included refraining from contacting Harriet or visiting her home.

2.2.39 The GMP IMR author noted that Ian's arrest maximised safeguarding by reducing risk through bail conditions. However, considering Harriet's severe injuries, there was no clarification on whether the case was referred to the CPS for prosecution during Ian's custody.

2.2.40 A DVPO/Domestic Violence Protection Notice[49] (DVPN) maybe implemented with bail conditions when suspects are released from detention on police bail for domestic incidents. This civil order enhances victim protection by enabling police and courts to implement immediate protective measures after a domestic incident, even when there is insufficient evidence to support an arrest. It also allows for bail conditions that further safeguard the victim, enabling the application of both measures together.

2.2.41 The GP received the high-risk domestic abuse notification involving Harriet, who had a suspected dislocated shoulder, a cut above the left eye, a wrist fracture, and a fractured finger. She was reported to be intoxicated at the time.

2.2.42 In April 2022, he was again arrested for assaulting Harriet, breached bail, and was charged with the assault, then remanded in custody for a court appearance.

February 2022

[48] When officers attend an incident deemed to be domestic abuse, a DAB is created, and a full update is added, including risk level and actions taken. If created as a High or Medium risk, these are then forwarded to the District Safeguarding Team, who complete an enhanced risk assessment and any necessary onward referrals.

[49] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

2.2.43 Harriet reported to GMP that Ian had breached his bail by attempting to contact her through a third party. She informed the GMP call taker that she was staying at a friend's house. As a result of the circumstances, the THRIVE assessment was established at a low level. An officer attempted to contact Harriet via her mobile device but received no response. The officer then emailed the Officer in the Case (OIC) about the incident.

2.2.44 Harriet requested to meet with GMP officers from her friend's address. The officer recorded that a message had been sent to task the log from the crime report and requested that the log be closed. However, another officer pointed out that the OIC might not be on duty for some time and asked that the log be sent to the division resource to speak with Harriet.

2.2.45 Harriet contacted GMP and expressed concern that the matter was not being taken seriously and that she felt scared. She disclosed that her sister had died by suicide in September 2021. Harriet provided a statement regarding the breach of bail, which was then sent to the OIC.

2.2.46 Harriet informed Derbyshire Police that Ian had attempted to contact her through her mother, Steven. GMP was provided with a log to communicate with Steven. Ian had contacted a third party, which resulted in a low assessment of THRIVE. The OIC informed the officer, who updated the log, that Ian was scheduled to answer his bail in five days and would be re-bailed due to several outstanding enquiries. Additionally, Harriet was advised that an officer would contact her upon their return from annual leave. The log was closed.

2.2.47 GMP handed Ian bail forms. The officer saw Ian outside his home and presented him with his re-bail forms. His bail conditions were reiterated, and he was provided with a comprehensive explanation of the definition of indirect contact with Harriet, which he confirmed he understood.

2.2.48 The GMP IMR author stated that Ian had violated his bail twice over two weeks by attempting to contact Harriet through third parties. Harriet submitted a statement concerning the breach on the initial occasion, which was sent to the OIC. No statement was obtained on the second occasion. Despite his escalating behaviour, no attempts were made to arrest Ian for the violations.

2.2.49 A robust strategy could have been implemented to promptly locate and arrest Ian for violating his bail. If Ian had been arrested, the threshold test would have allowed the police to charge the suspect and present them in court without the need for the Full Code Test.[50]) could have been considered, as the breaches of bail would have allowed the matter to be taken to the CPS for a charging decision.

[50] https://www.college.police.uk/app/prosecution-and-case-management/charging-and-case-preparation#:~:text=Threshold%20Test,-Where%20a%20suspect&text=This%20allows%20the%20police%20to,at%20court%20by%20a%20prosecutor.

March 2022

2.2.50 The Orthopaedic Clinic at Tameside General Hospital sent a letter to Harriet's GP requesting that they conduct a follow-up review of her right wrist fracture, which she sustained in January 2022.

2.2.51 Harriet called 999 and the GMP, reporting that Ian was outside her home and had threatened to kick the door in. She was contacted and informed the GMP call operator that she had fled from her home address and was at an address in Manchester. However, she disclosed the address only after GMP located Ian. She stated that Ian had previously committed the same offence twice, but GMP took no action. The assessment of THRIVE was medium since Harriet was a repeat victim of domestic abuse and had fled in fear of Ian. Derbyshire Police received the report for their review.

2.2.52 GMP contacted Derbyshire Police for an update and was informed they had spoken to Harriet. However, no offences were disclosed, and she was residing at an address in Manchester but did not wish to disclose the exact location. Derbyshire Police were advised to re-contact GMP once they had obtained the address. The record was subsequently closed pending further communication.

April 2022

2.2.53 Harriet reported to Derbyshire Police that her ex-partner, Ian, had arrived at the pub where she was. Ian was on bail from GMP for the charge of Section 20 (Offences against the Person Act 1861, GBH[51]). She reported that he had squeezed her thigh, resulting in a bruise and fled from him; however, she later encountered him on the street where she lived.

2.2.54 The officer asked whether it would be permissible to photograph the bruise. Harriet explained that she had self-tanned, so nothing was visible when she showed it to the officer.

2.2.55 DFRSA referral from the police for a Safe and Well Check[52] following a domestic incident. Derbyshire Police advised that the suspect should not be present at the address. Harriet was contacted to schedule a visit; however, no response was received.

2.2.56 Derbyshire Police arranged a joint visit with the Housing Officer.

2.2.57 Abandoned 999 call to GMP from Harriet, with a male shouting in the background. Subsequently, the line cleared. Harriet reported receiving several phone calls from a female advising her to drop the case against Ian.

[51] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/20
[52] https://www.derbys-fire.gov.uk/safety/at-home/safe-and-well-visits#:~:text=Safe%20%26%20Well%20visit-,What%20is%20a%20Safe%20and%20Well%20visit%3F,follow%20should%20the%20unthinkable%20happen.

2.2.58 On the same day, Derbyshire Police arrested Ian for breach of bail, stalking and Section 47 (Offences against the Person Act 1861[53]Actual Bodily Harm (ABH). He admitted to pinching Harriet but maintained that the action was out of affection. No additional information was provided. Ian was taken to the Police Station for an interview regarding the assault and breach of bail.

2.2.59 GMP was informed regarding the violation of bail. An IDVA referral was initiated, and a DVPN was issued.

2.2.60 The assault case from January 2022 was referred to the CPS for a prosecution decision based on a threshold test outlined in the Code for Prosecutors due to the additional breach of bail. The CPS authorised a charge for Section 18 assault. Ian was remanded in custody and charged with Section 18. Additionally, he was 'technically' released on bail to attend the police station in May 2022 for the offences of common assault and stalking without fear, alarm, or distress. Derbyshire Police completed their investigation in August 2022, and the case was discontinued due to evidential difficulties.

2.2.61 A joint Safe and Well Check was conducted with High Peak Borough Housing (HPBH) and DFRS. Harriet had been the victim of abuse by Ian. He had since been remanded in custody. Harriet confirmed that there had been no arson threats. Smoke detection was observed in the kitchen and hallway. DFRS and housing advised Harriet on conducting these tests. The primary recommendation was to smoke outdoors, and advice was provided on the use of candles, cooking, and electricity. The main entryway required either a code or a key.

2.2.62 The housing officer was to determine whether this involved modification, as Harriet suggested that it could be opened with a window key. The housing officer attempted to open the main entrance but was unable to. DFRS emailed Derbyshire Police and HPBH to confirm the outcome of the visit and notify them of DFRS's closure.

2.2.63 The Elm Foundation received a referral from Derbyshire Police. However, it only contained the name. Harriet later called the Helpline to request a referral, but was unable to speak because of her busy schedule. They scheduled a contact for support and referral to services. Harriet cut the call after two further attempts to call her. An additional call was attempted but went unanswered.

2.2.64 MARAC: DCHS had no health information to share. The outcomes were recorded in the DCHS patient records to ensure that staff were aware of Harriet's current safety and support needs should she attend DCHS.

[53] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/47

2.2.65 The Elm Foundation emailed Derbyshire Police to notify them of unsuccessful attempts to engage Harriet. The case was heard at MARAC, and Harriet was referred to an IDVA.

May 2022

2.2.66 Harriet attended Derbyshire Police Station to report that Ian violated his bail by contacting her. GMP obtained a statement from Harriet. Derbyshire Police contacted the IDVA, who said they had provided advice, and Harriet had declined support. Ian was arrested for violating the terms of his bail.

2.2.67 Harriet's mother, Steven, made three separate reports to Derbyshire Police. Steven disclosed that she had received three unsolicited telephone calls from Harriet. The messages received from Harriet were not deemed threatening. The police documented Steven's depression because of family bereavements. Alcohol was identified as a contributing factor, necessitating a referral to the GP and Derbyshire Alcohol Advice Service (DAAS). The risk was determined to be standard and NFA-ed.

2.2.68 Harriet reported to GMP that Ian had committed additional breaches of bail. He contacted her to request a meeting to provide her with some of her late sister's possessions. Harriet stated that she would be returning to Derbyshire.

2.2.69 GMP contacted Harriet via telephone, and she stated that she had an appointment with Derbyshire Police. GMP made additional attempts to contact Harriet; however, there was no response. The GMP IMR author noted that the breach of bail should have been promptly addressed.

2.2.70 The officer from Derbyshire was unable to obtain a statement due to Harriet's intoxication. The following day, efforts were made to contact Harriet, but no response was received. Subsequently, there was a two-day period during which the log contained no updates, and it appeared that no action was taken. Additional attempts could have been made to contact Harriet to obtain a statement regarding the breach.

2.2.71 Ian was arrested by GMP for breaching bail and remanded in custody to appear at the Magistrates' Court later that day.

June 2022

2.2.72 Ian was referred to the Drive project, delivered by Glow, which works with high-risk perpetrators to change their behaviour while collaborating with agencies like police and social services to manage risk and disrupt abuse[54]. The IDVA and Drive Case Manager collaborated to provide continuous support to Harriet and Ian.

[54] Drive challenges and support high-harm, high-risk perpetrators to change whilst working closely with partner agencies – like the police and social services – to manage risk and disrupt abuse.

2.2.73 Ken's mother contacted GMP due to concerns about her son's well-being and informed them that Harriet was occupying his property without permission. Ken's father was called to the address, and Harriet was asked to leave the premises. According to Ken's mother, she later returned, causing a disturbance, and posted her belongings in Ken's letterbox. Ken's family suspected she had a key to his flat.

2.2.74 Ken met Harriet in a mental health unit eight years ago and invited her over for coffee after her sister died in September 2022. He had transferred money to her for her electric bill and a taxi. Although Ken welcomed her stay to avoid distressing her, tensions rose when Harriet argued with a neighbour.

2.2.75 Ken's father told him he could not let Harriet stay because of his tenancy agreement. After Harriet left, Ken told GMP officers his mental health had improved. A care plan was submitted, and a referral was made to his care team. No offences were disclosed. However, the independent author suggested that informing his care team would help organise the necessary support.

July 2022

2.2.76 MARAC: Risk profile related to the alleged perpetrator: Ian. Ten police occurrences were documented, which included physical abuse, stalking, breach of court bail, and violent offences. Harriet was allocated an IDVA. However, her engagement was sporadic, as she reported having a busy social life. She was noted to have talked openly and honestly with her IDVA.

2.2.77 Harriet reported feeling much safer since Ian was in custody. GMP handled the breach and trial. Harriet was reluctant to move but realised that staying in the flat posed a risk upon Ian's release, as he had previously visited her home. Harriet was given housing and refuge options and agreed to consider these. Property target hardening (enhancing the security of a house[55]) was completed.

2.2.78 Steven contacted Derbyshire Police, reporting that Harriet had made death threats against her and blamed her for her sister's death. She reported that Harriet aggressively approached her. Both incidents were investigated together, and Harriet participated in a voluntary interview. A social worker who accompanied Steven provided a statement contradicting Steven's account. Steven was assessed as high risk, prompting the implementation of safeguarding measures. No further action was taken against Harriet.

2.2.79 Ken called 999, Derbyshire Police; he reported that Harriet had physically assaulted him. Ken terminated the conversation while the police operator enquired about the facts. Ken did not respond to numerous attempts to contact him. Officers attended the address; however, Ken did not respond.

[55] The process of making a property more difficult to break into by increasing its security.

2.2.80 Additional attempts were made to contact him. When the officers identified themselves as police, he hung up the phone. NFA was taken, as no further information was obtained. The operator and the police were unable to determine the relationship between Ken and Harriet, and as a result, domestic abuse was not documented.

August 2022

2.2.81 Ian was arrested and bailed in April 2022. Ian was released without charge for the offence of common assault and stalking without fear/alarm/distress due to evidential difficulties.

2.2.82 Harriet's father, Geoff, called Derbyshire Police because he was concerned he could not contact Harriet. Officers attended, saw Harriet, and reported no concerns. Harriet reported that she had been busy.

September 2022

2.2.83 Harriet contacted 999 and GMP for Ken. Harriet reported that Ken was acting strange after consuming unprescribed medication and did not want Ken to know about the call. She reported that he had been *"nasty"* during her visit to perform cleaning duties. The call was transferred to NWAS, and it was documented that Ken was not suicidal and was not making any statements regarding self-harm. GMP took no additional action.

2.2.84 NWAS received a 999 call from GMP regarding Harriet's concerns about Ken, who she believed may have consumed both prescribed and illicit substances. Ken stated he was prescribed medication and denied using illegal drugs. He reported being in good health and denied the need for medical assistance. The clinician found no medical concerns and resolved the incident. GMP was notified. The relationship status was unclear, so domestic abuse was not considered.

2.2.85 Harriet called Derbyshire Police to report that she was experiencing feelings of anxiety and was scared. She had heard voices outside and believed they were related to Ian. Officers met with Harriet. There was no indication that Ian was present. NFA and safety advice were provided.

October 2022

2.2.86 Telephone consultation with GP: The call concerned Harriet's mental health; however, the GP was unable to contact Harriet.

2.2.87 The IDVA contacted Derbyshire Police to notify them that Ian was on remand for an assault in the GMP area. However, Harriet was concerned that he might visit her at her home, so she requested that safety measures be implemented there. The Safer Neighbourhood Team was contacted to coordinate and oversee the installation of security locks, alarms, and safeguarding measures at the address and to offer safety advice and reassurance.

2.2.88 The domestic abuse team (IDVA) emailed the HPBH repairs team regarding the fitting of a window lock at the address.

2.2.89 An abandoned 999 call to GMP by Ken reporting a domestic incident with Harriet, who arrived at his home intoxicated and allegedly bit and struck him. She was accused of smashing windows and doors. Harriet later called GMP, reporting that Ken dragged her down the stairs, but declined to provide her location and directed profanities at the operator.

2.2.90 A medium-risk DASH assessment was conducted for Ken; due to the lack of consent, no onward referrals were made. The reported crimes were criminal damage and assault; Harriet was arrested, but Ken later withdrew his complaint, leading to NFA.

2.2.91 The GMP Superintendent ratified a DVPN, and the Magistrates Court issued a DVPO for one month, prohibiting Harriet from contacting Ken or visiting his home. Compliance checks were conducted twice in November 2022 to ensure protective measures were in place, despite no charges being brought against Harriet. The GMP IMR author stated that additional checks should have been performed until the DVPO expiration.

2.2.92 The GMP IMR author believed that an Evidence-led Prosecution (which does not require the victim's support) could have been considered. Ken, who sustained minor injuries, reported the incident to the police. The flat was damaged, which served as evidence to support his account. There was no indication that Harriet was questioned regarding the assault allegation she made against Ken.

2.2.93 Ken reported to GMP that Harriet had damaged a table and chairs that belonged to his friend. Ken apologised to his friend and consented to compensate for the damage. The complainant did not support the prosecution, and a crime was reported with no further action (NFA).

2.2.94 The GP recorded that Harriet was angry and upset. Harriet was scheduled to appear in court in November 2022. The records stated that Harriet's sister ended her life in September 2022 and that her brother was killed in a motorbike accident. Additionally, they discussed the two orthopaedic clinic appointments that she had not attended. Harriet agreed to be referred back to the orthopaedic team and to schedule an appointment with a mental health professional.

2.2.95 Crossroads (domestic abuse services working with the Elm Foundation) received an email from the Greater Manchester Criminal Justice Liaison Service's Health Liaison & Diversion Facilitator requesting support for Harriet. Return email signposting to Derbyshire Domestic Abuse Helpline (Elm Foundation) for triage and assessment.

2.2.96 The Liaison and Diversion Service referral requested Elm Foundation support for Harriet in the areas of mental health, bereavement, and domestic abuse counselling.

November 2022

2.2.97 Ian entered a guilty plea to the charge of assaulting Harriet. He received a five-year restraining order and a sentence of twenty-four months.

2.2.98 Elm Foundation tried to call Harriet, but the number was invalid. They emailed the Liaison and Diversion service to request an alternative method of communication. They were informed that no other numbers were available.

2.2.99 Harriet received a GP telephone consultation and was advised to visit a walk-in centre or ED on account of her mental health. However, she declined, asserting that she would be stable enough to make the appointment with the GP associate.

2.2.100 The associate contacted Harriet concerning her reported depression and anxiety. She disclosed that her anxiety was at an all-time high, making it difficult for her to leave the house. Harriet stated that her ex-boyfriend, Ian, had entered a guilty plea, and a court appearance was scheduled for the upcoming weeks, reporting, *"He had destroyed me".* Additionally, her sister died by suicide in September 2022, and her brother died in a motorbike accident, stating, *"Feel my heart is broken"*.

2.2.101 She stated that she was not suicidal and had no intention to end her life. Harriet requested medication to alleviate her anxiety symptoms. She was prescribed propranolol to be used on an as-needed basis.

2.2.102 The GP practice noted Harriet was to commence Cognitive Behavioural Therapy[56] (CBT). Harriet disclosed to the Mental Health Practitioner (MHP) that her mental health was adversely affected by stress, complex grief, numerous challenging life events, and being a victim of domestic abuse. A follow-up appointment was scheduled. The record did not indicate whether support for domestic abuse or bereavement was discussed.

2.2.103 The MHP made unsuccessful calls to Harriet and rescheduled the appointments.

2.2.104 Harriet called 999 and the GMP to report an issue with her neighbour. She reported that the male neighbour had kicked the door and had subsequently fled. A crime was submitted for harassment. Harriet did not wish to pursue the crime as she had no further issues, and the crime was closed accordingly.

2.2.105 A 999, GMP call from Harriet's neighbour, reporting that she had been at his flat, shouting, calling him a *"paki bastard,"* and accusing him of grooming and being a

[56] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/

paedophile. It appeared to be the male involved in the incident above. Harriet was identified as the perpetrator of a racially aggravated assault. A crime was recorded under Section 5 of the Racially Aggravated Public Order Act 1986, related to harassment, alarm, or distress.[57]

2.2.106 The victim refused to support a prosecution and stated that Harriet was *"usually a nice girl, but she was struggling with drug addiction."* The crime was filed, and the police took no further action.

December 2022

2.2.107 Harriet mentioned a friend named "Ken" to the IDVA, who would give her a lift to Glow. The sole reference Glow had concerning Ken.

2.2.108 Abandoned 999 GMP call from Harriet. The individual's speech was muffled, and they were heard to express, "*I am not feeling well."* An attempt was made to contact Harriet, and a voicemail was left because there was no response. A log was created as a grade 2 response with a medium-risk THRIVE assessment.

2.2.109 Harriet communicated with the GMP call operator via telephone, informing them that she was being threatened by a male who told her, *"No one is going to see you in X again."* Harriet declined to provide the police with her location but stated, "*You need to deal with him,"* and *"I'll be dead before you deal with this."*

2.2.110 Officers attempted to communicate with Harriet at her home; however, she did not respond. The log was closed, indicating that Harriet had been spoken to and cross-referenced with the log from November 2022. However, the log contained no information about the subject matter of the conversation. No crime was documented.

2.2.111 The GMP IMR author stated that Harriet, in her initial contact with the police, reported that the male had threatened her. No conversation was recorded between Harriet and the male regarding the reported threats. The GMP IMR author stated that officers must consult with all relevant parties to make informed decisions when addressing incidents.

2.2.112 Harriet received a telephone consultation with her GP and reported experiencing symptoms of a suspected chest infection. She was documented as speaking in complete sentences and without any perceptible wheezes. She indicated that she was living in Greater Manchester with her family. An appointment was scheduled to prescribe antibiotics.

January 2023

[57] https://www.legislation.gov.uk/ukpga/1986/64/section/5

2.2.113 Glow sent a referral to Crossroads Community Service. Elm Foundation was unable to contact Harriet.

2.2.114 The IDVA pursued a step-down referral for support for Harriet, which was forwarded to the Helpline. Harriet declared that she was no longer involved with Ian, who was in prison. However, she was extremely concerned about Ian's potential risk to her. Previous incidents included Ian being extraordinarily jealous and having made attempts to isolate her from her friends, threatening to hit her in the head with a hammer if she met them, and stalking.

2.2.115 He had forced her into his vehicle and kept her in his home, preventing her from leaving. Harriet had sustained severe facial bruising and oedema, as well as a dislocated shoulder and fractured wrist and received threats to kill her. Crossroads agreed that the Helpline would contact Harriet to provide support.

2.2.116 Glow referred Harriet to Talking Mental Health Derbyshire; however, they did not serve her region. Glow completed a referral to Healthy Minds for talking therapies.

2.2.117 Steven reported to Derbyshire Police that Harriet had verbally abused her in a pub and then contacted her four times over the next three days, accusing Steven of killing her sister (Steven's daughter). The police investigated the allegations, interviewing potential witnesses in the pub and gathering CCTV footage. Additionally, officers made numerous attempts to obtain a witness statement from Steven. Harriet died during the investigation. Consequently, the file was closed with no further action.

2.2.118 MARAC: Steven and Harriet were discussed. The Safer Neighbourhood Team was informed of the situation between the parties and the impending funeral of Harriet's brother. The OIC was directed to contact Crossroads, which was supporting Steven.

2.2.119 Elm Foundation made an unsuccessful telephone contact with Harriet.

2.2.120 The IDVA called Crossroads to inquire about the outcome of their contact. They were advised that contact had not been established. The IDVA agreed they would contact Harriet and inform her that Crossroads was attempting to establish communication.

2.2.121 Crossroads sent a text message to Harriet and received a response: *"Hi, who is that?"* A response was sent to explain the reason for the contact, but no response was received from Harriet.

2.2.122 GMP received a 999 call from Harriet to report a loud bang at her front door. Upon further inquiry, she disclosed that it was Ian. When asked whether he was

present, she responded, *"No".* She was informed that the police would not immediately respond to a bang at the door. Harriet became irritated when asked further questions.

2.2.123 The response was assigned to the non-priority queue because there were no presenting risks. Harriet was contacted the following day and informed that the caller was not in a suitable mental state to provide a statement because of the deaths of her siblings. The log was closed; no offences were recorded. The GMP IMR author stated that a safe and well-check should have been considered due to Harriet's history of domestic abuse.

2.2.124 Harriet contacted 999, GMP, to report that Ken had assaulted her and dragged her up and down the stairs. A male voice was heard in the background of the call, stating, *"I'll drag you back up again."* The THRIVE was assessed as high, and the log was graded 1 for response. Officers attended and separated the two parties to obtain their accounts. Harriet informed the officers that she had known Ken for eight years and that they had first met in a mental health ward.

2.2.125 She declared that they were exclusively in a sexual relationship. Ken was arrested for the offence of Section 47 Assault (ABH) and provided a no-comment interview. He was released under investigation and granted conditional bail, with the condition that he refrain from contacting Harriet. Harriet was uncertain whether she wanted to make a statement at the time of his arrest.

2.2.126 The attending officer noted that it was challenging to obtain information from Harriet because of the influence of drugs and alcohol and that both parties were intoxicated. The initial updates on the crime, however, indicated that the attending officers were shown an injury to Harriet's back, which appeared to be a carpet burn consistent with being dragged down the stairs. Photographs of the injury were obtained. Harriet pointed to her right eye, indicating Ken had hit her there. However, there was no visible injury. Harriet reported that Ken had threatened to throw her down the stairs.

2.2.127 Harriet declined to provide a statement or interact with officers. The Toxic Trio (domestic abuse, mental illness and alcohol use), enhanced risk assessment and RARA[58] were completed, and GMP recorded a medium-risk DASH.

2.2.128 Harriet contacted NWAS to report that Ken was suicidal and had taken medication. Harriet informed the police call handler that Ken had left voicemail messages on her phone, telling her that the police had placed him on bail for three months and that she was not to inform the police that he had contacted her. NWAS

[58] RARA is a risk management tool that helps officers record their decision-making rationale. Within GMP, RARA provides a framework to encourage officers to think creatively about ways to manage risk when attending a domestic abuse incident. Officers must provide a clear rationale for managing risk at the scene and preventing future risk.
RARA: remove the risk, avoid the risk, reduce the risk, accept the risk.

attended the address, and Ken declined to attend ED but consented to a referral to his GP.

2.2.129 The GMP IMR author noted the reported breach of bail was overlooked. Harriet had reported the bail violation by phone, stemming from Ken's assault on her in January 2023. She was entitled to an appointment and follow-up. The potential ongoing harassment by Ken was not addressed. Background checks were initiated to verify his bail conditions. All nominals[59] are expected to undergo checks; however, Harriet was not.

February 2023

2.2.130 Derbyshire Police was notified of a domestic incident in the GMP area in January 2023. It was reported that Ken had dragged Harriet down the stairs and had been arrested for ABH. A PPN was created for safeguarding purposes, and a DASH assessment was completed, with Harriet assessed as medium risk. Additionally, a more detailed referral from GMP was attached to the occurrence.

2.2.131 The GMP OIC requested that the Inspector review the crime for closure (re: 2.2.114). The OIC characterised the injury as a minor carpet burn on Harriet's back, and there was no indication that she was being dragged up and down the stairs. Harriet was unable to provide a coherent account of the incident and did not wish to make a statement. Ken conducted a no-comment interview. Additional attempts were made to contact Harriet at her home and telephone number; however, they were unsuccessful.

2.2.132 The GMP Inspector closed the case by recording the rationale: "This does not meet the threshold for CPS advice; there are no witnesses, CCTV is not applicable as this occurred in a private dwelling, and House-to-House was negative." *I have considered evidence-led prosecution; however, the victim has not stated she is refusing to support out of fear; victim confidence in the police will not diminish as there is no support."*

2.2.133 The initial DASH risk assessment was classified as medium. The attending officer reported that Harriet's drug and alcohol intake and her diverted attention impeded her ability to complete the DASH questions. The Multi-Agency Safeguarding Hub[60] (MASH) triaged the DAB.

2.2.134 The GMP IMR author stated that responding to risks that victims may be unable to identify or act upon themselves is necessary. The GMP Domestic Abuse Policy emphasises the importance of taking positive action in the event of domestic incidents, irrespective of whether a purported victim provides support or if a formal complaint has been filed.

[59] When people are created on the GMP iops system, they are referred to as nominals or subjects.
[60] The service that brings together core public agencies with responsibilities for safeguarding adults.

2.2.135 The GMP Inspector considered an Evidence-Led Prosecution and provided a rationale for its non-implementation. Nevertheless, an Evidence-Led Prosecution could have been pursued. The officer photographed an injury to Harriet's back, and the call handler overheard a male voice saying, *"I'll drag you back up again."* Additionally, checks could have been implemented with Derbyshire Police regarding Harriet's domestic abuse history and a search of the Police National Database[61] (PND).

2.2.136 Harriet spent significant time in the Greater Manchester area despite her residence in Derbyshire. Derbyshire received referrals to ensure Harriet's safety and provide relevant referrals. Nevertheless, GMP was unaware of the course of action that was taken. If victims and suspects are in distinct police jurisdictions, a liaison between the two forces must be maintained to safeguard the victims.

2.2.137 Harriet told her GP during a telephone consultation that she was experiencing anxiety and grief after her siblings died by suicide, and another brother was killed in a motorcycle accident. She was awaiting an appointment with Healthy Minds and had missed calls from the MHP.

2.2.138 Harriet was reported to have been prescribed mirtazapine in May 2018 and used diazepam as needed for anxiety. She was staying with a friend in Greater Manchester and displayed a high-pressure speech. She was scheduled to meet with the MHP and received a one-time prescription for two additional diazepam tablets.

2.2.139 Ken was referred to MARAC by Pennine Care NHS FT as a victim of domestic abuse by Harriet. Ken was allocated to an IDVA. A request for information was sent to the MASH via email. Ken was contacted by telephone, and the service was explained. Support was offered, but he declined to access it. Information was transmitted via postal mail, and a telephone call was made to the referrer. At times, the roles of victim and perpetrator have been reversed.

2.2.140 Harriet contacted Derbyshire Police because she was concerned that Ken violated his bail conditions by contacting her. GMP confirmed that the case had been NFA'd due to evidential challenges, and Harriet had not endorsed the investigation. No bail conditions were in place. Hence, no offences were committed, and no additional action was taken.

2.2.141 Harriet's neighbour reported to GMP that she was damaging his house and threatening to harm him, and suspected she was experiencing mental health issues. Harriet later called GMP, reporting that the neighbour was preventing her from leaving and harming himself, but her call ended when she was asked for her name.

[61] PND is a national information management system that improves the Police Service's ability to manage and share intelligence and other operational information to prevent and detect crime and make communities safer. The PND offers a capability for the Police Service to share, access and search local information electronically.

2.2.142 The situation was assessed as a high priority, prompting an immediate response from NWAS. Officers learned from the neighbour and his friend that Harriet, who had been drinking with them, became distressed and tried to self-harm. The neighbour restrained her and took away a knife. Harriet then left to call the police on a friend's phone, but was gone by the time the officers arrived. Attempts were made to locate Harriet that evening, and the log remained open to facilitate a welfare check.

2.2.143 The following day, an officer contacted Harriet, who stated she had no intention to self-harm and did not want to engage. She mentioned her family's bereavement and her declining mental health, but declined to give her location or allow a welfare check. The log was subsequently closed.

2.2.144 The GMP IMR author believes that the record should have been kept open and that additional efforts should have been made to locate Harriet and conduct a safe and well-check, as she disclosed that her mental health was spiralling.

2.2.145 The GP received a letter from Healthy Minds; they spoke with Harriet and informed her that she had been added to the waiting list for Step 3 CBT (for individuals experiencing moderate to severe anxiety disorders and depression).

2.2.146 Glow received notification of Ian's release from probation. The Glow IDVA contacted Harriet, who was informed that Ian had been released from prison 17 days earlier.

10 days before Harriet died

2.2.147 Telephone consultation with the MHP: They were unable to establish communication with Harriet; a message was left requesting that she contact them to schedule an appointment.

March 2023

2.2.148 MARAC: In February 2023, a high-risk external MARAC referral was initiated concerning Ken, identified as the victim, and Harriet, the perpetrator. Ken disclosed to his support worker that Harriet had thrown a bottle at him during the domestic abuse incident in January 2023 and was sending him abusive messages, leading him to fear for his safety.

2.2.149 The referral assessed Ken as a high-risk domestic abuse victim and Harriet as a high-risk perpetrator. Ken received support from Mental Health Services and was allocated an IDVA. No tasks were assigned to GMP from the MARAC meeting. The GMP IMR author noted that National Crime Recording Standards were not met as crimes were not properly registered.

2.2.150 A 999, GMP call from a neighbour, reported that Ken was assaulting Harriet, allegedly throwing her down the stairs. They heard her scream, *"You're killing me."*

Officers attended the address and found Harriet unconscious and not breathing; CPR was started. Ken reported that Harriet had been jumping on him and throwing herself down the stairs. He was later arrested for attempted murder upon returning to the scene.

Overview

3.1 Analysis Agency Involvement

3.1.1 This section examines the agencies' involvement with Harriet.

Harriet had contact with the following Agencies:

1. Bridges
2. Crossroads
3. Derbyshire Police
4. Elm Foundation
5. Glow
6. GP Practice
7. Greater Manchester Police

Bridges

3.1.2 Harriet was referred to Bridges as a victim of domestic abuse on four separate occasions between December 2012 and December 2016. These referrals identified three distinct perpetrators, none of whom was Ken.

3.1.3 Harriet was accommodated at a Women's Refuge from January 2013 to February 2013.

3.1.4 In February 2023, a MARAC referral identified Ken as the victim and Harriet as the perpetrator, which was Bridges' sole information regarding Harriet within the timeframe.

3.1.5 It was highlighted that Harriet and Ken had interchanged the roles of victim and abuser in previous instances.

Crossroads

3.1.6 Crossroads implemented the county's first Non-Domestic Abuse Stalking provision and has offered a perpetrator behaviour modification program since 2023 (post-timeframe).

3.1.7 The Derbyshire Domestic Abuse Helpline (commissioned by DCC) is the designated destination for all professional (agency) referrals. Self-referrals are welcome through the Helpline or can be made directly to the service.

3.1.8 In October 2022, Crossroads received an email from the Greater Manchester Criminal Justice and Health Diversion Liaison service requesting support for Harriet. Crossroads signposted to the Derbyshire Domestic Abuse Helpline (operated by Elm Foundation) for triage and assessment.

3.1.9 The Helpline received the referral from Glow in December 2022 and confirmed unsuccessful contact with Harriet. The referral indicated that Harriet had declined to communicate with mental health practitioners and was only in receipt of Universal Services (GP) regarding her mental health.

3.1.10 The referral from Glow indicated that *"Harriet would like continued emotional support due to the domestic abuse she has suffered".* As Harriet was being referred to Crossroads, it would have been determined/assessed at the time of referral that she was no longer classified as high-risk.

3.1.11 Glow's referral stated that Harriet *"has previously declined to speak with mental health services but occasionally communicates with a mental health practitioner through her GP".*

3.1.12 Crossroads did not provide the GP with any information. The referral was received in January 2023. However, Crossroads would only contact GPs or health services with consent in place. As a standard-to-medium-risk service, Crossroads is consent-led. Consent is only superseded in the event of substantial safeguarding concerns.

Derbyshire Police

3.1.13 Harriet was a resident of the Derbyshire force area. Most of the involvement with Derbyshire Police was attributed to incidents in which Steven reported that Harriet was verbally abusive towards her and condemned her for the death of her sister.

3.1.14 The significant contacts were related to Ian, who assaulted Harriet at an address in the GMP area in January 2022. The call related to an allegation of stalking and a common assault that he had committed. In November 2022, Ian was found guilty of the January assault and sentenced to two years of imprisonment. However, he was released in February 2023.

3.1.15 According to the Derbyshire Police IMR author, it is usual for an offender to serve half of their sentence in custody and, in certain instances, two-thirds. The remaining portion is served on probation or under a licence.

3.1.16 Harriet's reports to the police were primarily related to incidents that had taken place in the GMP area and were being investigated by that force.

3.1.17 Harriet had been involved in historical domestic abuse relationships. Given her residence in Derbyshire, the force implemented safeguarding procedures, including providing security locks and safety advice and reassurance, to ensure appropriate safety measures were in place.

3.1.18 The calls made to the police during the review period did not relate to Ken, except for a call in July 2022, in which Ken reported that Harriet had assaulted him.

3.1.19 Harriet had made previous contact regarding domestic abusive relationships, although Ken had not previously been featured. Therefore, it would be reasonable to visit Harriet to establish the facts following the July 2022 call.

3.1.20 In October 2022, Derbyshire Police received a call from the Glow IDVA that was supporting Harriet with domestic abuse perpetrated by Ian, who was at the time on remand for assaulting her. Harriet was "petrified" that Ian would attend her address and, as a result, requested specific safeguarding measures to reassure her.

3.1.21 Local officers attended, provided security measures, and offered safety advice and reassurance.

3.1.22 The domestic situation between Harriet and Steven, whom Harriet blamed for her sister's death, resulted in numerous complaints to the police. Around the same time, in January 2023, Harriet's brother passed away.

3.1.23 Although the Niche (Police System) record was finalised concerning the reports by Steven, it did not make clear whether the allocated officer contacted Harriet. If they did, there was no record of any interaction.

3.1.24 Derbyshire and GMP maintained effective communication, notably concerning Harriet's domestic abuse history with Ian. While Ian was on bail for assaulting her, effective safeguarding measures were implemented to reassure her.

Elm Foundation

3.1.25 Between July 2020 and January 2023, Derbyshire Police and Glow referred Harriet to the Domestic Abuse Helpline on multiple occasions. The Helpline's objective was to establish communication with Harriet regarding these referrals and to facilitate support and referrals to other domestic abuse services in Derbyshire. No communication was established with Harriet. However, the referral from Glow was forwarded to Crossroads Derbyshire for community outreach support.

Glow

3.1.26 Glow provides high-risk IDVA service throughout Derbyshire. A referral to medium-risk services (Crossroads, Elm, or WISH) is a step-down referral after the presenting risk has been reduced and the high-risk situation has been managed. Clients are requested to authorise step-down referrals.

3.1.27 Harriet received support from Glow from April 2022 to March 2023 following a referral from Derbyshire Police. Support was provided concerning domestic abuse perpetrated by Ian.

3.1.28 Glow and Victim Care provided victim support to Harriet. Harriet expressed significant anxiety in the lead-up to Ian's sentencing and concern that he would abuse her again upon his release.

3.1.29 The Crossroads referral was pursued in January 2023. They were informed that Harriet was on a waiting list. Harriet was reportedly challenging to contact by Crossroads. It was also difficult for the IDVA to reach Harriet until she returned the call in January 2023 and disclosed that she had experienced personal issues because of her brother's suicide.

3.1.30 In February 2023, the IDVA informed Harriet that Ian had been released. Probation reported that Ian was engaging well and accepting responsibility for his actions.

3.1.31 Harriet was in a state of extreme distress during the IDVA's conversation with her, as her brother had died and she had had a negative experience with the police regarding an unrelated matter (January 2023, related to the investigation by Derbyshire Police concerning allegations made by Steven towards Harriet). The IDVA concluded that Harriet was satisfied with the restraining order and that safety planning had been completed. Harriet reported that she was on the brink of a nervous collapse and abruptly terminated the conversation because of her nausea.

3.1.32 The IDVA responded by texting her to inform her that they understood that she would require time to process the information and would contact her the following day.

3.1.33 The IDVA attempted phone calls to Harriet in February and early March 2023, but she did not respond. Contact was made; however, it was brief as Harriet was en route to her brother's funeral.

3.1.34 The accusations that Harriet believed the police were pushing against her in connection with an incident that transpired at a pub in January 2023 (allegations made by Steven towards Harriet) caused her to experience considerable anxiety.

3.1.35 Glow did not communicate with Harriet further.

3.1.36 Glow informed Derbyshire Police that the case was being closed in March 2023. However, they were unable to notify Harriet or conduct an exit DASH because they could not establish contact. Glow reported that they had no additional professionals to notify.

GP Practice

3.1.37 Harriet saw her GP for the following:

1. Bereavement
2. Depression
3. Domestic Abuse
4. Physical Complaints: chest infection, UTIs, and a wrist fracture

3.1.38 Harriet received treatment and was referred to the MHP, who had limited success in engaging with her.

Greater Manchester Police

3.1.39 The IMR author acknowledged that this was a complex case, and there had been issues with officers failing to identify risk, safeguarding, and taking positive action at incidents.

3.1.40 Ian was arrested in January 2022 for a Section 18 assault against Harriet by GMP. He was bailed (police bail) with conditions not to contact Harriet or visit her home address.

3.1.41 The GMP IMR author reported two instances where Ian was missed for breaching bail.

3.1.42 On two occasions in February 2022, Ian violated his bail conditions by attempting to contact Harriet through third parties. On the initial occasion, officers obtained a statement from Harriet regarding the breach and conveyed it to the OIC. No statement was obtained on the second occasion. Despite Ian's escalating behaviour, the IMR author stated that no attempts were made to arrest him for the breaches.

3.1.43 In the statement that Harriet provided regarding the allegation of Ian breaching his bail conditions on the initial occasion, Harriet reported that Ian had asked a mutual friend to tell her that “he loves her”. Harriet did not want to give the name of this mutual friend but stated that this friend was unaware that Ian had bail conditions not to contact her.

3.1.44 In February 2022, Ian was seen by GMP and re-bailed for the original offence. At this stage of the investigation, the medical evidence and mobile phone downloads were

still outstanding. He was informed of his bail conditions, which stipulated that he could not contact Harriet indirectly.

3.1.45 The IMR author suggested that a more robust approach could have been taken to locate and arrest Ian as soon as possible for breach of bail. If Ian had been arrested, the threshold test could have been considered, as the breaches of bail would have allowed the matter to be taken to the CPS for a charging decision.

3.1.46 In April 2022, Harriet reported an assault and a breach of bail to Derbyshire Police. Following this, Derbyshire Police arrested Ian.

3.1.47 Due to this further offence/breach, CPS advice was obtained regarding the Section 18 assault that GMP investigated from January 2022. Ian was charged with Section 18 assault and remanded in police custody to attend court the next day, where he was granted court bail.

3.1.48 Derbyshire Police bailed Ian for the assault crime reported in April 2022.

3.1.49 In May 2022, Harriet reported that Ian had breached his court bail. She provided a further statement, and Ian was arrested for breaching court bail, where he was remanded.

3.1.50 In June 2022, Ken's mother contacted GMP and reported that Harriet had occupied his property. The independent author considered whether the "occupation" would be classified as "cuckooing."

3.1.51 GMP report cuckooing is directed at individuals who are isolated, lonely or have addiction issues. Organised criminal gangs may utilise individual homes as a base for drug trafficking.[62]

3.1.52 The IMR author confirmed that cuckooing was not considered during this attendance. Ken informed the GMP officers that he had invited Harriet to his flat and had given her money for her electricity bill and a taxi home. She subsequently stayed at his flat, and Ken approved her stay.

3.1.53 In September 2022, Harriet expressed her concern that Ken had allegedly taken her unprescribed diazepam medication.

3.1.54 In October 2022, Ken reported that Harriet had assaulted him, and Harriet reported that Ken had assaulted her.

[62] https://www.gmp.police.uk/advice/advice-and-information/cl/county-lines/

3.1.55 A DASH was completed, a crime was reported, and Harriet was arrested as the suspect. The IMR author stated that the appropriate course of action was implemented regarding Harriet's alleged assault on Ken.

3.1.56 According to the IMR author, the officers spoke with Harriet; however, Harriet's reports to GMP were not addressed. Consequently, an opportunity to resolve the situation was missed. She was not questioned regarding the allegation, and an assault was not confirmed, which prevented the implementation of a DASH for Harriet.

3.1.57 GMP has explicit policies and procedures (Think Victim and Think Victim 2) and has reviewed and updated its Domestic Violence Policy and Procedures to ensure that police officers are more informed about their obligations in all aspects of domestic abuse, from initial contact to investigation. This policy establishes the expectations for how GMP addresses domestic abuse at all levels.

3.1.58 Harriet reported that Ken was suicidal and had taken medication in January 2023. GMP prioritised his welfare, but the Chief Inspector neglected to address the bail violation, and the log was closed.

3.1.59 Organisational learning identified the need for additional inputs to ensure the effective application and comprehension of the process.

3.1.60 The Service Branch Development Unit determined that the log in January 2023 contained deficiencies. These issues were addressed on a branch-wide scale within the past 16 to 18 months, including implementing a multi-agency approach to this type of incident, managing incidents following escalation, and addressing the inadequate quality of THRIVE.

3.1.61 Following the attendance in February 2023, the IMR author stated that a care plan should have been submitted as officers were responding to Harriet, who was presenting with mental health-related concerns. Harriet informed the police over the phone that her mental health was deteriorating and that she had attempted to self-harm. The District Safeguarding Team would evaluate the care plan and determine whether to refer it to other agencies. Harriet lost the opportunity to receive support from specialised partner agencies.

3.1.62 GMP Adult at Risk (Adult Safeguarding) Policy was implemented in May 2020. The policy is intended to safeguard individuals at risk of harm and to employ a proactive, and whenever possible, multi-agency approach to preventing offences against them.

3.1.63 The IMR author summarised the following areas:

3.1.64 Officers neglected to create care plans for incidents involving vulnerable adults with mental health conditions. Care plans are essential for documenting incidents and

actions taken. Collecting information during such incidents is crucial for assessing risk and making informed decisions about additional measures, allowing the District Safeguarding Team to review and refer to appropriate agencies.

3.1.65 Additional input may be necessary to ensure frontline officers understand the care plan development process.

3.1.66 Officers are required to respond to domestic abuse consistently and evaluate all available opportunities when attending to domestic incidents. This encompasses the Domestic Violence Disclosure Scheme[63], Evidence-Led Prosecutions, DVPNs, and DVPOs.

3.1.67 Both Ian and Ken were released on bail after being arrested for assaults on Harriet, with the condition that they refrain from contacting her. Nevertheless, both individuals violated their bail.

3.1.68 The IMR author reported a lack of urgency and accountability in addressing these matters, and there were apparent issues with victims and suspects residing in separate police areas.

3.1.69 A more robust approach was needed to promptly identify and arrest suspects for breaches of bail in domestic incidents.

3.2 Analysis of Terms of Reference

3.2.1 This section discusses the Terms of Reference (TOR) to confirm that they have been addressed and fulfilled.

TOR 1: Trauma

3.2.3 According to Steven, Harriet had observed Geoff's abuse of Steven as a child. Barnado's reports that children who are exposed to domestic abuse are susceptible to both short-term and long-term physical and mental health complications. The trauma of domestic abuse will have a unique impact on each child.[64]

3.2.4 A study investigated the potential of children who witness parental domestic abuse to affect a young person's mental, physical, and social well-being, as well as to increase the likelihood of them experiencing domestic abuse in their adult relationships, either as a victim or perpetrator.[65]

3.2.5 Harriet previously received support from domestic abuse services and was housed in a refuge due to domestic abuse from her previous partners.

[63] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet
[64] https://www.barnardos.org.uk/get-support/support-for-parents-and-carers/child-abuse-and-harm/children-affected-domestic-abuse-violence
[65] https://doi.org/10.1016/j.chiabu.2021.104942

3.2.6 Coping responses of victim-survivors may be affected by domestic abuse, and experiences of coercive control may create barriers to seeking support and engaging with services and affect their relationships with others.[66]

3.2.7 The following risk factors have been identified as being associated with repeat victims of domestic abuse [67]:

- Repeat victimisation is reported to account for between 17 and 59% of all domestic abuse-related crimes and incidents.
- The likelihood of a repeat incident is higher for women and younger individuals.
- Low socioeconomic status is a known risk factor, with victimisation increasing women's risk of unemployment and reduced income.
- Living in an urban area, anti-social behaviour, income, and population density.

3.2.8 The factors indicate Harriet's circumstances and include the additional factor of witnessing parental domestic abuse.

3.2.9 Harriet's two siblings died by suicide (September 2021 and January 2023), and another in a motorbike accident.

3.2.10 The results of a national survey conducted in 2022 confirmed that individuals who have experienced suicide loss are at a heightened risk of experiencing adverse health outcomes and engaging in suicidal behaviour. As a direct consequence of the suicide loss, over one-third of the respondents reported suicidal ideation, and eight per cent had attempted suicide. Most individuals had not utilised support services, and the majority perceived the local suicide bereavement support as inadequate.[68]

3.2.11 The DARDR panel was unable to establish whether Harriet had accessed bereavement counselling.

3.2.12 The GP recorded that Harriet was awaiting CBT in November 2022. Following the referral from Glow in January 2023, she was added to the Step 3 CBT waiting list with Healthy Minds in February 2023.

3.2.13 Thematic reviews[69] identified the need to incorporate trauma-informed practices. The Office for Health Improvement & Disparities provides the working definition as:

"Realise that trauma can affect individuals, groups and communities."

[66] https://education.gov.scot/media/kwilejb4/da-trauma-companion-pack.pdf
[67] https://doi.org/10.1093/police/paae024
[68] https://doi.org/10.1111/sltb.12874
[69] https://warwick.ac.uk/fac/soc/law/research/projects/domestic-abuse-suicide-domestic-homicide/v2_999369_law_domestic_violence_executive_summary_research_report_final_final_pre-print.pdf

3.2.14 The following are the specific areas within the TOR that agencies are required to respond to:

a) How is trauma-informed practice embedded in your organisation?
b) Does your organisation have a trauma-informed policy and training programme for staff?
c) What measures were in place to facilitate and support a trauma-informed approach with Harriet?

Crossroads

3.2.15 This is a standard and mandatory practice supported by the policies and procedures; all Crossroads Domestic Adult Outreach staff have completed trauma-informed practice training.

Bridges

3.2.16 Jigsaw support[70] Staff are trained in trauma-informed practice.

GP Practice

3.2.17 The practice received trauma-informed training in March 2024, September 2024 and November 2024.

Greater Manchester Police

3.2.18 GMP acknowledges the importance of a trauma-informed approach in addressing incidents within the context of vulnerability. It recognises that the long-term effects on individuals and their capacity to establish trusting relationships with professional agencies, such as the police, can be detrimental when responding to emotive incidents involving harm or life-threatening circumstances.

3.2.19 GMP Domestic Abuse Policy was substantially revised in August 2022 and has been updated numerous times. The policy emphasises the importance of intervention opportunities and the need to act in the best interests of domestic abuse victims. This is implemented in practice by providing bespoke training to practitioners, complementing the policy revisions.

[70] Jigsaw Support and partners TLC: Talk, Listen, Change and Diversity Matters North West offers a specialist domestic abuse service, which provides an outreach for all and refuge provision for women and their children at risk. In addition, we offer dispersed properties on occasions when the refuge is not appropriate. https://support.jigsawhomes.org.uk/information-article/bridges-partnership-domestic-abuse/#:~:text=MARAC%20Referral%20Form&text=If%20you%20are%20a%20victim,or%20self%2Dreferral%20accepted).

3.2.20 The Think Victim and Think Victim 2 courses provide all front-line police officers with a clear understanding of their responsibilities regarding all aspects of domestic abuse, from initial contact to investigation.

3.2.21 GMP initiated the 'Domestic Abuse Matters'[71] training in November 2022, which was completed in March 2023. The objective was to establish a consistent and sustainable response to domestic abuse through sustainable enhancements. This program addressed all subjects related to domestic abuse, as well as coercive control, victim-blaming, and the identification of manipulation employed by perpetrators.

3.2.22 The training is mandatory for all public-facing roles within GMP. It encompasses considerations of the safety of the victim and any other parties, trustworthiness, and the development of confidence in policing by adhering to the Victim's Code of Practice. It also supports the victim's choice by reviewing alternative safeguarding methods, such as evidence-led prosecutions, DVDS, DVPN, and DVPO.

3.2.23 Additionally, bespoke Safeguarding Triage officer training has been provided to all staff in the district safeguarding team to facilitate appropriate collaboration with other agencies in supporting victims and engaging partners.

3.2.24 The GMP IMR author stated there was evidence of a trauma-informed approach to GMP's response to incidents. Most incidents were appropriately risk-assessed and triaged by relevant District Safeguarding Teams, notably using a DVPN/O.

TOR 2: **Substance Misuse and Domestic Abuse**:

3.2.25 In February 2021, Pennine Care NHS FT advised Harriet to reduce her consumption of alcohol and cannabis and consider self-referring to a drug and alcohol service.

3.2.26 In February 2023, GMP observed that Harriet's drug and alcohol consumption had impeded her ability to complete a domestic abuse risk assessment.

3.2.27 The following demonstrates the risks and potential obstacles that Harriet may have encountered:

3.2.28 A case analysis of domestic homicides found substance misuse common in intimate partner and adult family murders[72]. It is important to note that Harriet's case is not subject to homicide. Nevertheless, the findings reveal the prevalence of substance misuse in domestic abuse-related deaths.

[71] https://safelives.org.uk/training-courses/domestic-abuse-matters/?gad_source=1&gclid=Cj0KCQiAire5BhCNARIsAM53K1gigZPPbvvvEp1wy7OOpVWMBN5rGOl2eRSYInLz38emuzKMm4TE6QIaAqtkEALw_wcB
[72] http://repository.londonmet.ac.uk/1477/1/STADV_DHR_Report_Final.pdf

3.2.29 Studies have found that health professionals have stigmatised individuals with a history of substance misuse, resulting in negative attitudes and a lack of time and support for these individuals.[73] [74]

3.2.30 Drug users are stigmatised and often blamed for their continued use; they are excluded and discriminated against. The stigma of being a drug user may prevent people from accessing help.[75] Therefore, victims and survivors may be hesitant to request support.

3.2.31 Some of the consequences of domestic abuse may also result in the use of maladaptive coping strategies, such as alcohol misuse, prescription drug misuse, or substance misuse, as well as mental health issues, such as depression, anxiety, and a worsening of physical health conditions.

3.2.32 The following are the specific areas within the TOR that agencies are required to respond to:

a) Does your organisation acknowledge the connection between substance misuse/alcohol and domestic abuse, and if so, what was the approach to Harriet?
b) Does your organisation collaborate with specialised agencies to facilitate the response to all victims/survivors who are present with substance misuse and alcohol dependency, and was this actioned for Harriet?
c) How are staff provided with support to enhance their response to victims/survivors who present with substance misuse and alcohol dependency? This should encompass implementing domestic abuse policies and procedures, as well as providing training and supervision.
d) What should your organisation do to enhance its approach to victims/survivors who present with substance misuse and alcohol dependency?

Crossroads

3.2.33 The service was not formally aware of Harriet's substance misuse at the time of referral. However, communicating with other agencies is standard practice. All domestic abuse workers are aware of the substance and alcohol support services available in Derbyshire and the referral pathways.

Greater Manchester Police

[73] https://doi.org/10.1016/j.dadr.2023.100196
[74] https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf
[75] https://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf

3.2.34 GMP acknowledges that numerous domestic abuse incidents occur when one or both parties have consumed alcohol or drugs.

3.2.35 An analysis of DHRs in England and Wales revealed that more than two-thirds of the perpetrators had previously engaged with mental healthcare before the homicide. Furthermore, in contrast to those who did not use mental health services, perpetrators demonstrated a greater likelihood of having a history of substance misuse, interactions with the criminal justice system, and a background of self-harm or suicide attempts.[76]

3.2.36 When addressing domestic abuse, GMP implements a multi-agency strategy.

3.2.37 The current GMP force policy states that the attending officer can close off standard-risk incidents after each domestic incident. Any incidents assessed as medium or high risk are forwarded to the MASH team for an enhanced risk assessment to be completed, and consideration is given to any onward referrals to partner agencies.

3.2.38 Police respond to incidents at crisis points during or shortly after they have occurred. GMP has established explicit policies and procedures that dictate the actions that officers should take when interacting with victim-survivors who exhibit substance misuse and alcohol dependency.

TOR 3: Mental Health and Domestic Abuse

3.2.39 In 2015, Harriet was admitted to a mental health unit and diagnosed with Personality Disorder and was re-admitted following an overdose in 2021.

3.2.40 The following are the specific areas within the TOR that agencies are required to respond to:

a) Did your organisation know Harriet's mental health history?
b) How did your organisation address Harriet's mental health, and did you provide her with support through collaboration with specialised partners?
c) Are staff in your organisation encouraged to enquire about domestic abuse for individuals who present with poor mental health, and how is this implemented in practice?
d) How are staff provided with support to enhance their response to victims/survivors who present with poor mental health and exhibit suicidal ideation or self-harm?

Crossroads

[76] MacInnes P, Calcia MA, Martinuzzi M, Griffin C, Oram S, Howard LM. Patterns of mental health service use among perpetrators of domestic homicide: descriptive study of Domestic Homicide Reviews in England and Wales. BJPsych Bulletin. Published online 2023:1-9. doi:10.1192/bjb.2023.91

3.2.41 Crossroads was not formally informed of Harriet's mental health history other than what was recorded on the referral. The domestic abuse workers have expertise in supporting clients who are experiencing both domestic abuse and mental health issues. If Harriet had been active in the service. She would have had access to in-house counselling services.

Greater Manchester Police

3.2.42 The GMP IT system contained information indicating that Harriet had been previously diagnosed with a variety of mental health disorders.

3.2.43 GMP attended to an instance of concern regarding Harriet's mental health in February 2023. The police did not see Harriet in person, rendering it impossible for them to evaluate her mental health vulnerabilities or ensure that she was directed to the appropriate partner agencies.

3.2.44 The GMP IMR author stated that every effort should have been made to meet with her in person.

3.2.45 Additionally, a care plan should have been submitted in this case, as officers were responding to Harriet, who was presenting with mental health-related concerns. She informed officers over the phone that her mental health was deteriorating and that she had attempted to self-harm. This would have allowed the District Safeguarding Team to evaluate the care plan and determine whether to refer Harriet to other agencies.

3.2.46 Harriet potentially lost the opportunity to receive support from specialised partner agencies.

3.2.47 It is crucial that officers attending incidents involving vulnerable adults with mental health issues proactively attempt to understand the circumstances surrounding the individual, rather than relying on a single source of information and embracing it.

3.2.48 GMP has collaborated closely with health and social care partners in the past eighteen months to enhance and develop pathways to mental health services. This collaboration exemplifies the Mental Health Urgent Triage (M-HUT) model.

3.2.49 The M-HUT model will ensure that appropriate care is delivered at the appropriate time and location by integrating the work of all organisations in a coordinated manner. This will improve communities' support for individuals experiencing a mental health crisis.

3.2.50 GMP has policies and procedures that dictate how officers interact with vulnerable adults. The Adult at Risk Policy aims to safeguard adults at risk of harm and

implement a proactive, multi-agency approach to preventing offences against them whenever feasible.

3.2.51 The adult at-risk A-G model documents any relevant information regarding the individual and the incident. Officers are required to record any advice from the Mental Health Tactical Advice Service[77] (MHTAS), which is located within the Operation Communication Branch (OCB), or information from partner agencies that have influenced the decision-making process.

3.2.52 The MHTAS offer real-time clinical guidance to police officers and analyses call records to determine the severity of their needs. They collaborate closely with local triage services and urgent care teams, ensuring care is transferred to them as soon as possible.

3.2.53 The Vulnerability Support Unit (VSU) was established in 2018 to facilitate the identification and management of vulnerability, threat, harm, and risk within open incidents. Staff collaborate with districts and partners, including the NHS, mental health services, and NWAS, to address issues, mitigate vulnerability incidents, and reduce the frequency of repeat requests.

3.2.54 GMP initiated the Right Care Right Person initiative (seeks to ensure that the appropriate professional is consulted when individuals are experiencing a mental health crisis[78]) on 30 September 2024.

TOR 4: Access to Services

3.2.55 Harriet was referred to a mental health practitioner at her GP practice and referred to domestic abuse services. She was inconsistent in her engagement.

3.2.56 Harriet was a repeat victim of domestic abuse and had previously engaged with domestic abuse services.

3.2.57 Nevertheless, it is widely recognised that not all victims/survivors will either identify themselves as victims or disclose domestic abuse to agencies. Harriet had informed the GMP that she was not in a relationship with Ken and that they were exclusively sexual partners. Consequently, she may not have perceived that any abuse she experienced would be considered domestic abuse.

3.2.58 According to the Refuge[79], the police receive a call regarding domestic abuse every 30 seconds, yet just a quarter of domestic abuse incidents are reported to the police.

[77] MHTAS operates 24/7 from GMP Headquarters' Control Room. Pennine NHS FT, Greater Manchester Mental Health NHS FT, and GMP work together to help police officers and call handlers manage mental health difficulties.
[78] https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person
[79] https://refuge.org.uk/what-is-domestic-abuse/the-facts/

Women's Aid[80] also, reports that domestic abuse is frequently not reported or disclosed to the police by women.

3.2.59 Women's Aid[81] explored a potential reason for non-disclosure. Many emotions, such as sadness, abandonment, confusion, or grief, can be evoked by terminating a relationship without the presence of domestic abuse. The abuser may exploit these emotions to exert control over the relationship, including finances or to isolate the victim/survivor, rendering them unable to access financial resources or seek support and feel dependent on the abuser.

3.2.60 Harriet revealed to her friends that Ian had threatened her if she met with friends and had isolated her from them.

3.2.61 A further consideration is that the victim-survivor may be fearful about the repercussions of leaving; a study of domestic homicides revealed that in 9% of these cases, separation had occurred or was in progress.[82] These factors will support services in recognising victim-blaming as a further means of abuse.

3.2.62 Harriet was afraid of Ian and sought assistance from the police. She also reported her concern that he would attempt to harm her upon his release.

3.2.63 Coercive and controlling behaviour is a form of domestic abuse that the abuser may employ. This includes intimidating and frightening the victim and may consist of violence and threats or belittling the victim/survivor. The abuser uses these tactics to exert control over the victim/survivor. This behaviour frequently occurs in conjunction with other forms of abuse, such as financial, sexual, and physical abuse.[83]

3.2.64 Two individuals contacted Harriet: one asked her to drop the charges, and the other informed her that Ian loved her.

3.2.65 The following are the specific areas within the TOR that agencies are required to respond to:

a) Which domestic abuse services are accessible to your organisation? What methods do you use to help individuals access this information?
b) Did your organisation support Harriet in accessing domestic abuse services?
c) Did Harriet encounter any difficulties in accessing your organisation's services?
d) What is your organisation's approach to individuals who do not engage in your services?

[80] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/how-common-is-domestic-abuse/
[81] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/myths/
[82] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews
[83] https://assets.publishing.service.gov.uk/media/6267c429e90e0716982a3250/ContCoerBehavStatGuid_V3-_10-04-22_.pdf

e) How does your organisation support engagement? Consider what may have facilitated or impeded access to support. This should consider any effects of the COVID-19 pandemic.
f) Were there issues with your agency's capacity or resources that hindered your ability to provide services to Harriet or other relevant parties? If so, did these issues affect the agency's ability to collaborate effectively with other agencies?
g) What methods are employed to support staff when interacting with individuals who do not engage with them?

Crossroads

3.2.66 The Crossroads' policy is to make three attempts to contact new referrals using various methods on different days and multiple times whenever feasible and safe. It is unethical to continue with Crossroads if a client is not engaging in reciprocal contact, as it is a voluntary provision based on choice and consent.

3.2.67 Certain potential clients prefer to avoid acknowledging contact rather than engaging in verbal or written communication, indicating they no longer require assistance. The potential for barriers to engagement, or the inability to establish contact, should be carefully evaluated in light of the assumption of informed choice and the client's knowledge at the time of referral.

3.2.68 Telephone and text communication were employed over thirteen working days (approximately three weeks), as documented in the case records, which included two texts, three voicemails, and four calls. This is in addition to the Helpline's efforts.

Bridges

3.2.69 A robust disengagement policy is in place, unlike when Bridges supported Harriet.

Greater Manchester Police

3.2.70 Harriet spent significant time in Greater Manchester despite her residence in Derbyshire. If victims and suspects are in distinct police jurisdictions, liaison between the two forces must be maintained to safeguard victims and facilitate engagement.

3.2.71 When incidents were reported, officers tried to engage with Harriet; however, she declined to accept support. She declined to provide a statement or interact with officers following the assault in January 2023. Derbyshire Police received a referral following a risk assessment conducted by GMP at the location. Consequently, GMP did not provide Harriet with assistance in obtaining domestic abuse services.

3.2.72 Since Harriet was residing in Derbyshire at the time of the offence, GMP was unaware of her interactions with Derbyshire Police.

3.2.73 Concerns were expressed regarding Harriet's mental health and the potential for self-harm following the incident in February 2023.

3.2.74 GMP attempted to locate her after she left an address; however, despite attempts to locate and speak with her, they only managed to contact her the following morning. She declined to provide a location or consent to a safe-and-well check with officers.

3.2.75 The GMP IMR author stated a care plan should have been submitted in this case, as officers were responding to Harriet, who was presenting with mental health-related concerns. This would have allowed further attempts to engage with her, enabling a safe and thorough check.

3.2.76 There was minimal communication between GMP and Harriet during the review period. GMP attended incidents of domestic abuse between Ken and Ian. In both domestic incidents, the police responded positively by arresting the suspects.

3.2.77 A MARAC referral was sent to Derbyshire Police following the assault by Ian. Similarly, Derbyshire Police received details after the assault by Ken to ensure that she was appropriately safeguarded.

3.2.78 Ian and Ken were released on police bail, stipulating that they not contact Harriet. Harriet contacted the police to report that both perpetrators had breached their bail.

3.2.79 Harriet re-contacted the police and expressed her concern that the matter was not being taken seriously and that she felt frightened. Additionally, she reported her sister's death from suicide in September 2022.

3.2.80 GMP could have been more proactive in addressing these offences and taking more decisive action to arrest Ian and Ken for breaching bail. The failure to act was unquestionably a hindrance to her future interactions with the police.

3.2.81 COVID-19 did not impact the police's effectiveness in meeting Harriet's needs and providing consistent service throughout the pandemic.

3.2.82 The demand for police resources is consistently high, and it is imperative to prioritise and effectively assess the risks associated with incidents. An Incident Allocation and Escalation Policy has been implemented to resolve these concerns. Nevertheless, it did not seem that these demands influenced the capacity to protect Harriet or facilitate collaboration with other agencies.

3.2.83 Victims may refuse to cooperate with police for various reasons; however, upon investigation, it is discovered that they are collaborating with partner organisations. In those situations, it is advisable to collaborate with partner agencies to ensure that

information is disseminated within a reasonable timeframe and that engagement is attempted.

TOR 5: Poverty and Domestic Abuse

3.2.84 Harriet received PIP and applied for several Derbyshire Discretionary Funds.

3.2.85 According to a study, women in poverty are particularly likely to experience the most extensive violence. The report found that 14% of women in poverty have faced extensive violence and abuse compared to women not in poverty (6%).[84]

3.2.86 The following are the specific areas within the TOR that agencies are required to respond to:

a) What support is provided to adults experiencing financial difficulty, and how does your organisation collaborate with specialised support services to assist impoverished adults? What support services are available in Derbyshire?
b) How did your organisation identify and respond to Harriet, who may have experienced financial difficulty?

Bridges

3.2.87 The service has in-house specialists who can support clients regarding debt advice and welfare rights.

Greater Manchester Police

3.2.88 GMP cannot influence an individual's financial problems. Nevertheless, when officers respond to incidents that emphasise this, they refer them to partner agencies to ensure they are directed to specialised support services.

3.2.89 GMP did not possess any information regarding Harriet's financial circumstances.

TOR 6: Learning

a) Determine effective strategies for areas where your organisation's responses may have exceeded or fallen short of standard practice.
b) What changes have occurred in your organisation since Harriet's death?
c) What should your organisation do to enhance its approach to victims/survivors of domestic abuse?
d) Are there repercussions for working practices, training, management, and supervision?

[84] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-impact-of-domestic-abuse/

e) Has your organisation identified areas where the current legal and policy framework could be improved, both nationally and locally?

Crossroads

3.2.90 Crossroads and Glow, the two domestic abuse services, maintained effective communication. Harriet was contacted on numerous occasions. Nevertheless, it may have been advantageous for the two services to discuss any challenges the IDVA service encountered or was aware of during its tenure.

3.2.91 Crossroads frequently undertakes joint visits with other agencies to provide information about the service at the referral point or when already engaged with the service. However, this is not a standard procedure and is typically done when there is a significant history of previous attempts to engage. Support is offered by other services such as social care or health services.

3.2.92 The above is not reflected in the referral policy; however, the service has many examples of excellent practice. For instance, domestic abuse practitioners have participated in GP appointments in conjunction with Derbyshire Recovery Partnership and visited schools to meet with victims in the presence of teaching staff, with the victims' consent.

3.2.93 Ian was in custody, and the information at the time suggested that the risk was either minimal or non-existent. As a result, there was no indication of a concern at the time of the referral.

3.2.94 Regarding capacity, face-to-face visits are not implemented as a standard procedure at the referral point. The service's capacity cannot accommodate this as a means of engaging potential clients.

3.2.95 The partnership has implemented a hybrid model that provides most support through virtual or telephone communication unless in-person presence is necessary, such as during a court proceeding or appointment. This model has been operational both during and following the COVID-19 pandemic. As indicated by survivor feedback, this paradigm is more accessible and amenable.

Greater Manchester Police

3.2.96 During the review period, officers responded to two domestic incidents involving Harriet and Ken and made professional decisions following the GMP domestic abuse policy. The arrests of both Harriet and Ken were the result of positive action taken in response to reports of assaults in both incidents.

3.2.97 Arresting Harriet and Ken optimised safeguarding opportunities. Nevertheless, it was documented that neither party was charged with any offence, and the victim did not intend to assist the prosecution.

3.2.98 Harriet was released without charge after Ken declined to file a complaint with the police following a domestic abuse incident in October 2022. A DVPN was implemented, and the Magistrates' Court subsequently issued a DVPO.

3.2.99 Ratifying a DVPO was good practice, as it allowed the police and the magistrates' court to implement protective measures in the immediate aftermath of the domestic abuse incident, even though no criminal charges were filed against the perpetrator.

3.2.100 The IMR author identified the subsequent lessons learnt:

1. There are other opportunities open to officers dealing with domestic abuse, including evidence-led prosecutions.
2. This was considered when Ken was arrested for assault on Harriet, and a rationale was provided for why this was not pursued. Still, following the second domestic incident, it appears it was not considered.
3. GMP has created a guidance document checklist for officers to use when considering Evidence-Led Prosecutions (previously referred to as victimless prosecutions). This checklist provides officers with a clearer understanding of the evidence they need to gather to work towards an Evidence-Led prosecution. It provides greater clarity to police officers on their responsibilities regarding all aspects of domestic abuse, from initial contact to investigation.
4. Following the arrest of both Ian and Ken for assaulting Harriet, both were released on police bail not to contact Harriet. However, both breached their bail. Harriet contacted the police to report the breaches. In Ian's case, Harriet gave a statement. Despite this, it appeared that no attempt was made to arrest Ian, and when he was seen to extend his bail, he was not arrested but reminded of his bail conditions.
5. When Harriet reported Ken's breach of bail, it appears FCCO overlooked this. This was a domestic matter, which should have entitled Harriet to an appointment and follow-up. There was also consideration of ongoing harassment offences that subsequently went unreported.
6. FCCO has reviewed this incident and addressed it branch-wide since it transpired.
7. There were apparent issues with the victim and suspect residing in separate police areas, as well as a lack of ownership and urgency in progressing these matters.
8. Positive action is imperative when dealing with breaches of bail in domestic incidents, and a more robust approach should be taken to locate and arrest suspects as soon as possible.
9. Officers attend mental health incidents daily as people and families involved in a mental health crisis attempt to access mental health support via emergency services.

10. Officers attended several incidents involving Harriet because she was experiencing mental health episodes. GMP held information that she suffered from mental health issues and had been diagnosed with PTSD and Bipolar Disorder.
11. A care plan should be submitted on every occasion when GMP responds to a person presenting with mental health-related concerns. Regardless of whether the person presenting mental health problems is transferred by NWAS, taken into a health setting (S136 MHA suite/Accident & Emergency) or neither. The care plan enables the accurate recording of what occurred during the incident and the actions taken. Information gathered during the incident is essential for understanding the risk to the individual and others, as well as for making informed decisions about what further action may be needed. The District Safeguarding Team would review it, and referrals to other agencies would be considered (Chief Constable Order 2020/38, dated 21 September 2020 – Creation of a Care Plan for Mental Health Incidents).

3.2.101 In September 2024, GMP launched the Right Care, Right Person national program. This significant initiative encourages police forces to collaborate with partner agencies, including local authorities, NHS trusts, and mental health agencies, to ensure that individuals who call the police receive the proper support from the right organisation as soon as possible. This programme is crucial to improving police response to mental health-related incidents.

3.2.102 Officers did not submit care plans when they responded to Harriet, who was experiencing mental health-related issues.

3.2.103 This was a missed opportunity for Harriet to receive support from partner agencies. It highlights the importance of improved coordination and communication among agencies to ensure that individuals in need receive the support they need.

3.2.104 Harriet contacted NWAS in January 2023 to report a suicidal male who had overdosed on medication. Ken had left voicemail messages on her phone, informing her that the police had placed him on bail for three months and that she was not to tell them that he had contacted her. She informed the call handler of this information.

3.2.105 The IMR author identified several issues in managing this log, detailed in the GMP agency analysis.

3.2.106 There are no areas identified where national and local improvements to the existing legal framework could be made.

TOR 8: To identify any changes since Harriet's death

Crossroads

3.2.107 It is standard practice to inform agency referrers of unsuccessful contact and address engagement obstacles. The case management and referrals policy now reflects this.

Bridges

3.2.108 Bridges has implemented a new case management system, along with various new systems and processes, including a new risk assessment process and a file closure/disengagement procedure.

TOR 7: The reports should address any equality and diversity issues, including intersectionality, that appear relevant to the victim.

3.2.109 Please refer to section 1.13

4.1 Conclusion

4.1.1 The review's objective is to identify lessons and articulate life through the eyes of the victims.[85] This quote stresses the importance of understanding the victim's perspective in such cases.

4.1.2 Harriet, as a child, had witnessed her parents' domestic abuse relationship, and her mother, Steven, believed it was a factor in the strained relationship between the two. Steven believed Geoff, Harriet's father, portrayed her negatively, which led Harriet and Steven's other three children to have a negative opinion of her.

4.1.3 Harriet was a victim of domestic abuse in her prior relationships. She experienced further trauma following the loss of her three siblings; one died in a motorbike accident, and two died by suicide.

4.1.4 Regrettably, no communication was established with Harriet's surviving sibling or Geoff and friends to understand their relationship and gain a deeper understanding of Harriet.

4.1.5 Harriet disclosed to GMP that she had been affected by PTSD after the death of her siblings. She had been directed to grief counselling by her GP and Glow; the DARDR panel was unable to determine whether she had sought their support.

4.1.6 In April 2022, Ian was arrested and charged with S18 assault. CPS were aware of the breaches of police bail, and he was remanded in police custody until his court appearance the next day.

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

4.1.7 Ian was granted court bail and breached the condition in May 2022. He was arrested and charged with breaching bail, and he attended court the next day, where he was remanded in custody pending trial. In November 2022, he entered a guilty plea and was sentenced to two years of custody.

4.1.8 He was released in February 2023; Harriet was informed seventeen days later. The Victim Liaison Officer had attempted to contact Harriet.

4.1.9 Harriet was in a sexual relationship with Ken, and the police received a report of bi-directional abuse.

4.1.10 Elizabeth Bates[86] characterised bidirectional abuse as:

'*Bidirectional or mutual abuse can be prevalent and unrelenting in big and small matters. It suggests that both partners can display aggressive behaviours during a conflict. However, this may not be the case with each conflict episode and may not be symmetrical.'*

4.1.11 Ken and Harriet were arrested on separate occasions. Ken was released on bail and subsequently breached the condition by communicating with Harriet; however, he was not arrested for this offence.

4.1.12 Panel agencies were aware that Harriet was known to misuse alcohol and substances, as evidenced by police attendances that indicated her incapacity to complete risk assessments because of her intoxication.

4.1.13 Alcohol and substance misuse are frequently employed as a coping mechanism for trauma and can offer transient relief.

4.1.14 UK addiction treatment centres[87] have emphasised the following:

1. **Self-Medication Hypothesis**: Substances may be employed by individuals with PTSD to alleviate the distressing symptoms of the disorder. This avoidance behaviour has the potential to exacerbate and perpetuate addiction.
2. **Neurobiological Changes**: Changes in the brain's reward and stress systems are present in both addiction and PTSD. Addiction may result from the influence of substances on the brain's reward pathways.
3. **Impact on Coping Mechanisms**: An individual's capacity to manage stress adaptively can be impaired by trauma. The use of substances may be interpreted as a means of regaining control or alleviating the emotional distress that is linked to traumatic experiences.
4. **Cycle of Dysfunction**: Substance use may result in risky behaviours, which in turn increase the probability of re-experiencing trauma and vice versa.

[86] http://elizabethbates.co.uk/uncategorized/why-we-need-to-investigate-experiences-of-bidirectional-intimate-partner-abuse/
[87] https://www.ukat.co.uk/mental-health/ptsd-and-addiction/

5. **Social Isolation:** Social isolation can be exacerbated by both addiction and PTSD.

4.1.15 The panel was unable to determine whether Harriet had received support for alcohol and substance abuse. Harriet had been advised to self-refer to CGL; however, CGL confirmed that no referral had been received.

4.1.16 Harriet's GP practice was cognisant of her alcohol misuse and bereavements and made an unsuccessful attempt to connect her with their mental health practitioner.

4.1.17 Ken's neighbour reported that Harriet had expressed suicidal ideation on the day of her death. This was followed by concerns about shouting between Harriet and Ken and disturbances at home.

5.1 Lessons to be Learnt

5.1.1 The review identified the following themes to be drawn from this review:

5.1.2 **Response to Disclosures of Domestic Abuse and Holding Perpetrators to Account**

5.1.3 GMP arrested Ian and Ken in response to Harriet's reports of domestic abuse. However, Ian and Ken's breach of bail had not been addressed. Derbyshire Police arrested Ian in April 2022 for a further offence, and the CPS was made aware of the breach of bail.

5.1.4 When Ian was arrested in April 2022, the officer sought charge advice from the CPS regarding the original offence (from January 2022) and Section 18 was authorised. The CPS was informed that his police bail had been violated.

5.1.5 Ian entered a guilty plea and was sentenced to imprisonment. Ken was not subjected to any further action.

5.1.6 In April 2022, the Department of Health and Social Care published guidance[88] to strengthen the response to domestic abuse further

'Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'

'Health professionals have a responsibility to address the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.'

[88] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article

5.1.7 Harriet was referred to domestic abuse services by Derbyshire Police in December 2021 and again in April 2022. Ian was referred to Drive in June 2022.

5.1.8 The GP was notified of Harriet as a high-risk MARAC referral in January 2022; the subsequent contact regarding domestic abuse occurred in November 2022. She was directed to a mental health practitioner.

5.1.9 In April 2022, Harriet requested support from the Elm Foundation; they were unsuccessful in establishing consistent contact with her.

5.1.10 Harriet was referred to Healthy Minds in January 2023 by Glow.

5.1.11 If perpetrators of domestic abuse are to be held accountable, the justice system must act with urgency and decisiveness. Access to appropriate legal representation, offender accountability, secure reporting environments, and collaboration among relevant agencies is essential. All these components are critical to the effective support of survivors of domestic violence.

5.1.12 **Trio of Vulnerability**

5.1.13 Domestic abuse is a component of the “Trio of Vulnerability," also called a "Toxic Trio," and refers to three main factors: personal, situational, and relationship. These underscore the complexity of domestic abuse. Factors like mental health issues (personal), financial dependence (situational), and power imbalances (relationships) can heighten the risk of abuse. Survivors facing these vulnerabilities often feel helpless, which may lead them to stay in abusive relationships and avoid seeking legal help.

5.1.14 Harriet experienced numerous traumas that may have impacted her self-esteem, emotional regulation, and ability to recognise healthy relationships.

5.1.15 The second vulnerability: Ken reported providing her with funds for her utility bill and taxi. Agencies did not know whether Harriet was employed, and she received PIP.

5.1.16 The final vulnerability relates to relationships, where an imbalance of power is the key predictor of domestic abuse, as noted in section 1.13 on gender-based violence

5.1.17 As a means of coping with psychological turmoil, some people resort to self-harm. Self-harm is associated with domestic abuse.[89]

5.1.18 Harriet had reported self-harm in January 2023; GMP attempted to contact her but was unsuccessful.

[89] Dalton TR, Knipe D, Feder G, et al Prevalence and correlates of domestic violence among people seeking treatment for self-harm: data from a regional self-harm register emergency Medicine Journal 2019;36:407-409.

5.1.19 Alcohol was cited as a common theme in 39 DHRs, with 15 indicating that the victim and perpetrator had alcohol misuse issues.[90]

5.1.20 The Trio of Vulnerability emphasises the interconnected factors that elevate the likelihood of domestic violence. Understanding these components is crucial for identifying individuals at risk and providing effective support. The cycle of abuse can be broken, and vulnerability to abuse can be reduced by addressing mental health, financial and social support, and toxic relationship dynamics.

5.1.21 Interventions that address multiple vulnerabilities are often more effective than those that focus solely on one factor. For example, trauma-informed therapy, financial empowerment programs, and social reintegration strategies that accommodate various levels of vulnerability may aid domestic violence victims in their recovery and the re-establishment of control over their lives.

5.1.22 **Suicide Risk and Domestic Abuse**

5.1.23 Harriet's two siblings had died by suicide. Individuals who have experienced a loss because of suicide are at an elevated risk of suicide.

5.1.24 Harriet had disclosed suicidal thoughts to her neighbour on the day of her death.

5.1.25 According to The Lancet[91], one in every three women who attempted suicide in the previous year was a victim of intimate partner violence, compared to one in every twenty women in the general population. As a result, the findings advise routine enquiries regarding intimate partner violence in healthcare settings, along with protective measures for those who may be vulnerable. In addition, suicide attempts and self-harming behaviours are essential risk indicators for eventual suicide and are critical for suicide prevention.

5.1.26 A significant risk factor identified in the five-year national suicide prevention strategy is domestic abuse.[92]

5.1.27 The Derbyshire Mental Health and Suicide Prevention Team is in the process of creating a new strategy that will incorporate factors that contribute to suicide, such as domestic abuse. To facilitate this, the Self-Harm and Suicide Prevention Forum[93] is being developed in collaboration with partners.

[90] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf
[91] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2822%2900151-1
[92] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy
[93] https://derbyandderbyshireemotionalhealthandwellbeing.uk/suicide-prevention

5.1.28 A coroner's inquest in England determined that domestic abuse was the fundamental factor contributing to the suicide of a 34-year-old woman.[94] This was the first instance in which a coroner in the UK had attributed suicide to domestic abuse.

5.1.29 The coroner advised that first responders recognise the correlation between domestic abuse and suicide more readily and that interagency coordination be enhanced to avert similar deaths in the future.

5.1.30 It is imperative to prioritise suicide prevention through intervention and support. There is a pressing need for all agencies to work together to address this critical issue, ensuring that domestic abuse survivors do not feel trapped and can obtain the support they require.

5.1.31 Cross-County Working and Response to Domestic Abuse

5.1.32 The National Centre for Public Protection (NC4PP) is a proposed centre within the College of Policing to better support police forces in England and Wales responding to public protection-related offences.

5.1.33 The purpose of the NC4PP is to provide centralised strategic advice and operational support to policing by enhancing policing's understanding and response to public protection.

5.1.34 The NC4PP's vision for success is the creation of a unified strategic direction for public protection across policing and broader partnerships, providing clarity and leadership on practice standards and expectations for forces.

5.1.35 This proposal will support forces and seek single, central solutions, including the cross-border movement of offenders (and their victims and families), while developing intelligence and information sharing between police forces and partners.

5.1.36 The Domestic Abuse National Police and Crime Commissioner Lead and the Vulnerability Knowledge and Practice Programme collaborated on the proposal while writing the review.

5.2 Recommendations

Individual Agency Recommendations

5.2.1 Greater Manchester Police

[94] https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344_Published.pdf

1. Officers are to be reminded of the Creation of a Care Plan for Mental Health incidents (Chief Constable Orders 2020/38, dated 21 September 2020). When officers respond to a person presenting with mental health-related concerns, a care plan should be created. The care plan enables the accurate recording of what occurred during the incident and the actions taken. The District Safeguarding Team would review it, and referrals to other agencies would be considered.

   This action will be forwarded to Organisational Learning, which will consider further inputs to ensure a thorough understanding and effective application of the process on the front line.

2. Officers to be reminded of the Domestic Abuse Policy. In November 2022, the force launched DA Matters training, which was completed in March 2023. This training was mandatory for all public-facing roles within GMP. The aim was to create a long-term, sustainable improvement and consistency in the response to domestic violence. Evidence-led prosecution was a focus of this training, as were DVPNs, DVPO, and Clare's Law disclosure (DVDs).

   This action will be forwarded to the PPGU (Public Protection and Governance Unit) for review to ensure that the training's understanding and application are effective on the front line.

3. FCCO is learning about the quality of service provided in accordance with established policies and procedures. These issues have been addressed on a branch-wide scale within the last 17-18 months, which negates the need for feedback. Poor THRIVE quality, incident management following escalation and taking a multi-agency approach to this type of incident. The latter has been particularly emphasised in the recent training for 'Right Care, Right Person,' as the incident would still involve GMP. The breach-of-bail aspect had been missed and should have been addressed. This issue has been discussed on a branch-wide scale since the incident occurred.

   FCCO has completed this action.

4. Officers should respond more proactively to breaches of police bail. When a suspect is released from custody under police bail conditions, particularly in domestic cases, it is imperative that any violations of those conditions are dealt with expeditiously and that a robust approach is taken to locate and arrest the suspect at the earliest opportunity.

   This action will be forwarded to Organisational Learning, which will consider further inputs to ensure an effective understanding and application of the process.

Multi-Agency Recommendations

Recommendation One: Learning

It is essential that agencies and their staff fully understand the review's findings to strengthen and enhance responses to domestic abuse. This understanding is crucial for creating a more supportive and responsive environment for victim-survivors.

DARDR Panel Agencies

1.1 To share the lessons learned from Harriet's death, especially about understanding trauma and its significant effects on individuals. This will involve collaborating with relevant agencies and engaging in related forums within those agencies. To demonstrate to the CSP how this has been successfully achieved. For example, meeting minutes, training slides, or other associated documents.

Recommendation Two: User Engagement and Responding to Domestic Abuse Disclosures.
It is crucial to personalise responses for victim-survivors of domestic abuse. Fostering a mindset of professional curiosity across all agencies will enhance communication skills and improve situational understanding.

Addressing disclosures of domestic abuse requires a decisive, empathetic, and trauma-informed approach. When someone reveals their experience of abuse, it is essential to cultivate an environment where they feel acknowledged, supported, and safe.

DARDR Panel Agencies

2.1 All staff from participating agencies should have access to training and resources focused on professional curiosity and trauma-informed approaches. Provide the CSPs with meeting minutes, training slides, or other related documents to demonstrate how this has been achieved.

2.2 To provide domestic abuse victim-survivors with information and display clear and accessible information on support services such as domestic abuse hotlines and legal advice. This information should be easily accessible, especially during high-stress situations. To demonstrate to the CSP how this has been successfully achieved.

Community Safety Partnerships & Domestic Abuse Services

2.3 To implement targeted public awareness campaigns that highlight the signs of domestic abuse, how to get help, and ways to support victim-survivors. Address myths about domestic abuse and stress that it can happen to anyone, regardless of background or status.

2.4 To promote programs instilling healthy relationship behaviours, respect, and equality that engage men and boys as vital allies in the prevention of domestic abuse.

Recommendation Three: Trio of Vulnerabilities

Addressing domestic abuse, substance misuse, and mental health requires a collaborative and integrated approach. Community education and awareness can empower individuals to support those affected by the “Trio of Vulnerabilities”.

Suicide and domestic abuse are often interconnected, with victims at higher risk for suicidal thoughts and attempts due to emotional and physical trauma. Additionally, perpetrators may also struggle with their own mental health and suicidal risks.

DARDR Panel Agencies

3.1 Cross-Agency Training: To implement regular training for professionals across all sectors—including social care, healthcare, police, and education—focused on the trio of vulnerabilities. These trainings should enable individuals to recognise and effectively address the co-occurrence of domestic abuse, mental health issues, and substance misuse. A training program is to be developed and shared with the CSP.

3.2 Routinely ask victim-survivors of domestic abuse about depression, suicidal ideation, and other mental health issues. To present the outcome data to the CSPs.

3.3 When victim-survivors of domestic abuse express suicidal thoughts or behaviours, it is imperative that they receive immediate support through crisis intervention services. Provide procedures for responding to domestic abuse victim-survivors with suicidal thoughts or behaviours to the CSPs.

Mental Health Service

3.4 Enhance crisis intervention teams to respond effectively to suicide risks associated with domestic abuse. Develop immediate safety plans with emergency housing, mental health support, and legal protection measures. Outline how these objectives will be achieved, for example, by providing learning briefs, adding to existing policies and practices, and providing training for the CSP.

Community Safety Partnerships & Domestic Abuse Services

3.5 To implement public awareness campaigns that focus on the connections between domestic abuse, mental health, and substance misuse, which can help reduce stigma and encourage individuals to seek help.

Derbyshire and Greater Manchester Police Forces

3.6 Ensure that perpetrators who engage in domestic abuse are held accountable through appropriate legal measures, such as protective orders and DVDs, while also ensuring access to treatment programs for their mental health and substance misuse issues. To present the outcomes data to the CSPs.

Derbyshire and Greater Manchester Police Forces and Domestic Abuse Services

3.7 Perpetrators of domestic abuse may face suicide risks, particularly if they are dealing with mental health issues or substance abuse. Providing mental health services to those expressing suicidal thoughts can be crucial for preventing harm to themselves and addressing the cycle of abuse. To present the outcomes data to the CSPs.

Derbyshire Community Partnership is responsible for monitoring the implementation of the action plan. The actions are intended to facilitate safer and more effective responses to domestic abuse victims and survivors. This must be emphasised to ensure that agencies are accountable for completing their actions.

Acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
ABH	Actual Bodily Harm
ASC	Adult Social Care
CBT	Cognitive Behavioural Therapy
CID	Criminal Investigation Department
CGL	Change Grow Live
CPN	Community Psychiatric Nurse
CPR	Cardiopulmonary Resuscitation
CPS	Crown Prosecution Service
DAAS	Derbyshire Alcohol Advice Service
DAB	Domestic Abuse Event
DARDR	Domestic Abuse-Related Death Review
DASH	Domestic Abuse, Stalking and Honour-Based Violence
DCC	Derbyshire County Council
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDICB	Derby and Derbyshire Integrated Care Board
DDF	Derbyshire Discretionary Fund
DFRS	Derbyshire Fire and Rescue Service
DHR	Domestic Abuse Homicide Review
DVPO	Domestic Violence Protection Order
DVPN	Domestic Violence Protection Notice
DWP	Department of Work and Pensions
ED	Emergency Department
ESA	Employment Support Allowance
FCCO	Force Contact, Crime and Operations
FT	Foundation Trust
HPBH	High Peak Borough Housing
GBH	Grievous Bodily Harm
GMP	Greater Manchester Police
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MHA	Mental Health Act 1983
MHLT	Mental Health Liaison Team
MHP	Mental Health Practitioner
MHTAS	Mental Health Tactical Advice Service
M-HUT	Mental Health Urgent Triage
NCHA	Nottingham Community Housing Association
NFA	No Further Action
NWAS	North West Ambulance Service NHS Trust

OCB	Operation Communication Branch
PIP	Personal Independence Payment
PND	Police National Database
PPN	Public Protection Notice
PTSD	Post Traumatic Stress Disorder
OIC	Officer in the Case
TCSP	Tameside Community Safety Partnership
ToR	Terms of Reference
VSU	Vulnerability Support Unit