



Op Domino

# Executive Summary of the Domestic Abuse-Related Death of Harriet March 2023

Parminder Sahota



DATE REPORT COMPLETED: MARCH 2025

CONTROLLED

## 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 at the time of her death. She was described by family and friends as warm, caring, and creative, with a strong love of music, dance, and social connection. She trained as a hairdresser and was known for helping others in practical and emotional ways.

Harriet also lived with mental ill-health, had experienced multiple bereavements, and was a repeat victim of domestic abuse across previous intimate relationships. Her life was shaped by periods of vulnerability, resilience, affection for those close to her, and moments of hope.

Her story is central to this review. Learning from Harriet's life and experiences must inform practice, improve responses to victims of domestic abuse, and contribute to preventing future deaths. The author thanks the panel and people who submitted chronologies and materials for their time and cooperation.

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

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## Section One: The Review Process

- 1.1.1 This summary outlines the process undertaken by the Derby and Derbyshire Safer Communities in reviewing the death of Harriet, who was a resident in the area.
- 1.1.2 The following pseudonyms have been used in this review for the victim and family to protect their identities:
- The victim: Harriet
  - Harriet's mother: Steven
  - Harriet's father: Geoff
  - Harriet's brother: Jonathan
  - Recent Ex-Partner: Ken
  - Ex-Partner: Ian
- 1.1.3 Harriet was thirty-three, single, and had no children at the time of her death. Harriet had four siblings, one of whom died in a motorbike accident and two of whom died by suicide (September 2021 and January 2023). She is survived by one brother who works for the Armed Forces.
- 1.1.4 Harriet was passionate about dancing. She learned to play the piano in her youth and attended ballet lessons. She enjoyed attending concerts of various genres. After her brother's suicide, she turned to rap music, his favourite, to feel connected to him.
- 1.1.5 Her mother, Steven, reported that Harriet witnessed domestic abuse between Steven and Harriet's father, Geoff, which strained their relationship, as Geoff often spoke negatively about Steven to Harriet.
- 1.1.6 After completing secondary education, Harriet worked as a hairdresser but was unemployed at the time of her death. She was diagnosed with a Personality Disorder<sup>1</sup> and admitted to a mental health unit under the Mental Health Act 1983<sup>2</sup> (MHA) 1983, in 2015, when she met Ken. They had a sexual relationship before her death.
- 1.1.7 In February 2021, Harriet attended the hospital for an overdose, was assessed, and was discharged to her GP. She was not receiving secondary mental health services<sup>3</sup> at the time of her death.
- 1.1.8 The DARDR process commenced with the Safer Communities Partnership in June 2023, when a decision was made to hold a review. All agencies that potentially had contact

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<sup>1</sup> <https://www.nhs.uk/mental-health/conditions/personality-disorder/#:~:text=Symptoms%20of%20a%20personality%20disorder,disorder%20will%20have%20different%20symptoms.>

<sup>2</sup> <https://www.legislation.gov.uk/ukpga/1983/20/contents>

<sup>3</sup> Specialised care for people with complex or long-term mental health conditions that primary care services (GP) cannot meet.

with Harriet and Ken before their deaths were contacted and asked to confirm whether they had been involved with them.

- 1.1.9 Thirteen agencies contacted confirmed contact with Harriet and/or Ken and were asked to secure their files.
- 1.1.10 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.
- 1.1.11 Harriet was intimate 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.
- 1.1.12 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). Greater Manchester Police (GMP) attended to domestic abuse incidents concerning "C", "D" (2020), "E" (2021) and "F" (2021).
- 1.1.13 To facilitate learning and ensure that all facets of agency support were identified, they were asked to provide relevant information within the specified timeframe.
- 1.1.14 Harriet disclosed to GMP in January 2023 that she was in an exclusively sexual relationship with Ken. GMP and Derbyshire Police received assault reports from both Harriet and Ken.
- 1.1.15 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).
- 1.1.16 The post-mortem outcome was "inconclusive", and a subsequent post-mortem determined the cause of death:
  1. Hypoxic-Ischaemic Encephalopathy<sup>4</sup> and Aspiration Pneumonia<sup>5</sup>
  2. Cardio-Respiratory Arrest<sup>6</sup>
  3. Hanging
- 1.1.17 The inquest is scheduled for Spring 2025.

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<sup>4</sup> A brain injury occurs when the brain doesn't receive enough oxygen or blood flow

<sup>5</sup> A lung infection resulting from inhaling bacterial-rich fluids

<sup>6</sup> Loss of sufficient respiratory and cardiac function

- 1.1.18 The independent author invited Harriet’s brother, Darren and Geoff to participate; no response was received. An advocate supported Harriet’s mother, and the author met with Steven to gain a deeper understanding of Harriet’s life.
- 1.1.19 The author updated Steven via the advocate on the review’s progress. The report was sent to the advocate on 28 February 2025 for discussion and sharing with Steven.
- 1.1.20 Following Home Office approval, the reviewer was contacted by Geoff and Jonathan, who expressed concerns about their lack of involvement in the review process and the portrayal of Harriet in the report.
- 1.1.21 They also disputed Steven’s assertion that Harriet was a victim of domestic abuse by Geoff. Their comments were subsequently recorded as an addendum to the report and shared with the Home Office to ensure transparency.

## Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution
<b>Bridges</b> 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
<b>Crossroads</b> 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 <sup>7</sup> .	Chronology, Summary and Minutes of the High-Risk Perpetrator Panel regarding Ian.
<b>Department of Work and Pensions (DWP)</b>	Chronology, Summary and welfare right support/application/appeals
<b>Derbyshire Community Health Services NHS Foundation Trust (DCHS)</b> Specialist community health services in the country	Chronology
<b>Derbyshire County Council: High Peak North Adult Social Work Team.</b> Adult Social Care and Health (ASCH)	Chronology and Derbyshire Discretionary Fund (DDF) applications
<b>Derbyshire Fire and Rescue Service (DFRS)</b>	Chronology
<b>Derbyshire Police (Police)</b>	Chronology and IMR

<sup>7</sup> <https://www.ncha.org.uk/care-and-support/services-and-care-homes/all-care-homes-and-services/ncha-derbyshire-wish/>

<b>Elm Foundation</b> 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
<b>Glow</b> Deliver independent domestic violence advisor services throughout Derbyshire. A High-Risk Domestic Abuse Service	Chronology and Summary
<b>GP Practice</b>	Chronology, Summary and Three Documents Related to Harriet's Presentation Concerning Bereavement, Depression and Domestic Abuse.
<b>Greater Manchester Police (GMP)</b>	Chronology and IMR
<b>North West Ambulance Service NHS Trust (NWAS)</b>	Chronology
<b>Pennine Care NHS Foundation Trust (FT)</b> Provider of mental health, learning disability, and autism services to people across Greater Manchester and beyond.	Chronology

2.1.2 The chronologies and reports were written by professionals who were not involved in case management or service delivery.

### Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

Panel Member	Job Title	Organisation
Alison Boyce	Domestic Abuse Manager	DCC Lead on this DARDR Derbyshire County Council (DCC)
Darren Pope	Domestic Abuse Lead, Public Protection	Panel Member Derbyshire Constabulary
DC Debra Makin	Serious Case Review Team	Panel Member Greater Manchester Police
Julia Ashbrook	Senior Community Safety Officer	DCC Liaison Officer Derbyshire County Council
Darren 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

3.12 The panel met a total of five times.

#### Section Four: Author of the Overview Report

- 4.1.1 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.
- 4.1.2 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 in London.
- 4.1.3 Parminder had no prior contact with Harriet's family or friends and is independent of the agencies and partnerships involved.

#### Section Five: Terms of Reference for the Review

- 5.1.1 The statutory guidance sets out the purpose of DHRs:

- a. Establish what lessons are to be learned from domestic abuse-related death regarding how local professionals and organisations work individually and together to safeguard victims.
- b. Identify the lessons within and between agencies, how they will act on these lessons, and within what timescales, as well as the expected changes.
- c. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
- d. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- e. Contribute to a better understanding of the nature of domestic violence and abuse.
- f. Highlight good practice.

5.1.2 The panel agreed to address the following themes as part of the Terms of Reference (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

5.1.3 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.

## Section Six: Summary Chronology

**6.1.1 Significant events in Harriet's history before the specified timeframe, mainly focusing on her experiences with domestic abuse, mental health struggles, and interactions with various support services.**

### November 2012

6.1.2 Harriet was granted Employment Support Allowance<sup>8</sup> (ESA) until her death.

### December 2012

6.1.3 Harriet was referred to the Multi-Agency Risk Assessment Conference<sup>9</sup> (MARAC) by GMP as a high-risk victim of domestic abuse by "A." An Independent Domestic Violence Advisor (IDVA) was assigned to her.

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<sup>8</sup> <https://www.gov.uk/employment-support-allowance/what-youll-get>

<sup>9</sup> <https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/>

### **January 2013**

6.1.4 Harriet moved into a refuge after a joint visit from the IDVA and Derbyshire Police.

### **July 2013**

6.1.5 Harriet was admitted to Pennine Care NHS FT, mental health unit, due to low mood.

### **May 2014**

6.1.6 Harriet was closed to the Bridges service due to a lack of response.

### **January 2015**

6.1.7 Harriet was awarded Personal Independence Payment<sup>10</sup> (PIP) and had a home visit by the IDVA for ongoing harassment and mental health issues related to her brother's death.

### **February 2015**

6.1.8 Harriet received a home visit from the IDVA and the Sanctuary Scheme<sup>11</sup> was completed on the property. Harriet was referred for bereavement counselling.

### **May 2015**

6.1.9 Harriet was admitted to Pennine Care NHS FT, the mental health unit and diagnosed with a Personality Disorder. The IDVA conducted a home visit, and a refuge offer was declined after she reported domestic abuse from "B".

### **December 2016**

6.1.10 GMP responded to a domestic abuse incident; "C" was arrested, and Harriet was relocated to a refuge.

### **June 2017**

6.1.11 Harriet's friend raised concerns to Adult Social Care (ASC) about Harriet's safety and mental health. ASC confirmed that Harriet was safe and supported.

### **June 2018**

6.1.12 Harriet was involved in a domestic incident where she assaulted a male with scissors and a knife after drinking. She was listed as the perpetrator in the High Peak (Derbyshire) MARAC case.

### **July 2020**

6.1.13 Harriet reported a verbal altercation with "D" to GMP.

### **January 2021**

6.1.14 Harriet was found by GMP intoxicated outside a Manchester hotel, declined support, and was assessed with medium risk.

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<sup>10</sup> <https://www.gov.uk/pip>

<sup>11</sup> <https://www.gov.uk/government/publications/sanctuary-schemes-for-households-at-risk-of-domestic-violence-guide-for-agencies>

## **February 2021**

6.1.15 Harriet attended the hospital after an overdose and discussed medication and substance use with the Mental Health Liaison Team (MHLT). She was encouraged to seek further support with Change, Grow, Live, a drug and alcohol service.

## **May 2021**

6.1.16 Harriet called GMP regarding threats from "E" but declined to advance the report. Later, she made an abandoned 999 call, leading to a high-risk assessment and further concerns about her mental health.

## **July 2021**

6.1.17 Derbyshire Police contacted GMP regarding a domestic incident between Harriet and "F". A check on "F" was requested but returned due to a lack of officers.

## **6.1.18 A summary of the key events from the approved timeframe:**

## **September 2021**

6.1.19 GMP recorded an intimate relationship between Ian and Harriet.

## **December 2021**

6.1.20 Harriet's partner damaged property, prompting police intervention; however, no serious harm was reported. She expressed distress over her sister's suicide and concerns about the police investigation. Derbyshire Police referred Harriet to the Domestic Abuse Helpline, operated by the Elm Foundation.

## **January 2022**

6.1.21 GMP reported a domestic abuse incident where Ian reportedly assaulted Harriet, causing severe injuries. The incident was prioritised for emergency response, leading to Ian's arrest and bail. Based on previous incidents, Harriet's risk was assessed as high, and a MARAC referral was made. It was unclear if the case was referred to the Crown Prosecution Service (CPS) for prosecution while Ian was in custody.

## **February 2022**

6.1.22 Harriet reported that Ian had breached his bail by contacting her, which GMP recorded but did not result in an arrest. Despite multiple breaches and Harriet's expressed fear, Ian was not arrested and was handed bail forms, reiterating the bail conditions. Attempts to contact Harriet were unsuccessful.

## **March 2022**

6.1.23 Harriet reported that Ian threatened to break into her home, prompting her to flee. Derbyshire Police later contacted her, but she did not reveal her location. GMP tried to locate Ian, but no immediate action was taken.

## **April 2022**

6.1.24 Harriet reported Ian's presence at a pub and an assault, resulting in his arrest for breach of bail and stalking. The CPS authorised assault charges for the January 2022 assault, leading to Ian being remanded in custody. Further investigation was required to prosecute the other offences. Derbyshire Police arranged a home visit with the Housing Officer.

## **May 2022**

6.1.25 Harriet reported more bail breaches, leading to Ian's arrest.

## **June 2022**

6.1.26 Ian was referred to a project for high-risk perpetrators. Harriet had a dispute about staying at Ken's property, prompting concerns from Ken's family and a referral to his care team.

## **July 2022**

6.1.27 MARAC Risk Profile: Ian had ten police incidents involving physical abuse, stalking, and violence. Harriet received an IDVA and safety measures, such as property hardening.

6.1.28 Steven's Report: Steven reported Harriet for death threats, but no action followed a voluntary interview with her and conflicting social worker statements.

6.1.29 Ken's Report: Ken called 999 about Harriet's reported assault, but was uncooperative and did not provide details, resulting in no further action.

## **August 2022**

6.1.30 Ian was arrested in April 2022 but released without charge due to a lack of evidence. Geoff, concerned about being unable to contact Harriet, contacted the police, who visited her but found no issues.

## **September 2022**

6.1.31 Harriet's 999 Call: Harriet expressed concerns about Ken's behaviour after taking unprescribed medication, but police and medical teams found no significant issues.

6.1.32 Harriet's Anxiety: Harriet felt unsafe thinking Ian might be nearby, but the police found no evidence of his presence and gave safety advice.

## **October 2022**

6.1.33 Harriet's Mental Health: Harriet consulted her GP about her mental health, with her IDVA ensuring home security due to Ian's potential release.

6.1.34 Domestic Incident with Ken: Ken withdrew his complaint after a violent dispute. A Domestic Violence Protection Order<sup>12</sup> (DVPO) was issued, prohibiting Harriet from contacting Ken.

6.1.35 Mental Health Update: The GP noted Harriet's grief from recent family losses and planned further support.

### **November 2022**

6.1.36 Ian pleaded guilty to assaulting Harriet and was sentenced to 24 months with a 5-year restraining order. Harriet sought mental health support for anxiety and grief, receiving propranolol as treatment.

### **December 2022**

6.1.37 Harriet's Communications: Harriet identified "Ken" as a possible support and had multiple police interactions related to a threat, but did not provide details.

6.1.38 Final GP Consultation: Harriet received antibiotics for a chest infection, reflecting ongoing health issues.

### **January 2023**

6.1.39 Harriet was referred to Crossroads Community Service after she had expressed concerns about past abuse related to Ian (who was imprisoned). Crossroads agreed to contact her. Harriet was referred to Healthy Minds after Talking Mental Health Derbyshire was unable to help her.

6.1.40 During the investigation into reports made by Steven against her, Harriet died, and consequently, the case was closed. MARAC discussed her situation, prompting the Safer Neighbourhood Team to engage Crossroads.

6.1.41 Harriet reported an assault by Ken, resulting in a Section 47 assault allegation against him. He was arrested but released under investigation. Harriet was uncertain if she wanted to give a statement at the time of Ken's arrest, and it was evident that she was under the influence of drugs and alcohol. When recontacted, she declined to give a statement. A medium-risk DASH was completed, but she declined to provide a statement due to substance use.

### **February 2023**

6.1.42 Derbyshire Police and GMP reviewed incidents involving Ken, including the January assault, but took no further action despite evidence suggesting a prosecution was possible.

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<sup>12</sup> <https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpns-guidance-sections-24-33-crime-and-security-act-2010>

6.1.43 Failures in cross-jurisdiction communication and the need for proactive support were noted. Harriet reported that Ken had breached his bail conditions, but was met with inaction due to insufficient evidence. She experienced distressing incidents, including self-harm and ongoing mental health struggles, despite GP and mental health services involvement. Additionally, Harriet's concerns about her safety grew as Ian was released from prison.

### **10 Days Before Harriet's Death**

6.1.44 Harriet's scheduled appointment with mental health services failed to connect due to communication issues.

## **Section Seven: Analysis of Agency Contact**

### **Bridges**

7.1.1 Bridges had a historical connection with Harriet, especially before her relationship with Ken, which included a history of domestic abuse. The dynamics changed in February 2023 when Ken was identified as the victim and Harriet as the perpetrator, highlighting the complexity of their relationship. Harriet's past refuge stay and experiences with multiple perpetrators are crucial for understanding her behaviours.

### **Crossroads**

7.1.2 Crossroads referred Harriet to support services, but she faced significant barriers. She declined mental health services and only received care from her GP.

7.1.3 Her Glow referral indicated she was no longer high-risk, leading to a standard service referral. However, her complex circumstances, including disengagement from care and a history of abuse, suggested a need for urgent intervention. While respecting her autonomy, the Crossroads' consent-led policy may have limited proactive safeguarding, thereby missing opportunities for integrated support and information sharing.

### **Derbyshire Police**

7.1.4 Harriet lived in the Derbyshire Police area, with police involvement primarily driven by Steven's reports of verbal abuse. Harriet's emotional distress after her sister's death and the blame directed at Steven marked her interactions with the police as reactive rather than proactive regarding her safety.

7.1.5 Ian's assaults against Harriet in the Greater Manchester area led to his conviction in November 2022 and a two-year prison sentence. He was released in February 2023, just a few months before Harriet's death. This raises concerns about the protection of victims when offenders receive short sentences.

- 7.1.6 Derbyshire Police had limited involvement with incidents involving Ken, highlighting jurisdictional challenges. Although they took steps to safeguard Harriet, such as implementing security measures, these efforts may not have been enough given her ongoing risks, especially following a July 2022 call where Ken reported an assault by Harriet.
- 7.1.7 In October 2022, an IDVA's call concerning Harriet's fear of Ian prompted a positive police response. Focusing on Harriet's emotional distress might have distracted from the ongoing risks posed by Ian and Ken. Gaps in communication among officers regarding follow-ups and coordination with GMP may have led to missed opportunities to support Harriet more effectively during her vulnerable state.
- 7.1.8 Derbyshire Police's involvement in Harriet's case was primarily reactive. They relied on reports from individuals like Steven and Harriet herself. They took some appropriate actions, such as enhancing security against Ian.
- 7.1.9 The lack of follow-up on Ken's assault report and poor documentation of interactions with Harriet raised concerns about effectively assessing her ongoing domestic abuse risks. Coordination with GMP focused mainly on Ian, neglecting Harriet's broader vulnerabilities, including her mental health and relationship with Ken. This reflects the challenges of managing complex domestic abuse cases across jurisdictions.

#### **Elm Foundation**

- 7.1.10 Between July 2020 and January 2023, Derbyshire Police and Glow referred Harriet to the Domestic Abuse Helpline to help her connect with domestic abuse services in Derbyshire.

#### **GLOW**

- 7.1.11 From April 2022 to March 2023, Harriet received support from Glow and Victim Care. However, communication with her was often challenging, especially after personal losses.
- 7.1.12 In January 2023, Harriet revealed emotional distress from her brother's suicide, which impacted her engagement with services. Despite efforts from the IDVA and Glow, the case was closed without a formal exit assessment or notification to Harriet due to her emotional distress and anxiety related to police matters.

#### **GP Practice**

- 7.1.13 Harriet sought medical attention from her GP for a range of physical and emotional concerns, including:

- Bereavement – Likely related to the loss of her siblings, contributing to her emotional distress.
- Depression – Suggests ongoing mental health struggles, possibly exacerbated by domestic abuse and personal losses.
- Domestic Abuse – Indicates that Harriet disclosed abuse to her GP, demonstrating some level of help-seeking behaviour.
- Physical Complaints – These included chest infections, urinary tract infections (UTIs), and a wrist fracture, which may have been unrelated or potentially linked to stress or physical abuse.

7.1.14 Harriet was referred to the practice Mental Health Practitioner (MHP) for support, but engagement was limited. This reflects a pattern of inconsistent engagement with support services, possibly due to emotional distress, mistrust, or other personal barriers.

### Greater Manchester Police

7.1.15 GMP overlooked risks related to Ian's bail breaches and missing intervention opportunities despite Harriet's reports. Ian's assault in January 2022 prompted a police bail, but enforcement lacked urgency.

7.1.16 A DASH assessment was completed for Ken but not for Harriet, indicating inconsistent victim recognition.

7.1.17 Despite policy updates intended to improve responses to dealing with persons with mental health concerns, GMP did not create care plans for Harriet when mental health concerns were evident; therefore, no onward multi-agency referrals were made.

7.1.18 GMP struggled with timely arrests for bail breaches and lacked coordination with Derbyshire Police, necessitating a more assertive victim-centred approach for handling domestic abuse cases.

## Section Eight: Key Issues Arising from the Review/Lessons Learned

### Response to Disclosures of Domestic Abuse and Holding Perpetrators to Account

8.1.1 GMP arrested Ian and Ken following reports from Harriet of domestic abuse. Both men breached their bail conditions. In April 2022, Ian was arrested for another offence, and the CPS was informed of his previous violations. Ian pleaded guilty and was sentenced, while Ken faced no further action.

8.1.2 In April 2022, updated guidance from the Department of Health and Social Care<sup>13</sup> emphasised the role of health professionals in addressing domestic abuse. Harriet was referred to support services multiple times, but faced challenges with engagement.

8.1.3 To prevent further harm, accountability for perpetrators is crucial, requiring:

- Swift enforcement of bail conditions
- Access to legal representation for victims
- Safe reporting environments for survivors
- Collaboration among justice, health, and social care agencies

8.1.4 These measures are vital for protecting survivors and holding perpetrators accountable.

### **Trio of Vulnerability**

8.1.5 Domestic abuse is part of the "Trio of Vulnerability," which includes personal, situational, and relational risk factors. Personal vulnerabilities can involve mental health issues and low self-esteem, while situational factors may consist of financial dependence and lack of support. Relational vulnerabilities often stem from power imbalances and controlling behaviours.

8.1.6 These vulnerabilities can trap survivors in abusive relationships, making them hesitant to seek help. For instance, Harriet experienced multiple traumas affecting her self-esteem and emotional regulation. Situationally, she relied on financial assistance from Ken while receiving benefits.

8.1.7 Self-harm is commonly linked to domestic abuse,<sup>14</sup> in January 2023, Harriet reported self-harm. Alcohol misuse also features prominently in domestic homicide cases. Understanding the interconnected nature of these factors is vital for effective intervention. Solutions like trauma-informed therapy, financial empowerment, and social reintegration can help survivors regain safety and resilience.

### **Suicide Risk and Domestic Abuse**

8.1.8 Harriet experienced significant loss after both her siblings died by suicide, a risk factor for her mental health. On the day she died, she expressed suicidal thoughts to her neighbour, indicating an urgent need for intervention. Research shows that women who attempt suicide often experience intimate partner violence (IPV), emphasising the need for routine screening and protective measures in healthcare.

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<sup>13</sup> <https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article>

<sup>14</sup> 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.

- 8.1.9 The Derbyshire Mental Health and Suicide Prevention Team is addressing domestic abuse as a key suicide risk factor, launching a forum for collaboration with key agencies.
- 8.1.10 A landmark coroner's inquest in England<sup>15</sup> linked domestic abuse to a woman's suicide, prompting recommendations for increased awareness among first responders and better interagency coordination. Prioritising suicide prevention through early intervention and support services is crucial for survivors of domestic abuse.

### **Cross-County Working and Response to Domestic Abuse**

- 8.1.11 The National Centre for Public Protection (NC4PP) is an initiative within the College of Policing designed to enhance police responses to public protection offences across England and Wales. It aims to centralise guidance, improve operational support, and establish a unified framework for accountability and best practices across police forces and multi-agency partnerships.
- 8.1.12 The NC4PP's key focus is streamlining cross-border responses, which includes managing offenders and victims, enhancing intelligence sharing, and developing coordinated safeguarding measures. The initiative is informed by the Domestic Abuse National Police and Crime Commissioner Lead and the Vulnerability Knowledge and Practice Programme, emphasising improved national standards for addressing domestic abuse and vulnerability.

### **Section Nine: Conclusion**

- 9.1.1 This review highlights the complex interplay of trauma, domestic abuse, mental health struggles, and substance misuse in Harriet's life. From witnessing domestic abuse as a child to experiencing multiple bereavements, she faced profound emotional and psychological challenges that shaped her vulnerability. Despite some efforts from agencies to support her, gaps in communication, intervention, and multi-agency collaboration limited the effectiveness of these responses.
- 9.1.2 Harriet's experiences illustrate the far-reaching consequences of domestic abuse, not only in the immediate risk of harm but also in the long-term impact on mental health, coping mechanisms, and decision-making. The presence of bi-directional abuse in her relationship with Ken further complicated her circumstances, emphasising the need for nuanced responses to domestic abuse cases where multiple vulnerabilities exist.
- 9.1.3 Furthermore, the lack of consistent engagement with services, particularly alcohol misuse and mental health, highlights the critical need for proactive and sustained intervention strategies. While referrals were made, the absence of follow-up and the

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<sup>15</sup> [https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344\\_Published.pdf](https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344_Published.pdf)

reliance on self-referral placed the burden on Harriet, who may have struggled to navigate these systems.

- 9.1.4 Ultimately, Harriet’s case demonstrates the urgent need for a more integrated, trauma-informed, and survivor-centred approach to domestic abuse response. Greater emphasis must be placed on early intervention, cross-agency coordination, and tailored support for individuals facing complex vulnerabilities. By addressing these systemic gaps, agencies can enhance their capacity to identify risks, provide timely interventions, and prevent future tragedies.

## Section Ten: Recommendations

### Individual Recommendations

#### 5.2.1 Greater Manchester Police

1. Officers must 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, as necessary.

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 are 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 by 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.

## **DARDR 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.

- 2.1 All staff from participating agencies should have access to training and resources that focus 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, updating 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, mainly 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.