

# South Ribble Community Safety Partnership

## Domestic Homicide Review

### Overview Report

'Stephanie'

Died October 2020

Chair: Ged McManus  
Author: Carol Ellwood-Clarke  
Supported by: Dan Bettison

Date: August 2022

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## 1 Introduction

- 1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Stephanie<sup>1</sup>, a resident of South Ribble, prior to her death. The panel would like to offer their condolences to Stephanie's family on their tragic loss.
- 1.2 Stephanie was a single woman with two young children and was 33 years old when she took her own life. At the time of her death, Stephanie lived in a property in the Lancashire area, provided by Progress Housing. She had lived there with her youngest child since October 2018. For a short time, her eldest child also lived there with them; however, during the majority of the period under review, Stephanie's oldest child lived with Stephanie's mum in Yorkshire.
- 1.3 Although Stephanie was unemployed, she had made efforts to gain employment and engaged with support from her housing provider for this.
- 1.4 Stephanie lived close to her father and his wife, who she referred to as her step mum.
- 1.5 At the beginning of 2019, Stephanie formed a relationship with Karl<sup>2</sup>. At various points during the period under review, Karl also lived at her address, although this was not always disclosed to relevant agencies.
- 1.6 Karl had previous convictions for violent and dishonest offences. He had previously been subject to statutory orders as a result of abusive behaviour and assault in an intimate relationship.
- 1.7 Within a few months of forming a relationship with Karl, Stephanie was reported as being missing from home, prompting a police investigation to locate her.
- 1.8 During the period under review, Stephanie contacted police on three occasions to report incidents of domestic abuse. During interactions with them, she stated that she had been the victim of similar abuse on several previous occasions, albeit they were not reported. On each occasion, the offender was Karl.
- 1.9 In October 2020, Stephanie took her own life whilst at home. Her youngest child was present in the house at the time.
- 1.10 In addition to agency involvement, this Domestic Homicide Review also examines: the past to identify any relevant background or trail of abuse before Stephanie sadly

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<sup>1</sup> A pseudonym agreed with the victim's family.

<sup>2</sup> A pseudonym chosen from a list of names by the DHR panel.

took her own life; whether support was accessed within the community; and, whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

- 1.11 The review considers agencies' contact and involvement with Stephanie and Karl from 1 January 2019 until Stephanie's death in October 2020. This time period was chosen to ensure that any relevant information from the weeks preceding the beginning of her relationship was gathered. Background information prior to 1 January 2019 is used in the report for context.
- 1.12 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.
- 1.13 **Note:**  
It is not the purpose of this DHR to enquire into how Stephanie died. That is a matter that has already been examined during the coroner's inquest.

## 2 **Timescales**

- 2.1 This review began on 25 June 2021 and was concluded on 2 August 2022. More detailed information on timescales and decision-making is shown at paragraph 5.2

## 3 **Confidentiality**

- 3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including any support worker, during the review process.
- 3.2 Pseudonyms were agreed with the victim's mum to protect the identity of Stephanie, her family, and Karl.

## 4 **Terms of Reference**

### 4.1 The purpose of a DHR is to:

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

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

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

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

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

Highlight good practice.

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

### 4.2 **Timeframe Under Review**

The DHR covers the period 1 January 2019 to Stephanie's death in October 2020.

### 4.3 **Case Specific Terms**

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

Victim: Stephanie, aged 33 years

Stephanie's partner: Karl, aged 27 years

Stephanie's child: Sam, High school age

Stephanie's child: Alex, Primary school age

## Specific Terms

- 1.** What indicators of domestic abuse, including coercive and controlling behaviour<sup>3</sup>, did your agency identify for Stephanie?
- 2.** How did your agency assess the level of risk faced by Stephanie from Karl, and which risk assessment model did you use?
- 3.** What knowledge did your agency have that indicated Stephanie could be at risk of suicide as a result of any coercive and controlling behaviour?
- 4.** Did your agency consider that Stephanie could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?
- 5.** In the context of the family arrangements, what consideration did your agency give to any mental health issues or substance misuse when identifying, assessing and managing risks around domestic abuse?
- 6.** In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?
- 7.** What services did your agency provide for Stephanie; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?
- 8.** How did your agency ascertain the wishes and feelings of Stephanie and Karl about Stephanie's victimisation and Karl's alleged offending, and were their views considered when providing services or support?
- 9.** How effective was inter-agency information sharing (including with agencies providing services to Alex) and cooperation in response to Stephanie and her family (including Karl), and was information shared with those agencies who needed it?

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<sup>3</sup> The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

- 10.** Was there sufficient focus on reducing the impact of Karl's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?
- 11.** Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice, and were any gaps identified?
- 12.** What knowledge did family, friends and employers have that Stephanie was in an abusive relationship, and did they know what to do with that knowledge?
- 13.** Were there any examples of outstanding or innovative practice?
- 14.** What learning did your agency identify in this case?

## 5 **Methodology**

- 5.1 On 16 November 2020, South Ribble Community Safety Partnership agreed that the circumstances of the case met the criteria for a Domestic Homicide Review to be conducted (para 18 Statutory Home Office Guidance)<sup>4</sup>. The Home Office was informed on 19 November 2020.
- 5.2 The first meeting of the DHR panel took place on 25 June 2021. There was a delay in the review commencing due to the Covid-19 pandemic. Meetings took place using Microsoft Teams video conferencing, and the panel met seven times. Outside of meetings, issues were resolved by emails and the exchange of documents. The final panel meeting took place on 22 March 2022 – after this, minor amendments were made to the report, which were agreed with the panel by email.
- 5.3 The report was then shared with the victim's mum, who was supported by an AAFDA advocate. Minor amendments were made to the report to ensure factual accuracy. The report was also shared with the victim's stepmother, whose input is

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<sup>4</sup> Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it merges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

also reflected in the report. The process of family consultation was extended in order to allow both sides of the family sufficient time to read the report – logistical issues meant that additional time was needed in order to arrange meetings

## **6 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community**

### **6.1 Family**

6.1.1 The DHR Chair wrote separately to Stephanie’s parents, inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families and the Advocacy After Fatal Domestic Abuse (AAFDA)<sup>5</sup> leaflet.

6.1.2 Stephanie’s mum replied to the Chair and agreed that she wished to be involved. The Chair also outlined support available through AAFDA: this was something she agreed was appropriate and accepted. The Chair of the review met with Stephanie’s mum at her home, where she was supported by an AAFDA advocate.

6.1.3 Stephanie’s stepmum also replied to the Chair, and agreed to speak on behalf of her husband, Stephanie’s father. She did not think that she needed advocacy support, although it was offered. The Chair met with Stephanie’s stepmum by Microsoft Teams video conferencing and follow-up telephone calls.

The Chair met with Stephanie’s eldest child, who was supported by an AAFDA advocate. Information provided during the contact has been included in the report where relevant.

6.1.4 Stephanie’s mum and stepmum were able to provide background information which was not known to the review – it is presented here but also used to inform other sections of the report.

6.1.5 Stephanie was brought up by her father: having not lived with her mum since she was around eighteen months old. Stephanie moved to Yorkshire to live with her mum when she left school and obtained employment as a dental nurse.

6.1.6 When Stephanie gave birth to her eldest child, Sam, she was 17 years old. When born, the child was immediately very unwell and spent the first four years of their life mainly in hospital. Sam’s father has not had contact with the child.

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<sup>5</sup> Advocacy After Fatal Domestic Abuse (AAFDA) [www.aafda.org.uk](http://www.aafda.org.uk)

6.1.7 When Sam was first born, Stephanie would divide her time between living with her mum in Yorkshire and father in Lancashire. She rented houses in the private sector, and after a couple of years, Stephanie secured her own home through a housing association in Yorkshire; however, she continued to divide her time between both areas. Both parents would often care for Sam so that Stephanie could go out and maintain her network of friends and still live her life as a young woman. Sam told the Chair that the reason for them having lived for some of their childhood with grandparents was due to the medical care that was needed – this was more established in Yorkshire. Furthermore, it was not until they were older that they moved to South Ribble to live with their mother.

6.1.8 During this time, Stephanie also studied and obtained a law degree, as she wanted to be a solicitor. She formed another relationship and had her second child, Alex. She later decided to move back to Lancashire, with her children, after the break-up of the relationship with Alex's father. She was described as a beautiful, bright young woman, who was an amazing mum.

6.1.9 Family explained that despite Stephanie being the victim of domestic abuse with a number of previous partners, she never sought help. They believed that she would not have wanted any help from anyone. They expressed the opinion that agencies can only help to protect someone if they want to be protected, which in their opinion, Stephanie did not.

## 6.2 **Karl**

6.2.1 The DHR Chair made contact with Karl through his offender manager, in an attempt to offer an opportunity for him to contribute to the DHR. He chose not to have any involvement.

## 6.3 **Friends**

6.3.1 Through Lancashire Constabulary, the Chair was able to read original statements provided by a number of Stephanie's friends. One friend did agree to speak with the Chair personally.

6.3.2 Although the statements predominantly related to the events immediately prior to Stephanie's death, they did also provide an insight into her relationship with Karl. The information provided by Stephanie's friends was invaluable and was used to present important content within the background section of this report.

## 6.4 **Employer**

6.4.1 Stephanie was not in employment at the time of her death. Details about Stephanie's previous employment are covered at 13.1.5.

## 7 **Contributors to the Review / Agencies Submitting IMRs<sup>6</sup>**

7.1.1	<b>Agency</b>	<b>Contribution</b>
	Victim Support	IMR
	CCG – on behalf of Primary Care	IMR
	Lancashire Teaching Hospitals NHS Foundation Trust	IMR
	Probation Service	IMR
	Lancashire Constabulary	IMR
	Virgin Care	IMR
	Children's Social Care	IMR
	GTD	Chronology
	Progress Housing Group	Chronology
7.1.2	In addition to the IMRs, each agency provided a chronology of interaction with Stephanie and Karl, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR), and whether internal procedures had been followed and if, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Stephanie or Karl, nor had any involvement in the provision of services to them.	
7.1.3	The IMR should include a comprehensive chronology that charts the involvement of the agency with the subjects of the review over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Stephanie and Karl; and any other action taken.	

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<sup>6</sup> Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Stephanie, her children and/or the perpetrator.

- 7.1.4 It should also provide: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.
- 7.1.5 Each homicide may have specific issues that require exploration, and each IMR should carefully consider the individual case and how best to structure the review in light of the particular circumstances.
- 7.1.6 The IMRs in this case were of good quality and focussed on the issues facing Stephanie. They were quality assured by the original author, the respective agency, and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation. Where an IMR did not contain sufficient detail, additional information and clarity was sought during panel meetings, and checked against chronology documents.

## 7.2 **Information About Agencies Contributing to the Review**

### 7.2.1 **Victim Support**

Victim Support is the commissioned provider of support services for victims of crime in Lancashire. Victim Support provides practical and emotional support to any victim of crime, regardless of whether they have reported it to the police or not. This includes specialised support for victims of domestic violence, sexual assault, hate crime, and children and young people.

### 7.2.2 **NHS Chorley and South Ribble CCG**

Clinical commissioning groups (CCGs) were created following the Health and Social Care Act in 2012: they replaced primary care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area, including the majority of the hospital and community NHS services. NHS Chorley and South Ribble CCG is made up of 30 GP practices, who care for just under 189,000 patients (June 2020). The majority live in the districts of Chorley and South Ribble, with the remaining patients mainly coming from the districts of West Lancashire, Bolton, Preston and Wigan.

### 7.2.3 **Progress Housing Group**

Progress Housing Group are a not-for-profit housing provider who own and manage over 10,000 homes: operating mainly in Lancashire but also offering supported

living services nationwide, as well as delivering key worker accommodation in Lincolnshire.

#### **7.2.4 Lancashire Teaching Hospitals NHS Foundation Trust**

The Trust provides a wide range of general hospital services to 370,000 people from the Chorley, South Ribble and Preston areas, and several specialist services to around 1.5 million people from Lancashire and South Cumbria. Working together with other health services, local authority and private sector colleagues, the Trust aims to provide joined-up services that meet holistic health and social care needs.

#### **7.2.5 Probation Service**

The Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community.

#### **7.2.6 Lancashire Constabulary**

Lancashire Constabulary is a large organisation with 5,400 police officers and members of staff covering around 2,000 square miles.

The county is split into three main policing areas, known as Basic Command Units. Each Basic Command Unit (BCU) is run by a Chief Superintendent, known as the BCU Commander. Under each BCU Commander sits the local neighbourhood policing teams: these are supported by a range of other specialist departments.

#### **7.2.7 Virgin Care**

Virgin Care provides health visiting and school nursing across Lancashire, including Lancashire Healthy Young People and Families Service, in partnership with Lancashire County Council.

#### **7.2.8 Lancashire Children's Social Care**

Children's Social Care has a duty to protect children and young people from harm caused by neglect or abuse. This includes investigating any allegations that a child might be being neglected or abused, and if necessary, taking appropriate action to protect the child.

Children's Social Care support can provide help to children and their parents if the child:

- needs support with maintaining their health or development
- has a disability
- is in need of protection
- is fostered, adopted or lives in residential care.

### 7.2.9 **GTD Healthcare**

GTD Healthcare (GTD) is a not-for-profit provider of primary and urgent care services. GTD was established as a GP out-of-hours provider in Oldham and Tameside & Glossop in 1997 and has since grown to provide a range of scheduled and urgent primary care services across parts of Greater Manchester, Liverpool and Lancashire. The headquarters and clinical hub of the organisation are based in Denton in Manchester.

In 2016, GTD was awarded the contract for the provision of an Integrated Urgent Care Service (IUCS) for Preston and Chorley and South Ribble CCG. The service commenced in November 2016 and consists of:

- The traditional GP Out of Hours service, i.e. provision of advice and treatment when the patient's own GP practice is closed for patients who have contacted NHS 111. Patients call NHS 111 and if, following their assessment, it is deemed they need further clinical input either by telephone or face to face, the case is electronically transferred to our clinical hub based in Denton. A review is undertaken by a GTD clinician, which may be a GP, Advanced Practitioner, pharmacist or clinical assessor. Patients are then provided with self-care advice, given an appointment, receive a home visit, or are referred to secondary care. Following assessment, those patients going on to receive further care are provided with a specific call-back telephone number to contact us should there be a change in their condition. These calls are initially managed by our care-coordinators (non-clinical staff) who can provide status updates to the patients or escalate any concerns to clinical staff.
- The community DVT service which receives referrals from Preston and Chorley GPs.
- GP/Clinical element of the Patient Alternative to Transfer Service (PATS) and Acute Patient Assessment Service (APAS) with Northwest Ambulance Service (NWS). With the PATS service where patients have contacted 999 and, following an assessment by a paramedic on scene, it has determined that they may not require conveyance to hospital but can receive further clinical and advice

and management in primary care, the patient's care is transferred to GTD. For APAS, the service provides additional clinical input where a patient has contacted 999 and, following assessment by NWAS, they are categorised as a category 3 or 4 where primary care management can be considered so the cases are passed to GTD for clinical review.

- Two 24/7 Urgent Care Centres (UCCs), co-located within Lancashire Teaching Hospitals NHS Trust, Emergency Departments (ED) in Royal Preston Hospital and Chorley & South Ribble Hospitals. Patients are able to self-present at either UCC, or are booked an appointment following contact with NHS 111 (direct booking from NHS 111 or following further assessment at our clinical hub). On attendance, patients are assessed by a clinician (GP, Advanced Practitioner, Urgent Care Practitioner, dependent on their presenting condition) and provided with appropriate treatment and management, e.g. advice, provision of medication, referral to other specialties. On completion of the episode of care, a copy of the patient's clinical record is sent electronically to the patient's own GP by 8 am the following morning to ensure continuity of record-keeping.
- Direct calls from healthcare professionals, e.g. paramedics, district nurses, care home staff, who require a primary care opinion for their patient. These calls are received during the daytime and out-of-hours periods.

## 8 **The Review Panel Members**

8.1	Ged McManus	Chair
	Carol Ellwood-Clarke	Author
	Dan Bettison	Support to Chair and Author
	Susan Clarkson	Named Nurse Safeguarding Children, 0-19 Services
	Heather Corson	Community Safety and Safeguarding Manager, South Ribble Borough Council
	Claire Powell	Lancashire and Cumbria Victim Support

Dawn Swards	GTD Director of Governance and Adults Safeguarding Lead
Paula McDonald	Housing Needs Officer, South Ribble Borough Council
Rachel Holyhead	Named Nurse for Safeguarding Adults, Lancashire Teaching Hospitals
Ausra Pilitauskaite	Practice Manager, MASH Team Children's Social Care, Lancashire County Council
Helene Cooper	Policy, Information and Commissioning Manager, Lancashire County Council
Kristy Atkinson	Deputy Designated Professional for Safeguarding Adults and Mental Capacity Act
Tola Adesemowo	Head of Operations (Income and Communities) at Progress Housing Group
Kelly Mayall	Operation Safeguarding Manager, GTD Healthcare
Elaine Seed	Head of Central Lancashire Probation Delivery Unit
Garry Fishwick	Review Officer and Investigator, Lancashire Constabulary
Justine Green	Community Safety & Safeguarding Officer, South Ribble Borough Council

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

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

- 9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors.
- 9.2 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adults Reviews. He was judged to have the skills and experience for the role. Prior to leaving policing in 2016 he was a superintendent with particular responsibility for partnerships. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Lancashire or an adjoining authority). He has completed accredited training for DHR chairs provided by AAFDA.
- 9.3 Carol Ellwood-Clarke was the DHR Author. She retired from public service (British policing – not in Lancashire) during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives<sup>7</sup>. Carol has completed accredited training for DHR chairs provided by AAFDA.
- 9.4 Both practitioners served for over thirty years in different police services (not Lancashire) in England. Neither of them has previously worked for any agency involved in this review.
- 9.5 They were supported in their roles by Dan Bettison. Following a career in policing, (not Lancashire), he is now an independent practitioner and consults within mental health services, education and Children’s Social Care. He is an Associate Trainer for the College of Policing and an Associate Inspector for Her Majesty’s Inspectorate of Constabulary. He has completed accredited training for DHR chairs, provided by AAFDA, and has supported colleagues on numerous DHRs.

## 10 **Parallel Reviews**

- 10.1 An inquest was held on 16 March 2021.

The medical cause of death was hanging.

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<sup>7</sup> <https://safelives.org.uk/>

The circumstances recorded were: Stephanie died on [date redacted] at her home, having suspended herself by the neck

The coroner's conclusion, as to death, was suicide.

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

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

## 11 **Equality and Diversity**

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

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

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

Section 6 of the Act defines ‘disability’ as:

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

- 11.2 During the period under review, on one occasion, police officers recorded that Stephanie may have been suffering with poor mental health. No onward referrals were made, and no professional assessment was conducted. Stephanie had no long-term health conditions and was not considered to be disabled within the meaning or context of the Equality Act 2010.
- 11.3 On three occasions during the period under review, Stephanie was pregnant. Medical records revealed that all pregnancies ended following either miscarriage or medical termination. At the time of each reported pregnancy, it is believed that Stephanie was in a relationship with Karl.
- 11.4 The panel was mindful of the sensitivities surrounding this area and considered whether it should be included. However, considering that pregnancy early in a

relationship is widely considered to be an indicator of coercive and controlling behaviour within a relationship, the panel thought it was relevant and needed to be included to accurately reflect her relationship with Karl.

- 11.5 The following research by Women’s Aid was considered and supported the panel’s decision to include this within the report:

*‘Control over pregnancy itself can also be used as a tool of abuse – this form of coercive control is called reproductive control. For example the abuser may remove or tamper with contraceptives, or deny access to family planning or emergency contraception. This is because an abuser can use a woman’s pregnancy as a way of increasing her dependency and intensifying their control over her. Women who experience domestic abuse report a higher than average rate of unintended pregnancy. Risks of both unintended pregnancy<sup>8</sup> and domestic abuse during pregnancy are higher for younger and teenage women. Pregnant women find it harder to leave, particularly because of concerns about finance and housing.’*

*‘Prevalence studies suggest that between 20% and 30% of women will experience physical violence at the hands of a partner/ex-partner during pregnancy. About 36% of women report verbal abuse, 14% severe physical violence and approximately 20% of pregnant women reported sexual violence. For many women, domestic abuse begins in pregnancy, while for others it escalates in terms of frequency and severity of violence.’<sup>9</sup>*

- 11.6 There is evidence throughout the review that Stephanie and Karl drank alcohol and used illicit drugs. However, there is nothing to suggest that they were dependant on either and nothing to suggest that either were a contributory factor in terms of Stephanie’s ability to deal with day-to-day life.

- 11.7 Although drug and alcohol levels for Karl at the time of Stephanie’s death are not known, he did have a history of alcohol and drug use: these were considered contributory factors during previous criminal offending prior to meeting Stephanie.

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<sup>8</sup> Maxwell, L. et al. (2018) Intimate partner violence and pregnancy spacing: results from a meta-analysis of individual participant time-to-event data from 29 low-and-middle-income countries. *BMJ Glob. Heal.* 3, e000304

<sup>9</sup> <https://www.womensaid.org.uk/wp-content/uploads/2019/12/Supporting-women-and-babies-after-domestic-abuse.pdf>

- 11.8 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.
- 11.9 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.
- 11.10 All subjects of the review are white British. At the time of the review, they were living in an area which is predominantly of the same demographic and culture. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.
- 11.11 Domestic homicide, and domestic abuse in particular, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

‘There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner’.

‘Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)’.

‘Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)’.

Whilst Stephanie’s death was not as a result of homicide, the above statistics show the prevalence of domestic abuse linked to domestic homicide.

## 12 **Dissemination**

Stephanie's family  
Home Office  
South Ribble Community Safety Partnership  
Lancashire Constabulary and Crime Commissioner  
Domestic Abuse Commissioner  
All Agencies contributing to this Review

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

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

### 13.1 **Relevant History**

13.1.1 Family explained that throughout her life, Stephanie had relationships with partners who used drugs, including cocaine. They described how they did not approve of several of her partners and described them as being '*a challenge*'. There was an incident when Sam was around four or five years old when Stephanie went to Spain for six weeks with her partner, a male from Liverpool. Family were later made aware of a number of incidents that occurred whilst she was away, including her being locked in a hotel room by her partner: he was subsequently arrested. Stephanie flew home separately from him and although the family explained that there was police involvement when she arrived back in the UK, the panel was unable to confirm this.

13.1.2 Family described an incident which took place when Sam was around 12 years old. Stephanie and her partner had a violent confrontation within Sam's bedroom, resulting in her partner receiving injuries. Following this incident, Sam moved to live with Stephanie's mum in Yorkshire. The matter was reported to the police.

Sam described to the Chair an incident where Stephanie's then partner threatened her with a pair of scissors. This resulted in some people coming to the house and assaulting the partner: this left blood on the walls, which Sam then cleaned.

- 13.1.3 Family described how throughout Stephanie's life, generally her partners did not treat her well, with the exception of Alex's father. Stephanie ended that relationship after around three years and decided to move to Lancashire, with Alex.
- 13.1.4 In the couple of years before Stephanie died, family reported a distinct change in her behaviour. The family described how Stephanie became distant from her mum, who formed the impression that Stephanie was hiding things from her. Stephanie's appearance had deteriorated, and her mum felt that Stephanie was deliberately avoiding seeing her, as she knew that she would identify the changes and would challenge why. The relationship between Stephanie and her mum became strained and centred almost solely around the care for Sam.
- 13.1.5 Stephanie had a job working for a pharmaceutical company and was given a role in charge of the warehouse. She was good with accounts, was well thought of and respected. When Stephanie began a relationship with Karl, her work began to decline. She would arrive late or take extra time at lunch, and regularly be on her phone. Initially, Stephanie denied that she was in a relationship with anyone but eventually admitted that Karl was her partner. She was spoken to about her performance at work and was eventually told to leave the role.
- 13.1.6 Stephanie spoke with family about her efforts to seek information about Karl through the Domestic Violence Disclosure Scheme (Clare's Law)<sup>10</sup>. She did not fully progress this as she felt that Karl had told her everything she needed to know – including the fact that a previous assault by him on a former partner resulted in her receiving a fractured bone, which he claimed occurred accidentally.
- 13.1.7 Sam told the Chair that Karl appeared in their lives after they moved to the second house in South Ribble. The house move was in October 2018 and other relatives have suggested the start of the relationship was in was in early 2019. Karl just appeared in the house one day and gradually spent more time there. Karl was never really introduced. Sam stated that they spent most of the time in their room, gaming online with friends and did not have much to do with Karl. Sam stated that they were aware that there were drugs around as they had seen traces of drugs and a cannabis grinder, and that Karl had three 'burner' phones, which Sam thought strange.

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<sup>10</sup> <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet>

Sam stated that they were aware that their mum and Karl argued a lot and sometimes it got physical, and that whilst they did not see any physical violence, they had seen a bruise on their mum's arm, which they thought Karl had caused.

Sam described one incident, when they were in the house alone, when the windows were damaged. The matter was reported to the police. Sam told the Chair that they made the decision that they did not want to be involved with the arguments and violence between their mum and Karl, and so moved back to live with grandparents, occasionally returning to stay for a few days to see their mother and Alex.

- 13.1.8 Stephanie's friends and family described that from the moment she met Karl, it was clear that their relationship was volatile. On occasions, they witnessed incidents where Stephanie was physically assaulted by Karl, and often she would reveal injuries sustained during abuse from him. They described how Stephanie appeared to be in a dilemma when pregnant. She explained that although she loved Karl, she was not sure that to have a child with him was *'the right thing to do.'*

Stephanie's friends described an obvious decline in her physical and emotional wellbeing over the last six months of her life. She had always been someone who took pride in her physical appearance, but this declined. She appeared to leave her home less frequently, with Karl often taking Alex to school.

- 13.1.9 The night before Stephanie was found deceased, family explained that they had looked after Alex following school and had arranged for Stephanie to collect Alex at 20.00hrs. When Stephanie collected Alex, she was with Karl. They had both been drinking alcohol and the family described Karl as looking very 'shifty'. On two separate occasions later that evening, Stephanie's father received calls to say that Karl and Stephanie were fighting. He went to the house and told Karl to leave.

- 13.1.10 Following Stephanie's death, Alex described to family how they had found mum and kissed her twice, and that they had tried to get help, shouting out of the window. Family assumed from the way in which Alex explained the incident, that Alex found Stephanie deceased. When help did not come, Alex went to their bedroom to play on their iPad until Karl arrived.

- 13.1.11 Stephanie and Karl had spoken about marriage and having a child together. She described him as *'the one'*.

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

Within the timeframe of the DHR Terms of Reference, the following paragraphs summarise the issues affecting Stephanie that the panel felt were most relevant.

- 13.2.1 During the early part of 2019, Stephanie began a relationship with Karl. The exact date is not known to the panel.
- 13.2.2 On 14 February 2019, Stephanie contacted GTD healthcare and was provided telephone advice regarding severe head and ear pain. The doctor diagnosed a possible perforated ear drum and, as she was unable to attend a physical appointment immediately, advised her to contact her GP the following day.
- 13.2.3 On 17 April 2019, Stephanie attended the urgent care centre reporting foot and leg pain. She was unable to fully weight bear and reported previous bruising on her leg and swelling to her foot. Doctors could not rule out bone injury and referred her to the fracture clinic. Stephanie did not attend follow-up appointments and was discharged.
- 13.2.4 On 27 April 2019, Stephanie had a telephone consultation with a GTD doctor and was subsequently referred to Gynecology.
- 13.2.5 On 21 July 2019, Stephanie reported to police that she had received threatening text messages from another female who had previously been a friend. The messages were followed up by intimidating telephone calls from the female, threatening to stab her in the neck on the school run. The police took action to prevent an altercation.
- 13.2.6 On 29 July 2019, Stephanie called Progress Housing to make an agreement to pay her rent and stated that she needed to move house due to her son's medical needs.
- 13.2.7 On 3 August 2019, Stephanie was reported missing from home. She had informed a friend that she intended ending her life and stated that she had been '*dragged from railway lines*' earlier that day. A high-risk missing person investigation was commenced by Lancashire Constabulary and Stephanie was located later that day. Police reported that Stephanie was suffering with mental ill health. The review has seen no evidence of previous mental health issues.
- 13.2.8 On 9 October 2019, Karl attended the emergency department accompanied by Stephanie. He reported a punch injury to his right hand sustained the previous day

whilst play fighting with his brother. Swelling was noted and an X-ray revealed a fracture. He was treated and referred to the fracture clinic.

- 13.2.9 On 14 October 2019, Stephanie attended the emergency department and was admitted for post pregnancy related treatment. She self-discharged three days later.
- 13.2.10 On 18 October 2019, Stephanie electronically submitted a rehousing application. Further discussion with Progress Housing suggested that she needed a larger property with a suitable sterile room for her older child, who was at that stage living with her. She also stated that she did not feel safe at the property after recent incidents of criminal damage. She did, however, explain that the criminal damage incidents were not aimed directly at her: they were due to a friend staying briefly at her address.
- 13.2.11 On 23 October 2019, Stephanie attended the emergency department regarding an injury to a finger on her right hand. She stated that she sustained a laceration from a broken bowl. She was treated and discharged.
- 13.2.12 On 8 November 2019, Karl failed to attend a planned appointment with his probation offender manager. He was issued with a 'breach letter', which was sent on 12 November 2019. Until that stage, his attendance had been largely good, but there were now several failed appointments.
- 13.2.13 On 24 November 2019, Lancashire Constabulary received an emergency 999 call from Stephanie, reporting that she had been assaulted by Karl. She alleged that they had been on a night out when they began to argue, and Karl had thrown her to the floor and tried to strangle her. She stated that he had done this to her before and had done the same to a previous girlfriend. Stephanie informed police that she had been going out with Karl for about four months and described him as being very controlling – stating that he pulled her hair and spat in her face. Police attended the address, although Karl had already left. He was not arrested at the time and the police officer was later instructed to submit a crime report for coercive and controlling behaviour. The officer submitted a crime report for an assault and not coercive and controlling behaviour. This is covered in Section 14.
- 13.2.14 On 25 November 2019, Victim Support received a referral from Lancashire Constabulary following Stephanie being assaulted by Karl. They made three attempts to contact her, but she did not reply to their calls and, as such, the case was closed.

- 13.2.15 On 28 November, police undertook a disclosure under the Domestic Violence Disclosure Scheme (Clare's Law) to Stephanie, in respect of Karl.
- 13.2.16 At some point in December 2019, Sam returned to live with Stephanie's mum in Yorkshire.
- 13.2.17 On 6 December 2019, Progress Housing spoke with Stephanie, who requested she be moved as she did not feel safe in her property. She stated that she needed to *"get her family out of there"*. Progress Housing encouraged Stephanie to continue reporting any incidents of anti-social behaviour and, in the meantime, continue bidding on suitable properties.
- 13.2.18 In the early hours of 27 December 2019, Lancashire Constabulary received a 999 telephone call from Stephanie reporting that she had been assaulted by her partner, Karl. She reported that during the afternoon of Boxing Day, they went into a Lancashire town centre together and visited various pubs, in between visiting relatives. As they were walking home in the early hours, an argument began, with Karl demanding to know who Stephanie had been contacting on social media. Stephanie described Karl as being intoxicated and stated that when they arrived home, he grabbed her hair by her ponytail before pushing her over causing her to hit her head on the kitchen table. He then grabbed her with one hand around her throat and began to strangle her until she could not breathe. Stephanie described that he eventually let go and began to apologise before leaving the address. When he returned to the address a short time later, Stephanie contacted police and reported the incident: she described her injuries as being a sore and tender neck and scratch marks. She told officers that she felt she had nearly died. Police attended and Karl was arrested nearby.
- 13.2.19 Following Karl's arrest, Stephanie disclosed to police that she had also been assaulted by Karl on the morning of 22 December 2019, but this was not reported to police at the time. On that occasion, Stephanie reported that an argument had begun in the kitchen during which Karl had pulled her hair, grabbed her by her throat, and head butted her. She stated that she had photographed her injuries from the earlier incident.
- 13.2.20 Following the incident on 27 December, Victim Support received a referral via the MASH<sup>11</sup> for high-risk domestic violence. They engaged with Stephanie and agreed a support plan with her. During engagement, Stephanie outlined concerns regarding an insecure window at her address. She stated that Karl had previously entered her property through a rear window, and she had found him in her bed.

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<sup>11</sup> Multi Agency Safeguarding Hub

- 13.2.21 On 6 January 2020, Stephanie attended the emergency department complaining of headache. She reported a head injury from the previous week, with brief loss of consciousness. Hospital records suggest the injury was due to a fall. She was treated and discharged.
- 13.2.22 On 7 January 2020, Karl appeared before Preston Magistrates and was given the following bail conditions by the court:
1. Live and sAexp at [address redacted].
  2. Not to contact Stephanie directly or indirectly.
  3. Not to enter [address redacted], Lancashire
  4. Report to Preston Police Station between 17.00hrs and 21.00hrs on every Monday, Wednesday and Friday.
- 13.2.23 On 20 January 2020, Lancashire Constabulary met with Stephanie and undertook a disclosure under the Domestic Violence Disclosure Scheme, in relation to previous incidents of violence and domestic abuse committed by Karl. Lancashire Constabulary shared this information with an IDVA.
- 13.2.24 On 22 January 2020, the domestic abuse incidents in November and December 2019 were discussed at South Ribble MARAC. The discussion identified risks as:
- 'Verbal argument, toxic relationship, and referred to a child with a complex medical issue' (Stephanie's son).*
- 13.2.25 On 3 February 2020, police received a telephone call from Stephanie reporting that she had been assaulted by Karl. She stated that he had been telephoning and texting her to apologise and asked her to stop the court case against him. Stephanie stated that he informed her that if other witnesses gave evidence at court, he would terrorise them. She stated that he was still trying to control her and that he had grabbed her around the throat before running off prior to police arrival.
- 13.2.26 On 5 February 2020, Karl was arrested for breach of court bail and witness intimidation, following his contacts with Stephanie. He was charged with both offences and another assault against her on 19 January 2020, during which Stephanie was strangled. Karl remained in custody to appear at Preston Magistrates the following day.
- 13.2.27 On 26 March 2020, Karl was bailed from prison with the following conditions:

- GPS monitoring tag
- Exclusion zone
- To reside at dad's address.

- 13.2.28 On 11 May 2020, Karl contacted South Ribble Housing. He was informed that he was ineligible for housing – he claimed to be staying with friends so didn't need homeless assistance.
- 13.2.29 On 12 June 2020, Stephanie self-referred herself to LTHFT for maternity care. However, on 29 June, records show that antenatal care was cancelled after Stephanie miscarried.
- 13.2.30 On 15 June 2020, Stephanie amended her Progress Housing application. She indicated that her child was no longer living with her and her partner, Karl. She also stated that she was pregnant.
- 13.2.31 On 17 July 2020, the case of Witness Intimidation was placed back before the Magistrates and was dismissed. It is recorded that this was due to evidential difficulties.
- 13.2.32 On 13 August 2020, following a notification to Lancashire Constabulary from EMS<sup>12</sup> – the electronic monitoring company – that Karl was in breach of bail, he was arrested and placed before the court. He was released with the same bail conditions.
- 13.2.33 On 2 September 2020, the electronic monitoring equipment which Karl was fitted with, failed due to him not charging the battery. This was reported to Lancashire Constabulary as a breach of bail. No action was taken. Section 14 of the report covers analysis regarding further notification by EMS of breach of bail.
- 13.2.34 On 28 September 2020, Stephanie attended GTD at Chorley Hospital, reporting a sprain to her knee and a foreign body on the external eye.
- 13.2.35 On 2 October 2020, Stephanie's rehousing application was closed down due to rent arrears on her rent account.
- 13.2.36 On a date later in October 2020, Stephanie contacted a friend and informed them that she was upset as she and Karl had been arguing and he had tried to strangle her. She became more upset and informed the friend that she was going to kill

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<sup>12</sup> EMS is a trading name of Capita Business Services Limited.

herself. Her friend attended and saw Karl strangling Stephanie. Stephanie's father was informed and attended the address, ensuring that Karl left.

- 13.2.37 Later that evening, Stephanie contacted another friend by text message, stating: 'I NEED YOUR HELP'. A telephone call took place between the two in which Stephanie whispered: 'HELP ME'. The friend telephoned Stephanie's father who went to his daughter's address for a second time: he asked Karl to leave.
- 13.2.38 At 23.01hrs, the same friend received a message from Stephanie inferring that she was sat with a noose around her neck. The friend immediately attended her home and saw that she was safe and well and that she had not self-harmed.
- 13.2.39 On a date in October 2020, police received an emergency call from Stephanie's father, reporting that he had found his daughter deceased at the bottom of the stairs in her home. He stated that he had been alerted by Karl who informed him that he had visited Stephanie around 08.00hrs but could not get a reply. Karl informed him that he had climbed into the house and discovered Stephanie at the top of the stairs with a noose around her neck. He carried her downstairs and placed her at the bottom of the stairs before alerting her father.
- 13.2.40 Lancashire Constabulary secured the scene and opened an initial homicide investigation. Karl was arrested and interviewed under caution.
- 13.2.41 Further investigation of the scene was conducted and the full circumstances leading up to the death were considered, along with the results of a Home Office post-mortem. It was established that there was no third-party involvement in Stephanie's death.
- 13.2.42 Following the death of Stephanie, Karl appeared at Preston Crown Court on 17 March 2021, where he pleaded guilty to two offences of S.39 Assault on Stephanie for offences on 22 December and 27 December 2019. He was sentenced on this date and received a 2-year Community Order, a Rehabilitation Activity Requirement for 20 days, a Programme Requirement, and was ordered to pay a victim surcharge of £90. The following offences were left to lie on file:

Assault by beating – 24 November 2019

Assault by beating – 19 January 2020

Pervert the Course of Justice – Between 1 January 2020 – 9 January 2020.

Stephanie's family had been notified and involved in the decision-making regarding progression of the above matters.

## 14 **Analysis**

### 14.1 **What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Stephanie?**

14.1.1 The first reported incident of domestic abuse, within the review period, occurred on 24 November 2019. Stephanie reported to police that she had been assaulted by Karl, during which he had thrown her to the floor and attempted to strangle her.

Stephanie stated that she had been in a relationship with Karl for four months, and he was very controlling. Stephanie reported that he had assaulted her previously, but those assaults had not been reported to the police.

14.1.2 Stephanie did not provide a witness statement and did not support any further investigation at that time. However, there was evidence of an offence of coercive and controlling behaviour committed by Karl.

14.1.3 The attending officers were Special Constables<sup>13</sup> led by a Special Sergeant, who completed a DASH<sup>14</sup> risk assessment in which coercive and controlling behaviour was described by Stephanie. The officer graded the DASH as medium risk. The panel discussed whether it should have been graded as high risk, given that indicators recorded included strangulation, increase in frequency of abuse, coercion and control, recent prison release, and domestic abuse against a previous partner.

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<sup>13</sup> Voluntary officers with the same powers as regular officers, under the command of regular senior officers and with their own rank structure.

<sup>14</sup> The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

The panel was unable to come to a positive conclusion but agreed that the officers would have assessed the level of risk on the information presented to them and in accordance with their knowledge and understanding of domestic abuse. The panel was provided with details of the domestic abuse training provided by Lancashire Constabulary to Special Constables. [See 14.2.5].

The panel agreed that had the DASH been graded as high risk then a referral to MARAC would have been made. The panel was informed by the panel member from Children's Social Care, that regardless of the grading, the response from Children's Social Care would not have been any different as Stephanie had informed the MASH social worker that she had ended the relationship with Karl, and that Alex had not been present during the abuse – this would have resulted in no further involvement at that stage from Children's Social Care.

- 14.1.4 The police sergeant from the Investigation Management Unit instructed the attending officers to submit a crime report for coercive and controlling behaviour. However, the Special Sergeant did not do this and submitted a crime report for an offence of assault, subsequently creating a domestic abuse investigation on the Lancashire Constabulary 'CONNECT' I.T. system. The panel was clear in their views that two crime reports should have been created – one for the assault, and the second for the offence of coercive and controlling behaviour.
- 14.1.5 Lancashire Constabulary do not allocate Special Constables with a workload for investigation; therefore, the investigation was allocated to a 'regular' police officer. The review panel was informed that it is likely that the Special Constable did not pick up the instruction on the investigation in relation to the crime recording. There was no further investigation in relation to the offences that had occurred. Karl was not arrested or spoken to at that time, but he was later summonsed; however, the case was subsequently withdrawn from court following the death of Stephanie.
- 14.1.6 The DASH submitted following this incident included recommendations to share details with Children's Social Care and the IDVA service. The DASH was not shared with the IDVA service. The panel sought clarification from Lancashire Constabulary in relation to the referrals processes to agencies within the MASH. The panel was assured that since this case, there has been a change and restructure within the MASH, including a review of the information sharing protocol. The panel was satisfied that this area of learning has been addressed and has therefore not made a recommendation. [See Term 9].

- 14.1.7 A further incident of domestic abuse was reported by Stephanie on 27 December 2019, during which she disclosed a further unreported incident of assault that took place on 22 December 2019.
- 14.1.8 In both cases, it was recognised that Karl had attempted to strangle Stephanie, pulled her hair, and head butted her. Stephanie had taken photographs of her injuries sustained during the earlier assault on 22 December.
- 14.1.9 Karl was arrested on this occasion and was later charged with common assault in relation to both incidents in December.
- 14.1.10 The panel was informed that the attending officer did not view or consider the DASH from the incident the previous month and did not consider coercive and controlling behaviour when dealing with the incident.
- 14.1.11 The panel was informed that there was evidence of an offence of coercive and controlling behaviour under the provision of the Serious Crime Act 2015. However, despite that behaviour being well evidenced within the DASH, it was not appropriately highlighted within Stephanie's statement or submissions to the Crown Prosecution Service and, as such, the offence was not considered by the Crown Prosecution Service when they authorised charges of assault.
- 14.1.12 Lancashire Constabulary have identified this as an area of learning and made a single agency recommendation to respond to the learning.
- 14.1.13 Stephanie was seen very infrequently in Primary Care and there were no indicators of domestic abuse identified by them.
- 14.1.14 Lancashire Children's Social Care received the first Police Safeguarding Referral (PSR), completed by Lancashire Constabulary, on 25 November 2019: this reported that Stephanie was a victim of domestic abuse.
- 14.1.15 Although Stephanie had not reported any domestic abuse to Progress Housing, on 27 December 2019, they were informed by Victim Support that the property was unsafe and required repair due to damage occurring as a result of domestic abuse. They attended to repair damage to the property the same day, although they do not have any record of context around the incident.
- 14.1.16 Within their own internal records, Progress Housing first classified the case as domestic abuse following contact from MARAC on 13 January 2020 – in preparation for review at the MARAC meeting on 22 January 2020.
- 14.1.17 Although the Probation Service had been responsible for the statutory supervision of Karl under his Suspended Sentence Order since March 2018, it was apparent

that his relationship with Stephanie only came to light in December 2019, as it was not disclosed by Karl during offender management sessions.

- 14.1.18 Karl had been arrested and the information was shared across all appropriate agencies, including police, the Probation Service and Children’s Social Care. The nature of Karl’s abusive behaviour towards Stephanie had not been fully assessed by the time the order ended some four months later.
- 14.1.19 The nature of Karl’s abusive behaviour in previous relationships was recorded by the Probation Service as being driven by poor thinking skills, poor temper control, poor conflict management, and poor anger management. Whether, in hindsight, this was an erroneous assessment and in fact the issues actually related to coercive and controlling behaviour in relationships, remains unclear.
- 14.1.20 Although other agencies did identify that domestic abuse had taken place, none identified any indicators of coercive and controlling behaviour, apart from Lancashire Constabulary.
- 14.1.21 The panel considered whether there was evidence that Karl had subjected Stephanie to coercion and control. In doing so, the panel referred to the Crown Prosecution Service’s policy guidance.
- 14.1.22 The Crown Prosecution Service’s policy guidance on coercive control states:<sup>15</sup>
- ‘Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:
- Isolating a person from their friends and family
  - Depriving them of their basic needs
  - Monitoring their time
  - Monitoring a person via online communication tools or using spyware
  - Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
  - Depriving them access to support services, such as specialist support or medical services
  - Repeatedly putting them down such as telling them they are worthless

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<sup>15</sup> [www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship](http://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)

- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

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

- 14.1.23 The panel agreed that there was evidence of coercive control (those being outlined in paragraph 14.2.3), in addition to assault, criminal damage, intrusion into Stephanie's social media activity, and Karl controlling aspects of her everyday life. This has been identified as an area of learning by Lancashire Constabulary. [See 14.1.12].

- 14.2 **How did your agency assess the level of risk faced by Stephanie from Karl, and which risk assessment model did you use?**
- 14.2.1 Police officers should assess the level of risk posed by the perpetrator of domestic abuse by using the DASH risk assessment tool, together with their professional experience. The level of risk should be decided by the police officer based on past experiences and incidents between the involved parties, the incident they are attending, and the future risk to the victim.
- 14.2.2 The DASH risk assessment tool was used by Lancashire Constabulary to inform the reported domestic abuse incidents on 24 November, 27 December 2019 and 3 February 2020. They assessed the cases as medium in November 2019, high in December 2019, and medium in February 2020.
- 14.2.3 When reporting the November abuse, Stephanie disclosed that Karl was controlling. She alleged that he did not allow her to drive her car, took her telephone from her, and did not like her going out. This led to the attending officer being requested to submit a crime report for an offence of coercive and controlling behaviour. The crime report was not submitted, and no investigation into the alleged controlling behaviour was conducted. [See Term 1].
- 14.2.4 Lancashire Constabulary have identified this as an area of learning and made a recommendation in relation to the Supervisory and Investigative Management 'Footprint' in domestic abuse cases.
- 14.2.5 The review panel was informed by Lancashire Constabulary that there is a dedicated trainer for the Special Constabulary. As well as face-to-face training, Special Constables have access to electronic pre-reads prior to the course, with the learning then embedded into training sessions. The training includes legislation, police powers, coercion and control, diversity, dynamics of domestic abuse, and DASH. The training is in line with learning outcomes agreed by the College of Policing. In addition to this training, Special Constables are offered continuing professional development as part of their role, to include new legislation – including access to online training and information by the Constabularies Intranet.
- 14.2.6 Children's Social Care reported that referrals were reviewed by the MASH and a decision was made to speak to Stephanie. Furthermore, enquiries were made with relevant agencies involved with the family, to identify the risk and support needed for her youngest child.

The social worker used the Risk Sensible Model<sup>16</sup>, which was used by Lancashire Children's Social Care at that time. As part of the MASH assessment, the MASH social worker contacted Stephanie and her youngest child's school. The MASH Specialist Safeguarding Practitioner completed and collated health information from a range of NHS providers, including Lancashire and South Cumbria NHS Foundation Trust, Virgin Care, and Lancashire and South Cumbria NHS Foundation Trust Mental Health Services. The Specialist Safeguarding Practitioner reviews information received and considers any impact on the risk or needs assessment of the child/children.

- 14.2.7 The Probation Service was informed of the domestic abuse towards Stephanie towards the end of their statutory involvement with Karl. They had been managing him since April 2018 under a Suspended Sentence Order (SSO), following his conviction for an offence of affray in December 2016.

Following the assault on Stephanie in February 2020, he was remanded into custody and remained there until he was released on bail on 26 March 2020. During that time period, the prison keyworker was responsible for the completion of OASys.<sup>17</sup> However, given the remand status of Karl and the early stages of that, only a basic custody screening was completed. This was in line with expected practice, and a more detailed assessment of risk would have been completed once sentenced.

- 14.2.8 The SSO ended on 2 April 2020, by which point Probation had not completed a full assessment of the risks posed to Stephanie by Karl.

- 14.2.9 Victim Support used DASH to assess risks to Stephanie. Following the December 2019 incidents, they initially considered the police risk assessment to determine which team to allocate the case to. Stephanie was contacted by triage staff to explain the service, encourage engagement, establish any imminent risks, and give initial safety advice. Her case was then assigned to an IDVA for a full risk and needs assessment and support planning.

Contact was made with the Stephanie by an IDVA the same day (27 December) and the immediate safety needs were prioritised (repairing a window). An appointment was made to conduct a full assessment after the new year. Karl was in custody and there was therefore no immediate risk to her.

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<sup>16</sup> The risk sensible framework helps support practitioners in understanding how underlying and high-risk factors may be identified and evidenced in respect of the impact on the child, so that referrals into services are targeted appropriately.

<sup>17</sup> OASys (Offender Assessment System: the nationally approved Probation assessment).

- 14.2.10 A telephone appointment to conduct a full risk and needs assessment that was arranged for 6 January 2020, was not completed as Stephanie did not answer the telephone. The IDVA made numerous attempts to contact Stephanie, by telephone, to rearrange and provide appropriate support: these were unsuccessful. On 6 February 2020, after another incident, Stephanie did respond by telephone and arrangements were made to meet with her in person to complete the assessment on 18 February; however, this was subsequently cancelled by Stephanie. Further efforts to contact Stephanie between February and April were unsuccessful and the case was closed on 6 April, when the police confirmed that Karl had been remanded in custody. The panel agreed that the case closure was appropriate, as initial contact had been made and safeguarding had taken place. Furthermore, Stephanie had the capacity to decide not to engage further.
- 14.3 **What knowledge did your agency have that indicated Stephanie could be at risk of suicide as a result of any coercive and controlling behaviour?**
- 14.3.1 On 3 August 2019, Stephanie's friend reported concerns for Stephanie's welfare to Lancashire Constabulary. She informed police that Stephanie was feeling suicidal and had expressed thoughts to end her life. The friend was also told by Stephanie that she had been pulled away from the railway tracks. Police were aware that at the time this incident was reported to them, Stephanie was present with her friend. Despite being graded as a grade two response (requiring attendance within 60 minutes), the first officer did not arrive until 92 minutes after the call had been made, by which time Stephanie had left the scene.
- 14.3.2 The incident was reclassified as a Missing Person Investigation, and officers identified that this was high risk due to Stephanie's references to suicide and self-harm. As the investigation to locate her commenced, North West Ambulance Service contacted police and informed them that they believed they had seen Stephanie. She walked away from paramedics and made a comment that she wanted to '*go to the train tracks*'.
- 14.3.3 At 03.30hrs the following day, it was established that Stephanie had gone to a friend's address, where she remained until police officers attended to speak with her. A missing person risk assessment was conducted by officers who noted that Stephanie had had thoughts of self-harm earlier in the day. She informed them that she ran away from the ambulance as she thought she would be sectioned under the Mental Health Act.
- 14.3.4 Stephanie declined to provide details as to where she had been, and said she was in a low mood. She acknowledged that she needed support but was reluctant to attend hospital, despite her friend agreeing to attend the hospital with her.

- 14.3.5 The officer advised Stephanie to make an appointment with her GP and provided her with details for the Crisis Team and support services, including Lancashire Wellbeing<sup>18</sup> and Minds Matter<sup>19</sup>.
- 14.3.6 Lancashire Constabulary expect their officers in these circumstances to submit a Vulnerable Adults Referral (PVP), which is then reviewed by the MASH who decide if a Police Safeguarding Referral (PSR) is appropriate: this would then be shared with other agencies. The attending officer was instructed to submit a PVP for Stephanie, as a vulnerable adult.
- 14.3.7 Vulnerable Adult risk assessments are appended to a missing person report and are completed both when a person is reported as missing and when found. The review panel was informed that this form is not shared with the MASH and remains on the Missing Person file. When Stephanie was reported missing, she was assessed as a high-risk missing person. Stephanie was assessed as a medium-risk missing person once she had been found. Officers could have considered submitting a PVP/PSR in this case that would have been shared with the MASH and raised a Vulnerable Adult Investigation. A PVP/PSR was not completed, therefore the information about this incident and the issues raised around Stephanie's mental health, were not shared with other agencies.

It is noted that before the closure of the missing person incident record on 5 August 2019, an entry was made by a Police Missing Person Co-ordinator, asking: 'can an Officer consider submitting a PVP regarding mental health issues?' This was a suggestion, made by the Police Missing Person Co-ordinator, for the officer who had attended the incident to consider and complete. No checks were made by the Missing Person Co-ordinator to ascertain if that suggestion had been completed. The PVP/PSR was not completed.

The panel agreed that this was a missed opportunity to share information concerning the mental health of Stephanie and the risk of her self-harming. The panel was also clear in their views that the Police Missing Person Co-ordinator, who had identified the risks around Stephanie's mental health, should have completed a PVP. The panel has identified this as an area of learning for Lancashire Constabulary. [Recommendation 1].

- 14.3.8 There was no reference within the missing person report that Stephanie was in an abusive relationship. Police recorded one reference made by a friend of Stephanie that her boyfriend was called Karl. No further information identifying Karl was

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<sup>18</sup> <https://wellbeinglancashire.org.uk/mission/>

<sup>19</sup> <https://www.lscft.nhs.uk/Mindsmatter>

recorded within the missing person report, and there is no recorded information describing the relationship between Stephanie and Karl.

Police officers tried to identify Stephanie's boyfriend, referred to as Karl. An interrogation of Stephanie's mobile phone was difficult as it was damaged and did not yield any relevant information. Officers accepted that a significant factor in Stephanie going missing related to her mental health. Although she was not diagnosed with any specific mental health conditions, friends reported her behaviour and suicidal comments, which raised the level of concern to that of high risk. There was no reference to domestic abuse being a factor in the reason why Stephanie went missing.

The review panel was provided with the following extract from the missing person report –

The following questions are included within the question set on the risk assessment, which was completed when Stephanie was reported as a missing person:

1. Family / Relationship Problems or recent history of family conflict / abuse?  
Answer: NO
2. Are they the victim or perpetrator of Domestic Violence? Answer: NO

Domestic Abuse is considered within the finalisation welfare check, and there was no information provided at this point to identify domestic abuse.

14.3.9 The panel was made aware of research indicating a significant number of domestic abuse victims suffer from suicidal ideation. A study<sup>20</sup> in 2019, estimated that between 20 – 80% of victims of domestic abuse had suicidal ideation. The Panel felt that Stephanie's domestic circumstances could have been explored further to identify any link with her own threats to harm herself.

This is a learning point and linked to panel recommendation 3.

The report was updated before publication in 2025 with the following additional research.

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<sup>20</sup> From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse (*Vanessa E. Munro & Ruth Aitken*)

Findings from the fourth annual report from the national Domestic Homicide Project<sup>21</sup> published in March 2025. The report examines all deaths identified by police as domestic abuse related to improve understanding of risk indicators, victim, and perpetrator demographics. The unique dataset collects detailed information on these deaths not available from any other source to help police and partners improve their response to domestic abuse, domestic homicide and victim suicide following domestic abuse.

The follow key findings are detailed in the report:

262 deaths were recorded between 1 April 2023 and 31 March 2024:

- 98 suspected suicide following domestic abuse (SVSDA)
- 80 intimate partner homicides (IPH)
- 39 adult family homicides
- 28 unexpected deaths
- 11 child deaths
- 6 'other' (where the victim and suspect lived together, but were not related or intimate partners)

22 cases of deaths due to a fall from height were recorded across 13 forces during the four-year period, of those:

- 36% were recorded as SVSDA, 27% unexpected deaths, 23% IPH and 14% AFH
- Notably, three victims (14%) were pregnant at the time of their death
- In 70% of cases the suspect was arrested

For the second year in a row, suspected suicides following domestic abuse have overtaken the number of homicides involving current or previous partners.

- 14.3.10 Following Stephanie's death, the police investigation revealed that the evening before her death, she had expressed to family and friends that she had been assaulted by Karl and was considering taking her own life. This information was only received following Stephanie's death, and that specific information was not reported to the police or any other agency at the time.
- 14.3.11 Police stated that during the course of investigations into all incidents where Stephanie was the victim of domestic abuse, on no occasion was it identified that she was at risk of suicide.

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<sup>21</sup> <https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/>

The panel concluded that Lancashire Constabulary did not consider the previous missing person investigation, and agreed that had they done so, then they may have assessed the risk to Stephanie and prioritised subsequent actions differently. Considering all previous incidents when dealing with domestic abuse, should be a learning point for Lancashire Constabulary. [Recommendation 2].

14.3.12 Lancashire Children’s Social Care had no knowledge of Stephanie's potential mental ill health and had no evidence that she was at risk of suicide. Stephanie was spoken to by a MASH social worker on 28 November 2019 and by a MASH Early Help Officer on 22 January 2020: on both occasions, no reference was made to mental health. Checks undertaken within the MASH identified that Stephanie was not known to mental health services.

14.3.13 The panel was informed that if Lancashire Children’s Social Care had been aware of the missing person incident in August 2019, they would have been more professionally curious around Stephanie’s mental health and would have adopted a more holistic approach to the family following the domestic abuse incidents later that year.

14.3.14 Stephanie’s stepmum reflected that the family were unaware of the missing person episode and of Stephanie’s suicidal ideation at that time. Had they been aware, then they may have been able to provide more support.

14.4 **Did your agency consider that Stephanie could be an adult at risk within the terms of the Care Act 2014? Were there any opportunities to raise a safeguarding adult alert and request or hold a strategy meeting?**

14.4.1 Following the incident on 3 August 2019 when Stephanie was reported as a missing person, despite her disclosing thoughts of self-harm and suicide, there is no record of the Care Act 2014 being considered by Lancashire Constabulary. There was an opportunity to submit a PVP/PSR into the MASH, which could have been shared with Adult Mental Health Services and which could have triggered a strategy meeting.

Unfortunately, a referral did not take place. This was a missed opportunity to address any mental health support necessary for Stephanie, or to influence the way in which agencies supported her following future incidents of domestic abuse. [Recommendation 1].

14.4.2 Information was shared with the MASH following the November 2019 domestic abuse incident, which stated: ‘Stephanie is not known to LSCFT mental health services’.

- 14.4.3 Following the incidents in December 2019, Stephanie was subject of a safeguarding alert and had been referred to MARAC. However, prior to this, there was no evidence presented by any other agency to suggest that Stephanie was at risk of abuse within the terms of the Care Act 2014.
- 14.4.4 Children's Social Care did not consider Stephanie to be an adult at risk. Given that, on both occasions, she had advised that she was no longer in a relationship with Karl and that she was engaging with appropriate support agencies, it wasn't deemed at the time that strategy discussion was needed. It was assessed that Stephanie was taking appropriate steps to safeguard Alex, as well as herself, from further domestic abuse.
- 14.4.5 At the time incidents were reported, Progress Housing did not consider that Stephanie was an adult at risk. On reflection, they do feel that as there was an incident at the property on 27 December 2019 resulting in damage due to domestic abuse (reported to them by Victim Support), this should have alerted them to the fact that there may be a safeguarding issue and an alert could have been raised with the local authority. Progress Housing explained that they received the information 'out of hours' by the emergency response team, as their main office was closed due to the Christmas and New Year holidays period.

This will be addressed by means of a single service recommendation.

- 14.5 **In the context of the family arrangements, what consideration did your agency give to any mental health issues or substance misuse when identifying, assessing and managing risks around domestic abuse?**
- 14.5.1 As outlined at 14.3.7 (when dealing with the report of Stephanie going missing in August 2019), despite highlighting potential mental health issues, police did not share the information with mental health services, or any other agency at a critical point in the timeline leading to her death. Her relationship with Karl was at an early stage and appropriate interventions may have provided Stephanie with the confidence to accept support and deal with an abusive relationship with Karl.
- 14.5.2 Lancashire Constabulary recorded details of substance misuse by Karl during their interactions with Stephanie. They also identified that both he and Stephanie used alcohol. Officers were aware that Karl also used illegal drugs.
- 14.5.3 Children's Social Care reported that during conversations between Stephanie and a social worker on 28 November 2019, Stephanie recognised that alcohol was the main contributory factor for incidents of domestic violence; however, she had not reported that alcohol misuse was an issue for herself. Stephanie informed a social

worker that when she consumed alcohol, Alex was cared for by grandparents: this was recognised by Children’s Social Care as a protective factor to reduce the risk of Alex being exposed to frightening adult behaviours and reduced the risk of neglect due to being in the care of adults under the influence of alcohol.

14.5.4 The panel felt that this conscious decision by Stephanie suggested that she was aware abuse was likely to occur and, as such, was taking action to keep her child safe.

14.6 **In the context of the family arrangements, what did your agency do to safeguard any children exposed to domestic abuse?**

14.6.1 Following Stephanie being assaulted by Karl in November 2019, the police investigation revealed that her children were not present in the house at the time of this incident. Police created a PSR and assessed the risk as medium. Despite the children not being present, the case was highlighted within the MASH and shared with Children’s Social Care.

14.6.2 Stephanie informed police that during the assaults on her in December 2019, neither of her children were present to witness the incidents. Following Karl’s arrest for both incidents, officers submitted a High-Risk Domestic Abuse Referral, and a PSR was created within the MASH. Alex was recorded on the referral and the information was shared with Children’s Social Care. A referral was made to MARAC.

14.6.3 Following each referral made to the MASH, the circumstances were considered by a practice manager, and a MASH assessment was completed by a social worker to identify any risk to Alex, and to offer appropriate support to reduce the risk of exposure to domestic abuse.

14.6.4 Alex was not present during the domestic abuse incidents in November and December, and Stephanie informed her early help officer that she had never received any visible injuries that her child would have noticed. During both conversations between Stephanie, a social worker and an early help officer, Stephanie appeared to reflect on the incidents and appeared to take her own measures to safeguard Alex – by not allowing Karl to be around her child, or by stating that she had ended the relationship with him.

The MASH was confident that Alex’s school would be able to monitor Alex sufficiently, and if any concerns arose regarding Alex’s safety or emotional wellbeing, a referral would have been made to Children’s Social Care.

14.6.5 Lancashire Constabulary did not record whether or not Alex was present during the incidents of assault in January or assault and intimidation in February 2020;

therefore, it is not known if any further measures were needed to safeguard Alex. The panel agreed that considering the extent of abuse which had taken place, Lancashire Constabulary should have recorded this information and shared it with other agencies to ensure risks to Alex were fully considered. This is analysed further in Term 9.

- 14.6.6 Virgin Healthcare records state that a 'Specialist Safeguarding Practitioner' attended MARAC on 24 January 2020 and shared health information for both children. Virgin Care raised a health action to review school placements, including outstanding health needs for Sam, and also to liaise with Children's Social Care.

Alex was not present during the domestic abuse incident in December and therefore was not considered for further assessment by Virgin Care. There were no concerns raised by Alex's school or Stephanie regarding Alex's behaviour or demeanour.

- 14.6.7 On 6 July 2020, a Progress Housing member of staff telephoned Children's Social Care to notify them that Karl had returned to live with Stephanie. They also notified them that Sam had moved out of the address and that Stephanie was pregnant.

- 14.6.8 Children's Social Care has no record of any referral being received from Progress Housing around this date and explained to the panel that usual practice would be for the recipient of such a call to receive a call back from a social worker. Progress Housing has no record of receiving any call back.

The panel felt that although the intentions of Progress Housing were positive, proactive and timely, the absence of any method of tracking referrals and outcomes resulted in important information not being shared effectively. The panel agreed that this area was best addressed by means of a single agency recommendation for Progress Housing. Processes within Children's Social Care have changed since this incident – details of conversations are now recorded on a child's record where advice has been provided to another agency.

- 14.6.9 In August 2020, Stephanie took Alex to the Urgent Care Centre at Chorley and Royal Preston Hospital, as Alex had received a soft tissue injury following an alleged fall from a climbing frame. The clinical diagnosis was a sprained wrist: this injury did not require any further medical follow-up. The clinician shared information with the Paediatric Liaison Service as there was a safeguarding alert on the clinical system due to previous domestic violence in the family. The referral was shared with Virgin Care as they were the 0-19 caseload holders. This was in line with LSCFT procedures.

The role of the paediatric liaison service, in line with Lord Laming's recommendations (2003), is to provide a high quality service by working in partnership to ensure an effective two-way communication process of sharing information between the acute hospitals (anywhere in the country) and the community, in order to enable children and their families to receive targeted, seamless and appropriate care to meet their individual needs: this enables them to receive the right support at the right time. This facilitates an open and transparent approach to safety, care and protection. An electronic pathway has been embedded that enables all information to be referred out to the relevant community practitioners within the next working day. The information is entered into the child's records, minimising information governance risks.

The aim of the paediatric liaison service:

- Promote effective communication pathways which co-ordinate children's between hospital and community services
- To identify and target children and families who require increased support or services
- To safeguard children and young people and their welfare.
- To reduce preventable accidental injuries in children.

14.6.10 Following the incidents in December 2019, initially, police did not share any PSRs or PVPs with Children's Social Care, due to children not being present during either incident and Stephanie not providing consent for them to share details with other agencies. The Panel agreed that this was a high-risk incident of domestic abuse and consent should have been overridden. [See Term 9].

14.7 **What services did your agency provide for Stephanie; were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk, including the risk of suicide?**

14.7.1 As outlined previously, following the incident in August 2019, Lancashire Constabulary did not fully consider the extent or reasons behind Stephanie's poor mental health, and did not share the information with other agencies. The panel agreed that the organisational management of this incident was not effective.

14.7.2 Lancashire Constabulary attended reported incidents of domestic abuse within their own response time parameters. The attending officers provided safeguarding advice to Stephanie and supported her as a victim by providing details of third-party support services.

- 14.7.3 Karl was not arrested following the reported assault in November 2019: Lancashire Constabulary state that this was due to Stephanie not feeling able to support the investigation, despite making it clear that she was fearful of him. There is no evidence that consideration was given to an evidence-led prosecution, without the need for a statement of complaint from Stephanie.
- 14.7.4 A 2021 report by The Centre for Women’s Justice<sup>22</sup> (*‘submission to the VAWG Strategy call for evidence’*) outlines that the offence of coercive and controlling behaviour is rarely exercised: even after many years since its introduction in 2015. In 2018/19, such cases made up only 1.75% of all domestic abuse prosecutions. It is reported that frontline domestic abuse workers report the majority of police investigations focussing on physical injuries only.
- 14.7.5 The same report also outlines that frontline workers rarely see evidence-led prosecutions being instigated, despite the widespread issue of body-worn cameras, and a Joint Inspectorate report on this, in January 2020, criticised a lack of such prosecutions.
- 14.7.6 The panel acknowledged that evidence-led prosecutions were an important tool to bring perpetrators to justice where survivors are too frightened or unwilling to co-operate with the criminal justice process.
- 14.7.7 Despite Karl not being arrested at the time, Karl was later charged and summonsed for the November assault, when other offences were investigated following the incident in December. The panel felt that Lancashire Constabulary’s actions were not timely or proportionate, considering the risk indicators available at the time Stephanie first reported matters to the police in November, i.e. violence, strangulation, mental health, alcohol, coercive and controlling behaviour.
- 14.7.8 Lancashire Constabulary responded to the report of assault on 27 December 2019 by carrying out a prompt arrest of Karl. Officers explained support that was available to Stephanie, including ‘special measures’ for a victim to give evidence at court, and applied to the court for strict bail conditions to be applied, should Karl not be remanded into custody.
- 14.7.9 Stephanie described multiple indicators that she was the victim of coercive and controlling behaviour, and some DASH assessments did appear to reflect this.

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<sup>22</sup> The Centre for Women’s Justice is a charity, who aim to bring together specialist lawyers, academics and other experts in the field of violence against women, with those working on the frontline as activists, survivors and service providers to bring strategic law challenges and ensure access to justice for victims of male violence.

However, the lack of any evidence within CPS submissions to support that offence, resulted in charges not being considered and assault charges not being pursued.

- 14.7.10 Despite being on bail with conditions not to contact Stephanie, Karl assaulted her again on 3 February 2020, when he also attempted to persuade her to withdraw her evidence in the case against him. Stephanie reported that he also made threats regarding other witnesses in the case before leaving the scene prior to police arrival. Karl also placed his hands around her throat. Stephanie supported further prosecution against Karl and provided a statement.

The panel felt that this was a missed opportunity to refer Stephanie back to MARAC and revisit support options to protect her. This has been identified as an area of learning and a relevant recommendation has been made. [Recommendation 1].

- 14.7.11 Lancashire Constabulary recorded the matter as assault and did not appear to consider coercive and controlling behaviour within prosecution documents or the associated DASH risk assessment: this was described by the IMR author as *'incomplete'* and graded as medium risk.
- 14.7.12 Following each incident of domestic abuse, Lancashire Constabulary reflected the feelings of Stephanie through the DASH risk assessments completed. As outlined previously, they were completed to varying degrees of accuracy and therefore may not be a true portrayal of her state of physical or mental health.
- 14.7.13 Stephanie also provided witness statements describing the assaults committed by Karl. However, she declined to provide a Victim Impact Statement: this would have provided an opportunity to express her feelings to the court and explain the impact of the abuse she received from Karl.
- 14.7.14 On 26 March 2020, Karl was released from prison on bail, following a period where he had been remanded in custody. One of his bail conditions was that he was subject to electronic monitoring, often known as a 'tag'. EMS, the electronic monitoring company, notified Lancashire Constabulary on 35 occasions that Karl was in breach of bail. On only one occasion, on 13 August 2020, was the notification actioned by Lancashire Constabulary. This resulted in Karl's arrest and production before the court, where he was released with the same bail conditions.
- 14.7.15 The final breach of bail was reported to Lancashire Constabulary by EMS after Karl failed to charge the 'tag' on 2 September 2020. No action was taken by Lancashire Constabulary. This meant that after this date, Karl was able to visit Stephanie with impunity as EMS could no longer report a breach of bail.

- 14.7.16 The process of receiving, recording and actioning EMS breaches within Lancashire Constabulary is governed by a Constabulary EMS breaches protocol. An internal review of the circumstances by Lancashire Constabulary has shown that the protocol was suitable and adequate but had simply not been followed once the breaches had been referred to the local Basic Command Unit (BCU).
- 14.7.17 In December 2021, the HQ PPU senior management team contacted the senior management teams of all the BCUs reminding them of their responsibilities in relation to EMS breaches. This was supported by a reminder of the EMS protocols being published on the internal Lancashire Constabulary web page 'Sherlock', a site accessed by all Lancashire Constabulary employees.
- 14.7.18 Research has now highlighted good practice in dealing with EMS breaches in another BCU, and this good practice is to be recommended for implementation in all BCUs in Lancashire Constabulary. A review of performance in dealing with EMS breach notifications will take place later in 2022. Lancashire Constabulary identified learning in relation to their response to the EMS breaches and have made a relevant recommendation.

The panel was clear in their views that the response to the breaches by Lancashire Constabulary was a significant area of learning for this review and has made a panel recommendation for Lancashire Constabulary. [Recommendation 4].

- 14.7.19 NICE Guidance on Domestic Violence and Abuse (PH50), states:  
*Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.*

According to the above guidance, Stephanie's GP appointments should have prompted questions about domestic abuse. In the circumstances of the GP consultation on 20 August 2019, the panel agreed that this sort of sensitive questioning would have been inappropriate as Stephanie was in pain with a potentially dangerous ectopic pregnancy: her medical needs were the priority.

- 14.7.20 However, On 11 October 2019, she was seen again by the GP for complications following her pregnancy. In the circumstances of that consultation, expected practice would be to make enquiries into home circumstances and the possibility of abuse. This was not done, and the panel agreed that this was a missed opportunity to provide a platform for Stephanie to disclose domestic abuse or

reach out for help. The panel has identified this as an area of learning and has made a relevant recommendation. [Recommendation 5].

- 14.7.21 The Probation Service managed Karl throughout the majority of the period of review. Although Karl did not divulge his relationship to his offender manager, the panel was presented with examples of proactive and probing questioning around his behaviour, which appeared to be appropriate in the circumstances.
- 14.7.22 Following the incident in November 2019, Victim Support could not complete an assessment of the risks posed to Stephanie by abuse from Karl. This was due to Stephanie not answering their calls.
- 14.7.23 Victim Support made numerous attempts to contact Stephanie in accordance with policies; therefore, the case was closed in accordance with those policies.
- 14.7.24 Stephanie spoke with social workers and early help officers from the MASH, but only in terms of how she was managing the safeguarding of her children in the context of domestic abuse. Whilst discussion around specific abuse did not take place, the MASH social worker explored possible triggers, such as alcohol consumption, as well as the safeguarding of Stephanie and Alex and wider network support.

14.8 **How did your agency ascertain the wishes and feelings of Stephanie and Karl about Stephanie's victimisation and Karl's alleged offending, and were their views considered when providing services or support?**

- 14.8.1 Following each incident of domestic abuse, Lancashire Constabulary reflected the feelings of Stephanie through the DASH risk assessment completed. She also provided a witness statement describing the assaults committed by Karl. However, she chose not to provide a Victim Impact Statement: this would have expressed her feelings to the court and how the domestic abuse had affected her life.
- 14.8.2 The panel was informed that a Lancashire Constabulary Neighbourhood Officer did speak with Stephanie following the incidents in February and attempted to provide advice to her. The officer recalls asking her why she kept going back to Karl following incidents of assault and strangulation: Stephanie stated that it was because '*she gets lonely*'.

The panel considered the response by Stephanie to the police and recognised the barriers that victims of abuse can face when deciding whether or not to leave a

relationship. The panel took cognisance of the following information from Women's Aid<sup>23</sup>, which articulates the barriers faced by victims:

### **Danger and fear**

One of the most important reasons women don't leave is because it can be incredibly dangerous. The fear that women feel is very real – there is a huge rise in the likelihood of violence after separation. 41% (37 of 91) of women killed by a male partner/former partner in England, Wales and Northern Ireland in 2018 had separated or taken steps to separate from them. Eleven of these 37 women were killed within the first month of separation and 24 were killed within the first year (Femicide Census, 2020).

### **Isolation**

Domestic abuse often relies on isolating the victim: the perpetrator works to weaken her connections with family and friends, making it extremely difficult to seek support. Perpetrators will often try and reduce a woman's contact with the outside world to prevent her from recognising that his behaviour is abusive and wrong. Isolation leads women to become extremely dependent on their controlling partner.

### **Shame, embarrassment or denial**

Perpetrators are often well respected or liked in their communities because they are charming and manipulative. This prevents people recognising the abuse and isolates the woman further. The perpetrator often minimises, denies or blames the abuse on the victim. Victims may be ashamed or make excuses to themselves and others to cover up the abuse.

### **Trauma and low confidence**

Imagine being told every day that you're worthless and the impact that this has on your self-esteem. Victims have very limited freedom to make decisions in an abusive relationship, they are often traumatised, regularly told 'you couldn't manage on your own, you need me'. Fear is constant and they live in a world of everyday terror.

### **Practical reasons**

Abusers often control every aspect of their victim's life – making it impossible to have a job or financial independence. By controlling access to money women are left unable to support themselves or their children. They may fear having their

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<sup>23</sup> <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/>

children taken away or, if she has an insecure immigration status, may fear being deported.

### **The support isn't there when they need it**

Asking for help is not easy. Misunderstandings about domestic abuse often prevents professionals from knowing what to do, how to talk about it or where to direct women disclosing abuse.

#### **14.9 How effective was inter-agency information sharing (including with agencies providing services to Alex) and cooperation in response to Stephanie and her family (including Karl), and was information shared with those agencies who needed it?**

14.9.1 Following the missing person investigation in August 2019, Lancashire Constabulary collected significant information concerning Stephanie's mental ill health, including threats to end her own life. This information was not shared with any other agency and the panel felt that this would have been relevant in subsequent assessments that would subsequently take place over the following 14 months.

14.9.2 In November 2019, Stephanie did not support a police prosecution and did not provide her consent for Lancashire Constabulary to share information with other agencies. However, Lancashire Constabulary did consider the matter sufficiently serious for consent to be overridden and shared details of the incident with agencies, including Children's Social Care: the panel agreed that this was appropriate.

14.9.3 Following the reported assaults in December 2019, Stephanie felt able to support a police investigation. Although a DASH risk assessment was completed by Lancashire Constabulary and assessed as high risk, the referral into the MASH was not shared with Children's Social Care, although it was shared with an IDVA, and the case was referred to a MARAC. Consideration of sharing the incidents with Children's Social Care was completed by the MASH officer, who recorded their decision as follows:

'CSC Check – Alex was known but closed in Nov 2019. Sam is not known to services. I will not refer to Children Social Care as the children have not been present during the incidents and Stephanie confirms that she does not let the suspect in the address when the children are there, and Children Social Care have closed this after conversation with Stephanie who states that her children's safety

and well-being are the most important thing to her and she will ensure that they are safe guarded at all times. She does not need any support from CSC at this time, she will contact us if she has any concerns in the future’.

On 6 January 2020, it was recorded that the PSR had now been shared with CSC, following the request of a social worker.

In reviewing the response to the above incident, the panel sought clarification from Lancashire Constabulary as to the processes around information sharing within the MASH. The Author of the DHR spoke with the police panel member and police MASH supervisor to gain an understanding around the current MASH processes. The Author was informed that the police have access to the Children’s Social Care IT system. All incidents referred into the MASH by the police are checked against the Children’s Social Care IT system to ascertain if there is involvement from Children’s Social Care. Where it is recorded that children have an allocated social worker, then details of the incident are shared directly with the social worker. Where the children are not known to Children’s Social Care or there is no active involvement with Children’s Social Care, then consideration is given by the police to sharing details of the incident based on identified risk factors, level of risk, wishes and feelings of the victim, any previous incidents or evidence of escalation of risk, and other aggravating factors.

The Author sought clarification around the police MASH timescales for sharing of information and was assured that incidents are shared in a timely manner with no delays in information or referrals being made.

14.9.4 At the time of the missing person investigation in August 2019 and domestic abuse incidents in November and December 2019, Stephanie’s oldest child was living with her.

Children’s Social Care was not made aware of this by any other agency and it appears that Sam’s details were omitted from any referrals which passed through the MASH; therefore, no enquiries were completed with relevant agencies regarding Sam’s wellbeing or safety.

14.9.5 As outlined within paragraph 14.6.8, Progress Housing believed that they had shared significant information, regarding Stephanie, with Children’s Social Care. They have made this subject of a specific agency action.

14.9.6 Virgin Care received the police sharing information regarding the domestic abuse incident in November 2019. Following this, information was requested by, and shared with, the MASH: in regard to any outstanding health needs for the children.

14.9.7 The Virgin Care Domestic Violence and Abuse policy and the Domestic Abuse Standard Operating Procedure (SOP) were followed by them in response to the PSR received. This procedure is embedded within practice through training and is clearly accessible on their intranet. Their SOP 'Responding to Domestic Violence and Abuse' was updated in June 2020.

However, the panel learned that there remains a vulnerability in the sharing of information between Virgin Care and the CCG. To access patient information owned by Virgin Care, GPs are required to have signed information sharing agreements. This has not taken place widely and although this did not adversely affect service provision in this case, it could have.

The panel recommend that this should be considered as an action plan for Virgin Care and the CCG to resolve collectively.

14.9.8 Not all agencies involved in this DHR were notified of Stephanie's death and, as such, her children were not assessed and supported as they should have been. Stephanie's youngest child had moved away from the area to live with their father – until actions were raised by the DHR panel, that local authority was unaware of the circumstances of the case or what the child had witnessed.

14.9.9 The panel was informed that Lancashire Constabulary did submit a high-risk vulnerable child safeguarding report to the Lancashire MASH: this was received by them two days after Stephanie's death.

*It is recorded on the referral: 'Shared with GMP<sup>24</sup> for the attention of MASH to provide safeguarding support. Alex lives in Manchester with (redacted) father...'*

There is no record of this referral being shared with any Lancashire agencies and no record of Greater Manchester Children's Social Care being aware of the case.

14.9.10 Lancashire Constabulary informed the panel that it would have been appropriate for them to share the information with Lancashire Children's Social Care, along with health and education authorities, but this was not done. Although Alex's Primary School in Lancashire was notified of Stephanie's death, and the fact that Alex had been present at the time, it was not shared through Operation Encompass, which had been effective since May 2019. Lancashire Constabulary accepted that it would have been appropriate to utilise Operation Encompass in the circumstances.

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<sup>24</sup> Greater Manchester Police

- 14.10 **Was there sufficient focus on reducing the impact of Karl’s alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?**
- 14.10.1 Lancashire Constabulary focussed on securing evidence to support prosecutions and to apply conditions to reduce the risk to Stephanie through the judicial system.
- 14.10.2 As outlined previously within this report, following the November 2019 incident in which Stephanie was assaulted and strangled by Karl, she did not feel able to provide a formal complaint to Lancashire Constabulary. Irrespective of this, if sufficient evidence existed, an arrest could still have been made and prosecution sought. The panel was not presented with the strength of evidence at that time nor the rationale for not following that course of action. However, following Stephanie’s death, Karl was summonsed for that offence.
- 14.10.3 Following the assaults in December, Lancashire Constabulary identified the continued high-risk Stephanie faced from Karl and sought CPS authority to charge and remand him into custody.
- 14.10.4 The Magistrates Court subsequently released Karl on bail with various conditions, including not to contact Stephanie. However, in February, he breached those conditions by assaulting her again: he was subsequently arrested and released on bail with conditions.
- 14.10.5 Throughout the majority of the period under review, Karl was subject of statutory suspended sentence order – arising from a conviction for affray from before he formed a relationship with Stephanie.
- 14.10.6 Karl had completed an intervention to address that issue. At the time, he was assessed as not presenting an imminent risk due to this, and also as he did not have a current partner.
- 14.10.7 The focus of the sentence plan was to: *‘address consequential thinking, lifestyle, pro-social activity and reduce conflicts with neighbours and locals’*. All of this was appropriately based on the nature of the index offence; however, a more holistic sentence plan would also have included some focus on healthy relationships. Even if not included in the sentence plan, the risk management plan should certainly have included measures to manage, control and reduce risk of serious harm in relationships; however, this was not evidenced and will be progressed as a single agency recommendation for Probation.
- 14.10.8 In the months leading up to the first reported domestic abuse incident in November 2019, Karl’s offender manager identified that he was becoming non-compliant with the requirements of his offender management programme. His

offender manager was appropriately intrusive in his supervision of him and issued a formal breach warning. It was noted that Karl insisted he was not using alcohol to excess, was not in a relationship with anyone, and was actively seeking employment.

14.10.9 Karl's GP records reveal that twice in May 2020, he engaged with his GP about his mental health. The risk assessment conducted by the GP included asking about potential harm to others as well as himself, which Karl denied. The consultations are described by the CCG as being thorough and evidencing excellent holistic care.

14.11 **Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice, and were any gaps identified?**

14.11.1 Following the domestic abuse incident in November 2019, a Domestic Violence Disclosure Scheme disclosure was made to Stephanie. In January 2020, a further disclosure was carried out, following a number of attempts by a Domestic Violence Protection Officer to make contact with Stephanie. This was carried out within the 35-day national policy guidance and contained appropriately detailed information regarding Karl's previous violent behaviour, including domestic abuse and sexual assault.

14.11.2 On 22 January 2020, Stephanie's case was heard at South Ribble MARAC. Neither Stephanie or Karl's GPs, nor Children's Social Care, were aware of the MARAC meeting. The panel has identified this as an area of learning and made a relevant recommendation. [Recommendation 6].

14.11.3 The panel noted that the MARAC discussion identified risks as:

*'Verbal argument, toxic relationship, and referred to a child with a complex medical issue' (Stephanie's son).*

The panel felt that the language of 'toxic relationship' was inappropriate and that feedback should be provided to those chairing MARAC.

14.11.4 The panel felt that following Karl's arrest in February 2020 for breach of bail, the case should have been referred back to MARAC. The threshold was met, and that forum may have provided support options for Stephanie following a series of traumatic events.

14.12 **What knowledge did family, friends and employers have that Stephanie was in an abusive relationship, and did they know what to do with that knowledge?**

- 14.12.1 Stephanie's family in South Ribble were aware that her relationship with Karl was abusive. They described that throughout her life, she had been in relationships with partners who did not treat her well and believed Karl to be the same.
- 14.12.2 Stephanie's family in South Ribble knew that she had been abused by Karl but were of the opinion that she would not accept support from anyone, or any agency, to help remove herself from that relationship; indeed, she did not want that to happen and considered marriage and raising a child with him. Stephanie's family and friends tried hard to persuade her to end her relationship with Karl. Stephanie confided in a family member that when she had attended hospital with a knee injury, she had told health professionals that it was sustained in a fall, whereas Karl had caused the injury by assaulting her.
- 14.12.3 Stephanie's family focussed on supporting her by providing safe environments for her children and were there to address her immediate needs in the aftermath of serious abuse incidents.
- 14.12.4 The night preceding Stephanie's tragic death, she had multiple contacts with multiple friends. During those contacts, Stephanie stated that she had been assaulted and strangled by Karl, that she was considering ending her life, and had a noose around her neck.
- 14.12.5 Stephanie's friends tried to help by speaking with her and informing her father what had happened. He attended her address twice in an attempt to resolve the situation. However, on both occasions, he was met with confrontation from Karl, although he did persuade him to leave. Tragically, she took her own life in the hours that followed.
- 14.12.6 Following Stephanie's death, police spoke with some of her friends and neighbours who were aware that she was in an abusive relationship and, in some cases, had witnessed her being assaulted by Karl. Some appeared to have been frustrated that Stephanie kept returning to Karl but acknowledged that she had strong feelings for him. One friend who witnessed Stephanie being strangled by Karl, stated that they were reluctant to provide a statement to the police regarding this as they expected Stephanie to retract complaints at a later date. The panel agreed that friends and neighbours felt that they would not have helped Stephanie by reporting matters to the police.
- 14.13 **Were there any examples of outstanding or innovative practice?**
- 14.13.1 The Review Panel saw no evidence of outstanding or innovative practice.
- 14.14 **What learning did your agency identify in this case?**

#### 14.14.1 **Lancashire Constabulary:**

- Review of EMS Protocol.
- Police responses to breaches of orders, including EMS breaches and court bail.
- Recognition and investigation of coercive and controlling behaviour.
- Supervisory and investigative management of domestic abuse cases.

#### 14.14.2 **CCG:**

- Links exist between Domestic Abuse and Pregnancy related consultations yet the opportunity for routine enquiry was missed in this case. We will take this forward into our single-agency action plan.

#### 14.14.3 **Children's Social Care:**

- Sam was not included within the enquiries made by MASH and this needs to be reflected on to ensure that all children are included in the enquiries made. This could have been avoided had the social worker clarified with the mum whether any other children were residing at the address and by confirming the household composition at the time.

#### 14.14.4 **PHG:**

- We identified a gap in internal communication after the report of property damage due to domestic abuse was referred in to us by Victim Support on 27 December 2020. There was no recorded follow up of this. We will incorporate guidance on following up reports of this nature within our review of procedures.
- Although the South Ribble Select Move Allocations Sub-Regional Choice Based Lettings Policy was followed, it would have been prudent to check and record the position in relation to the Discretionary Housing Payment application and we will address this through training of colleagues.

#### 14.14.5 **Probation Service:**

- Risk management and sentence planning must be holistic, taking account of previous offending and behaviour linked with risk of serious harm.
- Enforcement of the order must be consistent and clearly recorded.

- There needs to be a rationale recorded for any change to risk registers.

#### 14.14.6 **Virgin Care:**

- On 22/10/2020, The Universal duty practitioner received a request from the police asking for urgent information regarding details of Alex's father following Stephanie's death. The request did not disclose the reason for the request and so Virgin Care was not made aware that Stephanie had died or the circumstances surrounding her death. The Universal practitioner responded to the request on 22/10/2020 and advised that Virgin care did not hold this information and advised the family had moved in from Yorkshire. The learning is that the practitioner must be clear as to the rationale and purpose for an information sharing request prior to any disclosure.
- There was an action from MARAC that was not acted upon. Practitioners should record clearly that they have reviewed the action and provide clear rationale if a decision is made not to pursue.
- There was a missed opportunity when reviewing information shared by police in relation to a domestic abuse incident. It would have been best practice to liaise with school at this point to ensure sufficient support was available for the child.

### 15 **Conclusions**

- 15.1 Stephanie was a mother of two children. Stephanie was a victim of domestic abuse. Karl had previous convictions for domestic abuse and was the perpetrator of domestic abuse against Stephanie.
- 15.2 Stephanie reported incidents of domestic abuse to the police, which included physical assaults and coercive and controlling behaviour. In December 2019, Karl was arrested by the police after he had assaulted Stephanie on two separate occasions. Karl was released from custody with bail conditions; however, less than a month later, he breached the bail conditions and assaulted Stephanie a further two times.
- 15.3 In January 2020, the case was referred to MARAC; however, not all agencies were aware of the MARAC meeting. This included Stephanie and Karl's GP practice and Children's Social Care.

- 15.4 In March 2020, Karl was released from prison. As part of his release, Karl was fitted with a GPS monitoring tag. Karl breached the conditions of the GPS monitoring 'tag', 35 times. All breaches were reported to the police, yet Karl was only arrested on one occasion (August 2020), where following an appearance at court, he was released with the same bail conditions. The final breach occurred on 2 September 2020, when Karl failed to charge the 'tag'. No action was taken by the police: this meant that after this date, Karl was able to visit Stephanie with impunity, as the monitoring company could no longer report a breach of bail.
- 15.5 It was not until after the death of Stephanie that Karl was convicted of assaulting Stephanie in December 2019. Other offences of domestic abuse were left to lie on file.
- 15.6 The review identified issues and learning for agencies that included -
- A lack of professional curiosity and routine enquiry within health settings, where information was taken at face value.
- A lack of information sharing and joint working across agencies, especially as risk increased.
- That domestic abuse incidents were seen in isolation, previous contacts not always reviewed and therefore risk assessments were not reflective of previous information.
- 15.7 Stephanie's family, including her eldest child, were involved in the review process: the review panel wish to express their thanks for their involvement and contribution.

## 16 **LEARNING**

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

### 16.1 **Narrative**

There were opportunities in this case for the police to have shared information with agencies following the identification of risk factors, including mental health and domestic abuse.

#### **Learning**

Sharing information amongst agencies when risk factors have been identified, provides an opportunity for agencies to review those risk factors and, where relevant, offer support and advice to those concerned.

**Recommendation 1 applies.**

16.2 **Narrative**

There was an opportunity in this case to consider and review all contacts with the police to identify any previous risk factors to help inform the current risk and response. This also provided an opportunity to consider wider sharing of information amongst partner agencies.

**Learning**

Reviewing all incidents and prior contacts with the police will allow for informed risk assessment and decision-making to take place.

**Recommendation 2 applies.**

16.3 **Narrative**

The panel agreed that research linking domestic abuse to the risk of suicide was not well known by staff in their organisations.

**Learning**

Professionals will be better able to manage risk if they are familiar with research linking domestic abuse and suicide.

**Recommendation 3 applies.**

16.4 **Narrative**

There were incidents during the timeframe of this review where the perpetrator repeatedly breached a court order in relation to the requirements of electronic tagging. The court order had been imposed to reduce the risk to the victim. Each incident was reported to the police, but no action was taken.

**Learning**

Proactive and effective management of breaches of orders, including breaches of electronic tagging and court bail breaches, will result in reducing the risk to victims

of domestic abuse and other crimes, and allow perpetrators to be brought to justice.

**Recommendation 4 applies.**

16.5 **Narrative**

There were opportunities in this case for the victim to have been asked whether they had experienced domestic abuse – even when there were no indicators of abuse. This did not take place.

**Learning**

The use of routine enquiry within health settings is part of good clinical practice and provides an opportunity for victims of domestic abuse to disclose abuse.

**Recommendation 5 applies.**

16.6 **Narrative**

There were a number of agencies not involved in the MARAC process for this case, including the victim and perpetrator's GP practice and Children's Social Care. Following a further incident of domestic abuse, the case was not referred back into the MARAC process to allow agencies to review the risk to the victim and children, and to respond appropriately.

**Learning**

The effective management of cases heard at MARAC needs to take place with all relevant information having been shared, all relevant agencies involved being present and represented, and a review of risk when further incidents of domestic abuse occur.

**Recommendation 6 applies.**

17 **RECOMMENDATIONS**

**DHR Panel**

17.1.1 **Recommendation 1**

That Lancashire Constabulary provides evidence and assurances to South Ribble Community Safety Partnership that where they are responding to incidents, which identify potential risk factors, including mental health and domestic abuse, they are sharing information to agencies, in accordance with relevant policies and processes.

**17.1.2 Recommendation 2**

That Lancashire Constabulary provides evidence and assurances to South Ribble Community Safety Partnership that they are reviewing all incidents and prior contacts with the police to inform risk assessment and decision-making.

**17.1.3 Recommendation 3**

Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been provided with information in relation to the link between domestic abuse and suicide risk.

**17.1.4 Recommendation 4**

Lancashire Constabulary should provide a report to the Community Safety Partnership to give the partnership assurance that its review of the EMS Protocol and police responses to all breaches of orders, including EMS breaches and police and court bail breaches, is effective and has resulted in improvements which protect victims of domestic abuse and other crime.

**17.1.5 Recommendation 5**

That Chorley and South Ribble Clinical Commissioning Group provides a report to South Ribble Community Safety Partnership on the implementation and compliance, within GP practices, in relation to NICE Guidance on Domestic Violence and Abuse (PH50).

**17.1.6 Recommendation 6**

That South Ribble Community Safety Partnership seeks evidence and assurances from agencies involved in this review that they are actively involved in the MARAC processes, information sharing is taking place, and cases are being referred in accordance with MARAC policy, including where there have been repeat incidents of domestic abuse.

17.2 **Single Agency Recommendations**

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

**Appendix A**  
**Action Plans**

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
1	That Lancashire Constabulary provides evidence and assurances to South Ribble Community Safety Partnership that where they are responding to incidents, which identify potential risk factors, including mental health and domestic abuse, they are sharing information to agencies, in accordance with relevant policies and processes.	Local	Action Taken	Lancashire Constabulary	<p>Lancashire Constabulary have a robust referral system via CONNECT. Officers flag up referrals for the information of Multi-Agency Safeguarding Hub (MASH).</p> <p>Referrals into MASH, follow the multi-agency sharing protocols for sharing with the relevant agencies.</p> <p>On the 01/08/2025 Lancashire Constabulary implemented a new referral process called Domestic Abuse Risk Assessment (DARA) which replaced the Domestic Abuse, Stalking, Harassment and Honour Based Violence. (DASH) risk assessment. The</p>	N/A	Completed & ongoing throughout all training.

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
					<p>system has been developed using international evidence, experience of practitioners and the advice of survivors of domestic abuse. Coercive control is the most harmful form of domestic abuse and indicates the greatest risk of serious injury and homicide.</p> <p>DARA has been designed to make it easier for officers to identify the presence of coercive and controlling behaviour, so that they are able to make better informed risk assessments.</p> <p>The risk assessment will be reviewed by the Multi-Agency Safeguarding Hub (MASH).</p>		

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					<p>Referrals into MASH, follow the multi-agency sharing protocols for sharing with the relevant agencies. There is a training package for all officers which is mandatory. It remains available on the Police training system.</p> <p>I have attached a copy of the template that the officers now use.</p> <p><a href="#">New Template MASH Referrals</a></p> <p><a href="#">DARA Form Police</a></p>		
2	That Lancashire Constabulary provides evidence and assurances to South Ribble Community	Local	Action Taken	Lancashire Constabulary	All Police Officers as part of their domestic abuse training are instructed when deciding what risk grading, they attach to a	N/A	Completed & ongoing throughout all training.

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
	Safety Partnership that they are reviewing all incidents and prior contacts with the police to inform risk assessment and decision-making.				specific case to review all previous contacts. The current incident, and future risks to the victim / partnership. The Officers should then base their risk grading of an incident on those three factors. In 2025 the new DARA form as highlighted and attached in recommendation one was implemented. DARA has been designed to make it easier for officers to identify the presence of coercive and controlling behaviour, so that they are able to make better informed risk assessments.		
3	Agencies contributing to the review should provide South Ribble Community Safety Partnership with evidence that their staff have been	Local	Action Taken	Victim Support	All our staff who deliver services to victims of domestic abuse are required to undertake domestic abuse training. This includes bespoke	N/A	Ongoing for all staff as part of induction

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
	provided with information in relation to the link between domestic abuse and suicide risk.				training developed by Jane Monkton Smith. Jane Monkton Smith is a leading expert in the Homicide and Suicide Timeline. Training is delivered via e-learning		
		Local	Action Taken	Lancashire Constabulary	<p>As a result of this review, details were passed to the force development manager with responsibility for Domestic Abuse for their information and attention.</p> <p>A review of training around domestic abuse has taken place and now includes domestic abuse and suicide risk.</p> <p>Senior officers have been instructed to consider the history of any domestic abuse/ coercive and controlling behaviour when attending cases of suspected suicide.</p>	N/A	Completed and ongoing throughout all training.

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
		Local	Action Taken	GTD healthcare	<p>Article to be added to the next GTD clinical hot topics to raise awareness regarding the link between domestic abuse and suicide.</p> <p>Resources highlighting the link between domestic abuse and suicide to be added to the staff intranet.</p> <p>Link between domestic abuse and suicide to be discussed as a topic at the next GTD safeguarding committee meeting.</p> <p>In addition, an article on non-fatal strangulation was shared internally to enhance awareness and knowledge.</p> <p><a href="#"><u>GTD Hot Topics March 2024</u></a></p>	10 <sup>th</sup> March 2024	Completed

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
		Local	Action Taken	Progress Housing Group	<p>Staff have been briefed about the link between Domestic Abuse and suicide. Staff have received safeguarding training. This is also included within our new suite of training being rolled out from March 2024</p> <p>Attached document shows a screenshot of available training on DA and Safeguarding within PHG which includes in-person training by the Ann Craft Trust (delivered twice a year). We also delivered a tenants talk session covering all aspects of safeguarding and in particular the importance of professional curiosity was delivered to involved tenants on 10 December 2025. We promote ways to report safeguarding to our</p>	Dec 2021 and ongoing	Training is ongoing for all staff – new and existing and will take place at varying times. As of November 25 98%, of all PHG colleagues have completed mandatory safeguarding training. Specific training was delivered on December 24 to our colleagues on DA by our partner organisation Ley Unlocking Futures who

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					tenants on our website and through social media.  <a href="#"><u>PHG Additional Info Appendix A PDF</u></a>		specialises in DA services
		Local	Action Taken	Virgin Care/HCRG Care Group	Bitesize training has been introduced internally as a CSAP priority. More recently "Tom's Story" (which is linked to a Lancashire DHR where the victim completed suicide) is being rolled out internally and support is being provided to support this training to MA via CSAP.	Complete	July 24- The training is now delivered as a rolling programme. Toms story training is increasing practitioner awareness of the child's voice in DA cases and in particular the link to DA and suicide.
4	Lancashire Constabulary should provide a report to the Community Safety	Local.	Complete a report to review the compliance	Lancashire Constabulary	A Senior Detective conducted a systems review covering the period 1 <sup>st</sup> June – 1 <sup>st</sup> December	N/A	Completed

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
	Partnership to give the partnership assurance that its review of the EMS Protocol and police responses to all breaches of orders, including EMS breaches and police and court bail breaches, is effective and has resulted in improvements which protect victims of domestic abuse and other crime.		around EMS GPS Breach notifications following missed opportunities identified within this DHR.		<p>2022 which included supervisors and managers within Force Control Room / Risk &amp; Threat and CJS Project Managers.</p> <p>Significant gaps were identified around risk management and accountability for breaches.</p> <p>CJS have developed a flow chart to ensure that all EMS breaches are effectively captured and shared with the CJ Prosecutions Mailbox, who ensure that Courts are informed around compliance.</p> <p>ACC Dawson has tasked BCU Commanders with a root and branch review of the process from early risk assessment, appropriate triage, improved tasking</p>		

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					<p>and accountability, and improved co-ordination.</p> <p>Since the review Lancashire Police have provided guidance for front-line officers for EMS Breah of Court bail Guidance in 2024. A flow chart has been added to ensure that all EMS. breaches are effectively captured and shared with the CJ Prosecutions Mailbox, who ensure that Courts are informed around compliance.</p> <p>I have attached the EMS Court bail breach guidance, and I have also attached the guide.</p> <p><a href="#">The importance of getting a grip of EMS breaches</a></p>		

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					<a href="#">EMS Breach of court bail</a>		
5	<p>That Chorley and South Ribble Clinical Commissioning Group provides a report to South Ribble Community Safety Partnership on the implementation and compliance, within GP practices, in relation to NICE Guidance on Domestic Violence and Abuse (PH50).</p> <p>Amended Jan 26: That Lancashire and South Cumbria ICB provide an update on the learning from the review in relation to NICE Guidance on Domestic Violence and Abuse (PH50)</p>	Regional	<p>Share learning with the Central and West Lancashire practices further to Lancashire and South Cumbria and regional.</p> <p>Please note this DHR was commissioned whilst CCGs were still in place.</p> <p>The actions were strengthened to incorporate</p>	CCG/ICB	<p>Practices will be briefed on learning points.</p> <p>The ICB has an executive nurse lead for domestic abuse.</p> <p>ICB has a duty to collaborate and work together with the Local Authorities when commissioning services.</p> <p>The ICB has developed a trauma informed approach to DA service delivery and improvement. A Trauma Informed Lead post is in place.</p> <p>ICB Domestic Abuse Health Strategic Group is in place with a priority work plan. This includes a</p>	April 2022	<p>Completed</p> <p><a href="#">2023-03-16 Primary Care event IG</a></p> <p><a href="#">DA Sample Template GP</a></p> <p><a href="#">DA Resource Booklet PC</a></p>

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
			<p>learning across the ICB footprint.</p> <p>Circulate recent newsletter identifying the importance of routine enquiry.</p> <p>Please note these actions were further developed across the L&amp;SC footprint</p>		<p>targeted approach to governance, learning and best evidence, partnership working, and frontline actions.</p> <p>Voice of child, adult, victims/survivors is incorporated into improvement activity and embedded across all areas of work.</p> <p>The ICB is represented at the DA partnership groups across Lancashire, Blackburn with Darwen, Blackpool and West Morland and Furness.</p> <p>The ICB engages in MARRAC/MARAC improvement activity across L&amp;SC.</p> <p>A thematic review has been undertaken of all commissioned DHR's completed from the</p>		<p><a href="#">DA rural comms</a></p> <p><a href="#">DA and Workplace Policy</a></p> <p><a href="#">Template Introductory Letter</a></p> <p><a href="#">250211LSCI CB DA Health Group ToR</a></p>

DHR Panel Recommendations							
No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
					<p>original CCG footprints and new reviews, since inception of the ICB. The top three themes across the ICB and primary care include recording and coding of records, routine enquiry and information sharing across primary care. This exercise will consider further scoping of wider health providers learning themes during 2026/27.</p> <p>An ICB audit plan is in place and will include a focused audit to support embedding practice across primary care. A routine enquiry audit is due to take place in Q4 2026.</p> <p>Policies and procedures are in place which include domestic abuse in the workplace and sample</p>		

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
					<p>policies on DA for primary care.</p> <p>Targeted learning is provided to primary care on DA and learning from reviews within the lunch and learn sessions and protected learning events. Sessions include non-fatal strangulation and Tom's Story – lived experience.</p> <p>Domestic abuse routine enquiry prompts are now in place across primary care on the EMIS tool (recording template).</p> <p>The ICB has contributed to the development of the Lancashire DA Strategy and multi-agency DA Toolkit for all ages.</p> <p>The ICB has developed specific DA awareness resources for primary care</p>		

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
					<p>based on themes from learning reviews.</p> <p>ICB is strengthening its approach to DA awareness within Human Resources department with planned activity in Q3/4 2025/26</p> <p>ICB is a member of Employers Initiative on DA with executive nursing and Medical Directors as sponsors.</p> <p>IRIS programme implemented across selected sites across primary care across L&amp;SC. The project has concluded however practices can access IDVA via Victim Support Services.</p> <p>ICB is proactive in DA awareness campaigns e.g. White Ribbon – 7 Minute Briefings and podcast,</p>		

<b>DHR Panel Recommendations</b>							
<b>No</b>	<b>Recommendation</b>	<b>Scope local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones achieved in enacting recommendation</b>	<b>Target Date Completion</b>	<b>Completion Date and Outcome</b>
					<p>"Why Speaking Up Matters".</p> <p>ICB is proactive in contribution to multi-agency audits action plans etc. e.g. JTAI.</p> <p>ICB has undertaken awareness raising activity across CSP's in DA in rural communities.</p>		

6	That South Ribble Community Safety Partnership seeks evidence and assurances from agencies involved in this review that they are actively involved in the MARAC processes, information sharing is taking place, and cases are being referred in accordance with MARAC policy, including where there have been repeat incidents of domestic abuse.	Local	Action Taken	Victim Support	<p>Victim Support is commissioned to provide Independent Domestic Abuse Services (IDVA) to high risk victims of domestic abuse across Lancashire 12 which covers South Ribble.</p> <p>The role of the IDVA is to work within the structure of MARAC and be the voice of the victim, advocating for their wishes and needs.</p> <p>All cases that are referred to IDVA will also be referred to MARAC either by the referring agency or the IDVA in the event the referrer hasn't.</p>	Ongoing	Ongoing
		Local	Action Taken	Lancashire County Council – Children's Social Care (MASH)	<p>1.CSC is now a core partner in the Lancashire MARRAC model alongside Police, Health Probation, Adults Services, and IDVA Services.</p> <p>MASH Social Workers attend all MARRAC meetings (held 3 times weekly) and contribute to multi-agency safety planning.</p>		

					<p>CSC provides input on household composition and ensures all children are considered in risk assessments and safety plans.</p> <p>Statutory Safeguarding processes remain unchanged (S17 &amp; S47 Children Act) but are now embedded within MARRAC discussions.</p> <p>CSC ensures that any child linked to a MARRAC case is flagged on internal systems and monitored for welfare concerns.</p> <p>2.CSC actively shares relevant information at MARRAC and receives updates via the dedicated MS Teams MARRAC platform and CONNECT system.</p> <p>All Actions assigned to CSC are tracked and completed within agree timescales, with escalation routes in place for delays. PSR's shared with schools to</p>		
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					<p>notify of DA incidents via Operation Encompass. Early Years Operation Encompass shared PSR's with nursery.</p> <p>3.Social workers explore who resides within the household and confirm household composition during MASH screening.</p> <p>This addresses previous learning where a child (Sam) was missed in enquiries during the DHR report.</p>		
		Local	Written assurances that the safeguarding team and MARAC Managers have put a protocol in place to ensure the Safeguarding team are aware of all MARAC meetings	Lancashire Constabulary	Case lists are sent out in advance to allow safeguarding officers to research and prepare their reports. This will contain the names of victim, perpetrator, and any known children. Each BCU will have a safeguarding officer or police representative in attendance at every meeting. The information is password protected with	N/A	Completed

			and are provided with the details of those being discussed at these meetings		<p>passwords that change each month.</p> <p>A new model MARRAC is due for implementation in the first half of 2024 which will entail a multi-agency action tracker, held available to update all actions within Teams. Specific completion dates will be allocated with the expectation for all agencies to update their own actions. Any remaining outstanding following the closure date will be chased through escalation to line managers and brought up as AOB in the next MARAC.</p> <p><b><u>MARRAC Policy</u></b></p>		
		Local		gtd healthcare	<ul style="list-style-type: none"> <li>gtd healthcare actively engages in the MARAC referral process – in the past 4 months there have been two cases which have been</li> </ul>		Completed

					<p>reported via our urgent care service.</p> <p>gtd healthcare receives monthly case summary lists from Lancashire police and shares information regarding patient contacts with our GP OOHs service and urgent care centres for patients residing in the Preston and Chorley area.</p>		
		Local		Progress Housing Group	<p>Progress colleagues are actively involved in the MARAC process. We attend MARAC meetings and provide updates and undertake recommended actions where required. We share information with the relevant agencies in line with data sharing protocols</p> <p>Since the MARRAC process has been adopted in Lancashire PHG is no longer a regular participant in the meetings. We are invited as required and will contribute and participate fully, sharing information in line with data-sharing</p>		Ongoing

					<p>protocols. Key Unlocking Future will be delivering the IDVA service from April 2026 and will automatically become part of the core group, improving communication in future.</p> <p>PHG have also reviewed their safeguarding process, and all cases are tracked in core housing management systems and actions. This includes actions such as multi-agency meetings; all cases are reviewed by a manager before they are closed.</p> <p>Performance reports are presented quarterly to the Safeguarding Review Group who oversee safeguarding across the group.</p>		
		Local	HCRG Care group to be involved in the health implementation plan of	Virgin Care/ HCRG Care Group	We are involved in the new Lancashire MARRAC 12 process, including where applicable sharing health information, and attending panel	June 24	June 24- Complete – HCRG Care group are now an integral part of

			the new MARRAC model, ensuring that systems and processes are in place to share information into the panel and attend		discussions. We flag cases of high-risk DA on our clinical systems and there is a system in place where referrals to MARRAC are overseen by our safeguarding team		information sharing for MARRAC
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<b>Single Agency Recommendations Lancashire Constabulary</b>						
<b>No</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcome</b>	<b>Lead Officer</b>	<b>Sign off date</b>
1	Lancashire Constabulary to undertake a full review of its EMS Protocol and police responses to all breaches of orders, including EMS breaches and police and court bail breaches.	Review of EMS Policies and Protocols.	Please see response to Action 4.	Please see response to Action 4.	Detective Chief Inspector Horne	February 2024
2	Lancashire Constabulary to consider, as part of their annual auditing calendar,	To conduct audits of police	To be carried out under new	The Headquarters Public Protection Unit has	Detective Superintendent Drummond	25/03/2024

<b>Single Agency Recommendations Lancashire Constabulary</b>						
<b>No</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcome</b>	<b>Lead Officer</b>	<b>Sign off date</b>
	an audit on police response to coercive and controlling behaviour in relationships. This audit is to consider if police both recognise coercive and controlling behaviour and investigate controlling and coercive behaviour alongside substantive offences.	response to coercive and controlling behaviour.	department structure.	<p>undergone a full review; this has resulted in a complete restructuring of the department. HQ PPU will be replaced on 25<sup>th</sup> March 2024 with the Vulnerability Governance Unit (VGU).</p> <p>Whilst HQ PPU have conducted a number of audits over the last two years, including DA Audits, those audits have not included Coercive and Controlling Behaviour. A request will be made to the new VGU Department Heads for such an audit to be included over the next 12 months.</p> <p>In May 2023 Lancashire Constabulary introduced mandatory 'DA Matters' is part of the new recruits training programme. It is also available to police staff. It has been devised by the</p>		

<b>Single Agency Recommendations Lancashire Constabulary</b>						
<b>No</b>	<b>Recommendation</b>	<b>Key Actions</b>	<b>Evidence</b>	<b>Key Outcome</b>	<b>Lead Officer</b>	<b>Sign off date</b>
				College of Policing, and the course runs over a full day. Part of the programme covers recognising coercive and controlling behaviour and investigating controlling and coercive behaviour alongside substantive offences. These investigations are reviewed by supervision and concentrate on four main areas; victim centred, suspect focussed, quality of investigation and supervisor reviews. Completing all investigations by the due date is mandatory.		
3	Lancashire Constabulary to consider, as part of their annual auditing calendar, an audit on its Supervisory and Investigative Management 'Footprint' in domestic abuse cases.	As per recommendation 2 above.	To be carried out under the new department structure.	On the 31/08/2023 Lancashire Constabulary introduced Quality Assurance Thematic Testing (QATT) This aims to ensure the quality of investigations and the outcomes for victims. From 31/08/2023, all Inspectors and Chief Inspectors who oversee investigations will receive an	Detective Superintendent Drummond	31/08/23

Single Agency Recommendations Lancashire Constabulary						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				email outlining a number of investigations which they are required to review for levels of quality. The process will run weekly and contains a number of questions around the quality of the investigation which will concentrate on four main areas; victim centred, suspect focussed, quality of investigation and supervisor reviews. Completing the QATT on all investigations by the due date is mandatory.		

NHS Chorley and South Ribble CCG						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	To raise awareness of the link between pregnancy and domestic abuse.	To include in Primary Care newsletter as a learning theme.	<a href="#">220216 ICB-CCG Action Plan</a>	Practices will be briefed on learning points. Practices are aware of importance of routine enquiry and discharging their responsibilities appropriately	Kristy Atkinson	April 2022

Progress Housing Group						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	Review Progress Housing Group Procedures in relation to domestic abuse.	Process review	<p>Revised policy and procedure attached.</p> <p><a href="#">PHG Domestic Abuse Procedure</a></p> <p><a href="#">PHG DA Policy Document</a></p>	<p>The procedure was reviewed in 2021 and updated in March 2024.</p> <p>From September 2023 our internal approach changed, and all Domestic Abuse cases identified are now referred in through our specialist Domestic Abuse Outreach Service.</p> <p>The policy was reviewed in 2021 and is due to be reviewed again in December 2024</p> <p>PHG DA Policy was reviewed again in December 25 and is in final draft. It was revised to align with the Lancashire Domestic Abuse Strategy 2025-2028 and incorporate reference to the Lancashire Domestic Abuse Toolkit. The revised policy includes all 13 principals from the Lancashire Domestic Abuse Strategy and the six principals of trauma informed approaches. It was</p>	Tola Adesemowo	November 2021

Progress Housing Group						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				initially 3 but a perpetrator accountability section has been added and references the multi-agency working through the LDAPB and MARRAC.		
2	Provide training on the revised domestic abuse procedures to relevant colleagues.	Train Progress colleagues		<p>Training on Domestic Abuse procedures is provided to all colleagues through our online training portal. Face to face training is also provided and the latest version of this is due to be rolled out in March 2024.</p> <p><a href="#">PHG Additional Info Appendix A</a></p>	Tola Adesemowo	<p>March 2024</p> <p>This is an ongoing process and training materials and details are included in the attached evidence.</p>

Virgin Care						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	To develop a guide for managing information requests from outside agencies to include prompts for staff to clarify the reason for the	This issue in relation to not understanding the reason for information being	<a href="#">HCRG Information Governance</a>	All staff are required to adhere to our IG policy, which is attached and includes relevance and proportionality,	Susan Barber	Learning session to be completed by Dec 2024

Virgin Care						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
	information request and therefore be able to document a clear rationale as to why the information is being shared. This will also support the development of a safeguarding plan for the child going forward.	requested for outside agencies has not been highlighted as an issue in any other case. However, a bite sized learning session is to be developed in relation to the single and multiagency learning in this case and cascaded out as training to our staff		understanding the reason we are sharing information		
2	Review the Domestic Abuse SOP and make revisions where necessary, to include MARAC action follow-up and review of information sharing in relation to domestic abuse incidents.	Update DA SOP to include actions to take following case being heard at MARRAC and information sharing process	<a href="#">HCRG Responding to DA</a>	HCRG Care Group DA SOP has been updated to include MARAC action follow-up and review of information sharing in relation to domestic abuse incidents. HCRG Care Group have also signed multiagency MOU in respect of information sharing and MARRAC	Susan Barber	Feb 2023

Virgin Care						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
3	Share learning across Virgin Care Services.	Learning from this case to be discussed at Lessons learnt portfolio group and a bite sized learning session to be delivered to staff on the learning from this case.			Susan Barber	

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
1	Improve guidance and training with regards to domestic abuse	Provide improved guidance and training for staff on domestic abuse.	Training materials: <a href="#">GTD DA Referral Pathways</a>  <a href="#">GTD DA Training Slides</a>	1) Additional Hot Topic articles have been shared to raise awareness of other risks associated with domestic abuse. Topics covered have included domestic abuse in pregnancy and the importance of professional curiosity in identifying		

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
			<a href="#">GTD Professional Curiosity</a>  <a href="#">GTD Safeguarding Agenda 13052025</a>  <a href="#">GTD Staff Intranet Page</a>  <a href="#">GTD April Hot Topics</a>	<p>and responding to risk.</p> <p>2) Domestic Abuse was the safeguarding theme of the months in March 2025. The safeguarding team raised awareness of domestic abuse, its impact, how to recognise the signs and provide details of support agencies available to ensure all GTD staff can recognise the signs of abuse and know how to escalate concerns appropriately. A patient pathway was launched for our urgent care services to support staff by providing step-by-step guidance on how to respond to disclosures of abuse. The pathway outlines the necessary actions</p>		

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				<p>and key considerations to ensure victims, children and families affected by domestic abuse receive the right support, protection, and care. The guidance specifically makes reference to disclosures of non-fatal strangulation and how to refer to MARAC.</p> <p>3) At the GTD Safeguarding Forum in May 2025 the launch of the Urgent Care Patient Pathway for Domestic Abuse was discussed, and we took the opportunity to re-share the NHS Rapid Read on non-fatal strangulation. The resources were disseminated to attendees, and they</p>		

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				<p>were asked to share with colleagues across their services to raise awareness.</p> <p>4) A dedicated domestic abuse page has been established on the staff intranet to bring together all relevant resources, guidance, and information for staff, supporting consistent access to up-to-date safeguarding materials.</p> <p>5) We have also updated our inhouse DVA training to include a discussion regarding non-fatal strangulation and how to complete a referral to MARAC with the aim of improving knowledge, awareness,</p>		

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				<p>recognition, and associated risks. The feedback from staff has been positive and that they found this information useful.</p> <p>6) The safeguarding team audits all reported safeguarding cases on a quarterly basis to ensure appropriate management and compliance with safeguarding standards. Over the past 18 months, these audits have demonstrated a significant improvement in the management of domestic abuse cases, which is reflected in an improved recognition of risk, more</p>		

GTD Healthcare						
No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Sign off date
				consistent application of safeguarding processes and timely escalation.		

## **Appendix B – Home Office Quality Assurance Panel Letter**

[Chorley South Ribble Feedback Letter](#)