South Ribble
Community Safety Partnership

Executive Summary

Domestic Homicide Review

Name: Stephanie

Died: October 2020

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

Date: August 2022

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1 The Review Process

1.1 This summary outlines the process undertaken by the South Ribble Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Stephanie, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and their daughter in order to protect their identities.

Name	Who	Age	Ethnicity
Stephanie	Victim	33	White British
Karl	Stephanie's partner	27	White British
Sam	Stephanie's child	High school age	White British
Alex	Stephanie's child	Primary school age	White British

1.3 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.

1.4 Although Stephanie was unemployed, she had made efforts to gain employment and engaged with support from her housing provider for this.

1.5 Stephanie lived close to her father and his wife, who she referred to as her step mum.

1.6 At the beginning of 2019, Stephanie formed a relationship with Karl. At various points during the period under review, Karl also lived at her address, although this was not always disclosed to relevant agencies.

1.7 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.

1.8 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 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)[1]. The Home Office was informed on 19 November 2020.

1.11 An inquest was held on 16 March 2021.

The medical cause of death was hanging.

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.

2 Contributors to the Review

Agency	Contribution
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

[1] 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.

	Children's Social Care	IMR
	GTD	Chronology
	Progress Housing Group	Chronology

The Review Panel Members

3	Ged McManus	Chair
3.1	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 Sewards	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

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

4 Chair and author of the overview report

4.1 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.

4.2 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[2]. Carol has completed accredited training for DHR chairs provided by AAFDA.

4.3 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.

4.4 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.

5 Terms of Reference

5.1 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

[2] https://safelives.org.uk/

Reviews 2016 section 2 paragraph 7)

5.2 Timeframe under Review

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

5.3 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[3], 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

[3] 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).

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?

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?

6 Summary chronology

6.1 During the early part of 2019, Stephanie began a relationship with Karl. The exact date is not known to the panel.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

6.6 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.

6.7 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 son, 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.

6.8 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.

6.9 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.

6.10 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.

6.11 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.

6.12 On 28 November, police undertook a disclosure under the Domestic Violence Disclosure Scheme (Clare's Law) to Stephanie, in respect of Karl.

6.13 At some point in December 2019, Sam returned to live with Stephanie's mum in Yorkshire.

6.14 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.

6.15 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.

6.16 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.

6.17 Following the incident on 27 December, Victim Support received a referral via the MASH[4] 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.

6.18 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.

6.19 On 7 January 2020, Karl appeared before Preston Magistrates and was given the following bail conditions by the court:

1. Live and sleep at [address redacted].
2. Not to contact Stephanie directly or indirectly.

[4] Multi Agency Safeguarding Hub

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.

6.20 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.

6.21 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).

6.22 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.

6.23 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.

6.24 On 26 March 2020, Karl was bailed from prison with the following conditions:

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

6.25 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.

6.26 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.

6.27 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.

6.28 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.

6.29 On 13 August 2020, following a notification to Lancashire Constabulary from EMS[5] – 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.

6.30 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.

6.31 On 28 September 2020, Stephanie attended GTD at Chorley Hospital, reporting a sprain to her knee and a foreign body on the external eye.

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

6.33 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.

[5] EMS is a trading name of Capita Business Services Limited.

6.34 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.

6.35 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.

6.36 Lancashire Constabulary secured the scene and opened an initial homicide investigation. Karl was arrested and interviewed under caution.

6.37 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.

6.38 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.

7 Key issues arising from the review

- Opportunities to share information were no maximised.
- Prior contacts were not always reviewed when Stephanie contacted the police this meant risk assessments did not take account of all known information.
- The risk of suicide related to domestic abuse is not well known by professionals.
- 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.
- Routine enquiry into domestic abuse by practitioners in health settings was not embedded.
- Not all appropriate agencies were actively engaged in the MARAC process.

8 Conclusions

8.1 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.

8.2 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.

8.3 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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.

9 Learning identified

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

9.1 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.

9.2 **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.

9.3 **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.

9.4 **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.

9.5 **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.

9.6 **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.

10 Panel Recommendations

10.1 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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).

10.6 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.

Single agency recommendations are shown in the DHR action plan.