Pennine Lancashire Community Safety Partnership

Domestic Homicide Review

Victim – Christine who is believed to have been murdered in late January or early February 2019.

Independent Author – David Mellor BA QPM

Report completed on May 2023
Home Office Quality Assurance Panel December 2023
Home Office Feedback February 2024
Revised document July 2024

1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Christine (a pseudonym chosen by her mother), a resident of Darwen in Lancashire prior her murder which is believed to have occurred in late January or early February 2019.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

1.3 In early February 2019 Christine was reported as a missing person to Lancashire Constabulary by her mother. Christine had been in a relationship with Paul (also a pseudonym) for no more than two months prior to her disappearance and the last professional contact with Christine was when she visited her GP practice, accompanied by Paul, in mid-January 2019. At that time, Christine had serious facial injuries and was advised by the GP to attend hospital, although there is no indication that she did so. The police missing person investigation was unable to trace Christine and after concluding that there was no evidence that she was alive, the police arrested Paul on suspicion of her murder. After an extensive police investigation, which involved interviewing several former partners and which confirmed that Paul was a serial perpetrator of domestic abuse over several decades, he was charged with the murder of Christine, whose body has never been found. In April 2021 Paul was convicted of the murder of Christine and several offences of violent and controlling behaviour towards former partners who had been supported to overcome their deep seated fear of Paul and give evidence in the trial. Paul was sentenced to life imprisonment and must serve a minimum term of 27 years before being eligible to apply for parole.

1.4 On 29th May 2020 representatives of Pennine Lancashire Community Safety Partnership decided to commission a Domestic Homicide Review (DHR) in respect of the then alleged murder of Christine. The Community Safety Partnership decided to delay the start of the DHR until after Paul's trial had taken place on the grounds that this was an extremely complex investigation which involved many agencies, several of which would also be involved in the DHR.

1.5 The DHR has considered agency contact/involvement with Christine from the point at which she relocated from Glasgow to Darwen in August 2017 until her family reported her missing to Lancashire Constabulary in February 2019. Any

significant events prior which took place outside these timescales were also considered. As stated the DHR understands that Christine's relationship with the perpetrator Paul was quite brief. Paul was a serial perpetrator of domestic abuse in a number of other intimate relationships with women and evidence of the abuse he inflicted on other partners was a key factor in securing his conviction for the murder of Christine. Therefore the review will also consider agency contact with Paul but will not confine consideration of his conduct to the brief period during which he was in a relationship with the victim Christine.

1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is murdered as a result of domestic violence and abuse or apparent suicides of victims of domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

DHR Timescales

1.7 Although Christine was first reported missing to Lancashire Constabulary in February 2019, her body was never recovered and the criminal investigation was complex. Paul was charged with the murder of Christine in April 2020 and the case was referred for consideration of a DHR a matter of days later. The Pennine Lancashire Community Safety Partnership decided that the criteria for conducting a DHR had been met in May 2020, but the review was then deferred until after the conclusion of Paul's trial in April 2021. The DHR did not recommence until October 2021 due to local capacity issues and the impact of responding to the Covid-19 pandemic and was largely concluded in October 2022. However, there was a further delay of several months whilst attempts were made to clarify whether or not the perpetrator wished to contribute to the DHR. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. A pseudonym for the victim was agreed with Christine's mother and used in the report to protect the identity of the individuals involved. At the time of the murder, the victim Christine was 45 years old and the perpetrator Paul was 46. Both the victim and the perpetrator were White British.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. In this case the victim leaves five adult children, her mother and her siblings. Pennine Lancashire Community Safety Partnership therefore wishes to express sincere condolences to the family and friends of Christine.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

1. 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;

2. 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;

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

4. 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;

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

6. Highlight good practice.

2.2 The case specific terms of reference are as follows:

The victim:

- When the victim moved to the area from Scotland were her needs adequately assessed, her vulnerabilities recognised and information appropriately shared?

- How did agencies respond to any indications or disclosures of domestic abuse by the victim? Were opportunities taken to routinely ask her whether she was a victim of domestic abuse?

- Did the victim receive, or was she offered, support from domestic abuse services?

- Were there any barriers to the victim disclosing domestic abuse or seeking support?

- How effectively were her mental health and alcohol dependence issues addressed?

- How effectively did agencies respond to difficulties in engaging with the victim?

- Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

The relationship between the victim and the perpetrator:

- What did agencies know about the relationship between the victim and the alleged perpetrator? How did agencies respond to any indications or disclosures of domestic abuse arising from the relationship?

- How effectively did partner agencies comply with policy, work together, assess risk and share information?

The perpetrator

- The perpetrator was a serial perpetrator of very serious domestic abuse in a number of prior intimate relationships. The evidence given by some of his previous victims was instrumental in securing his conviction for murder in the case of DHR 7. What can we learn about serial perpetrator behaviour and how to address it from the evidence given by his previous victims? What can we learn from the support provided to the previous victims which enabled them to give evidence in court despite their continuing fear of the perpetrator?

3.0 Methodology

3.1 On 5th May 2020 Lancashire Constabulary referred the case to the Pennine Lancashire Community Safety Partnership for consideration of holding a DHR. On 29th May 2020 representatives of Pennine Lancashire Community Safety Partnership decided that the circumstances of the death met the criteria for a DHR.

3.2 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with the victims, the victim's families and the perpetrator. Several agencies also provided summary IMRs. The authors of the IMRs had the discretion to interview members of staff if this was required.

3.3 The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

Contributors to the DHR

3.4 The following agencies provided Individual Management Reviews to inform the review:

- Blackburn with Darwen Borough Council Housing Needs
- Blackburn & Darwen District Without Abuse Ltd (The WISH Centre)
- Lancashire Constabulary
- Lancashire and South Cumbria NHS Foundation Trust
- NHS Lancashire and South Cumbria Integrated Care Board (Formerly NHS Blackburn with Darwen Clinical Commissioning Group).
- Housing Provider 1

The following agency provided summary Individual Management Reviews to inform the review:

- Blackburn with Darwen Children's Social Care

3.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

The DHR Panel Members

3.6 The DHR Panel consisted of the following members. It is normal practice to include the names of DHR Panel members but on this occasion, having considered the history of the perpetrator, it was decided not to include DHR Panel member's names.

Role	Organisation
Specialist Safeguarding Practitioner	NHS Lancashire and South Cumbria Integrated Care Board
Hospital IDVA	East Lancashire Hospitals NHS Trust
Review Officer	Lancashire Constabulary
Head of Service	Blackburn with Darwen Adult Social Care
Service Manager	Delphi Medical Drug and Alcohol Addiction Treatment Service.
Community Safety Support Officer	Blackburn with Darwen Council
Chief Executive Officer	The WISH Centre
Domestic Abuse Development Officer	Blackburn with Darwen Borough Council Community Safety Team.
Assistant Director Supported Housing & Neighbourhood Safety	Together Housing
Named GP for Safeguarding	NHS Lancashire and South Cumbria Integrated Care Board
Independent Chair and Author	
Housing Needs Team Leader	Blackburn with Darwen Council.

3.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions; on 4th October 2021, 14th December 2021, 26th April 2022 and 23rd June 2021.

3.8 Christine's mother was advised of the decision to commission the DHR and sent the relevant Home Office leaflet. She decided to contribute to the DHR and was supported by her Victim Support Homicide Worker to meet the independent author at her home address and provide her account. Christine's sister joined Christine's mother part way through this meeting and also shared her views. Christine's mother chose the pseudonym used in this report. A late draft of the DHR report was shared with Christine's mother which she read. She was again supported by her Victim Support Homicide Worker. Christine's sister was also offered the opportunity to read

the DHR report but did not wish to do so. Christine's mother was offered the opportunity to meet the DHR Panel but decided not to do so.

Author of the overview report

3.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has ten years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

3.10 The independent chair and author was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

3.11 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

3.12 He has no current connection to services in local authorities who are represented on the Pennine Lancashire Community Safety Partnership.

Parallel reviews

3.13 As Christine's body has not been found it is not currently possible to hold an inquest.

Equality and diversity

The protected characteristics relevant to the victim Christine are addressed in Paragraphs 6.29 to 6.32.

Dissemination

In additional to the DHR Panel members, the report will also be sent to:
(List to be compiled in due course to include the Police and Crime Commissioner and the Domestic Abuse Commissioner for England and Wales).

List of recipients who will receive the report:

- The Home Office.
- Domestic Abuse Commissioner
- Family members involved in the review
- Pennine Lancashire Community Safety Partnership
- Blackburn with Darwen Local Domestic Abuse Partnership Board

4.0 Involvement of the family of the victim Christine

4.1 Christine's mother met the independent author at her home address. One of Christine's sisters later visited her mother and joined the conversation. Christine's mother's Victim Support Homicide Worker was also present to offer support.

4.2 Her mother said that Christine was her first born child. She described Christine as a 'difficult' child who had learning difficulties and attended a school for children with additional needs. Her mother was asked if Christine had ever been diagnosed with a learning disability and she said that her daughter had not had such a diagnosis and that the term 'learning difficulties' was always used. During her early childhood, her mother said that Christine was always 'banging herself' and she experienced a setback when she lost the sight in her right eye following an operation for retinal detachment when she was around 7 years old.

4.3 When asked how Christine's learning difficulties affected her life as she was growing up, her mother said that Christine struggled to 'think for herself' and needed support in areas of her life such as finding her way from one place to another. She went on to say that Christine struggled to care for herself although she was generous in offering help to others.

4.4 Her mother said that Christine started using illicit drugs and alcohol from a young age in common with the young people who were her friends at that time of her life. Her mother felt that Christine thought that 'everything was a laugh' at that stage of her life and didn't think through the consequences of her actions.

4.5 Her mother said that Christine had a long term relationship with a man who was the father of her five children. They mainly lived together in the Blackburn area and both used drugs. She recalled that Christine and her partner's eldest child was removed from their care by children's social care after the child sustained an injury which was regarded as non-accidental. Her mother went on to say that Christine's eldest child was placed with her (Christine's mother) followed by Christine's second and third children. She (Christine's mother) said that she then parented Christine's elder three children for the remainder of their childhood. She added that Christine's fourth and fifth children were later removed from her care and permanently placed with one of Christine's brothers.

4.6 When asked what was the impact on Christine of permanently losing custody of her children, her mother replied that it 'broke' Christine. Her mother said that all Christine wanted was to have a family, but she (Christine's mother) said that her daughter was 'not capable' of parenting her children because of her dependence on alcohol and drugs. She went on to say that the pain of losing custody of her children

was softened slightly by the fact that she was able to see her elder children on a daily basis because they were placed with Christine's mother and Christine lived nearby at that time.

4.7 Christine's mother said that her daughter lived in Scotland for around a decade. She said that whilst living in Scotland, Christine suffered two bereavements when successive partners died. Christine's mother and Christine's sister – who had joined the conversation by this stage – said that they persuaded Christine to return to Darwen following a fire in her home in Glasgow. They said that Christine had suffered severe smoke inhalation and had initially not been expected to survive. They understood that the fire had been caused by 'some lads' who she had invited into her home or had 'invited themselves' because of Christine's vulnerabilities.

4.8 Her mother and sister felt that she 'settled in fine' following her return to Darwen. After living with her mother for a short period, she moved into her own flat and her family helped her to decorate it. They said that she had left Glasgow with no possessions apart from her clothes. They felt that she was 'doing alright', keeping the flat clean, managing her money and going to her mother's house for meals quite regularly. They said that her chest was 'bad' and so she tried to cut down on her smoking and succeeded to an extent.

4.9 Her mother and sister said that Christine began a relationship with Jon which lasted for around nine months. They said that Christine was 'quick to jump into' relationships. They said they didn't know why that was and suggested that loneliness was a factor. Her mother and sister felt that when she began the relationship with Jon, she was 'desperate' to have a baby she could keep. They recalled that, as an adult, Christine rocking her doll – as if to rock it to sleep – and treating it as if it was a live baby.

4.10 Her mother and sister recalled that at some stage she left her flat and moved in with Paul. They said they didn't know how the relationship with Paul began but he was a friend of Jon's. They went on to say after beginning the relationship with Paul, they never saw Christine – not even over the Christmas 2018 period. The sister said that she felt that there was something not right about the relationship. She said that she didn't know Paul but visited his Facebook page and, from the images he had posted, he appeared to be showing off his muscular body and she wondered why someone who presented that type of image would start a relationship with Christine, who was kind and loving but very vulnerable. Looking back, her mother and sister felt that Christine would have been particularly at risk in a relationship with Paul who, they have subsequently found out through the evidence given in his trial, was a very controlling man. They felt that Paul would have been able to manipulate and

control Christine without difficulty and she may have struggled to keep herself safe in the relationship.

4.11 Reviewing the contact Christine had with agencies, her mother and sister felt that after her return to Darwen, Christine settled in well but she needed more support than she received. They felt that she would have benefitted from a social worker. They also said that they were disappointed with the response of her GP practice to her injuries when she visited the surgery with Paul shortly before she went missing.

4.12 Christine's mother had the opportunity to read and comment on the final draft DHR report. She was supported by her Victim Support Homicide Worker. She said that reading the report had made her feel depressed because it had entailed reliving distressing events. She said she had no comments to make on the contents of the report.

4.13 Efforts were made to enable the perpetrator Paul to contribute to the DHR. However, when arrangements were made to interview him in the prison where he is serving his life sentence he did not attend and cited a medical appointment which was believed to be non-urgent. After further efforts were made to provide Paul with an opportunity to contribute to the DHR without success it was decided to proceed without his contribution.

5.0 Chronology/Overview

Background information (Paragraph 5.1 and 5.2)

5.1 Christine was born in 1973 and attended a school for children with additional needs. Her mother has advised this DHR that Christine was considered to have learning difficulties as a child but there doesn't appear to be any reference to learning difficulties in the adult medical records shared with this review. She was born and brought up in the Blackburn with Darwen area and lived there for much of her life with the exception of a nine year period residing in Glasgow. She had been blind in her right eye - following retinal detachment – from her early childhood. She had a history of depression and opioid and alcohol dependence. She was a heavy smoker, had asthma and had been diagnosed with COPD whilst living in Scotland although this was later ruled out by her Darwen GP practice.

5.2 She gave birth to five children during a long term relationship with the children's father, but all of the children were eventually removed from their care by children's services and permanently placed with Christine's family members. Her family feel that losing custody of her children had a profound effect on Christine, but they said that she never gave up hope of becoming a mother – and retaining custody of the child - as she entered early middle age. As well as losing custody of her children, Christine's family have advised this review that she suffered bereavements following the deaths of two of her partners. The most recent bereavement of a partner had taken place in 2016.

5.3 Background information in relation to the perpetrator Paul can be found in Paragraphs 6.36 to 6.38 where there is a summary of relevant information from statements made by previous victims of domestic abuse by Paul – which were instrumental in securing his conviction for the murder of Christine on the basis of evidence of 'bad character'.

5.4 On 25th July 2017 Christine suffered severe smoke inhalation during a fire at her home in Glasgow and spent 12 days in intensive care in Hospital 1 in that city. She was later stepped down to a High Dependency Unit and then to a general ward. Hospital discharge arrangements are unclear. It appears that she had no home to return to in Glasgow and that her family in Darwen were anxious for her to return to live near them so that they could support her in her recovery and help her to keep safe. It is understood that Christine had been drinking heavily at the time of the fire in her home and that she was treated for alcohol dependence during her hospital admission.

5.5 On 14th August 2017 Christine's brother phoned Blackburn with Darwen (BwD) Council to inform them that his sister was 'fleeing Scotland after her flat was set on fire'. The brother said that the police were investigating the incident as an 'attempted murder' and that Christine had been 'in a coma' in Scotland for 11 days. An appointment was arranged with BwD Council's Housing Needs team which Christine attended, accompanied by her mother two days later. During this appointment Christine said that she had been staying with her mother for two weeks following her arrival from Scotland.

5.6 Housing Provider 1 - which is a provider of social housing - received an application for housing in respect of Christine from BwD Council Housing Needs team who had assessed Christine as homeless and in priority need of rehousing. Housing Provider 1 has advised the DHR that they were not provided with information about Christine's needs or any vulnerabilities by the Housing Needs team and that the information shared consisted only of the level of banding awarded to her application which determined the priority. BwD Council Housing take the view that there was no evidence of Christine having any vulnerabilities when their service assessed her homelessness application and that she was given priority banding because of the fire which left her homeless in Scotland.

5.7 Also on 14th August 2017 Christine registered with a GP practice in Darwen. She was accompanied by her sister who helped her complete the patient registration forms. Christine scored 'high' on questionnaires relating to alcohol consumption and anxiety. A brief intervention in respect of Christine's excessive alcohol consumption was completed and she was also given smoking cessation advice.

5.8 Christine was seen again at her GP practice on 17th August 2017. She had what appeared to be a healing pressure ulcer on her left heel which may have been related to the house fire in Scotland. She was referred for tissue viability nurse input. Her medications were also reviewed. When seen by her GP a week later it was documented that Christine felt her 'skin lesion' to have improved although she had not any input from tissue viability.

5.9 On 21st August 2017 BwD Housing Needs amended Christine's banding to afford her higher priority on the grounds of over-crowding in her mother's home – which Christine's arrival had exacerbated, the risk of violence Christine faced at her previous address and her wish to be housed close to her mother in order to receive family support. BwD Housing Needs team advised Housing Provider 1 of Christine's banding two days later but there is no indication that they shared any detail of the concerns which justified the banding awarded.

5.10 On 25th August 2017 Christine was seen by a nurse at her GP practice for an asthma review. The history of the house fire in Scotland was documented. It was also noted that Christine had been diagnosed with asthma in 2003 but had not been compliant with her inhalers whilst residing in Scotland.

5.11 On 4th September 2017 Housing Provider 1 offered Christine the property at address 1 and her tenancy commenced on 19th September 2017. BwD Housing Needs team made an award of a double bed and mattress, an electric cooker and a voucher to the value of £100 on the grounds that Christine was 'fleeing violence'. Housing Provider 1 completed a tenancy sustainability assessment in respect of Christine. However, this lacked detail, stating that Christine had moved to Darwen following a 'recent incident' and concluded that there was a risk related to 'capability'. Expected practice would be for a Housing Provider 1 Neighbourhood Officer to undertake a 'settling in' visit shortly after the commencement of Christine's tenancy where any vulnerability or risks had been identified in the homeless assessment conducted by BwD Housing Needs and/or the Housing Provider 1 sustainability assessment. There is no indication that the 'settling in' visit took place. BwD Housing Needs closed Christine's case.

5.12 On 5th September 2017 Christine's Darwen GP practice was faxed patient records from Christine's previous GP practice in Glasgow. These records documented problems with COPD dating to 2014.

5.13 On 20th September 2017 Christine was seen by her GP for leg pain which she reported experiencing for three years. She was advised to attend the healthy leg clinic. Christine also reported no improvement in her depression symptoms. The GP issued a fit note in respect of her depression and the pain in her legs. Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work (1). Fit notes were frequently issued whilst Christine was registered as a patient at the Darwen GP practice. In November 2017 the Job Centre assessed Christine as being capable of doing some work and no further fit notes appeared to be issued by her GP until June 2018. It is believed that Christine was in receipt of unemployment benefits throughout the period she was registered with the GP practice.

5.14 Later in September 2017 Christine was seen at GP practice for a further asthma review at which the diagnosis of COPD was discussed with her.

5.15 Christine was seen at her GP practice again in late October 2017 when her 'social history' and her local family support was discussed. Christine reported that she was coping with depression and presented as 'cheerful' and responsive.

5.16 Christine's contact with her GP practice diminished for a time. However, there is an entry in Christine's GP records dated 20th March 2018 referring to a head injury to Christine who was documented to have been found in a hotel corridor. The entry states that Christine experienced amnesia and a headache but that there were no adverse findings from a CT scan. However there is no reference to this incident in the main body of Christine's GP records or evidence of an attendance at any Hospital Emergency Department (ED). The entry is referred to as a 'minor past problem' in the Primary Care chronology. (The independent author attempted to clarify this incident with Christine's mother but she was unable to shed any light on the matter).

5.17 On 12th June 2018 Christine was seen by her GP with what was documented to be a 'stress related problem'. She reported struggling to cope with her 'physical ailments' and was experiencing stress due to financial issues*. She also reported experiencing difficulty mobilising, becoming breathless and having disturbed sleep. She said that she was living alone although her family were nearby. She said that she was drinking 3 bottles of wine each day although she had previously drunk 6 bottles per day. She said that she had no thoughts or intent to self-harm. A fit note was issued as Christine said that she did not feel physically or emotionally fit to work. No referrals for support in respect of mental health, alcohol use or any follow up appears to have been considered.

*Housing Provider 1's income team regularly contacted Christine from early in her tenancy to discuss her rent account which she struggled to maintain.

5.18 On 20th June 2018 Christine attended for a health review with a GP practice nurse. Christine was noted to be underweight and was referred to the re:fresh team due to feeling low in mood. The re:fresh team provide health and wellbeing support in areas such as healthy eating, exercise, smoking cessation and reducing alcohol consumption. Later the same day Christine was also reviewed by her GP due to her weight loss and was advised to stop drinking alcohol. Christine also reported smoking cannabis and disclosed that she was in a relationship but was unsure if she was happy. The GP documented that Christine reported that she was 'being used?' No record of her partner's identity was documented and there is no further information about this partner in Christine's patient records. Christine said that she had no thoughts of self-harm but reported feeling hopeless at times. Supplements were prescribed. Christine was also seen by a practice nurse for an asthma review the following day when COPD was ruled out following a spirometry. Spirometry is a

group of tests that assess how well the lungs work by measuring lung volume, capacity, rates of flow, and gas exchange.

5.19 Christine did not engage with the re:fresh team and was discharged by that service.

5.20 On 9th July 2018 Christine saw her GP and discussed the leg pain which she had experienced for several years without previous investigations. Additionally, her chest was noted to be 'rattly'. She was referred to the vascular clinic in respect of possible claudication, which is a condition in which cramping pain in the leg is induced by exercise, typically caused by obstruction of the arteries. She was also referred for a chest X-ray and the medication prescribed to help her sleep was changed. A further fit note was issued due to depression.

5.21 On 18th July 2018 Christine was reviewed by the advanced nurse practitioner at her GP practice. She had been 'scared' by being assessed to be pre-diabetic and, as a result, had cut sugar, cakes, biscuits etc. from her diet. She also said that she had stopped drinking alcohol. Her weight was stable although she had not gained weight since commencing the supplement drink. A referral to dietetics was planned, although there is no evidence that the referral was made.

5.22 On 27th July 2018 an optician wrote to Christine's GP practice after she attended for a routine eye examination - which was normal. The optician requested information relating to Christine's right eye blindness but there is no indication that the GP practice shared any information with the optician.

5.23 On 9th August 2018 Christine's GP practice was notified that she had been examined in the Hospital 2 General and Vascular Surgery Department and it had been agreed that an angioplasty of her left external iliac artery would be performed. An angioplasty is a procedure used to widen blocked or narrowed arteries.

5.24 On 10th August 2018 Christine attended her GP practice for weight monitoring. She said that she was consuming the supplemental drink. She was documented to look well and was described as 'chatty'.

5.25 On 16th August 2018 Christine attended her GP practice with a female 'friend', whose name was not recorded, who advised the GP that she felt that Christine's mood remained low and that she was struggling to sleep. Her prescribed sleep medication was altered and a fit note issued.

5.26 On 17th August 2018 Christine self-referred to Mindsmatter – a wellbeing service provided by Lancashire and South Cumbria NHS Foundation Trust as part of

the nationwide Improving Access to Psychological Therapies (IAPT). The self-referral stated that Christine was struggling with low mood/low level depression. She expressed a preference for 1:1 counselling but did not engage with the telephone welcome call scheduled for 28th August 2018 and was discharged back to the care of her GP.

5.27 On 20th August 2018 Christine was seen by the advanced nurse practitioner at her GP practice for an annual asthma review. Christine reported that her asthma symptoms affected her activities, lifestyle and her mood. Her medication was changed.

5.28 On 21st August 2018 Christine attended Hospital 3 ED following a seizure which was reported to have been witnessed by 'friends'. The seizure was documented to have been Christine's first seizure and was investigated and 'normal examination and bloods' were found. Her GP was requested to refer Christine to the local first seizure clinic. The first seizure clinic is a specialist clinic run weekly by a Consultant Neurologist and Epileptologist for anyone with a suspected first seizure or a new diagnosis of epilepsy.

5.29 On 28th August 2018 Christine's GP practice was notified that she had not engaged with the Mindsmatter service and had been discharged. The letter provided information on how to self-refer to the service. The GP practice did not arrange any follow up conversation with Christine about her mood and no further discussions about her mood are documented in her patient records.

5.30 On 5th October 2018 Christine was admitted to Hospital 4 for day case surgery for the angioplasty. Her recovery was to be subsequently reviewed as an outpatient by her consultant.

5.31 On 13th October 2018 Christine contacted NHS 111 to report constipation, abdominal pain for two days and made reference to her recent angioplasty operation. She said that she was in a lot of pain. She was visited at the home of a person documented to be her 'partner' – whose first name was recorded (not Paul) - by East Lancashire Medical Services (Out of Hours) who examined her, prescribed medication and advised her to contact 999 if her pain and discomfort were not reduced by the medication. It was documented that she didn't have enough money to attend the treatment centre.

5.32 On 8th November 2018 her pharmacy phoned Christine for a medication review. A face to face review was to be arranged as Christine was documented to 'sound confused' about her medication. The face to face appointment with the pharmacist took place on 15th November 2018. Christine reported that her asthma

was not under control, that she smoked 15 half cigarettes daily – shared with her partner -and she was not concordant with her prescribed medication. She also reported dizziness and was advised to see her GP about this. Christine was accompanied to this appointment by a 'friend' (no further details).

5.33 On 16th November 2018 Christine attended an outpatients appointment in the Hospital 4 General Surgery Clinic following the angioplasty and was discharged. Christine reported knee pain, having fallen downstairs prior to the surgery. The Vascular Registrar prescribed co-codamol for Christine's knee pain and she was advised to see her GP. Christine attended the appointment with her 'sister-in-law'.

5.34 On 22nd November 2018 Christine saw her GP and requested a back-dated fit note for 'ongoing problems'. A fit note was issued for the period from 8th November 2018 until 8th January 2019 due to depression and post-operative issues. Christine also reported sciatica and was signposted to the spinal drop-in service.

5.35 Her GP practice had no further contact with Christine until she presented, accompanied by Paul with serious facial injuries on 16th January 2019. According to the account Paul subsequently provided to the police, his relationship with Christine began in early December 2018. It is understood that Christine left her home and moved into Paul's flat although on 17th December 2018 Christine phoned the Housing Provider 1 call centre to report that she had no central heating or hot water in her flat. An appointment was made to visit her home to repair the central heating on 20th December 2018 but no reply was received on that date and a card was left for Christine to rearrange the appointment. There is no record of Christine doing this. In their contribution to this review, Christine's mother and sister have said that they had no contact with her over the Christmas 2018 period.

5.36 On 7th January 2019 Christine's GP practice attempted to phone her to arrange a GP appointment for medication and fit note review and left a message on her answerphone. The next day the GP practice followed up by writing a letter to Christine to advise that they had been attempting to contact her without success and she responded to the letter by phoning her GP practice and made an appointment for 16th January 2019.

5.37 On 15th January 2019 Housing Provider 1's anti-social behaviour (ASB) triage team received an initial log from a Police Community Support Officer (PCSO) regarding 'possible domestic nuisance' raised by one of Christine's neighbours. The ASB triage team contacted the neighbour who said that things had been quiet for the past few days but during the previous week, there had been two or three incidents of arguing, shouting, screaming and generally causing a disturbance. The neighbour agreed to record incident log sheets and a 'case' was created and passed

to the Housing Provider 1 neighbourhood office. No contact was made or attempted with Christine at that time.

5.38 Around noon on 16th January 2019 Christine visited her GP practice. She spoke to reception staff who noticed that Christine had sustained bruising to her jaw and the left side of her face. The reception staff noticed that Christine was upset and 'jittery'. One of the reception staff made a cup of tea for her and spent time supporting her in a more private area of the surgery. During this period Christine disclosed that she had been 'beaten last night'. The reception staff were aware that Christine had an appointment with one of the practice GPs during the same afternoon and had no further contact with her. Christine saw a GP shortly after 4pm. It is not known whether she had stayed in the GP practice from her initial arrival or had left and subsequently returned. She had been unaccompanied when she had first arrived at the GP practice but by the time of her GP appointment she was in company with a man the GP documented to be 'her partner Paul'. This is assumed to be Paul who was registered at a different GP practice and therefore previously unknown to Christine's GP practice.

5.39 On examination, the GP noted Christine had sustained bruising over both sides of her face extending over the cheeks and up to her eyes with extensive swelling. Due to the swelling her right eye was almost closed up. She had also sustained an injury to her left ear with swelling and erythema (redness of skin) of the cartilage with serous fluid coming from the upper part of her ear. She also reported an injury to her left index finger with a laceration which was causing her difficulty in flexion. This laceration had signs of infection with erythema around it and pus coming from the wound. She did not report any further injuries. Paul did not report any injuries to himself and the GP did not notice any, although the GP did not formally examine him. The GP strongly advised Christine to attend Hospital 2 ED as she required 'immediate medical care'. The GP printed off a record of his consultation with Christine and asked Christine to pass it to ED staff when she arrived at the hospital. The GP documented that Christine's injuries had been sustained during attacks on two separate occasions in both 'Reading and then Berkshire'. (Reading is located in Berkshire but this is how the GP documented the locations of the 'attacks'). The GP also documented that Christine was unsure who attacked her or why. The GP documented that Christine hadn't called the police or sought medical attention in respect of the attacks. The GP asked Christine to make the police aware of the assault. There is no indication that Christine was seen alone during this consultation. Following the consultation with her GP there is no evidence that Christine attended hospital ED or contacted the police. There was no follow up by her GP practice.

5.40 On 5th February 2019 Christine's mother reported her daughter as a missing person to Lancashire Constabulary. She said that her daughter had been living with

Paul at his flat and that Paul had informed Christine's family that he had last seen her on 30th January 2019. Christine's mother said that she had not seen her for a 'few weeks' as they had 'fallen out'. Christine's relationship with Paul had previously been unknown to the police who had received no calls to Paul's flat during the period Paul and Christine are believed to have been in a relationship.

5.41 The police began a missing person investigation and assessed the case as medium risk. They visited Paul and searched his flat. Paul had been known to the police for many years and had numerous convictions for violence including domestic violence.

5.42 On 6th February 2019 Christine did not attend the first seizure clinic appointment at Hospital 5 following the referral from her GP in September 2018.

5.43 Housing Provider 1 first attempted to phone Christine about the concerns raised by her neighbour (see Paragraph 5.36) on 6th February 2019 and were unable to obtain a reply and left a message on her answerphone asking her to contact Housing Provider 1 urgently – which she did not do. Housing Provider 1 also made an unannounced visit to Christine's home address on the same day and received no response. A card was left requesting urgent contact. On 19th February 2019 Housing Provider 1 contacted Christine's neighbour who said that things had 'quietened down'. On 27th February 2019 a Housing Provider 1 neighbourhood officer visited Christine's address and heard shouting, screaming and banging coming from the address but received no reply when they knocked on the door. On the same date the neighbour submitted log sheets which provided details of incidents of shouting, swearing, arguments between a male and a female and loud music from 31st December 2018 onwards. Housing Provider 1 contacted Christine's brother who said that his sister had been missing from the property since January 2019 and that one of her sons had been staying with Christine at the property. The Housing Provider 1 neighbourhood officer made a visit to Christine's home on 28th February 2019 and spoke to Christine's son who said that he had been living at the address for six months. During a further visit to Christine's address on 5th March 2019 the Housing Provider 1 neighbourhood officer spoke to Christine's son again and established that he was living at the address with his partner and accepted responsibility for the series of complaints received from Christine's neighbour.

5.44 On 2nd March 2019 the missing person case was reviewed by a Detective Inspector and escalated to a high risk missing person investigation and two days later it was escalated to a criminal investigation. By this time the police had ascertained the details of Christine's visit to her GP practice in company with Paul on 16th January 2019.

5.45 On 18th March 2019 the case became a murder investigation in the absence of any evidence that Christine remained alive and on 23rd March 2019 Paul was arrested on suspicion of the murder of Christine. He was later released under investigation and charged with the murder of Christine on 30th April 2020 following a lengthy and complex police investigation. The body of Christine has never been recovered.

6.0 Analysis

6.1 In this section of the report each of the case specific terms of reference questions will be considered in turn.

The victim:

When the victim moved to the area from Scotland were her needs adequately assessed, her vulnerabilities recognised and information appropriately shared?

6.2 Christine was a previous resident in the Blackburn with Darwen area but had resided in Glasgow for at least nine years prior to relocating to Darwen in August 2017 following her discharge from hospital in Glasgow.

6.3 On arrival in Darwen she initially stayed at her mother's address and was promptly registered with the Darwen GP practice which was able to clarify her health needs. Information from her previous GP practice in Glasgow was shared with her Darwen GP practice promptly, including hospital discharge documentation from Hospital 1 in Glasgow to which Christine had been admitted following the fire in her home. The DHR has been advised that the hospital discharge information was clear and all the health needs referred to in the hospital discharge information were attended to.

6.4 Christine presented as homeless to BwD Council Housing Needs team. Whilst the assessment conducted by Housing Needs was effective in ensuring she received an appropriate level of priority there is no indication that the details of any vulnerabilities disclosed during the Housing Needs assessment were shared with Housing Provider 1.

6.5 This lack of information sharing about Christine's vulnerabilities was compounded by the lack of detail documented in Together Housing's own sustainability assessment, and the absence of a 'settling-in' visit from a Housing Provider 1 neighbourhood officer. As a result any tenancy support needs which Christine may have had at that time were overlooked.

6.6 Professionals found themselves in the difficult position of having to piece together the details of what had happened to Christine in Scotland by speaking to Christine and her family members, but from the information gathered at the time it appeared that the fire in her home which had led to her hospitalisation with severe smoke inhalation had been caused by others, that there was or had been an active

police investigation in Glasgow and that Christine had been drinking heavily prior to the incident.

6.7 This DHR also lacks a complete picture of the events which preceded Christine's relocation from Glasgow. Dunbartonshire Housing Needs declined to return any information pertaining to Christine as the law and guidance relating to Domestic Homicide Reviews does not apply in Scotland and they requested a court order if their involvement was deemed necessary. Police Scotland advised the DHR that Christine's home was used by local youngsters as a 'drinking den and congregation point'. Police Scotland went on to advise that Christine was within her home when it was set on fire by one of the people she allowed to drink in the house. Police Scotland implied that an attempted murder investigation was initiated but later discontinued. Glasgow Women's Aid had no information relating to Christine on their records. Given that there was no suggestion that domestic abuse was a factor in the fire in Christine's home in Glasgow and given the anticipated difficulties in requesting further reports from agencies in a country to which DHR law and guidance did not apply, it was decided to request no further information from the authorities in Scotland.

6.8 However, it is clear that Christine was extremely vulnerable in that she had been drinking heavily since the death of her previous partner in 2016. The information shared with this DHR by Police Scotland states that she had been on a 'downward spiral' since her partner's death. She had suffered severe smoke inhalation during the fire in her home and spent 12 days in intensive care. It appears that she was unable to return to the home which had been set on fire following her discharge from hospital in Glasgow. Relocating to the Blackburn with Darwen Council area involved a return to an area with which she was very familiar and where she would be supported by her family. She was promptly registered with a GP and allocated a new home. However, as stated, any support needs she may have had were not ascertained. No referral to Adult Social Care appears to have been considered necessary by any agency. Christine may have had unassessed care and support needs and may have benefitted from an assessment under the Care Act. Following Christine's visit to the GP practice on 12th June 2018 (Paragraph 5.16) the GP could have considered a multi-disciplinary approach to supporting Christine which may have included a Care Act assessment. Overall, there appeared to be insufficient attention paid to the trauma she may have experienced as a result of the life threatening incident in Glasgow. Since 2017 there has been considerable work done to develop trauma informed approaches amongst professionals, but this may not have been at the forefront of professional's minds at that time.

How did agencies respond to any indications or disclosures of domestic abuse by the victim? Were opportunities taken to routinely ask her whether she was a victim of domestic abuse?

6.9 It appears that agencies were unaware that Christine was in a relationship with Paul until she visited her GP in his company on 16th January 2019. This appears to have been the single opportunity to intervene in order to safeguard Christine. She appears to have attended the GP practice unaccompanied in the first instance and received sympathetic support from the senior receptionist who made her a cup of tea and sat with her in the relative privacy of the nurse's bay for a time. During this period Christine, who had clearly sustained facial injuries, disclosed that she had been 'beaten' the previous night. Asked if she would like to talk about what happened, Christine declined the offer, and said that she would wait to speak to the GP. Christine's planned GP appointment was not scheduled to take place until 3.30pm on 16th January 2019 and she had arrived at the GP practice and spoken to the senior receptionist around noon. The senior receptionist and her colleague had no further contact with Christine and both left the surgery in the early afternoon when their working hours ended.

6.10 By the time Christine saw her GP at 4.08pm the same day (the appointment was scheduled for 3.30pm so it assumed that the GP who saw Christine was running late) Christine was accompanied by Paul, who she introduced as her partner. Paul was registered at a different GP practice and so it is assumed that he would have been completely unknown to Christine's GP practice. Christine was not a regular patient of the GP she saw on 16th January 2019. The GP documented Christine's serious facial injuries and concluded that she needed immediate medical care and advised her to go straight to the Hospital 2 ED. Paul was present throughout the GP consultation – which lasted for 19 minutes. No consideration appears to have been given to speaking with Christine alone. In the witness statement the GP later made to the police, he stated that Paul appeared 'friendly and supportive' towards Christine during the consultation. The GP had not been made aware of Christine's visit to the surgery earlier the same day nor the disclosure that she made to the senior receptionist that she had been 'beaten' the previous night. Had this information been shared with the GP, it would have contradicted the explanation which she and Paul gave the GP for her injuries.

6.11 The Primary Care IMR states that if the GP felt Christine's account matched her presentation, the advice given to Christine - to go to the Hospital 2 ED without delay and to report the assault to the police - was in line with what would be expected. The explanation provided by Christine and Paul for her injuries could be said to have matched her presentation in that they alleged that she had been assaulted in Reading and in Berkshire. They said that they didn't know why they had been

attacked. However, Paul did not report any injuries to himself and the GP did not observe any - although the GP did not formally examine him. The absence of any visible injuries to Paul chipped away at the credibility of an account which claimed that Christine had been assaulted on two separate occasions whilst her partner had somehow remained unscathed. The Primary Care IMR emphasises the importance of professional curiosity which might have enabled the GP to probe the account given by Christine and Paul and potentially undermine it. There is no indication that the advice of the safeguarding lead for the GP practice was sought.

6.12 The Primary Care IMR went on to state that if there was suspicion that the account shared was not accurate it would have been beneficial to attempt to see Christine on her own and use 'targeted enquiry' to understand the relationship and seek and signpost to appropriate services. In this case 'appropriate services' would likely be the police and transfer to hospital via ambulance. The DHR independent author takes the view that Christine should have been spoken to on her own in any event. In this case it is quite difficult to avoid hindsight bias but Christine was a woman with known vulnerabilities who was presenting with serious facial injuries. Whether or not she provided an explanation which appeared to match her presentation should not in the independent author's view be a factor which determines whether Christine was seen alone or not. When discussing this issue the DHR Panel acknowledged that it can be challenging to engineer an opportunity to speak to a potential victim of domestic abuse on their own, if accompanied by their suspected abuser. Reference was made to techniques such as asking the suspected abuser to leave whilst a urine sample is obtained. The DHR Panel felt that in the circumstances in which Christine saw her GP in the presence of Paul, the GP should say to the person accompanying them that the GP needed to examine the patient and ask them (the person accompanying the patient) to wait outside. The WISH Centre CEO advised that it is their firm policy to speak to victims of domestic abuse on their own.

6.13 Christine's mother said that she disappointed with the response of the GP practice to her daughter's injuries (Paragraph 4.11).

6.14 It should be borne in mind that Paul was unknown to Christine's GP practice, he had been using violence and the threats of violence to exercise control over his intimate partners for a quarter of a century, he was a well-practiced manipulator of professionals and Christine's GP appointment took place in the context of a busy surgery in which her GP saw her 38 minutes after the scheduled time. However, there is much learning for GP practices and for professionals generally arising from the response to Christine's presentation on 16th January 2019. Firstly it is clear that GP practice need to adopt a 'whole practice' approach. The senior receptionist had managed to elicit information from Christine which completely undermined the

account Christine and Paul later provided to the GP. On this occasion, no priority was given to bringing the information obtained from Christine by the senior receptionist around noon to the attention to the GP who saw Christine four hours later or the GP practice safeguarding lead. Whilst it is accepted that sharing information is more challenging in reactive, over-burdened working environments, the DHR Panel was advised that the initial disclosure elicited from Christine should have been clearly documented in the GP records as well as the clinic ledger. The DHR Panel was advised that when a patient is booked into a clinic, notes can be added beneath their name as well as notes asking people to view the relevant entry etc.

6.15 Many (so-called) honour based violence (HBV) and forced marriage policies refer to the 'one chance rule' which highlights the fact that a professional may have just 'one chance' to speak to a potential victim and 'one chance' to save a life. If the victim is not offered support following disclosure that 'one chance' may be lost. The essence of the 'one chance' rule is that professionals are primed to act decisively and urgently when a disclosure of forced marriage/HBV is made to them. With hindsight, the GP practice had 'one chance' to safeguard Christine. This case suggests the potential benefit of adopting a 'one chance' mentality when a person discloses domestic abuse.

6.16 The Primary Care IMR went onto observe that opportunities were generally not taken to routinely enquire about domestic abuse during consultations with Christine. 'Routine enquiry' - i.e. routinely asking people if they are experiencing domestic abuse, if safe to do so is expected practice within healthcare settings. Christine regularly presented to her GP with low mood and could have been asked if there was anything which was making her mental health worse, such as relationship issues. However, the DHR has been advised that, in response to learning from previous national and local DHRs, an EMIS (electronic patient record) routine enquiry template has been designed by the former Blackburn with Darwen Clinical Commissioning Group (CCG). This template is designed to pop up when the GP enters a mental/ psychological/ emotional health condition onto EMIS. The template was launched in April 2022.

6.17 Christine disclosed problems in an intimate relationship during a health review appointment in June 2018, when she said that she was in a relationship but was unsure if she was happy and stated she was unsure if she was '?being used' (Paragraph 5.17). Whilst the GP explored whether Christine had any thoughts of self-harm it is not documented if there were any discussions in relation to routine enquiry of domestic abuse within the relationship. This health review appointment took place several months prior to the date on which Christine's relationship with Paul is believed to have begun.

6.18 Housing Provider 1 received an initial log from the police in January 2019 regarding a possible 'domestic nuisance' at Christine's home address which had been reported to a PCSO by a neighbour who had complained about arguing, shouting, screaming and disturbance which had been emanating from Christine's address (Paragraph 5.36). It may have been beneficial for Housing Provider 1 and the PCSO to have followed this up together. There was a delay in Housing Provider 1 fully responding to this incident which may have been primarily viewed through an anti-social behaviour lens. The DHR understands that the concerns raised by Christine's neighbour related to the conduct of one of Christine's sons, who appeared to have moved into his mother's property. The son's partner also appears to have spent time in the property. Housing Provider 1 is unable to definitively confirm that the complaints made by Christine's neighbour fully related to Christine's son as opposed to Christine as their records refer only to 'subject and complainant' rather than named individuals. No record has yet been found of the involvement of the PCSO in the incident, although she has been spoken to and has stated that there was a single male living in Christine's property at the time, whose name the PCSO does not recall. She added that she recalled the property to be a 'regular haunt' of drug users at that time.

6.19 The private landlord of Paul's flat has been contacted as part of the DHR to ascertain whether there were any indications of domestic abuse during the period when Christine is believed to have been staying with him in the flat. The private landlord has advised the DHR that there were no incidents 'as far as they can ascertain or recall' and described Paul as a 'model tenant' in many respects.

Did the victim receive, or was she offered, support from domestic abuse services?

6.20 Christine was not offered any support from domestic abuse services. As stated she made a disclosure of domestic abuse to reception staff at her GP Practice on 16th January 2019 and during an earlier GP appointment on 20th June 2018 indicated that she felt that she may be being 'used' in an intimate relationship.

Were there any barriers to the victim disclosing domestic abuse or seeking support?

6.21 The Primary Care IMR observes that within Christine's GP records in 'past history' it is highlighted that Christine had specific delays in development although the impact of this on her daily functioning was unclear. The IMR states that there is no flag in her records to suggest a learning disability and no regular learning disability health checks were undertaken. Christine's mother said that her daughter had not been diagnosed with a learning disability although she had attended a

school for children with additional needs as a result of learning difficulties. Christine appears to have needed a degree of support from family members and friends to accomplish certain tasks and activities such as completing medical questionnaires, attending hospital appointments and signing documents. She appeared confused about her medication on one occasion and was not always concordant with them – which may, or may not, have been linked to any confusion she experienced about her medication. It seems possible that her learning difficulties may have affected her ability to self-manage her asthma.

6.22 Paul was a serial domestic abuser who had previously demonstrated a desire to dominate women he entered into relationships with, through very severe levels of violence together with coercive and controlling behaviour. It seems likely that once her relationship with Paul began, Christine would have faced the repertoire of violent, controlling and coercive behaviours which he subjected previous victims to. It is possible that Christine's learning difficulties may have been an additional barrier to seeking help, although Christine appears to have independently sought help from her GP practice during the first visit she made to the surgery on 16th January 2019. In their contribution to this DHR, her mother and sister observed that Christine had a tendency to 'jump into' relationships – through loneliness in their view. Her mother and sister also observed that Christine may have particularly struggled to pick up on indications that her relationship with Paul was unsafe. This appears to be quite an important observation. It is not known how Christine's learning difficulties affected her ability to recognise that she may be in danger in an intimate relationship and take action to keep herself safe. As stated, she questioned whether she was being used in an earlier relationship and attempted to seek help from her GP practice after sustaining injuries from what is assumed to be an assault by her then partner Paul.

6.23 It is of value to apply the eight stage homicide timeline developed by Jane Monckton Smith (2) to the little that is known about Christine's brief relationship with Paul. Stage One: 'History of victim and perpetrator' highlights Paul's status as a serial domestic abuser and Christine's vulnerabilities as a person who had suffered bereavement in two previous intimate relationships and possible trauma from the removal of her five children. It is not known if she experienced domestic abuse in past relationships. Stage Two: 'Early Relationship' is when research suggests that controlling relationships often form very quickly, with early co-habitation, early pregnancy, and early declarations of love being common. Although little is known about the start of Christine's relationship with Paul, it coincided with a period in which Christine had little or no contact with her family, although there may have been additional factors in this estrangement from family. State Three: 'Relationship' is when research suggests that control and violence may begin very early in the relationship. It seems that Christine may have been particularly vulnerable during

stages two and three when she may have struggled to pick up on initial indications of controlling behaviour as a result of her learning difficulties.

6.24 The DHR Panel discussed Christine's mental capacity. It was noted that in all her many contacts with her GP, her capacity was never questioned. Christine's learning difficulties could have caused professionals to consider whether Christine may lack mental capacity in certain areas but in such circumstances Principle 2 of the Mental Capacity Act states that a person must be given all practicable help before anyone treats them as not being able to make their own decisions. Christine appeared to need support in a number of areas such as comprehending and signing documents but appeared to be able to make decisions for herself with support from family and friends. However, it seems unlikely that she would receive support to make decisions once her relationship with Paul began, although, apart from her visits to the GP practice on 16th January 2019, agencies were unaware of her relationship with Paul until her family reported her missing and were therefore unable to consider whether being in a relationship likely characterised by coercion and control affected her capacity to make decisions.

How effectively were her mental health and alcohol dependence issues addressed?

6.25 Christine's GP referred her to re:fresh in June 2018 but she did not engage with this service. Christine self-referred to MindsMatter but also did not engage with this service and was discharged back into the care of her GP. Her GP prescribed her an antidepressant – Mirtazapine - and her medications were regularly reviewed.

6.26 Christine was given brief alcohol intervention support shortly after she joined the Darwen GP practice but no referrals were made to specialised services for her alcohol dependence issues. Advice was given regarding reducing or stopping alcohol at the consultation in June 2018 and Christine self-reported reducing and stopping at a pre diabetic health check.

6.27 The Primary Care IMR observed that support from alcohol services may have been beneficial as Christine had been alcohol dependence for a number of years. It is unclear why Christine was not offered specialist support from alcohol services or encouraged to avail herself of these services given her longstanding problematic relationship with alcohol. She demonstrated the motivation to change when assessed as being pre-diabetic and, as a result, reported stopping drinking alcohol for a period (Paragraph 5.20). She said that the prospect of diabetes had 'scared' her. This may have represented an opportunity to gauge Christine's openness to addressing her long term alcohol dependence.

How effectively did agencies respond to difficulties in engaging with the victim?

6.28 Christine engaged quite well with her GP practice apart from a period when she had little contact between October 2017 and June 2018 and during the period from late 2018 when it is believed that her relationship with Paul began. However, as stated, she did not engage with either re:fresh or Mindsmatter following referral or self-referral in June and August 2018. There is no indication that this absence of engagement was explored with Christine. Given the frequency with which Christine was presenting to her GP with low mood, the lack of engagement with Mindsmatter appeared to be a valuable opportunity to follow up with her.

Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

Sex

6.29 Domestic abuse research has found the difference between men and women to be stark, with men significantly more likely to be repeat perpetrators and men significantly more likely than women to use physical violence, threats and harassment (3).

Disability

6.29 Christine had been blind in her right eye from childhood. When Christine attended for a routine eye examination in June 2018, the optician requested information from her GP practice relating to Christine's right eye blindness but there is no indication that the limited information held by the GP practice in this regard was shared with the optician (Paragraph 5.21). It is unclear why this was not done.

6.30 The impact of Christine's learning difficulties on her life have been commented on elsewhere in this report. There is no indication that Christine's learning difficulties led to reasonable adjustments being made apart from the pharmacy deciding that it would be preferable to invite her for an in-person consultation after they attempted to review her medication by telephone and she appeared 'confused'.

Pregnancy and maternity

6.31 It is unclear whether Christine experienced adverse childhood experiences. As an adult all five of her children were removed from her care. This seems likely to have been a traumatic experience. Her mother said that it 'broke' her. Christine cared for her first three children for a number of years prior to their lawful removal but it appears that the children she subsequently gave birth to may have been removed at birth. Although the research literature is limited, it demonstrates that the removal of a child from the mother at birth is 'acutely traumatic' and has a 'far reaching impact' (4). Women from whom their children have been removed at birth described it as 'deeply distressing and de-humanising' with shame and stigma also present (5). One study posited the construct of 'disenfranchised grief' which captures the lack of social acceptance of this particular form of grief when a child is removed at birth (6). The independent author is currently conducting a thematic review into parents who appear to have taken their own lives following the lawful removal of children from their care and the impact of the removal of children appears to have had profound effects on the parents including inducing a sense of hopelessness as well as feelings of shame and guilt. The removal of her children from her care may also have affected Christine's view of statutory services. It seems possible that she may have found it more difficult to place her trust in, and to share information with, statutory services.

Intersectionality

6.32 Intersectionality has been defined as a 'metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking' (7). Although she engaged well with her GP practice and some specialist care, Christine was not in employment, experienced low mood, didn't have much money and at times spent quite a lot of her income on alcohol and needed support from family and friends in respect of some activities of daily life. As previously stated, whilst some care and support needs were met by individual agencies, no statutory Care Act assessment was instigated. These factors may have led to Christine becoming marginalised to an extent. Additionally, the impact of losing custody of all of her five children appears to have had a profound impact on Christine and her desire to give birth to and keep a child may have been a factor which could have been exploited by intimate partners.

The relationship between the victim and the perpetrator:

What did agencies know about the relationship between the victim and the alleged perpetrator? How did agencies respond to any indications or disclosures of domestic abuse arising from the relationship?

6.33 With the exception of Christine's presentation at her GP practice accompanied by Paul in January 2019 (which is analysed in Paragraphs 6.9 to 6.16) agencies appear to have been unaware of this relationship until Christine's mother reported her missing to the police. Paul said that their relationship began in early December 2018 although Christine appears to have got to know Paul through her then partner earlier in 2018.

How effectively did partner agencies comply with policy, work together, assess risk and share information?

6.34 The independent author has challenged the police on their initial assessment of Christine as a medium risk missing person on the grounds of Paul's criminal history, including domestic violence to previous partners and Christine's vulnerability. Lancashire Constabulary take the view that their assessment of risk was appropriate.

6.35 Christine's housing provider Housing Provider 1 appeared to be unaware that Christine had been reported missing until several weeks after the event. Although the police were justified in regarding Paul's address as the place in which Christine had been living prior to being reported missing, it would have been helpful for the police to contact Housing Provider 1 in respect of Christine's tenancy, as Housing Provider 1 may have held information of value to the missing person enquiry and, before it was established that there was no evidence that Christine was alive, there was the possibility that she may return to her tenancy.

The perpetrator

The perpetrator was a serial perpetrator of very serious domestic abuse in a number of prior intimate relationships. The evidence given by some of his previous victims was instrumental in securing his conviction for murder in the case of DHR 7. What can we learn about serial perpetrator behaviour and how to address it from the evidence given by his previous victims? What can we learn from the support provided to the previous victims which enabled them to give evidence in court despite their continuing fear of the perpetrator?

6.36 As stated, little is known about Paul's relationship with Christine. It appears to have been quite brief, possibly beginning in early December 2018 and ending with Christine's murder in late January/early February 2019. It seems reasonable to conclude that the severe facial injuries inflicted on Christine – which were observed by her GP on 16th January 2019 – had been caused by Paul.

6.37 Statements provided by previous victims of Paul were instrumental in securing his conviction for the murder of Christine on the basis of evidence of 'bad character' and Lancashire Constabulary have kindly shared these statements with the DHR after obtaining the consent of the victims. The statements disclose the following:

- Paul has been a perpetrator of domestic abuse in intimate relationships since at least the age of 17.

- He was extremely violent towards his intimate partners. One victim described being punched to the ground and then being kicked and pummelled, being thrown over a first floor balcony, routinely being grabbed by the hair and Paul rubbing his knuckles into her head, kicking her legs with steel toe caps and subsequently picking at her scars and threatening her with a weapon.

- His victim's described being shocked by his violence towards them at first but quickly realising that anything they did which Paul was unhappy about could trigger violence, such as burning food during cooking. The victim described how she flinched when he came near her.

- One victim described how he sent her up into the loft of the property they shared and then removed the ladder, trapping her. She said that this ordeal had left her with a long term fear of heights.

- One victim described Paul as paranoid and jealous and, as a result, would time how long it took her to visit the shops to limit her opportunity to speak to other men.

- One victim described how he would often say that 'you only hurt the ones you love' implying that he hit her because he loved her.

- His victim's described the ways in which he manipulated professionals such as portraying an incident to the police as an aggravated burglary when in fact he had violently assaulted his partner. He also accompanied a victim to a meeting with Housing Needs - the purpose of which was to help the victim get away from Paul. Paul posed as a friend of the victim and gave a false name and the professional concerned was unaware that Paul was the

perpetrator. The victim felt compelled to play along with Paul's deception of the professional and she recalled that he kept pinching her leg under the table to remind her that he was present and that she was powerless to do anything about it.

6.38 There was also some excellent practice by Lancashire Constabulary and the WISH centre in supporting Paul's previous victims in making statements and giving evidence against him which may have wider application. A discussion with the Lancashire Constabulary SIO highlighted the following points which may be transferrable to other investigations of domestic abuse where the victim is reluctant to support a prosecution:

- There was a strong focus on treating the victims with kindness, empathy and compassion and making it clear that investigating or prosecuting their disclosure was important and most definitely not a 'routine chore'.

- There was also a strong focus on maintaining consistent contact with the same officer so that the victim did not have to repeat their story continually.

- By adopting the above approach it was hoped to exclude the possibility of any unsatisfactory interactions with the victim as it was felt that a single poor interaction with a professional could diminish the confidence of the victim.

- All events including the taking of statements were regarded as part of a process in which the maintenance of the victim's trust and confidence was regarded as the highest priority. The focus was on safeguarding the victim rather than on the process of gathering evidence – important though that is – so that the victim felt that the police were there to look after her and did not just see her as a source of evidence.

- Interestingly, the SIO felt that special measures put in place to protect the identity of the victim in the court environment could potentially undermine the impact on the jury of the evidence given by the victim. The SIO felt that it was important for members of the jury to be able to relate to the victim. This observation is not intended to question or undermine the importance of special measures.

- The victims only went to the court when it was time for them to give their evidence and were supported in a nearby hotel until the appointed time in order to avoid the experience of waiting to give evidence in the court

environment and potentially interacting with witnesses and defendants from other cases.

Good practice

6.39 There was much good practice when Christine relocated to Blackburn with Darwen from Glasgow, particularly the prompt registration with the GP and the continuity of her care following her hospital admission in Glasgow and the prompt offer of a property after Housing Needs afforded her an appropriate level of priority.

6.40 Whilst there is much to be learned from the overall response of the GP practice to Christine's two attendances on 16th January 2019, it would be remiss not to comment positively on the humanity displayed by the senior receptionist in providing initial support to Christine which appears to have given her the confidence to make an important disclosure.

6.41 As stated the support provided by Lancashire Constabulary to previous victims of Paul to encourage them to give evidence which was instrumental in securing Paul's conviction on the grounds of 'bad character' was exceptional.

7.0 Conclusion

7.1 The DHR focusses on the period from Christine's relocation from Glasgow to Blackburn with Darwen in August 2017 until she was reported missing to the police by her mother in early February 2019. Overall, although she was promptly provided with housing following her arrival in Blackburn with Darwen, there appeared to be insufficient attention paid to the trauma she may have experienced as a consequence of the life threatening incident which precipitated her departure from Glasgow and her support needs were overlooked to an extent. An opportunity was missed to refer her for support to address her excessive use of alcohol and the reasons for her apparent reluctance to engage with secondary mental health services could have been explored.

7.2 Christine was murdered by Paul after what appears to have been a brief relationship of which agencies were unaware except for Christine's two visits to her GP practice on 16th January 2019, which represented a key opportunity to safeguard her.

7.3 Christine was deeply unfortunate to find herself in a relationship with Paul who had a shocking history of violence, cruelty, coercion and control in prior intimate relationships. Her significant vulnerabilities, including learning difficulties may well have contributed to Paul being able to be violent towards her, exercise control over her, isolate her from support and eventually murder her.

8.0 Recommendations and lessons to be learned

8.1 It is clear that Christine was extremely vulnerable when she relocated from Glasgow to Blackburn with Darwen in August 2017. Whilst she was promptly registered with a GP and allocated a new home, any tenancy support needs she may have had were not ascertained because BwD Council Housing Needs team did not share the details of any vulnerabilities disclosed during the Housing Needs assessment with Housing Provider 1 whose own sustainability assessment lacked detail and the anticipated 'settling-in' visit from a Housing Provider 1 neighbourhood officer did not take place. However, Christine's homelessness application was dealt with under the Homelessness Act 2002. Since that time homelessness is now dealt with under the Homelessness Reduction Act 2017 (which came into force in 2018). A significant difference between the two pieces of legislation is that the Homelessness Reduction Act 2017 places a stronger focus on an individual's needs and there is a requirement to agree a Personalised Housing Plan (PHP) for the person applying for accommodation.

8.2 Housing Provider 1 has identified a number of single agency actions (see Appendix A) but it is recommended that Pennine Lancashire Community Safety Partnership seeks assurance from BwD Council Housing Needs and all local housing providers that their policies and practices ensure that the needs of people presenting as homeless are fully ascertained, appropriately shared and result in the offer of, or signposting to, sources of any support they may need.

Recommendation 1

That Pennine Lancashire Community Safety Partnership obtains assurance from BwD Council Housing Needs and all local housing providers that their policies and practice ensure that the needs of people presenting as homeless are fully ascertained, appropriately shared and result in the offer of, or signposting to, sources of any support needed.

8.3 There was no escalation of Christine to the health safeguarding lead in her GP practice, so there was no referral to the safeguarding lead of respective agencies and a referral to Adult Social Care was not considered necessary at the time of Christine's relocation to Blackburn with Darwen. Christine may have had unassessed care and support needs and may have benefitted from an assessment under the Care Act. It is therefore recommended that Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Safeguarding Adults Board so that the latter board may consider how proportionate consideration of a Care Act

assessment could be brought to the attention of professionals involved in responding to the needs of a person presenting as homeless in Blackburn and Darwen.

Recommendation 2

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Safeguarding Adults Board so that the latter board may consider how proportionate consideration of a Care Act assessment could be brought to the attention of professionals involved in responding to the needs of a person presenting as homeless in Blackburn and Darwen.

8.4 There is much learning for GP practices and for professionals generally arising from the response to Christine's two visits to her GP on 16th January 2019. Firstly it is clear that GP practices need to adopt a 'whole practice' approach. The senior receptionist had managed to elicit information from Christine which completely undermined the account Christine and Paul later provided to the GP. The GP practice concerned has advised the DHR that reception staff would usually add this information to the patient records or send a task to the relevant GP, but this did not happen on this occasion. The GP practice has also advised that all staff at the GP practice, including non-clinical staff have since undertaking domestic abuse awareness training. The GP who saw Christine and Paul reflected that Paul presented as positive and supportive throughout, which further emphasises the importance that all professionals should be aware of the potential for domestic abusers to manipulate the situation. Whilst it is acknowledged that sharing information is more challenging in reactive, over-burdened working environments, Pennine Lancashire Community Safety Partnership may wish to seek assurance that GP practices adopt a 'whole practice' approach to addressing domestic abuse and have effective systems in place for sharing information within the practice.

Recommendation 3

That Pennine Lancashire Community Safety Partnership seeks assurance from Lancashire and South Cumbria Integrated Care Board that all GP practices adopt a 'whole practice' approach to addressing domestic abuse and have effective systems in place for sharing information within the practice.

8.5 Christine's visits to her GP practice on 16th January 2019 represented the only opportunity to safeguard her from domestic abuse arising from her relationship with Paul. It is worthy of note that many (so-called) honour based violence (HBV) and forced marriage policies refer to the 'one chance rule' which highlights the fact that a professional may have just 'one chance' to speak to a potential victim and 'one chance' to save a life. If the victim is not offered support following disclosure that

'one chance' opportunity may be lost. The essence of the 'one chance' rule is that professionals are primed to act decisively and urgently when a disclosure of forced marriage/HBV is made to them. This case suggests the potential benefit of adopting a 'one chance' mentality when a person discloses domestic abuse. It is therefore recommended that when the learning from this DHR is disseminated, Pennine Lancashire Community Safety Partnership takes the opportunity to highlight the applicability of the 'one chance rule' to all forms of domestic abuse, including honour based violence. In making this recommendation, the DHR is not wishing to diminish in any way the focus of practitioners on their responsibilities to act decisively to safeguard the victims of (so-called) honour based violence.

Recommendation 4

When the learning from this DHR is disseminated, that Pennine Lancashire Community Safety Partnership takes the opportunity to highlight the applicability of the 'one chance rule' to all forms of domestic abuse, including honour based violence.

8.6 When Christine saw her GP on 16th January 2019 she was seen in the presence of Paul. It would have been preferable for Christine to have been seen alone. However, when discussing this issue the DHR Panel acknowledged that it can be challenging to engineer an opportunity to speak a potential victim of domestic abuse on their own, if accompanied by their suspected abuser. Reference was made to techniques such as acting the suspected abuser to leave whilst a urine sample is obtained. As stated, the DHR Panel felt that in the circumstances in which Christine saw her GP in the presence of Paul, the GP should say to the person accompanying them that the GP needed to examine the patient and ask them (the person accompanying the patient) to wait outside. It would be beneficial if good practice in engineering a situation in which the potential victim of domestic abuse is seen alone could be gathered and widely shared. The WISH Centre have considerable experience in this regard. It is therefore recommended that Pennine Lancashire Community Safety Partnership arranges for 'tips and hints' on how to engineer a situation where potential victims of domestic abuse are seen alone are pulled together and widely shared with professionals.

Recommendation 5

That Pennine Lancashire Community Safety Partnership arranges for 'tips and hints' on how to engineer a situation where potential victims of domestic abuse are seen alone are pulled together and widely shared with professionals.

8.7 It is understood that Christine had learning difficulties. Whilst there is no indication that she had a learning disability, it seems clear that she needed help to deal with written documents. Her learning difficulties may have increased her vulnerability to a serial perpetrator such as Paul and she may have struggled to pick up on initial indications of controlling behaviour. It is therefore recommended that Pennine Lancashire Community Safety Partnership reviews written and spoken communication material relating to domestic abuse to ensure that it is suitable for conveying messages to people with learning difficulties – and indeed people with a learning disability.

Recommendation 6

That Pennine Lancashire Community Safety Partnership reviews written and spoken communication material relating to domestic abuse to ensure that it is suitable for conveying messages to people with learning difficulties – and indeed people with a learning disability.

8.8 The statements courageously provided by previous victims of Paul were instrumental in securing his conviction for the murder of Christine on the basis of evidence of 'bad character'. Lancashire Constabulary have kindly shared these statements with the DHR after obtaining the consent of the victims. The statements reveal much about how a serial perpetrator such as Paul abused and controlled his victims but also how he interacted with professionals. There may well be valuable learning for professionals arising from what is known about how Paul interacted with and manipulated professionals. It is therefore recommended that Pennine Lancashire Community Safety Partnership make use of suitably anonymised information from the victim's statements to prepare a case study providing examples of how perpetrators of domestic abuse may try and manipulate professionals.

Recommendation 7

That Pennine Lancashire Community Safety Partnership make use of suitably anonymised information from the victim's statements to prepare a case study providing examples of how perpetrators of domestic abuse may try and manipulate professionals.

8.9 The DHR was also some advised of excellent practice by Lancashire Constabulary in supporting Paul's previous victims in making statements and giving evidence against him which may have wider application to cases in which the victim is reluctant to support a prosecution. Paragraph 6.38 sets out the excellent practice in more detail. It is recommended that Pennine Lancashire Community Safety Partnership arranges for a task and finish group to examine how the learning from

how Paul's victims were supported could be applied more widely in cases where victims of domestic abuse are reluctant to support a prosecution.

Recommendation 8

That Pennine Lancashire Community Safety Partnership arranges for a task and finish group to examine how the learning from how Paul's victims were supported could be applied more widely in cases where victims of domestic abuse are reluctant to support a prosecution.

Appendix A

Single Agency Recommendations

Blackburn with Darwen Borough Council Housing Needs

- No recommendations

Lancashire Constabulary

- To remind all personnel that an incident log should always be created even for minor incidents so that an incident number is generated.

Lancashire and South Cumbria NHS Foundation Trust

- No recommendations

NHS Lancashire and South Cumbria Integrated Care Board (formerly Blackburn with Darwen Clinical Commissioning Group)

- To ensure Routine Enquiry is utilised in health reviews.

- To ensure Targeted Enquiry is discussed if a patient attends following an assault or with suspicious circumstances.

- To undertake bespoke training for the GP Practices around targeted enquiry and professional curiosity)

- Having the knowledge of risk factors that could be an indicator of being a perpetrator of domestic abuse - and making part of regular discussion – e.g. 'everything alright at home?'

Together Housing Association

- Review information-sharing protocols following homeless assessments with Blackburn with Darwen (BwD) Council Housing Needs team.

- Together Housing Association (THA) tenancy sustainability processes for those being referred as homeless.

- Strengthen processes, including triaging relating to complaints referred through anti-social behaviour (ASB) processes complaints where there are indicators of possible underlying causes of concern.

- Ensure accurate information recording and sharing of information.

- Review data storage in relation to housing applications.

Appendix B

Executive Summary

Pennine Lancashire Community Safety Partnership

Domestic Homicide Review Executive Summary

Victim – Christine who is believed to have been murdered in late January or early February 2019.

Independent Author – David Mellor BA QPM

Report completed on July 2023, revised April 2024

Contents
Introduction
Terms of Reference
Summary Chronology
Key issues arising from the review
Conclusion
Lessons to be learnt/recommendations

1.0 Introduction

1.1 This report is an Executive Summary of a Domestic Homicide Review (DHR) undertaken by Pennine Lancashire Community Safety Partnership following the murder of Christine (a pseudonym).

1.2 In early February 2019 Christine was reported as a missing person to Lancashire Constabulary by her mother. Christine had been in a relationship with Paul (also a pseudonym) for no more than two months prior to her disappearance and the last professional contact with Christine was when she visited her GP practice, accompanied by Paul, in mid-January 2019. At that time, Christine had serious facial injuries and was advised by the GP to attend hospital, although there is no indication that she did so. The police missing person investigation was unable to trace Christine and after concluding that there was no evidence that she was alive, the police arrested Paul on suspicion of her murder. After an extensive police investigation, which involved interviewing several former partners and which confirmed that Paul was a serial perpetrator of domestic abuse over several decades, he was charged with the murder of Christine, whose body has never been found. In April 2021 Paul was convicted of the murder of Christine and several offences of violent and controlling behaviour towards former partners who had been supported to overcome their deep seated fear of Paul and give evidence in the trial. Paul was sentenced to life imprisonment and must serve a minimum term of 27 years before being eligible to apply for parole.

1.3 The DHR process began with an initial meeting of representatives of Pennine Lancashire Community Safety Partnership on 29th May 2020 when the decision to hold a DHR was unanimously agreed. All agencies that potentially had contact with the victim and/or perpetrator prior to the murder were contacted and asked to confirm whether they had involvement with them. The agencies which confirmed contact with the victims and/or perpetrator and were asked to secure their files.

Contributors to the DHR

1.4 The following agencies provided Individual Management Reviews to inform the review:

- Blackburn with Darwen Borough Council Housing Needs
- Blackburn & Darwen District Without Abuse Ltd (The WISH Centre)
- Lancashire Constabulary
- Lancashire and South Cumbria NHS Foundation Trust
- NHS Lancashire and South Cumbria Integrated Care Board (Formerly NHS Blackburn with Darwen Clinical Commissioning Group).
- Housing Provider 1

The following agency provided summary Individual Management Reviews to inform the review:

- Blackburn with Darwen Children's Social Care

1.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

1.6 Christine's mother contributed to the DHR.

The DHR Panel Members

1.7 The DHR Panel consisted of:

Specialist Safeguarding Practitioner, NHS Lancashire and South Cumbria Integrated Care Board
Hospital IDVA, East Lancashire Hospitals NHS Trust.
Review Officer, Lancashire Constabulary.
Head of Service, Blackburn with Darwen Adult Social Care.
Service Manager, Delphi Medical Drug and Alcohol Addiction Treatment Service.
Community Safety Support Officer, Blackburn with Darwen Council.
Chief Executive Officer, The WISH Centre
Domestic Abuse Development Officer, Blackburn with Darwen Borough Council Community Safety Team.
Head of Supported Housing & Safeguarding Lead, Together Housing.
Named GP for Safeguarding, NHS Lancashire and South Cumbria Integrated Care Board.
Independent Chair and Author.
Housing Needs Team Leader, Blackburn with Darwen Council.

1.8 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on four occasions; on 4th October 2021, 14th December 2021, 26th April 2022 and 23rd June 2021.

Author of the overview report

1.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has ten years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

1.10 The independent chair and author was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

1.11 Since 2006 he has been an independent consultant. He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case

Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.12 He has no current connection to services in local authorities who are represented on the Pennine Lancashire Community Safety Partnership.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

7. 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;

8. 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;

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

10. 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;

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

12. Highlight good practice.

2.2 The case specific terms of reference are as follows:

The victim:

- When the victim moved to the area from Scotland were her needs adequately assessed, her vulnerabilities recognised and information appropriately shared?

- How did agencies respond to any indications or disclosures of domestic abuse by the victim? Were opportunities taken to routinely ask her whether she was a victim of domestic abuse?

- Did the victim receive, or was she offered, support from domestic abuse services?

- Were there any barriers to the victim disclosing domestic abuse or seeking support?

- How effectively were her mental health and alcohol dependence issues addressed?

- How effectively did agencies respond to difficulties in engaging with the victim?

- Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

The relationship between the victim and the perpetrator:

- What did agencies know about the relationship between the victim and the alleged perpetrator? How did agencies respond to any indications or disclosures of domestic abuse arising from the relationship?

- How effectively did partner agencies comply with policy, work together, assess risk and share information?

The perpetrator

- The perpetrator was a serial perpetrator of very serious domestic abuse in a number of prior intimate relationships. The evidence given by some of his previous victims was instrumental in securing his conviction for murder in the case of DHR 7. What can we learn about serial perpetrator behaviour and how to address it from the evidence given by his previous victims? What can we learn from the support provided to the previous victims which enabled them to give evidence in court despite their continuing fear of the perpetrator?

3.0 Summary Chronology

Background information (Paragraph 3.1 and 3.2)

3.1 Christine was born in 1973 and attended a school for children with additional needs. Her mother has advised this DHR that Christine was considered to have learning difficulties as a child but there doesn't appear to be any reference to learning difficulties in the adult medical records shared with this review. She was born and brought up in the Blackburn with Darwen area and lived there for much of her life with the exception of a nine year period residing in Glasgow. She had been blind in her right eye - following retinal detachment – from her early childhood. She had a history of depression and opioid and alcohol dependence. She was a heavy smoker, had asthma and had been diagnosed with COPD whilst living in Scotland although this was later ruled out by her Darwen GP practice.

3.2 She gave birth to five children during a long term relationship with the children's father, but all of the children were eventually removed from their care by children's services and permanently placed with Christine's family members. Her family feel that losing custody of

her children had a profound effect on Christine, but they said that she never gave up hope of becoming a mother – and retaining custody of the child - as she entered early middle age. As well as losing custody of her children, Christine's family have advised this review that she suffered bereavements following the deaths of two of her partners. The most recent bereavement of a partner had taken place in 2016.

3.3 On 25th July 2017 Christine suffered severe smoke inhalation during a fire at her home in Glasgow and spent 12 days in intensive care in Hospital 1 in that city. She was later stepped down to a High Dependency Unit and then to a general ward. It appears that she had no home to return to in Glasgow and that her family in Darwen were anxious for her to return to live near them so that they could support her in her recovery and help her to keep safe. It is understood that Christine had been drinking heavily at the time of the fire in her home and that she was treated for alcohol dependence during her hospital admission.

3.4 On 14th August 2017 Christine's brother phoned Blackburn with Darwen (BwD) Council to inform them that his sister was 'fleeing Scotland after her flat was set on fire'. The brother said that the police were investigating the incident as an 'attempted murder' and that Christine had been 'in a coma' in Scotland for 11 days. An appointment was arranged with BwD Council's Housing Needs team which Christine attended, accompanied by her mother two days later. During this appointment Christine said that she had been staying with her mother for two weeks following her arrival from Scotland.

3.5 Housing Provider 1 - which is a provider of social housing - received an application for housing in respect of Christine from BwD Council Housing Needs team who had assessed Christine as homeless and in priority need of rehousing. Housing Provider 1 has advised the DHR that they were not provided with information about Christine's needs or any vulnerabilities by the Housing Needs team and that the information shared consisted only of the level of banding awarded to her application which determined the priority. BwD Council Housing take the view that there was no evidence of Christine having any vulnerabilities when their service assessed her homelessness application and that she was given priority banding because of the fire which left her homeless in Scotland.

3.6 Also on 14th August 2017 Christine registered with a GP practice in Darwen. She was accompanied by her sister who helped her complete the patient registration forms. Christine scored 'high' on questionnaires relating to alcohol consumption and anxiety. A brief intervention in respect of Christine's excessive alcohol consumption was completed and she was also given smoking cessation advice.

3.7 On 21st August 2017 BwD Housing Needs amended Christine's banding to afford her higher priority on the grounds of over-crowding in her mother's home – which Christine's arrival had exacerbated - the risk of violence Christine faced at her previous address and her wish to be housed close to her mother in order to receive family support. BwD Housing Needs team advised Housing Provider 1 of Christine's banding two days later but there is no indication that they shared any detail of the concerns which justified the banding awarded.

3.8 On 4th September 2017 Housing Provider 1 offered Christine the property at address 1 and her tenancy commenced on 19th September 2017. BwD Housing Needs team made an award of a double bed and mattress, an electric cooker and a voucher to the value of £100 on the grounds that Christine was 'fleeing violence'. Housing Provider 1 completed a tenancy sustainability assessment in respect of Christine. However, this lacked detail, stating that Christine had moved to Darwen following a 'recent incident' and concluded that there was a risk related to 'capability'. Expected practice would be for a Housing Provider 1 Neighbourhood Officer to undertake a 'settling in' visit shortly after the commencement of Christine's tenancy where any vulnerability or risks had been identified in the homeless assessment conducted by BwD Housing Needs and/or the Housing Provider 1 sustainability assessment. There is no indication that the 'settling in' visit took place. BwD Housing Needs closed Christine's case.

3.9 On 5th September 2017 Christine's Darwen GP practice was faxed patient records from Christine's previous GP practice in Glasgow. These records documented problems with COPD dating to 2014.

3.10 Christine engaged quite well with her GP practice apart from a period when she had little contact between October 2017 and June 2018 and during the period from late 2018 when it is believed that her relationship with Paul began.

3.11 In June 2018 Christine reported low mood to her GP who noted that she was also underweight. The GP referred her to the re:fresh team which provides health and wellbeing support in areas such as healthy eating, exercise, smoking cessation and reducing alcohol consumption but Christine did not engage with this service. Christine later self-referred to MindsMatter - a wellbeing service provided by Lancashire and South Cumbria NHS Foundation Trust as part of the nationwide Improving Access to Psychological Therapies (IAPT). When she did not engage with this service, Christine was discharged back into the care of her GP. Her GP prescribed her an antidepressant – Mirtazapine - and her medications were regularly reviewed.

3.12 During June 2018 Christine also disclosed to her GP that she was in a relationship but was unsure if she was happy. The GP documented that Christine reported that she was 'being used?' No record of her partner's identity was documented and there is no further information about this partner in Christine's patient records. Christine said that she had no thoughts of self-harm but reported feeling hopeless at times.

3.13 Christine was given brief alcohol intervention support shortly after she joined the Darwen GP practice. In June 2018 Christine disclosed to her GP that she was drinking 3 bottles of wine each day although this had reduced from 6 bottles per day. Advice was given regarding reducing or stopping alcohol at this consultation but no referrals were made to specialised services for her alcohol dependence issues at that, or any other time.

3.14 During August 2018 Christine attended Hospital 2 ED following a seizure which was reported to have been witnessed by 'friends'. The seizure was documented to have been

Christine's first seizure and was investigated and 'normal examination and bloods' were found. Her GP was requested to refer Christine to the local first seizure clinic. The first seizure clinic is a specialist clinic run weekly by a Consultant Neurologist and Epileptologist for anyone with a suspected first seizure or a new diagnosis of epilepsy.

3.15 During October 2018 Christine was admitted to Hospital 3 for day case surgery for an angioplasty. Her recovery was to be subsequently reviewed as an outpatient by her consultant.

3.16 During November 2018 her pharmacy phoned Christine for a medication review. A face to face review was arranged as Christine was documented to 'sound confused' about her medication.

3.17 Later in November 2018 Christine attended an outpatients appointment in the Hospital 3 General Surgery Clinic following the angioplasty and was discharged. Christine reported knee pain, having fallen downstairs prior to the surgery. The Vascular Registrar prescribed co-codamol for Christine's knee pain and she was advised to see her GP.

3.18 On 22nd November 2018 Christine saw her GP and requested a back-dated fit note for 'ongoing problems'. A fit note was issued for the period from 8th November 2018 until 8th January 2019 due to depression and post-operative issues. Christine also reported sciatica and was signposted to the spinal drop-in service.

3.19 Her GP practice had no further contact with Christine until she presented, accompanied by Paul, with serious facial injuries on 16th January 2019. According to the account Paul subsequently provided to the police, his relationship with Christine began in early December 2018. It is understood that Christine left her home and moved into Paul's flat although on 17th December 2018 Christine phoned the Housing Provider 1 call centre to report that she had no central heating or hot water in her flat. An appointment was made to visit her home to repair the central heating on 20th December 2018 but no reply was received on that date and a card was left for Christine to rearrange the appointment. There is no record of Christine doing this. In their contribution to this review, Christine's mother and sister have said that they had no contact with her over the Christmas 2018 period.

3.20 On 7th January 2019 Christine's GP practice attempted to phone her to arrange a GP appointment for medication and fit note review and left a message on her answerphone. The next day the GP practice followed up by writing a letter to Christine to advise that they had been attempting to contact her without success and she responded to the letter by phoning her GP practice and made an appointment for 16th January 2019.

3.21 Around noon on 16th January 2019 Christine visited her GP practice. She spoke to reception staff who noticed that Christine had sustained bruising to her jaw and the left side of her face. The reception staff noticed that Christine was upset and 'jittery'. One of the reception staff made a cup of tea for her and spent time supporting her in a more private area of the surgery. During this period Christine disclosed that she had been 'beaten last

night'. The reception staff were aware that Christine had an appointment with one of the practice GPs during the same afternoon and had no further contact with her. Christine saw a GP shortly after 4pm. It is not known whether she had stayed in the GP practice from her initial arrival or had left and subsequently returned. She had been unaccompanied when she had first arrived at the GP practice but by the time of her GP appointment she was in company with a man the GP documented to be 'her partner Paul'. This is assumed to be Paul who was registered at a different GP practice and therefore previously unknown to Christine's GP practice.

3.22 On examination, the GP noted Christine had sustained bruising over both sides of her face extending over the cheeks and up to her eyes with extensive swelling. Due to the swelling her right eye was almost closed up. She had also sustained an injury to her left ear with swelling and erythema (redness of skin) of the cartilage with serous fluid coming from the upper part of her ear. She also reported an injury to her left index finger with a laceration which was causing her difficulty in flexion. This laceration had signs of infection with erythema around it and pus coming from the wound. She did not report any further injuries. Paul did not report any injuries to himself and the GP did not notice any, although the GP did not formally examine him. The GP strongly advised Christine to attend Hospital 2 ED as she required 'immediate medical care'. The GP printed off a record of his consultation with Christine and asked Christine to pass it to ED staff when she arrived at the hospital. The GP documented that Christine's injuries had been sustained during attacks on two separate occasions in both 'Reading and then Berkshire'. (Reading is located in Berkshire but this is how the GP documented the locations of the 'attacks'). The GP also documented that Christine was unsure who attacked her or why. The GP documented that Christine hadn't called the police or sought medical attention in respect of the attacks. The GP asked Christine to make the police aware of the assault. There is no indication that Christine was seen alone during this consultation. Following the consultation with her GP there is no evidence that Christine attended hospital ED or contacted the police. There was no follow up by her GP practice.

3.23 On 5th February 2019 Christine's mother reported her daughter as a missing person to Lancashire Constabulary. She said that her daughter had been living with Paul at his flat and that Paul had informed Christine's family that he had last seen her on 30th January 2019. Christine's mother said that she had not seen her for a 'few weeks' as they had 'fallen out'. Christine's relationship with Paul had previously been unknown to the police who had received no calls to Paul's flat during the period Paul and Christine are believed to have been in a relationship.

3.24 The police began a missing person investigation and assessed the case as medium risk. They visited Paul and searched his flat. Paul had been known to the police for many years and had numerous convictions for violence including domestic violence.

3.25 On 2nd March 2019 the missing person case was reviewed by a Detective Inspector and escalated to a high risk missing person investigation and two days later it was escalated

to a criminal investigation. By this time the police had ascertained the details of Christine's visit to her GP practice in company with Paul on 16th January 2019.

3.26 On 18th March 2019 the case became a murder investigation in the absence of any evidence that Christine remained alive and on 23rd March 2019 Paul was arrested on suspicion of the murder of Christine. He was later released under investigation and charged with the murder of Christine on 30th April 2020 following a lengthy and complex investigation. The body of Christine has never been recovered.

4.0 Key issues arising from the review

Assessing the needs of people presenting as homeless and ensuring they are offered support to address their needs

4.1 It is clear that Christine was extremely vulnerable when she relocated from Glasgow to Blackburn with Darwen in August 2017. Whilst she was promptly registered with a GP and allocated a new home, any tenancy support needs she may have had were not ascertained because BwD Council Housing Needs team did not share the details of any vulnerabilities disclosed during the Housing Needs assessment with Housing Provider 1 whose own sustainability assessment lacked detail and the anticipated 'settling-in' visit from a Housing Provider 1 neighbourhood officer did not take place. However, Christine's homelessness application was dealt with under the Homelessness Act 2002. Since that time homelessness is now dealt with under the Homelessness Reduction Act 2017 (which came into force in 2018). A significant difference between the two pieces of legislation is that the Homelessness Reduction Act 2017 places a stronger focus on an individual's needs and there is a requirement to agree a Personalised Housing Plan (PHP) for the person applying for accommodation.

4.2 Housing Provider 1 has identified a number of single agency actions but it is recommended that Pennine Lancashire Community Safety Partnership seeks assurance from BwD Council Housing Needs and all local housing providers that their policies and practices ensure that the needs of people presenting as homeless are fully ascertained, appropriately shared and result in the offer of, or signposting to, sources of any support they may need.

Recommendation 1

That Pennine Lancashire Community Safety Partnership obtains assurance from BwD Council Housing Needs and all local housing providers that their policies and practice ensure that the needs of people presenting as homeless are fully ascertained, appropriately shared and result in the offer of, or signposting to, sources of any support needed.

Care Act assessment

4.3 There was no escalation of Christine to the health safeguarding lead in her GP practice, so there was no referral to the safeguarding lead of respective agencies and a referral to

Adult Social Care was not considered necessary at the time of Christine's relocation to Blackburn with Darwen. Christine may have had unassessed care and support needs and may have benefitted from an assessment under the Care Act. It is therefore recommended that Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Safeguarding Adults Board so that the latter board may consider how proportionate consideration of a Care Act assessment could be brought to the attention of professionals involved in responding to the needs of a person presenting as homeless in Blackburn and Darwen.

Recommendation 2

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Safeguarding Adults Board so that the latter board may consider how proportionate consideration of a Care Act assessment could be brought to the attention of professionals involved in responding to the needs of a person presenting as homeless in Blackburn and Darwen.

The response of the GP practice to Christine's disclosures of abuse and evident injuries in January 2019

4.4 There is much learning for GP practices and for professionals generally arising from the response to Christine's two visits to her GP on 16th January 2019. Firstly it is clear that GP practices need to adopt a 'whole practice' approach. The senior receptionist had managed to elicit information from Christine which completely undermined the account Christine and Paul later provided to the GP. The GP practice concerned has advised the DHR that reception staff would usually add this information to the patient records or send a task to the relevant GP, but this did not happen on this occasion. The GP practice has also advised that all staff at the GP practice, including non-clinical staff have since undertaking domestic abuse awareness training. The GP who saw Christine and Paul reflected that Paul presented as positive and supportive throughout, which further emphasises the importance that all professionals should be aware of the potential for domestic abusers to manipulate the situation. Whilst it is acknowledged that sharing information is more challenging in reactive, over-burdened working environments, Pennine Lancashire Community Safety Partnership may wish to seek assurance that GP practices adopt a 'whole practice' approach to addressing domestic abuse and have effective systems in place for sharing information within the practice.

Recommendation 3

That Pennine Lancashire Community Safety Partnership seeks assurance from Lancashire and South Cumbria Integrated Care Board that all GP practices adopt a 'whole practice' approach to addressing domestic abuse and have effective systems in place for sharing information within the practice.

The 'One Chance' Rule

4.5 Christine's visits to her GP practice on 16th January 2019 represented the only opportunity to safeguard her from domestic abuse arising from her relationship with Paul. It is worthy of note that many (so-called) honour based violence (HBV) and forced marriage policies refer to the 'one chance rule' which highlights the fact that a professional may have just 'one chance' to speak to a potential victim and 'one chance' to save a life. If the victim is not offered support following disclosure that 'one chance' opportunity may be lost. The essence of the 'one chance' rule is that professionals are primed to act decisively and urgently when a disclosure of forced marriage/HBV is made to them. This case suggests the potential benefit of adopting a 'one chance' mentality when a person discloses domestic abuse. It is therefore recommended that when the learning from this DHR is disseminated, Pennine Lancashire Community Safety Partnership takes the opportunity to highlight the applicability of the 'one chance rule' to all forms of domestic abuse, including honour based violence. In making this recommendation, the DHR is not wishing to diminish in any way the focus of practitioners on their responsibilities to act decisively to safeguard the victims of (so-called) honour based violence.

Recommendation 4

When the learning from this DHR is disseminated, that Pennine Lancashire Community Safety Partnership takes the opportunity to highlight the applicability of the 'one chance rule' to all forms of domestic abuse, including honour based violence.

Guidance on how to engineer an opportunity to speak to victims alone

4.6 When Christine saw her GP on 16th January 2019 she was seen in the presence of Paul. It would have been preferable for Christine to have been seen alone. However, when discussing this issue the DHR Panel acknowledged that it can be challenging to engineer an opportunity to speak a potential victim of domestic abuse on their own, if accompanied by their suspected abuser. Reference was made to techniques such as acting the suspected abuser to leave whilst a urine sample is obtained. As stated, the DHR Panel felt that in the circumstances in which Christine saw her GP in the presence of Paul, the GP should say to the person accompanying them that the GP needed to examine the patient and ask them (the person accompanying the patient) to wait outside. It would be beneficial if good practice in engineering a situation in which the potential victim of domestic abuse is seen alone could be gathered and widely shared. The WISH Centre have considerable experience in this regard. It is therefore recommended that Pennine Lancashire Community Safety Partnership arranges for 'tips and hints' on how to engineer a situation where potential victims of domestic abuse are seen alone are pulled together and widely shared with professionals.

Recommendation 5

That Pennine Lancashire Community Safety Partnership arranges for 'tips and hints' on how to engineer a situation where potential victims of domestic abuse are seen alone are pulled together and widely shared with professionals.

Communication about domestic abuse to people with learning difficulties

4.7 It is understood that Christine had learning difficulties. Whilst there is no indication that she had a learning disability, it seems clear that she needed help to deal with written documents. Her learning difficulties may have increased her vulnerability to a serial perpetrator such as Paul and she may have struggled to pick up on initial indications of controlling behaviour. It is therefore recommended that Pennine Lancashire Community Safety Partnership reviews written and spoken communication material relating to domestic abuse to ensure that it is suitable for conveying messages to people with learning difficulties – and indeed people with a learning disability.

Recommendation 6

That Pennine Lancashire Community Safety Partnership reviews written and spoken communication material relating to domestic abuse to ensure that it is suitable for conveying messages to people with learning difficulties – and indeed people with a learning disability.

Case study on how perpetrators may attempt to manipulate professionals

4.8 The statements courageously provided by previous victims of Paul were instrumental in securing his conviction for the murder of Christine on the basis of evidence of 'bad character'. Lancashire Constabulary have kindly shared these statements with the DHR after obtaining the consent of the victims. The statements reveal much about how a serial perpetrator such as Paul abused and controlled his victims but also how he interacted with professionals. There may well be valuable learning for professionals arising from what is known about how Paul interacted with and manipulated professionals. It is therefore recommended that Pennine Lancashire Community Safety Partnership make use of suitably anonymised information from the victim's statements to prepare a case study providing examples of how perpetrators of domestic abuse may try and manipulate professionals.

Recommendation 7

That Pennine Lancashire Community Safety Partnership make use of suitably anonymised information from the victim's statements to prepare a case study providing examples of how perpetrators of domestic abuse may try and manipulate professionals.

Supporting victims to make statements and give evidence in Court

4.9 The DHR was also some advised of excellent practice by Lancashire Constabulary in supporting Paul's previous victims in making statements and giving evidence against him which may have wider application to cases in which the victim is reluctant to support a prosecution. A discussion with the Lancashire Constabulary SIO highlighted the following points which may be transferrable to other investigations of domestic abuse where the victim is reluctant to support a prosecution:

- There was a strong focus on treating the victims with kindness, empathy and compassion and making it clear that investigating or prosecuting their disclosure was important and most definitely not a 'routine chore'.

- There was also a strong focus on maintaining consistent contact with the same officer so that the victim did not have to continue to repeat their story.

- By adopting the above approach it was hoped to exclude the possibility of any unsatisfactory interactions with the victim as it was felt that a single poor interaction with a professional could diminish the confidence of the victim.

- All events including the taking of statements were regarded as part of a process in which the maintenance of the victim's trust and confidence was regarded as the highest priority. The focus was on safeguarding the victim rather than on the process of gathering evidence – important though that is – so that the victim felt that the police were there to look after her and did not just see her as a source of evidence.

- Interestingly, the SIO felt that special measures put in place to protect the identity of the victim in the court environment could potentially undermine the impact on the jury of the evidence given by the victim. The SIO felt that it was important for members of the jury to be able to relate to the victim. This observation is not intended to question or undermine the importance of special measures.

- The victims only went to the court when it was time for them to give their evidence and were supported in a nearby hotel until the appointed time in order to avoid the experience of waiting to give evidence in the court environment and potentially interacting with witnesses and defendants from other cases.

4.10 It is recommended that Pennine Lancashire Community Safety Partnership arranges for a task and finish group to examine how the learning from how Paul's victims were supported could be applied more widely in cases where victims of domestic abuse are reluctant to support a prosecution.

Recommendation 8

That Pennine Lancashire Community Safety Partnership arranges for a task and finish group to examine how the learning from how Paul's victims were supported could be applied more widely in cases where victims of domestic abuse are reluctant to support a prosecution.

Good practice

4.11 There was much good practice when Christine relocated to Blackburn with Darwen from Glasgow, particularly the prompt registration with the GP and the continuity of her care following her hospital admission in Glasgow and the prompt offer of a property after Housing Needs afforded her an appropriate level of priority.

4.12 Whilst there is much to be learned from the overall response of the GP practice to Christine's two attendances on 16th January 2019, it would be remiss not to comment positively on the humanity displayed by the senior receptionist in providing initial support to Christine which appears to have given her the confidence to make an important disclosure.

4.13 As stated the support provided by Lancashire Constabulary to previous victims of Paul to encourage them to give evidence which was instrumental in securing Paul's conviction on the grounds of 'bad character' was exceptional.

5.0 Conclusion

5.1 The DHR focusses on the period from Christine's relocation from Glasgow to Blackburn with Darwen in August 2017 until she was reported missing to the police by her mother in early February 2019. Overall, although she was promptly provided with housing following her arrival in Blackburn with Darwen, there appeared to be insufficient attention paid to the trauma she may have experienced as a consequence of the life threatening incident which precipitated her departure from Glasgow and her support needs were overlooked to an extent. An opportunity was missed to refer her for support to address her excessive use of alcohol and the reasons for her apparent reluctance to engage with secondary mental health services could have been explored.

5.2 Christine was murdered by Paul after what appears to have been a brief relationship of which agencies were unaware except for Christine's two visits to her GP practice on 16th January 2019, which represented a key opportunity to safeguard her.

5.3 Christine was deeply unfortunate to find herself in a relationship with Paul who had a shocking history of violence, cruelty, coercion and control in prior intimate relationships. Her significant vulnerabilities, including learning difficulties may well have contributed to Paul being able to be violent towards her, exercise control over her, isolate her from support and eventually murder her.

6.0 Lessons to be learned and recommendations

Assessing the needs of people presenting as homeless and ensuring they are offered support to address their needs

Recommendation 1

That Pennine Lancashire Community Safety Partnership obtains assurance from BwD Council Housing Needs and all local housing providers that their policies and practice ensure that the needs of people presenting as homeless are fully ascertained, appropriately shared and result in the offer of, or signposting to, sources of any support needed.

Care Act assessment

Recommendation 2

That Pennine Lancashire Community Safety Partnership shares this DHR report with Lancashire Safeguarding Adults Board so that the latter board may consider how proportionate consideration of a Care Act assessment could be brought to the attention of professionals involved in responding to the needs of a person presenting as homeless in Blackburn and Darwen.

The response of the GP practice to Christine's disclosures of abuse and evident injuries in January 2019

Recommendation 3

That Pennine Lancashire Community Safety Partnership seeks assurance from Lancashire and South Cumbria Integrated Care Board that all GP practices adopt a 'whole practice' approach to addressing domestic abuse and have effective systems in place for sharing information within the practice.

The 'One Chance' Rule

Recommendation 4

When the learning from this DHR is disseminated, that Pennine Lancashire Community Safety Partnership takes the opportunity to highlight the applicability of the 'one chance rule' to all forms of domestic abuse, including honour based violence.

Guidance on how to engineer an opportunity to speak to victims alone

Recommendation 5

That Pennine Lancashire Community Safety Partnership arranges for 'tips and hints' on how to engineer a situation where potential victims of domestic abuse are seen alone are pulled together and widely shared with professionals.

Communication about domestic abuse to people with learning difficulties

Recommendation 6

That Pennine Lancashire Community Safety Partnership reviews written and spoken communication material relating to domestic abuse to ensure that it is suitable for conveying messages to people with learning difficulties – and indeed people with a learning disability.

Case study on how perpetrators may attempt to manipulate professionals

Recommendation 7

That Pennine Lancashire Community Safety Partnership make use of suitably anonymised information from the victim's statements to prepare a case study providing examples of how perpetrators of domestic abuse may try and manipulate professionals.

Supporting victims to make statements and give evidence in Court

Recommendation 8

That Pennine Lancashire Community Safety Partnership arranges for a task and finish group to examine how the learning from how Paul's victims were supported could be applied more widely in cases where victims of domestic abuse are reluctant to support a prosecution.

Appendix B

Executive Summary

Multi agency Action Plan – BwD DHR7

Independent Chair & Author – David Mellor

	Organisation	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Completed Date
1	**Lancashire Constabulary**	To remind all personnel that an incident log should always be created even for minor incidents so that an incident number is generated.	Implement Protocols from Lancashire Target Operating Model (TOM)	Lancashire Constabulary introduced a new Target Operating Model (TOM) in June 2023. The new TOM covers all aspects of Police Interaction with members of the public. What this means; • As a Response, Response Investigations Officer or Detective Sergeant, you will be given access to the CONNECT Investigation allocation worktray for your area and role. • This is how investigations will be allocated from the FCMU and handovers between departments completed. • The investigation allocation trays are separate to your usual CONNECT worktrays used to manage the workload of your teams. • Investigations will be sent to allocation trays by the FCMU, either following telephone investigation by an FCMU Officer or a quality handover from another team. • **I am Sergeant - what is my role in allocating investigations?** One of your core responsibilities as Sergeants from Monday 12 June will be the allocation of investigations to your teams.	All members of the public receive suitable and appropriate levels of service.	Det Supt Neil Drummond	Sept 23

				• **All investigations sent to an allocation tray must be allocated to an OIC within 24 hours of input.** • The new OIC must contact the victim as soon as possible on allocation, and in any event within 24 hours, and provide contact details as per the Victims Code of Practice. Calling cards can be used for this. • Here we outline what you need to do, based on your role: • **Response Investigations Sergeants** • Response Investigations Sergeants on **earlies** will have responsibility for allocating **all** investigations which have been **sent to their allocation tray** between the hours of **14:00 the previous day and 08:00 that day** to an OIC on your team • Response Investigations Sergeants on **lates** will have responsibility for allocating **all** investigations which have been **sent to their allocation tray** between the hours of **08:00 and 14:00 that day** to an OIC on your team • **Response Sergeants** • Response Sergeants **on each early shift only** will have responsibility for allocating **all** investigations which have been **sent to their allocation tray** between the hours of **07:00am the previous day and 07:00am that day** to an OIC on your team. • Some non-crime incidents will be deployed to via dedicated pathways to specialist departments. All other standard incidents which require officer deployment will be attended by Response as directed by the Force Control Room.			

				Protocols for Crimes • Every victim of crime will speak to an Officer and every crime will have an Officer in Case (OIC). • The Officer will not only record the crime, but they will also provide crime prevention and scene preservation advice if required. • There will be fewer contact points for victims of crime when they report to us; if a deployment is needed as grade 1 or 2 this will be done by the Control Room, but if it doesn't require an immediate deployment – so for a grade 3 – the caller will be transferred to the Crime Recording Team who will take all details, carry out an initial investigative assessment of the crime and either close the crime, or allocate it for further enquiries. • The victim will get a crime number within 24 hours, and in most cases at the first point of contact. • The victim will know who is investigating their incident – an OIC will be allocated within 24 hours and the victim will be provided with their Officers contact details. • Where there are no lines of enquiry, the crime will be QA'd by a Supervisor and then closed by the Crime Recording Team and we will inform the victim and provide the appropriate referrals and support, including giving crime prevention advice if needed. • If an investigation is required, the Crime Recording Team will apply the Crime Allocation Policy meaning the crime is given to the right person with			

				the right skills, so the victim won't get passed around.			
2	**NHS Lancashire and South Cumbria Integrated Care Board**	To ensure Routine Enquiry is utilised in health reviews.	The Domestic Abuse Enquiry template is initiated for consultations for: mental health, all NHS health screening, new patient checks and female sexual health. This was launched with GP practices in April 2022.	Domestic Abuse Enquiry template launched with Bwd GP practices. Routine Enquiry into Domestic Abuse – EM	For Domestic Abuse enquiry to be embedded into practice and opportunities are taken at contacts with patients to enable them to disclose domestic abuse.	NHS Lancashire and South Cumbria Integrated Care Board	April 2022
3	**NHS Lancashire and South Cumbria Integrated Care Board**	To ensure Targeted Enquiry is discussed if a patient attends following an assault or with suspicious circumstances. (To undertake bespoke training for the practices around targeted enquiry and professional curiosity)	Share learning at GP champions forum.	Pennine GP champions events regarding Domestic abuse held on: June 22: Learning from a local DHR, Sept 22: DA Update, Oct 22: Safe recording, coding and information sharing of domestic abuse Dec 22: Learning from CSPR & DHRs	For clinicians to feel able to see patients alone and to use professional curiosity and targeted enquiry around Domestic Abuse.	NHS Lancashire and South Cumbria Integrated Care Board	Dec 2022
				Two ICB wide primary care conferences were held on: 13th October and 19th October including Domestic Abuse			Oct 2022
			To share a brief amongst primary care in	Briefing shared amongst Primary Care Safeguarding champions for dissemination within practice.			Dec 2022

			Pennine Lancashire to highlight the importance of seeing a patient alone when attending with an alleged assault and to ensure targeted enquiry is undertaken in relation to domestic abuse.	 Briefing.doc			
			Develop prompt card to aid GP's with domestic abuse enquiry.	GP specific ASK prompt card developed with WISH Centre  Health Professionals ASK flyer.png			Dec 2022
			To share identified learning from the DHR with the practices involved.	Completion of session with the practices  Feedback and learning following a D	The GP practice staff understand lessons learnt and actions needed to address.		Sept 2022
4	**NHS Lancashire**		To raise awareness at	Sharing information at Pennine GP Champions and presentation circulated following the event to all	For GP Practices to	NHS Lancashire	Dec 2022

	and South Cumbria Integrated Care Board	Having the knowledge of risk factors that could be an indicator of being a perpetrator of domestic abuse- and making part of regular discussion- 'everything alright at home'	GP Safeguarding Champions.	Safeguarding champions for dissemination within their practices. Pennine GP champions events held on Domestic abuse on: June 22: Learning from a local DHR, Sept 22: DA Update, Oct 22: Safe recording, coding and information sharing of domestic abuse Dec 22: Learning form CSPR & DHRs	have a knowledge of risk factors that could be an indicator of being a perpetrator of domestic abuse	and South Cumbria Integrated Care Board	
				Two ICB wide primary care conferences were held on: 13th October and 19th October including Domestic Abuse			Oct 2022
			GP Training brochure updated to include signposting to online domestic abuse awareness training.	Training brochure updated and circulated to Pennine Lancashire Primary Care on 30.03.2022  Training brochure.docx	Primary Care staff to undertake Domestic Abuse Training commensurate to their roles.		March 2022
			Update of Safeguarding Assurance Framework for primary care highlights for clinical and non-clinical staff to complete Domestic Abuse	Updated SAF circulated to Pennine Lancashire Primary Care December 2022. For BwD Primary Care this is not currently contractual to completed, however good practice.  Worksheet in X 10.07.2023 - DHR7.xls			Dec 2022

			awareness training.				
			To share identified learning from the DHR with the practices involved.	Completion of session with the practices  Feedback and learning following a D	The GP practice staff understand lessons learnt and actions needed to address		Sept 2022
5	**Together Housing Association**	Review information-sharing protocols following homeless assessments with Blackburn with Darwen (BwD) Council Housing Needs team	*Joint Task and Finish group – to clarify current arrangements re information-gathered as part of homeless assessment, including how needs and risk are assessed and information sharing on associated support measures required, risk/vulnerability indicators*	*Minutes of meeting* *Protocols that clarify are incorporated into into respective procedures (Housing Needs and THA)* *Training session for respective teams*	*All relevant information identified as part of homeless assessments (risks, vulnerabilities, support requirements and arrangements in place) by Housing Needs (BwD) to be shared as part of housing application* *This enables the*	*Ben Saynor – Lettings Manager*	*31/03/22* Completed Also since action plan- further developed processes around joint meetings with Housing Needs team for applicants with complex needs

			Revised protocols to strengthen understanding		*Landlord to identify vulnerable tenants/tenancies more at risk of failing and provide early interventions if/when indicators are highlighted*		
6	**Together Housing Association**	Together Housing Association (THA) tenancy sustainability processes for those being referred as homeless	*THA review group to review dovetailing of information provided via homeless assessments with TS assessments (and those with multiple complex needs)*	*Revised procedures in place* *Briefing sessions for Lettings and Neighbourhood teams*	*Tenancy sustainability assessments are informed by information held and shared with THA by other agencies to inform and better manage applications for rehousing*	*Clare Atkinson – Senior Manager – Neighbourhood Operations/ Matt Newman Senior Manager Income*	*31/03/22* *Tenancy sustainability assessments that identify applicants as medium to high risk (e.g. homelessness, leaving care , supported housing etc) – action plans now in place* *Lettings processes reviewed incl seeking internal advice where necessary and multi-agency liaison for applicants with complex needs/ vulnerabilities* *Completed*
7	**Together Housing Association**	Strengthen processes, including triaging	*Review arrangements to identify how*	*Produce guidance to assist staff when dealing with ASB complaints where there are indications of possible underlying causes*	*Appropriate and timely responses*	*Martin Jackson-ASB/Neigh*	*31/03/22*

		relating to complaints referred through anti-social behaviour (ASB) processes complaints where indicators of possible underlying causes of concern.	*processes are further aligned with Cause for concern / safeguarding & domestic abuse procedures*		*to complaints/ concerns which may be potential domestic abuse*	*bourhood Safety Manager & Zoe Aspinall – Safeguardi ng Manager*	*Completed- now referenced in ASB procedures incl triaging and in addition to references already being made in safeguarding procedures, ASB procedures updated to reinforce also /more aligned* *Underpinned by the need for staff to be professionally curious* *And in 2023 – further case mgmt. training has been carried out on ASB* *Also cases where DA is underlying cause but initially reported as ASB are now no longer recorded as ASB but recorded as safeguarding/victim*
8	**Together Housing Association**	Ensure accurate information recording and sharing of information	*Use roll-out of case to reinforce Formulate learning package (e-learning and team discussion) Agree timeline for roll out and relevant teams with Safeguarding learning group*	*Case study package* *Elearning completion rates*	*All recordkeepi ng is in line with standards as set out in procedures and consistently compliant*	*Zoe Aspinall – Safeguardi ng Manager*	*30/06/22* *Completed –* *decision made by THA Strategic Safeguarding learning group to change approach and not roll out each individual case as standard but instead include key learning points within themed learning roll outs where appropriate to do so* *Key learning points relevant here re professional curiosity and understanding of*

							underlying causes, precise and detailed record keeping, info-sharing are all within safeguarding training programme (ongoing) . refresher training reminds and reinforces using cases as examples to illustrate . Updated included in further themed learning sessions as part of safeguarding week in June 2023

Appendix D

Home Office Quality Assurance Panel Feedback

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lindsay Frew
Pennine Community Safety Coordinator
Community Safety Team
Blackburn with Darwen Borough Council
Localities & Prevention
L Floor, Old Town Hall
King William Street
Blackburn
BB1 7DY

15th February 2024

Dear Lindsay,

Thank you for submitting the Domestic Homicide Review (DHR) report (Christine) for Pennine Lancashire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel thought this was an open and probing report that considered the chronology of events in detail with the victim at the centre. The report had specific Terms of Reference, included illustrations of good police practice, and was overall thoughtful in its recommendations which were generally appropriate, although some of these could be made more targeted. The views of Christine's mother are well represented, and it appears she was able to pick the pseudonyms used, but this could be clarified and set out earlier in the report.

The report explored previous patterns of abuse including controlling and coercive behaviour of the perpetrator in depth and the QA Panel were pleased to see the time-period under review in the report was widened to include evidence from previous survivors. The report also considered the protected characteristics, diversity information, multiple disadvantages, and other factors relevant to Christine, which felt applicable to the case.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There is some lack of clarity about the sequencing of events, specifically paragraphs 5.39 to 5.44, which should be revisited to make sure there are no gaps. It was felt that an overview section might be useful to summarise clearly the information known to the agencies and professionals about the victim and perpetrator.

- Information about the perpetrator set out at paragraph 6.37 may be useful in earlier analysis in the report. There is also a flag in this section that the information may need to be removed which should be revisited.

- Although the Panel generally praised the inclusion of the equality and diversity information, it was felt that all 9 characteristics, and specifically 'sex', should have been considered in the report. Some panel members found the relevance to adverse childhood experiences of the victim unclear in the section on 'pregnancy and maternity'. There was also a view that more discussion was needed on how the victim and perpetrator perceived services relevant to their protected characteristic.

- In terms of the specific recommendations made in the report, the Panel have suggested:
    - It was felt that valuable learning could arise from more attention given to the missed opportunities for information sharing. Specifically, in regard to the Housing Provider and the PCSO as detailed in section 5.
    - The "one chance" for DA victims is innovative but may need to be reworded to not detract from the specific risks to 'honour' based abuse victims.
    - Could include specific recommendations for *how* the GP could adopt a 'whole practice approach' – for example by joining a named specialist project or undertaking specific training, e.g., IRIS.
    - Given the perpetrator's previous pattern of offending, it might have been beneficial to include a recommendation relating to how the Domestic Violence Disclosure Scheme could have been used.
    - Owner or 'target' of the recommendations could be made clearer in some cases.

- The Panel felt there were some areas that may be inappropriate for inclusion in the report, namely:
    - The reflection that special measures were detrimental to the evidence given in court by a victim.
    - Paragraph 6.13 should be reworded to avoid appearing to make excuses for the GP surgery.
    - Paragraph 6.34 provided an author's challenge on police's initial assessment of risk; it was felt this was not the role of the author to include.

- It is sometimes unclear which of Christine's children contributed to the report, and whether the views of her adult children were represented. Pseudonyms should be explained earlier in the report.

- There are several typos, inconsistencies and some unnecessary repetition in the report. A thorough proofread is required with jargon or specialist terms explained for the reader's clarity.

- Role and names of panel members should be included as well as an updated dissemination list. Training received by the DHR Chair should also be noted.

- Paragraph 6.12 includes a sentence which describes the 'DHR independent author's view', this should be the DHR Panel view.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

References

(1) Retrieved fromhttps://www.gov.uk/government/collections/fit-note

(2) Jane Monkton-Smith Homicide Timeline – reference to be added

(3) Retrieved from https://www.welshwomensaid.org.uk/wp-content/uploads/2017/06/Who-Does-What-to-Whom.pdf

(4) Retrieved from https://www.nuffieldfoundation.org/wp-content/uploads/2019/12/Literature-review_Born-into-Care_Dec-2019.pdf

(5) ibid

(6) ibid

(7) Retrieved from https://www.gov.scot/publications/using-intersectionality-understand-structural-inequality-scotland-evidence-synthesis/pages/3/#:~:text=%22Intersectionality%20is%20a%20metaphor%20for,among%20conventional%20ways%20of%20thinking.%22

Glossary

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

DASH (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.