WIGAN

BUILDING STRONGER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Victim Jess

Died May 2016

Review Panel Chair	David Hunter
Report Author	Paul Cheeseman
Date	26 July 2018

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Wigan Building Stronger Communities Partnership domestic homicide review (DHR) panel in reviewing the homicide of Jess who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, and perpetrator to protect their identities and those of their family members:

Name	Who	Age	Ethnicity
Jess	Victim	29	White British
Sarah	Offender	31	White British

1.3 This table shows the relationship of other people to Jess and Sarah

Designation	Relationship
Vicky	Mother of Sarah
Helen	Previous partner of Sarah

1.4 Sarah and Jess met in 2009 and they lived together in the Wigan area from 2011. While Sarah described her as a 'friend', Jess told others that Sarah was her 'partner'. Vicky also lived with them. There is evidence that Sarah was abusive, confrontational and aggressive towards both Jess and Sarah's previous partner Helen.

1.5 On a day in late Spring 2016 Sarah says she found Jess at the bottom of the stairs in the house they shared. An ambulance was called and Jess was taken to hospital where she was pronounced dead. Jess had many injuries including extensive facial bruising. Greater Manchester Police commenced a homicide enquiry.

1.6 Sarah and Vicky were arrested and both were charged with the murder of Jess and assault upon Helen. They appeared before a Crown Court and after a lengthy trial Sarah was found guilty of both offences. She received a term of life imprisonment and will not be considered for release on licence until she has served at least eighteen years and three hundred and fifty-eight days in prison. Vicky was found not guilty of murdering Jess and guilty of assault upon Helen. She received a suspended sentence of twelve months imprisonment.

1.7 Wigan Building Stronger Communities Partnership met on 14 October 2016 and decided that the criteria for a domestic homicide review had been met. The Home Office were informed, and an independent domestic homicide review was commissioned. All agencies that potentially had contact with Jess, Sarah and Vicky prior to the death were contacted and asked to confirm whether they were involved with them.

1.8 Nine agencies confirmed contact with the victim and/or perpetrator and her mother and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

2.1 The table below shows the agencies that contributed to the review and the material they were able to supply.

Agency	IMR[1]	Chronology	Report
The Brick	Yes	Yes	
Bridgewater Community Healthcare NHS Foundation Trust	Yes	Yes	
GMP	Yes	Yes	
Housing Options-Adult Social Care & Health – Homes	Yes	Yes	
North West Borough's Healthcare NHS Foundation Trust	Yes	Yes	
Stepping Stones			Yes
Wigan Borough Clinical Commissioning Group	Yes	Yes	
Wigan Council Adult Social Care and Health Leigh Locality Adult Social Work Team	Yes	Yes	
Wrightington Wigan & Leigh NHS Foundation Trust	Yes	Yes	

2.2 The authors of the Individual Management Reviews included in them a statement of their independence from any operational or management responsibility for the matters under examination.

[1] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

3. THE REVIEW PANEL MEMBERS

3.1 The panel members were:

Name	Job Title	Organisation
David Hunter	Chair	Independent
Paul Cheeseman	Author	Independent
Reuben Furlong	Assistant Director Adult Safeguarding	Wigan Borough Clinical Commissioning Group
Sarah Martin	Named Nurse Safeguarding Adults	Bridgewater Community Healthcare NHS Foundation Trust
Lynda Cunliffe	Named Nurse Safeguarding Children	Bridgewater Community Healthcare NHS Foundation Trust
Jim Eatwell	Named Nurse, Adult Safeguarding	Bridgewater Community Healthcare NHS Foundation Trust
Margaret Jolley	Head of Adult Safeguarding	Wrightington, Wigan and Leigh NHS Foundation Trust
Nicola Compton Jones	Senior Nurse	Wrightington, Wigan and Leigh NHS Foundation Trust
Sarah Shaw	Head of Adult Safeguarding	North West Boroughs Healthcare NHS Foundation Trust
Jackie Hodgkinson	Named Professional	North West Boroughs Healthcare NHS Foundation Trust
Nick Woods	Advanced Practitioner, Safeguarding Adults	North West Boroughs Healthcare NHS Foundation Trust
Alison Troisi	Detective Sergeant	GMP
Simon Hurdley	Detective Constable	GMP
Nazia Rehman	Councillor	
Lauren Crews	Team Leader, Homes	Wigan Council
Louise Green	Operational Director	The Brick Project
Gemma Noden	Probation Officer	HMPPS
Sarah Owen	Service Manager Partnerships	Wigan Council

Steve Martlew	Business Manager, Domestic Abuse and Sexual Violence	Wigan Council
Kieran Davies	Domestic Abuse Operational Manager	Wigan Council
Heather Brown	Complex Dependency Key Worker	Wigan Council
Paul Whitemoss	Service Manager Safeguarding	Wigan Council
Carolyn Whalley	IRO, Adult Safeguarding Team	Wigan Council
Pat Darbyshire	IRO, Adult Safeguarding Team	Wigan Council
Jill Cunliffe	Wigan Safeguarding Adult Board Business Support Manager	Wigan Council

3.2 The panel met four times and the review chair was satisfied that the members were independent and did not have operational and management involvement with the events under scrutiny. The DHR panel also held two practitioner events during which they met professionals and/or community workers who had direct involvement with the couple or had worked in the area they lived.

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 David Hunter was appointed as the Independent Chair. He was supported by Paul Cheeseman who wrote the DHR overview report and executive summary. Both are independent practitioners who have chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adult Reviews. Neither has been employed by any of the agencies involved with this review nor are they connected to Wigan Building Stronger Communities Partnership who judged they had the necessary experience, skills and independence to undertake the review.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 These were set as:

The purpose of a DHR is to:[2]

a) 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;

b) 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;

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

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

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

f) Highlight good practice.

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[3] did your agency identify?

2. How did your agency assess the level of risk faced by the victim from the perpetrator, did it take into account all your agency knew about their individual and joint histories, including information from family and friends?

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

[3] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

3. What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

4. How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

5. What barriers may the victim have faced in disclosing her victimisation?

6. How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?

8. What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

9. Did your agency comply with its domestic abuse policies and procedures and were any gaps identified?

10. How effective was your agency's supervision and management of practitioners involved with the response to the needs of the victim and perpetrator and did managers have effective oversight and control of the case?

11. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

12. What learning did your agency identify?

13. Does the learning arising from this review appear in other reviews held by Wigan Building Stronger Communities Partnership?

14. What areas of good or innovative practice did your agency identify?

Timescale

5.2 The DHR covers the period from 1 January 2013[4] until the date of Jess's death in the late spring of 2016.

[4] This period captured the first occasion when GMP held information concerning an incident of domestic abuse involving Sarah.

6. SUMMARY CHRONOLOGY

6.1 Jess

6.1.1 Jess's mother was seen by the Chair of the DHR and provided information about her daughter. She said she was one of five siblings; three sister and two brothers. Jess attended schools in Stockport and was well trusted by families as evidence by the demand for her babysitting services. She left school and spent some time working in retail. Jess liked animals and children and had one daughter. After Jess began her relationship with Sarah the child remained with Jess's mother.

6.2 Sarah

6.2.1 There was little information available to the DHR panel about Sarah. It is known she was referred to mental health services (psychiatrist) at the age of four due to what was termed, "behavioural problems". She was placed in a residential special school for three nights each week because of emotional disturbance. Sarah told psychology services in 2015 that she had anger issues since a young age. She said her father was physically violent towards her and to her siblings. Sarah said he left the family home around 2005 and passed away in 2008.

6.2.2 Records held by Adult Social Care show that while at school in 1998, Sarah disclosed to a member of staff that her father had head-butted her in the face following an argument over money. The same year records show that Sarah was involved in two episodes of inappropriate behaviour at the school. She was said to have been threatening towards staff. Sarah and fellow pupils had struck another girl resulting in minor injury. She was said to have gestured with broken glass and a bread knife.

6.2.3 The DHR Chair and report author visited Sarah in prison. She denied she was responsible for Jess's murder although she conceded there had been arguments between them. Sarah presented as someone who was angry, could not accept responsibility for their own actions and was prepared to blame everyone except herself.

6.3 Jess and Sarah's Relationship

6.3.1 Before meeting Jess, Sarah had been in a relationship with Helen. Sarah was violent towards Helen and Sarah was referred to MARAC[5] in 2008 as a High[6] risk Domestic Violence perpetrator. The relationship ended in 2008 when Greater Manchester Police (GMP) received a call about Helen having been found with facial injuries following an argument with Sarah. She was arrested although not charged because of a lack of evidence[7]. Helen went on to obtain a non-molestation order against Sarah.

6.3.2 Sarah and Jess began a relationship in 2009. At that time Sarah lived in Wigan and Jess lived in Stockport. Jess moved to Wigan to live with Sarah and Vicky in August 2011. Jess's mother said it gradually became clear that Sarah was beginning to control what Jess did. For example, Jess's mother was aware from her daughter that Sarah wanted to control her telephone and that there was friction between the couple.

6.3.3 The full nature of Sarah and Jess's relationship only emerged during the trial of Sarah and Vicky. Evidence was heard that Sarah regularly kicked, punched and stamped on Jess. Jess was said to have lost a significant amount of weight in the last few months of her life. Sarah was seen to drag Jess by the hair and abuse her in the street. Many of the attacks by Sarah upon Jess were carried out in full view of neighbours who did nothing to help.

6.4 Key Events

6.4.1 Greater Manchester Police attended a number of incidents at the address occupied by Jess, Sarah and Vicky. Many of these did not involve Jess and were disputes between Sarah and members of her family and/or neighbours. While not directly relevant to the homicide of Jess, they tend to show that Jess was frequently involved in confrontational events.

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[5] A Multi-Agency Risk Assessment Conference (MARAC) is a regular local meeting to discuss how to help victims at high risk of serious harm. A domestic abuse specialist (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information.

[6] GMP and other police forces and some agencies conduct a risk assessment whenever they receive a report of domestic abuse. Risk to the victim is categorised as High, Medium or Standard. All High-risk cases are referred to MARAC.

[7] Following their trial for the murder of Jess, Sarah and her mother Vicky were found guilty of this assault upon Helen.

6.4.2 In July 2014 a PCSO was on patrol when they heard two female voices screaming at each other from the property where Jess, Sarah and Vicky lived. They chose[8] not to give any information about the dispute and the PCSO created an intelligence log on the GMP system about the incident.

6.4.2 In August 2014 Jess disclosed to her GP that she had been attacked a few months previously. She did not name her assailant and the GP did not explore the possibility of her being the victim of domestic abuse or violence.

6.4.3 In June 2015 Sarah was referred by her GP to Psychology Services[9]. Sarah had told her GP she had low mood, anxiety and anger. Jess was present when Sarah attended her first appointment with the Service. During the consultation Sarah said she had assaulted her friend and her mother in the past. It was felt Sarah had full insight and capacity and that medication would have a limited role. The plan was for Sarah to self-refer to IAPT[10] and she was given a 24-hour contact number.

6.4.4 In July 2015 a social worker visited Sarah to complete an assessment as Sarah wanted to be a carer for one of her sister's children. During the visit Sarah became agitated, raised her voice and became annoyed. The social worker decided to terminate the meeting. Sarah became aggressive, pushed the social worker and refused to let them out of the house. She only relented when Jess intervened.

6.4.5 As a result of her behaviour, a violence warning was entered on the Wigan social care computer system relating to that address. The matter was not reported to the police and it does not appear that any other agencies knew about the incident until the DHR panel started its work.

6.4.6 In September 2015 Sarah was assessed in the North West Borough's Healthcare NHS Foundation Trust Outpatient Clinic. She presented with a longstanding history of anger, poor sleep pattern, difficulty socialising and low mood. She said she became aggressive and angry and got into fights,

[8] The DHR panel recognised that there are often complex reasons why victims of domestic abuse make the 'choices' they do and that not all choices are made freely.

[9] This is delivered by North West Borough's Healthcare NHS Foundation Trust

[10] IAPT [Improving Services to Psychological Services] is a Primary mental health service. Primary mental healthcare providers deal with people suffering from mild to moderate mental health problems. People with more serious or complex psychiatric disorders are referred to secondary mental health care.

particularly with Jess. About two to three months ago she said she had tied a belt around her neck in the bathroom and was going to hang herself. Jess found her and stopped her from doing this. Sarah was referred to the 'Live Well' dual diagnosis Practitioner.

6.4.7 Later that month an anonymous caller contacted GMP and said there was a domestic incident at the address occupied by Sarah, Jess and Vicky. The caller said a female had a knife and was threatening to stab her girlfriend, had kicked her in the face and had dragged her inside. The caller also told the police there was constant arguing and screaming from the address. The description the caller provided matched the physical description of Sarah as the perpetrator and Jess as the victim.

6.4.8 A police patrol visited the address and recorded there was no disturbance when they arrived. There had been a verbal argument between Sarah and Jess. Sarah and Jess both denied that anyone had a knife. They also denied they were in a relationship so the matter was not recorded as domestic abuse.

6.4.9 In early January 2016 Sarah attended her first appointment with the Live Well Team. Jess was with her. She was said to be a 'family friend' who lived with Vicky. During the session Sarah said she had hit Jess. She said she did not want to report the incident as she understood things were difficult for Sarah. No further action was taken in accordance with Jess's wishes.

6.4.10 Later that month Sarah attended a second appointment with the Team. Jess was with her and remained in the waiting room. Staff there saw that Jess had a black eye, cuts and bruising. This was explored with Jess who did not wish to report the matter to the police. During the session, Sarah said she had tried to take an overdose earlier that month and she hit her friend who tried to stop her.

6.4.11 During the third session with the Live Well Team at the end of January 2016 Sarah became increasingly agitated and angry. She shouted and swore at staff and at Jess, who staff reported was sat in the waiting area and had facial cuts and bruising. Jess was asked questions by staff about potential abuse. She chose not to take any action.

6.4.12 The following day IAPT raised concerns with the NWBH Safeguarding Team about Jess's welfare. A plan was set to speak privately with Jess when Sarah

next returned to the Service and offer her information about support services.

6.4.13 The Team Consultant believed Sarah was too complex and risky for the IAPT services. Sarah was therefore contacted by telephone to discuss plans for support and intervention. Jess answered the telephone and relayed the conversation to Sarah who refused to take the call. She could be heard shouting and swearing in the background. During the call Jess was advised that she needed to safeguard her own well-being in connection with Sarah's violent behaviour towards her.

6.4.14 The following day a practitioner from mental health services made a further telephone call to Sarah to discuss her mental health needs. Jess answered and Sarah could be overheard in the background in an extremely angry and distressed state. She swore and became personally abusive about the IAPT service. Although she was offered appointments Sarah did not take them. A final contact was made by telephone with Sara the next day. She again became aggressive and declined the offer of any support.

6.4.15 On an afternoon in March 2016 a PCSO met Jess in the street. The PCSO saw Jess had severe bruising to her forehead and cheekbone and one of her ears was badly swollen and very black. Jess said she had been jumped by four girls who had 'battered her'. She said she had contacted the police who had carried out a search and taken statements from her. The PCSO recorded this contact as intelligence on the GMP computer system. They could not find any record of a crime or incidents in the area correlating with the information Jess had given.

6.4.16 Two days later a police officer and another PCSO were alerted to concerns for a female who had been seen in the street with injuries. The police officer and PCSO spoke to Jess who had bruising around both eyes and was holding her lower back. She said she had been attacked by some girls in the local park and had reported this to the police. She chose not to answer any further questions or have a confidential chat at home or a community venue.

6.4.17 The police officer who spoke to Jess made an intelligence entry on the GMP system relating to the conversation. The police officer was also told by another colleague of a conversation they had recently had with Jess in which she claimed she had sustained the injuries when she had been knocked down by a car. About a week after this event the same police officer and

PCSO2 again saw Jess in the street and offered to help and talk to her. Jess told them she wanted to be left alone.

6.4.18 Later the same month Women's Housing Action Group (WHAG)[11] reported to GMP concerns for the safety and welfare of Jess. A friend of Jess had contacted the charity saying that Jess's partner had assaulted her. The friend said that if Jess's partner knew the police had been informed they would kill Jess. The friend also said that Jess had been telling people she had been run over, however she had now admitted her partner had been assaulting her. WHAG had secured Jess a place in a refuge.

6.4.19 As a result of the call a police officer visited Sarah, Jess and Vicky's address. They could not gain a reply. The police officer made enquiries nearby and was told that the occupants had not been seen that morning. Jess's mobile telephone was switched off. The police officer who attended spoke to their colleague who had seen Jess in the street with bruising (see paragraph 6.4.16).

6.4.20 The attending officer mistakenly assumed the injuries Jess had were old and that she had already given other explanations for them. The log of the call from WHAG was therefore closed as 'False call, good intent, old injuries.' It was not referred to the Public Protection Investigation Unit (PPIU) and Consequently, no assessment was made in relation to the risks that Jess faced[12].

6.4.21 The final contact between Sarah, Jess and GMP was in the early hours one morning in May. Sarah reported that she and Jess had been assaulted in the street by two females. Police officers visited them at home and Jess nor Sarah chose not to confirm that any offences had occurred.

6.4.22 On a day in late spring 2016 Sarah called the emergency services. She said she heard a noise and found Jess at the foot of the stairs and commenced first aid. Jess was taken by ambulance to the accident and emergency department. She was pronounced dead. Staff found she had extensive bruising and abrasions and contacted GMP who commenced a homicide enquiry.

[11] Women's Housing Action Group-a registered charity providing support for vulnerable women

[12] Incidents closed as domestic and risk assessed by the responding officer as Medium and High are automatically sent to the PPIU for triage.

7. FINDINGS

7.1 Sarah was a violent person who used force to coerce and control her victims, Helen and Jess. It is clear to the DHR panel that many of the appalling incidents that where seen by neighbours and witnesses were not known by agencies within Wigan. Some professionals saw Jess with injuries, including police officers, to whom she gave explanations that did not involve domestic abuse. Many agencies, including the GP did not realise there was an intimate relationship between Jess and Sarah and the GP did not explore the possibility that the injuries Jess presented with might have been the result of domestic abuse.

7.2 The panel feel opportunities were missed to identify what was happening in the couple's relationship. For example, when the police visited address one in response to an anonymous call (see paragraph 6.4.7). Although Sarah and Jess denied they were in a relationship, had Sarah's background been researched it would have emerged that she had abused a previous partner and had been the subject of a non-molestation order and a high-risk MARAC.

7.3 There was direct evidence available to the 'Live Well' Service that Sarah had perpetrated abuse upon Jess. In line with Jess's wishes this was not shared with the police. Professionals now recognise it should have been. Instead safeguarding advice was sought. The Service had a plan to see Jess again and discuss her safety when she next attended with Sarah. That never happened as Sarah disengaged from the Service. Although professionals warned Jess about her safety in a telephone call, the DHR panel believe there should have been a plan to do more.

7.4 It was clear to the DHR panel that the police officer who spoke to Jess in the street (see paragraph 6.4.16) tried hard to encourage her to speak about her injuries. The panel do not believe, based upon what the officer knew at the time, that it was reasonable for that police officer to have realised the extent to which Jess was being controlled by Sarah. This would have explained her reluctance to talk and her fear of being seen engaging with the police.

7.5 The information provided by WHAG (see paragraph 6.4.18) might have given the police the opportunity for specialist support to be put in place (for example, an IDVA[13]). The DHR panel recognised that the reason the police closed the log was because they made all the enquiries they thought they could at the time. The panel do not believe the police recognised this was domestic abuse. They should have done so, particularly after it was known that her friend said Sarah was frightened of Jess.

7.6 It is disappointing and concerning that many people who lived in the area had direct evidence of the abuse suffered by Jess yet chose not to report what they knew until after her homicide. However, the DHR panel are reassured that much is being done by agencies in the area to give communities the courage and confidence to come forward and report what is happening. Agencies need to continue the good work they are doing to educate the community at every level about the signs of domestic abuse.

7.7 The panel conclude that agencies acted with integrity and believed they were following the appropriate course of action in accordance with Jess's wishes. Even if all the information now available had been available at the time, it is impossible to conclude whether Jess would have taken the help and support that was available and left Sarah. The panel concur with the trial judge's comments, that the control Sarah exercised may have been so powerful that Jess simply could not make rational decisions.

[13] Independent Domestic Violence Advocates are professionals that have received training to engage with victims of domestic abuse and provide them with help and support.

8. LEARNING

Learning 1 (Panel recommendation 1)
Narrative
It is now evident from the homicide enquiry and from this DHR, that Jess was subjected to repeated acts by Sarah that were intended to subjugate her and were clear examples of coercion and control. Some of the most abusive examples involving acts of physical violence were unseen by agencies. Sarah engaged in some behaviour in the view of professionals that did not involve a physical assault yet was suggestive of coercion and control. It was not identified as such by professionals until after Jess was killed and consequently opportunities to protect Jess were missed.
Lesson
In order that they can assess risk and protect victims, all professionals need to understand the range of acts that might indicate a victim is being subjected to coercion and control.

Learning 2 (Panel recommendation 2)
Narrative
The DHR identified there were missed opportunities by some agencies to identify that Jess was a victim of domestic abuse at the hands of Sarah. For example, Jess's injury to her face, and a subsequent later presentation to her GP, having been the victim of an assault should have caused the GP to ask questions about how they were caused. Another example was when the police attended address one on 21 March 2016 and mistakenly thought the call related to old injuries that Jess had been seen with and therefore did not record the matter as domestic abuse.
Lesson
All professionals need to recognise the indicators of domestic abuse. They should ask routine questions of persons who present with these indicators. Professionals need to avoid making assumptions about injuries and should always try and ask the victim in person how an injury was caused.

Learning 3 (Panel recommendation 3)
Narrative
Not all the agencies that Jess had contact with were using the DASH risk assessment process. Consequently, when Jess did engage with professionals they were not able to ask her the range of questions within DASH that can help identify the subtler indicators of domestic abuse and acts that indicate there is increased risk.
Lesson

DASH turns a reactive 'it's just a domestic' into a proactive 'you must ask' questions approach. DASH provides a common checklist for identifying, assessing and managing risk that can be used and understood across all agencies. It is an important step in assessing risk and protecting victims.

Learning 4 (Panel recommendation 4)
Narrative
During contacts with the 'Live Well' service Sarah disclosed to professionals that she had abused Jess. In turn Jess was seen by professionals from that service with physical injuries that had been caused by Sarah. Although Jess chose not to report her victimisation, professionals recognised she was at risk and sought advice about safeguarding. A plan was developed to speak with Jess when she next attended the service with Sarah. That did not happen because Sarah disengaged with the service.
Lesson
Professionals now recognise that an opportunity was missed to share information about Jess's victimisation. Agencies need to recognise the circumstances in which the need to protect victim's over-rides the victim's choice not to report their victimisation and the circumstances in which they can then share that information with other agencies.

Learning 5 (Panel recommendation 5)
Narrative
During the homicide investigation it emerged that members of the community held significant information about Jess's victimisation. They did not share that information with agencies while Jess was alive. The DHR panel identified during its work that local elected councillors had good contacts with the community and that members of the community were prepared to engage with them on a range of matters involving anti-social behaviour.
Lesson
Agencies should recognise the importance of community representatives such as elected councillors. They should use them as a resource for building a bridge and getting messages about domestic abuse in and out of areas where communities sometimes find it difficult to engage with agencies such as the police.

9. RECOMMENDATIONS

9.1 Panel and Agency Recommendations

9.1.1 The recommendations are set out in Appendix A.

Appendix A Action Plan

DHR 5 Action Plan

No	Recommendation	Scope local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date Completion	Completion Date and Outcome
1	Wigan Building Stronger Communities Partnership should satisfy itself that partner agencies have programmes, or access to programmes, that train their professionals to understand domestic abuse and to identify the signs that a victim is subject to coercion and control by a perpetrator.	Local	Domestic Abuse awareness training for front line practitioners across the Building Stronger Communities Partnership. Followed up by specific Coercion & Control training to same cohort of professionals	Building Stronger Communities Partnership – sub group Domestic Abuse Steering Group	Domestic Abuse Awareness Training delivered by Summer 2018 Coercion & Control Training delivered by Spring 2019	July 2019	

2	Wigan Building Stronger Communities Partnership should satisfy itself those training programmes include asking routing questions from persons when they see or suspect the signs or indicators of domestic abuse.	Local	All training is based upon the Coordinated Community Response Model Toolkit which contains routine enquiry advice and guidance	Building Stronger Communities Partnership – sub group Domestic Abuse Steering Group	Domestic Abuse Awareness Training delivered by Summer 2018 Coercion & Control Training delivered by Spring 2019	July 2019	
3	Wigan Building Stronger Communities Partnership should satisfy itself that partner agencies have trained their staff in the use of the DASH risk assessment process or have plans to do so.	Local	All training is based upon the Coordinated Community Response Model Toolkit which contains DASH completion advice and guidance	Building Stronger Communities Partnership – sub group Domestic Abuse Steering Group	Domestic Abuse Awareness Training delivered by Summer 2018 and then ongoing cycle of training for new staff and refresher training for existing staff	July 2018 and ongoing	

4	Wigan Building Stronger Communities Partnership should satisfy itself that partner agencies have trained their staff to recognise the circumstances under which information they receive about domestic abuse should be shared with other agencies and that the agencies have processes in place for this to happen.	Local	All training is based upon the Coordinated Community Response Model Toolkit which contains information sharing guidance and processes.	Building Stronger Communities Partnership – sub group Domestic Abuse Steering Group	Domestic Abuse Awareness Training delivered by Summer 2018 and then ongoing cycle of training for new staff and refresher training for existing staff	July 2018 and ongoing	
5	Wigan Building Stronger Communities Partnership should ensure they increase the understanding of elected members about domestic abuse and the indicators of coercive and controlling behaviour. Elected members should be encouraged to use this knowledge when engaging	Local	All training is based upon the Coordinated Community Response Model Toolkit which contains routine enquiry advice and guidance	Building Stronger Communities Partnership – sub group Domestic Abuse	Domestic Abuse Awareness Training delivered to Elected Members in January 2018. Further Coercion & Control Training delivered by Spring 2019	July 2019	

	with their communities to identify potential victims and engage agencies in protecting them.			Steering Group			
6	Wigan Building Stronger Communities Partnership should consider ways in which community awareness of domestic abuse can be improved: for example by introducing a scheme such as Women's Aid 'Ask Me'.	Local	Initiate a role of a domestic abuse community worker who will be responsible for linking in with communities. This will build awareness and knowledge around domestic abuse and provide a channel for reporting.	Building Stronger Communities Partnership – sub group Domestic Abuse Steering Group	This role has now been established and has been successful in rolling out Wigan Councils domestic abuse champions programme throughout a range of sectors including community settings.	July 2018	July 2018
7	Wigan Building Stronger Communities Partnership should consider ways in which they can improve the way in which instances or indicators of domestic abuse are reported for example by exploring the	Local	Initiate a role of a domestic abuse community worker who will be responsible for linking in with communities. This will build awareness and	Building Stronger Communities Partnership – sub group Domestic	This role has now been established and has been successful in rolling out Wigan Councils domestic abuse champions programme	July 2018	July 2018

	introduction of a third-party reporting system.		knowledge around domestic abuse and provide a channel for reporting.	Abuse Steering Group	throughout a range of sectors including community settings.		

Agency Recommendations

The Brick							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	Ensuring sufficient information is captured and offered to every visit in Crisis intervention.	Local	Deliver ongoing and continuous training on information capturing and recording.	The Brick	Staff and volunteers to have increased knowledge of issues facing clients in crisis which allow them the confidence to ensure appropriate	Complete	Ongoing training has already been implemented and is envisioned to continue ongoing

					conversations take place throughout the visit and that these conversations are recorded and acted upon accordingly.		whilst the service is provided.
2	Ensuring every individual who attends Crisis intervention Service is given the opportunity to express their concerns, hardships etc.	Local	Continuous ongoing training will allow staff and volunteers the confidence to lead discussions allowing the client to confide in a safe and confidential manner. Using an Asset Based approach will also ensure clients feel in control of the service.	The Brick	By ensuring individuals feel safe in our Crisis Intervention Centre, individuals will be more likely to disclose any hardships or abuse they may be facing. This will then allow the staff and volunteers the confidence to implement our Policies and Procedures and	Complete	Training is already implemented and is review for relevance and robustness.

					ensure the client remains safe.		

Greater Manchester Police

Greater Manchester Police							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	Issue professional guidance or training, for front-line staff concerning the correct categorisation or coding of intelligence submissions. This should	Local	As recommendation	GMP	Improved understanding and professional response by front-line staff in relation to domestic violence incidents.	1 April 2018	

	pay particular attention to safeguarding issues.				Higher incidents of intelligence referred to PPIU.		
4	Conduct a dip sample on the Wigan division of incidents with domestic violence opening codes and assess what proportion are properly and appropriately closed with referrals to PPIU and appropriate partner agencies.	Local	As recommendation	GMP	To provide management with an accurate assessment as to whether DV incidents are being properly processed. To inform management whether further action is required.	1 April 2018	

End of DHR Executive Summary