PENNINE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW IN THE CASE OF CHAN

REVIEW PERIOD JUNE 2006 – MARCH 2014

OVERVIEW REPORT
FINAL VERSION
March 2017

At the request of the family, the victim in this case is referred to as 'Chan' and the perpetrator is referred to as 'the offender'.

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Appendices

1 INTRODUCTION

The Review Panel offers condolences to the family of Chan and thanks them for their contributions to this review.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated, under which guidance Rossendale Community Safety Partnership commissioned this DHR. The Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the revised guidance issued by the Home Office to support the implementation of the Act.

1.1 Significant People in the Case

Pseudonym	**Relationship to Subject**	**Address at time of incident**
Chan	Victim	Address 1
The offender	Perpetrator	Address 2
Child 1*	Child of Chan	Address 3
Chan EP	Ex-partner of Chan	Address 2
Chan M	Mother of Chan	Address 4
Chan SF	Step-Father of Chan	Address 4
Chan F	Father of Chan	Address 5
Chan S1	Sister of Chan	N/A
Chan S2	Sister of Chan	N/A
The offender S	Sister of the offender	N/A
AF2	Previous Partner of the offender	Deceased
AF7	Previous Partner of the offender	N/A

* References to Child 1 in this report are gender neutral and they will be referred to as them/their/they.

1.2 Professional Pseudonyms (Key Professionals Only)

Offender Manager (OM) 6	The offender's Offender Manager from September 2011 to March 2014

Police Officer 1	Police Officer attending Address 1 on the date of death
Police Officer 2	As above
GP Chan	The GP for Chan
GP the offender	The GP for the offender

1.3 Incident Leading to the DHR

In March 2014 Chan was murdered by the offender in the street outside Address 1. The offender had a previous conviction for murdering a female partner and was subject to a life licence at the time of the murder of Chan.

Police Officers 1 and 2 attended Address 1 following a phone call from OM6 who had spoken to Chan that same morning. Chan disclosed that the offender had assaulted her and that she was in fear of him. Whilst Chan was speaking to officers at Address 1 the offender appeared carrying a bag containing a hammer. An altercation ensued during which one of the police officers was rendered unconscious. Whilst the officer was unconscious, the offender went into the kitchen and returned with a knife with which he threatened the second police officer. As Chan was attempting to flee from the scene, the offender pursued her into the street, where he stabbed her to death.

1.4 Period Under Review

The panel agreed the timeframe of the DHR should cover the period from June 2006 to the date of the murder in March 2014. This pre-dates the relationship between Chan and the offender by several years. However, the panel judged it was important to understand Chan's background and history, particularly in relation to emotional health and vulnerabilities.

This timeframe also enabled the panel to take into consideration the latter part of the offender's prison sentence for the murder of a previous partner, and the decision to release the offender on life licence.

This case has also been the subject of a separate Multi Agency Public Protection Arrangements (MAPPA) review that will be cross referenced throughout this DHR overview report.

1.5 Background to Chan, the offender and Summary Narrative

Note: the following section of this report is a significantly abridged version of the information contained within the integrated chronology. This section is intended to simply provide a background summary to the case. Further details are considered in further detail in Section 3.

1.5.1 Chan

Chan ran a successful business and was a protective and devoted mother to Child 1. She was described as being a spirited and vibrant individual who had a positive impact on those who knew her. She was an animal lover and kept several dogs as pets and supported animal charities.

Chan experienced episodes of increased vulnerability during her adult life. These periods of increased vulnerability were due to a number of traumatic and emotional events in her younger life. She had been victim of abuse at the hands of an older perpetrator (not a member of her family) and, subsequently, had encountered abusive relationships with other males. Chan sought help with these difficulties from her GP, and Counselling and Psychological services.

She met her long-term partner in the late 1990s. They had a child, referred to in this report as Child 1. Chan was described by her family as having a very strong relationship with them and being devoted to Child 1.

During the latter years of their relationship, Chan and her long-term partner experienced some relationship difficulties. Chan disclosed to her GP that she had, on occasions, been aggressive towards him, although there was no inference that he was violent or abusive towards her. Chan also told her GP that she had feelings of anger towards some members of her family.

Chan made a permanent separation from her long-term partner in mid-2013. This was a difficult period of time. When the couple separated permanently, Child 1 spent time living with both parents. There were no issues regarding the custody of Child 1. Chan tried to ensure that the separation had as little impact on Child 1 as possible.

Chan ran a successful business. This is where she first met the offender, in or around July 2013, when he purchased some items from her shop. Within a short time of meeting, the offender went to work for Chan and it appears that this is when their relationship began. It appears that at this time Chan was unaware of his previous offending and that he had been convicted of murdering a previous partner.

When he met Chan the offender was aware of the conditions of his life licence and that he must disclose his previous conviction to anyone with whom he was forming an intimate relationship. It is likely that the first that Chan knew of the full details of the offender's previous offending was when she met with his Offender Manager (OM6) in October 2013. At this meeting both Chan and the offender said that they were not forming an intimate relationship.

On the 11th of September 2013, the offender attended an appointment with OM6 who asked him about his relationship with Chan. The offender denied that he was in a relationship with Chan saying that she was his employer.

The first that any agency knew of Chan's relationship with the offender was when the offender disclosed it to OM6 during an appointment at the office of his offender manager in October 2013. On the 2nd of October 2013, the offender told OM6 that on the 25th of September he took Chan out for a meal and that they had kissed. During this appointment, the offender also stated that he had not been to Chan's house. OM6 made a request to see Chan in order to complete a referral to Children's Services (with regard to Child 1). At that time, OM6 had not been given the name of Child 1.

1.5.2 The offender

The offender had a long criminal history before he met Chan. His offending dated back to his youth, when he had become involved in acquisitive and violent crime.

In 1998 the offender was found guilty of the murder of his partner, AF2, and was given a life sentence. He served his custodial sentence at a number of prisons where he was risk assessed and undertook various treatment programmes that are described in detail later in this report.

Following a Parole Board review and a move to a Category C/D (semi-open) prison, the offender was risk assessed and approved to take Releases on Temporary Licence (ROTL). He was subsequently released on life licence from HMP Kirklevington Grange in April 2012. He initially lived in Approved Premises (AP) in Greater Manchester. He then moved, on two occasions, to rented accommodation in Greater Manchester and Lancashire. It is important to note that there is no single agency recommendation regarding this issue because the offender remained under the supervision of Offender Manager 6 whilst resident in both Greater Manchester and Lancashire. Whilst this is not common practice it is allowable for an Offender Manager to continue to supervise an offender if they move outside of the geographic area covered by the Offender Manager if it is practicable to do so

One of the conditions set following the Parole Board Review (Oral Hearing) on 15th February 2012 was a requirement on the offender's licence conditions that he should notify his supervising officer of any developing personal relationships. This was undertaken as part of the general risk management planning pertaining to domestic abuse perpetrators, whereby consideration is given to disclosure to new partners in order to inform and protect potential victims.

Within a short period of time after release on life licence he had met and begun a relationship with AF7. He disclosed this relationship to his offender manager. The relationship with AF7 ended in 2013 shortly before he met Chan. AF7 had children which resulted in agencies sharing information about her relationship with the offender in relation to risk management. AF7 lived in the Lancashire Constabulary area and Lancashire Police were made aware of the relationship between AF7 and the offender in this context. There was no evidence of domestic abuse in the offender's relationship with AF7.

The offender met Chan in or around July 2013. The offender did not disclose his relationship with Chan to his offender manager when it first began. However, he did disclose that he had obtained work at a shop that was owned by Chan. However, it was not known whether an intimate relationship had begun at this time. OM6 met with Chan as the offender's employer before it was disclosed that the offender was having a personal relationship with her. The offender informed OM6 about the relationship in early October 2013 and, consequently, OM6 met Chan again in October 2013 in order to ascertain the details of Child 1 so that a referral to Children's Social Care (CSC) could be expedited.

1.5.3 Summary Narrative

The offender and Chan met in July 2013 approximately 17 months after he had been released from prison on life licence having served a life sentence for the murder of a previous female partner. In September 2013, the offender told his Offender Manager that he had met Chan and that she was employing him. He did not indicate at this time that they were in an intimate relationship, although disclosure of any such relationship was a condition of his life licence. In October 2013 the OM6 met Chan and established that she had a child. At the end of October 2013 OM6 informed Children's Social Care about the relationship and of the offender's history. CSC spoke to Chan and noted the information. Children's Social Care did not initiate any Section-47 enquiry following this conversation and no further action was taken.

In early November 2013, at a family gathering, members of Chan's family saw that she had facial injuries. However there had been no disclosure that the offender had inflicted these injuries and Chan said that she and the offender had been drinking and she had fallen down the stairs.

The relationship continued with no apparent incidents until, in January 2014, Chan presented to a local A&E department with a facial injury that she said had been sustained in a fight with a woman. The offender accompanied her to Accident and Emergency service and to a subsequent appointment with a specialist on the same day. The injury was diagnosed as a fracture to the jaw. No enquiries were made about domestic abuse although staff did note their procedures regarding not questioning whilst a partner was present.

On 1st March 2014, Chan disclosed that the offender was physically abusing her to a close family member and asked them not to tell anyone about the disclosure for fear of reprisals, saying that the offender had already made threats that he would harm Chan and her family if she told anyone about the abuse. The close family member felt that they must share the information and told another member of the family, who then reported the disclosure to the police. Chan also told another family member and that he had broken her jaw and held her hostage for three days.

Following this disclosure a series of events took place that are described in more detail below. From 1st March 2014, Chan made and retracted disclosures about the offender's abuse to police officers and to Offender

Manager 6 (OM6). She was identified as a high risk victim, a rating that was downgraded following the retraction of the disclosures to the Police.

On the day of the homicide, Chan rang OM6 to tell them that the disclosures and allegations that she had made about the offender were true and that she was in fear of him. OM6 rang the police and requested that they immediately attend Chan's address. The events described at 1.3 then occurred.

1.6 Parallel Processes

1.6.1. Multi Agency Public Protection Arrangements (MAPPA) Review

A MAPPA Serious Case Review commenced in April 2014. The terms of reference for this review are attached at Appendix 2.

At the commencement of the DHR in August 2014, the Chairs of both reviews discussed the alignment of the processes to ensure that each had sight of any significant issues, and could share relevant information. The Chairs also wished to avoid duplication in engaging with family and friends, whilst offering them the opportunity to respond to each review separately, should they so wish.

The Chair of the MAPPA review attended DHR meetings, with the DHR author attending MAPPA review meetings (until the author withdrew due to ill health in January 2015).

Both chairs met with Chan's Mother in August 2014, and again with family members in April 2015 and in August 2015 to update them on the progress and early findings of the reviews.

The MAPPA Serious Case Review had a term of reference to consider the information given to the Parole Board in order to make a decision to release the offender on Life Licence and this term has been thoroughly fulfilled by the MAPPA Serious Case Review. The DHR panel recognised that it is not the role of the DHR to examine the decision of the Parole Board and the Panel are content that the MAPPA Serious Case Review has sufficiently examined this issue.

Further reference will be made to the offender's background and offending history in this overview report as relevant. However, the primary focus in relation to the offender will be upon the period July 2013 to March 2014 when the offender and Chan were in a relationship together.

1.6.2 Greater Manchester Probation Trust Serious Further Offending Review (SFOR)

Prior to the commencement of the DHR, the Greater Manchester Probation Trust had undertaken a Serious Further Offences Review.

Information from the SFOR was made available to the DHR panel as part of the Independent Management Report submitted by the agency. It should be noted that the SFOR was concerned with, amongst other matters, the management of the offender whilst he was serving a custodial sentence for a previous murder, the decisions regarding his release on life licence and the management of the offender whilst he was on licence. Some of these matters pre-date, by some considerable time, the offender's relationship with Chan.

1.7 Criminal and Coronial Matters

The offender was arrested and charged with the murder of Chan.

The offender appeared at the Crown Court in Preston where he pleaded guilty to:

1. Murder of Chan, contrary to Common Law, and received a Whole Life Sentence;
2. Wounding with Intent, contrary to S18 of the Offences against the Person Act (OAPA) 1861;
3. Common Assault, contrary to S39 (OAPA) 1861.

It is important to note that offences 2 and 3 above were committed against the police officers attending Address 1 on the day of the homicide

Paragraph 15.1 of the Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) states:

> *Where a person has been sent for trial for causing, allowing or assisting a death, for example by murder or manslaughter, any inquest is in most cases adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the particulars that are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume the inquest. There may be no need, for example, if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.*

The Office of the Coroner did not inform the Panel that an Inquest would be resumed. The Panel assumed that this was the case since the trial and the associated criminal justice processes sufficiently established who the deceased was and how, when and where the deceased came by her death.

Consequently, the Panel did not have to consider this matter further, other than engaging in courteous communication with the Office of the Coroner and letting them know that the DHR was taking place and the expected time-frame of the Review.

1.8 Diversity Factors

The panel considered this issue and determined that there were no specific diversity factors identified that had an impact on the case.

1.9 Involvement of Family and Friends of Chan

Chan's family have provided an insight into Chan's relationship with the offender and raised a number of key questions to be answered by the review. Although the family had met the offender and knew that Chan was in a relationship with him, the family told the Chair of the Panel that they had no idea about his history or that he was abusing Chan until she made a disclosure to a close family member in February 2014.

The DHR Panel is indebted to Chan's mother and sisters for their contributions, which are included throughout this report and set out in detail at Section 3.1.

Chan's previous partner, the father of Child 1, was invited to contribute to the review but declined to do so.

The panel also contacted Chan's friend (to whom she had made disclosures about the abuse she was suffering from the offender) and the offender's previous partner (AF7) to invite them to participate in the review. However neither responded to these communications. The communication sent to the friend of Chan was returned to the sender and the panel attempted to contact them once again without success.

The Review Panel discussed whether Child 1 should be invited to participate in the Review but concluded that it was not in their best interests to involve them.

Advocates from AAFDA (Advocacy After Fatal Domestic Abuse) and from Victim Support supported the family and were involved in meetings with the Chairs of both the DHR and Multi Agency Public Protection Arrangements Serious Case Review.

The Chair of the DHR met with members of Chan's family on five occasions during the review, the family viewed the final report before submission and had an opportunity to influence the content of the final report and the action plan.

Chan's family were consulted prior to submission of this version of the report and felt it was important to highlight that there were a number of important missed opportunities. Whilst they agree that these are highlighted throughout the report, they asked that a list of missed opportunities is referred to in this section so that readers of the report are clear about the family's concerns. The family also feel that individuals should be more strongly held to account in the report. The DHR has discussed this with the family and agreed to hold a

follow up meeting with them once the DHR report has been submitted to the Home Office.

Missed Opportunities Identified by the Review and endorsed by Chan's Family are attached at Appendix J.

1.10 Involvement of the Perpetrator

The panel invited the offender on two occasions to contribute to this review. An appointment was made to see him in prison, however he cancelled the appointment at short notice. The panel took a decision, based upon knowledge of the offender's behaviours and previous conviction that it was unlikely that the offender would co-operate with the review and therefore decided not to make any further approaches to him.

1.11 Submission of the Report to Home Office

The DHR commenced in August 2014 four months after the death of Chan. The delay in starting the DHR was due to the trial of the offender and to the commissioning process of appointing a suitable Independent Chair and Independent Author.

The initial independent author withdrew due to ill health in January 2015. A replacement was sought and appointed at the end of February 2015.

During the early part of the review process it became clear that it was unlikely that the process would be completed within a six months timeframe due to the complexity of the detailed enquiries related to establishing the key significant events in the case and cross referencing these with local systems and other parallel processes. The commissioning officer from Lancashire County Council kept the Home Office notified of the report delays.

2. Conduct of the Review

This Review, commissioned by the Pennine Community Safety Partnership has been completed in accordance with the regulations set out by the Domestic Violence, Crime and Victims Act (2004) and with the revised guidance issued by the Home Office to support the implementation of the Act.

The Chair of the Panel wishes to express her personal appreciation to the colleagues who have contributed to the completion of this review – particularly so for their time, co-operation and patience. Thanks were recorded for the original Author of the Review who had to resign from the position due to ill health.

2.1 Terms of Reference

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

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

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

- Apply these lessons to service responses including Changes to policies and procedures as appropriate; and

- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this report at Appendix E.

2.1.1 Specific Terms of Reference and Key Lines of Enquiry

Agencies were asked to provide information in relation to both the Victim (Chan) and the Perpetrator (the offender) where appropriate.

- To establish the circumstances surrounding the homicide of Chan during the review period. Initially agencies were invited to provide chronological information regarding contacts with Chan and the offender from January 2006 to the date of the incident in March 2014.

- To establish whether Chan was known as being at risk of domestic abuse by any statutory agency, non-government organisation (including the third sector) or any other individuals?

- To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities and worked together to safeguard Chan and to manage any risks posed by the offender.

- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result. An action plan identifying lessons and actions to be taken to

implement recommendations is monitored by the local Community safety partnership.

- To establish whether any safeguarding concerns by professionals or others were expressed in relation to Chan (or AF7), either historically or during the time leading up to the incident

- To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.

- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

- To determine whether it was possible for any agency to have predicted or prevented the harm that came to Chan.

2.2 The DHR Panel

Following notification of the death of Chan, the Pennine Community Safety Partnership (CSP) agreed to undertake a Domestic Homicide Review.

A DHR Review Panel was established by the CSP and met on fifteen occasions to oversee the process. The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

The CSP appointed an independent Chair, Maureen Noble, to oversee and direct the Review, in accordance with the Home Office Guidance. The Independent Chair has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair had no contact with the subjects of this case and had no professional or personal contact with any of the agencies involved in the Review prior to the incident occurring. In turn, an independent author, Ian Philips, was appointed to write the overview report – with a replacement, John Doyle, being appointed to complete the process. Neither of the independent authors had any connection with the case or with the agencies involved in the review.

Panel members were appointed based on their seniority within relevant agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to serve on the panel.

Designation	**Agency**
Chair of the Panel	An independent consultant with experience of chairing senior multi-

	agency working groups, public protection proceedings and community safety.
Chair of the Multi Agency Public Protection Arrangements Serious Case Review	An independent consultant with experience of chairing senior multi-agency working groups, public protection proceedings and community safety.
Named Nurse for Safeguarding Adults	Pennine Acute Hospitals NHS Trust
Safeguarding Practitioner	East Lancashire Hospitals NHS Trust
Domestic Abuse Lead Officer	Lancashire County Council
Business Support Officer	Lancashire County Council
Head of Public Protection	National Probation Service, North West Division
Senior Probation Officer	National Probation Service, North West Division
Domestic Abuse Coordinator: (Specialist Representative)	Burnley Council
Assistant Director of Nursing Safeguarding Adults	Lancashire Care Foundation NHS Trust (LCFT)
Review Officer	Lancashire Police
Chief Executive	Rossendale Borough Council
Head of Public Protection & Probation Manager, HMP Kirklevington Grange	Public Sector Prisons
Public Sector Prisons North West. HMPS Regional Operations Manager	Public Sector Prisons
Associate Head of Safeguarding, Named Professional for Vulnerable Adults	East Lancashire Clinical Commissioning Group
Head of Safeguarding	East Lancashire Clinical Commissioning Group
Manager, Pendle CLA and Leaving Care Team	Lancashire Children's Social Care service (attended meetings from February 2015)
Practice Manager – East Lancashire	Lancashire Children's Social Care service (attended meetings from February 2015)
Assistant to Independent MAPPA Chair	Multi Agency Public Protection Arrangements Serious Case Review
In attendance	
Author of the report	Independent Practitioner with experience of writing Domestic Homicide Reviews.
Business and administrative Support	Lancashire County Council

The panel had a representative from a specialist third sector agency, however this was only for a short period of time due to work pressures, so the Domestic Abuse Co-ordinator working at Burnley Council, who also has specific experience working in the third sector, acted in this capacity.

The Chair of the panel liaised closely with both the nominated AAFDA representative and the Victim Support service during the review process and shared the report with them prior to submission.

There were no conflicts of interest recorded during the Review. The authors of Management Reports and Short Reports were not directly connected to the subjects of the case.

2.3 Key Lines of Enquiry for the Domestic Homicide Review

The DHR Panel agreed 14 key lines of enquiry. These are set out, along with responses, at section 4 of this report.

2.4 Agencies Submitting Individual Management Reviews (IMRs), Short Reports and/or supporting information

Agency	Type of report	Reason for request	Completed and submitted by:
Lancashire Police	IMR	Lancashire Police had knowledge and/or contact with Chan and the offender prior to the incident occurring, were at the scene when the incident occurred and conducted the investigation into the homicide.	The author is a Review Officer with the Lancashire Police. The author has no prior involvement with the subjects concerned and is not the line manager of the staff involved in the investigation, the decision making or in the management of the case. The IMR was quality assured and approved by a Detective Chief Inspector in the Lancashire Police.
General Practitioners (East Lancashire Clinical Commissioning Group)	IMR and summary of contact	The GPs in the Practice had contact with Chan and Child 1 prior to the incident occurring.	The author is a GP Principal and the named GP for Safeguarding Children and Vulnerable Adults. The author is entirely independent of the case and independent of the management of the decision making within the case. The author had no involvement with the subjects of the case.
East Lancashire Hospital NHS Trust (ELHT)	IMR	ELHT had contact with Chan and the offender prior to the incident occurring	The author of the IMR is a Safeguarding Children Practitioner based within the Children's Safeguarding

			Team. The author had no direct involvement with any of the subjects of the Review. The IMR was quality assured and approved by the General Manager in the Division of Family Care.
Lancashire Care Foundation NHS Trust	IMR	The Trust had contact with Chan and Child 1 prior to the incident occurring.	The author is the lead for safeguarding within the Trust and has had no previous involvement with the subjects of the case.
North West Ambulance Service	Short Report	North West Ambulance Service NHS Trust (NWAS) had contact with Chan prior to the incident occurring in 2014 and attended the scene of the incident outside Address 1	The author is responsible for managing the Safeguarding Team and for ensuring relevant policies and procedures are in place to protect the public and staff. The author is the 'Named Professional' and has responsibilities for the management and development of the North West Ambulance NHS Trust safeguarding processes in relation to both children and adults.
Lancashire County Council Children's Social Care (CSC)	IMR	Lancashire Social Services were in contact with Chan and Child 1 prior to the incident occurring	The author is a Team Manager within CSC at Lancashire County Council. The author had no direct involvement with the subjects of the case the report is, therefore, independent. The IMR was quality assured and approved by a Senior Manager within the Division.
The STAR Centre	Short Report	The STAR Centre received a MASH referral for Chan prior to the incident occurring.	The author of the short report is the manager of the STAR Centre
HMP Services	IMR	HMP Kirklevington Grange had contact with the offender prior to his release from prison.	The author of the IMR is the Head of Public Protection and Probation Manager at HMP Kirklevington Grange.

The Pennine Acute Hospitals NHS Trust (PAHT)	IMR	The Trust had contact with Chan prior to the incident occurring.	The Author of the report is the Named Nurse for Safeguarding Adults and had no clinical or managerial responsibilities or connection to the subjects of this Review. The IMR was quality assured and approved by the Head of Safeguarding.
Greater Manchester Probation Trust (GMPT) [1]	IMR	The Greater Manchester Probation Trust provides services to manage offenders and had contact with the offender prior to the incident occurring.	The author of the IMR is presently the cluster lead for safeguarding children and risk including MAPPA. The author had no operational involvement within the case and did not line manage operational staff involved in the case
Magdalene Project (MP)*	Face to Face interview*	A third sector Counselling Service for Victims of Abuse	The manager of the service and Chan's counsellor met with the Chair and Commissioning Officer

***** The Magdalene Project were at first asked to produce an IMR for the Panel but they were, understandably, concerned about their capacity to fully engage with the Panel and all of the meetings it convened and their capacity to complete a full and comprehensive IMR. The project was also concerned about maintaining accordance with their protocols concerning client confidentiality. The Panel discussed at length the balance it needed to strike regarding the involvement with small voluntary organisations. Consequently, the Panel agreed that a personal interview with the project would be the most efficient and effective approach.

2.5 Other Sources of Information

The review panel invited authors to present IMR reports at a panel meeting that enabled further questioning and clarification of the information provided. Following this process revised IMRs were submitted.

The Chair and a panel member visited the Magdalene Project, a third sector support service, to discuss their involvement with Chan. This enabled the agency to fully participate in the review.

Following consideration of the revised IMRs the panel invited representatives from the MASH and from CSC to a panel meeting to consider and discuss aspects of policy and practice relevant to the review. This enabled the panel

[1] Greater Manchester Probation Trust was abolished on the 31st of May 2014

to gain a better understanding of how these services operate and what impact this had on decision making in this case.

2.6 Contributions and Questions from Chan's Family

Chan's mother and sisters made important contributions to the review. The DHR Chair met with the family on four occasions (on two occasions with the Chair of the MAPPA Serious Case Review).

The Chairs of the DHR and MAPPA Serious Case Review met with Chan's mother in August 2014, shortly after the DHR commenced. An advocate from Victim Support accompanied Chan's mother during these meetings. Chan's mother had a lot of questions that she felt should be answered by the Reviews and set these out in some detail for the Chairs.

The DHR Chair met with one of Chan's sisters in February 2015, accompanied by an advocate from AAFDA who also asked questions about agency involvement and decision making. Again these are set out below.

The MAPPA and DHR Chairs met with Chan's mother and sisters in May 2015 to provide an update on the progress of the Reviews. Both AAFDA and Victim Support advocates were present at this meeting.

Both Chairs met with Chan's mother and sisters to discuss the final report with them in August 2015 and met with them again prior to submission to the Home Office. Their views and comments are included in this report.

Chan's family were aware of her increased vulnerabilities, of the issues she had experienced in the past and that these had led to some difficulties in terms of family relationships and dynamics. Chan had suffered abuse as a young person, from someone outside the family. This was believed by family members to be at the root of Chan's low self-esteem. As in many families, these issues were not discussed in detail; the family said there was a tendency to push this to one side. When the perpetrator of this abuse died a number of years ago this was a trigger for Chan's mental health issues to re-emerge.

Chan's family described her as being in a vulnerable position when she first met the offender. Chan had been through a difficult time in her long-term relationship with her partner and this intensified when they went through the process of separation.

Chan had a very strong relationship with Child 1, who she 'put first' in everything she did. Child 1 was seen by the family to be a positive and protective factor in Chan's life. The family felt that this would be one of the reasons why Chan would have been fearful of talking about the abuse she was suffering from the offender, as it later transpired that the offender had threatened Chan that he would harm Child 1 if Chan told anyone about the abuse.

Chan-S2 recalled that after her father first became aware of the offender he had expressed his indifference to him, saying that he was useless. There is however no suggestion that Chan's father was initially concerned about the offender presenting any risk to Chan.

Chan-S2 had only met the offender on two occasions, once when he had come round for a meal at New Year (2013/14). She did not know about his previous conviction, nor did other members of the family.

It appears that, in all probability, from November 2013 onwards (and definitely on Bonfire Night 2013, when Chan said she had fallen downstairs and hurt her face), the offender was making verbal and physical threats to Chan; saying that if she told anyone about the nature of the relationship he would harm members of her family. Although it was not known by anyone at the time, the offender had told Chan he would take a shotgun to her father and to Child 1. The panel considered this issue at some length and recognised that this threat would have placed considerable pressure on Chan and, in sharing this information with a close family member, the fear experienced by Chan may well have been transferred to them.

Chan's mother said that if she had had any suspicion that the offender was being abusive towards Chan she would have dragged him away from the relationship and made sure that he did not return.

The fact that Chan did not confide in the family in the early stages of her relationship with the offender has been very difficult for them to deal with. However the family are aware that it is not uncommon for victims of domestic abuse to be fearful about disclosing what is happening to them to friends and family.

2.7 Questions Raised by Chan's Family

Chan's family were aware of the questions being asked by the Domestic Homicide review and the MAPPA review, and they asked a number of specific questions when they met the Chairs, as follows:

- Why was the offender not recalled by Probation when they knew about the allegation made by Chan in March 2014?
- Was there a domestic abuse marker on Address 1 after the 1st of March, and if so what was the procedure in relation to it and why was this not followed?
- Did the Probation Service make Chan aware that the offender had been told to stay away from her on the weekend beginning the 14th of March?
- What did the Probation Service disclose to Chan about the offender's offending history?
- Did they tell her about the frenzied attack that the offender had made when he killed his previous partner?

Both Reviews have taken these questions into account when receiving and analysing reports from the agencies involved the review. The Chair of each review (the DHR and the MAPPA Serious Case Review) have, where they can, addressed each question and engaged in direct communication with the family.

With regard to the questions concerning events after the homicide occurred, the family have been directed to the appropriate agency in order to receive a response.

3. Agency Contacts and Key Events Chronology

During the period under review Chan had a large number of contacts with agencies, particularly her GP and other health services, many of these contacts did not have any direct relevance to this review.

The offender had considerable contact with prison and offender management agencies; he was serving a custodial sentence for the majority of the period under review (until 3rd April 2012).

The chronology of key events is drawn from the information submitted to the Panel by the participating agencies.

As is usual, authors of IMRs and Short Reports were invited to submit any pertinent information concerning the subjects of this Review, even if they fell outside the formal parameters of the Review as set by the Panel.

3.1 Events pre-2006

In 1998 the offender commenced a life sentence and was confirmed as a MAPPA Category 2, Level 1 prisoner. He served the first phase of his sentence in a number of Category A and B establishments. During this period he completed the 'Focus Programme' – examining triggers to substance misuse and the cognitive deficits that can contribute to the cycle of ongoing misuse; the Alcohol Education Programme; Enhanced Thinking Skills; the Healthy Relationships Programme; and the Sycamore Tree Victim Awareness programme.

In 2004, when the offender was in HMP Gartree, he was assessed for the 6 block Cognitive Self-Change Programme using a Psychopathy Checklist. The offender was recorded as having a score of 25, a score of 30 would equate to a psychopathic personality. The checklist score indicated that the offender was on the threshold of psychopathy. He was, nevertheless, still suitable for the programmes that he subsequently commenced whilst in prison. However, his Offender Manager (OM6) was never told the outcome of his psychopathy checklist which remained on his psychology file.

3.2 Events in 2006 to 2008

Chan had a higher than average number of consultations with her GP. These contacts were considered as routine appointments. A small number of them (less than three) concerned issues related to stress. As a consequence of one consultation, Chan was referred to a local counselling service.

In March, the first OASys[2] assessment was completed for the offender that indicated a High Risk of Serious Harm to known adults (including future partners) and a medium Risk of Serious Harm to the public and prisoners. A number of further OASys reports were completed during 2008 and 2009 all of which indicated the offender should remain as high risk.

The offender was moved to HM Prison Wolds and was considered for accompanied visits in the community.

3.3 Events in 2009

Chan attended her GP Practice twenty seven times. A significant number of the consultations were routine in their nature. However, in June she reported a low mood. Chan completed a PHQ9[3] questionnaire. Whilst the score did not indicate an episode of depression, Chan was referred for Cognitive Behavioural Therapy and soon after, attending the GP with similar concerns, the GP expedited the involvement of the Community Mental Health Team (CMHT).

In August, Chan consulted her GP and shared information about an episode of historical abuse. Chan was at this time on the waiting list for Cognitive Behavioural Therapy (CBT). However, Chan missed her first CBT appointment and was discharged back to her GP.

A domestic abuse assessment was completed, for the first time, on the offender. This assessment is referred to as Spousal Assault Risk Assessment (abbreviated to SARA) and is a 20-item assessment process used by criminal justice professionals to help predict the likelihood of domestic violence. The assessment was undertaken by Greater Manchester Probation Trust whilst the offender was at HM Prison Wolds. The submission made by Greater Manchester Probation Trust recorded that when the SARA was completed, the risk was “kept as high”. The Risk Management Plan produced for the offender included the need for extra conditions on his temporary licence. These included a condition to reside in Approved Premises when he was released on temporary license.

[2] OASys is the abbreviated term for the Offender Assessment System used by the National Probation Service since 2002 and by HMPS

[3] The PHQ9 is a self-administered questionnaire used to monitor the severity of depression and the response to treatment. PHQ9 has been validated for use in primary care.

3.4 Key events 2010

Chan consulted with her GP on eighteen occasions. In February, Chan reported to her GP that she had a low mood and low levels of energy. However, by the April of 2010, Chan reported that her mood was stable and that she wanted to reduce her anti-depressant medication.

In June of 2010, Chan attended her GP and repeated the PHQ9 questionnaire. Her score had increased. An increase in the score when completing the PHQ9 demonstrates an increase in the likelihood of experiencing depression. As part of the consultation with the GP, a prescription for Mirtazapine (an anti-depressant) was given.

By the end of the year, Chan's low mood and anxiety was still the subject of the majority of the GP consultations. Chan reported that she was finding counselling to be of benefit.

The offender commenced release on temporary licence with accompanied visits into the community. This was seen as integral to his eventual release plan as it allowed him family contact and social familiarisation and also allowed his learning from the offending behaviour programmes to be tested and put into practice.

In September, the offender was transferred to HMP Kirklevington Grange. His risk level was re-assessed and he was allocated to an Offender Supervisor (usually referred to as a 'Lifer Officer') with support from a seconded Probation Officer. As he was categorised as high risk he was to be managed via the Interdepartmental Risk Management Meeting. This management process mirrors the Multi Agency Public Protection Arrangements process insofar as it seeks views from representatives from all prison departments and the external Offender Manager and any external agencies as to whether the prisoner can progress and what the risk management plan should comprise.

3.5 Key events 2011

Chan attended her GP Practice 29 times and reported low mood and agitation at a small number of these consultations.

In February, Chan reported that she was feeling better but had palpitations and some insomnia. Chan shared with her GP that she had separated from her partner.

From the middle of April, until his release on Parole Licence the offender availed himself of the privilege of weekly unsupervised Community Visits. He also undertook Resettlement Overnight Release to approved premises in June.

In July, the offender's Offender Supervisor undertook an OASys review. This review concluded that his risk of serious harm remained assessed as High to

Known Adults. His Offender General Reconviction Score came within the high-risk band; his Offending General Predictor score fell within the medium risk band; and his Offending Violent Predictor fell within the Low risk band. These scores were based on static risk factors and were automatically generated by OASys.

In October, Chan attended her GP Practice and repeated the PHQ9 questionnaire. The score had fallen from the previous PHQ9 assessment. Chan reported that she was still receiving counselling.

In December, the offender received a Parole assessment recommending release *'with a robust risk management plan'* involving the Offender Manager, the Police Public Protection Unit, the Victim Liaison Officer, Approved Premises (to include alcohol and drug testing) and Alcohol and Drug services.

Additionally, the Parole assessment stated that: '*Cognitive Self-Change Programme work will continue with the Offender Manager delivering Module 6 via one to one sessions'.* The report prepared by the Offender Supervisor for the Parole dossier advised that *"risk management reviews will take place under the terms of MAPPA level one management'*. An OASys assessment recorded the risk of serious harm as being high to known adults and medium to the public. A risk management plan was developed for his release and this included home area exclusion, no contact with the victim's family, residence at approved premises and an alcohol and drugs condition.

At this point, the risk management plan did not include a licence condition that he should notify his Offender Manager of any developing personal relationships. A psychologist attempted to contact Offender Manager 6 to ascertain that Cognitive Self Change Programme – Block 6 would be taking place in the community and offered to support that process. No response was received to this communication.

3.6 Key events 2012

In February, the Parole Board hearing reached a decision to release the offender on life licence. In April, the offender was released on licence with the following conditions: residence in approved Premises; imposition of an exclusion zone; he must address offending behaviour; alcohol and drugs service monitoring; no contact with the family of his former partner; and he must notify his Probation Officer (Offender Manager) of any developing personal relationships. The Parole Board inserted this latter condition.

Greater Manchester Police Service contacted the Greater Manchester Probation Trust to receive details of the offender's life license conditions.

In May the offender disclosed to OM6 that he had formed a sexual relationship with AF7 and that he had told her about his sentence. He was instructed by OM6 not to have any more physical contact with her and not to visit her house.

In June, Offender Manager 6 visited AF7 and disclosed the nature of the offence the offender had committed. However, it appeared that he had already provided her with a detailed account. OM6 told AF7 that he can visit her no more than twice a week and that these visits must take place away from the house as she had children living with her. In July, the offender informed OM6 that the relationship with AF7 had ended.

Chan visited her GP on eight occasions. The majority of these consultations were routine.

In July, Chan's GP received a letter from the counselling service to provide an update on the progress being made. Chan and her long term partner had decided to separate. Chan was to explore ways in which she could manage this transition with support from a Cognitive Behavioural Therapy (CBT) Therapist.

From July, Chan was seen by her CBT therapist and engaged in 4 sessions of CBT to the end of August.

In July, the offender had two negative alcohol tests at the community substance misuse service.

In August, the offender disclosed to OM6 that he had met a woman on a chat line. Offender Manager 6 outlined to him the conditions he must comply with if he entered into a relationship with her.

In October, the offender was seen and assessed by a drugs outreach worker. The offender disclosed that had used amphetamines and alcohol in the past but had been abstinent for 14 years. It was concluded that he had no current drug or alcohol issues.

In November, the Children's Social Care service contacted Offender Manager 6 and disclosed that there were risks in relation to AF7 regarding alcohol use and drug use.

In November, a 'Lifer Review' was conducted and an OASys was completed and the risk of serious harm to known adults was reduced from high to medium. This was the last OASYs conducted before the homicide.

3.7 Key events 2013

Chan consulted her GP Practice 38 times. A significant number of these contacts were by telephone and a significant number concerned anxiety, depression and worry.

The offender moved into a private rented flat in the Greater Manchester area.

In February, Chan attended her GP and reported thoughts of self-harm, and financial worries regarding housing and her business. Chan was referred

immediately to the Mental Health Crisis Team and was seen by them 2 days later.

In April, during a telephone consultation with her GP, Chan said that her long term partner had left the family home.

In April Chan was admitted to hospital following what was described in the IMR submitted by the Clinical Commissioning Group as an impulsive overdose of Co-codamol. The IMR stated that Chan had been arguing with her partner and that she had a number of financial difficulties. Chan was interviewed and supported by a mental health liaison service whilst in hospital and the General Practitioner provided further details of local support agencies.

Chan attended her GP in June and the GP record stated that she was very worried, had suicidal ideation, had had a row with her partner and asked him to leave the home.

In July, the offender reported to his offender manager that he was volunteering at a cat's home and was also helping out at a shop. It later transpired this shop was owned and managed by Chan.

In August, the offender informed Offender Manager (OM) 6 that he had met Chan and that she was his employer. The offender told OM6 that he had not made a full disclosure to Chan. He reported that they 'were not forming a relationship'.

In late August, OM6 met with Chan (who was introduced as the offender's employer) who told OM6 that she was aware of the murder committed by the offender and stated she was not in a relationship with the offender. Chan did not disclose the name of her child because she said she was not in a relationship. OM6 was clear that if a relationship developed they must be informed.

In August a letter to the GP from the counselling service stated that Chan was on the waiting list for Cognitive Behavioural Therapy and on the waiting list to see a Psychiatrist.

A letter was sent to Chan in September from the GP Practice to let Chan know that she had missed 6 appointments.

In September, Chan called her GP. She was very upset, she had been back with her partner but Chan said that it ended badly. Chan's mood was recorded as flat.

On the 4th of October, Chan attended A&E services at North Manchester General Hospital with her Mother. Chan reported to the triage nurse that she was depressed and upset and finding it difficult to cope. She was seen by a duty Psychiatrist from the Manchester Mental Health and Social Care Trust who provide a mental health liaison service to the Pennine Acute Hospitals NHS Trust at North Manchester General Hospital. Following this assessment

she was discharged home, and a letter forwarded to her GP, recommending that Chan may well benefit from referral to Cognitive Behaviour Therapy. She was discharged back to the care of her GP.

Chan saw the Psychiatrist in October but did not attend a follow up appointment in November and was discharged back to the care of her GP.

In October, after a series of requests for the information, the offender and Chan met with OM6 and Chan provided the details of Child 1 so that a referral to Children's Social Care could be made.

The information provided in the chronology submitted by the Probation Trust states that in November, Children's Social Care (CSC) were sent a referral from the Probation Service requesting an assessment of Child 1. This referral included notes about the previous murder committed by the offender and that Chan had commenced a relationship with him. In the Probation chronology, it states that the CSC will "….visit in the following week".

Following a home visit in late November, CSC undertook a single assessment of Child 1 and stated that no further action was required and that Chan was able to safeguard Child 1.

In November, Chan attended a family bonfire party and was seen to have a black eye. According to the family, her step-father challenged the offender about whether he had done this and the offender did not reply. Chan said that she and the offender had been drinking and she had fallen down the stairs.

In early December the offender registered with a local GP. He did not disclose his offending history. It appears he had not registered with a GP immediately following release from prison. Whilst there is no requirement for registration, advice on local GPs is provided by prison healthcare services.

Once the offender had registered with a GP, he completed a health check questionnaire but failed to attend an appointment for a physical examination. He did not answer any questions about alcohol.

Two days after registering with the GP, the offender presented complaining of low mood and he presented again at the end of December complaining of low mood. This was reviewed and he was prescribed Diazepam. He also asked to be prescribed Viagra but this was refused as the GP did not feel he knew enough about the offender to warrant prescribing this medication.

In December, CSC closed the case on Child 1 as no further action was required following the assessment.

3.8 Key Events in January and February 2014

Chan consulted her GP Practice on 11 occasions – the majority of these consultations (some of them being to the out of hours service) concerned episodes of anxiety, depression, panic attacks and low levels of energy.

In January, Chan called the Out of Hours (OOH) Service and reported 'angry outbursts', and a fear that she may hit someone.

In January, the offender and Chan attended East Lancashire Hospitals Urgent Care Department together, where they reported that they believed their drinks had been spiked at a friend's house. Following toxicology tests, they were both discharged with no follow up required. The toxicology tests showed nothing of significance.

In mid-February the offender presented to his GP with back pain and he asked to be prescribed Tramadol. This was refused and he was prescribed co-codamol. He also complained of pain in his elbow and tennis elbow was diagnosed.

In February, Chan told her counsellor at the Magdalene Project that the offender had hit her 'over Christmas' but that this was a 'one off' and she was sure it would not happen again. The counsellor advised Chan to let her know if this happened again and to let her know if she was afraid of the offender.

On the 2nd of February, the offender saw OM6 and told them that he drinks alcohol on rare occasions but has not taken drugs since the index offence.

In February, Chan called the Out Of Hours service reporting pain after being hit in the jaw at the weekend. Chan was advised to visit the Accident and Emergency service. Chan went to the A&E service at Fairfield General Hospital. She was accompanied by the offender and claimed that she had been in a fight with a woman. Chan was assessed and referred to North Manchester General Hospital (NMGH) and the offender then took Chan to the maxillo-facial outpatient services at NMGH and a diagnosis was made of a closed fracture of the left jaw. Chan was treated with analgesia and antibiotics. Both North Manchester General Hospital and Fairfield Hospital General Hospital are part of the Pennine Acute Service NHS Trust.

Following this incident, Chan spoke to a close family member about her relationship with the offender; she reported that he was violent and abusive towards her and that she was in fear of him. She asked the close family member not to tell anyone about the abuse as the offender had threatened to harm members of her family, including Child 1.

The offender had registered with his GP in December 2013, had no physical examination, offered no response to questions concerning alcohol consumption, was refused a prescription for Viagra and complained of pain in his elbow. He received injections for the pain in his elbow in February 2014. This was his final appointment with the GP.

It is the case that there were no disclosures about his history, the GP didn't know about his licence and the GP expressed their disappointment to the Clinical Commissioning Group's named nurse concerning the lack of communication of information[4]. This issue is something that repeats across DHRs and is addressed in the conclusions and recommendations in this DHR.

Additionally, the single agency recommendations submitted by the Prison Service (particularly recommendation 2) emphasise the importance of ongoing regular communication with and between relevant partner agencies.

3.9 Events in March 2014

On the 1st of March (Saturday), Lancashire Police received information from Greater Manchester Police stating that Chan's step-father (Chan-SF) had reported that Chan had told a close family member that she had been assaulted by the offender and received a broken jaw.

The incident was treated as a grade one emergency call and two patrols were dispatched. The incident was recorded as an ongoing violent domestic incident (when dispatched officers did not know that the injury had occurred more than two weeks previously). Two uniformed police officers arrived at Address 1. They were met there by Chan-M and Chan-SF. They were all admitted to the house by Chan who was talking to someone on the telephone.

The officers talked to Chan about the allegation. Chan stated that she had not been assaulted. No concerns were raised around Child 1. There was no injury apparent to Chan and nothing to suggest to the officers that they should not believe Chan's account.

Chan then held a conversation with a family member within the hearing of both police officers during which she disclosed that she had been assaulted by the offender and had sustained a fractured jaw. Chan also disclosed that the offender had forced or persuaded her to dress up and had taken digital photographs of her which he had refused to delete from his phone.

Chan was asked by the Police to complete a DASH risk assessment but she refused to do so[5].

Following the visit to Chan, the reporting officer submitted a Protecting Vulnerable People (PVP) referral for Domestic Abuse and risk assessed it as a High Risk referral. The officer e-mailed a Detective Sergeant within the Public Protection Unit and also completed an entry on the intelligence system. The referral was sent to the Multi Agency Safeguarding Hub (MASH).

[4] The review of DHRs conducted by the Centre for Public Health at the Liverpool John Moores University re-enforced the view that partner communication is vital for the support provided to victims of abuse and the efficient delivery of MARAC policies.

[5] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was accredited by the Association of Chief Police Officers (ACPO) to be implemented across all Police services from March 2009.

At this stage the referral was graded as High Risk. This rating was based on a number of factors i.e. officers having overheard Chan talking to her mother and telling her that the offender had in fact assaulted her, despite her denial of this to the police officers, and the offender's previous conviction.

On the 3rd of March, two domestic abuse specialist police officers visited Chan again. On the same day, after the police had visited Chan, the Children's Social Care (CSC) service received a referral from Lancashire Police stating that the offender had assaulted Chan. According to the IMR submitted by the CSC to the panel, MASH procedures were followed with an immediate referral to the district team.

CSC visited address 1 on the 3rd of March and allocated a social worker following a Section 47 referral. Chan and Child 1 were seen alone and they did not convey any concerns with regard to the offender. Chan was not observed to have any injuries and stated that she had falsely accused her boyfriend of assault. The offender was aware of the referral and stated he was not angry about this and understood the reasons behind the police and CSC involvement. A strategy discussion took place in line with Section 47 referral procedures and it was agreed that the Police would revise the assessment to be medium risk given that Chan had denied being assaulted by the offender. The CSC IMR stated: "Children & Families (C&F) to be completed as opened in response to 'High Risk'". Once the C&F assessment was completed, no further action was advised.

The Children's Social Care service did not notify the GP or Child 1's father of their assessment.

Following this visit, the referral, with the updated information from the home visit, was reviewed within the Multi Agency Safeguarding Hub (MASH) and a decision taken at this stage by the MASH supervisor, following consultation with the Detective Sergeant, to lower the risk assessment to Medium Risk.

An e-mail was then sent (on the 3rd of March) from the MASH to all relevant agencies, including Offender Manager 6, informing them of the allegation and the subsequent denial of the assault. This e-mail did not reach OM6 as the e-mail address it was sent to was incorrect. (This was only discovered during enquiries as part of the DHR process).

On the 4th of March The Star Centre (a Domestic Abuse Support Service) received the referral from the MASH (sent late on the 4th of March) and subsequently contacted Chan (on the 6th of March). The Star Centre noted that the case had been reviewed and the grading had been altered from 'High' to 'Medium' risk. When a member of staff from the Star Centre contacted Chan by telephone (on 6th March), Chan said there were no issues; that there were problems with the family and there was some historic abuse.

Chan said to the member of staff from the Star Centre that she did not want any support in relation to domestic abuse. She said she had retracted her report and denied allegations made by her family to the police. She was

signposted to support services and sent details by post of a domestic abuse programme.

On the 10th of March, the list of cases for the Multi Agency Risk Assessment Conference (MARAC) was circulated and Chan was included on the list. However, later that day the list was revised and Chan was removed from the list as the risk to Chan had been altered to 'Medium risk'.

On the following day, the 11th of March, Chan telephoned the police and said again that she had made up the report that the offender had assaulted her. This was followed by another home visit and she reassured officers that she had no concerns for her own safety and she was fully aware of the offender's conviction. (It later transpired that the offender was hiding in a cupboard at the address whilst police officers were present).

On the 11th of March, Offender Manager (OM) 6 called the Constabulary Domestic Violence Unit and was given information about the home visits to Address 1 and of Chan's denial of assault by the offender**.** OM6 consulted the Principal Offender Manager about possible recall and a decision was made not to recall the offender. It was decided to advise the offender that he must stay away from Chan until OM6 had had an opportunity to speak with her. A home visit to Chan was arranged by OM6 for the 21st of March.

On the 12th of March the offender visited OM6 and told her that Chan had made a false complaint to the police about him assaulting her.

On the day of the murder, Chan contacted OM6 by telephone and disclosed that the offender had assaulted her. OM6 contacted Lancashire Police and reported what Chan had said and that she had told OM6 that she was *'scared for her life and that of her child'.* Chan had told OM6 that the offender was not in the house although she was frightened he may come back. She also told OM6 that she had to go hospital every two weeks because of the injury to her jaw from the assault.

OM6 telephoned the police and spoke with a Detective Sergeant in the Public Protection Unit. OM6 shared information with the Detective about the conversation they had had with Chan. OM6 also told the Sergeant that when the police officers had recently visited Chan, the offender had been hiding in a cupboard in the house. OM6 told the police that they did not think a visit to Chan should wait. The Detective Sergeant took the decision to attend address 1 with a colleague immediately.

Officers arrived at Address 1, where the incident resulting in Chan's death occurred.

4 Agency Responses to the Terms of Reference and Key Lines of Enquiry and analysis

This section of the report sets out information submitted by agencies for each key line of enquiry. It also includes relevant information from the IMRs and short reports and the further enquiries made by the DHR panel in relation to specific key events. A brief analysis of each Key Line of Enquiry is made under each heading.

4.1 KLOE 1:

Were the services offered by your agency accessible, appropriate and sympathetic to presenting needs of Chan?

4.1.1 CSC

The first referral to the Lancashire Children's Social Care (CSC) Service, was made in November 2013 and it was a notification from Offender Manager 6 regarding Chan's relationship with the offender and his previous conviction for murder. In this regard, OM6 was making sure that CSC was aware of the offender, his license conditions and his relationship with Chan.

This initial referral in November 2013 was not treated as a Section 47 by the fieldwork team. The reasons given for this were that, upon reading the referral and following a documented phone call between Probation and CSC on the 21st of November 2013, the first Social Worker (SW1) determined no immediate safeguarding risk to Child 1. This decision was based upon an interview with Chan who confirmed there was no access to the child by her new boyfriend. Chan also confirmed that she had an awareness of the offender's conviction for murder and his life licence. She is documented as having told the probation officer previously, and later to SW1, that he was reformed and that she had attended probation appointments with him. It was shared that he was not visiting her home except when Child 1 was staying elsewhere overnight with her father at another address.

Child 1 was seen alone, as appropriate, and asked about their feelings in relation to the offender, whom they said they liked.

It is apparent that, whilst Chan informed SW1 that the offender had no access to Child 1 and that the offender visited the home of Chan only when Child 1 was staying elsewhere, when Child 1 was seen alone and asked about the offender, Child 1 stated that they liked the offender. This clearly suggests that Child 1 had met the offender and possibly met him a number of times.

The second referral, in March 2014, was from the Multi Agency Safeguarding Hub (MASH) and was treated as a Section 47 inquiry. This is because it held information about an alleged domestic incident that had caused an injury to Chan. Consequently, conference proceedings were initiated.

Chan was assessed to be a protective factor for Child 1. However she did not disclose the true nature of her relationship with the offender (that he was violent and abusive towards her) and Chan probably did not disclose the nature of the relationship in order to protect Child 1 from the offender.

4.1.2 Lancashire Police

Lancashire Police sought to ensure the safety of Chan. They assured her that both she and Child 1 would be safeguarded and the officers outlined what support was available to her and were sympathetic to her circumstances. However, they acknowledged that Chan had stated that she would not co-operate with an investigation into assault.

There was no information on the Lancashire police intelligence systems regarding the offender. However, it is important to note that Lancashire Police had been notified that the offender was in a relationship with AF7 and an incident log had been created and a Vulnerable Marker had been placed on the address of AF7. Additionally, of course, the offender's offending history was on the Police National Computer to which Lancashire police have ready access.

In the period prior to the homicide, the Lancashire police system recorded no specific contemporaneous concerns regarding Child 1. The officers were aware of the welfare of Child 1, because they knew of a vulnerable child referral received by the Constabulary some years before. With regard to this incident, there was no separate Vulnerable Child referral because the details pertaining to Child 1 were included in the domestic abuse referral, as is usual in the MASH process. There was a visit by CSC following a S47 referral. This was appropriate practice.

Lancashire police liaised appropriately with Greater Manchester Police in response to the information shared by Chan-SF concerning an allegation of assault that had taken place (where Chan's jaw had been broken).

The Police were unable to complete a DASH Risk Assessment because Chan refused to do so. Despite this, officers, as a matter of professional judgement, graded the risk as high due to an overheard conversation.

The police officers did not telephone hospitals in the region to establish the truth of this overheard conversation. However, it would not be usual practice for those officers to make telephone enquiries in such circumstances. The officers, therefore, did not know which hospital Chan had attended and, within the panel discussions, there was a view shared by some that when hospitals are contacted in such circumstances, they will not always disclose information about patients without a signed consent form from the patient concerned.

However, this view was not shared by all members of the panel and colleagues from the NHS were clear that GMC regulations and Caldicott

guidelines (a useful guidance document is referred to in footnote[6]) allow for patient information to be shared in certain circumstances, including the detection or prevention of a serious crime. The imperative to share information is enhanced when there is a potential for child safeguarding policies to be effected. In this case, the NHS Trust representatives on the Panel were clear that information would have been shared with the Police and OM6 if a request had been made.

One of the police officers who attended address 1, prior to the murder occurring, carried out a check on his personal radio on the Police National Computer (PNC) relating to the offender. It is usual practice for officers to carry out PNC checks on individuals at domestic incidents to provide them with up to date information on each person concerned. The PNC Operator confirmed that the offender had been released on a Life License following a conviction for the murder of a former girlfriend (AF2) in 1998. This information alerted the officers to a potential heightened risk to Chan, and prompted the officer to submit a high risk referral (a Protecting Vulnerable People – PVP – submission)

Following the visit to Chan on the 1st of March the officers returned to the police station, updated senior colleagues and a PVP referral report was forwarded to the MASH (Multi Agency Safeguarding Hub). At this stage the referral was graded as High Risk.

Following the visit to Chan on the 3rd of March, the information was reviewed within the MASH. A decision was taken by the MASH Detective Sergeant, following consultation with others concerning the information gathered by the officers who had visited Chan, to alter the risk assessment to that of Medium Risk on the basis that Chan had denied the allegation of assault by the offender resulting in a broken jaw. The MASH attempted to inform OM6 by email (as is usual practice), however an incorrect email address was used and OM6 never received this communication.

Chan attended a hospital in Greater Manchester for an investigation into a closed fracture of her jaw. NHS services in Greater Manchester do not attend the Lancashire MASH. The issue concerning the gaining of access to cross border information in a timely manner has been raised by the panel. GP details would be necessary to allow access to A&E letters sent to the GP and, of course, Chan's GP didn't inform the MASH because they didn't attend the MASH. It is also worth noting that at the time this tragic incident occurred, the MASH in Lancashire had only recently formed and was in the process of fully engaging with all relevant partners.

On Friday the 14th of March, OM6 telephoned Lancashire Police and informed them that the offender had told her that Chan had made an allegation of assault against him. OM6 had been told about this allegation of assault by the

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6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215064/dh_133594.pdf

offender when he visited OM6 on the 12th of March. Lancashire Police described the details of what they knew about the allegation and that Chan had been insistent that she had lied and denied that she had been assaulted by the offender. There had been no response following the e-mail from the MASH to OM6 (because OM6 had not received the email).

On the day of the homicide, OM6 contacted the Police by telephone with concerns regarding Chan who, on the same day, had disclosed to her, via telephone, that she had in fact been assaulted by the offender and that she was '*scared for her life and that of her child'.* Chan had expressed a fear that, although the offender was not presently at the house, he may return.

The Police created an incident log. However this log was created as a '*Concern for Safety'* and graded as a 'non-emergency' and recorded as a Grade 4 response. Lancashire Police noted that this grading was incorrect and that the appropriate grading for this incident should have been at least Grade 2 if not Grade 1, i.e. 'Emergency', requiring an immediate response; or 'Priority', requiring a response within one hour.

However, following further assessment and review of the available information by the Police, it was agreed that an officer would contact Chan and arrange for a Response Officer to visit her to ensure her immediate safety. The officer telephoned Chan who informed the officer that she *'did not have any immediate concerns'.* Chan said that she had not been assaulted by the offender. She was asked if she would make a statement that afternoon. Chan said that her daughter was due home from school and she did not wish to make a statement then. Chan was reluctant to attend the police station, but agreed to attend at 9.00am the following morning, once her daughter was back at school.

As the log was being updated, the Police received a call from OM6 stating that she had received a 'phone call from Chan saying that when the Constabulary visited her (two weeks before the murder), the offender had in fact been hiding in the house. Taking everything into account, a Detective from the Lancashire Police made the decision to visit Chan with a Detective Constable.

Throughout the attack by the offender both police officers were exposed to extreme violence, with each moment recalled in detail in the statements of the Officers interviewed as a part of this Review. Both police officers responded to the attack with the safety of the victim in mind and did everything possible to protect Chan from harm.

The Detective Constable was in possession of protective equipment consisting of stab vest; baton; and quick cuffs. The officer was not in possession of her PAVA Spray (please refer to Appendix F). Although the officer had been trained to use PAVA they did not possess it and did not feel confident in using it. The use of PAVA may not have stopped the attack in the house. However, the officer's use of the baton caused the offender to drop the hammer. The Detective Constable had been issued with PAVA, and has

stated that they always carry protective equipment when they leave the police station[7].

On the day of the homicide the Police liaised appropriately with the North West Ambulance Service and adhered to their protocols concerning investigation and prosecution.

Taking the events managed by the Lancashire Police into consideration, it appeared that Chan changed her mind on a number of occasions concerning her disclosure of violence and her fear of the offender. It must be assumed that this is because Chan was in fear of the offender and afraid of the perceived consequences of making or sustaining a disclosure.

4.1.3 GP Chan

Chan had 162 contacts with her GP Practice over the time period set for this Review. This included 97 face-to-face GP consultations, 13 GP telephone consultations, 14 Nurse Practitioner consultations and 38 Practice Nurse consultations. In the twelve months prior to the incident, Chan had 40 contacts with a GP, 29 of these face-to-face and 11 telephone consultations[8].

On five occasions Chan was in distress when she spoke to her GP on the telephone. On all those occasions she was given an immediate appointment on the same day. She often presented with a number of concerns at the same consultation and it would appear that her GP spent time discussing these with her.

Although she did not attend for a number of appointments (for which she was sent a letter by the Practice Manager) this did not affect her access to GP services in any way. It is clear from the staff interviews, that Chan had, over the years, developed a good relationship with her General Practice.

Chan did not disclose that she was suffering domestic abuse from the offender to her GP at any of her consultations. Chan's GP did not make any routine enquiries about domestic abuse with Chan despite the frequency of her contacts, the nature of her problems and her willingness to discuss her relationship.

4.1.4 GP the offender

The offender's general practitioner provided appropriate services on the five occasions that the offender consulted with them. The GP had no information about the offender's previous offending history or that he had been released from prison on a life license.

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[7] A description of the standards concerning personal protective equipment and its use is included in the Appendices

[8] The author of the GP IMR reported that, on average, a patient consults their GP 5.5 times annually (ref: 'Pulse Magazine', 2013).

The offender reported low mood to his GP shortly after registering. There is no indication that the underlying cause of this was explored. The offender was prescribed diazepam. The offender asked his GP to prescribe Viagra to him. However, the GP, as a clinical judgement, refused to do so based on the short time that the offender had been with the practice.

The offender later presented with back pain and asked to be prescribed Tramadol (an opiate based drug), this was refused on the basis of clinical judgment and co-codamol was prescribed instead.

4.1.5 East Lancashire (ELHT) and Pennine Acute Hospitals (PAHT) NHS Trusts

Both NHS Hospital Trusts provided accessible, appropriate and sympathetic care to Chan. Chan was seen more than ten times by ELHT and Pennine Hospitals NHS Trust for various reasons over the period set for this Review, being seen by a variety of practitioners and on all occasions both Hospitals considered her treatment was appropriate to her presenting needs.

On the occasion that Chan presented with the offender to ELHT Accident and Emergency Department suspecting that her drink had been spiked, her treatment was to the expected standard. There was no suggestion that Chan was being abused by the offender and no enquiries made about the nature of their relationship, as would be expected. Both Chan and the offender were treated appropriately, toxicology tests were undertaken and they left the A&E department with no follow up necessary.

Pennine Acute Hospitals NHS Trust provided acute emergency NHS treatment to both Chan and Child 1. These services were provided in a timely and appropriate manner.

When Chan presented with an anxiety related problem, staff saw her alone affording her the opportunity to be open and honest about her current situation and to do this in a safe and secure way.

Staff also demonstrated further awareness of the nature of domestic abuse when considering the need to take a detailed history of events when Chan presented with a broken jaw. Consideration was also given as to whether or not a referral to the police in respect of the assault had been made. Chan (who stated that she had sustained the injury following an assault by a woman) had chosen not to pursue this matter. Staff were aware that they should not ask direct questions concerning domestic abuse and violence whilst Chan was in the clinical consultation with another person (the offender). In this regard it is important to note that the staff of PAHT were acting in accordance with the current NICE Guidance concerning domestic abuse, i.e. their inquiries were constructed in such a way as to ensure that Chan was not placed at any magnified risk during the consultation.[9]

[9] www.nice.org.uk/Guidance/PH50

Chan was appropriately assessed for her injuries and subsequently referred to a maxillo-facial specialist at another hospital site. At this presentation, Chan was accompanied by the offender and it was the offender who drove her from one site to the other. At this presentation no specific enquiries were made about domestic abuse. Chan said that she had been in a fight with another woman, which was recorded as the reason for the injury.

4.1.6 Lancashire Care NHS Foundation Trust (LCFT)

The Panel noted from the submission made by LCFT that Chan had a number of vulnerabilities centred on her self-esteem and long-standing emotional difficulties. Throughout her contact with the Trust, LCFT offered her support from five different professionals, one of which was a joint assessment by a Hospital based Mental Health Liaison officer.

It is also important to place the involvement of LCFT in some context. LCFT provide two distinct services – specialist mental health services and children and families services (including Health Visiting and School Nursing Services)

LCFT acknowledged that this pattern of provision caused some concern regarding two key issues: firstly, a lack of service continuity and secondly a concern as to whether Chan was fully engaged in the service in a meaningful way in order for her to feel comfortable sharing her concerns and being able to seek support.

The Panel discussed the history of Chan's engagement with LCFT – Chan had engaged with the service in the past in order to, amongst other things, ensure Child 1 received the full offer of school health services. However, the Panel agreed that further details of Chan's engagement with LCFT would not be included in the overview report – a decision made to protect the dignity of Chan.

The reason for her assessments being undertaken by different staff was due to the pattern of referral. One of the assessments was undertaken over the telephone as a response to a request made by Chan. This was not standard practice but was provided in response to her direct contact. A further face-to-face assessment would have been offered. However, the Trust noted that Chan had not attended follow up appointments in the past.

In the view of LCFT, Chan had been supported appropriately in all her previous contacts with the service and had engaged with the services offered since the birth of Child 1.

4.1.7 Magdalene Project

Chan had her first contact with the service in 2010, following a referral by her GP. The service had worked with Chan for 9 months from that initial referral. Chan requested support to work through issues from her past. Chan was in a long-standing relationship at the time and Chan told the Magdalene Project

that she was about to commence a course of learning at college and so closed her counselling sessions.

Chan had her second contact with the service in October 2013. This contact focused upon an assessment of the services she may have required. Chan was booked into weekly sessions and commenced these sessions in February 2014. The reason for the delay was attributed to Chan frequently cancelling them. Chan did attend sessions in February and March 2014.

During the sessions attended in 2014, the counsellor said that they had noticed a big change in Chan compared to her first contact in 2010-11. The counsellor was concerned about Chan's presenting state. The counsellor said that Chan's mental health had "gone to zero" and she was unable to organise her appointments. Her depression was a lot heavier, and at the last session the counsellor had told her to call her GP and let the GP receptionists know that her counsellor had said it was urgent.

The counsellor stated that Chanh a lot of aggression towards her family and didn't want them around. The counsellor, in hindsight, wondered if this was due to threats from the offender, but can only proceed with their therapy based on what the client is willing to share with them.

The counsellor stated that Chan was 'seeing someone' who she had met at the shop where she worked. Chan didn't talk about him a great deal but the counsellor recalled that that they were not living together because of Child 1.

There was no indication made to the counsellor that there was anything untoward in Chan's relationship with the offender until Chan's final session, when she disclosed an argument that had occurred between her and the offender. The counsellor explored this issue with Chan and considered that Chan was not disclosing that the relationship was abusive but the counsellor felt that Chan was beginning to doubt the relationship. She also checked how safe Chan felt. Chan said she did not want any statutory involvement and made no reference to the offender's history of violence. The counsellor went to talk to and de-brief with her manager immediately after the session.

The Panel discussed the interaction between the Magdalene Project and Chan at some length. The discussion focused upon whether the service should have disclosed to another agency the perception they had about Chan's mental health, her relationship and the fact that Chan shared information about an argument and that she had been hit. It is the view of the Panel that the Magdalene Project missed an opportunity to share vital information with other services concerning the safety and health of Chan. This was an error and the procedures concerning client confidentiality and the sharing of information when disclosures of assault are made need to be reviewed.

4.1.8 North West Ambulance Service (NWAS)

The services provided to Chan were appropriate to her needs. During the first incident that NWAS recorded, staff responded to her wishes and transported her to an appropriate hospital.

4.1.9 Probation

Prior to meeting the offender, Chan had no contact with the Probation Service. When the offender disclosed that he had met Chan, this was noted by Offender Manager (OM) 6. OM6 had contact with Chan for a preliminary disclosure at the point when the offender entered into employment with Chan. This 'pro-active disclosure' was noted because Chan was the sole proprietor of the shop where the offender was working. This disclosure occurred before the offender and Chan began their relationship. OM6 contacted Chan again soon after it became clear that the offender was having a relationship with her. From that point, Chan was encouraged to maintain contact and report any issues of concern to the OM6. The Probation Service did state that, owing to their lack of knowledge of Chan's vulnerabilities, there was minimal on-going contact or review with Chan directly. However, it is important to note that Chan was given the contact details for OM6 should there be any issues or concerns to discuss. Nevertheless, it is the case that the second disclosure visit – when the offender and Chan were in a relationship – and the contact following the Children's Social Care assessment was the last direct point of contact with Chan prior to March 2014.

4.1.10 Star Centre (Specialist Domestic Abuse Service)

The Star Centre contacted Chan following the MASH referral in line with usual practice. Chan refused the service saying that she did not need support. Chan was given information about domestic abuse services and advised to contact the service if she needed them in the future. This verbal information was followed up with written information, sent by post.

4.2 KLOE 2

Did your agency have knowledge of current or previous domestic abuse of Chan? If so how was this acted upon?

Please note that this key line of enquiry addresses the specific question of whether any agency knew of any incident of domestic abuse that had affected Chan during the scope of the review and if they did, what action they had taken to respond to that knowledge. If agencies involved in the review had no knowledge of any domestic abuse of Chan then they were not expected to respond to this line of enquiry.

Chan did make disclosures of domestic abuse to agencies involved in this review, although she minimised and retracted these allegations, presumably because she was in fear of the offender.

These disclosures were made at different points in time with the earliest disclosure being made to her counsellor at the Magdalene Project in February 2014. Chan told her counsellor that the offender had hit her (at some point around the Christmas of 2013). However, she said that this was a 'one off' and that she was not in fear of the offender. The counsellor did not know about the offender's history or any details about him. The counsellor offered advice to Chan and said that she should inform her if there were any further occurrences.

In February 2014, Chan disclosed to a close family member that the offender was abusing her, that she was in fear of him, that he had broken her jaw and that the offender had taken photographs of her and had refused to delete them from his phone. The close family member felt they could not keep this information to themselves, despite promising Chan that they would do so. The close family member told another family member. Subsequently, on the 1st of March 2014, Chan-SF contacted Greater Manchester Police and informed them that Chan had told a close family member that the offender had assaulted her. Greater Manchester Police contacted Lancashire Police to inform them.

On receipt of this information Lancashire Police went to visit Chan at Address 1 to ask her about the allegation (at this time Lancashire Police were not aware that this was a retrospective allegation – the incident having taken place in January 2014).

Upon being asked about the allegation, Chan denied that she had been assaulted and said that she had made the story up to 'get back' at the offender. However, police officers overheard her talking to her mother, confirming that the offender had hit her and broken her jaw. Chan refused to complete a DASH risk assessment. However, the overheard conversation, coupled with the knowledge of a number of photographs being taken of Chan by the offender, influenced the officers to complete a PVP that assessed Chan as being 'high risk'.

The panel considered this matter at some length. If it was the case that officers clearly overheard Chan telling her mother that she had sustained a broken jaw following an assault by the offender, then the sharing of this information would have offered OM6 the very clearest evidence to progress with a recall of the offender.

The Protecting Vulnerable People submission was sent via the Multi Agency Safeguarding Hub to agencies including OM6 at the Probation service (whom it did not reach due to the email being sent to an incorrect e-mail address), Children's Services, the Children and Family Health Service, the STAR Centre, Lancashire Probation Service and the Independent Domestic Violence Advocate Service. Had the e-mail been correctly addressed, OM6 would have been aware that an allegation of assault by the offender against Chan had been made on the 1st of March 2014 rather than 11 days later when the offender shared the allegation with OM6 during one of his visits to his offender manager.

Lancashire Police visited Chan again on the 3rd of March and some time later on the same day, the Children's Social Care service made a visit to Address 1 (a Section 47 referral had been made to the Children's Social Care service) to follow up their initial contact and to undertake an assessment. Chan continued to deny that she was subject to abuse from the offender and re-iterated that she had made up the allegation to 'get back' at the offender as she thought he was seeing someone else. The outcome of these visits was to lower the risk rating from high to medium, which in turn had an impact upon the escalation of the case to Multi Agency Risk Assessment Conference (MARAC). The case was subsequently withdrawn from the MARAC list.

The Star Centre received a referral from the Lancashire MASH on the 4th of March 2014. This referral was received as a 'medium risk' category referral. The Star Centre noted in their report that the category of the case had been altered from 'high to medium risk' by the PPU at the Lancashire Police. The Star Centre stated that this alteration of the risk category was changed following an interview with Chan.

On the 6th of March 2014, the Star Centre made a telephone call to Chan. Chan clearly stated to the Star Centre that she did not want any support, that there had been some abuse but the abuse was historic. Chan stated that the family were interfering and that there were no issues except with the family. The Star Centre informed Chan about the 'Be Free, Stay Free' Programme which would offer help for Chan to deal with the historical abuse. This information was sent to Chan on the 6th of March 2014.

Chan stated to the Support Worker from the Star Centre that she had retracted the report she had made to the Police and denied the allegations made to the Police by members of her family concerning domestic abuse.

The Children and Family Health Service (an NHS service that is a part of the Lancashire Care Foundation NHS Trust) received information, in February 2014, from the Lancashire MASH detailing the incident in which Chan sustained a fractured jaw. Chan was not contacted following receipt of the information concerning this incident. It is not routine practice for School Nurses to contact victims of domestic abuse after a domestic abuse incident. The Lancashire Care NHS Foundation Trust guidance (*Procedures for Working with Domestic Abuse*) determines that it is best practice to consider all the information available and make a professional judgement as to the plan of care. This judgement included a consideration of the information that CSC had been informed of the incident and that the Police were investigating it. The School Nurse contacted the school to enquire about the wellbeing of Child 1, after reviewing the documentation, and no significant information came to light concerning the welfare of Child 1.

Offender Manager (OM) 6 became aware of the allegations of abuse by the offender on the 12th of March. OM6 spoke to their manager and discussed the recall of the offender. OM6 contacted the Lancashire police to ascertain further details concerning the allegation of assault and made a telephone call to Chan. A decision was made not to recall. Further details of the rationale for

not recalling the offender are set out in more detail within the relevant key line of enquiry on page 58. OM6 instructed the offender that he must not have contact with Chan over the weekend. On 17th March OM6 received a call from Chan saying that she was in fear of the offender and that he had been abusing her. OM6 contacted Lancashire Police and reported what Chan had told her, advising that the police should visit Chan at home without delay.

Despite Chan's close and frequent contact with her GP she did not disclose abuse by the offender during any of her consultations, nor did the GP make any routine enquiry about domestic abuse with Chan.

KLOE 3:

Did your agency undertake any assessments including alcohol, drugs or mental health, physical and sexual health or social care/housing in relation to Chan and/or the offender?

NB: Specific Risk Assessments are addressed in KLOE 13

Both Chan and the offender received a range of assessments in different settings and by different agencies. In relation to Chan, these were related to mental, emotional and physical health and (outside of the period under review) in relation to the safeguarding of Child 1 – although this was not a matter that has relevance to this review.

The Manchester Mental Health and Social Care Trust, on behalf of the Pennine Acute Hospitals NHS Trust, undertook an assessment of Chan's mental health on 4th October 2013. This assessment included alcohol use, social arrangements, housing and financial situation, and an appropriate risk assessment was completed before facilitating her discharge from Accident and Emergency (A&E) service.

The Trust, in their IMR submission, stated that all patients who attend A&E and Urgent Care Centres should have an "Audit C" completed[10] and when it is completed, this will prompt frontline staff to offer referral to alcohol services, if appropriate. With regard to Chan, her alcohol use was assessed during the mental health assessment, and given her disclosure that she had resumed her use of alcohol recently and that this had become excessive, then the Trust stated that Chan should have been offered a referral to alcohol services. However, an Audit C was not completed in this case and, therefore, no referral to alcohol services was made.

Chan returned a routine health questionnaire regarding Child 1 in January 2013. There is also a separate child questionnaire that Child 1 completed in December 2012. This is a core element of the Healthy Child programme. The responses in these questionnaires did not indicate any concerns for either Child 1 or Chan. The response by Chan to the question "Are there any people

[10] Audit C is a set of three questions that should be asked around a person's use of alcohol

or services that support your family?" the answer she gave was 'no'. In response to the question: "Do you often worry about your family and would you like to talk to a school nurse about any worries?" Child 1 answered 'no'. In answer to the question: "Do you feel happy and do you have someone you can talk to about any problems?", Child 1 answered 'yes'.

In October 2012, the offender was seen by a drug service in Rochdale and assessed as being drug free and not requiring any further interventions or appointments.

KLOE 4:

Did your agency undertake any specific assessments in relation to domestic abuse for Chan and/or AF7 (e.g. DASH risk assessment or other).

This line of enquiry invites agencies participating in the Review to outline any specific assessments they may have undertaken in relation to domestic abuse.

The police officers attending Address 1 on the 1st of March could not complete the DASH risk assessment because Chan refused to complete it. However, as explained under the response to KLOE 2, officers assessed Chan as being High Risk based on the belief that Chan had, at some time prior to the visit, been assaulted by the offender (the officers had overheard Chan talk about the assault to a family member).

Following a second visit to Chan on the 3rd of March the PVP risk assessment was lowered from high risk to medium risk based on the following rationale:

- *Chan was visited by two experienced PPU officers and fully de-briefed over a two-hour period. Chan was fully aware of the conviction of the offender, and the circumstances of the murder for which he was convicted.*
- *Chan stated that she was happy to be in the relationship with the offender. She stated that she was not frightened of him, and had lied when she claimed that the offender had assaulted her.*
- *Chan did not appear to have any injuries, and was offering no evidence to support that she had been assaulted, or that the relationship was in any way abusive.*
- *The offender was being supervised as a MAPPA 1 offender.*
- *Although there was an initial referral to MARAC, this case was taken off the MARAC list once the risk assessment had been reduced to medium.*
- *The S47 visit by the CSC to Address 1 to see Chan and Child 1 and the subsequent completion of the Children and Families Assessment.*

The Panel noted that the police stated in their submission that the perception of an individual officer led them to understand that as the offender was being

supervised by the Probation Service under the MAPPA guidelines (and that the Probation Service would ensure the conditions of his Life License were being met) there would have been no value in referring the case to MARAC. Sections 22.19 through to 22.25 of the MAPPA Guidance, Version 4 issued in 2012 cover the relationship between MAPPA and MARAC and this assumption was incorrect.

The Panel noted that the submission made by the Probation Service stated that there was no evidence of any incidents that would require an assessment to be undertaken until Chan reported being the victim of abuse by the offender and this report to Offender Manager (OM) 6, as verified by the probation service, took place on the day of Chan's murder. It is important to note that the risk document was initiated during the week prior to the murder occurring because there was information shared with OM6 of a significant event, although this event was refuted at the time the information was made available (the offender refuted the allegation and Chan had denied that an assault had occurred). However, it was important for OM6 to reflect upon the possible repercussions of these events, whether they were true or not, and the possibility of a significant change in circumstances. For example, the potential for a breakdown in the relationship and anger on the part of the offender. OM6 engaged in a process of actions to manage the potential risk before completing the risk assessment document and also reflected on these circumstances with the Principal Offender Manager. The Probation Service, in their IMR submission, stated that the Police Service assessed the report as 'medium risk' on the basis of Chan denying that an assault had occurred. The Probation Service stated that it was only after the death of Chan that information was forthcoming about previous injuries as a result of violence perpetrated by the offender.

(b) <u>What actions did your agency take following these assessments?</u>

Following the Police visit to Chan on 1st March the Multi Agency Safeguarding Hub informed the Lancashire Probation Service and then, in turn, this information was shared with the Greater Manchester Probation Service, for the attention of OM6 (however this email never reached OM6 due to an incorrect address).

The information was shared with other agencies, in line with procedure. Lancashire Police spoke with Chan concerning their actions and provided encouragement and opportunities to pursue a complaint of assault against the offender, reassuring Chan that she would be protected. Officers informed her of and provided her with details of support organisations and gave the contact details for the officers. The officers also ensured that Chan had a safety plan, having put to her hypothetical questions relating to her personal safety. A domestic violence marker was placed on Chan's address so that responses to any call to the Police from the address would be treated as a Grade 1 emergency response, ensuring that patrols would respond and arrive there as soon as possible.

Although the Protecting Vulnerable People record was fully updated, and a marker was placed on the address, no intelligence was placed on the Sleuth Intelligence System.

A Children and Families assessment was commenced on the 3rd of March at a home visit by a social worker from the Children's Social Care service. This was in response to a Section 47 referral and, unusually in this case, this was not a joint visit as the police had already been out twice and therefore a single agency home visit was conducted. Chan and Child 1 were seen alone and did not convey any concerns regarding the offender. A strategy discussion took place in line with S47 procedures. It was known beforehand that the police had revised the risk to medium as Chan had denied that she had been assaulted.

Offender Manager 6 informed the Children's Social Care service when they became aware that a relationship between Chan and the offender had commenced. The Probation Trust informed the Panel that they were satisfied that the information sharing was sufficiently robust for that purpose. Prior to the completion of the OASys on the day that the murder occurred, an interim risk management plan was put into place. This plan included:

- *Informing the offender to have no contact with Chan until advised otherwise by OM6*
- *Contact with the police to ascertain further details concerning the allegation. OM6 was told that the assault had been denied but OM6 was still concerned considering the potential outcome of the disclosure and the impact this may have on the relationship between Chan and the offender*
- *Ensuring that the address of Chan was 'flagged'*
- *Making a telephone call to Chan to advise her of the concerns felt by OM6 and to question the denial of the assault*
- *Arranging a home visit to Chan in the following week and informed Chan that the offender had been told to not have any contact with her and that if he did then Chan should contact the police immediately*

OM6 had a discussion regarding recall immediately following the 'phone call from Chan on the day that the murder occurred, i.e. that Chan had in fact been assaulted by the offender. Additionally, OM6 contacted the police with regard to the need to visit Chan immediately.

KLOE 5:

Was your agency aware of any allegations of domestic abuse in relation to the perpetrator, the offender, and how did your agency respond?

Prior to July 2012, Lancashire Police did not know the offender. In July 2012 the Constabulary was informed by the Probation Service of the relationship between the offender and AF7. There were no reports of any incidents of domestic abuse between AF7 and the offender and there was no intelligence

recorded in Lancashire Police of any incidents of domestic abuse that the offender had been involved in within Lancashire.

The Police National Computer contains information about the offender's previous convictions and this information was considered by Police officers attending Address 1 when the initial assessment of the risk was set as high. However, at that time, there was still no reference on the local Police intelligence system to connect the offender with either Chan (or AF7)

The Probation Service and the prison service knew, of course, that the offender was a domestic abuse perpetrator and had detailed information about his previous history and convictions during the period under review and had been engaged with the offender for a considerable period of time in order to undertake work to address his management of relationships, his alcohol and drug use.

The Children's Social Care service was notified of the previous domestic violence issues associated with the offender's conviction and life licence by the Probation service in their referral dated November 2013. This stated that Chan was aware of his criminal history and murder conviction as she had attended some probation sessions with him. She was next visited at home by the Social worker as part of an assessment and confirmed she held knowledge as stated about him.

Following the second referral in March 2014 another home visit was made, by a different social worker. The panel noted the anomaly regarding the timing of the report of the broken jaw and the actual injury. Hence, when the CSC made their visit, Chan had no visible injuries, leading the social worker to believe the substance of the victim's retraction of the allegation of domestic abuse and injury. Chan had, in fact, been assaulted and suffered a broken jaw some weeks prior to the visit by the Children's Social Care service. However, because the social worker, as part of the section 47 investigation, did not contact the General Practitioner, this information was never confirmed.

Until the Protecting Vulnerable People referral was made on the 1st of March, none of the other agencies involved in this review knew that the offender was a domestic abuse perpetrator or that he had been convicted of a domestic abuse related murder.

The offender's GP knew nothing of his history until they were contacted to participate in this review. The panel considered this matter at some length. All offenders are registered with a GP when they are in prison. The panel considered that this should have been flagged upon his release. Moreover, at the point of release, the GP would or should have known that the offender had an offending history on the basis that the offender was registering with the practice from an "approved premises" address. It is not automatic that the GP would necessarily have referred any issues discussed during consultations through to the probation service. There is a possibility that issues discussed during consultations with the GP, if the GP had shared them with OM6, may

have triggered a conversation between the offender and OM6 during a regular supervision visit or a home visit to Chan.

East Lancashire Hospitals NHS Trust (ELHT) services were aware that Chan was in a relationship with the offender. However, they were not aware of the offender's criminal history or of the risk that he may have posed to Chan. Therefore, they did not have information that would have generated a specific domestic abuse risk assessment and specific domestic abuse responses in order to safeguard individuals. If there had been any concerns, ELHT staff had electronic access to the ELHT Safeguarding Children Policy and the ELHT Domestic Abuse Policy.

The staff at ELHT also had access to advice from one of the safeguarding practitioners during office hours and the hospital Independent Domestic Violence Advocate for advice and guidance.

There was no evidence made available to ELHT Staff to make them aware of any allegations of domestic abuse in relation to the offender. Therefore, there were no risk assessments or safety planning procedures carried out

Chan was known to Adult Mental Health services at Lancashire Care NHS Foundation Trust. No risks were disclosed regarding the offender. Until the receipt of the information from Lancashire MASH, the Children and Family Health Service had no knowledge of the offender.

Chan did not disclose domestic abuse when she presented at Pennine Acute Hospitals Trust with a fractured jaw, though she was with the offender at the time. Staff did not make any enquiry about domestic abuse because they did not have the opportunity to question Chan alone.

KLOE 6:

To your knowledge were Chan's family and friends aware of domestic abuse and were they offered support in responding? Were there any confidentiality issues in relation to family/friends being aware of domestic abuse?

6.1 Lancashire Police

Lancashire Police became aware that Chan had disclosed domestic abuse to a close relative, who then shared this information with her step-father.

Following Chan's death it became apparent that Chan had disclosed the abuse to a friend, information from the police statement is included below that provides an insight into what Chan was experiencing. This information was not known to any agency at the time that the abuse was taking place.

As part of the investigation, a witness made a statement indicating that they had visited Chan about one week after Christmas 2013. Chan's face was

described as badly bruised. Chan explained that she had fallen down stairs, but did not say when this had occurred. The offender was present during the conversation. The witness statement said that Chan contacted them in February 2014 admitting that the offender had assaulted her causing her to sustain facial injuries, and that she had made up the account of falling down the stairs. Chan also disclosed that the offender had assaulted her and broken her jaw, and that she had to go back to the hospital once the swelling had gone down. Chan further disclosed that the offender had twice '*held a knife to her'.*

Witnesses have provided statements in which they describe the gradual change in the demeanour and appearance of Chan during the period of her relationship with the offender. A reference was also made to the demeanour of Child 1 who was observed on the 16th of March by another witness who provided a statement. This person described Child 1 as looking 'down', as if Child 1 had the 'weight of the world on their shoulders'. These witnesses were under the impression that the offender was living at the address, but he did not interact with them. No one heard the sounds of any domestic arguments that would give rise to the police being called.

It is now apparent that Chan had been subjected to domestic abuse and violence over a period of months leading up to her death. Taking account of witness statements, it is apparent that Chan had disclosed this to a few people.

In a statement made to police by the offender's sister following the homicide, it became apparent that the offender had told her that he had hit Chan and broken her jaw. The offender's sister did not share this information with anyone until she made a statement to police as part of the criminal investigation.

6.2 Probation Service

During the disclosure interviews with Chan, there was an opportunity to assess what her support network consisted of. However, OM6 recorded that Chan was asked if she wanted anyone else to be told about the offender's conviction so that other agencies could support her and Chan declined this offer. There would also have been limitations concerning the extent of disclosures to a third party unless someone was deemed to be particularly vulnerable and at no point did Chan present as such.

KLOE 7:

Was the impact of alcohol, drugs or mental health issues properly assessed or suitably recognised. What action did your agency take in identifying and responding to these issues?

The offender was known to have used drugs and alcohol in the past and these factors were identified as triggers to his offending behaviour.

The assessment of the offender carried out by the drug and alcohol agency in prison, following his arrival, indicated that there was no further work to be done in addressing these. However, given that there had been a link between substance misuse and violence, the Inter-Departmental Risk Management Meeting proposed regular drug and alcohol testing. There is no available evidence that this was done to inform his risk assessment. The offender does not appear to have been selected for random testing nor is there any evidence to suggest that there was felt to be a need for suspicion testing at any point.

The offender's licence conditions included reporting of any issues with drugs and/or alcohol.

Chan reported that she, on occasions, consumed alcohol. She reported alcohol use to her GP and in her sessions with mental health services. She was not formally assessed in relation to her alcohol use nor did she receive alcohol treatment services. Chan's family reported that she did not have any drug or alcohol problems. Alcohol consumption is often used as a coping mechanism to deal with stress and mental health issues.

These two positions appear to demonstrate some degree of disguised compliance with regard to alcohol consumption, a situation, which is common across the whole population and to the offender and Chan. When health information is requested, there is a tendency to comply with certain expectations. This tendency toward compliance also casts doubt on the potential efficacy of home visits by Offender Manager 6 to determine the degree of alcohol consumption by the offender.

7.1 Lancashire Police

The Public Protection Unit officers who visited the home of Chan did ask her about the influence of alcohol and drugs pertaining to the offender. Chan stated that there were no issues concerning alcohol or other drugs. There was no evidence presented to the officers that either alcohol and/or drugs were a risk factor, though these issues were considered when taking account of the history of the offender.

7.2 Probation Service

There was an initial appointment made upon the offender's release to introduce him to the alcohol service. Following his release from Prison on life license, the submission from the Probation Service stated that the offender was tested for alcohol and drug use and was compliant with the conditions of his license, including the conditions of abstinence and the offender was compliant with his curfew condition. However, the submission went on to point out that prohibition conditions concerning 'substances' (alcohol and illicit/illegal drugs) could only be tested during approved premise residency. The submission stated that when someone on life license lives 'independently', reliance is placed upon self-reporting, observations during supervision, or third party reporting. It is the case that, because the offender

was abstinent at the time, no additional appointments were made for him by that agency.

The contingency planning within the Risk Management Plan incorporated strategies of how to respond if the offender returned to excessive consumption. With regard to the qualification of 'excessive', the Panel was told that this would not be specified in his license conditions and would be left to the professional judgement of the Offender Manager. The Panel was assured that this issue would have been discussed with the offender and he will have been subjected to rigorous questioning by his Offender Manager.

Despite alcohol being assessed as a critical factor in the offender's violence and controlling behaviour, the Probation Service submission stated that there appeared to be a reliance on self-reporting, partially due to an assessment in the early stages of licence, as already stated, that led to no further intervention by the alcohol services. As already outlined, however, it is likely that the offender would have been able to manipulate the home environment – his own home and the home of Chan – to ensure that information concerning the true extent of alcohol consumption could have been kept from the probation service.

7.3 GP Chan

Alcohol consumption was referred to in a number of consultations with Chan. A regular entry was: "advised about alcohol" but it is important to note that there is no record of actual consumption and it may be the case that it was just general advice that was given. A GP consultation in June 2010 records "no alcohol" and a consultation in the following November states: "doesn't take alcohol or drugs".

At a consultation in July 2013 Chan said that she drank three bottles of wine during the previous evening. Again this was not explored further. Patients with mental health issues may use alcohol or drugs to "self-medicate" and it would be good practice to consider whether drug or alcohol abuse is an issue in those presenting with mental health problems. It is also recognised that increased alcohol consumption heightens the risk of becoming a victim of crime or violence[11]

There are references to illegal drug use during the consultations with Chan. She told her mental health practitioner that she had bought Diazepam on the street.

Chan was prescribed a number of medications and she was referred to the Community Mental Health Team a number of times. She used a third sector counselling service. At times of 'crisis' her GPs always ensured she was given an urgent appointment and there appears to have been no delays in referral.

[11] Rossow, I. 1996; Room et al 1995.

Chan was prescribed Diazepam by her GP practice on ten occasions. The policy of the practice for prescribing this drug is a maximum of four weeks of Diazepam in any year. The potential for dependence was explained to Chan. Her request for further Diazepam was declined on four occasions. It would appear that the practice's policy of only four week's supply in a year was not strictly adhered to. However, the practitioners only prescribed a small number of tablets on any given occasion and at times there may have been no other viable option given her worsening mental state and the occasional necessity for rapid intervention.

7.4 Lancashire Care NHS Foundation Trust (LCFT)

The submission by LCFT stated that all practitioners considered that Chan engaged well with the service, that she was open about her difficulties and the possible solutions. It was reported that Chan had a positive relationship with the Counselling Service (a third sector provider).

The LCFT Children and Family Health Service was not aware of any drug or alcohol problems and not aware of Chan's emotional difficulties and self-esteem problems.

7.5 North West Ambulance Service (NWAS)

Chan's health status was correctly identified and documented on the Patient Report Form. A copy of this form was handed to the receiving staff in the Emergency Department of the Hospital Chan attended.

7.6 Pennine Acute Hospitals NHS Trust

Chan received an appropriate assessment and recommendations were made to her GP.

KLOE 8:

Were there are any specific diversity issues relating to Chan and/or the offender?

No specific diversity issues were reported to the Panel concerning the perpetrator or the victim in this case. Chan and the offender were both white British people. It is important to point out that Chan was, for a period of time within the scope of this Review, the primary carer for Child 1.

KLOE 9:

Were adult and child safeguarding issues suitably addressed by agencies involved with AF7, Chan and Child 1 or the offender?

9.1 Children's Social Care Services

The Children's Social Care service was informed by relevant agencies and followed safeguarding procedures. A joint discussion with Probation was undertaken and there was liaison with the assigned social worker during the early part of the relationship between Chan and the offender.

It is recognised that there were some missed opportunities for multi-agency working across county boundaries including the Multi Agency Public Protection Arrangements, more formal information sharing networks such as strategy meetings and Multi Agency Risk Assessment Conference, and that the referral in November 2013 should have led to a full section 47 child protection investigation which would have allowed for robust information sharing and gathering.

It has been noted that at both points of the referrals received, information sharing could have been more comprehensive and linked to the important safety network within the family of the victim.

Linked to this was the omission in alerting the father of Child 1 to the two referrals received because he was undoubtedly a supportive factor within the family. This is also the case for the father of the victim who not only ran a business with Chan but also made a referral relating to Domestic Violence to the Greater Manchester Police in March 2014.

The Children's Social Care service faced a number of challenges during the time leading up to the murder. This included the introduction of a new electronic recording system in March 2014 and difficulties faced in relation to the recruitment and retention of staff, though this is a national problem.

The Children's Social Care service has robust safeguarding policies and procedures to follow. However, as identified in November 2013, the safeguarding procedures were not invoked due to the classification of the referral as a 'child in need' assessment.

There is evidence of appropriate communication with both the Probation service and the Police in November 2013. However, no joint visits or strategy meetings were convened that would have assisted with the pooling of information. The GP was not contacted at any point within the management of either referral and the child's school was given only partial information.

9.2 Lancashire Police

In relation to the information provided to Lancashire Police in 2012, the period of time in which the offender was in a relationship with AF7, a Protecting Vulnerable People referral was not made and no police assessment was carried out on AF7 or her children. There was no intelligence within the Lancashire Police system relating to the offender's relationship with AF7. Lancashire Police identified no safeguarding issues in relation to risk from the offender.

The submission made by the Lancashire Police states that the service made efforts to safeguard Chan, despite her initial denial that she had been the victim of abuse.

It is important to note that during this time the Lancashire Constabulary followed their procedures pertaining to the management of suspected incidents of domestic abuse.

9.3 Probation Service

The initial Risk Management Plan did not include reference to the offender's children (they had become adults at the point of his release) but, as a part of the license conditions, there was active information sharing and risk assessments requested when the offender entered into a relationship with a woman who had children. In relation to AF7, there was, with other relevant agencies, a joint assessment and monitoring of risk.

In 2012 the offender began a relationship with AF7, who has three children. The Children's Social Care service completed an assessment of the children resulting in all children having 'Child in Need' status accorded to them. There was, subsequently, regular meetings and liasion between Offender Manager 6 and the Children's Social Care service.

With regard to Chan, following an assessment visit, no further action was taken regarding Child 1. OM6 sought written clarification from Children's Social Care as to why no further action was taken but there is no evidence that this clarification was received, nor was there any contact made with any other agencies that could have provided informal monitoring of Child 1. Children's Social Care, following their assessment of Child 1, concluded that Chan was able to safeguard Child 1, based on her presentation, and recommended no further action and closed the case.

9.4 GP Chan

The submission by the East Lancashire Clinical Commissioning Group (CCG) stated that, during Chan's long-term relationship with Child 1's father there was a number of consultations in the record documenting incidents that the author of the CCG submission felt should have given rise to safeguarding concerns. Chan was at times too tired to clean or cook, she felt she was unable to do as much for Child 1 as she would like and felt guilty about this. There were episodes where she was angry, snappy, had mood swings and argued with Child 1's father. Fourteen consultations mention issues with anger and rage, with violent thoughts.[12]

The CCG submission goes on to state that, from July 2013 onwards, Child 1 lived with their father as Chan Had difficulty coping with her and her GP thought she was transferring her anger towards her ex-partner onto Child 1.

[12] It is known that 3/4 of all domestic violence incidents are witnessed by children (Royal College of Psychiatrists, 2004).

Three consultations noted that Child 1 was safe with their father. It should be stressed that Chan continued to see Child 1 regularly and stated she would never harm Child 1. The practitioners interviewed as a part of the CCG submission stated that, at times of crisis for Chan, they ensured Child 1 was safe. The recording of these safeguarding actions was inconsistent.

The CCG submission stated that whilst Chan was not, by strict definition (i.e. in accordance with the Lancashire County Council policies pertaining to the safeguarding of adults), a "vulnerable adult" she could certainly be considered as "vulnerable". The possibility that Chan may have been experiencing domestic abuse was not considered or assessed, despite her history of abusive relationships, her emotional difficulties, and her self-esteem issues.

9.5 East Lancashire Hospitals NHS Trust (ELHT)

ELHT Hospitals NHS Trust staff did not identify any adult or child safeguarding concerns. In April 2013 Chan arrived at the Emergency Department and was admitted to a ward due to what was described as ‘an impulsive overdose’ and soon afterwards discharged home. It is not documented if staff asked Chan if she had any dependent children and therefore, no safeguarding children concerns were highlighted. The GP was notified of this admission by letter.

The Panel noted that the staff employed by ELHT have received domestic abuse awareness training, which is incorporated into their training regarding the safeguarding of children.

9.6 Lancashire Care NHS Foundation Trust (LCFT)

Safeguarding children assessments were in place for Chan. However, the IMR author noted some gaps in the updating of the assessments and questioned whether conversations had taken place with Chan regarding Child 1.

In one assessment, in April 2013, despite the information being recorded in the assessment form, the Mental Health Liaison Practitioner had not fully completed the safeguarding assessment form. It was also identified that a safeguarding assessment form was copied from one assessment (undertaken in August 2013) to the next assessment (in February 2014). This was discovered because it stated in the form that Child 1 was at a Primary School in August 2013 and again in February 2014 when Child 1 was beyond primary school age. This indicates that the safeguarding assessments were not discussed openly with Chan on each assessment.

The Children and Family Health Service contributed to the safeguarding process for Child 1, particularly in relation to the Child Protection Conference and the Lancashire Multi Agency Safeguarding Hub (MASH) processes.

The Lancashire Care Foundation Trust (LCFT) submission noted a delay in the School Nurse review of the MASH information. There was an expectation

that MASH documentation should be reviewed weekly. The LCFT investigation, completed as a part of this Review, has not been able to establish exactly why this did not happen, although it appears that this may have been due to a communication pathway not being robust and a resource capacity issue in the team. On review of the records, the School Nurse could have made more timely enquiries with the school regarding Child 1's health and wellbeing as two weeks had lapsed before she contacted the school. This, however, would not have led to a further intervention by the School Nurse, as the school raised no concerns when the enquiry did take place.

There was a Section 47 referral made within Lancashire MASH and a home visit was made by Children's Social Care service to assess Child 1. There is nothing in the CSC records to indicate that the CSC contacted the Children and Family Health Service at LCFT for information to support the Section 47 enquiry that had commenced. This would have highlighted the need for the School Nurse to review the documentation. However, the School Nurse could have acted by contacting Children's Social Care directly. However, due to the delay in reviewing the MASH documentation, this did not take place.

With regard to the MASH, the Panel benefited from a thorough discussion of its protocols and performance during the time leading up to the incident with the MASH Co-ordinator, who attended one of the meetings of the Panel.

KLOE 10:

Were there any issues in relation to capacity/resources in your agency that had an impact on your ability to provide services to Chan and to work effectively with other agencies?

10.1 Probation Service

The submission made to the Panel by the Probation Service highlighted issues concerning the number of offender managers who held responsibility for the offender's case, both during his time in custody and during community supervision. However, no issues with regard to capacity were highlighted that would, in the judgement of the Probation Service author, have had an impact upon information sharing and working effectively with other agencies. It is important to note that when Offender Manager 6 was managing the offender they were, according to the workload management tool, operating at 160% of their workload capacity.

However, the submission went on to state that serious understaffing in one Local Delivery Unit resulted in OM6 being asked to move temporarily to this office to assist with covering vacancies. This is the time that OM6 assumed responsibility for the management of the offender's case. OM6 maintained responsibility for this case when they returned to their original workplace. Whilst this was assessed by the Probation Service author as positive for the offender (it enabled continuity), the case transfer process which would ordinarily result in immediate listing for annual lifer reviews within the MAPPA

level 1 Risk Assessment and Management Arrangements, was not undertaken. This resulted in a lack of independent management risk oversight and risk management planning. OM6's workload then increased to over 160% on the workload management tool in November 2013. This is the time when the offender disclosed a more intimate relationship with Chan. Significant workload pressures may explain the delays in gathering the required information to make a timely referral to Children's Social Care service, and for the lack of pro-active or expedited liaison with partnership agencies in this case.

10.2 Lancashire Care Foundation NHS Trust (LCFT)

In March 2014 the Children and Family Health Service team were below capacity for the school nursing service. This was due to a vacancy in the team. This had been addressed, to some extent, by two days cover being provided by another team. The Health Visitors in the team were also taking allocated work in relation to primary school referrals. The communication pathway within the team did not support efficient sharing of information. The LCFT review author noted that this issue will be reviewed as part of the single agency action plan.

10.3 Magdalene Project

The manager of the service explained that the demand placed upon the service is manageable and they have no significant concerns regarding capacity or resource availability. Confidentiality is fundamental to that process. Their policy regarding disclosures was in line with the NHS, and they had robust safeguarding procedures in place. They have regular management meetings and are always reviewing their practice. A significant proportion of referrals to the service come from local GPs and the local NHS mental health services.

The service manager explained that all counsellors are fully trained to advanced diploma level and they do 30 hours per year of training on top of this. This included being part of a multi-agency training network and links to a local women's refuge.

Children's Social Care service (CSC)

The CSC Service identified in their IMR some of the challenges that they faced at the time. This included the introduction of a new electronic recording system, in March 2014, and the difficulties faced in relation to the recruitment and retention of staff, which is a national problem.

KLOE 11:

Was information sharing between agencies appropriate, timely and effective?

11.1 Lancashire Police

The Protecting Vulnerable People referral submitted by the Lancashire Police was in line with force policy. This was forwarded to the Multi Agency Safeguarding Hub who shared the information with agencies in a timely manner, allowing agencies to review their own records. Information was shared with Lancashire Probation Service and it was anticipated that the service would signpost the information through to the appropriate Probation Service office in Greater Manchester. However, this did not happen.

The Protecting Vulnerable People referral that took place on the 1st of March was sent electronically to agencies. However, an incorrect email address resulted in the referral not reaching OM6, thereby a crucial piece of information regarding the offender's abuse of Chan was not communicated. This would have alerted OM6 to the offender's risk to Chan that could have resulted in the consideration of recall.

The Police Sergeant within the Multi Agency Safeguarding Hub passed the referral through to the Public Protection Unit so that arrangements would be made to visit Chan, which officers did on the 3rd of March. The results of that visit were transcribed and appended to the Protecting Vulnerable People referral and the referral was then altered from High Risk to Medium Risk.

11.2 Probation Service

Offender Manager (OM) 6 was allocated the report concerning the offender at the point when the Parole hearing was being prepared. There was both a file review and contact with relevant professionals within the prison at this time, in order for OM6 to develop a working knowledge of the offender's situation and general progress. There was good internal liaison with the Victim Liaison Officer.

The submission made by the Probation Service identified a gap concerning liaison with the Police Service. The offender's tariff date (the precise date set for when the term of imprisonment comes to an end) was brought forward due to a late re-calculation of dates (to include remand already served) and although there is a Joint National Protocol (JNP) with the Police, the Police were not informed of his release, nor were they informed that the offender has been subject to ROTL. According to the author of the probation trust IMR, this was not in line with the Probation Service information sharing agreement and not good practice.

When the offender disclosed that he had begun a relationship with AF7, OM6 was pro-active in gathering all details pertaining to AF7. OM6 immediately contacted the Police and requested a joint visit to AF7's home address so that a full disclosure of the offender's conviction could be made. However, Lancashire Police responded by stating that they did not have the staffing to resource such a visit at that time. The result of this was that AF7 received a formal disclosure just less than six weeks later.

The Probation submission goes on to state that a Children's Social Care referral was not completed until seven weeks later. All necessary actions were eventually undertaken, albeit later than expected.

The Probation submission refers to some provision being included in the Risk Management Plan (RMP) for the Police Public Protection Unit to provide enhanced supervision and monitoring of the offender. This remained in the RMP at the review stage. However, there is no evidence of active Police involvement within the case.

When the offender disclosed to OM6 that he had met Chan, despite there being active liaison between the Offender Manager, Children's Social Care and the Police in relation to the previous relationship, there are no records which detail any information being provided to flag the relationship nor make any form of regular contact with Chan. This remains the case throughout the offender's relationship with Chan. Good practice suggests joint assessment and monitoring should occur, and although a referral was made to Children's Social Care, there remained a lack of pro-active information sharing and joint risk management planning with Police in respect to Chan. Offender Manager 6 was unable to offer any explanation for this omission. No specific domestic abuse liaison was made until the period immediately preceding the murder of Chan. It is relevant to note, however, that even if regular contact had been made between some or all of the agencies, there was at the time only limited information to share and there was no verified record or report of an assault taking place.

In the submission made by the Probation Service, there is an expression of concern because, following the report of Chan being assaulted by the offender (whereby Chan sustained a broken jaw) and when information was requested by the Multi-Agency Safeguarding Hub (MASH), a nil return was submitted which stated he was not known to probation. This was because the request was sent to the wrong probation office (i.e. to Lancashire Probation Office rather than Greater Manchester). Chan lived in Lancashire and the offender was subject to supervision by Greater Manchester Probation Trust (GMPT). There was no evidence of any liaison between Lancashire Probation Trust and Greater Manchester Probation Trust.

This is despite the request clearly detailing that the offender had been released on life licence in 2012. If Offender Manager 6 had provided details of the offender's and Chan's relationship to the Police in Lancashire, this may well have alerted them to the involvement in the case of the Probation Office in Greater Manchester and may then have allowed for direct contact with the case manager and/or for an alert to be passed to the local representative in the Multi-Agency Safeguarding Hub (MASH). However, the request was sent to the probation representative in the MASH, which in this case was an administrator in Lancashire, and following a check of their systems for the names of those involved, the nil return was submitted.

The Probation submission goes on to state that this situation should no longer occur due to the introduction of an electronic recording system (nDelius) that allows access to a national search of data rather than a local search of data.

The submission by the Children's Social Care service stated that verbal information sharing across agencies was good but that written documentation from Probation and Police was not readily available.

However, the Panel noted that the Probation Service made a referral to Children's Social Care (adding to a history of referral concerning the offender and AF7 and the children of AF7) and that the Probation submission stated that all available information would have been shared. There was an acknowledgement that the sharing of Police and Probation information via the Multi Agency Safeguarding Hub requires review.

According to the submission made for the GP, it appeared that Chan's GP practice were completely unaware of the offender's history and the episodes of violence towards Chan. From the information provided by other agencies to the DHR panel it is clear that a number of agencies held some highly significant information that had not been passed on to Chan's GP.

The Children's Social Care service saw Chan in November and December 2013 due to the referral from Probation about her relationship with the offender. Her GP was not informed about these concerns. However, it would not be usual practice to inform the GP in these circumstances and there is no usual conduit from the Multi Agency Safeguarding Hub directly to the GPs involved in the case.

The submission by East Lancashire Hospitals NHS Trust (ELHT) stated that there was good practice concerning information sharing between the GP and ELHT regarding Chan's health needs. However, since there was no information shared with ELHT by any other agency about domestic abuse, no information was shared on this issue.

11.3 Lancashire Care Foundation NHS Trust (LCFT)

On each assessment, conducted by Lancashire Care Foundation NHS Trust, the GP was sent feedback. Staff did not contact the Health Visitor or School Nurse as they had no concerns about Child 1 and there was no reciprocal contact from them. Child 1 was in receipt of School Nurse Services.

The Children and Family Health Service were not aware of Chan's involvement with Adult Mental Health Services. At the time of the incident, the records held by Adult Mental Health Services were electronic and Children and Family Health Service were in paper form. There was no linkage between the systems that would have allowed for either service to see who was involved with the family and subsequent information sharing.

It is recorded in Children and Family Health Service records that the Health Practitioner in Lancashire Multi Agency Safeguarding Hub (MASH) contacted

the Children and Family Health Service to request that information should be shared and done so within the expected timescales. The Health Visitor service provided the information within the agreed timescale. However, the information shared with the Health Practitioner (as recorded by the Health Visitor service) does not reflect the information recorded by the Health Practitioner within Lancashire MASH.

Because the Children and Family Health Service was not aware that Adult Mental Health knew Chan, they did not share information about their involvement.

KLOE 12:

Were there effective and appropriate arrangements in place for risk assessment and escalation of concerns?

This line of enquiry effectively asks agencies to consider the functionality of their risk assessment procedures. It is important to note when considering the responses to this enquiry that not all agencies completed a risk assessment and, hence, not all agencies could respond to this question.

12.1 HM Prisons

Prior to moving to Her Majesty's Prison (HMP) Kirklevington Grange the offender's risk factors were identified as: use of violence; substance misuse; use of weapons; cognitive skills deficits; relationship difficulties; and poor coping.

Whilst at HMP Wakefield, he completed the "FOCUS Programme" (concerned with drug and alcohol use); a "Prisoner Development and Pre-Release" (PDPR) programme and also an Alcohol Education programme. The offender also undertook the Enhanced Thinking Skills programme but failed to complete the post course objectives and his action in throwing away this material from the course was suggested to have been 'impulsive behaviour'.

The post programme report commented that despite being "a quiet member of the group…it was evident that he had progressed well during the course and clearly had the ability to continue to improve". His progress generally, at this early stage in his sentence, was reported to be mixed. Work and education reports suggested that he was "lazy" and on occasions he demonstrated "an immature approach and a less than constructive attitude to staff. The offender described feeling frustrated with the system and the slow progress with his sentence plan…"

At Her Majesty's Prison Gartree the offender completed the Cognitive Self-Change Programme (blocks 1 to 4 and also commenced Block 5, concerned with relapse prevention, which he continued at HMP Kirklevington Grange) and the Healthy Relationships Programme. The Cognitive Self Change Programme Block 5 progress report states that the offender "demonstrated

his continued commitment to the process of self-change", although he accrued a further adjudication at this establishment two years prior to commencing Block 5. There are no further reports of impulsive or immature behaviour. At this point he renewed contact with his father and "abandoned most of his friendships with past associates". His seconded Probation Officer is reported to have assessed him as medium risk of serious harm but he remained High Risk to Known Adult on OASys throughout his time in custody.

At Her Majesty's Prison Wolds he completed the Cognitive Skills Booster Course. The post programme report stated that the offender "has a very good understanding of how the course material is relevant to his own life and that he is trying to implement the skills that he has learnt".

At HMP Kirklevington Grange, the focus was on resettlement. He continued to address violence via Block 5 of the Cognitive Self Change Programme with psychology. He was encouraged to improve his employability and to seek paid employment. He was also supported and monitored very well by his Offender Supervisor during his first visits back into the community both in terms of re-kindling family relationships and accessing appropriate accommodation for Release On Temporary License (ROTL) and eventual release (to Approved Premises).

The offender's behaviour and attitude at Kirklevington reflected learning from the programmes he had undertaken and this was reinforced by his ongoing engagement with Block 5 of the Cognitive Self Change Programme. It is understood that Block 6, which was to be completed following release, was not implemented. The psychologist delivering Block 5 at Kirklevington made an offer to support this delivery but this was not responded to. This is seen as a crucial intervention in managing any ongoing risk in the community as it holds the offender accountable and reinforces the work done in custody on strategies for self-management.

12.1 Lancashire Police

The Multi Agency Safeguarding Hub (MASH) was established in Lancashire on the 1st of April 2013. The MASH facilitates the risk assessment and escalation of concerns around cases. Lancashire Police use the ACPO DASH risk assessment tool that provides a series of questions to ask the victim of domestic abuse in order to assess the level of risk posed to the victim and their children. The assessment was not carried out in this case as Chan refused to answer the questions. All Lancashire Police Officers are fully trained and aware of how to complete the assessments and escalate any concerns they may have

Although Chan did not complete a DASH risk assessment, the police officers who visited her at home used their experience and professional judgement to rate Chan's risk as 'high'. This was later altered to 'medium'.

12.2 Probation Service

The submission made by the Probation Service stated that there was evidence, from the supervision notes recorded between OM6 and the Probation Operations Manager, that the case was discussed. However, the submission stated that at no point was there a decision to refer into the Risk Assessment and Management Arrangements (RAMA). This point was clarified at the meetings of the DHR panel and it was confirmed that the case was reviewed in RAMA throughout the offender's time in custody and up until the case was transferred to the probation office in Greater Manchester. There was a risk management plan in place. The only element that could be considered as missing from this plan was purposeful home visiting but the efficacy, or otherwise, of these has already been highlighted.

There are two managers responsible for the line management of Offender Manager (OM) 6; neither of the managers had extensive experience in the management of Offender Managers who had case responsibility for high risk or 'lifer' cases. This does not detract from their own professional experience of offender management. There is evidence of management oversight and support for the offender manager when the offender is presenting with challenges to his license.

The Probation submission suggested that there may have been a degree of complacency within the offender management process and that this led to a lack of continuous analysis and assessment; and that the missed appointment (at Christmas and New Year 2013/2014) did not prompt a greater exploration as to why contact was not made by the offender and why there was no attempt to verify the offender's account for not attending. However, this was the first time in nearly two years of probation that the offender had missed his appointment. The Panel considered that it may have been considered as being of greater concern, particularly because the missed appointment was during a holiday period when risks may become more acute, if this event had been a continuation of behaviour that resulted in the offender avoiding contact with OM6.

Whilst the Risk Management Plan stated that the OASys would be reviewed every 16 weeks, this did not happen and the submission from the author of the probation trust IMR considered this to be a missed opportunity for review of the changes in circumstances around the offender that may have necessitated further risk management strategies or offence focused intervention work to be implemented. The Panel considered that the significant missed opportunities for reviewing and updating the OASys included the start and ending of the offender's relationship with AF7 and the start of the relationship with Chan.

After a period of time on license in the community, the submission suggests that there is more of a reliance on appointments with the offender and on his self-reporting behaviour as being sufficient monitoring. In part, it is suggested that this was due to the perception of the offender being honest and open about his relationships. The working relationship with Offender Manager 6

was based upon their trust of the offender, which, in turn, was based on assumptions that he would manage his relationship with Chan in the same way he had with AF 7.

This lack of stringent monitoring and challenge led to a lack of awareness of any issues that may have had an impact upon robust assessment of risk. However, what information could have been sought by OM6 and then shared with others is still open to question. Whilst there may have been a lack of robust checking, the offender had been out of prison for two years, had successfully negotiated the end of one relationship and there were no known vulnerabilities pertaining to Chan.

The offender disclosed information concerning the allegation of assault to OM6 on the 12th of March. When information was shared by the Police on the 13th and 14th March 2014, OM6 immediately discussed the potential for recall with their operational line manager and liaison took place with the Assistant Chief Executive of the Trust. It has been noted by the DHR panel that, in order to satisfy recall in relation to an indeterminate sentenced offender on life licence:

> "*their behaviour must indicate they present an increased risk of serious harm. This can either be where the risk has been clearly demonstrated or where the risk cannot be measured, for example where the licensee fails to report on a regular basis or is out of contact entirely.*

The Recall can be effected where an offender:

1. *Exhibits behaviour similar to behaviour surrounding the circumstances of the index offence (a causal link);*
2. *Exhibits behaviour likely to give rise (or does give risk) to the commission of a sexual or violent offence;*
3. *Exhibits behaviour associated with the commission of a sexual or violent offence;*
4. *Is out of touch with probation and the assumption can be made that any of (i) to (iii) may arise"* (Part A, Request for Recall Document).

The recall decision making process was described fully in the Probation service IMR, thus:

On the 12th of March the offender made the disclosure concerning the allegation made by Chan. The offender was told not to have any contact with Chan until further information and facts could be established regarding any criminal offence. A discussion occurred, immediately following the session with the offender, with a colleague since no senior manager was available in the office at that time. A telephone call was made to the Police to establish the existence of any report or investigation into the alleged broken jaw. There was no one available in the domestic abuse unit at the Police service.

On the 13th of March there was a telephone call to the Police and again there was no response from the domestic abuse unit. Consequently, an email was

sent. A discussion occurred with the Principal Offender Manager to look at the potential for recall. The decision was based on self-disclosure as there was no evidence of any injury taking place.

The decision not to recall was made because there was no evidence at this point of any report to the Police of an allegation of assault. There was concern that the offender may have been "testing the water" by assessing if the Probation service was aware of any information pertaining to such an allegation. However, the Probation services needed clarification that there was in fact an injury.

There was an agreement for an interim risk management plan, due to concerns for the safety of the victim. This was based upon the potential relationship breakdown and the risk of volatility given the allegation - false or otherwise. Further instruction was given to the offender by 'phone that he must not make any contact with Chan until the Police had been spoken with'. Contact was made with Chan and a voicemail message was left that detailed the Probation service concerns for her safety given the allegation and the fact the offender had been informed not to contact her and if he did she should speak with the Police. Further review regarding recall was to be made once the Police information had come through.

On the 14th of March – the Probation service had a conversation with Police. The Police stated that Chan had been visited by officers who noted no signs of any injury and detailed that she refuted any injury had been perpetrated against her.

It was felt that she gave a plausible explanation for her report to the family (who then contacted the Police) on the basis that she believed the offender had been having a relationship with another woman and knowing him to be on licence wanted to exercise an element of revenge. However, it is possible that the realisation of the gravity of this scenario may have had an impact on Chan's willingness to go through with a formal report. During the initial visit by Police officers, Chan did not state to the Police that an assault had happened; though the Police had overheard this statement made by Chan in whispered tones to her mother, resulting in the initial assessment of High Risk. A domestic abuse response marker was consequently put on the house.

A telephone call was made to Chan – and it was re-iterated that she had lied to the family with regard to the assault and it was based on a rumour that the offender was involved with another woman. Chan stated that she now knew this was not to be true and wished to reconcile the relationship.

Chan was advised that the offender had been instructed not to make contact until after the Probation service had made contact with Chan. An appointment was made for the following week (due to leave commitments). Chan was aware that the police had a response marker on the address and to call 999 should the offender attend Address 1.

There was no defensible position allowing for recall to custody since the

information made available at the time appeared be a malicious allegation of assault.

The day of murder - Information was received that Chan wanted to formally report an allegation of a broken jaw, having previously denied that this was a false allegation and stressing that the offender was present in the property when Police had previously called leading to the denial. Police made contact with Chan but deferred a visit on the basis of Chan stating that Child 1 would be home from school. Chan phoned Offender Manager (OM) 6 to express that she may retract her disclosure again due to the attitude she perceived that she had been treated with by the Police. This information was shared with the Lancashire Constabulary who undertook an investigation of the incident and reported to the Panel that the receiving officer had been spoken to and suggested that they had attended to the call in a professional and appropriate manner. OM6 encouraged Chan to give a full and honest account due to the gravity of the matter, which she did, and that OM6 would be seeking to take action to ensure her safety. Chan was advised to go to her father's to keep safe in the meantime, but it is now known she remained at home, Address 1. A telephone call was made to Police to visit immediately with a view to gaining a statement and recalling the offender back to custody.

Of significance to the decision concerning the potential for recall was a discussion with Chan and the information that she made the allegation to her family about the offender assaulting her due to her belief that he had cheated on her. Chan knew that there would be extreme consequences for the offender if she pursued the allegation of assault (bearing in mind that it is likely that Chan was afraid of the offender and frightened that he would kill her). This could have been assessed as an acute factor linked to risk on the basis that the offender committed the first offence following his relationship breakdown. However, a discussion with line management on two occasions in the week prior to the incident occurring concluded that recall was not appropriate because the acute risk factor (a relationship ending) had subsided. Chan then stated that the offender did not cheat on her and therefore the imminent risk of relationship breakdown (a causal link) would not allow recall to be supported.

However, it is clear that an interim risk management plan – including a discussion with Chan concerning her need for self-protection – was established and implemented.

Additionally, the offender was considered able to negotiate the end of a relationship (as with AF7) with no serious harm being caused and there was some expectation that he could do this again, so long as he was not drinking. Instead of recall the decision of managers was to impose a self-monitored restriction with regard to the offender not going to the property of Chan over the weekend. It is not clear from the records if this message was passed to Chan or to the Police to monitor. Information received by the Panel suggests that the information shared with the Police resulted in greater oversight and that the constabulary put in place a marker for response. There was still a

delayed action but because the OM pushed for a visit to occur, the visit did take place.

The submission made by the Probation Service states that there was no consideration of a discussion with the National Offender Management Service (NOMS) when an internal management consultation was being undertaken with regard to recall. The submission noted that it is sometimes a difficult decision to make when the test for the recall of a life sentenced prisoner is not based upon a further charge and that in this case there was the added complexity of Chan denying the allegation made by a third party. Whilst there is no evidence this would have changed the course of action, having an independent view may have assisted in the decision making process. In this regard, it is important to note that there was a discussion with the Assistant Chief Executive at the time and this was an independent view.

The submission made by the Probation Service then goes on to note a number of sub-sections, thus:

1. Breakdown of risk assessments: Start of the Licence, April 2012:

The OASys was completed on time by OM6 and the Principal Offender Manager noted, in countersigning comments, that it was a "very good OASys". The Risk of Serious Harm (RoSH) levels were assessed as correct and the circumstantial information was up to date and very detailed.

There was no review of OASys when the offender left the approved premises, started his first relationship with AF7 or when they separated; or when the offender commenced a relationship with Chan. The author of the Probation Trust IMR stated: "the only review is done to reduce the RoSH to medium".

2. Reduction to Medium Risk of Serious Harm (RoSH), November 2012

Offender Manager (OM) 6 set the offender's risk to 'high' on release from custody because he was 'untested' in the community. The offender responded well to the Approved Premise regime, there was no evidence of alcohol or drug issues, he was keen to work and appeared to be dealing with a relationship appropriately. The reduction to medium risk appears appropriate. This is the last OASys prior to the Serious Further Offending Review (SFOR).

When the offender separated from AF7, the OASys was not reviewed because the Offender Manager considered his situation did not warrant raising the RoSH to 'high' due to the lack of acute triggers. The offender then commenced a relationship with Chan. The offender's situation was considered to be the same as in the last OASys – he was in a relationship with a woman, with children, but not living with her. There were no known relationship concerns, no alcohol or drug use and no Children's Social Care involvement.

Closer to the incident that led to the murder of Chan, there were concerns and changes happening when the offender was reaching a high risk of serious harm (in mid-March 2014). When the allegation was made by Chan-SF, OM6

immediately discussed the potential for recall with their operational line manager

In the view of the author of the Probation Trust IMR, whilst there was no formal charge, it could be assessed that the offender had exhibited violent behaviour indicative of an escalation in the risk of serious harm. However, there was no information provided to the probation service that included the conversation overheard by the police officers between Chan and her mother describing that Chan had sustained a broken jaw following an assault by the offender. The information provided stated that, following a third party report, officers visited address 1 and there were no signs of assault and Chan denied the allegation stating that she had not been abused by the offender. This information leads to the conclusion that there was not a manifestation of violent behaviour by the offender.

Of significance to the decision was the discussion with Chan and her disclosure that she made the allegation to her family due to her belief that the offender cheated on her. Chan stated that she knew there would be extreme consequences for the offender should Chan detail an assault. This could be assessed as an acute factor linked to risk on the basis that the offender committed his index offence following the breakdown of a relationship. An interim risk management plan had been put in place because relationship breakdown was considered as an acute factor for the offender's behaviour. This demonstrates that there were concerns for the safety of Chan, however, despite relationship breakdown being an acute factor, recall of the offender could not have been defended at this time.

Further discussion with the Probation Operations Manager on the 14th of March concluded that recall was not appropriate because the acute risk factor of the relationship ending had subsided. Instead of recall, the decision of managers was to impose a self-monitored restriction with regard to the offender not going to the property of Chan over the following weekend.

However, at this point the Offender Manager was occupied with undertaking risk management actions that were urgently required, including liaison with the Police. Therefore Offender Manager (OM) 6 was responding to the rise in risk appropriately and prioritising actions over formal re-assessment. The author of the submission from Probation states that they would not expect an OASys review to be started until these immediate urgent actions had been completed and the imminent risk was averted or contained.

With regard to the offender, the Panel noted that the Probation Service stated that, whilst the offender's risk was assessed as 'high', he was manageable in the community. The Risk Management Plan (RMP) initially constructed by the Probation Service at the point of release included the requirement to reside in approved premises with a 'no alcohol and drugs condition'; a contingency plan should the offender relapse into problematic alcohol consumption or break his protective victim conditions; and a dual assessment with alcohol agencies and the Police Service prior to or in conjunction with any consideration of recall or additional license restrictions.

3. Pre-Parole Risk Assessment and Management Planning

When initially assessed within OASys, the offender is assessed as posing a high risk of serious harm. A release Risk Management Plan was constructed including the following elements:

- *A Multi Agency Public Protection Arrangements (MAPPA) Level 2 referral to be made nearer release, if needed;*[13]
- *the need to address alcohol/drugs, via the Prison Drug and Alcohlol service and community agencies (including OM liaison);*
- *to link with housing when release is being considered;*
- *liaison with Police to ensure multi agency working;*
- *completion of Cognitive Self Change Programme and one-to-one victim work, if available, and assessed as suitable;*
- *the need for additional licence conditions to be considered nearer to release including attending appointments with alcohol and drug agencies; offending behaviour programmes; non-contact with the victim's family; informing the OM of developing relationships.*

The Panel noted that the Probation Service submission made a specific note concerning the lack of reference to the need to liaise with the Victim Liaison Officer (VLO).

The Panel were told that all relevant information was passed to the VLO. However, the Police stated that the first they knew of the offender's release was via the father of the victim of the index crime. This occurred because the father had been informed of this by the VLO. This in itself may not be relevant to this review, but a learning point may be raised by the relevant bodies in this case questioning the use of joint national protocol documentation. The point concerning a separate notification procedure has been verified by the fact that the Panel were told that the Police record the license conditions of released prisoners on the Police National Computer (PNC) and that the Police are notified automatically by the Prisoner Information Notification (PIN) system.

Offender Managers became more actively involved in risk management at the time of release on temporary license (ROTL). The Risk Management Plan defines additional agencies and individuals involved in the plan, including liaison with the Police concerning temporary release as well as residency within probation approved premises (the location of which is considered after giving due thought to the family of the victim).

OM6 completed a review of OASys in September 2011 incorporating a Risk Management Plan (RMP) for release. The RMP included:

- *A home area exclusion zone;*
- *Non-contact with the victim's family;*
- *Approved premises residency;*
- *A no alcohol and drugs condition;*

[13] MAPPA guidance concerning 'lifers' Changed during the period of time that the offender was in custody

- *Active management oversight via level 1 Multi Agency Public Protection Arrangements meeting prior to release;*
- *Contingency plans should the offender relapse into problematic alcohol consumption or breaks protective victim conditions (the latter including dual assessment with alcohol agencies and Police prior to or alongside consideration of recall or additional restrictions);*
- *A curfew to ensure additional monitoring during the early phase of his release.*

4. Treatment Interventions

In 2002 the offender was assessed as suitable for the Cognitive Self Change Programme (CSCP) at HMP Gartree. The pre-programme assessment phase for this includes completion of the Hare Psychopathy Checklist (revised) (PCL-r). The offender recorded a score of 25. A score of 30 or more would have resulted in further referral for assessment regarding Personality Disorder or assessment for the Dangerous and Severe Personality Disorder Programme.

There is evidence of bespoke intervention work focusing on risk factors. Additionally, there is a central psychologist whose job is to provide support for Offender Managers to assist offenders completing the CSCP on licence.[14] However, the Panel noted that the submission referred to this service being "patchy". The psychologist noted that it is important that Block 6 is completed for programme integrity, but this was not available or done. Offender Manager 6 stated in the submission that they were intending to build on the offender's learning from Block 5 as it was indicated this was important at the parole hearing. However, the Offender Manager recognised this was an "over-promise which could not be fully delivered…" The Psychologist who had supported the offender within Block 5 of the CSCP offered to help the offender manager with the post-release phase of the programme, i.e. Block 6. It is important to note that there was a significant amount of offence focused work undertaken upon the offender's release from custody.

5. Parole Risk Assessment

In 2002 a Senior Registered Psychologist completed the PCL-r, during the assessment process for the offender's enrolment on the Cognitive Self Change Programme (CSCP). The offender scored 25 out of 40. Whilst not significantly high, it is high when compared to the normal adult male offender population, including those who have committed violent offences. This report would have been placed in the prison psychology file and passed to prison psychology departments as the offender was transferred. However, if the receiving prison does not have a psychology department, as in the offender's case, the Serious Further Offence author was informed that the report would be sent to be filed centrally.

[14] It should be noted that the CSCP is now referred to as the "Self-Change Programme".

The Parole Dossier was assessed as an "extremely thorough document, comprehensively summarising progress made throughout the offender's time in custody". There were a relevant number of proportionate and necessary restrictive conditions imposed that addressed relevant risks within the community and to protect the victim's family from unwanted contact. Contingency planning was evident within the risk management plan section, especially in relation to problematic alcohol consumption and contact with the family of the index victim. A condition was requested within the oral hearing pertaining to a requirement to disclose developing relationships.

The potential risk to children was not separately analysed. The author of the Probation submission considered this to be of some concern as there was still a requirement to consider a risk to children that may result from the offender entering into a relationship in the future. It is important to note that the offender's children were all of adult age at the point of his release from custody. The offender manager in this case was cognisant of the safeguarding issues associated with children witnessing domestic abuse.

The offender's OASys Violence Predictor (OVP) was assessed as low (27%) whilst at HMP Kirklevington Grange. This suggested that the imminence of specifically violent offending was low. This would initially lead to a consideration that risk of serious harm had reduced to a manageable level. However, OM6, who had only just commenced management of the offender's case, chose to override this with professional judgement and retained the offender as high risk of serious harm because he was ultimately untested (particularly regarding relationships) until released. However, combined with additional protective and support conditions available for release, the conclusion was reached that the offender's risk, despite still being assessed as high by OM6, was manageable in the community.

The Serious Further Offences review author commented that:

> "if he was "medium risk" of serious harm at Parole, then he would not be able to get into an Approved Premises on release as they will only accept High Risk of Serious Harm offenders".

The Probation Service submission goes on to state that this was an arguable point, particularly in the case of "lifers" because the need for re-adjustment to allow for effective resettlement can prove challenging, hence a requirement for additional monitoring and support during the initial period following release. This is the understanding of OM6 who asserted that the reasoning behind his continued assessment as high risk was the aforementioned un-tested element of his self-risk management strategies in the community over a prolonged time frame as opposed to short periods of Release on Temporary License (RoTL).

There was a pre-release Risk Assessment Management Arrangement (RAMA – a MAPPA level 1 high risk review meeting) held but, according to the author of the Probation Trust IMR, it was not properly recorded on the system so it was difficult to ascertain if the decision of the offender manager to support

release is fully supported. However, there was a need for all Parole documentation to be countersigned by a Probation Operations Manager, and in this instance, the line manager of OM6 was the risk lead. In order to countersign, the report was, the Panel assumed, read and the recommendations authorised by the Probation Operations Manager.

The submission stated that, as per Multi-Agency Public Protection Arrangements (MAPPA) Guidance 2012, offenders are managed at one of three levels, the lowest of which is level 1 (ordinary agency management) and it was at this level where the offender's case was managed. Whilst there was still an obligation to share information across agencies, there was no formal requirement for active conferencing and a multi-agency meeting to be convened.

However, later in the Probation submission, it is stated:

> "the offender was correctly recorded as a MAPPA category 2 offender – because of his offence and custodial sentence of 12 months or more".

His category and level registrations were assessed as appropriate.

6. Post Release

The Probation Service IMR stated that in Supervision, the offender did continue to work from the Cognitive Self Change Programme and was encouraged to address issues pertaining to relationships, self-esteem, motivation and understanding other people's views. During Block 5 of the Cognitive Self Change Programme, the offender demonstrated his commitment to the process of self-change. In doing so it was assessed at the time of Parole that he had shown a preparedness to take responsibility for his risks, recognise triggers for offending, and was able to identify strategies to overcome such risks.

OM6 described the offender as being motivated to undertake work that challenged any attitudes or beliefs that may have been at the root of his offending. The offender had also identified deficits in terms of his problem solving and self-management skills. He was able to consider life scenarios where, in the past he may have responded in a violent manner, and was instead able to generate alternatives and prevent an escalation in violence.

The offender's disclosure of being in a relationship with AF7, soon after release, was judged as an indicator of his compliance with licence conditions.

Disclosures pertaining to his relationship with Chan also highlight a degree of compliance with licence conditions. During this relationship, both Chan and the offender attended a hospital because they were under the influence of drugs and/or alcohol. Whilst this would not have been known or disclosed to Offender Manager (OM) 6, behaviours indicative of risk were clearly present within the relationship. The offender was present when disclosures were

discussed with Chan, and Chan was told that alcohol use was an acute factor linked to a risk of serious harm.

It could be concluded that the offender's reported compliance during the period prior to the incident leading to the death of Chan led to a judgment on the part of OM6 that the offender was able to put in place positive self-management strategies associated with risk.

7. Home Circumstances Review

The Panel noted that the Probation Service, in their IMR submission, stated that: "in addition to the lack of Police contact there is a lack of any purposeful home visiting to the offender's/Chan's home". This is not considered within the RMP and is never added when residency changes from probation approved premises to independent living.

12.3 Lancashire Children's Social Care service (CSC)

A DASH RIC assessment was not completed because Chan did not wish to complete the RIC so the assessment could not be done.

It is important to note that, even though the DASH risk assessment was not completed, all relevant agencies will have received the Protecting Vulnerable People form, completed by the Police, via the Multi Agency Safeguarding Hub (MASH). This form provides details of the family, the incident in question and initial assessment of the level of risk.

The submission from Children's Social Care stated that Offender Manager 6 corroborated the view that the offender was 'low risk'. However, the Probation Service confirmed to the Panel that the assertion made in their submission – that they never assessed the offender as being a low risk of serious harm – was accurate.

The submission from Children's Social Care went on to state that their information suggested that Chan had no history of alcohol or drug use and that her mental health was not 'compromised'. It recorded that Chan was fully aware of the offender's history and specifically stated that he had separately resolved his own alcohol and drug issues alongside his anger management. However, it was acknowledged that the volume of information held by Children's Social Care concerning Chan's background vis-à-vis her health status was not 'copious'.

12.4 General Practice for Chan and the offender

GP – Chan

The author of the GP IMR stated that a risk assessment was performed by the General Practitioner whom Chan consulted soon after her jaw was fractured.

Chan stated that she was not involved with the perpetrator and that the Police had been informed of this. She was therefore not considered to be at any on-going risk. The chronology from the GP IMR refers to the receipt of letters from the receiving hospital concerning the initial treatment and review of the fractured jaw. However, there is no reference to domestic abuse being referred to in these letters. Chan stated at the Hospitals she attended that she wasn't involved with the person who broke her jaw and the GP concluded that there was no ongoing risk. Of course, the panel noted that the GP did not know the offender and his history, did not know that Chan was in a relationship with the offender and did not know what the offender's violence 'triggers' were.

GP – the offender

The Panel, through the relevant representative, made repeated attempts to invite the GP for the offender to make submissions to the Panel. The GP did provide some limited information, following a conversation with the Named Nurse for the host Clinical Commissioning Group but the scope for making any worthwhile analysis from the information provided was limited. It is the case that the GP for the offender was concerned that they did not know and were not informed of the offender's history and license conditions.

KLOE 13:

Does your agency have a domestic abuse policy which includes guidance, training or supervision for your employees or service users who may disclose domestic abuse? Is your domestic abuse policy up to date and effective?

This line of enquiry specifically asks agencies to confirm that they have policies and procedures in place to address domestic abuse, including the disclosure of domestic abuse, and whether the policy and procedures are up to date. The Panel agreed to report on the outcome of this line of enquiry by exception – i.e. that only those agencies that have specific issues to report would be recorded here, since all others complied with the requirement to have the relevant policies and procedures in place. The Panel noted a number of particular issues, as set out below:

13.1 GP – Chan

The IMR author noted that Chan's GP practice does not routinely screen patients for domestic abuse and there is as yet no consensus on the benefits of routine screening for all patients in the practice.

The author of the GP report concluded that this should be a routine part of good clinical practice, even where there are no indicators of such violence

and abuse[15]. This guidance was only issued one month before Chan's death and may not have been embedded in practice. In future it should be expected practice that patients with mental health issues would be asked about the possibility of domestic abuse.

Chan's mental health issues were the main focus of the consultations with General Practice. However the panel acknowledged the need to be aware, when dealing with an adult patient, that there may be a "child behind the adult" and ensure that the needs of the child are not overshadowed by the needs of the parents[16]. Parental Mental Health problems are well known to be a significant factor in child abuse.

Although the practice in this Review does not have a specific domestic abuse policy, the author of the CCG submission stated that domestic abuse is included in their regular safeguarding training. A member of the practice safeguarding team would deal with disclosures about domestic abuse from employees or service users.

13.2 East Lancashire Hospitals NHS Trust (ELHT)

There have been guidelines in place for ELHT Staff concerning Domestic abuse since 2010. The guidance covers the need for staff to receive appropriate training on recognising Domestic abuse and action to take where there is a disclosure of domestic abuse. This guidance is due for review in 2017. However there is work on-going on a gap analysis against NICE guidance 50 (2014) and the policy will need updating to reflect this.

Staff also receive awareness training in domestic abuse and have access to safeguarding children and safeguarding adult practitioners for advice.

All Urgent Care Centre and Emergency Department staff receive Domestic abuse training which incorporates CAADA–RIC–DASH training and the completion of the Risk Identification Checklist and appropriate escalation to the safeguarding children's team or safeguarding adult team, as appropriate.

The Trust's Safeguarding Children Team attend the 4 local Multi-Agency Risk Assessment Conferences (MARACs) and flag victims and their children who have been identified as high risk on the hospital Patient Administration System as being vulnerable.

13.3 Lancashire Care Foundation NHS Trust (LCFT)

Lancashire Care NHS Foundation Trust have a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children, young people and vulnerable adults.

[15] NICE Guideline 50 - 2014
[16] "Keep Me Safe"; RCGP, 2005

The LCFT submission referred to Child 1 being cited in the Mental Health Risk Assessment for Chan as a 'protective factor' against future self-harm following Chan's over-dose in April 2013. This features in what is known as STORM training (this is the name given to the risk assessment training undertaken in the Trust). However, this needs clear exploration with the individual concerned because this factor is specific to individuals and it can fluctuate. The risk assessment did not detail the reason for Child 1 being cited as a protective factor. There was a lack of information in the assessment to determine whether this issue was fully explored with Chan.

Within Adult Mental Health in Lancashire Care NHS Foundation Trust (LCFT), a comprehensive safeguarding assessment was devised which sits separately from other assessments. It allows practitioners to explore and record relevant information about children and young people that the service user may be in contact with and it refers to certain situations where referral to Children's Social Care must be made.

Practitioners also have access, during office hours, to specialist safeguarding practitioners who operate a duty system to provide advice, support and guidance. However the investigation lead in this case, who submitted the IMR on behalf of the LCFT, noted in all interviews that there were no concerns for Chan or Child 1's safety. Therefore, no contact was made with Lancashire Care NHS Foundation Trust Safeguarding Team.

Practitioners who work with children have mandatory training in safeguarding. This is at induction and then a minimum of once every three years. Practitioners are also able to access the Lancashire Safeguarding Children's Board (LSCB) courses for their continuing professional development. At this training there is reference to domestic abuse and the supporting policies and procedures.

As an element of the IMR submission by the LCFT, on interview, staff were advised of the domestic abuse statistics available and all expressed a lack of knowledge regarding the prevalence of domestic abuse amongst women with mental health issues[17]. The NICE guidance (50: February 2014) has advised of the need to develop the practice of routine enquiry of domestic abuse in Mental Health Services given the increased risk of people with mental health problems experiencing domestic abuse. Currently, Lancashire Care NHS Foundation Trust are undertaking a bench marking exercise in regard to progress and implementation of the NICE guidance to identify actions to be taken.

13.4 Lancashire Police

Lancashire Police has a domestic abuse policy that is under continuous review and kept up to date by the Public Protection Compliance Unit within the Police Headquarters. Police officers and staff across the force undergo

[17] Women's Aid, 2013

training that is updated periodically. There is guidance for staff contained within the Public Protection pages within the internal force website (known as Sherlock). Specialist officers within the Multi Agency Safeguarding Hub and Public Protection Units are also available to offer advice. The Lancashire Police judged that their domestic abuse policy is effective and was followed in this case.

13.5 Lancashire CSC

The submission from Children's Social Care stated that policies are in place within Lancashire County Council, including Lancashire Safeguarding Children Board (LSCB) procedures and Child Protection Protocols and Multi Agency Risk Assessment Conferences (MARAC). However, the submission stated that MARAC was not instigated when the third party domestic abuse report was received in March 2014 (this was due to the risk rating being altered from high to medium).

The submission stated that the Lancashire County Council safeguarding procedures were followed in this case, Strategy Discussions were held and a Section 47 enquiry was conducted on the 3rd of March 2014. The Panel noted that S47 enquiries should result in multi-agency consultation and that there was no evidence in the Probation record this this occurred. The Children's Social Care service has referred to this in their single agency action plan.

The author of the submission noted that this case could have been discussed at MARAC but found that this did not happen and considered this to be a missed opportunity for multi-agency discussion and potential signposting or involvement of an Independent Domestic Violence Advisor (IDVA) for the victim. However, it is important to note that Chan was murdered before the date the case was due to be heard at MARAC. The IDVA received the Protecting Vulnerable People submission from the MASH and made contact with the Chan ahead of the scheduled MARAC, something that is routine practice.

13.6 North West Ambulance Service (NWAS)

NWAS has a Domestic Abuse Policy for employees and a separate one for patients. These Policies are up to date. The Policies are covered in mandatory training. Guidance, supervision and advice is available 24/7 for clinicians who have patient contact.

13.7 Pennine Acute Hospitals NHS Trust (PAHT)

Pennine Acute Hospitals NHS Trust has a Domestic Abuse policy, which is up to date. The Trust states that considerable investment has been made into domestic abuse training in the recent past and is part of the Trust's mandatory training, for all staff.

13.8 National Probation Service

The Greater Manchester Probation Trust confirmed that they have a domestic abuse policy that is up to date and regularly reviewed.

KLOE 14:

Could any agency involved in this review reasonably have predicted or prevented the harm that came to Chan?

This is considered in detail in section 5.7

1. Lessons learnt and conclusions

The DHR Panel, throughout the process of constructing the Overview Report, worked very closely with the MAPPA Serious Case Review and was, via shared membership, fully cognisant of their discussions. The DHR Panel are aware that the MAPPA Serious Case Review will not be published but, as a consequence of on-going dialogue between the two Panels, consistency in approach and outcome has been ensured.

Whilst this case is not unique, it is highly unusual in that it involves the murder of a victim of domestic abuse, perpetrated by an offender who had been released on Life Licence after being convicted of a similar murder 16 years earlier.[18]

The DHR panel has concluded that the key learning in this case relates to the following areas:

- The management of offenders released from prison on life licence
- A lack of routine enquiry regarding domestic abuse in General Practice and other health settings and the necessity to adhere to current NICE Guidelines concerning domestic abuse
- The quality of information sharing and information sharing systems, particularly the sharing of information with the NHS
- Effectiveness of Multi-agency safeguarding systems (Multi-Agency Safeguarding Hub, Multi-Agency Risk Assessment Conference and Multi-Agency Public Protection Arrangements) and processes and the decision making therein in relation to day to day case management
- Adherence to police policy in relation to the use of safety equipment
- Increasing the confidence of family and friends to report domestic abuse disclosures; strengthening third party reporting
- Safeguarding children who live with domestic abuse
- The role of voluntary and third sector agencies in dealing with disclosures and referring to specialist domestic abuse services
- The predictability/preventability of the harm that came to Chan

5.1 Conclusion 1

<u>The Management of Offenders Released from Prison on Life Licence</u>

The conditions placed on the offender were clearly stated and understood by him, and were intended to prevent re-offending based on known risk factors. The DHR panel noted that there is a degree of reliance on self-disclosure as a means of monitoring and managing the risk factors of offenders in the community.

[18] It should be noted that, on the date of writing this report, 12 offenders released on life licence have gone on to murder again (see Appendix G)

The panel judged that the following elements of risk management could and should have been strengthened:

A. The offender was assessed as requiring management at Multi-Agency Public Protection Arrangements (MAPPA) Level 1, based upon the level of risk of serious harm he presented and the resources and agencies required in order to manage that risk. The DHR panel believe that, whilst the judgment to manage him at this Level was based on sound principles, this case illustrates the degree of risk presented by an offender with the history of this particular offender and his propensity for further violence.

B. The requirement for self-disclosure in relation to alcohol consumption and new relationships may have afforded the offender the opportunity or latitude to disguise his behaviours, but it would be expected that the offender manager would recognise that self-reporting is a biased source of information that would need to be cross checked. However there appears to have been a presumption that the offender would be truthful about his behaviours and relationships. This presumption, coupled with a lack of proactive cross checking with other agencies, meant that it was not possible to substantiate, or otherwise, the information that the offender was providing. It is important to note that the offender had successfully ended a previous relationship and the offender manager will have been looking for certain patterns of behaviour concerning the offender's risk factors. This reinforces the necessity for the multi-agency sharing of information,

C. Prohibition conditions concerning 'substances' (alcohol and illicit/illegal drugs) could only be tested during approved premise residency. Where someone on life license lives 'independently', there is obviously a need for some reliance to be placed upon self-reporting, observations during supervision or third party reporting. These methods of assessing compliance with prohibition conditions also need to be triangulated via a system of multi-agency information sharing[19].

D. Prior to his release, the offender was subject to inter-departmental Risk Management Meetings to which the Offender Manager was invited. Other than these high level meetings, there was no professional multi-agency forum in which the offender was discussed and this case was never discussed at the Multi-Agency Risk Assessment Conference (MARAC). Guidance concerning the management of offenders at MAPPA Level 1 states that a multi-agency meeting can take place but the offender manager would need to have a clear record of the detail of a specific incident in order to call a meeting and in this case, such details were not apparent.

[19] It is important to note that offender managers can now test for illicit drug use during standard office visits with offenders

E. There is no requirement to routinely share information about violent offenders on life license with health professionals, including GPs.

F. The offender's GP was not notified that he had been convicted of murder or that he was on life licence. Had the GP been aware of this they could have shared information regarding his request for Viagra and diazepam. There could also have been an arrangement for the GP to report on alcohol issues to the offender manager. The offender was, however, in an apparently consenting adult relationship and it is debatable if this would have been considered as an acute risk factor.

G. Information sharing between police and probation was ad-hoc and based on 'events' rather being than routine and specific.

H. There were two opportunities to discuss the process required to implement the recall of the offender. Offender Manager (OM) 6 correctly discussed these with a senior officer. A decision to recall was not made due to the absence of any information that would support such a decision. If the information over-heard by the Police when Chan was discussing the assault by the offender with her mother and had this been verified and then shared with the Probation Service, then recall would have occurred.

I. There is no requirement for offenders being managed in the community at MAPPA Level 1, as the offender was, to be subject to an intense programme of purposeful home visiting to facilitate a more extensive monitoring of his risk management strategies. This level of management coupled with the offender being categorised as a medium risk of serious harm appears to have obviated the need for in-depth investigation into any potential problems.

5.2 Conclusion 2

Chan disclosed to a friend and to a close family member that she was the victim of domestic abuse from the offender. These disclosures took place at different times in Chan's relationship with the offender. However, the panel concludes that in sharing this information Chan was in fear of the offender and was afraid of reprisals on both occasions.

Chan's friend did not share what she had been told about the abusive relationship until after the homicide. As the friend did not contribute to the review it is difficult to say why they did not disclose on Chan's behalf, but the panel feel it is safe to assume that this was out of Chan's fear of reprisals.

The close family member, to whom Chan disclosed, decided that they had to share the information with another family member who in turn decided to share the information with the police. The Police acted on these concerns and made efforts to safeguard Chan.

It is well documented that family, friends, neighbours and others who may receive disclosures of domestic abuse experience a dilemma as to how and when to share this information safely, in a way that will not increase the fear of the victim or result in acts of reprisal.

Family, friends, neighbours and others who may be aware of domestic abuse being perpetrated require immediate and ongoing support and reassurance to enable them make disclosures and share information in a way that does not compromise the safety of the victim or the third party. A recommendation is made in this regard.

5.3 Conclusion 3

Lack of routine enquiry into domestic abuse in GP settings

Chan had frequent contact with her GP, more than 8 times the national average in the period under review. Despite Chan's presenting conditions and willingness to discuss personal and psychosocial issues with her GP, Chan never made a disclosure of domestic abuse to her GP, nor did her GP make a routine enquiry.

Chan's GP did not pick up any of the triggers of domestic abuse and did not raise the issue with her.

Despite many of Chan's contacts with her GP and Mental Health services involving relationship issues as a cause of her low mood and the reason for referral, there was a lack of routine enquiry into the full nature of her relationship difficulties and whether domestic abuse was a factor in her presenting conditions

The offender's GP had no information about the offender's background or that he was on life licence. This information is not routinely shared with general practice by criminal justice agencies.

All offenders are assigned to a GP whilst in custody and records should be flagged from this point. Whilst it may be unlikely that this would have had an impact on the outcome in this case, this should be considered as an important factor in relation to information sharing amongst agencies when managing life licence offenders. The responsibility for information sharing needs to sit equally with all participating agencies. A recommendation is made in this regard.

5.4 Conclusion 4

Information systems, standards and sharing were not consistent in this case and on occasion lacked rigour and quality assurance.

The East Lancashire Clinical Commissioning Group submission concludes by stating that the offender's forensic history was known by the Probation Service, Police, the Multi-Agency Safeguarding Hub, Lancashire Children's Social Care service and Chan and it would appear that a lack of interagency information sharing played a very large part in this tragic case.

There is no single database that contains information about all violent offenders (this would amount to an extension of the Violent and Sex Offender Register (referred to as the VISOR system), which might have alerted agencies to the risks posed by the offender.

The Police National Computer (PNC) contained information about the offender's previous convictions and this information was considered when the initial risk assessment was set. However, there was still no reference on the intelligence system to connect the offender with his visits to either Chan or AF7 and the Police were aware of the relationship between the offender and AF7.

There was no evidence of communication between Greater Manchester and Lancashire Probation Trusts due to the lack of a shared information system (this has now been rectified by the introduction of nDelius).

The Probation Service, in their submission, stated that the Police Service assessed the report made on the 1st of March as 'medium risk' on the basis of Chan denying any allegation of assault. The Probation Service state that it is only after the death of Chan that information is forthcoming from the Police about previous injuries as a result of violence perpetrated by the offender.

Although the PVP record was fully updated, and a marker was placed on the address, no intelligence was placed on the Sleuth[20] Intelligence System.

The submission made by the Probation Service identified a gap concerning liaison with the Police Service in relation to the offender's release date and license. It is the responsibility of the releasing Prison to notify the Chief Constable in the receiving area. It is apparent from the submission made that clear evidence exists that copies of the offender's release date and license were sent to the Greater Manchester Probation Trust but there is no equally clear evidence, apart from the existence of the Joint National Protocol (JNP) with the Police that states that communication of this sort should occur (via a letter to the Chief Constable), that the Police were informed of the offender's release, nor that they were informed that the offender has been subject to ROTL.

In the submission made by the Probation Service, there is an expression of concern because, following the report of Chan being assaulted by the offender (whereby Chan sustained a broken jaw) and when information was requested by the Multi-Agency Safeguarding Hub (MASH), a nil return was submitted which stated he was not known to probation. This is despite the

[20] SLEUTH is the intelligence database used by the Lancashire Police

request clearly detailing that the offender had been released on life licence in 2012. The police could have sought further information and the e-mail from the MASH to OM6 failed to be received due to a technical error.

If OM6 had provided details of the offender's and Chan's relationship to the Police in Lancashire, this would have alerted them to the involvement in the case of the Probation Office in Rochdale and allowed for direct contact with the case manager. However, the request was sent to the probation representative in the MASH, which in this case was an administrator in Lancashire and following a check of their systems for the names of those involved, the nil return was submitted. Chan lived in Lancashire and the offender was subject to supervision by Greater Manchester Probation Trust. There is no evidence of any liaison between Lancashire Probation Service and Greater Manchester Probation Trust.

A meeting, bringing together all relevant agencies, could have been convened which would have allowed information to be exchanged in respect to the offender's partners and their children. Such a meeting would have assisted in the effective risk management of the case. There is a case to suggest that the Multi-Agency Safeguarding Hub could have fulfilled this function.

The Children and Family Health Service were not aware of Chan's involvement with Adult Mental Health Services At the time of the incident, the records held by Adult Mental Health Services were electronic and Children and Family Health Service were in paper form. There was no linkage between the systems that would have allowed for either service to see who was involved with the family and subsequent information sharing.

A Children and Families assessment was completed by Children's Services in March 2014 in response to the information received by the Police from Chan's father that she had been assaulted by the offender and had received a broken jaw. This assessment included interviews with the Chan and Child 1. These established that Chan and her child did not feel threatened or intimidated by the offender and also recorded that Chan had advised the social worker that she had maliciously accused the offender of domestic abuse, believing he had been unfaithful and wishing her father to challenge him. The investigating social worker in noting no current and visible injury, subsequently felt that the victim's explanation was credible. This was an error that enquiries made to the GP would have resolved and as such this source of information should have been approached to clarify this significant timing issue. However the GP was not contacted as part of these enquiries.

In this case, there may have been an over-reliance placed upon Chan's ability to protect herself and Child 1 and perhaps an over-optimistic view of Chan's understanding of the dynamics of domestic abuse and the tactics used by abusers. For example, when Chan stated to the Social Worker that the offender was a 'reformed character' that he had received anger management training and was not drinking this view was not challenged by the Social Worker and an opportunity was missed to outline that domestic abuse is about power and control and not just anger and alcohol use.

5.5 Conclusion 5

The role that Children's Services play in the safeguarding of children who live with domestic abuse cannot be underestimated.

The local response to risk management, in relation to the offender as a violent offender, was driven by an adherence to national guidance.

The view of the panel is that Children's Services should revise their policy on safeguarding children and adults to accommodate incidents where allegations of domestic abuse by known violent offenders have taken place. This should include direct liaison with GPs, if verification of injuries is considered necessary. It should also include assurances that, when parents have separated, the circumstances of the separation are noted and appropriate decisions about safeguarding are made.

The panel has made a recommendation that the specific circumstances of this case should drive Change at national level by strengthening guidance to LSCB's and to CSC services relating to risk management for children who are living with, or in close proximity to, offenders on life license for previous domestic abuse murder or manslaughter.

5.6 Conclusion 6

Police guidance relating to the use of safety equipment was not followed in this case. The decision making model employed by the Police is in accordance with the National Decision Making Model, attached to this Report at Appendix E, and it concerns 'dynamic risk assessment' in cases such as this. This policy was adhered to.

The attending officers explained why they did not take PAVA spray with them and explained why its use in a confined space is not recommended; additionally, the attending officer explained their decision making with regard to not hitting the offender on the head with their police baton at the scene of the assault. The Panel discussed all of these issues at length and the Panel could not conclude, unequivocally, that if the police officers had taken any alternative actions the final outcome would have been altered. Nevertheless, the DHR panel has made a recommendation in this regard.

As a result of this DHR and the MAPPA Serious Case review, Lancashire Police has carried out a review of its policies and procedures regarding the use of protective equipment by officers. The Force has provided assurance that their policy is clear and in line with national guidance. Reminders about the use of protective equipment have been placed on the force intranet system and officers have each received emails on the subject.

A single agency recommendation is made in relation to on-going training and the policy on use of protective equipment is reinforced at every opportunity.

5.7 Conclusion 7 – Predictability/Preventability

The difference between this case and the significant majority of other DHR cases is that the offender was on life license having been convicted of murdering a female partner. The likelihood is that, under certain known circumstances, such as the misuse of alcohol and drugs and the ending of a relationship, (a number of the offender's license conditions were aimed at controlling these risks), the offender had the potential to murder again. Offender Manager (OM) 6 and colleagues in the probation service believed that they had an appropriate risk management plan, as determined by Multi-Agency Public Protection Arrangements (MAPPA) Level 1 guidance. It is apparent from the events and circumstances described in this report, the behaviour of the offender and the impact of his behaviour on Chan, that this plan was not sufficient to protect the victim.

Using the standard of proof in criminal prosecutions, the DHR Panel believes that, taking into account what was known to the police service and others about the offender, it was not possible for them to predict beyond all reasonable doubt that he would kill again and that his victim would be Chan. However, had all agencies pooled their information and known what was available to be known about the offender and Chan (the broken jaw, the drinking and the possible drug taking) then on the balance of probabilities, the Panel believes it was predictable that the offender would cause serious harm to, or kill, Chan.

It is the view of the DHR panel and the MAPPA review that there were two things that may have prevented the death of Chan: the recall of the offender to prison or his overpowering by officers from the Lancashire Police on the day of the murder at the scene where the murder occurred. However, there were missed opportunities by agencies to discover that Chan had sustained a broken jaw. Had these opportunities been taken and the information agencies had combined, it is very probable that the offender would have been recalled to prison before the incident occurred. Therefore, on balance, the DHR Panel conclude that the death of Chan was preventable.

RECOMMENDATIONS

Recommendation 1

National recommendation: *When offenders who are released on life license or temporary license following a conviction for a domestic violence associated murder, or manslaughter, disclose that they are forming a relationship with a new partner, this should trigger an immediate referral to MARAC.*

Recommendation 2

Local Recommendation: *The local MARAC protocol should be revised to ensure that anyone who is forming an intimate relationship with domestic abuse offenders who have been convicted of murder or manslaughter and are on life licence and are referred by an offender manager are prioritised as high risk cases and immediately heard at MARAC. This should include the immediate sharing of information with the NHS and General Practice as an integral part of the MARAC process*

Recommendation 3

When Probation services are working with offenders released on life license following a conviction for a domestic violence associated murder or manslaughter, they should adhere to the procedures associated with "Claire's Law"[21] and disclose, in accordance with the guidance, the offenders history to specialist IDVA services.

Recommendation 4

Local Recommendation: The CSP should ensure that work is undertaken to facilitate an increase in third party reporting and increase confidence amongst family and friends of victims of domestic abuse.

Recommendation 5

Local commissioners should ensure the safety of information sources and systems so as not to deter third party reporting

Recommendation 6

The CCG should implement a programme of work to achieve GP compliance with NICE and RCGP guidance in relation to domestic abuse.

Recommendation 7

Mental Health Services should review policy on domestic abuse to ensure that staff are able to properly assess for the presence of domestic abuse at each stage of engagement and treatment and in line with NICE guidance.

[21] Further information on "Claire Law" can be found in Appendix I

Recommendation 8

The learning from this case should be used to review multi agency data sharing for those offenders previously convicted of domestic abuse murder or manslaughter who are on life licence

Recommendation 9

(a) Local Recommendation:

MASH information systems and processes should be audited and tested against the learning from this case to ensure that there are no gaps in the system.

(b) Local Recommendation:

The mechanism for communication across all agencies involved in the MASH needs quality assurance, in this case email communication alone was not sufficient to ensure the transfer of important information, therefore e-mail communication alone should not be relied upon.

Recommendation 10

National Recommendation:

Specific guidance should be issued to LSCB's in relation to the risks posed by violent offenders on life licence and should be explicitly referenced in the continuum of needs thresholds for Child Protection.

Recommendation 11

Local Recommendation:

The Domestic Abuse Strategy Group should ensure that local independent sector agencies have a robust disclosure and referral policy in place and that suitable training is available to promote compliance.

Local recommendation:

All relevant statutory and voluntary/independent agencies that work to support families, should undertake domestic abuse training.

APPENDIX C
Glossary of Terms

A&E – Accident and Emergency Service
AAFDA – Advocacy After Fatal Domestic Abuse
CARAT – Counselling Assessment Referral Advice and Through-care
CBT – Cognitive Behavioural Therapy
C&F assessment – Children and Families Assessment
CMHT – Community Mental Health Team
CSC – Children Social Care (Services)
CSP – Community Safety Partnership
DASH – Domestic Abuse, Stalking and Honour Based Violence risk identification tool
DHR – Domestic Homicide Reviews
ELCCG – East Lancashire Clinical Commissioning Group
ELHT – East Lancashire Hospitals NHS Trust
GMPT – Greater Manchester Probation Trust
GP – General Practice
HMP – Her Majesty's Prison
IDRMM – Interdepartmental Risk Management Meeting
IDVA – Independent Domestic Violence Advocate
IMRs – Individual Management Reviews
LCFT – Lancashire Care Foundation NHS Trust
MAPPA – (Multi Agency Public Protection Arrangements)
MARAC – Multi Agency Risk Assessment Conference
MASH – Multi-Agency Safeguarding Hub
NMGH – North Manchester General Hospital
NPS – National Probation Service
NWAS – North West Ambulance Service
OAPA – Offences against the Person Act 1861
OASys – Offender Assessment System
OGP – Offending General Predictor
OGRS – Offender General Reconviction Score
OM – Offender Manager
OOH – Out of Hours (GP Service)
OVP – Offending Violent Predictor
PAHT – Pennine Acute Hospitals NHS Trust
PHQ9 – Patient Health Questionnaire (with 9 questions)
PNC – Police National Computer
PPU – Public Protection Unit
PVP – Protecting Vulnerable People
RAMA – Risk Assessment and Management Arrangements
RMP – Risk Management Plan
ROR – Resettlement Overnight Release
RoSH – Risk of Serious Harm
ROTL – Releases on Temporary Licence
S47 – Section 47 of the Children Act 1989
SARA – Spousal Assault Risk Assessment
SCR – Serious Case Review
SFOR – Serious Further Offending Review

APPENDIX D

MAPPA TERMS OF REFERENCE*

The terms of reference for the Serious Case Review were:

1. To identify what treatment was undertaken with the offender while he was in custody and what bearing it had on agencies submissions to the Parole Board.

2. To determine whether the Parole Board was furnished with sufficient information to make a fully informed decision, including any views of AF7's family.

3. To establish whether MAPPA Guidance was followed pre the offender's release and any risks posed by him were assessed appropriately at that stage.

4. To determine whether the level of MAPPA management was appropriate for any identified risks at the point of release and thereafter.

5. To determine whether any risk management plan was appropriate for the assessed risks and whether it was managed effectively and in accordance with MAPPA Guidance and agencies policies.

6. To establish whether the risks presented by the offender were kept under review and whether any new information was factored into the risk assessment.

7. To establish whether the conditions of the offender's licence were managed effectively in so far as they related to risk identification and management.

8. To determine what was known about AF7 and Chan and whether appropriate steps were taken to safeguard her and any other females the offender might have formed a relationship with.

9. To identify any areas of good practice

10. To establish whether there are any lessons to be learned, including how agencies worked together and shared information.

11. To identify any gaps in MAPPA policy.

12. To consider other matters relevant to this SCR.

*** For consistency, acronyms from the DHR have been used to replace the acronyms used by the MAPPA SCR**

APPENDIX E

The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that 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: an 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."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

a. a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

b. where a victim lived in different households at different time, "the same household as the victim" refers to the household in which the victim was living at the time of the act that caused the victim's death.

APPENDIX F

The use of PAVA (Pelargonic Acid Vanilly-Amide)

On Monday 17th March 2014 two Police Officers attended at an address in Rossendale to safeguard a victim of domestic abuse.

The officer carried out a dynamic risk assessment from the office. There was no information to suggest that the offender was present at the address. It was not certain if the relationship between AF 1 and the offender was continuing.

In this case the first officer was not wearing Body Armour, nor were they carrying a Baton; Quick Cuffs or PAVA. The second officer was wearing Body Armour, and was carrying Quick Cuffs and Baton; however, they were not carrying PAVA. The second officer stated that they wear Body Armour as a matter of routine and also carry Baton and Cuffs. The officer stated that they were not carrying PAVA as they were not confident in using it.

Officer safety training is carried out every 12 months. This has recently been increased to every 18 months. Both officers had attended training courses within the preceding 12 months authorising them to carry / use their protective equipment.

The Review Officer from the Lancashire Police (who attended the DHR Panel) was asked to liaise with an appropriate colleague in the Public Order and Safety Training Unit in order to consider the query raised by the DHR Panel concerning the possibility that had the officers who attended the scene been in possession of and deployed PAVA there was a likelyhood that the offender would have been incapacitated and therefore unable to carry out the attack on the victim and officers.

Lancashire Police Policy states:

When an officer perceives there is a significant threat of harm or violence and the use of an incapacitant is commensurate with that threat, incapacitant sprays may be used as a response option in the following circumstances:

- *When officers find it necessary to defend themselves or others;*
- *To effect the arrest and detention of suspects; and*
- *Where it is necessary to use an incapacitant to prevent the commission of an offence and lower levels of force have proved ineffective or would, in the opinion of the officer, have been inappropriate in the circumstances.*

In this case the Police Officers were:

- Working in a confined space within the living room of the house.
- Had PAVA been deployed the effects may have been felt not only by the offender but also by others in the room, and may have incapacitated the officers and victim.
- The effects of the spray may not have been effective on the offender.

- It is not known what would have been the outcome if the officer(s) had deployed PAVA.
- Both officers in this instance should have been in possession of their full protective equipment in accordance with Lancashire Police policy.
- Had both officers been in full possession of their protective equipment it would not necessarily have saved the life of the victim.
- The first officer was struck on the head with a hammer. Therefore their body armour had they been wearing it would have been ineffective to protect that area of their body.
- Had the officers been in possession of PAVA each would still have made an assessment and a conscious decision to use it or otherwise. In these circumstances it is unlikely that the officers could have deployed it due to the speed with which the attack happened.

In the opinion of the Public Order and Safety Training Unit, PAVA should be carried in accordance with policy. This may not have made any difference to the outcome, as described above. However, it is recognised that there is a culture concerning officers who are not working in uniform to not wear their Body Armour and not carry protective equipment.

It was also drawn to the attention of the Lancashire Police Review officer that PAVA was not easily accessible within some departments, and in some cases was kept within one place within a Police Station. Consequently, the Review Officer will undertake an audit of PAVA lockers across the force to ensure that CID and PPU offices are in future provided with their own PAVA lockers to give officers easy access and encourage the carrying of this piece of equipment.

APPENDIX G

HOMICIDE STATISTICS

Murder [1] Statistics England and Wales

Year	Number of people Convicted Of a second murder	Number of murders recorded
2002-03	0	873 [2]
2003-04	0	904
2004-05	2	868
2005-06	0	764 [3]
2006-07	1	758
2007-08	1	775
2008-09	3	664
2009-10	1	620
2010-11	3	639
2011-12	1	553
Total	12	7366

1 Murder includes manslaughter, corporate manslaughter and infanticide
2 This figure does not include the 173 victims of Harold Shipman
3 This figure does not include the 52 victims of the London Bombings

Sources:

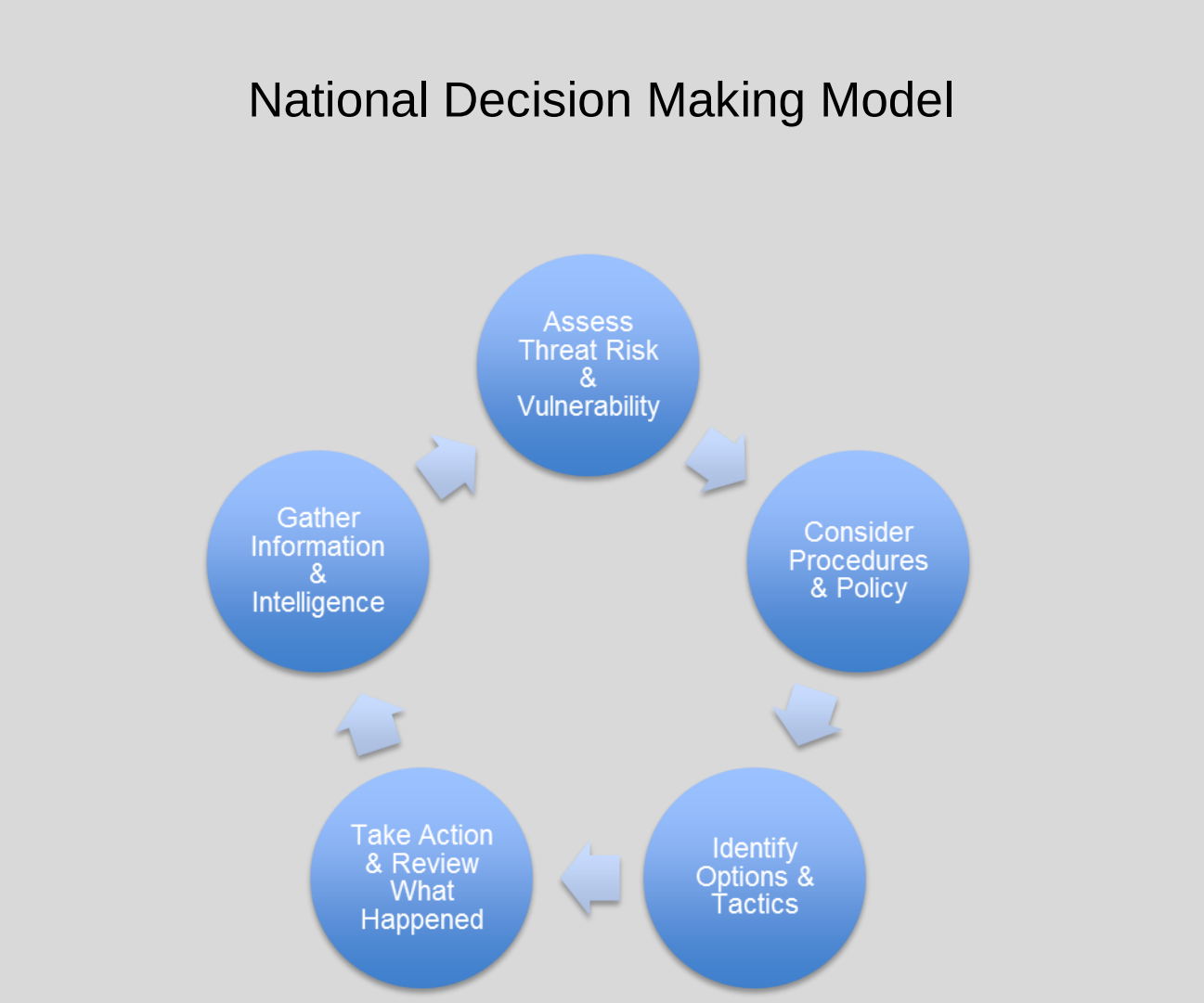
Second conviction figures: provided to Andrew Rosindell MP by Mr Jeremy Browne MP in answer to a Parliamentary question. HC Deb 9 Sep 2013: Column 594W PQ 167617

All murders: www.gov.uk/government/statistics/homicides

APPENDIX H

National Decision Making Model employed by Lancashire Police

In order to adopt an ethical, balanced, problem solving approach to deployments, the use of the adapted National Decision Making Model will be key



APPENDIX I

Clare's Law

Domestic Violence Disclosure Scheme, Guidance for Third Party Applicants,

What is the Domestic Violence Disclosure Scheme?

The Domestic Violence Disclosure Scheme is a national scheme that has been set up to give members of the public a formal mechanism to make enquiries to Police about an individual who they are in a relationship with, or who is in a relationship with someone they know, and there is a concern that the individual may be abusive towards their partner.

What is the aim of the scheme?

The aim of the scheme is to give you, a third party, a mechanism to make enquiries about the partner of a friend or a member of your family if you are worried that this individual may have been violent or abusive in the past. If Police checks show that this individual has a record of abusive offences, or there is other information to indicate that your friend/family member may be at risk from the individual, the Police will consider sharing this information. Where there is a risk and there is a need to provide information, the scheme aims to give these partners information that will enable them to make an informed choice on whether to continue their relationship. The scheme also aims to provide help and support when making that choice.

Who can ask for a disclosure?

A disclosure under this scheme is the sharing of specific information about the partner either with your friend/family member, you or someone else who is best placed to use the information to protect your friend/family member from Domestic Violence.

You can make an application to Police about the partner if you have a concern that they may harm your friend/family member.

Under the scheme, a person can make an application themselves if they have concerns about their partner, and there is a separate guidance leaflet for those making an application for themselves.

Who would a disclosure be made to?

Just because you have made an application does not mean that you are the best placed person to receive information about the partner if a decision is made to make a disclosure. Usually disclosures under the scheme would be made directly to the individual at risk, unless it is more appropriate to involve a third party. If you or someone else is approached with information, this is done in order to protect the friend/family member from abuse. In certain

circumstances, you as the applicant may not be informed whether a disclosure has or has not been made.

How does the Scheme work?

The first thing you need to do if you want to make an application under the scheme is contact your local Police. There are four stages to the process.

Stage One: Making an application

When you attend a Police Station to make an application, a Police Officer or member of Police Staff will take the details of what prompted your enquiry. A safe means of contacting you and the person you are concerned about will be established. You will need to give your name, address and date of birth. The Police will run some checks based on the information you have provided to establish if there are any immediate concerns.

If, when speaking to the Police you make a criminal allegation against the partner, for example, that the partner has hit your friend/family member, then the Police are required by law to record and investigate the crime.

No disclosure of information will take place at this stage unless it is necessary to provide immediate protection to your friend/family member.

If the Police believe they are at risk and in need of protection from harm, they will take immediate action.

Stage Two: Face to face meeting to complete the application

Depending on the outcome of Stage One, you may be required to participate in a face to face meeting with an officer from the Police's Community Safety Unit. During this meeting you will need to provide further details about the nature of your relationship with your friend/family member and their partner. This meeting will be with a specialist officer and will establish further details about your application in order to assess any risk. You will be required to provide proof of your identity - this should comprise two forms of ID. At least one of these should be photo ID. Forms of ID that could be used are your passport, driving licence, a household utility bill, your bank statement or your birth certificate.

The Police will use the information gathered at the meeting to decide if your friend/family member is at risk from domestic abuse. As well as using Police held information, Police will also work with partner agencies such as Social Services, the Prison Service and the Probation Service to get as full a picture of any risk as possible.

Police will aim to process the application, complete all the checks and, if appropriate, make a disclosure within no more than 35 days.

The Police will act immediately if at any point they consider your friend/ family member to be at risk and in need of protection from harm.
To make an enquiry about the scheme you can -Always call 999 in an
Stage Three: Multi-agency forum considers disclosure

The Police will liaise with other safeguarding agencies (such as Social Services, the Probation Service, the Prison Service) to discuss the information you have provided. The Police and the other agencies may also have additional information relevant to your application.
This multi-agency forum will then decide if any disclosure of information is necessary, lawful and proportionate to protect your friend/family member from their partner. If a decision is made to disclose information, the forum will decide who should receive the information and set up a safety plan tailored to the needs of your friend/family member to provide them with help and support.

Stage Four : Potential Disclosure

If the checks show that the partner has a record of abusive offences or there is other information that indicates that there is a pressing need to make a disclosure to prevent further crime, the Police may disclose this information to your friend/family member or to a person who is more able to protect them, which may be you.
An individual's previous convictions are treated as confidential and the information will only be disclosed if it is lawful, proportionate and there is a pressing need to make the disclosure to prevent further crime.

If it is decided that a disclosure is to be made, this may not be to you. This may be where the disclosure is to be made directly to your friend/family member or it is decided that there is another person better placed to use the information to protect your friend/family member from abuse.

If the checks do not show that there is a pressing need to make a disclosure to prevent further crime, Police may inform you of this. This may be because the partner does not have a record of abusive offences or there is no information held to indicate they pose a risk of harm to your friend/family member. Or it may be that some information is held on the partner but this is not sufficient to demonstrate a pressing need for disclosure.

It may be the case that the partner is not known to the police for abusive offences or there is insufficient information to indicate they pose a risk of harm to your friend/family member but they are showing worrying behaviour. In this case, the Police or other support agencies can work with you and your friend/family member by providing advice and support.

How to use disclosed information

You should be aware that Police checks and any disclosure made are not a guarantee of safety. The Police will, however, give you advice on how to best protect your friend/family member and will make you aware of what local and national support is available.

Who can I tell?

If you receive a disclosure it should be treated as confidential. Information is only being given to you so that you can take steps to protect your friend/ family member. You must not share this information with anyone else unless you have spoken to the Police, or the person who gave you the information, and they have agreed with you that it can be shared. You should discuss with Police if you want to discuss what you have been told with your friend/ family member.

Subject to the condition that the information is kept confidential, you can:

- use the information to make decisions about your friend/family member's safety
- use the information to make decisions about keeping any children involved in the situation safe
- use the information to seek further support from Police and other agencies - seek further advice on how to keep your friend/family member safe

The Police may decide not to give you information if they think that you will discuss it with others. However, the Police will still take steps to protect your friend/family member if they are at risk of harm.

The Police may take action against you if the information is disclosed without their consent, which could include civil or criminal proceedings. You should be aware that it is an offence (under Section 55 of the Data Protection Act 1998) for a person to 'knowingly or recklessly obtain or disclose personal data without the consent of the data controller', which in this case is usually the Police.

If no disclosure is made but you still have concerns the Police can provide you with information and advice on how to protect your friend/family member and how to recognise the warning signs of domestic abuse.

There are also a number of specialist services and organisations providing information about domestic abuse, how to spot it, and how to work with the authorities to intervene.

Right to know

Under the Scheme, you may receive a disclosure even if you have not asked for one. That is because, if the Police receive information about a person you know which they consider puts them at risk of harm from domestic abuse, they may consider disclosing that information to you if they consider that you are the best placed person to use that information to protect that individual from harm.

Information can be disclosed where Police feel there is a right to know this information. When you have not asked for a disclosure but one is made the disclosure will only be made if it is lawful and proportionate.

Appendix J - Summary of missed opportunities agreed with Chan's Family

	Opportunity	**Response**
1	Prior to his release, the offender's history and circumstances were examined by a number of Risk Management Meetings. The Offender Manager (OM) was invited to these meetings. However, there were no other multi-agency meetings in which the offender was discussed and this case was never discussed at the MARAC	The actions recommended by the Panel, therefore, suggest a change to the system so that when people are released from Prison in these circumstances they must make a full disclosure when they form a relationship with a new partner. **A National recommendation was made by the Panel:** When offenders who are released on life license or temporary license following a conviction for a domestic violence associated murder, or manslaughter, they MUST disclose when they are forming a relationship with a new partner. This should then trigger an immediate referral to MARAC.
2	There is no requirement to routinely share information about violent offenders (who are released on a life license) with health professionals, including General Practitioners.	The Panel understood why information sharing with various parts of the NHS and General Practitioners was not pursued. The learning from this case is clear and it is that this issue needs to be tackled so that relevant information flows freely from one organisation to another to ensure that risk management plans can be put in place.
3	Chan had frequent contact with her GP. Despite Chan's presenting conditions and willingness to discuss personal issues with her GP, Chan never made a disclosure of domestic abuse to her GP, nor did her GP make a routine enquiry.	The Panel has recommended that the Clinical Commissioning Group should implement a programme of work to achieve compliance with both the national guidance and the guidance specifically for General Practitioners issued by the Royal College of General Practice (RCGP) in relation to domestic abuse. The Panel has also asked the CCG and the GP to implement a revised policy and training programme to encourage GPs to make

		sensitive enquiries about domestic abuse and to apply all professional guidelines concerning domestic abuse.
4	There was no evidence of communication between the Greater Manchester and the Lancashire Probation Trusts due to the lack of a shared information system.	When Probation services are working with offenders released on life license and the offender has been convicted of a domestic violence associated murder or manslaughter, they should adhere to the procedures associated with “Claire’s Law”. In short, they should disclose the offender’s history to specialist Independent Domestic Violence Advocate (IDVA) services. The Panel has recommended Claire’s Law should be used in future. It was not used in this case.
5	The panel noted that following the report of Chan being assaulted by the offender and the Lancashire MASH requested information about the offender they were told that the offender was not known to the probation service. This is despite the request clearly detailing that the offender had been released on life licence in 2012. It transpired that an e-mail to the OM had not been received because an incorrect address had been used. The police could have sought further clarification and further information.	The Panel examined the mechanism for communication across all agencies involved in the MASH and concluded that it needs greater quality assurance. In this particular case, email communication alone was not sufficient to ensure the transfer of important information. Therefore e-mail communication alone must not be relied upon.
6	There were two opportunities to discuss the process required to implement the recall of the offender. The OM discussed these opportunities with a senior officer.	The decision not to recall was made because there was an absence of any specific and detailed information (such as clear and verified information that Chan had been subject to an assault) that would support a decision to recall.

7	The Panel asked to be given a clear description of what happened in the MASH to explain the rationale for altering the risk rating of the referral from high to medium.	The Protecting Vulnerable People form was completed by the police officer who attended Chan's address. This form was submitted into the MASH and was assessed. Due to the PVP being graded as 'high-risk' it was passed to the Detective Sergeant in the MASH. A decision was made to send officers from the Public Protection Unit to Chan's address. Following the visit (where Chan denied any assault had taken place) the PVP was updated and referred back in to the MASH. The decision was then made by the Detective Sergeant in the MASH to alter the risk grading to Medium Risk. During this time a MARAC form was completed and submitted with a grading of 'High Risk'. Later the same day, when the PVP has been re-submitted to the MASH, the decision to re-grade the Risk Assessment from High to Medium was sent to MARAC. This alteration to the grading from high to medium led to the case being removed from the MARAC list. The Panel has requested that from now onwards anyone convicted of a domestic abuse murder or manslaughter and who is released and forms another relationship will be discussed as a 'high risk' at the local MARAC.
8	A Children and Families assessment was completed by Children's Services in March 2014. This was done in response to the information received by the Police via Chan's step-father. The social worker, in noting no current and visible injury, subsequently felt that the victim's explanation of the events (that the offender had not assaulted her) was credible.	The view of the panel is that Children's Services should revise their policy on safeguarding children and adults. The new policy should specifically describe how to manage incidents where allegations of domestic abuse by known violent offenders have taken place. This should include direct liaison with GPs, if verification of injuries is considered necessary.

	This was an error because if enquiries had been made to the GP then the record of an injury would have been verified. However the GP was not contacted as part of these enquiries.	**National Recommendation:** Specific guidance should be issued to LSCB's in relation to the risks posed by violent offenders on life licence and should be explicitly referenced in the continuum of needs thresholds for Child Protection.
9	Police guidance relating to the use of safety equipment was not strictly followed in this case. The attending officers explained why they did not take PAVA[22] spray with them and explained why its use in a confined space is not recommended.	The Panel noted the reasons why PAVA spray was not taken by Police officers to the scene where the homicide occurred. The Panel accepted these reasons and acknowledged that the officers did not contravene their policy on this matter. The Panel believe that police policy on use of protective equipment should be implemented on every occasion and that the Force should quality assure this. The Panel has the Police to ensure that all officers are regularly reminded about the purpose and the importance of protective equipment.
10	Considering a more general point, the Panel wishes to ensure that domestic abuse is considered as a high priority by all relevant services.	The Panel has asked Lancashire Constabulary to amend its domestic abuse policy so that all reports of domestic abuse, where the allegation concerns a person with a conviction for murder, attempted murder or manslaughter, are always graded as 'high risk'.
11	The Panel wished to know if it is usual for patients with a suspected broken jaw are not seen alone when they attend A&E or equivalent service?	The Panel noted the response from the NHS that stated that it is not unusual for patients presenting with a broken jaw, or any other injury, to be seen in the presence of someone else. Any patient can request for someone to be present whilst they are seen. However, the NHS response did state that the expectation would be

[22] PAVA – this is a spray used to minimise a person's ability to resist control and restraint

		that if the practitioner seeing the patient suspected that the injury **could** be as a result of domestic violence or abuse, arrangements would be made to see the person alone. In this case Chan made it very clear that the injury had been sustained a week before she attended for treatment and that the injury was as a result of a fight with another woman.
12	The Panel wanted to know when the OM insisted that the offender disclose his previous crime to Chan and whether the OM verified this disclosure?	The Panel noted that the offender manager was not obliged to insist on a full disclosure from the offender when Chan was his 'employer'. The Panel has emphasised that whenever these circumstances arise and an offender forms a new relationship when released from prison, the offender manager will <u>insist</u> upon a full disclosure from the offender.