Trafford Safeguarding Adults Board

Safeguarding Adult Review

for

'Jeanette'

May 2025

Contents

Acknowledgements

This Safeguarding Adult Review was undertaken by Trafford Strategic Safeguarding Partnership and concluded by its successor Trafford Safeguarding Adult Board. The statutory membership of both bodies remains unchanged, and those agencies wish to acknowledge that there has been unacceptable delay in the completion of this review. Some of the delay can be attributed to the time taken to commence the review; whilst the rest is because the first version of the report required further work to identify important learning in respect of safeguarding practice.

Trafford Safeguarding Adult Board Executive recognise that such delays will create additional distress to those who knew and loved Jeanette, and also delay the embedding of learning within our safeguarding practice.

Trafford Safeguarding Adult Board is committed to learning from the way it has conducted this review and will include in its 2024-2025 Annual Report the impact of the revised arrangements that are being put in place to complete timely and high-quality learning reviews that promote effective learning and improvement action to prevent future deaths or serious harm occurring.

1. Introduction

1.1 Jeanette was in her fifties when she died of cancer. She was known to multiple services over the years who supported her with both physical and mental health needs. Jeanette had a history of suicidal ideation and took several overdoses of prescribed medication. Jeanette was admitted to hospital under a section and received a formal diagnosis of bipolar disorder. Other diagnoses over the years included paranoid personality disorder[1] and obsessive-compulsive disorder,[2] alongside periods of anxiety and psychosis.

1.2 Jeanette was also known to have problematic alcohol use and physical health issues including a history of gastrointestinal issues, hyperthyroidism and diabetes. Jeanette was known to be a heavy smoker, and it is recorded that she would smoke around 40 cigarettes each day.

1.3 Jeanette was described by practitioners as knowing what she wanted and being very able to communicate this. Jeanette's GP described her as "living a chaotic lifestyle", which was linked to her mental health diagnoses and alcohol use.

1.4 Jeanette was also known to the police who attended multiple call outs where she presented as paranoid and confused. Jeanette was admitted as an in-patient for a short period in a Mental Health inpatient ward. When she was discharged, Jeanette was referred to the Greater Manchester Mental Health (GMMH) Crisis Team who supported her on and off until she passed away.

1.5 Jeanette had been in a relationship with Nishtar for 4 years before she died. Nishtar had a history of violence against partners and was observed by practitioners to be aggressive and volatile. He also had a diagnosed mental health condition and is recorded as suffering from psychosis which was managed by medication which he often did not take.

1.6 Jeanette died at home where Nishtar was also present. Due to bruising on Jeanettes body, Nishtar was arrested by the police but the case was closed when it was found that Jeanette's cause of death was caused by her physical illnesses.

[1] A mental health condition characterized by a pattern of distrust and suspicion of others without adequate reason. People with PPD believe that others are trying to demean, harm or threaten them.
[2] A mental health condition where a person has obsessive thoughts and compulsive behaviours.

2. Methodology

2.1 Following Jeanette's death, and arrest of Nishtar, a Domestic Homicide Review (DHR)[3] referral was made by the police. However, when it was understood that there was no third-party involvement, Jeanett's case was considered for a Safeguarding Adult Review (SAR) and a decision made to conduct a discretionary review.

2.2 Due to the presence of domestic abuse, and the need for a contextual analysis of the case, a traditional review methodology was adopted to assist with systems learning linked to domestic abuse.

2.3 The scoping period for the review covered the three years prior to Jeanette's death, as this was the period where concerns were initially raised regarding Nishtar's controlling behaviour. Agencies were also asked to provide information pertaining to any domestic abuse prior to this date.

Key Lines of Enquiry

2.4 The key lines of enquiry for this SAR were as follows:

a) Did practitioners treating, or responding to Jeanette, recognise coercive control, and how did they adapt their responses accordingly?

b) Was information sharing between agencies proactive and in line with safeguarding, and domestic abuse related information sharing protocols?

c) Did risk assessments take into account Jeanettes mental and physical health, alongside her experiences of coercive control?

d) An analysis of DASH (Domestic Abuse, Stalking and Honour Based Violence Risk Identification) completed in respect of Jeanette by all agencies to understand if professional judgment was correctly applied and were practitioners confident in their assessment of risk.

e) An analysis of MARAC (Multi-agency Risk Management Conference) process in respect of Jeanettes and Nishtar's relationship, including:

i. Quality of referrals into MARAC – also see paragraph above

[3] DHR_Stat_Guidance_DRAFT_Final.pdf (publishing.service.gov.uk)

ii. Quality of decisions made, and action plans created at the MARAC

f) How did health and social care services, responding to Jeanettes mental and physical health, interact with specialist services?

g) In what ways could this joined up approach have been improved?

h) Risk analysis and support for Nishtar as a perpetrator of domestic abuse, with his own complex needs

i) Was Nishtar identified as a carer for Jeanette? And if so, was he offered a carer assessment?

j) An analysis of the impact of caring for Jeanette, on Nishtar's mental health – and how Nishtar's mental health was assessed in terms of risk to Jeanette.

k) How were Jeanette, and Nishtar, supported following Jeanette's diagnosis of cancer as part of an end of life pathway?

l) Understanding of the escalation process available to practitioners when the home environment is recognised as not being safe. How are practitioners supported to challenge situations where patients who are vulnerable are returning to an unsuitable environment?

m) An analysis of hospital discharges plans and consideration of risk in the decision-making process.

n) How was mental capacity and executive functioning considered throughout the scoping period.

2.5 Due to changes in personnel within Trafford's Safeguarding Adult Board the review experienced significant delays. The review process involved a series of sessions held with practitioners who directly supported Jeanette, as well as their relevant line managers and commissioners. The SAR report was completed in 2024 however further work was requested by the TSAB Executive on the analysis and recommendations in the report and after a period of review the final version was completed in May 2025.

2.6 In order to protect the identity of individuals involved in this review the Executive requested that an Executive Summary be produced for publication on the website.

Contributing Organisations

Organisation
ViMar Solutions LTD
Greater Manchester Police (GMP)
Greater Manchester Mental Health (GMMH)
Manchester University NHS Foundation Trust (MFT)
Manchester University NHS Foundation Trust (MFT)
NHS Greater Manchester Integrated Care Board (ICB)
L&Q housing provider *(formally Trafford Housing)*
Trafford Domestic Abuse Service (TDAS)
Northwest Ambulance Service (NWAS)
Adult Social Care (ASC)

3. Summary Extract from the Timeline and Review Findings

3.1 Prior to the review period, Jeanette was contacted by a previous partner who was in prison for violent offences. A letter sent to Jeanette was intercepted by prison staff and GMP were alerted. The letter requested funds to buy drugs and made threats to harm if she did not send money. Jeanette did not initially appear afraid, however she re-contacted police after speaking to a friend, who became concerned for her. Adult Social Care (ASC) were alerted, and Jeanette told them she was planning to move house.

3.2 Later Jeanette told GMMH staff that she was planning to move out of Manchester with a partner who was moving to another county for work. She was seen again by GMMH in 2018 and early 2019 but had not progressed her intention to move house. GMMH staff record "Jeanette's partner" being present during one of the home visit and other visits involved her 'sister' but no details were recorded.

3.3 In April 2019, Jeanette called GMP about Nishtar. She had asked him to leave her property as they had separated but he was refusing to leave. He eventually left with his belongings once the police had spoken with him. Jeanette was risk

assessed as low risk. Two days later she called police again, as Nishtar had been texting Jeanette to say he wanted to come back to the property. Jeanette described Nishtar as controlling and she was nervous about him turning up at the house, another low risk assessment was made and "no crime" was recorded.

3.4 Jeanette called the police again three days later to state that Nishtar was continuing to harass her. At this point a medium risk assessment was made due to the pattern of behaviour occurring over the week, and a Multi-Agency Risk Assessment Conference (MARAC)[4] referral was considered – however this was not progressed as there was no indication of serious risk of harm. This would have been a good time to refer Jeanette to specialist domestic abuse services. During the scoping period TDAS were commissioned to deliver domestic abuse services, and a referral into TDAS could have provided Jeanette with a trained domestic abuse specialist to speak to, who could have raised her awareness of healthy relationships and helped her to recognise Nishtar's controlling behaviour.

3.5 A few days later, Jeanette spoke to her GMMH worker about Nishtar, not accepting the relationship being over and that she had called police to remove him from the house. The GMMH worker initially tried to explore this further, however Jeanette's apparent lack of fear or concern about the situation was taken on face value, with no ongoing actions or consideration of Jeanette's additional vulnerabilities and a safeguarding referral to Adult Social Care was not completed.

3.6 Jeanette continued to contact the police about Nishtar stating that he was subjecting her to mental abuse and was refusing to leave her property. Police attended her property, spoke to Jeanette and called Nishtar to tell him not to return to Jeanette's property. This was recorded as no crime and Jeanette was assessed as low risk. The officer referred Jeanette into the STRIVE team, which was an initiative to reduce police call outs by volunteers offering support and early intervention, including signposting into relevant services. Although records indicate that the attending officer considered the history between Jeanette and Nishtar, the risk level of standard was arrived at due to the lack of threats, or offences occurring. However, consideration could have been given to the fact that Jeanette was finding it difficult to remain resolute regarding the relationship ending, and Nishtar was able to make his way back into the home and then refuse to leave. Nishtar had a criminal history of violence against women and girls, which was not considered at this point.

3.7 Nishtar had a history of violence, aggression, threats to kill, intimidation and sexual assault and spent a period of time in prison. In August 2019 GMMH recorded a Risk of Violence Alert on Jeannette's file highlighting her "partner has

[4] MARAC FAQs General FINAL.pdf (safelives.org.uk)

history of assaulting females". During this period Jeanette was resolute that they had separated. However, in December 2019, GMMH staff visited Jeanette, and Nishtar was at the property when they arrived. Jeanette stated that after he had left previously, they remained friends, and he stayed over occasionally. During this period Jeanette's mental health state was assessed as stable with no indications of psychosis. As a result, this information was taken on face value and there was no further exploration.

3.8 Jeanette continued to speak to GMMH about her "friend/former partner" visiting and staying over, and references that she has "had enough" of the relationship. There was a lot of discussion recorded regarding Jeanette no longer wanting to be in this relationship – whether this was an intimate or platonic relationship. It does not appear that the possible barriers to her ending the relationship were explored.

3.9 In March 2020, the National Covid-19 restrictions were introduced which reduced the movements of the public, who were told to "stay home" and "self-isolate". For Jeanette, this would have meant being socially isolated from supportive people in her life, and self-isolating with Nishtar in her home.[5] In April 2020, she told GMMH that "her partner" was supporting her to get essential items. No name was asked or recorded for the partner, and the GMMH did not ask if this was Nishtar, who had posed an issue to Jeanette a couple of months before.

3.10 In May 2020, Jeanette called the police, to report that she wanted Nishtar to be removed from the property. She stated that he had not been taking the medication for his mental health conditions, and his behaviour had become erratic. At this point "no offences" were identified by police. However, Jeanette was discussed in the Daily Risk Management Meeting[6] and information was passed to GMMH to speak to her about the relationship. This highlights how the sharing of information can lead to a more positive and joined up response to concerns of abusive behaviour, particularly when the victim is a vulnerable person.

3.11 There does not appear to be any record of GMMH undertaking a needs assessment of Jeanette and Nishtar.

3.12 At this point, aside from the STRIVE volunteer contacting Jeanette, no additional referrals had been made to specialist domestic abuse services for Jeanette. During this period, she was isolated at home due to the Covid-19 restrictions, and there was a clear pattern of behaviour where she asked Nishtar to leave the home and he either refused or left when told by police and later returned. Jeanette was

[5] COVID-19_-_guidance_for_domestic_abuse_safe-accommodation

[6] This is a meeting held by Greater Manchester Police, which is also attended by Adult Social Care – any cases which have come in overnight or over the weekend are discussed and responded to/referred appropriately.

clearly not able to navigate Nishtar's behaviour on her own, and specialist services may have provided her with the support to follow through with ending the relationship.

3.13 During this time GMMH contacted Jeanette each day for updates. She advised that Nishtar was trying to move back to the home and in May GMMH suggested a referral to specialist domestic abuse services, which was good practice, however Jeanette declined this support. Later in the same month, Jeanette called the police to state that she had allowed Nishtar back into the property as she felt sorry for him, however he had not changed and started immediately telling her what to do. It is recorded by police that there was no "coercive behaviour" however this does not align with the behaviour's that Jeanette had been describing for the past months. Again, this was recorded as standard risk, which appears to omit consideration of patterns of behaviour, cumulative risk and Jeanette's additional vulnerabilities.

3.14 Jeanette also spoke to GMMH who recommended that Jeanette have her locks changed, so that Nishtar would not have a key to the property. Jeanette stated she could not afford this. This could have been an opportunity to revisit a referral to domestic abuse services, who may have been able to assist with changing her locks via her Social Housing Provider.

3.15 Through her regular contact with GMMH, Jeanette said that she was also supported by Women's Aid and Victim Support services, however there was no record within any of the agency case notes from this period that Women's Aid or Victim Support were in place at this time. This could have been identified if a joint meeting had been called to formulate a safety plan.

3.16 In June 2020 Jeanette had a housing move planned via a mutual exchange.[7] However a call was made to Jeanette's social housing landlord stating that Jeanette had a male living at her property. Jeanette believed this call was malicious and that it had been made by Nishtar, indicating that his behaviour continued to have an impact on her life.

3.17 Jeanette's physical health then started to deteriorate. She attends A&E due to chest pain on three occasions between September and October 2020.

3.18 In December 2020 Jeanette disclosed to the police that Nishtar had assaulted her after asking him to leave. Nishtar was arrested but denied the assault, and at this point Jeanette declined to give a statement. Nishtar was handed a Domestic

[7] This is the opportunity to swap social rented homes with another resident who is renting a home through either a social housing landlord, or the local authority. Mutual exchange | L&Q Group (lqgroup.org.uk)

Violence Protection Notice (DVPN)[8] and the case was "no further action." Nishtar breached the DVPN upon release from custody, and a Domestic Violence Protection Order (DVPO)[9] was granted. At this point Jeanette was spoken to about the Domestic Violence Disclosure Scheme (DVDS)[10] referral but stated that her and Nishtar were no longer in a relationship, they were just friends, and she didn't want him back in her life. She did however agree that if they were to resume a relationship that she would like a disclosure, but she was adamant at that time that they wouldn't get back together. It was deemed by a GMP Inspector that as they were no longer together, she was not eligible for a DVDS disclosure, as the safeguarding risk was deemed to be reduced.

3.19 The police made a referral to TDAS (Domestic Abuse) outreach support following the incident in December. Jeanette spoke with the TDAS worker and stated she was well and did not need support.

3.20 In February 2021, Jeanette reported Nishtar to GMP, as he was staying at her property again and was refusing to leave. Upon attendance, Nishtar told police he was caring for Jeanette who was unwell. Jeanette told the police in front of Nishtar that she did not want him at her property. Nishtar was asked to leave and told police he was homeless and had nowhere else to go. An Adult Concern Care Plan (CAP)[11] was submitted for Nishtar, as he contacted police shortly after leaving the property stating he was suicidal. The incident was recognised as a domestic abuse incident by the attending officers, who created and submitted a medium risk DAB to the police District Safeguarding Team.[12] An enhanced risk assessment was then completed by the specialist officer within the District Safeguarding Team – as per procedure in place at the time. This officer then attempted to contact Jeanette several times to discuss the incident, however they did not receive a reply. A voicemail and text message were sent to Jeannette with contact details.

3.21 During March and April 2021, Jeanette contacted her social housing landlord regarding a move, as she had been waiting over a year and needed a walk-in shower due to mobility problems. Jeanette struggled with the online bidding system, so was referred for assisted bidding[13] with the Creative Solutions Team. However, her request for adaptations could have triggered the housing association to submit a request for a Care Act assessment.

[8] The Crime and Security Act 2010 Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) guidance - GOV.UK (www.gov.uk)
[9] *Ibid*
[10] Domestic Abuse Act 2021 Domestic_Violence_Disclosure_Scheme.pdf (publishing.service.gov.uk)
[11] Greater Manchester Police process when a vulnerable adult with care and support needs is identified
[12] The equivalent of the Multi Agency Safeguarding Hub (MASH)
[13] Trafford Homechoice - Login

3.22 Following two A&E visits due to abdominal pain, Jeanette was admitted to hospital where she disclosed to nursing staff that she was unhappy with how Nishtar treated her. Nursing staff completed a DASH and liaised with GMP. This was good practice.

3.23 Whilst she was in hospital, Nishtar had been calling the ward, and her friends, trying to find out where she was. Jeanette stated she did not want action taken against Nishtar but just wanted him to leave her alone. A crime of stalking was initially recorded, and an assessment of medium risk was made. This was downgraded to standard risk a crime of harassment was recorded.

3.24 The hospital completed a DASH assessment for Jeanette which resulted in a MARAC referral citing professional judgement. This was good practice. A plan was made at the MARAC, to provide Jeanette with information about Nishtar's offending history, under the DVDS.

3.25 Officers contacted Jeanette to arrange to attend and deliver the DVDS, however it was Jeanette's decision at that time that she didn't want the DVDS, as she was in pain and poorly. Further attempts were made to contact Jeanette, and she was left a voicemail to re-contact the officer, however, Jeanette never made contact and no follow up was done and the DVDS plan was not completed.

3.26 There was a referral made by GMP to TDAS for an Independent Domestic Violence Advisor (IDVA)[14,] who called Jeanette on four occasions. The first call focused on Jeanette's safety at home, and she indicated that she did not want to move house, so a safety plan was discussed with her for when she was discharged from hospital. On the second call with the IDVA, Jeanette stated that Nishtar had tried to visit her and was harassing her friends. The IDVA requested GMP place a marker on Jeanette's address for immediate response and requested a Fire Service assessment for when she returned home.

3.27 At this point Jeanette indicates that she does not want to move and requested the IDVA case be closed as the engagement between Jeanette and the IDVA was focused mostly on housing and a possible house move. The IDVA also liaised with police and the social housing landlord during this time.

3.28 The police recorded an action from the MARAC meeting for GMMH to confirm if Jeanette's care needs were being considered. This action was not documented in GMMH records by the representative who attended MARAC.

[14] The IDVA role is to support victims of domestic abuse, who are at high risk of serious harm from their partner, ex-partner, or family member.

3.29 Jeanette informs GMMH that she had been diagnosed with terminal cancer.

3.30 Throughout 2021 Jeanette's Cancer treatment leaves her feeling "wiped out". This reduced her mobility and she also reported financial difficulties. Both elements would have increased her dependency upon other people, including Nishtar.

3.31 Jeanette then has several recorded contacts with NWAS and A&E where she received care and then returned home. Jeanette spoke about her fear of having no one at home to care for her. Despite this, in July 2021 NWAS reports a "partner" at the property acting "oddly".

3.32 Jeanette remained in contact with her social housing landlord regarding offers of alternative properties but either declines the one on offer as not appropriate or misses offers due to being in hospital.

3.33 In July 2021 NWAS requested a Care Act assessment, citing Jeanette's worsening physical health due to the recent diagnosis of lung cancer and reduced ability to care for herself. ASC contacted Jeanette who stated that her partner does cooking and some of the shopping, and that Macmillan had provided her with a volunteer to take her out shopping. Jeanette requested befriending, which the ASC duty worker organised, and also signposted her to the Christie Hospital Centre for support.[15] This information was not shared with GMMH professionals.

3.34 NWAS also raise a safeguarding concern relating to physical/emotional abuse following Nishtar's behaviour. When crews arrived to convey Jeanette to an outpatient appointment, he shouted abuse at the driver and pushed Jeanette back into the home, stopping her from getting into the ambulance. Discussing her case with GMMH, the worker confirmed that she had been quite unwell due to the chemotherapy, but they were not aware of any current relationship.

3.35 GMMH attempted to call Jeanette unsuccessfully and the safeguarding concern was not documented in clinical records or progressed. ASC also closed her case so there was no safeguarding outcome and NWAS were not updated regarding the referral.

3.36 Between August and December 2021 there is good multi-agency communication between ASC, GMMH, MFT and GMP who advised that Jeanette was currently at high risk of domestic abuse. The ASC duty team called Jeanette, who stated she was currently living on her own and requires support with personal care and food

[15] This was at the time that the Adult Social Care Safeguarding hub was being established. At the time information was passed to the community safeguarding team for screening, the team is no longer configured in this way.

preparation. An assessment was completed over the phone, and a visit would be undertaken by GMMH once Jeanette was feeling better.

3.37 A safeguarding referral was raised by the Macmillan nurse about Jeanette's safety at home. Information gathering by the Safeguarding Hub identified that Jeanette was in hospital, so the care notification (an alert sent between ASC teams on the recording system) was sent to the hospital team to utilise her time in hospital to speak to her away from Nishtar – this was positive practice.

3.38 An email was also sent to GMMH in relation to the safeguarding concern raised to establish if the previous Section 42 enquiry was progressing, as ASC's care records indicate GMMH were already aware of the safeguarding concerns. There is no documentation contained within GMHH records regarding the above safeguarding concerns or email correspondence.

3.39 Jeanette was discharged to a reablement placement. The placement raised a concern about Nishtar turning up and being abusive to staff. Jeanette had told staff she had no concerns about Nishtar and was happy to see him. The placement had not been provided with information about the relationship or concerns held by agencies.

3.40 On discharge home there was a pattern of concerns involving NHS 111 where Jeanette asked for help but refused to go to hospital as she was not allowed to smoke there. On one occasion a District Nurse called an ambulance for Jeanette, but upon arrival an unnamed male refused to allow them into the property, stating that Jeanette did not want to go to hospital. The crew liaised with ambulance control, who contacted Jeanette to confirm this was her wish and that she wasn't being kept home against her will. This is good practice. A further 999 call was made, this time by the GP receptionist, again the crew were turned away, however on this occasion there were no further actions taken to determine whether this was Jeanette's wish.

3.41 On another occasion, the Police were called following concerns raised by a friend that Nishtar was not feeding her. Police attended the property, Jeanette stated she no longer wanted Nishtar to reside there, he had been controlling her, and she had been giving him money. Nishtar was arrested on suspicion of coercive and controlling behaviour. She stated he was not her carer, although she did indicate that he cooked, cleaned and shopped for her, and during the police interview with Nishtar, he stated he was Jeanette's carer.

3.42 Nishtar presented during interview as experiencing his own mental health issues and required an appropriate adult[16] due to his demeanour. Nishtar was released with no further action, and police noted that he appeared to be performing care services for Jeanette. Considering their history, a repeat MARAC could have been considered and has been identified as learning.

3.43 However a referral was made to TDAS. The IDVA attempted to call Jeanette on three occasions, these were unsuccessful, and the case was closed due to lack of engagement.

3.44 In December 2021, Police received a report from Jeanette, who was a hospital inpatient, stating that she had allowed Nishtar to stay at her property for a few days as he had nowhere else to live, and now he was refusing to leave again. The situation was assessed as high risk, due to this being a repeat incident. It was recorded that Nishtar was a carer for Jeanette and also named as her next of kin.[17] Jeanette was asking for her keys back and wanted him to leave her property.

3.45 The case was heard at MARAC in January 2022 to consider Nishtar's situation. It was agreed at the MARAC that when Jeanette was about to be discharged, a professionals meeting should be held around safeguarding her return home, considering his continued presence at her home. This action was allocated to GMMH. Whilst this is recorded in GMP and ASC records, there is no evidence of this within GMMH's case notes.

3.46 Jeanette self-discharged from hospital against medical advice, and Nishtar collected her from the hospital. It was felt that Jeanette had mental capacity to make this decision, although there is no evidence that a formal capacity assessment was completed. Jeanette also declined consent for a safeguarding referral to be submitted. Police requested that a professionals' meeting should take place, as per the MARAC actions. This did not happen and there was no formal support, or care package, when she returned home.

3.47 ASC made a safe and well phone call to Jeanette on the same afternoon she self-discharged – and she stated she was home, and in pain, and "could do with someone popping in everyday to help". She asked for help with making food and getting washed and dressed. ASC updated GMMH who confirmed they would make contact, however, there are no records of this within the GMMH case files.

[16] This is an individual who safeguard and advocates for the rights of vulnerable individuals, including children or those with mental health conditions – during police interviews

[17] This is not a legal term, the next of kin recorded in health records refers to a contact name – someone who can organise discharge etc, and can be anyone they choose Is there a role for next of kin? - University Hospital Southampton (uhs.nhs.uk)

3.48 There followed multiple calls to NHS 111, NWAS and her GP. Jeanette was repeatedly falling off the sofa where she was sleeping but declining hospital care. NWAS crews reported clutter and self-neglect and poor personal hygiene and raised a safeguarding concern on two separate occasions with ASC. One included concern regarding fire hazard as Jeanette was smoking whilst lying on the sofa. Jeanette was deemed to have mental capacity to refuse conveying to hospital.

3.49 Despite a hospital bed being delivered and support offered by the GP, Occupational Therapist, District Nurse and Community Response Team Jeanette declined this. Jeanette was deemed to have mental capacity to refuse to move to the hospital bed, to go into hospital or a hospice. During this time, Nishtar is reported as being obstructive, however the GP reflected that he seemed to be acting out Jeanette's wishes to be left alone.

3.50 In February 2022, Jeanette was found deceased at her property. She was reportedly found sitting upright on her sofa; she had multiple bruising. Nishtar was initially arrested, but the case against him was closed as the pathologist report found that Jeanette had died from cancer. It was considered by the GP, when speaking to the Independent Reviewer, that the bruising may have come from Nishtar attempting to move Jeanette.

4. Reflection of Learning

4.1 The following section presents the lessons to be learnt from this review.

Section 75 and Caused Enquiries

4.2 This review has demonstrated that clarity is needed around Section 75 arrangements, particularly around caused enquiries. As per Section 79 Care Act 2014, the Local Authority cannot delegate its duties under S42 – S47. They can decide that another agency can undertake a S42 enquiry and report its findings back to the local authority (*caused enquires*).

Learning Point 1: *Under Section 75, responsibility remains with the Local Authority to gain assurance from the provider/s to decide whether further enquiry or action is required and, if so, what further enquiry or action is required. It is then the LA's responsibility to review the actions, outcomes and records the reasons to conclude the enquiry.*

Learning Point 2: *Clear escalation processes should also be in place and understood by professionals as part of the Section 75 arrangements and partners should feel confident to escalate concerns about delays and/or outcomes as part of the safeguarding activity.*

Management Oversight

4.3 There were periods of time in the review when appropriate procedures were not followed due to allocated workers being absent from work. It is important that there is consistent management oversight of cases held by allocated workers to ensure that adults with care and support are having their needs met.

4.4 The following Learning Point link to Management Oversight:

Learning Point 3: *Management oversight of cases should include regular and appropriate procedures to review cases involving adults with care and support to ensure their needs continue to be met when allocated workers are absent from work.*

Information Sharing, Record Keeping and Escalation

4.5 There does not appear to be any point throughout the scoping period where every organisation involved with Jeanette was fully aware of all her circumstances. For example, Jeanette's housing provider were not kept in the loop regarding Nishtar, particularly around his refusal to leave Jeanette's property. The Macmillan nurse was also not made aware of the risk posed by Nishtar, as the referral made by the acute hospital staff did not reference the DASH they had completed, or the MARAC referral they had made. The GP was not aware of any of the issues involving Nishtar and was only made aware of these issues during the SAR process. Additionally, NWAS were not kept updated regarding the risk levels.

4.6 There were several occasions where not all organisations linked to Jeanette were made aware that there had been MARACs, nor were they asked to contribute to the process. Most notably, the GP had no involvement in the MARACs, nor was MARAC information shared with them to ensure the primary care systems were flagged. It is important that, in addition to meetings and forums to promote the sharing of information, information should be shared consistently between organisations, particularly when there have been changes in circumstance or fluctuations in risk.

4.7 Specific names were not recorded in some of the agency case notes. There are references to “ex-partner” and “partner”, along with “friend”, and “sister”. This makes it difficult to cross-reference relationships when information is shared between agencies. Professionals across all services should be reminded of the importance of recording names alongside relationship types within their records.

> ***Learning Point 4:*** *Professionals across all services should record names alongside relationship types within their records to enable a clearer understanding of the people involved with a vulnerable person.*

4.8 There is no evidence that professionals considered or instigated the Escalation Protocol at any point in their involvement with Jeanette.

4.9 The following Learning Points link to effectiveness of record keeping, information sharing and Escalation:

> ***Learning Point 5:*** *Agency protocols should reflect the importance of documenting MARAC actions in case notes and clearly state the responsibility of feeding back against identified actions.*
>
> ***Learning Point 6:*** *Information provided on referrals needs to not only ensure an accurate picture of the patient/ client’s needs but also needs to highlight relevant risk information to ensure professionals are appropriately safeguarded when undertaking visits.*
>
> ***Learning Point 7:*** *Consistency in comprehensive and detailed case note recording and information sharing across agencies.*
>
> ***Learning Point 8:*** *If Adult Social Care identify that other professionals are supporting an individual, they should share relevant information with them to ensure a multi-agency approach to supporting adults with care and support needs.*

4.10 Since the review period, the following practice developments have been implemented:

- The introduction of Adult Safeguarding Care Documentation in GMMH’s electronic patient records will capture all safeguarding activity, including decision making, determination of the three-stage test, outcomes planning and partnership working. This has been successfully running in other parts of Greater Manchester and being developed in preparation to be launched in Trafford.

- A Service Manager for Mental Health Social Work has recently been employed by Trafford Council, who as part of their role will complete monthly safeguarding and social care audits on teams throughout GMMH Trafford. This will provide GMMH's Corporate Safeguarding Team, and Trafford Council, assurance around safeguarding systems, the application of legal and ethical literacy, Making Safeguarding Personal, and identifying if the delegated functions are being met.

- HIVE was launched in MFT in September 2022 except for Community services who continued to use EMIS electronic patient records. The HIVE systems allow for flagging of patients who attend and are assessed as high risk of domestic violence. District Nurses have "read only" access which enables them to review the risks and concerns that are flagged on the patients HIVE record. The review has highlighted that not all staff who have access to EMIS will have read only access to HIVE. However, if staff have concerns in relation to patient safety, they would be expected follow the safeguarding process and contact the safeguarding team who would support and advise in respect of pertinent information.

Coercive and Controlling Behaviour

4.11 Post separation abuse can take many forms.[18] There appeared to be a lack of professional understanding of domestic abuse, how this can (and does) continue after an intimate relationship ends. As part of the refresh of the Domestic Abuse Act 2021 coercive and controlling is now formally recognised as part of the act including the impact of coercive and controlling behaviour after separation, and once a couple no longer co-habit.[19]

4.12 This review will be developed into a case study highlighting the importance of concerned curiosity, especially when identifying coercive control alongside care and support needs. Professor Evan Stark - one of the architects of the Coercive and Controlling Behaviour offence[20] - describes coercive control as being "invisible in plain sight".[21] Marianne Hester describes coercive control as a "long thin offence." Coercive behaviours can be subtle and tend to be particular to the individuals in the relationship.

[18] Spearman, K, et al "Post=Separation Abuse: A literature Review Connecting Tactics to Harm" *Journal of Family Trauma, Child Custody and Child Development* (May 2023)
[19] Amendment to the controlling or coercive behaviour offence - GOV.UK (www.gov.uk)
[20] S.76 Serious Crime Act 2015
[21] Stark E *Coercive Control: How Men entrap Women in Personal Life* (2007) p.13

4.13 The elements of the offence of Coercive and Controlling Behaviour are as follows:

a) A person (A) commits an offence, repeatedly or continuously engage in behaviour towards another person (B), that is controlling or coercive.

b) At the time of the behaviour, A and B are personally connected[22]

c) The behaviour has a serious effect on B, and

d) A knows or ought to know that the behaviour will have a serious effect on B.

4.14 The serious effect element in Jeanette's case can be identified as her increasing reluctance to engage with health services, despite her health diminishing. This was assumed to be wholly her choice, however taking into account Nishtar's persistence in remaining in a relationship and/or living with Jeanette, and his staking and harassing behaviours when Jeanette was in hospital; it is easy to recognise that keeping Jeanette away from the positive influence of health care professionals would have worked in his favour.

4.15 It is not clear from the information gathered throughout this review, that any of the services fully understood or acknowledged Nishtar's coercive and controlling behaviour or understood the impact of this behaviour for Jeanette.

4.16 The information available was not viewed by practitioners through the lens of coercive and controlling behaviour, instead practitioners often relied upon the identification of direct threats of harm and/or violence in order to assess the risk which Jeanette was facing. As a result, it may have been the case that the level of risk Nishtar posed was not fully understood, and the extent of the effects of coercive control not fully appreciated, by professionals but also by Jeanette herself.

4.17 Jeanette was an adult with care and support needs, who had lived with paranoid personality disorder, and mental health conditions for many years. This led her to distrust many people and may have led her to isolate herself from wider society. Coercive control further isolates victims, and without the support and guidance of external influences, alongside the dependency that Jeanette had on Nishtar due to her illnesses, Jeanette would have been fairly easy to manipulate. Hence the pattern of separating and rekindling the relationship which was identified by professionals engaged with Jeanette. Contrary to what is often thought, victims do not return to relationships because they do not fear the perpetrator, or because the other partner is not coercively controlling, but because they are

[22]A and B are personally connected if they are - or have been - in an intimate relationship, or they live together and are members of the same family or are - or have been - in an intimate relationship

controlled to believe the abuser is sorry, that the abuser's behaviour is the victims fault, because they don't want to be alone, and (particular to Jeanette's situation) they won't find anyone else to care for them.

4.18 In 2021/2022 Macmillan Cancer Support and Standing Together[23] undertook a consultation with professionals working in cancer care, and victim/survivors living with cancer.[24] The following quote is taken from the title of the report "cancer made me weaker to abuse and abuse made me weaker to cancer." The consultation found that professionals working within cancer care did not have an eye to identifying domestic abuse, one consultant said, "I never thought about domestic abuse and cancer, I just think all my adults can speak for themselves…". Within the study it was found that of the twenty victim/survivors living with cancer who were interviewed, only 9 had disclosed domestic abuse to cancer professionals. The two biggest barriers to disclosing were them not thinking it was relevant to tell the person providing their cancer care, and that they were not asked the right (or any) questions about abuse.

4.19 Aside from DASH risk assessments completed by acute hospital ward staff, no other non-police DASHs were completed. This may have been due to Jeanette declining to answer questions; however, the assessments could have been completed with information known to professionals. There was also a lack of discussion and challenge with Jeanette regarding healthy relationships. There was also very little linking in with specialist TDAS staff, although Jeanette did not always give permission for referrals into TDAS, health and social care staff could have spoken to TDAS staff for advice and support around engaging Jeanette in conversations about healthy relationships.

4.20 Victims should be responded to in and around their current circumstances. During the practitioner sessions TDAS staff reflected that news of Nishtar's possible deportation which led them to assume that longer term Jeanette's risk would be reduced. However, learning highlights the need for safety planning to be based on immediate circumstances rather than any potential changes to future risk. This is also linked to the learning around utilising the time when someone is deemed to be in a "safe space" such as hospital, to speak with them, rather than waiting for them to return home. This is particularly important when an abuser has successfully manipulated the victim back into the relationship multiple times, and upon their return home it is highly likely that this will happen again.

[23] Standing Together
[24] 2022.04_Enhancing+the+cancer+workforce+response+to+DA_Setting+the+Scene.pdf (squarespace.com)

4.21 As the hospital were able to recognise that Jeanette was a victim of coercive control, they could have called a multi-agency professionals' meeting to information share and make plans for her return home.

4.22 It would appear that throughout the scoping period, Jeanette, and some of the professionals engaged with Jeanette, were occupied with Jeanette moving house. In hindsight, this appears to have distracted practitioners from the issues faced by Nishtar, and it may be that Jeanette was attempting to move without his knowledge so he would not know where she lived. Housing association landlords are in a good position to identify unhealthy dynamics in relationships and are also well placed to have challenging conversations about who is living where. It does not appear that housing recognised Nishtar's behaviours as problematic, and/or took advantage of their position to speak with Jeanette and/or Nishtar about their living arrangements. This may have been due to a lack of information being shared by professionals with the landlords. Domestic Abuse Housing Alliance (DAHA) accreditation is the UK benchmark for how housing providers should respond to domestic abuse in the UK. By becoming DAHA accredited, housing providers and services are taking a stand to ensure they deliver safe and effective responses to domestic abuse.

4.23 Since this review there has been a number of new initiatives that have been positive steps forward in providing specialist support to specific client groups, but also enhancing information sharing routes, which will in turn encourage practitioners across health to ask difficult questions.

4.24 In October 2023, TDAS have recruited a Safer Ageing Domestic Abuse Advisor (SADAA). The criterion for the project is anyone aged 55 and above, who is experiencing domestic abuse, and who lives or works in the Trafford area. The SADAA works alongside victim/survivors to increase their safety and provides guidance on matters include care and support needs, finances and housing, civil and criminal justice process. This SADAA role would have been suitable for Jeanette, and if it had been in place during the scoping period, it would be hoped that professionals would have referred Jeanette to the service. Early outcomes indicate that the project has a positive impact on the lives of the victim/survivors engaged with the project.

4.25 In April 2024, Primary Care introduced a Health IDVA, which is currently funded by the Integrated Care Board until March 2025. This role meets the gap between information sharing between MARAC and General Practices. This role followed a specific recommendation in two previous DHRs in Trafford.[25] Jeanette's GP told the Independent Reviewer of this SAR that he had a good rapport with Jeanette,

[25] Barbie (2020) Trafford-DHR-Barbie-Overview-Report-After-PQAA-feedback.pdf (traffordpartnership.org); and Dyanne (2021) Trafford-Domestic-Homicide-Review-Overview-Report.pdf (traffordpartnership.org)

but had not asked her about domestic abuse, or safety at home. He stated this was because he did not identify or consider that Jeanette was a victim of domestic abuse. This is in large part due to his Practice not being made aware of the MARAC referral for Jeanette. Had this role been in place at the time of the MARAC, the Practice would have been informed, and the GP may have been encouraged to ask Jeanette questions about her relationship. Jeanette may have opened up to the GP, who told the Independent Reviewer that he would often have very open and frank conversations with Jeanette about other matters.

4.26 GMP Launched a new Domestic Abuse Policy in August 2022. This was updated again in May 2023. The Policy Launch was followed by Mandatory DA Matters training[26] which commenced in November 2022, for all officers of rank and role. The policy now aims to provide greater clarity to police officers and staff on their responsibilities in relation to all aspects of domestic abuse from initial contact to investigations. This policy sets out expectations in how police tackle domestic abuse at every level.

4.27 Op Horizon was a police initiative first introduced during the UEFA European Football Championship competition in 2021. Due to its success, it has remained in place. The initiative involves an IDVA accompanying police officers to visit victim/survivors who have found it difficult to access services – for example they may not have access to a phone. There were periods of time where Jeanette did not answer the phone to professionals, and this initiative may have been beneficial, however it was not in place during the period in question.

4.28 The following Learning Points link to coercive and controlling behaviours:

Learning Point 9: *It is important for responding officers to consider any ongoing coercive and controlling behaviour, in Jeanette's case this may have helped to trigger a safeguarding response including information sharing with Jeanette's Care Coordinator and a referral to the Safeguarding Hub.*

Learning Point 10: *Jeanette was in a place of safety (hospital) which would have been an appropriate setting for the DVDS to be shared with her. Under circumstances where an individual is admitted to hospital and they decide, due to health reasons, not to accept the DVDS disclosure at that point, it is important that professionals ensure follow-up so that the disclosure is given at some point.*

[26] Domestic Abuse Matters - SafeLives

Lack of Multi-Disciplinary Meeting's

4.29 The Care Act 2014 sets out the "duty to cooperate" between agencies and working in partnership is one of the 6 safeguarding principles. Safeguarding planning meetings provide an opportunity to bring together all professionals involved with an adult with care and support needs who has experienced abuse or neglect. The purpose of the meeting is to share information, identify and manage risk, plan how to safeguard the person and review actions. They are a very important aspect of the safeguarding enquiry process when there are complex or rapidly changing circumstances, where the individual has complex and compound needs, and therefore many organisations with different remits and thresholds are involved with their care.

4.30 Professionals across all health and social care services, including non-statutory and charitable organisations should be empowered to set up multi-agency meetings/conversations, to pool information about the person they are supporting in order to risk assess, safety plan and provide appropriate ongoing support. The person in question must consent to this sharing of information, unless there is an urgent safeguarding issues – in which case, there should always be consideration of raising a safeguarding referral with ASC, or with permission from the individual, agencies should share information regardless of whether there is an established multiagency process in place.

4.31 A professionals' meeting for Jeanette would have been beneficial at various points throughout the scoping period, as this would have provided an opportunity to pull together the complexities of her case, in a formal setting, to aide communication and ensure robust multiagency plans could be made, actioned and monitored

4.32 Multiagency professionals' meetings prior to and following Jeanette's discharges from hospital could also have been considered. On the occasions when Jeanette self-discharged prior to a multidisciplinary meeting taking place, professionals could have considered progressing safety planning for Jeanette.

4.33 During the final week of Jeanette's life, there were multidisciplinary meetings, however these were impromptu, and reactive, and they did not involve GMMH.

4.34 TDAS is now based within ASC and the local authority Housing Options team and have recently become present at the Front Door.[27] The Front Door also has a specialist domestic abuse officer within the team, employed by Trafford Council.

[27] This is one place to make referrals - Trafford Adult Social Care Front Door (traffordsafeguardingpartnership.org.uk)

Informal carers

4.35 For the majority of the scoping period Jeanette did not have a care package. Nishtar was never identified formally as a carer, however he did describe himself as a carer for Jeanette at times, and Jeanette did describe some of his caring responsibilities.

4.36 There is no record of there being a carer assessment offered or discussed. Had a carers assessment been undertaken, this would have enabled discussions with Nishtar about his relationship with Jeanette and may have provided an opportunity to assess the risk he posed to her. Greater awareness of the fact that any professional or individual can make a referral for a carer's assessment, and everyone is entitled to a carer's assessment, would be beneficial.

4.37 Research indicates that often perpetrators of abuse are not spoken to, questioned or dealt with directly by practitioners.[28] There was no communication with Nishtar by professionals, apart from police asking him to remove himself from Jeanette's property. He was not spoken to about his behaviour, his motivations for remaining in the home and/or in a relationship with Jeanette. He was not asked about the nature of the relationship with Jeanette, whether he viewed himself as a carer, or whether he needed support. His behaviour was also not challenged by any professionals. In this way, he remained largely invisible yet continued having an impact on Jeanette's life.

6. Recommendations

1) Trafford Safeguarding Adults Board (TSAB)[29] to seek assurance that
   - the importance of comprehensive and detailed record keeping,
   - effective information sharing and the
   - Trafford Escalation protocol

   is communicated and understood by practitioners.

2) Trafford Safeguarding Adults Board in conjunction with the Community Safety Partnership to undertake multi-agency audits, with all partners in relation to caused to make enquiries under Section 42 of the Care Act, involving the safeguarding response to adults with care and support needs who are victims of Domestic Abuse, including coercive and controlling behaviours. This should

[28] Responding to perpetrators - SafeLives; Symonds, J. (2014: updated 2018) *Working with Fathers in Child Protection: Lessons from Research* Community Care Inform

[29] Trafford Safeguarding Adults Board (TSAB) however, during the period of this review, the TSAB was formally Trafford Strategic Safeguarding Partnership (TSSP).

include adults who are receiving a Care Plan Approach from a care coordinator in GMMH.

3) Trafford Safeguarding Adults Board and Trafford Domestic Abuse Service to deliver learning which highlights potential additional indicators of risk for Domestic Abuse, for example where the perpetrator could be in a caring role.

4) Trafford Safeguarding Adults Board to seek assurance that there are mechanisms in place to plan and oversee enquiries which are caused by ASC, through to completion, and where issues arise ASC are taking appropriate action to ensure enquiries are completed. TSAB to also seek assurance that there is sufficient emphasis on the provision of appropriate training and support for practitioners who manage Section 42 Safeguarding Enquiries.

5) Trafford Safeguarding Adults Board will undertake a multi-agency audit to seek assurance that information obtained following the submission, and receipt, of a safeguarding concern is shared with the referrer to enable appropriate statutory and local pathways to be instigated.

6) Trafford Safeguarding Adults Board will review the current Multi-Agency Safeguarding Procedures and seek assurance that Multi-Agency/ Professionals meetings are an effective part of safeguarding responses and assist all agencies to coordinate and facilitate professional's meetings. Particularly at points of discharge and when self-discharging, it's important that discharge planning meetings to continue to assess and manage risk.