ROCHDALE SAFER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'David'

REPORT FOR PUBLICATION

DECEMBER 2016

Review Panel Chair: David Hunter

Report Author: Paul Cheeseman

CONTENTS

1. INTRODUCTION

1.1 The principal people[1] and places referred to in this report are:

David	Victim	White British
Geoffrey	Perpetrator & Son of David	White British
AF1	Partner of Geoffrey at date of homicide	
AF2	Deceased daughter of David and AF3, sister of Geoffrey	
AF3	Deceased mother of Geoffrey and AF2 and partner of David	
AM1	Brother of David	
AM2	Brother of AF3	
AF4	Partner of AM1	
Female AF5	Former partner of Geoffrey and mother of JM1	
Juvenile Male JM1	Son of AF5 and Geoffrey, grandson of David	
Address one	Home of AM1 and scene of homicide	
Address two	Home of David	

1.2 This report concerns the homicide of David. He was killed by his son Geoffrey on an afternoon in spring 2015. The relationship between David and Geoffrey had

[1] A family tree is included at Appendix B

deteriorated over recent years since the death of AF2 and AF3. Geoffrey made threats to relatives that he would harm David. David was terminally/chronically ill and was cared for by AM1. In the weeks before he died David complained to family members that Geoffrey had stolen money and items of property from his home. He informed Greater Manchester Police of harassment and threats to harm from Geoffrey. Geoffrey was also wanted by Greater Manchester Police for an offence of robbery.

1.3 On the afternoon of the homicide Geoffrey entered address one covertly. It is believed he climbed up some scaffolding and through an insecure window. AF4 found him leaving the house. He was covered in blood and he assaulted AF4 and fled. David's body was discovered a few minutes later and the emergency services were called. His life could not be saved. A post mortem concluded that he died of multiple stab wounds. He had been subjected to a sustained and forceful attack.

1.4 Geoffrey later approached police officers and said he had come to hand himself in. He was arrested and admitted killing David. When interviewed, he said he held David responsible for the deaths of his sister AF2 in 2006 and his mother AF3 in 2010. Geoffrey was charged with David's murder and the assault on AF4.

1.5 Geoffrey appeared before a Crown Court where he was found not guilty of his Father's murder, but guilty of his manslaughter. Imprisoning him for 10 years, with another three years of extended licence, a judge said Geoffrey was a violent and dangerous man who posed a "significant" risk to others.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Decision Making

2.1.1 Rochdale Safer Communities Partnership decided that the death of David met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 (the Guidance).

2.1.2 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set as 15.12.2015. This date could not be met because further information was required from some agencies. The chair of Rochdale Safer Communities Partnership therefore approved an extension to the completion date of 24.02.2016.

2.2 DHR Panel

2.2.1 David Hunter was appointed as the Independent Chair and Author on 18.05.2015. He is an independent practitioner who has written previous DHRs, child serious case reviews and multi-agency public protection reviews. He was supported by Paul Cheeseman who authored the report and is also an independent practitioner and has chaired and written previous DHRs. Neither has been employed by any of the agencies involved with this DHR and they were judged to have the experience and skills for the task. The first of four panel meetings were held on 29.06.2015. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

The Panel comprised of:

➢ Paul Cheeseman	Independent review author
➢ Rebecca Duggan	Detective Inspector Greater Manchester Police
➢ Janet Emsley	Cabinet member Culture, Health and Wellbeing Rochdale Borough Council (RBC) (Independent Panel Member)
➢ Ian Halliday	Rochdale Safer Communities Partnership
➢ David Hunter	Independent Chair
➢ Merissa Kenny	Pathways
➢ Karen McCormick	Heywood, Middleton & Rochdale Clinical Commissioning Group

➢ Claire Ousey	Pennine Care NHS Foundation Trust
➢ Caroline Page	Renaissance Drug and Alcohol Service
➢ Glenn Parkes	National Probation Service (National Probation Service)
➢ Stephen Watson	Adult Care RBC
➢ Pamela Wharton	Head of Practice Improvement Children's Social Care RBC
➢ Ruth Wilson	Victim Support

2.3 Agencies Submitting Individual Management Reviews (IMRs)

2.3.1 The following agencies submitted IMRs;

- Greater Manchester Police;
- Heywood, Middleton & Rochdale Clinical Commissioning Group (GPs);
- Pennine Care NHS Foundation Trust Rochdale Pathways Integrated Alcohol and Drug Service;
- Adult Care;
- The Guinness Housing Partnership

2.3.2 The following agencies provided reports or other relevant information;

- West Yorkshire Police;
- National Probation Service;
- Rochdale Borough Council Children's Social Care;
- Leeds City Council Children's Services.

2.4 Notifications and Involvement of Families

2.4.1 The DHR panel wish to record their condolences to David's family on their loss. David Hunter wrote to AM1 and AF4 to explain the DHR process and determine whether they wanted to contribute. Following the trial of Geoffrey, the police family liaison officer spoke to AM1 to ascertain he had received the letter and Home Office leaflet on DHRs from David Hunter. He said he had received them and did not want to participate in this process. AM1 said he did not want any further contact regarding the DHR. Information attributed to AM1 has therefore been drawn from material provided by Greater Manchester Police from their homicide investigation and IMR.

2.4.2 Because AM1 did not wish to contribute to the DHR process it was felt important to try and engage other members of the family. David Hunter and Paul Cheeseman visited AM2 and his wife at their home. AM2 was the brother of AF3 and the uncle of Geoffrey. He and his wife could provide some information about the relationship between Geoffrey and David.

2.4.3 David Hunter and Paul Cheeseman also visited AF5 and her son JM1. AF5 is a former partner of Geoffrey and JM1 is their son. JM1 is therefore the grandson of David. Except for Geoffrey, JM1 was the closest relative of David the DHR could engage with. Both AF5 and JM1 have maintained contact with Geoffrey and could provide some information about the relationship between him and David. JM1 also provided pseudonyms which he said he would like used in the DHR report to ensure the anonymity of the family.

2.4.4 David Hunter also wrote to the Senior Investigating Officer in Greater Manchester Police and HM Coroner informing them of the DHR.

2.4.5 Following Geoffrey's conviction David Hunter wrote and offered him the opportunity to contribute to the DHR. He agreed and he was seen in prison on 07.12.2015 by David Hunter and a member of the National Probation Service. Geoffrey's views are included within the report at section 3.7.

2.4.6 Prior to the murder of David Greater Manchester Police circulated Geoffrey as a wanted person for an offence of robbery. He was also wanted for harassment of David and AM1. The Independent Police Complaints Commission investigated whether Greater Manchester Police's response to effecting Geoffrey's arrest was appropriate. David Hunter therefore wrote to the IPCC and notified them of the DHR process and established an information sharing protocol. The Independent Police Complaints Commission determined that Greater Manchester Police should be responsible for the local resolution of this issue.

2.5 Terms of Reference

2.5.1 The purpose of a DHR is to;

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

(Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7)

2.5.2 Timeframe under Review

The DHR covers the period 09.06.2013 to the date of David's death. The reason for this was because it coincided with Geoffrey's return to the area from West Yorkshire where he had lived for a number of years.

2.5.3 Definitions

The Government definition of domestic violence can be found at Appendix A. (Hereinafter referred to as domestic abuse).

2.5.4 Case Specific Terms

1. What indicators of domestic abuse did your agency identify, including any threats to kill or harm David and what risk assessment[s] were undertaken?

2. How did your agency manage those risks and how did it respond to any new information which may have impacted on the risks?

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

4. How effective was inter-agency information sharing and cooperation in response to David and Geoffrey and was information shared with those agencies who needed it?

5. How did your agency ascertain the wishes and feelings of David and Geoffrey about any domestic abuse and were their views taken into account when providing services or support? Did you seek the views of their families?

6. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, including age and disabilities, when completing assessments and providing services to David and Geoffrey?

7. Were single and multi-agency domestic abuse policies and procedures followed and were any gaps identified?

8. How effective was your agency's supervision and management of practitioners who were involved with supporting David and Geoffrey and did managers have effective oversight and control of the case?

9. Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to David and/or Geoffrey or to work with other agencies?

10. To consider how this review can benefit workforce development and enhance partnership working.

3. BACKGROUND: DAVID AND GEOFFREY

3.1 The information in this section is drawn from material in the IMRs and information that Greater Manchester Police obtained during the criminal proceedings.

3.2 David

3.2.1 David was the youngest of five children. The family were separated from an early age and lived in care homes. David was addicted to unlawful drugs for most of his life and these included heroin. David did not work.

3.2.2 AF3 was David's long term partner and they had two children: Geoffrey and AF2. AF3 also had a son from another relationship. Because of AF3 and David's long term addiction to drugs other relatives say they and their children had never been a family unit. A relative also says that David perpetrated domestic abuse on AF3 and their children had a chaotic upbringing.

3.2.3 David was well known to criminal justice agencies. Between 1973 and 2008 he had thirty-nine convictions recorded against him for seventy offences. These included damage, theft, burglary and drug offences. As well as these convictions, there is information held by police forces that indicates during 2000-2001 David operated as a significant supplier of illegal drugs.

3.2.4 AM1 said that David had been ill for several years. He said around five or six years ago, before he died David was in intensive care and on a life support machine. AM1 said David was in a coma due to his drug taking but survived. He said David managed to come off the drugs and eventually moved into address two.

3.2.5 David suffered from chronic chest disease and needed an oxygen supply for about twenty hours each day. AM1 said David's health was so poor he moved in with him at address one. AM1 believed David did not have long to live but did not want to die in hospital. Therefore, AM1 and AF4 cared for David over a period of about eight months before his death except for a period of six weeks in 2015 when David returned to address two to live with Geoffrey.

3.3 Geoffrey

3.3.1 As stated earlier Geoffrey was felt by a relative to have had a chaotic upbringing because of his parents' addiction to illegal drugs. A relative says that from an early age David made Geoffrey steal for him. Consequently, the relative believes Geoffrey fell into the same lifestyle as his father.

3.3.2 Geoffrey's GP states he had a long history of being low in mood since childhood. He was known to have a poor relationship with David who he alleged physically abused him. Geoffrey ran away when he was 15 years old and never returned home. West Yorkshire Police records contained limited information from 22.05.1996 that AF2 ran away from home on that date and claimed AF3 and David were assaulting her. Because of the age of this information there is no record as to what action was taken. However, it tends to confirm the troubled family life that Geoffrey and AF2 had.

3.3.3 Geoffrey was also well known to criminal justice agencies and between 1995 and 2013 had twenty-seven convictions recorded against him for sixty-three offences.

These included assaults, damage, burglary, robbery, drugs, offensive weapons and motoring offences. There is also intelligence held by police forces that Geoffrey was known to be of a violent nature and had access to weapons, usually a knife, and on one occasion a firearm from which live rounds were discharged.

3.3.4 Geoffrey is known to be the father of four children. West Yorkshire Police hold a significant amount of information about Geoffrey which they helpfully provided to the DHR. Not all information is repeated here. It is clear from the information supplied that Geoffrey was known to West Yorkshire Police for several offences involving violence and weapons. On 09.01.1998 he was arrested in possession of a butcher's meat cleaver.

3.3.5 On 03.07.2004 he argued in the street with his girlfriend, produced a knife from his sock and smashed a car window. On 04.02.2005, whilst being arrested for an offence of criminal damage, he produced a knife and caused an injury to the hand of a police officer. While in prison in 2005, he was known to have used scissors to stab another person. He was dealt with for this matter through the prison discipline process.

3.3.6 Geoffrey lived with a woman in the West Yorkshire area for about four years and they had two children. West Yorkshire Police hold information about incidents of domestic abuse in which he was the perpetrator. On 24.04.2007 Geoffrey was arrested to prevent a breach of the peace after attending at his partner's house in drink and arguing. On 22.07.2007 Geoffrey was involved in a verbal argument in the street with his partner. On 07.08.2007 a third party reported that Geoffrey had assaulted his partner. Despite persistent enquiries by West Yorkshire Police his partner chose not to pursue this matter.

3.3.7 The most serious, and final, event involving his partner was on 16.11.2007. On this date police officers from West Yorkshire Police attended a report of a domestic incident involving Geoffrey and his partner. His partner jumped out of a window to escape leaving Geoffrey in the house with the two children. Geoffrey threatened police officers with a knife and eventually the officers broke into the house and used a Taser to subdue him. He appeared before a court and received a two-year community order, two years' supervision and a programme requirement.

3.3.8 His partner disclosed she wanted to flee the relationship after months of alcohol and drug fuelled violence. The house Geoffrey and his partner lived in was squalid and there was little food. Geoffrey's partner moved with her children to a women's hostel. West Yorkshire Police made all necessary referrals and are satisfied the actions they took were compliant with contemporary force policy.

3.3.9 As part of the investigation into David's homicide Greater Manchester Police obtained a statement from this partner. She said Geoffrey and she split up because he was bringing drugs into her flat. She said their relationship was "regretful, violent and volatile". On more than one occasion Geoffrey had threatened to kill her. She said the incident on 16.11.2007 resulted in Geoffrey "head butting" her.

3.3.10 Records from National Probation Service (at that time Greater Manchester Probation Trust) show that on 03.11.2009 Geoffrey received a sentence of 22 months' custody for a racially aggravated public order offence. He was also remanded in

custody for attempted murder. He was subsequently acquitted of this offence following a trial. Greater Manchester Probation Trust conducted a serious further offence report[2] (SFO) due to the fact Geoffrey was already subject to community order imposed for a domestic abuse offence of common assault (see paragraph 3.3.5). No significant issues were identified in relation to risk assessment, management planning or intervention.

3.3.11 The attempted murder charge related to an incident in which it is alleged Geoffrey and another man confronted four men known to him. They alleged Geoffrey threatened them with a knife or gun. The men made off in their vehicle and were pursued by Geoffrey in another vehicle. Both vehicles pulled up and Geoffrey is alleged to have approached the car shouting "come on let's sort this out". Geoffrey started discharging a firearm at the men. None of them were injured and they alerted a police patrol. On examining the victim's vehicle Greater Manchester Police found discharged rounds in its fabric. Geoffrey then made threatening phone calls to one of the victims saying "your body is going to get left on the floor". The details of the 2009 incident are recorded, in brief, on the Police National Computer (PNC)[3], and are mentioned on a crime report on the intelligence record held for Geoffrey on the Greater Manchester Police intelligence system OPUS.

3.3.12 In addition to the racially aggravated public order offence he was also dealt with for burglary and possession of cocaine. National Probation Service state a multi-agency case conference was called prior to Geoffrey's release from custody. There was also significant management oversight given the serious further offence. While in custody Geoffrey completed offence focused work and engagement during a period on licence. However National Probation Service state he still led a transient existence and was offending again within a short duration of the termination of the licence.

3.3.13 National Probation Service records show that on 08.06.2011 Geoffrey was sentenced to a 24 months suspended sentence order with 12 months' custody. He was also subject to an Addressing Substance Related Offending programme and 24 months' supervision. This was imposed for an offence of Burglary of a Dwelling. Geoffrey burgled a house where he believed the victim grew cannabis. He did not believe the cannabis was worth stealing and instead left with a knife and phone.

3.3.14 A report and assessment identified Geoffrey had been subject to parental substance misuse and led a transient existence residing with extended family members. Geoffrey disclosed significant levels of daily cannabis misuse. It was reported that

[2] The SFO Notification and Review procedure is intended to ensure rigorous scrutiny of those cases where specified offenders under the supervision of the Probation Provision have been charged with a violent or sexual offence Serious further offence

[3] PNC is the acronym for Police National Computer. This system holds records on people and vehicles. It can be accessed by all police officers and some police staff in all UK police forces. It contains information relating to the convictions recorded against a person together with other information, for example, whether they are wanted for an offence, are disqualified from driving etc. It does not contain a complete record of a person's arrest history.

Geoffrey displayed high levels of disengagement throughout the time he was subject to the supervision order.

3.3.15 National Probation Service identified potential risks associated with Geoffrey previous domestic abuse history, substance misuse, offending and anti-social behaviour. The National Probation Service report states strong attempts were made to engage Geoffrey and develop his understanding of emotional harm and neglect to children resulting from domestic abuse and parental substance misuse.

3.3.16 It is reported Geoffrey was apathetic towards supervision and derogatory towards his previous offender manager. These arrangements were changed due to the breakdown in their relationship and Geoffrey's refusal to see them. He was said to be nonchalant in supervision sessions. Eventually Geoffrey breached his licence conditions and requested to go to prison.

3.3.17 When he was released on licence following 6 months in custody National Probation Service report that Geoffrey made a more considered start to his licence. Geoffrey was treated by his GP for depression during this period and a Community Drug Outreach Team referral was made. Geoffrey was prescribed Mirtazapine for a short period. His cannabis use increased and motivational work was undertaken with him.

3.3.18 In 07.2012 Geoffrey spoke to Greater Manchester Probation Trust staff about AF3 and AF2's deaths and mentioned there was an inquest in respect of AF3 because of suspicious circumstances. Geoffrey was said to be unwilling or unable to articulate what these were when questioned. However, he blamed his own use of substances on the negative experiences he had during childhood. Geoffrey did not discuss David when asked about him, except to say that both his parents had substance misuse problems and that he did not maintain contact.

3.3.19 During this time National Probation Service report that Geoffrey presented significant challenges within the lifetime of his supervision. There was nothing suggestive of a specific risk towards David. Domestic abuse issues were considered towards previous partners and the safeguarding of his children.

3.3.20 When AF5 was visited by David Hunter and Paul Cheeseman she was specifically asked whether she had experienced any domestic abuse at the hands of Geoffrey. She said she had not and that she felt he was not an abusive person. She believed that comments David had made to Geoffrey about him (Geoffrey) being a 'smack head' had been too much for him and were the reason Geoffrey killed David. AF5 has continued to maintain contact with Geoffrey and she and JM1 visit him in prison.

3.4 The deaths of AF2 and AF3

3.4.1 AF2 died at the Royal Oldham Hospital on 02.03.2006. A report held by the Coroner's Office records that she was a known intravenous drug user and was admitted to hospital on 01.03.2006 with pneumonia and severe sepsis. There are no police records beyond the Coroner's report.

3.4.2 AF3 died on 23.06.2010. Her death was the subject of an investigation by Greater Manchester Police and an inquest was held into her death by HM Coroner at Rochdale. The police report indicates AF3 was found by David beneath a mattress after she had taken methadone, Valium tablets and heroin. Two other males were arrested on suspicion of murdering AF3. David said one of these males "tipped" AF3 off her mattress. The second male was arrested after it was alleged he injected AF3 with heroin the day before she died.

3.4.3 The arrested males made no admissions when interviewed and no one was charged in connection with AF3's death. An inquest held on 04.09.2012 found the death of AF3 was misadventure and HM Coroner recorded she died from combined toxicity of methadone, amitriptyline and morphine and chronic intravenous drug abuse with associated liver disease.

3.5 Relevant events preceding the homicide of David

3.5.1 AM1 said Geoffrey had "no relationship with his dad at all" up until about eight or nine months before the homicide. It was only because of David being very ill that Geoffrey had contacted his father in 2014.

3.5.2 AM1 is critical of Geoffrey and suggested he only made contact when he realised he could get money from David who was in receipt of disability living allowance. AM1 said David started to give Geoffrey money every day. He said Geoffrey was a drug addict who smoked cannabis.

3.5.3 AM1 says Geoffrey persuaded David to leave address one and return to live at address two. David lived there in 2015 for a period with Geoffrey and his girlfriend AF1. There were arguments between David and AM1. In 03.2015 David's mobility scooter was stolen. This was reported to Greater Manchester Police and AM1 believed Geoffrey was responsible (see paragraph 4.2.11).

3.5.4 Because Geoffrey had allegedly been taking advantage of David, AM1 says he moved back to address one. AM1 said that towards the end of 03.2015 "things got really nasty" when arrangements were made for a locksmith to change the locks at address two. This left nowhere for Geoffrey to live. He then sent threatening text messages to David and these were reported to Greater Manchester Police (see paragraph 4.2.15). In a telephone call made by Geoffrey to AM1 on 30.03.2015 he threatened to stab AM1.

3.5.5 Immediately after this call Geoffrey sent text messages to David saying he wanted him to die quickly, that he was a drug addict. In these messages, Geoffrey, blamed David for the deaths of AF2 and AF3.

3.5.6 Other witnesses give a similar insight into the fractured relationship between Geoffrey and David. In text messages Geoffrey sent to one of his cousins on 30.03.2015 he admitted taking David's mobility scooter. In the same text messages Geoffrey said that he would kill David. These threats were not reported to Greater Manchester Police as the person receiving them did not take them seriously.

3.5.7 Shortly before the homicide of David, Geoffrey spoke in person to another cousin. He said to them "If I didn't know my dad was already dying, I would go up and kill him." At this time, Geoffrey was holding a knife. He then said "I'm going up there now." This cousin did not believe that Geoffrey was being serious and consequently did not contact Greater Manchester Police.

3.5.8 AM1 said that on the afternoon of David's homicide he saw Geoffrey at address one talking to David. When Geoffrey left, David told AM1 that if Geoffrey returned to address one he should not let him in. AM1 said Geoffrey left his mobile telephone at address one. David therefore told his partner AF4 that, should Geoffrey return to it, she should hand the telephone to him through a window. AM1 then went to bed. When Geoffrey returned about thirty minutes later this is what she did.

3.5.9 Although AM1 and David knew Geoffrey was wanted by Greater Manchester Police in connection with a robbery and harassment crimes they decided not to ring the police. About thirty minutes after giving Geoffrey his mobile telephone Geoffrey appeared inside address one and for no obvious reason he punched AF4 in the face before leaving. It was not clear to AF4 how Geoffrey gained entry to the house. It was later discovered he climbed some scaffolding and entered through an upstairs window.

3.5.10 AF4 woke AM1. He then went to check on David. He found him in his bedroom covered in blood although he appeared to be breathing. An ambulance was called and David was taken to hospital. He died there from his injuries a short time later.

3.6 Admissions by Geoffrey

3.6.1 When arrested by the police Geoffrey said; "I don't mind doing life for him, buzzing, I feel so much better. He killed my mum and sister…..He only had two weeks left to live and I did not want him to die without paying for what he has done. He was terminally ill, he was gonna die in two weeks anyway."

3.6.2 When interviewed by police officers Geoffrey blamed his father for a bad upbringing. He said David introduced him to stealing and petty crime from an early age. Geoffrey also blamed his father for the death of both his sister and mother. He said David introduced them both to heroin.

3.6.3 Geoffrey said he had a cannabis habit and smoked the drug each day. He said he would get angry if he did not get his cannabis. Geoffrey said that after his mother's death he did not speak to David again until 2014 when he was told that his father was seriously ill.

3.6.4 Geoffrey said David told other people that Geoffrey had sold the mobility scooter. Geoffrey said David was calling him a "smack head[4]," which infuriated him. He hated to be associated with those words because of the history surrounding the deaths of AF3 and AF2.

[4] An expression used to describe people who misuse the drug heroin.

3.6.5 Geoffrey said that on the day of the homicide he argued with AF1 and bought some alcohol. He also said he smoked cannabis and took temazepam tablets. Geoffrey said he went to address one to confront David about the remarks he made. Although his father apologised Geoffrey said he stormed out. After consuming more alcohol and temazepam tablets Geoffrey said he climbed scaffolding outside address one and gained entry.

3.6.6 Geoffrey said David refused to let him in so Geoffrey climbed through an open window. He said he then repeatedly stabbed and beat David. During interview Geoffrey said he did this because of what David had put him through. Geoffrey said "He's hurt me that much yeah, and just things, the smack head thing...and just everything else...just sent me over the top and I just had to do it." Geoffrey also claimed he had mental health problems because of the way he had been brought up. That claim was not substantiated from medical information although Geoffrey had been treated for 'low mood'. The panel discussed and agreed that a person with a condition of depression has mental health needs.

3.7 Meeting with Geoffrey post-conviction

3.7.1 Geoffrey gave a detailed account[5] of his childhood during which he was exposed to his parents' use of unlawful drugs. He was taken into care when he was twelve years old and returned to the care of his parents when the home closed. Geoffrey said his life was awful and returned many times to the theme that he was never given a chance and only wanted to be treated like other people.

3.7.2 Geoffrey described his time living in West Yorkshire where he lived with his first partner and two children. He worked in a scrap yard where he earned income that he said provided for his family. Geoffrey said he did not drink alcohol although he did use cannabis. When asked about the domestic abuse in that relationship, Geoffrey minimised his part suggesting he only 'head-butted' his partner after she hit him.

3.7.3 Although he felt angry towards David after the deaths of his mother and sister, Geoffrey said he reached out to his father when he heard he was terminally ill. However, Geoffrey said very little had changed and that his father was still using heroin. He heard that David had called him a "Smack Head" and that upset Geoffrey. He said it reignited his "hatred" of his father. Geoffrey said he stewed on it for a few days and got angrier and angrier until he carried out his threats to kill his father David.

3.7.4 During the interview Geoffrey presented as a very angry man with deep resentment against his father. He did not accept responsibility for his previous domestic abuse believing it was all right to fight with his then partner if she hit him. Perpetrators of domestic abuse often minimise their abuse and this something that has been seen in many other domestic homicide cases. Geoffrey gave permission to use anything he had said in the domestic homicide review. When asked what advice he would

[5] Geoffrey's comments and views have not been verified. A detailed note of the conversation he had with the Panel Chair is included at Appendix C

give other people in his position and what he would have done differently Geoffrey replied bluntly, "Don't get in touch with your father if he's ill."

4. THE FACTS BY AGENCY

4.1 Introduction

4.1.1 The agencies who submitted IMRs and chronologies are dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 5.

4.2 Greater Manchester Police

4.2.1 On 09.06.2013 Greater Manchester Police received a telephone call from ambulance control reporting that David had been assaulted by AM1. Greater Manchester Police received a second call from ambulance control a few minutes later stating the police were no longer needed because both parties had made up and did not want to see the police. As Greater Manchester Police identified this as a domestic related incident a police officer was sent.

4.2.2 The officer who attended recalls David and AM1 had been drinking. David refused to give details to the officer attending and would not engage in the completion of a DASH risk assessment form. The FWIN[6] was updated with information that David had a cut above his eye and said he fell over drunk. Despite this the FWIN was still closed as a domestic incident and a PPI[7] log was created. The risk was classed as 'standard'. Because of David's reluctance to provide information and his explanation no further action was taken by the Public Protection Investigation Unit.

4.2.3 On 27.06.2014 a nephew of David reported to Greater Manchester Police that David had been the victim of an assault. He was punched by a man who had approached address two looking for another male. The information provided was that David had permitted a man who was wanted by the police for burglary to stop with him there. A police officer attended and spoke to David. He had been drinking alcohol and is referred to as an alcoholic in the FWIN. Consequently, David was not in a fit state to provide information. He was seen later the same day and a crime report for assault (actual bodily harm) was recorded. There were no lines of enquiry and the crime remains undetected.

4.2.4 On 19.04.2014 Greater Manchester Police were contacted by ambulance control that reported Geoffrey was cutting his wrists with a knife after leaving a public house. A police officer was sent to the incident and located Geoffrey. FWIN recorded that Geoffrey was safe and well and had a superficial injury to a wrist. The officer attending recorded that Geoffrey had been drinking and had fallen out with someone. He picked up a knife, ran outside the pub and started to cut his wrists. Geoffrey refused medical attention and said he regretted what he had done. He said he behaved that way because of alcohol and his emotions after AF3 died three years earlier.

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[6] . FWIN is an acronym for Force Wide Incident Numbering. This is a computerised system for recording and auditing all incidents reported to GMP requiring a police response. (See Appendix A)

[7] PPI is a Public Protection Investigation log. There is a requirement by GMP to complete one of these whenever an incident of domestic abuse is identified. These are then sent to the Public Protection Investigation Unit for triaging (See Appendix A)

4.2.5 The police officer that attended finalised the FWIN log as a concern for safety. The matter was assessed as a medium risk[8] incident. The police officer did this to ensure the Public Protection Investigation Unit were aware for follow up and a referral to Adult Social Care if deemed appropriate. The log was reviewed within the Public Protection Investigation Unit and a referral was sent to Adult Social Care.

4.2.6 The officer in the Public Protection Investigation Unit who made the referral believes it was appropriate to do this for several reasons. They wanted to bring a number of things to the attention of Adult Social Care. These included the self-harm issues and whether Geoffrey needed mental health assessment or support; emotional issues following the death of AF3; alcohol related issues as this seemed to be a factor in what happened and medical issues to confirm Geoffrey had attended for medical treatment.

4.2.7 On 01.02.2015 a shopkeeper contacted Greater Manchester Police and reported a male had brandished a kitchen knife at him. He stole money and cigarettes after making threats to kill if a till was not opened. A police officer from Greater Manchester Police attended the shop and recorded the matter as a robbery. A finger print recovered from the scene was identified on 04.02.2015 as belonging to Geoffrey. The same day a Detective Sergeant from Greater Manchester Police was allocated the crime to investigate.

4.2.8 Enquiries to arrest Geoffrey were not successful. Consequently on 22.02.2015 Geoffrey was circulated on the PNC as wanted for this robbery. On 05.03.2015 the Detective Sergeant responsible for the case spoke by mobile telephone to Geoffrey. He asked Geoffrey to attend a police station however Geoffrey said "You'll have to wait to see me; I don't really like the police."

4.2.9 Police officers continued to make enquiries to trace and arrest Geoffrey. On 28.03.2015 police officers searched address two where Geoffrey had been stopping with David during 2015. Geoffrey was not there and a report of this action included a reference to locks having been changed and that AM1 had the key for the property in his possession. This was the last proactive event in the investigation to trace and arrest Geoffrey.

4.2.10 The last entry on the crime report before the homicide is dated 01.04.2015. The Detective Sergeant responsible for the investigation requested that a police constable make further attempts to arrest Geoffrey. It states Geoffrey was believed to be with AF1 and requests the constable visit her family's address. All the enquiries to trace Geoffrey were unsuccessful.

4.2.11 On 13.03.2015 AM1 reported to Greater Manchester Police that David's mobility scooter had been stolen from outside address two. This was recorded by Greater Manchester Police as a crime. The police constable completing the crime report recorded that "The FWIN provides the names of possible suspects for this theft; however, as these persons were inside the aggrieved person's (David's) house at the time of the incident, it could not be possible that they have also stolen his vehicle." The initial report did not elaborate further.

[8] This risk level relates to an adult currently safe and where further support and assessment is needed.

4.2.12 The same police constable also recorded on the crime report there were "negative lines" of enquiry and the report should be considered for filing pending further information coming to light. On 14.03.2015 a police officer on the crime desk filed the crime report. They recorded; "Initial evaluation completed. No further investigation required." The suspects were not named on the report or on the FWIN.

4.2.13 Although the police constable that dealt with the theft of the scooter did not believe there was enough evidence to arrest Geoffrey for this offence they were aware he was wanted for robbery. Entries on the crime report for the robbery show the same police constable attended address two after 14.03.2015 to arrest Geoffrey for robbery. They were not successful in arresting Geoffrey.

4.2.14 At 14.14 hours on 30.03.2015 AM1 telephoned Greater Manchester Police and reported he had been threatened by Geoffrey. A police call handler (Call Handler one) recorded details of the threat on a FWIN as follows: "Threats by male, via mobile...from Geoffrey ...stating I'm going to come down and stab you..."

4.2.15 Call Handler one also recorded that; "His father (David) won't give him (Geoffrey) any money and therefore making threats to informant (AM1) who is the contact closest via mobile to them both." The IMR author listened to an audio recording of the call made by AM1 and identified the following salient points;

- AM1 said Geoffrey telephoned him and made "death threats." Geoffrey told AM1 that "he's gonna come down and knife me";
- AM1 said Geoffrey also sent several threatening text messages;
- AM1 said that Geoffrey had fallen out with his father David;
- In one text message Geoffrey sent to David he had stated he hoped his father "dies quick";
- As AM1 was speaking to Call Handler 1 Geoffrey was still sending text messages, one of which was a threat directed at David. AM1 told Call Handler one: "it says, dirty smack head, crack head, um killed his (Geoffrey's) mum, he killed his (Geoffrey's) sister, and he's gonna come kill him (David);
- AM1 confirmed to Call Handler one that the house at address one was secure; he was advised by Call Handler one that should Geoffrey arrive at the house before police attendance, he should ring the police on 999.

4.2.16 The police response to the call made by AM1 was categorised as a grade 3 routine response[9]. The IMR author reviewed the FWIN for this call. The following entries are of relevance.

Time	**Action**

[9] Policy for a grade 3 response requires allocation by a police radio operator within two hours and police attendance within four hours from the creation of the incident log (See Appendix A).

14.14	Call handler one receives the call from AM1.
14.14	Whilst Call Handler one is obtaining details from AM1, Radio Operator One updated the FWIN, recording: "Delay for 1 hour."
14.50	Radio Operator one updated the FWIN with details of police warning markers recorded against Geoffrey. Radio Operator one noted that Geoffrey had warnings for "firearms, weapons, violence, self-harm and drugs."
14.50	Radio Operator one also updated the FWIN with details of Geoffrey being wanted for a robbery after entering a store and threatening a shopkeeper at knife point.
15.05	The FWIN was updated by Call Handler two with details of a further call from AM1 who said "he has been waiting over half an hour" for the police to attend. Call Handler two advised AM1 that the police would be "out to see him today" but could not give him an exact time; however, they recorded AM1 was "extremely unhappy" about the police response and AM1 put the phone down after saying: "So what that means is someone can come and kill us in our house because the police can't be bothered to come and see us."
15.09	Radio Operator one updated the FWIN after the entry made by Call Handler two recording: "noted."
15.20	Radio Operator one updated the FWIN recording: "Delay for 20 minutes."
15.38	The FWIN was reviewed by a Response Inspector who updated the FWIN as follows: "In view of the circumstances and the fact that the offender (Geoffrey) is already on bail for a knife point robbery, please re-grade as 2 (a priority response – attendance within one hour).
16.34	The incident was allocated to a police constable. At this time, they are shown as on route. This is two hours and 20 minutes after AM1 reported this incident.

4.2.17 While the reasons why the Call Handlers and Radio Operators made the decisions to grade this call in the way they did has been analysed in detail by the Greater Manchester Police IMR author they do not have any bearing on the homicide of David. They are therefore not considered to be within the scope of this report.

4.2.18 A police constable (PC1) attended address one and obtained a statement from AM1. AM1 also provided details of a deteriorating relationship between David and Geoffrey. David was considered too ill to make a written statement. PC1 recalls that when he first attended address one a nurse was present tending to David. PC1 recalls this nurse said something to AM1 about whether there was a need for David to go into a "convalescence" home. PC1 says AM1 was adamant that he would look after David and told the nurse he was not going anywhere.

4.2.19 AM1 said he received several text messages between 13.20 and 13.32 hours on 30.03.2015 from Geoffrey who wanted a key to address two as the locks had been changed. AM1 did not reply to the texts. Geoffrey then rang AM1 at 13.32 hours and said he needed to get into address two as he had property in there. AM1 refused to give him a key. He told Geoffrey that he had been responsible for "ripping David off". Geoffrey then said "I'm gonna come down there and stab you." AM1 ended the call.

4.2.20 AM1 then started to receive several text messages on his own mobile from Geoffrey. These texts included wanting David to 'hurry up and die' and blaming him for the death of AF3 and AF2. The written statement from AM1 does not include any mention of a specific threat to harm (or kill) David. It does not include any mention of the text message AM1 shared with Call Handler one (see paragraph 4.2.15) in which Geoffrey threatened to kill David.

4.2.21 PC1 recorded two crime reports for harassment. One with AM1 as the victim and one with David as the victim. The perpetrator for both crimes was recorded as Geoffrey. The officer also completed a DASH risk assessment form for David. He was recorded as being at medium risk. AM1 was also recorded as a secondary victim. PC1 felt there was no indication AM1 or David wanted other services although he did leave a leaflet about the options available to seek support from other agencies. PC1 also believed that, because a nurse was present, David was already receiving necessary medical support. Greater Manchester Police made a referral to Victim Support in respect of the harassment although they were unable to contact David.

4.2.22 The DASH form included the following information of relevance;

- Geoffrey had assaulted David in the past and had made threats before;
- Geoffrey can be violent;
- Geoffrey had been sending threatening and abusive texts to both David and AM1;
- Geoffrey "is threatening violence to us now";
- When asked if Geoffrey had ever threatened to "kill the victim", AM1 said "he has threatened me this time, which he is capable of doing if he is desperate enough;"
- AM1 said "Geoffrey has threatened David before. I think he has assaulted other family members in the past too;"
- "Geoffrey uses heroin about 2 bags a day. He possibly takes others too;" and
- "Geoffrey has a lengthy history with the police."

4.2.23 Geoffrey was already wanted for the robbery (see paragraph 4.2.7) which PC1 had initially investigated on 01.02.2015. After speaking to David and AM1, PC1 decided he would attend address two and search this for Geoffrey using a key provided by David. PC1 completed this search. Geoffrey was not there and there was no sign he was stopping at the address.

4.2.24 The FWIN was closed as a domestic incident. This generated a PPI log. PC1 also included a comment that Geoffrey had a "turbulent life in and out of prison due to father and mothers drug abuse…his mother died some time ago; since then Geoffrey has held his dad responsible." The officer also recorded on the DASH summary that the locks had been changed at address two. It was because of this that Geoffrey attempted to contact David to demand that someone attend with a key. As David and AM1 said they were unwilling to meet with Geoffrey who then started to send threatening text messages saying he was "going to come down and stab AM1."

4.2.25 PC1 also recorded that attempts to arrest Geoffrey were ongoing, that address one could be secured and there was a mobile phone with which to call for help. PC1 also stated other family members across the street were keeping an eye on AM1 and David. They could not be moved anywhere else due to David's condition and they have refused to move. PC1 placed an 'urgent marker' against address one.[10]

4.2.26 At 20.39 hours on 30.03.2015 Call Handler three received a call from the sister of AM1 and David who lived in the same street as them. She said they needed assistance straight away. The IMR author summarised the call as follows;

- Sister: "it's (Redacted Address), we are on call, and they said they will send somebody out as soon as they get the call."
- Call Handler three: "they (the police) are on the way now; they (the police) need to know what's going on."
- Sister (in an anxious state) could be heard saying to someone in the background to "get something to hit them with" and repeatedly said "we need to go."
- Call Handler three; "they (the police) are asking me what's going on or they won't attend."
- Sister: "Look basically, they threatened to come and stab the family, they are here, they've turned up in a white van right. We need assistance straight away."
- Call Handler three; Sought confirmation that the door was locked at address one.
- Sister: "Yes the door is locked but we need assistance straight away cause they won't hesitate."
- Call Handler three: Confirmed that the police were on their way.
- Sister: responded by saying that she had to go as she needed to ring someone. She said "my grandad is dead old, he'll open the door, and he'll get his machete. You will need to hurry up because he will open the door."
- Sister: Said she had to go and the line then went dead.

[10] An urgent marker is a 'flag' that appears on the GMP computerised FWIN system indicating that from previous incidents further calls require an urgent response.

4.2.27 Call Handler three then categorised the call as a grade 2 'priority' response. This meant that attendance should be made within one hour. It was not graded for an immediate response and no patrol was dispatched to the incident. Contrary to what Call Handler three told the sister of AM1 and David the police were not on their way. The IMR author identified the following relevant entries from the FWIN.

Time	**Action**
20.40	Call Handler three updated the FWIN: "This is poss in connection to (Previous) FWIN 30.03.2015 (See paragraph 4.2.12)
20.49	Radio Operator two updated the FWIN: "Delay for 10 minutes for available patrol".
21.00	Call Handler three updated the log with: "Patrols currently on handover".
21.01	Call Handler three updated the log with: "Delay for 15 minutes for available patrols".
21.17	Call Handler three updated the log with: "Delay for 10 minutes for service call to establish circs".
21.18	Call Handler three updated the log with: "PC1 is currently at the address, trying to sort this out."

4.2.28 By coincidence PC1 retuned to address one to drop off the key for address two having searched it and to update David and AM1 about their enquiries. PC1 was informed that a short time earlier Geoffrey had been at address one in a white van. Geoffrey had tried a door at the property and he could not get in as it was locked. He then left. The police constable said that no further threats had been made and he was not aware of any conversation taking place with Geoffrey. If PC1 had not coincidentally attended address it is not clear when an officer would have been dispatched.

4.2.29 After making enquiries at address two PC1 updated the two harassment crime reports with details of outstanding enquiries to be completed. This included a requirement to make arrest attempts at a local public house and the address of AF1's father. PC1 says he received information that Geoffrey frequented this public house and may also have been using a van owned by AF1's father. PC1 says he was tasked by his supervisors in making further enquiries to arrest Geoffrey on dates after 30.03.2015. He was unable to make these enquiries because of other commitments. The reasons for this are discussed in section 6.

4.2.30 As a DASH form had been submitted by PC1 this generated a PPI log. When this occurs Greater Manchester Police policy is that a full risk assessment review and enhanced risk assessment is undertaken by specialist Public Protection Investigation Unit domestic abuse staff[11]. A Detective Constable (DC1) in the Public Protection Investigation Unit completed this on 31.03.2015. DC1 recorded on this PPI log that

[11] See Appendix A for a description of Greater Manchester Police risk assessment processes.

this was the first reported domestic incident between David and AM1. Reference was made to Geoffrey "financially abusing" David who was suffering from a terminal illness; DC1 obtained this detail from the DASH summary. DC1 recorded that "no referrals necessary" as David had the support of other family members.

4.2.31 DC1 also recorded that Geoffrey had a number of warnings, which they recorded as "suicidal, firearms, violent and drugs" and that he had a lengthy criminal history and was believed to be a regular heroin user. DC1 also recorded on the enhanced risk assessment that there was a history of violence for Geoffrey. The officer recorded details of Geoffrey's criminal record, documenting both convictions and not guilty disposals. These included convictions for violence and public order offences and a not guilty disposal at Crown Court for attempted murder.

4.2.32 DC1 recorded David was on oxygen and could not provide a written statement due to being terminally ill. However, he was "now safe at his brother's address and away from his son who can no longer take his money and belongings." The concluding entry by DC1 stated "aggrieved persons (David and AM1) will be updated through crime progress once the perpetrator (Geoffrey) has been arrested." A letter was sent to David and AM1 on 31.03.3015 from Greater Manchester Police with contact details of the Public Protection Investigation Unit. DC1 updated the log with "PPI has been marked as awaiting finalisation". The PPI log was then filed.

4.2.33 When completing their research for this log DC1 was not aware of information held by West Yorkshire Police in relation to domestic abuse perpetrated by Geoffrey (see paragraph 3.3.7). This was because the Police National Database (PND)[12], where this information is held, was not researched on this occasion. Force policy dictates it is only checked in high risk cases. The PPI log in this case was assessed as medium risk.

4.2.34 The action board entries[13] for the two harassment crimes committed on 30.03.2015 indicate that between that date and the date of the homicide there were difficulties in progressing enquiries to trace and arrest Geoffrey. This was because of competing demands and a lack of available resources. These reasons are discussed at section 5.9. After some initial enquiries by PC1 on 30.03.2015 the next occasion any proactive attempts were made to trace and arrest Geoffrey was on the day of the homicide. However, there is evidence that police officers were tasked to make enquiries by supervisors.

4.2.35 A police constable (PC2) recorded on the action board for the harassment crimes that at 17.05 hours on the date of the homicide they attended a local public house and spoke to a relative of AF1's. They told the officer AF1's relationship with Geoffrey ended 6-8 months earlier. Geoffrey was not at the public house. The living

[12] Police National Database (PND) is a research tool providing information held by other police forces about people who have come to their attention such as Geoffrey and David. PND was introduced because of a recommendation from the Bichard inquiry into the Soham murders in 2002.

[13] An action board is a running log showing maintained on the electronic crime report showing what actions have been taken or need to be taken.

quarters of the public house were searched and the police were told Geoffrey did not frequent the establishment.

4.2.36 PC2 also recorded on the two harassment crime reports that they attended address two on the day of the homicide, checked the address and the surrounding area, and there was no sign of Geoffrey. There is no record on the two crime reports of enquiries being made to establish the whereabouts of AF1's father who had been named by PC1 as someone that Geoffrey could be stopping with. It was at 17.43 hours that day that ambulance control contacted the police to report David had been stabbed.

4.3 National Probation Service

4.3.1 National Probation Service (formerly Greater Manchester Probation Trust) had the following alert flags recorded on their systems in respect of Geoffrey; Medium Risk of Serious Harm (2010 – 2013); High Risk of Serious Harm (2009); Child Concerns (Safeguarding); Domestic Abuse Perpetrator; Hate Crime; Risk to Staff (2009). There is no alert flag relating to firearms or weapons.

4.3.2 They only had one contact with Geoffrey during the period of this review, albeit they had some contact with him before this date (see paragraph 3.3.10 et al). On 19.07.2013 Geoffrey received a suspended sentence order for twelve months with a stand-alone curfew. This followed a breach of a community order with unpaid work initially imposed on 25.01.2012 which he subsequently breached on three occasions due to non-compliance with appointments for work.

4.3.3 The initial community order was imposed for two counts of criminal damage. These occurred when Geoffrey was walking home from a night out with his partner. National Probation Service believe alcohol was a significant precipitating factor, along with an inability to resolve conflict. The pre-sentence report states he had been "arguing earlier in the day with a friend and feeling angry and frustrated". This argument appears to have continued with his friend via a telephone on the way home when he "expressed his anger on two parked vehicles by kicking the wing mirrors off them".

4.3.4 National Probation Service assessed that Geoffrey had poor levels of emotional self-management. It was felt that alcohol consumption had also impacted on his thinking and behaviour. Their report referred to Geoffrey as a perpetrator of previous domestic abuse.

4.3.5 Geoffrey was not interested in engaging in alcohol treatment and was not willing to recognise this as a problem. The National Probation Service report states Geoffrey could demonstrate an insight into emotional self-management issues. There was contact with Geoffrey's then girlfriend and a domestic abuse screening request was made.

4.3.6 National Probation Service concluded there were no issues with the risk assessment and management of this event following a review of all associated risk assessment documentation. This considers previous behaviours and risk factors, alongside updated social circumstances. National Probation Service state they hold no information either during the review period or earlier that suggest David was a target of intense negative feelings or threats from Geoffrey. The domestic abuse

information collated at different stages of Geoffrey's contact with National Probation Service is not felt to be indicative of any risk to David.

4.3.7 While Geoffrey showed a propensity for violence, and there is intelligence recorded concerning firearms, National Probation Service believe it is difficult to ascertain how any specific risk to David was predictable or preventable.

4.4 Heywood, Middleton & Rochdale CCG (GPs)

4.4.1 David was well known to several NHS services due to his drug and alcohol problems and his long-term conditions. In the last twelve months of his life David had twelve hospital admissions as well as numerous outpatient appointments. He was referred to Adult Care on at least two of these occasions, but then declined assessments later. He gave his next of kin as either AM1 or a niece, never Geoffrey.

4.4.2 David was known to his GP because of longstanding physical health needs. He was reluctant to comply with suggested treatments from several medical professionals. The GP tried to assist David with support from the community matron who managed his condition. However, he still accessed secondary care when his condition deteriorated. He was prescribed oxygen therapy whilst he was at home. He continued to smoke against advice. There were documented incidents where he was seen at Accident and Emergency department with thermal burns probably because of smoking while using oxygen.

4.4.3 There are only two entries on the GP records relevant to this DHR concerning David. The first of these is a notification from 09.06.2013 that David attended accident and emergency with a laceration above his right eye. Although there is no record of how this was caused it is known, by cross reference to the Greater Manchester Police records, that this was the date on which Greater Manchester Police received a call to state David and AM1 had been fighting (see paragraph 4.2.1).

4.4.4 The second relevant entry is on 11.03.2015 when David spoke to his GP. He said he had fallen out with Geoffrey over a gift for his grandson. David did not give his son the money as he believed Geoffrey was using crack and would not give his grandson the money. The record shows David was very distressed and moved back to AM1's house (address one). It is documented in the GP record that when David last moved into AM1's house he was smoking heavily and drinking two litres of cider a day. Due to a family fall out he was not getting on with his brother.

4.4.5 There is nothing in the GP records to indicate that David was considered as at risk from Geoffrey nor that Geoffrey had made any threats towards him. This was the last date on which David was seen by his GP.

4.4.6 The only relevant contact Geoffrey had with his GP during the period of the review was documented in his GP notes on 03.06.2014. This states Geoffrey was referred to psychiatry. He had previously self-harmed and he had stopped drinking as it had landed him in prison for a total of ten years. The GP notes show he served a five-year sentence for attacking someone with a machete. Geoffrey had low mood since he was a child. His parents were both Heroin addicts. He lived in a boarding house until he was 15 when he ran away and did not return home. His mother died of a suspected Heroin overdose and he attacked the person he believed was responsible (there is no reference to who this was).

4.4.7 Geoffrey told his GP he had a poor relationship with his dad and said he had physically abused him as a child. He blamed his dad for what happened to him. At the time of the visit Geoffrey lived with his partner who paid the bills. He had three children and was only in touch with the eldest who was then 14 years of age. Not all the children had the same mother. Geoffrey was low in mood and had difficulty sleeping. He was pessimistic and his girlfriend described him as having an emotional block. He was still smoking Cannabis and was refusing to give it up. The notes record that Geoffrey was very casually dressed. He is said to have given an intimidating look when talking about the assault on the person he believed caused his mother's death. Geoffrey broke down in tears during the interview. He had no current suicidal ideation and had full insight. The GP prescribed Mirtazapine 15mg and asked for a Mode Deactivation Therapy (MDT)[14] psychological intervention.

4.4.8 On 30.2014 a notification was sent to his GP showing Geoffrey did not attend an access and crisis appointment. On 18.12.2014 Geoffrey did not complete a questionnaire for an access and crisis device. On 23.02.2015 the GP was informed the Access and Crisis team had closed his case.

4.5 Pennine Care NHS Foundation Trust Rochdale Pathways Integrated Alcohol and Drug Service

4.5.1 David had a long history of alcohol and drug misuse. His health was also affected by other conditions some of which were connected to his misuse of alcohol and drugs. David received a comprehensive package of care from health agencies although he was resistant to altering his lifestyle.

4.5.2 On 07.01.2015, during an appointment at Rochdale Pathways, David disclosed that Geoffrey had contacted him after many years of not seeing him. He said Geoffrey had asked him to stop drinking. On 18.02.2015 a home visit was made to address two by a drug and alcohol worker and a Pathway worker. David said he had moved away from AM1's address and that Geoffrey was staying at address two to look after him.

4.5.3 On 11.03.2015 a drug and alcohol worker visited David. He was close to tears after falling out with Geoffrey. He gave the same explanation to the worker as he later provided to his GP (see paragraph 4.4.4). David said he had moved back to address one. The worker arranged for David's GP to conduct a telephone consultation to discuss his low mood.

4.5.4 David was admitted to hospital on 19.03.2015 for an inpatient detoxification programme for ten days. When he was discharged, he met with a worker from Rochdale Pathways on 01.04.2015. He said he was living with AM1 at address one. David said he was no longer in contact with Geoffrey as he stole his mobility scooter and money. David said AM1 had reported this to Greater Manchester Police. This was the last contact between David and Rochdale Pathways.

[14] Mode deactivation therapy (MDT) is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviours and cognitive processes and contents.

4.6 Adult Care Services Rochdale Borough Council

4.6.1 Adult Care had several contacts with David during the period of this review. On 07.10.2014 a request was made by the Community Matron for an assessment of need and support to David with possible rehousing. Amongst the concerns raised was the fact the property was very cold and David was wrapped in a blanket as he had not used his gas meter since 01.2013. Guinness Housing (the social landlord for address two) also raised concerns about this matter.

4.6.2 Adult Care discussed these issues with the Matron and Guinness Housing. It was felt David had capacity, however he chose to spend his money on alcohol and drugs and to an extent this was a lifestyle choice he made. The matron advised that she would make a referral to Community Champions[15] that could provide support to David around managing his finances and budgeting.

4.6.3 On 09.10.2014 a staff member from Adult Care conducted a telephone assessment with David. This covered a range of social and personal needs. It did not include any information about Geoffrey nor any risks he presented to David. David was content with the proposal to refer him to Community Champions. The only further contact Adult Care had with David was a notification to them of his discharge from hospital on 25.03.2015. This triggered a letter to David from the Transfer of Care Team in Adult Care.

4.7 The Guinness Partnership

4.7.1 The Guinness Partnership Limited is a registered provider of social housing. Their records show that David took a tenancy on address two on 13.08.2012. David was well known to The Guinness Partnership and their staff and they had worked with the District Nurse with regards to looking at relocating him to a sheltered scheme to meet his needs. There were also concerns about David not heating his property correctly due to financial issues (see paragraph 4.6.1).

4.7.2 On 30.03.2015 a housing officer from The Guinness Partnership received a telephone call from Geoffrey to advise that he had fallen out with David. Geoffrey said the locks at address two had been changed and consequently Geoffrey and his girlfriend could not get access to their belongings. Geoffrey said David told him he had handed the keys to The Guinness Partnership. Geoffrey wanted someone to meet him at the property to allow access. Geoffrey was advised to speak with David to gain access.

4.7.3 The same day two housing officers from The Guinness Partnership called at address two to talk to David as he had not handed his keys in as stated by Geoffrey. The officers found the locks had been changed and the curtains were closed. They left a contact card as they did not receive an answer when they knocked. On leaving the address the officers were told by two passers-by there was no one living there. One of them claimed to be Geoffrey's girlfriend. She had been living at the property and caring for David and wanted her property back.

[15] Community Champions is an expression used to describe volunteers that give up their own time to involve themselves in improving the community they live in.

4.7.4 On returning to the The Guinness Partnership offices the housing officer contacted Adult Care to see if David was known to them. The housing officer spoke by telephone to the duty social worker who advised them David was known to them. The housing officer told the social worker about the conversation with Geoffrey and that they could not get hold of David and raised concerns. The social worker agreed to try and contact him. Following the telephone call the housing officer raised a safeguarding case through The Guinness Partnership's procedures and telephoned Greater Manchester Police for a concern for welfare visit to be made by them. The following day the housing officer was notified that Greater Manchester Police had located David. He was OK and there were no safeguarding concerns. The next contact The Guinness Partnership had was when AM1 notified them of David's death. The panel felt the actions of The Guinness Partnership were an example of good practice and should be copied.

5. ANALYSIS AGAINST THE TERMS OF REFERENCE

Each term appears in ***bold italics*** and is examined separately. Commentary is made using the material in the IMRs and the DHR Panel's debates. Some material would fit into more than one term and where that happens a best fit approach has been taken.

5.1 What indicators of domestic abuse did your agency identify, including any threats to kill or harm David and what risk assessment[s] were undertaken?

5.1.1 Both Rochdale Pathways and the GP knew on 11.03.2015 that David had fallen out with Geoffrey and the reasons for this (see paragraph 4.4.4). However, the information David provided to both agencies did not contain any direct or indirect reference to a threat from Geoffrey to David. The panel has not seen any information to indicate that Geoffrey had made a threat to David at that time. Although his GP knew on 03.06.2014, when Geoffrey visited them, that he had a poor relationship with David, Geoffrey did not say anything which would indicate he posed a risk to David. His GP never saw Geoffrey in person again before the homicide and therefore did not have the opportunity to explore his relationship with David any further.

5.1.2 Greater Manchester Police was the only agency with information that identified Geoffrey had made a threat against David who was therefore at risk. This was on 30.03.2015 when AM1 contacted Greater Manchester Police to report Geoffrey had threatened to stab him (see paragraph 4.2.15). AM1 also told police call handler one that Geoffrey had sent several text messages to David including one stating that he was "gonna come and kill" David.

5.1.3 Geoffrey was a perpetrator of domestic abuse on his female partner when he lived in the West Yorkshire area. These events fall outside the timescale of this DHR. However, they are mentioned within the background information at section 3. Information about his behaviour as a perpetrator of domestic abuse was held by Greater Manchester Probation Trust (now National Probation Service) and by West Yorkshire Police. However, information about these offences was not held on Greater Manchester Police systems. It would have been available to Greater Manchester Police had any police officers or staff with access to the Police National Database (PND) carried out a check on Geoffrey. There was also information on the PNC in respect of Geoffrey's conviction for common assault on his former partner in West Yorkshire (paragraph 3.3.7).

5.1.4 PC1, who attended address one and spoke to AM1 and David following that call was aware Geoffrey had threatened to stab AM1. When seen about the DHR review PC1 told the Greater Manchester Police IMR author he did not know of any specific threat being made to kill or harm David nor did he know of the threatening text from Geoffrey that he was going to kill David and which AM1 shared with call handler one.

5.1.5 The threat to kill David is not recorded on the Greater Manchester Police FWIN, is not mentioned in the statement taken from AM1 by PC1 and was not found on the text messages the officer retrieved from David's phone. PC1 does not recall David

or AM1 telling him about any specific threat by Geoffrey to harm David. The officer states they only recall several derogatory texts being sent to David by Geoffrey.

5.1.6 The fact Call Handler one did not record the threat to kill David when completing the FWIN appears to have been an oversight. In highlighting the omission of this text message the IMR author recognises that Call Handler one would have had some difficulty when recording and interpreting everything AM1 told them over the telephone on 30.03.2015. Call Handler one also had to contend with having to listen to a female in the background. She can be heard relaying David's text messages to AM1 as he was talking to the call handler.

5.1.7 Despite the fact PC1 was not aware of a threat to kill Geoffrey the IMR author cites the following factors as reasons why PC1 should have recognised Geoffrey was a violent person with a grievance against David;

- Geoffrey assaulted David and threatened him in the past (PC1 recorded this on the DASH form);
- Geoffrey can be violent (PC1 recorded this on the DASH form);
- Geoffrey is "threatening violence now" (PC1 recorded this on the DASH form);
- Geoffrey held his father responsible for the death of AF3 (PC1 recorded this on the DASH summary);
- AM1 said that Geoffrey had threatened to kill him this time and he was capable of doing it if desperate enough (PC1 recorded this on the DASH);
- Geoffrey was taking drugs, possibly using two bags of heroin a day (PC1 recorded this on the DASH form);
- Geoffrey had police warning signs for weapons, violence, firearms, drugs and self-harm;
- There was an indication in the statement taken from AM1 by PC1 that Geoffrey was unpredictable; and
- Geoffrey had a long history with the police (convictions for 63 offences, including a number for violence, public order and possession of offensive weapons).

5.1.8 PC1 told the IMR author that AM1 said he was not frightened of Geoffrey. David did not tell the officer about any threat from Geoffrey. PC1 says they recorded a medium risk on the DASH form because of the threat to stab AM1. The officer also said they did not believe they would have had time to fully research Geoffrey on the PNC or to research his criminal history. Fully researching a perpetrator is a key factor in informing a risk assessment.

5.1.9 PC1, having now seen the police record for Geoffrey and the comments they recorded on the risk assessment, has reflected on their decision making. In conversation with the IMR author the officer says that, with hindsight, they could have recorded this as a high-risk case[16]. However, PC1 still believes that, at the time they made the classification, medium[17] risk was appropriate based on the lack

[16] A high-risk classification is defined as: "There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious."

[17] A medium risk classification is defined as: "There are identifiable indications of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in

of concern by David and AM1. The DHR Panel felt that people at risk were not always best placed to make an objective judgement of the level of risk they faced.

5.1.10 DC1 mentioned Geoffrey offending history and warning markers when preparing the enhanced risk assessment, the day after the incident. They told the IMR author that in doing so they would have focused more on whether there was previous domestic violence history between Geoffrey and David than looking closely at Geoffrey's offending criminal history. DC1 also agreed that, with hindsight and given Geoffrey's history of violent offending, the risk could have been stated as 'high'. However, DC1 told the IMR author they were guided significantly by PC1's assessment of risk in this case. On 31.03.2015 when completing the enhanced risk assessment DC1 agreed with the medium risk classification.

5.1.11 DC1 said that because of the volume of referrals to the Public Protection Investigation Unit daily, there are often constraints on the time the Triage Desk personnel can spend on each referral, reviewing and researching history held on victims and perpetrators. DC1 explained that research can take some time to complete, and there is pressure to reduce the number of jobs that appear in the Triage Desk queues. This can impact on the time allocated to researching individual cases (resource issues are specifically considered at section 5.9).

5.1.12 The Greater Manchester Police author says there are significant demands placed upon both Response and Public Protection Investigation Unit staff. This is not the first DHR in the Greater Manchester area in which practitioners working in these units have raised concerns around demand and resilience. The IMR author believes that in this case more consideration should have been given to the violent nature of Geoffrey, his offending history, his police warnings, his unpredictability and his drug abuse to fully inform the risk assessment.

5.1.13 The IMR author states that what appears to be evident from the entries in the DASH form is that Geoffrey was also someone who was prepared to use violence against family members. Both PC1 and DC1 told the IMR author that, had they known about a threat to kill David, this would have been considered as part of the risk assessment and, with hindsight, would have prompted a high-risk classification.

5.1.14 As part of the preparation of the Greater Manchester Police IMR the author spoke to the Police Sergeant (PS1) within the Response Team that supervised PC1. The Sergeant said, given the time to progress the task, there would clearly have been merit in completing a thorough review of the recorded police history and convictions of Geoffrey. This would have allowed the piecing together of Geoffrey's conduct and behaviour and thereby fully informed the risk assessment.

5.1.15 The IMR author believes a high-risk classification could have been applied solely to the threat Geoffrey made to stab AM1 considering Geoffrey's violent offending history, his unpredictable nature, his drug abuse and the comments made on the DASH form. The author believes a high-risk classification might have prompted more focus on the control strategy to manage and mitigate any risk, such as an

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circumstances, e.g. failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse."

assessment of security at address one and an overt police response. They say further consideration could have been given to moving the occupants from this address. Further proactive options to try and arrest Geoffrey could have been made. The author says it might also have prompted consideration as to whether a multi-agency risk assessment conference (MARAC)[18] was required. The DHR panel agreed with the IMR author's views and acknowledge PC1, DC1 and PS1's reflectiveness which demonstrates a willingness to learn from experience.

5.2 How did your agency manage those risks and how did it respond to any new information which may have impacted on the risks?

5.2.1 PC1 considered several factors and steps when responding to the risks that Geoffrey presented. DC1 told the IMR author they believed PC1 had adequately addressed safeguarding and had managed the risk appropriately. Given the risk was medium and not high it seems these were all appropriate steps to mitigate risk from the events on 30.03.2015.

5.2.2 The IMR author draws attention to the second event that night when Geoffrey went to address one (see paragraph 4.2.26) prompting a call to Greater Manchester Police from the sister of David and AM1. They believe this should have prompted consideration as to whether there was a greater risk to AM1 and David than was first evident. This visit by Geoffrey to address one should have raised questions as to whether this was the safe environment referred to in the assessment by DC1.

5.2.3 PC1 told the IMR author he considered Geoffrey's visit to address one when completing the risk assessment. However, the author believes that should have prompted a review of the control strategy to manage and mitigate the risk and to further consider whether it was possible to move AM1 and David from address one.

5.2.4 One of the key steps that could have been taken to mitigate the risks to David and AM1 was the swift arrest of Geoffrey. The IMR author highlights there is no record of any attempts being made to arrest Geoffrey in the days after the harassment crimes were reported on 30.03.2015. Although there is some evidence of officers being tasked to make enquiries by Response Supervision. The IMR author believes the lack of ownership of these harassment crimes after PC1's initial investigation, and the competing demands placed on Response staff, were factors that impacted on attempts to arrest Geoffrey. The panel agreed with this view.

5.3 What services did your agency provide for David and Geoffrey in relation to the identified levels of risk and were they timely, proportionate and 'fit for purpose'?

5.3.1 In relation to the actions of Greater Manchester Police in response to the risks posed by Geoffrey on 30.03.2015, a medium level risk was identified that day by PC1 and supported by DC1 when they conducted the enhanced risk assessment the following day. Mitigating actions were considered and these were felt to be fit for purpose in response to a medium level risk (see paragraph 4.2.33).

[18] A Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

5.3.2 The IMR author spoke to PC1 about the descriptions of David and AM1 they put on the DASH summary. The officer described David as having a terminal illness and AM1 as appearing to look as though he had been drinking heavily. The IMR author asked the officer whether in these circumstances AM1 was a suitable person to care for David.

5.3.3 PC1 said they believed AM1 was capable of looking after David and, because a nurse was present at address one when the officer visited, they also believed David was receiving medical support from health services. The officer says there was no indication they wanted or needed other services. He left a leaflet with AM1 about support from other agencies.

5.3.4 The primary responsibility of the officer related to the investigation of the crimes and ensuring any risks to David and AM1 from Geoffrey were identified and mitigated. PC1's role in health matters was therefore limited to sign posting or referring victims to other services. The presence of a district nurse provided reassurance that health professionals were already engaging with David. The DHR Panel felt the assumptions PC1 made about the health needs of David appear to be reasonable ones to have reached.

5.3.5 Although PC1 would not have known this on 30.03.2015 there was an extensive history of attempts by agencies to engage with David and to improve his health outcomes. These included discussions about his use of illicit drugs, his consumption of alcohol and his smoking and use of oxygen. Discussion had taken place involving the community matron, Guinness Housing and Adult Care in 10.2014. These concerned the fact that David was living in address two without heating and efforts had been made to relocate David to sheltered housing. However, it was assumed appeared that David had capacity and made lifestyle choices that other people may not have done[19].

5.4 How effective was inter-agency information sharing and cooperation in response to David and Geoffrey and was information shared with those agencies who needed it?

5.4.1 West Yorkshire Police and National Probation Service (then Greater Manchester Probation Trust) held historic information about Geoffrey as a perpetrator of domestic abuse. That information related to events that took place between 2005 and 2008. None of that information concerned any threats to David. The relevance of that information was that it would have helped Greater Manchester Police assess the risk Geoffrey posed to David and AM1. The information held by West Yorkshire Police was available to other police forces through PND. However, because the risk Geoffrey posed was assessed as medium and not high, a check was not carried out on PND by DC1.

5.4.2 The information held by NPT was not held on an information system accessible to the police or other agencies. It would only have been available if a specific request

[19] Mental Capacity Act 2005: Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision. Everyone has the right to make their own life choices, where they have the capacity to do so. NHS Choices.

was made to NPT. That may have happened had Geoffrey become the subject of a multi-agency approach such as a MARAC. Because the risk Geoffrey posed was set at medium, consideration was not given to a MARAC and, therefore, information NPT held was not shared or requested.

5.4.3 No other agencies held information concerning any risk from Geoffrey towards David. Although David's GP and Rochdale Pathways did hold information concerning the disagreement between Geoffrey and David. On its own that information did not indicate David was at risk from Geoffrey and there was no reason why it should have been shared with other agencies. It may have had some value in re-assessing the level of risk, had a MARAC been held, as it contained information that Geoffrey might have been using crack.

5.4.4 There was evidence of information sharing and cooperation between agencies such as GP's, Health, Guinness Housing and Adult Care in relation to the health and welfare needs of David. As well as issues surrounding his health, consideration had also been given to David's housing needs particularly as, when living at address two, he was not heating the property. While information was shared, it is doubtful it had a positive impact upon David's welfare. The stark fact was that David had capacity and could make choices that would have improved his health and possibly have extended his lifespan. It appears, as evidenced by his remarks, that he made a conscious decision not to follow the advice he was given.

5.4.5 It is clear from the DASH summary PC1 completed and the enhanced risk assessment submitted by DC1 that they believed David had the support of other family members. Consequently, a referral was not made to any other agency. The IMR author believes that a referral to Adult Social Care could have been considered in respect of whether David and AM1, as his carer, needed any further support. The IMR author also believes consideration could have been given to sharing information with Adult Care in respect of Geoffrey as he had previously been the subject of a referral by Greater Manchester Police in 2014 (see paragraph 4.2.5).

5.4.6 Given David was already receiving support from a range of health and housing agencies, and had made life-style choices not to follow much of the advice they gave him, it is doubtful whether a referral would have led to any additional support being accepted. The greater value of a referral would have been to alert agencies to the threat Geoffrey posed to David and AM1. Agencies were in regular contact with AM1 and David, were visiting address one regularly and had contact with Geoffrey by telephone. They may have been able to provide valuable information to Greater Manchester Police about what was happening at address one and particularly about Geoffrey's whereabouts. It therefore had potential to increase opportunities to arrest Geoffrey.

5.4.7 While there was no referral to MARAC, there might have been other opportunities or mechanisms to share information within a multi-agency context. Some of the behaviours displayed by Geoffrey are those to be found in Troubled Families[20]. In

[20] Troubled families are characterized by inter-generational transmission, large numbers of children, shifting family make-up, dysfunctional relationships and unhelpful family and friends social network, abuse, institutional care, teenage mothers, early signs of poor behaviour, troubles at school, anti-social behaviour, mental illness (particularly depression, impeding ability to function in life), and drugs & alcohol use: Listening

2011 government launched a Troubled Families programme. The programme is intended to change the repeating generational patterns of poor parenting, abuse, violence, drug use, anti-social behaviour and crime in the most troubled families in the UK. Families identified as troubled are assigned lead family workers.

5.4.8 Early identification of individuals such as Geoffrey, as members of a troubled family, allows agencies to share information. In turn this means a holistic picture can be built as to what is happening within their lives and earlier interventions can be implemented. For example, while Geoffrey was not always under the supervision of NPS, they held some important background information about his lifestyle and attitudes that might have informed a plan to manage Geoffrey within a troubled family programme. The panel feel there is a lesson to be learned about sharing information around troubled families (See lesson four and recommendation four).

5.4.9 In early 2015 Rochdale implemented a Multi-agency Risk Management protocol (MRM). This protocol provides professionals with a framework to facilitate effective multi-agency working with adults who are deemed to have mental capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. It aims to provide professionals from all Rochdale Borough Safeguarding Adults Board (RBSAB) partner agencies with a framework for the management of complex cases where, despite ongoing work, serious risks are still present. MRM allows for the formulation of a plan identifying appropriate agencies responsibility for actions. It also provides a mechanism for review and re-evaluation of the action plan.

5.4.10 David had capacity, he misused alcohol and drugs, engaged in behaviour and had associations that put him at serious risk of harm. For example, smoking while using oxygen and not looking after himself by not heating his property. While much of David's behaviour predated the implementation of MMR, in future, cases such as his would be suitable to be considered within the scope of that protocol. Agencies such as social services held key information about David's behaviour. In future, the use of MMR will allow such agencies to share relevant information and develop plans to address those who engage in risk taking behaviour or refuse to engage with services.

5.5 How did your agency ascertain the wishes and feelings of David and Geoffrey about any domestic abuse and were their views taken into account when providing services or support? Did you seek the views of their families?

5.5.1 Geoffrey told his GP that as a child he had been physically abused by David (paragraph 4.4.7). It appears to the panel that, as an adult, Geoffrey was also a perpetrator of domestic abuse. The panel recognises there is evidence of causal links between the two[21]. No agency had the opportunity before the homicide to discuss with him that his actions towards David comprised domestic abuse. From events in West Yorkshire it is clear that Geoffrey abused his former partner on

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to Troubled Families: A report by Louise Casey CB, Department for Communities and Local Government, Department for Communities and Local Government.

[21] Behind Closed Doors: The Impact of Domestic Violence on Children. UNICEF 2006

several occasions resulting in his conviction for assault and his engagement with Greater Manchester Probation Trust. Geoffrey therefore had every opportunity to understand what domestic abuse is, albeit he may not have fully understood such behaviour also applied to other relationships he had, such as with his father.

5.5.2 National Probation Service state that Geoffrey was someone who was difficult to engage with when trying to address his offending behaviour (see paragraph 4.3.5). It is therefore speculative whether Geoffrey understood his behaviour was offensive and where the boundaries were in relationships. It certainly does not appear that he was truly contrite and prepared to engage in modifying his behaviour.

5.5.3 PC1 spoke to David and AM1 about domestic abuse when he visited them on 30.03.2015. The officer told the IMR author that neither of them appeared unduly concerned about the abuse, or any threat made by Geoffrey. There is also evidence that the nurse who was present when PC1 visited address one also offered some support by suggesting that David might need to move into a convalescence home. The officer says AM1 was adamant that moving from address one was not an option and that David was not going anywhere.

5.5.4 The Greater Manchester Police IMR author also commented on the fact that AM1 and David did not contact the police to report that Geoffrey had visited them on the day of the homicide. The author states this could be interpreted as amounting to a lack of concern on their part, and might support PC1's initial assessment on 30.03.2015.

5.5.5 The panel noted that David, AM1 and other members of their family did not contact Greater Manchester Police with information about Geoffrey's whereabouts. This included family members to whom Geoffrey also repeated threats to kill David (see paragraph 3.5.7). Had Greater Manchester Police known what the family knew it may have led to the earlier arrest of Geoffrey.

5.5.6 While recognising that David and AM1 may well have not shown concern about Geoffrey's actions, the panel feel it is important to stress that victims of domestic abuse can sometimes minimise their fears. This may happen for a variety of reasons[22]. It is something that has been commented on within research into domestic abuse and in other DHR reviews. It should be stressed Geoffrey had a history of violence. Family members may therefore have had many reasons why they chose not to tell the police about what they knew about Geoffrey's threats to David and his whereabouts.

5.5.7 While recognising family members did not to come to the police with information there is equally no evidence that police officers were proactive in seeking the views of the wider family about domestic abuse. DC1 told the IMR author that, given more time, they might have contacted David to discuss services or support. However, they believed this would only duplicate what PC1 had already done on 30.03.2015.

[22] Everyone's business: Improving the police response to domestic abuse. HMIC 2014 p31.

5.6 How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, including age and disabilities, when completing assessments and providing services to David and Geoffrey?

5.6.1 David was seriously ill, suffered from COPD and relied upon a scooter for mobility. It was therefore important these factors were considered when assessment and services were provided to him. David was receiving health and/or welfare services from his GP, Rochdale Pathways, Adult Care and Guinness Housing. These all appeared to take his medical condition and disabilities into account and were focused upon improving his quality of life. He made clear to professionals that he chose not to follow much of the advice he was given and was not ready to address his substance misuse.

5.6.2 The IMR author for Greater Manchester Police highlights that, given David's disabilities and AM1's drinking, a referral could have been made to Adult Care (see paragraph 5.4.5). However, in all other respects the services provided to David by Greater Manchester Police appear to recognise these factors and were well documented within the DASH risk assessment.

5.7 Were single and multi-agency domestic abuse policies and procedures followed and were any gaps identified?

5.7.1 There are some issues in the way in which Greater Manchester Police sought to arrest Geoffrey for the robbery (see paragraph 4.2.7), the way the theft of David's mobility scooter was dealt with (see paragraph 4.2.11) and in the way in which police staff handled and graded the second call made to Greater Manchester Police on 30.03.2015 (see paragraph 4.2.26). These do not relate to domestic abuse policy and are therefore outside the scope of this DHR. However, the IMR author has made a thorough and detailed analysis of them from which some important learning for officers and staff in Greater Manchester Police has emerged.

5.7.2 The Greater Manchester Police IMR author says that, when domestic abuse was identified on 30.03.2015, there is some evidence policies and procedures[23] were followed. The author also states the two crimes of harassment were recorded in accordance with the National Crime Recording Standards (NCRS). While policy was generally followed, the weaknesses in this case relate to the fact that more emphasis should have been placed on Geoffrey and a full assessment made of all the information to hand. In particular Geoffrey's behaviour, criminal history and violent conduct.

5.7.3 The panel believes that, given the information both PC1 and DC1 saw, the assessment they reached of a medium risk was appropriate. However, there was information they did not consider when reaching that assessment. More information was available to be found had a more detailed search of systems such as PNC and

[23] GMP Tackling Domestic Abuse Policy and Operational Procedures 2013, now replaced by the Domestic Abuse Policy and Procedures May 2015. These provide a framework to ensure that by dealing with victims of abuse effectively and by conducting thorough risk assessment processes with victims, likelihood of future harm, including homicide, serious injury and acts of violence are reduced.

PND been undertaken. For example, the details of the 2009 incident involving Geoffrey in the discharge of a firearm are recorded, in brief, on the PNC, and are mentioned on a crime report on the intelligence record held for Geoffrey on the Greater Manchester Police intelligence system OPUS.

5.7.4 The panel recognises that many offenders have warnings for weapons and firearms. However, Geoffrey was a man who, although acquitted of murder, had been charged with an offence the circumstances of which involved discharging a firearm and live rounds at victims. The ability to acquire a firearm and ammunition and then using it in those circumstances placed Geoffrey in a small cohort of particularly dangerous people. Not recognising the potential Geoffrey had for committing serious offences like that was a weakness in the procedures followed by officers from Greater Manchester Police when assessing risk.

5.7.5 The DHR Panel considered the 'chicken and egg' dilemma that is apparent in this case. That is, if a police officer follows the procedures and determines the risk is low or medium then there is not a requirement to pursue other sources of information. Had those other sources (PNC/PND) been pursued then the risk would have been high. The panel recognised this and the issue that this is a key point in many other DHRs.

5.7.6 There are no gaps identified in the domestic abuse policies of other agencies.

5.8 How effective was your agency's supervision and management of practitioners who were involved with supporting David and Geoffrey and did managers have effective oversight and control of the case?

5.8.1 When the DASH risk assessment was completed by PC1 on 30.03.2015 it was reviewed by a supervisor. The supervisor was satisfied the correct level of risk had been apportioned, albeit the panel believes that risk was understated because the officer completing it did not research all the information that was available. The supervisor also ensued that Geoffrey was added to the Response Supervisors' Rolling Log for attempts to be made to arrest him.

5.8.3 No weaknesses were found in relation to the management and supervision of professionals in other agencies.

5.9 Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to David and/or Geoffrey to work with other agencies?

5.9.1 Capacity and resources were not considered to be an issue in any agency except for Greater Manchester Police. Their IMR author says the issue was touched on by several officers and staff they spoke to about this review as follows;

- Radio Operator two said there is often significant demand and insufficient Response officers to service that demand, which could have been a factor on 30.03.2015 when there was a delay in allocating both FWINS;

- The action board entries on the two harassment crimes taken by PC1 on 30.03.2015 indicate that between then and the date of the homicide Greater Manchester Police officers had difficulty in completing enquiries to try and

arrest Geoffrey because of competing demands and a lack of available resources;

- PC1 said they did not believe they would have had the time to fully research Geoffrey on the PNC, or his criminal history;
- PC1 said, with hindsight, if they had more time to fully research Geoffrey 's record and consider his violent history, together with the comments made on the DASH about his violent behaviour towards family members, this might have prompted them to consider recording the DASH as high risk;
- A Response Team supervisor said there is often other competing demands for Response to address. In this case, they and other supervisors had made entries on the harassment crimes tasking constables to make enquiries but these enquiries were thwarted by either competing demands or a lack of resources;
- The same supervisor said, given the time to progress the task, there would clearly have been merit in completing a thorough review of the recorded police history / convictions of the perpetrator in this case, to piece together the offender's conduct / behaviour and to fully inform the risk assessment;
- DC1 said because of the volume of referrals made to the Public Protection Investigation Unit there are often constraints on the time that the Triage Desk can spend on each referral, which has some bearing on the time spent reviewing and researching history held on a victim and perpetrator;
- DC1 explained that research can often take time to complete and that there is pressure to reduce the number of jobs that appear in the Triage Desk queues; this can impact on the time allocated to researching individual cases.

5.9.2 In relation to the references that some staff make to lack of resources, the Greater Manchester Police panel member felt it was important to state these were the subjective opinions of individual officers and staff. The panel believes it is important to understand the context within which domestic abuse sits in Greater Manchester Police. The force receives over 65,000 reports of domestic abuse incidents every year. That represents around 170 incidents a day and about 6% of Greater Manchester Police's total workload. The IMR author believes this reflects some, although far from all, of the demands placed upon Response and Public Protection Investigation Unit personnel.

5.9.3 The panel recognises that capacity and resource issues and the way in which resources are allocated are operational matters within the purview of the Chief Constable of Greater Manchester Police. Consequently, it makes no recommendations in this area. However, the panel are reassured by the IMR author's statements that domestic abuse is a number one priority in Greater Manchester Police. The panel understand governance meetings are in place at Assistant Chief Constable (ACC) and Police and Crime Commissioner (PCC) level and work is being undertaken in several areas, including a commitment to continue to monitor resources both in Response and the Public Protection Investigation Unit. The panel welcomes the commitment from Greater Manchester Police that the IMR

in relation to this DHR will be shared with the senior leadership team in the Public Protection Division.

5.10 To consider how this review can benefit workforce development and enhance partnership working.

5.10.1 The only agency that identified learning from this review was Greater Manchester Police. Their IMR author undertook a comprehensive scrutiny and wrote a detailed analysis of the learning that emerged. This included some reflective learning for individual officers and staff from Greater Manchester Police that were involved in this case. Although they did not repeat this in full the panel felt the following points set out below were important to emphasise. In addition, the Greater Manchester Police IMR author made several single agency recommendations which appear in Appendix D.

5.10.2 There was recognition by call handlers and radio operators that Greater Manchester Police could have responded earlier to the two calls made on 30.03.2015 given the nature of the threats made by Geoffrey. The second call from the sister of David and AM1 could have presented a potential risk to life situation, which should have prompted a grade one (immediate) response. Greater Manchester Police are satisfied their Incident Response Policy (2011) is still fit for purpose. However, they have undertaken work to ensure their staff understand the importance of recognising, recording and assessing risk.

5.10.3 As outlined at paragraph 5.1 et al the initial and enhanced risk assessments did not fully consider the violent nature of Geoffrey, his offending history or the threat that he posed to AM1 or David. More emphasis should have been placed on an assessment of the threat made by Geoffrey and an analysis of the probability of the threat being carried out. This should have considered the capability and intent of Geoffrey, his history of violence and his motivation.

5.10.4 Greater Manchester Police recognise more needs to be done around an assessment of domestic abuse perpetrators, including providing more guidance to practitioners that will improve awareness around the threat and risks perpetrators can present. This extends to a need to ensure the behaviour and the history of perpetrators is considered as part of the risk assessment process. Work is currently being undertaken in Greater Manchester Police around identifying processes that identify and risk assess domestic abuse perpetrators within the community. Greater Manchester Police is providing enhanced DASH training to practitioners working in Response and on Public Protection Investigation Unit Triage Desks following an inspection by Her Majesty's Inspectorate of Constabulary (HMIC) who raised concerns in 2014.[24] The Greater Manchester Police IMR author believes that any guidance needs to consider the role of supervisors who have a responsibility for oversight of domestic abuse investigations and to review the risk assessments undertaken (See agency recommendation one-Appendix D).

5.10.5 PND would have provided important information that could have informed the assessment of risk on 30.03.2015 and the enhanced assessment the following day. Greater Manchester Police policy states a Public Protection Investigation Unit

[24] Everyone's Business: Improving the Police Response to Domestic Abuse HMIC March 2014

investigator will, "Complete further police checks, i.e. Intelligence, previous history, PNC and PND where appropriate." A PND check did not happen in this case because the incident was not classified as high risk. The Greater Manchester Police IMR author believes this policy needs to be reviewed and has made a recommendation about this (See agency recommendation two-Appendix D).

5.10.6 The IMR author also draws attention to the National Threats to Life Guidelines[25]. While not applicable to all cases it could have been considered based on the threat made to stab AM1 if not the threat to kill David. The IMR author says the appointment of an investigating officer under these guidelines is key in accepting ownership and managing the police response. In this case, it would have been significant as there was no ownership of the two harassment crimes and no officer had responsibility for the ownership and investigation of these crimes. The appointment of an investigating officer and the creation of a threats to life tracking document would have been a more effective means of managing the threat and risk in this case.

5.10.7 To be effective, this policy needs the cooperation and support of victims and witnesses. David, AM1 and AF4 knew Geoffrey's whereabouts on the day of the homicide as he visited address one yet they did not take any steps to alert Greater Manchester Police. This report has already discussed why the victims of domestic abuse choose to minimise threat (see paragraph 5.5.6). Given they did not fully engage with Greater Manchester Police it therefore throws into some doubt how effective use of the Threats to Life Guidelines would have been in this case.

5.10.8 Neither PC1 nor their supervisor were aware of these guidelines although training has been given to some officers in management positions. The IMR author believes that Response constables and supervisors need to have an awareness of the National Threats to Life Guidelines to consider those cases where it might be appropriate to invoke its principles. Accordingly, they have made a recommendation to provide training/guidance (See agency recommendation two-Appendix D).

5.10.9 The IMR author also repeats their belief that a referral to Adult Care could have been considered in this case. They accept the decision to refer and share information with other agencies is a judgement call for practitioners. Current Greater Manchester Police policy states that initial investigators and Public Protection Investigation Unit staff should make relevant referrals where appropriate. Consequently, they make no recommendations around this issue.

[25] This guidance is followed in cases where there is a real and immediate threat to loss of life or to cause serious harm or injury to another. The principles outlined in this guidance may be adopted to manage threats to cause non-fatal serious injury. The processes contained within this guidance prompt the completion of a documented assessment / analysis of the threat (completed by a supervisor), a response to mitigate the threat / risk and an agreed strategy to remove the risk. Significantly, the framework set out in these guidelines would include ownership of the threat / risk, with the appointment of an investigating officer and a clearly defined control strategy that is included in a threat to life tracking document.

6. LESSONS IDENTIFIED

Lesson 1

Not identifying all risk factors may lead to an understatement of the risk a victim faces and an offender presents, thereby leading to weaker risk management plans which leave victims vulnerable to further abuse.

Narrative:

The initial telephone call from AM1 to Greater Manchester Police contained information that Geoffrey had made a threat to kill David. Because of an error this information was not included on the FWIN log and not given to PC1 who attended address one. Neither AM1 nor David told PC1 that such a threat had been made.

The initial and enhanced risk assessments completed following the threats made on 30.10.2015 did not fully consider the violent nature of Geoffrey, his offending history or the threat that he posed to AM1 or David. The panel recognises that, as a minimum, to carry out those checks needed time, access to systems, training and experience.

Panel recommendation 1 & 2 and agency recommendation 1 applies

Lesson 2

The current process for determining an enhanced risk assessment within Greater Manchester Police poses a professional dilemma that can lead to the understatement of risk.

Narrative:

A check was not carried out on the Police National Database (PND) because the original risk assessment showed Geoffrey presented a medium risk of harm. Had this happened it would have identified important information about Geoffrey his history of violence and that he was a perpetrator of domestic abuse against a former partner. This in turn may have led to the enhanced risk assessment concluding Geoffrey presented a high risk of harm. If further checks rely on an initial risk assessment being "high" before they are carried out, then initial risk assessments will always face the possibility of being understated. This case is not unique in this respect.

Lesson 3

There is a need to improve the understanding of why people like Geoffrey behave in an angry and violent way and then go on to commit homicides.

Narrative:

The root cause of Geoffrey's anger and violence had never been fully explored. During the period that the review covered the panel saw no evidence of when opportunities had arisen to really explore this behaviour. While referrals for support had been made (i.e. during the period he engaged with National Probation Service) these came very late in his life when his attitude was well embedded and did not appear to make any difference to the way in which Geoffrey behaved.

Panel recommendation iii applies.

Lesson 4

Many agencies hold important information about individuals and family patterns of poor parenting, abuse, violence, drug use, anti-social behaviour and crime. Some times that information can go back many years. Early identification of those behaviours and sharing of information can help develop plans to prevent such negative behaviour being repeated through future generations.

Narrative:

Geoffrey experienced a troubled childhood and as a child was exposed to drug misuse and crime. In turn Geoffrey became angry and violent himself, committed crime, misused drugs and engaged in some of the behaviours he had been exposed to in his childhood. Geoffrey also became a father. Agencies such as NPS and social care teams as well as the police had considerable contact with Geoffrey and his family. While they did not hold information that Geoffrey presented a risk to David, the information they held when brought together, indicated a pattern or behaviour that was intergenerational.
Panel recommendation iv applies.

7. CONCLUSIONS

7.1 David misused drugs for most of his adult life and ended his life suffering from COPD and had little mobility. David had capacity to make life-style choices that would inevitably shorten the length and quality of his life. Both his partner AF3 and daughter AF2 suffered deaths that were directly related to their misuse of drugs. While the panel were not able to gather much information about their lives when children they believe from what was available that Geoffrey had a chaotic upbringing and chose to leave home and make a life elsewhere.

7.2 The panel considered the number and range of convictions David, AF3, AF2 and Geoffrey amassed during their lives. They questioned whether such records were extraordinary and what, if any, early intervention from agencies would now take place with a family such as this. The panel learnt that such records of offending are not unique particularly given many years of abusing drugs such as heroin, a habit which is costly to maintain. The panel are reassured a family with complex needs would now be identified through the Troubled Families Agenda and would be given intensive multi-agency support and attention.

7.3 Geoffrey had no contact with David for many years. Geoffrey lived in West Yorkshire where he started to abuse his partner and he was convicted of assault. Geoffrey regularly used weapons including knives. He had a history of violent behaviour and was charged with attempted murder. Although he was acquitted, the circumstances involved the use of a vehicle to pursue victims and the discharge of live rounds at them from a firearm. This behaviour showed resourcefulness, persistence and intent. Being able to acquire live ammunition and a weapon and demonstrating the motivation and ability to use such a weapon against another human places Geoffrey in a small cohort of people who pose a high risk of harm.

7.4 When Geoffrey discovered David was very poorly there appears to have been a reconciliation of sorts between them and they lived together at address two for a period. AM1 thought this was driven by Geoffrey's belief he could get money from his father. Unfortunately, the panel have not been able to explore these issues further with AM1 as he does not wish to engage with the DHR.

7.5 The reconciliation was short lived and David then went to live with AM1 at address one after he fell out with Geoffrey. The reason for this was that David accused Geoffrey of using crack or heroin. This was an accusation that appears to have made Geoffrey very angry and may well be because of the circumstances of his mother and sister's death. David told both Rochdale Pathways and his GP that he had fallen out with Geoffrey and the reasons why although he did not disclose any threats from Geoffrey to them. The panel felt there was no reason why that information should have been shared with other agencies.

7.6 Geoffrey committed a robbery at a shop in which he used a knife and made threats to kill. The panel feels that this shows Geoffrey continued to follow a pattern of criminal behaviour that involved the use of weapons. As such it would be reasonable to believe he might use weapons when committing other offences. Geoffrey was identified from a finger print and circulated as wanted although never arrested for that matter.

7.7 Geoffrey was also suspected of stealing David's mobility scooter. This matter was reported to Greater Manchester Police. However, Geoffrey was not recorded as a

suspect, and the crime was filed 'undetected'. The Independent Police Complaints Commission investigated whether Greater Manchester Police's response to effecting Geoffrey's arrest was appropriate. The DHR agreed it would therefore not examine Greater Manchester Police's response to that matter.

7.8 However the panel felt it important to conclude that, had Geoffrey been arrested for any of the offences he had committed, during the time he was in custody he would not have presented a risk to either David or AM1. The panel are not able to speculate as to whether, having been arrested, Geoffrey would have been charged and remanded in custody. That would have been reliant upon several factors including the willingness of AM1 and David to support a prosecution as well as the Crown Prosecution Service's assessment of whether the evidence met their thresholds for prosecution.

7.9 When AM1 contacted Greater Manchester Police on 30.03.2015 and reported the threats made by Geoffrey, a simple, and understandable lapse, meant the specific threat to kill David was not recorded on the FWIN. It was therefore not known to PC1 when he attended address one. Neither AM1 nor David told the officer about this threat and details of the text it was contained in were not found on the mobile telephone of David.

7.10 Despite PC1 not being aware of the threat to kill David they correctly recorded two crimes of harassment, one each against AM1 and David, with Geoffrey as the suspect. The officer followed Greater Manchester Police policy and completed a DASH risk assessment. This contained details of the threats and some information about Geoffrey's history of violence. PC1 carried out some checks on the PNC and Greater Manchester Police systems and concluded the risk Geoffrey presented was medium. The officer did not have access to PND which would have given them a more comprehensive picture of Geoffrey's history of violence and domestic abuse. Based upon the information PC1 saw and the fact they were not aware Geoffrey had made a specific threat to kill David the panel conclude that was a reasonable assessment to reach.

7.11 Similarly when DC1 conducted the enhanced risk assessment the following day they relied upon the information PC1 had included on the DASH form. Because the risk was medium a PND check was not carried out and therefore DC1 was not aware of the important information it contained. Again, they concluded the risk to AM1 and David was medium. The panel also agree this was a reasonable assessment to reach based upon the information DC1 saw.

7.12 The panel agree that, with more detailed research and knowledge of Geoffrey's offending behaviour, the risk he posed towards AM1 and David should have been classified as high. However, the panel recognise the officers did not have access to all the information and their ability to conduct more detailed research was constrained by other competing demands. The complexities of Geoffrey's previous behaviour and of the sequence of events in this case also meant it was difficult for police officers to fully understand what was really happening and therefore properly assess risk. The panel welcomes the fact Greater Manchester Police have already undertaken to increase awareness around assessing risk when calls are made and have made recommendations to review the use of PND and extend knowledge of

the Threats to Life guidance[26]. The panel believe these will improve the way in which Greater Manchester Police deal with domestic abuse and will help reduce the risk for future victims.

7.13 The fact that no active enquiries were made to arrest Geoffrey between 30.03.2015 and the day of the homicide appears to have been due to competing demands and availability of resources as opposed to deliberate omission. The need to make active enquiries was recognised on the day of the homicide when an officer visited a public house where Geoffrey was believed to be. Unfortunately, those enquiries were not successful.

7.14 The panel recognised that AM1, David, AF4 and other members of their family had information about Geoffrey's whereabouts and did not to give that information to Greater Manchester Police. The panel have not been able to engage with the family and therefore do not know why they did not tell the police of Geoffrey's whereabouts. The panel repeats the earlier view that victims of domestic abuse sometimes choose to minimise risk for a variety of reasons.

7.15 Geoffrey made extensive admissions to Greater Manchester Police when he was interviewed. It is clear he harboured considerable hatred towards his father whom he blamed for the deaths of his mother and sister. He was aggravated further by David's remarks that were made about the theft of David's scooter and that Geoffrey was a 'smack head'. Given the way his mother and sister died this seemed to particularly provoke him. He had already confronted David earlier on the day of the homicide and says David apologised to him. Geoffrey did not accept these apologies. The conversations he had and text messages he sent that day indicated it was his intent to kill David. Why he decided to return to address one when he did is not clear. It may be that Geoffrey's consumption of alcohol and cannabis were factors that increased his feelings of anger and boldness. National Probation Service identified that alcohol misuse was linked to his offending.

[26] National Threats to Life Guidelines (January 2013); this guidance is followed in cases where there is a real and immediate threat to loss of life or to cause serious harm or injury to another. The principles outlined in this guidance may be adopted to manage threats to cause non-fatal serious injury.

8. PREDICTABILITY/PREVENTABILITY

8.1 Geoffrey had a long history of offending and had used violence and weapons against victims, including police officers. Geoffrey was a dangerous individual.

8.2 When Geoffrey made threats to kill David on 30.03.2015, for the reasons already discussed, the precise nature of the threat was not understood. Neither was his history of violent offending fully understood. Had it been, the panel believe that, on the balance of probabilities, it was predictable that Geoffrey would harm or kill David. However, based upon what police officers knew, rather than what could have been discovered, the panel believe it was not predictable that Geoffrey would kill David. If further checks rely on an initial risk assessment being "high" before they are carried out, then initial risk assessments will always face the possibility of being understated. This case is not unique in this respect.

8.3 The full extent of the threat to David was not known and the risk to him was assessed as medium. The protective measures appropriate to that risk were in place and sufficient. It was clear that David and AM1 would not move from address one and the protective measures in place were therefore reasonable. Arresting Geoffrey would have ensured he was not able to harm David. However, for reasons discussed earlier, these had not been successful. The panel therefore concluded that, on the balance of probabilities, the death of David could not have been prevented.

9. RECOMMENDATIONS

9.1 The DHR Recommendations appear below and in the Action Plan.

9.2 The DHR panel recommends that:

i. Rochdale Safer Communities Partnership request Greater Manchester Police provide reports to them on progress with the implementation of the single agency recommendations within this review;

ii. That Rochdale Safer Communities Partnership use this case as a learning opportunity so that professionals understand the importance of correctly assessing and documenting risk and of researching a perpetrator's offending history.

iii. The Home Office commission national research to identify what makes people like Geoffrey behave in the violent and aggressive way they do and then to commit homicides. This research should attempt to identify what works to prevent people behaving in this manner.

iv. That Rochdale Safer Communities Partnership reinforce to all agencies the importance of early identification of families as 'troubled' and the mechanisms for referring concerns and sharing information.

Appendix A

Definitions

Domestic Violence

1. The Government definition of domestic violence against both men and women (agreed in 2004) is:

   "Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 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

3. *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.

4. *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.

Vulnerable Adults No Secrets (Now superseded by Chapter 14 Care Act 2014)

5. The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides?* issued by the Lord Chancellor's Department, is a person:

   "Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

6. A consensus has emerged identifying the following main different forms of abuse:

   - physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;

   - sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;

- psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;

- financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

- neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

7. Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm. (Source: Section 2 No Secrets Department of Health 2000)

Risk Factors

Individuals at risk for domestic violence could include those with the following risk factors:

- Planning to leave or has recently left an abusive relationship
- Previously in an abusive relationship
- Poverty or poor living situations
- Unemployed
- Physical or mental disability
- Recently separated or divorced
- Isolated socially from friends and family
- Abused as a child
- Witnessed domestic violence as a child
- Pregnancy, especially if unplanned
- Younger than 30 years
- Stalked by a partner

The following factors may indicate an increased likelihood that a person may choose violence:

- Abuses alcohol or drugs
- Witnessed abuse as a child
- Was a victim of abuse as a child
- Abused former partner
- Unemployed or under employed/financial worries
- Abuses pets
- Criminal history including weapons
- Mental health issues/suicide attempts

Greater Manchester Police Terms Used in the Report

FWINS

FWIN is an acronym for Force Wide Incident Numbering. This is a computerised system for recording and auditing all incidents reported to Greater Manchester Police requiring a police response. A FWIN is allocated a unique reference number on a daily basis. For example FWIN 1112 of 30/03/15 refers to incident number 1112 on the 30th March 2015. Opening and closing codes are applied to FWINs in order to categorise them for statistical purposes and to ensure appropriate 'follow up' responses.

For example a typical relevant closing code on a FWIN for a domestic related incident is D62; this indicates that an incident has been categorised as a domestic incident involving adults. A closing code such as D62 would generate an automatic referral to the Public Protection Investigation Unit on the relevant police division for an assessment / follow up response by a specialist Public Protection Investigation Unit officer. A similar process applies to a FWIN closed G16 (concern for safety of an adult), which would also generate an automatic referral to the Public Protection Investigation Unit (Public Protection Investigation Unit) for an assessment / follow up response by a specialist Public Protection Investigation Unit officer.

DASH risk assessment model (Greater Manchester Police Policy April 2013)

Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment form (DASH) is the risk assessment model currently used in Greater Manchester Police when reporting domestic incidents. DASH is an essential element to tackling domestic abuse and providing the information that could influence whether or not to refer the victim to a Multi-Agency Risk Assessment Conference (MARAC); it is designed to improve the process that would identify and manage risk to the victims of domestic abuse. There are three parts to the DASH risk assessment model as set out in the Tackling Domestic Abuse Policy and Operational Procedures 2013:

- Part 1: risk identification by first response police staff;
- Part 2: the full risk assessment review and enhanced risk assessment by specialist Public Protection Investigation domestic abuse staff; and
- Part 3: risk management and intervention plan by public protection investigation domestic abuse staff.

The DASH checklist must now be used for all domestic abuse and honour based violence incidents and it is imperative that all questions (and there are 28 in total) are asked and answers completed and recorded accurately by first response officers. Once an officer has asked the 28 questions and completed the risk assessment he / she must then use their professional judgement along with the risk indicators to identify and grade the risk posed to that individual or any other person who resides at the address.

A risk classification is required on the 1-28 form to be recorded as either standard, medium or high based on the following:

- Standard - Current evidence does not indicate likelihood of causing serious harm

- Medium - There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances
- High - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious

On completion of this risk assessment, the reporting officer has a responsibility for the completion of the DASH on the Greater Manchester Police Operational Policing Unit System (OPUS); it is only once this has been completed that the risk assessment will be viewable by specialist domestic abuse staff within the Public Protection Investigation Unit who can then act accordingly on the information that has been provided.

The DASH risk assessment model places a responsibility on specialist public protection investigation domestic abuse staff to complete a full risk assessment review and enhanced risk assessment, which will enable specialist investigators to make a more informed analysis. This enhanced risk assessment requires specialist domestic abuse investigators to consider eleven further questions, including a requirement to obtain details of domestic violence history. The completion of this enhanced risk assessment should inform the specialist domestic abuse investigator as to whether the risk to the victim is standard, medium or high, and to consider what further action is necessary and whether a Multi-Agency Risk Assessment Conference (MARAC) referral should be considered.

Triage Desk

As reflected in Public Protection Investigation Unit Divisional Handbook of 2012 under roles and responsibilities, the Triage Desk is at the core of the Public Protection Investigation Unit and aims to provide, amongst other things:

- Consistency in identifying and flagging vulnerable people;
- Timely identification of safeguarding concerns, risk assessments and risk management;
- Ensure information regarding domestic abuse, child protection, adult protection/mental ill health is not assessed in isolation;
- Early identification of high risk cases that are then referred to Public Protection Investigation Unit investigation teams; and
- Recording and management of all referrals, both internal and external.

Graded Response

Police call handlers have a responsibility to identify and mitigate risk, taking into account all the circumstances of the incident, including the vulnerability of the victim when making the incident grading decision. The incident grade will determine the level and timeliness of our response to incidents.

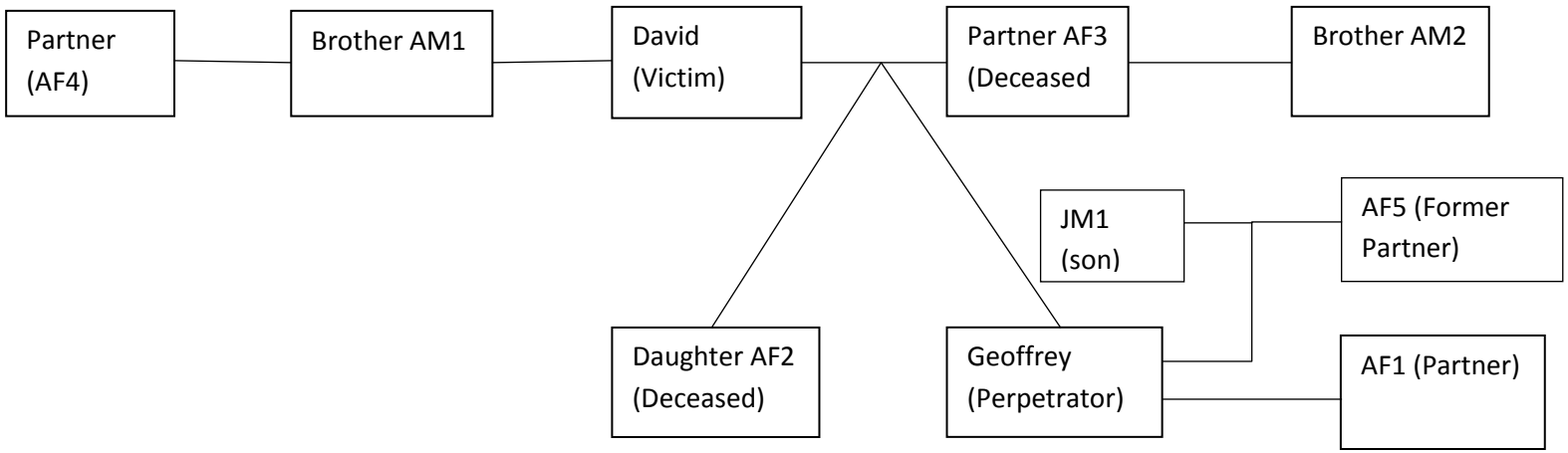
The overarching objective is to deliver a response to incidents, which meets the needs of the community, whilst identifying and mitigating risk and harm. The graded response will be subject of comment in sections of this IMR report; in summary the graded response policy is as follows:

Grade 1 : Emergency Response	Allocate within 2 mins and attendance within 15 mins;
Grade 2 : Priority Response	Allocate within 20 mins and attendance within 1 hour;

Grade 3 : Routine Response	Allocate within 2 hours and attendance within 4 hours;
Grade 4 : Scheduled Response	Attendance or other resolution within 48 hours; and
Grade 5 : Telephone Resolution	First-time telephone resolution of a call

Appendix B

Family Tree



Appendix C

Note Meeting with Geoffrey

1410 hours Monday 07.12.2015 in (Redacted) Prison.

Also present Geoffrey's Offender Manager (Redacted Name)

Victim David who is Geoffrey's [David terminal ill]

AM1 is Geoffrey's Uncle and David's brother

Geoffrey's mum is AF3 [deceased] 2010

Geoffrey's sister is AF2 [deceased] 2007

Date of homicide (Redacted)

Geoffrey was found not guilty of murder but guilty of manslaughter on and sentenced to 10 years on 16.11.2015

Geoffrey has a girlfriend and a baby who was born recently and who he's not seen.

Explain purpose of meeting and DHR process

Cover confidentiality

Pseudonyms for Geoffrey and Graham agreed.

Geoffrey said he went to school but as he got older his father took him our stealing including shop theft. His father sold the goods to pay for heroin. He was often beaten by his father who he blames for a very poor childhood. Having satisfied his father's need for money, Geoffrey then had to steal something for his tea. Geoffrey was closer to his mother [who was also a heroin user] but the relationship was not great. He got on ok with his sister and again blames his father for introducing her to heroin. Geoffrey said his father showed far greater favour to his sister than him. [Differential parenting]

Geoffrey said his life was shit and retuned many time to the theme that he was never given a chance and only wanted to be treated like other people.

He recalls being taken into care and living in a home [redacted]

He has a sixteen-year-old son from a previous relationship [redacted]

Geoffrey spoke about his time in Leeds when he formed a relationship with a female and they had two children together. Geoffrey was working in a scrap yard and was skilled at cutting metal and operating the machinery of scrap yards. He was earning and providing for his family. He didn't drink but used cannabis. When asked about the DA in that relationship, Geoffrey minimised his part suggesting he only head-butted his partner after she hit him.

The children were taken into care and he returned to the Rochdale area in 2007. He has not seen or maintained contact with them or their mother since then.

The relationship with his father had broken down many years before and his anger towards his father increased when his sister and mother died of what he says were heroin misuse, encouraged by Graham.

He felt his Aunty Sue [redacted] would speak with us. She has telephoned him in prison. His Uncle AM1 does not speak to anyone; he just watches TV [redacted].

He reached out to his father when he heard he was terminally ill. However, he found very little had changed and that his father was still using heroin and would die soon. He heard through family members that his father called Geoffrey a "Smack Head" [27] and that upset him. It reignited his "hatred" of his father for "causing" the deaths of his mother and sister. He stewed on it for a few days and got angrier and angrier until he carried out his threats to kill his father.

Geoffrey felt his mistake was reaching out to his father but he did it because a friend said he might regret not seeing his dad before he died.

Throughout the meeting Geoffrey was polite but his body language, including the tap, tap tapping of his leg, and facial tension suggested he was not at ease with himself. He showed no remorse for the homicide and wanted to leave HMP [redacted].

In summary I believe that Geoffrey it a very angry man with deep resentment against his father on two levels; one for "making his life shit" and denying him the opportunities that other people had and two for the deaths of his mother and sister. He does not accept responsibility for his previous domestic abuse believing it was ok to fight with his then partner if she hit him.

Geoffrey gave permission to use anything he had said in the DHR.

End

[27] An urban term for a person with a significant heroin addiction

Appendix 'D'

DHR Panel Action Plan

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	Rochdale Safer Communities Partnership request Greater Manchester Police provide reports to them on progress with the implementation of the single agency recommendations within this review.	GMP PPD report progress to the RSCP	Email or other written confirmation of completion / progress provided for perusal by the RSCP at least a half-yearly basis until action signed off as complete	Single agency recommendations are fully implemented	GMP Head of Public Protection Division	November 2016
2	That Rochdale Safer Communities Partnership use this case as a learning opportunity so that professionals understand the importance of correctly assessing and documenting risk and of researching a perpetrator's offending history.	Domestic Abuse Working Group consider findings and measures that may help to drive up range and quality of risk assessment and referral, and of understanding of perpetrator offending and risk posed	Domestic Abuse Working Group minutes and report on work undertaken	As broad a range of agencies and services as possible understand processes for risk assessment and referral, and the intervention options available	Member agencies of the Domestic Abuse Working Group	April 2017
3	The Home Office commission national research to identify what makes people like Geoffrey behave in the violent and aggressive way they do and then to commit	RSCP to write on Chair's behalf to Home Office to highlight Panel recommendation	Home Office consider findings and seek to commission appropriate research and / or take appropriate learning from any such research and/or good	Learning from research and / or studies of good practice is cascaded and used to help in	RBC Principal Community Safety Officer	December 2016

	homicides. This research should attempt to identify what works to prevent people behaving in this manner.		practice already in the public domain	preventing people from offending in such a manner		
4	That Rochdale Safer Communities Partnership reinforce to all agencies the importance of early identification of families as 'troubled' and the mechanisms for referring concerns and sharing information.	Joint work between RSCP and Early Help & Schools to highlight and reinforce process for identification and referral	Appropriate levels of identification and referral of families where domestic abuse is evident for early help and intervention, with view to key worker allocation if thresholds are met	Families with multiple issues that include domestic abuse are identified early and support put in place	Member agencies of the Domestic Abuse Working Group, in conjunction with Early Help & Schools	June 2017

Greater Manchester Police Single Agency Action Plan

No.	Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Date
1	**That the Head of the Public Protection Division provides guidance to practitioners and supervisors around the DASH risk assessment process to ensure that full consideration is being given to the 'perpetrator' and the threat / risk they pose. Research should look beyond PPI history and include an assessment of the**	• At the next PPD review of domestic abuse policy, consideration is to be given to an addition / addendum to policy in relation to identifying risk factors for perpetrators; • Dissemination of	Review Panel to be informed of any addition / addendum made to domestic abuse policy in line with key actions, and confirmation that it has been disseminated to practitioners and supervisors. Review Panel to be informed of any bulletin circulation made to practitioners and supervisors providing guidance in	The aim is to ensure that at the point of completing DASH risk assessments, practitioners and supervisors are giving full consideration to the perpetrator and the threat / risk they pose to victims of domestic abuse. This	DCI Nicky PORTER (PPD)	December 2015

	perpetrator's behaviour, motivation and offending history, to inform risk and to consider the capability and intent of the perpetrator.	any addition / addendum to policy to both practitioners and supervisors; and • Circulation of PPD bulletin to practitioners and supervisors in relation to risks posed by perpetrators setting out the requirement for holistic analysis when completing risk assessments.	relation to risks posed by perpetrators and the requirement for holistic analysis when completing risk assessments. PPD to confirm to Review Panel that a dip sampling process is in place to ensure compliance with any addition to policy and guidance circulated to practitioners and supervisors.	should include an assessment of the perpetrators behaviour, motivation and offending history, to inform risk and to consider the capability and intent of the perpetrator (looking beyond PPI history). The overarching objective is to seek to ensure that greater emphasis is placed on an assessment of the perpetrator and the threat / risk they pose, in order to consider measures to mitigate risk and safeguard victims.		
2	**That the Head of the Public Protection Division reviews current policy around the**	• At the next PPD review of domestic abuse	Review Panel to be informed of outcome of review of the PPD policy around the	The aim is to ensure that information held on the PND that	DCI Nicky PORTER (PPD)	December 2015

	requirement to complete PND checks as part of the DASH risk assessment. Consideration should be given to when it is appropriate to complete PND checks and whether this should extend to standard and medium risk classifications.	policy, consideration is to be given to an addition / addendum to policy around the completion of Police National Database (PND) research in cases of 'standard' DASH risk assessments, in addition to 'medium' and 'high' risk cases. • Dissemination of policy around PND research to be provided to practitioners; and • Capability assessment to be completed by PND lead (Helen CRITCHLEY) to consider proportionality.	completion of PND research in domestic abuse cases, and evidence of dissemination of this policy to practitioners to be provided.	could inform the DASH risk assessment is being considered and is not being overlooked. The overarching objective is to ensure that there are no missed opportunities to assess the threat / risk from perpetrators and that relevant information is being considered in order to safeguard victims of domestic abuse.		
3	**That the Threats to Life Champion considers the**	The Threats to Life Champion in Greater	Review Panel is to be informed of the method	To provide first response	Detective Supt. Alex MILLETT	February 2016.

	provision of guidance / training to first response constables and their supervisors to provide an awareness of the National Threats to Life Guidelines, and the principles to be followed in cases where there is a real and immediate threat to loss of life or to cause serious harm or injury to another.	Manchester Police is to coordinate the provision of guidance / training to first response constables and supervisors to provide an awareness of the National Threats to Life Guidelines, and the principles to be followed in cases where there is a real and immediate threat to loss of life or to cause serious harm or injury to another.	and completion of guidance / training that is to be provided to first response constables and supervisors in Greater Manchester Police.	constables and supervision with an awareness of National Threats to Life Guidelines and the principles to be followed in cases where there is a real and immediate threat to loss of life or to cause serious harm or injury to another. One objective will be to seek to ensure that in appropriate domestic abuse cases, constables and supervisors consider using the principles set out in these guidelines in order to take all reasonable steps to protect a person whose life is in 'real and immediate' danger from the		

				criminal acts of another.		

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Ian Halliday
Principal Community Safety Officer
Rochdale Borough Council
Rochdale Police Station
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The Esplanade
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11 10 2016

Dear Mr Halliday,

Thank you for submitting the Domestic Homicide Review report for Rochdale to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 2 September 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel felt the report contained a good level of detail and was clearly written. The Panel found the background information about the Victim and Perpetrator particularly insightful.

There were some aspects of the report which the Panel felt could be revised, which you will wish to consider before you publish the final report:

- The Panel felt the interview with the Perpetrator should be included;
- The Panel felt it would be helpful to have an explanation of what Mode Deactivation Therapy (MDT) is;

- The Action Plan needs completing and updating. Actions need to be SMART and have tangible target dates;
- The Panel suggested reconsidering the pseudonyms with the family or including a family tree as it was quite difficult to follow;
- The Panel would value a specific recommendation on what the review has learned about working with troubled families;
- The Panel felt there were more lessons that could be learned in regard to the role of social services and probation and these should be explored further;
- The Panel felt the Executive Summary could be revisited to provide less commentary and more on key learning;

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for Greater Manchester information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

End of for Report for Publication