Bolton Vision | Be Safe Bolton Strategic Partnership

BE SAFE BOLTON STRATEGIC PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

MICHELLE

OVERVIEW REPORT

19th June 2019

Independent Chair and Author: David Mellor

Domestic Homicide Review MICHELLE

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1.0 Introduction

1.1 In January 2017, the body of Michelle was discovered by the police concealed in the boiler cupboard of the home she had shared with her partner Scott. Michelle's family had not been in contact with her for over a year and had reported her as a missing person to Lancashire Constabulary in October 2016. A post mortem concluded that the condition of her body indicated death may have occurred approximately a year and a half prior to the discovery of her body. The formal date of Michelle's death has been recorded as the date on which her body was discovered. However, it seems likely that she died shortly after she was last seen on 6th October 2015 when she would have been 43 years of age.

1.2 Scott was arrested on suspicion of murdering Michelle but there was insufficient evidence to prosecute him. However, he was charged with preventing the lawful burial of a body and perverting the course of justice. In June 2017, Scott was convicted of these offences at Bolton Crown Court and sentenced to four years and four months imprisonment.

1.3 On 12th May 2017, Be Safe Bolton Strategic Partnership decided to conduct a Domestic Homicide Review (DHR) regarding the case. The Chair of the Be Safe Partnership determined that, whilst it had not been possible to charge Scott with Michelle's murder, Michelle's death appeared to have resulted from violence, abuse or neglect. The phrase "appears to have" in national guidance regarding DHRs indicates that proof to a criminal standard is not required in order for a DHR to be undertaken. In addition, DHR guidance states that Community Safety Partnership's do not require a potential perpetrator to have been charged with murder or manslaughter in respect of the death. Ultimately, the Chair took the view that there appeared to be lessons to be learned from this case which could assist in potentially preventing harm occurring to future victims of domestic abuse.

1.4 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has over six years experience as an independent author of DHRs and other statutory reviews. He has no connection to services in Bolton. Membership of the DHR Panel and a description of the process by which the DHR was conducted is set out in Appendix D and E. A statement of the independence of the author and chair of the DHR Panel can be found at Appendix F.

1.5 An inquest into the death of Michelle took place on 9th November 2017. An open verdict was declared with the cause of death recorded as 'unascertained' in the absence of sufficient evidence to reach a conclusion.

1.6 In this report Michelle will be referred to as the "victim". Whilst it was not possible to prosecute Scott for the murder of Michelle, she was a victim in the sense that her body was unlawfully concealed for around sixteen months by Scott, who must have known that this act of deliberate concealment would frustrate the process of determining her cause of death.

1.7 Be Bolton Strategic Partnership wishes to express sincere condolences to the family and friends of Michelle.

2.0 Family Composition

Code	Relationship to victim
MICHELLE	Victim
SCOTT	Partner of victim
SARAH	Daughter of MICHELLE
DANIEL	Elder son of MICHELLE
Child 1	Younger Child of MICHELLE
LINDA	Mother of MICHELLE
SANDRA	Guardian of Child1
BRIAN	Husband of MICHELLE (deceased)
AMY	Cousin of MICHELLE
FARUQ	Ex-boyfriend of MICHELLE

3.0 Terms of Reference

3.1 It was decided that the time period to be covered by this review should be from January 2014, when it is believed that Michelle and Scott began their relationship, until the discovery of Michelle's body on 16th January 2017 (subject to any significant events prior to this period being considered for inclusion within the scope of this review). Using this timeframe as the basis for review means that events which took place after the date on which Michelle is believed to have died (October 2015) are within the scope of the review. It is intended that this will enable lessons to be learned about how agencies responded to Michelle's disappearance and how the police investigated her disappearance once she had been reported missing by her family.

3.2 The general terms of reference are as follows:

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 inform national and local policies and procedures as appropriate;

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

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

- Highlight good practice.

3.3 The case specific terms of reference are as follows:

- How effectively were any disclosures or indicators of domestic abuse by Michelle addressed?

- How effectively were the risks to others presented by Scott assessed and managed?

- If Scott had contact with his son, how effectively were any child safeguarding issues addressed?

- If Michelle had contact with her Child 1, how effectively were any child safeguarding issues addressed?

- How effectively were any indications of Michelle's absence, or that she may have come to harm, responded to?

- After Michelle's family reported her as a missing person, how effective were efforts to locate her?

4.0 Glossary

Benzodiazepine any of a group of chemical compounds that are used as minor tranquillizers, such as diazepam (valium) and chlordiazepoxide (librium).

A **Community Order** can be imposed for offences that are serious but not so serious as to warrant custody. Punishment is carried out in the community instead of prison. The Order is made up of one or more 'requirements' that the court can order the offender to do.

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

- Psychological;
- Physical;
- Sexual;
- Financial;
- Emotional.

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

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

Methadone is a synthetic opiate manufactured for use as a painkiller and as substitute for heroin in the treatment of heroin addiction.

Mirtazapine is an antidepressant.

Psychosocial interventions are activities aimed at improving both psychological wellbeing and social functioning, with a view to improving quality of life.

Suboxone is a prescription narcotic medication that is used to help recovering addicts with the symptoms of withdrawal from opiates.

Supervised consumption of methadone includes ensuring that the correct patient is identified and observed to take receipt of the methadone; that this patient is observed within a dedicated private and secure area to drink the methadone, under observation; that the patient is clearly seen to use all of the supply and that this is swallowed without any remainder within the mouth or elsewhere on the person of the patient; taking back the empty receptacle from the patient to visually check that this has been taken fully; reporting to the substance misuse service providers any events of concern; reporting to the same if the patient fails to attend for collection and supervision on three consecutive days.

Special Guardianship Order is an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act (1989) and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement.

Thinking Skills Accredited Programme (TSP) is a cognitive skills programme which addresses the way offenders think and their behaviour associated with offending. The programme aims to reduce reoffending by engaging, motivating, coaching and responding to individual need and building on this continually. TSP supports offenders developing skills in setting goals and making plans to achieve these without offending.

5.0 Synopsis

The synopsis prepared for this DHR is quite lengthy and detailed. The reason this approach has been adopted is that it is hoped it may illuminate possible indications of domestic abuse which agencies in contact with Michelle may not have noticed at the time.

5.1 Michelle was originally from the Preston area where many members of her family reside. She was not in good health having suffered with epilepsy, depression and short term memory loss. She became addicted to heroin which contributed to an unsettled lifestyle and estrangement from her children and other members of her family. She had also suffered from pleurisy, pneumonia, hepatitis B and C and received medical treatment for serious falls and suffered from dizziness. She was a smoker. Michelle had three children, two of whom were adults at the time of her death (Sarah and Daniel). For a number of years, she had had limited contact with her younger child (Child 1) who was cared for under a Special Guardianship Order (SGO) by Sandra. She gave birth to a still born child in 2013.

5.2 Michelle appears to have been a victim of domestic abuse in September 2011 when she told the Discover Substance Misuse Service in Preston that she had to leave her home in Preston and go to Blackpool as a result of domestic abuse. She requested a transfer to equivalent services in Blackpool which was arranged. There is no indication that services in Blackpool were alerted to the fact that Michelle was fleeing domestic abuse nor is there any record of support for Michelle being discussed or offered when she subsequently returned to Preston.

5.3 After returning to Preston, Michelle experienced accommodation instability for a period and approached the local authority for assistance but was classed as intentionally homeless. At some point she appears to have re-established a relationship with her husband Brian who had moved into Address 1 in Blackburn. She managed to abstain from illicit drugs and alcohol for a period and moved to live with Brian at Address 1 in Blackburn in February 2012. Address 1 provides accommodation for homeless adults and consists of forty units. Michelle and Brian stayed in separate units with a common living area.

5.4 The handover process to Blackburn services highlighted that Michelle had experienced domestic abuse. At that time, she was receiving a prescription of 40 ml of methadone daily. Michelle said she had not used heroin for several months although a drug test at that time tested positive for opiates. She said she had suffered with epilepsy for around 18 months and during a fit had injured her head which had resulted in short term memory loss. She mentioned a suicide attempt several years previously when she had taken an overdose. However, Michelle was described at the

time of her move to Blackburn as optimistic about the future and very motivated to reduce the dose of methadone, convert to suboxone and ultimately stop taking prescribed opiate substitutes. She had little contact with Child 1 who at that time was living with his father who was a previous partner of Michelle.

5.5 In August 2012, Brian contacted the police following an argument with Michelle over whether to spend their money on food or an evening out. Brian apparently put the phone down after concluding that this was not a matter for the police. The police attended and found both parties to be "calm and civil". Michelle was subsequently contacted by Blackburn with Darwen Wish Centre which provides support to victims of domestic abuse. Michelle described her argument with Brian as "very minor" before adding that she tended to be the one who initiated arguments as Brian was "very laid back". She said that she had been in an abusive relationship for twelve years and took out some of the anger she experienced as a result of that abusive relationship on Brian. It was suggested that Michelle may wish to attend a programme for women who find it difficult to communicate effectively and retaliate in an argument with hostility and anger. Michelle expressed interest in this and asked for a referral which was made the following day. Michelle did not subsequently attend the programme and her file was closed. The Wish Centre would normally have contacted Michelle after she failed to attend the first session but decided that this was unnecessary as she had volunteered for the programme and the risks she faced were not considered to be significant.

5.6 In May 2013, Brian died suddenly, and Michelle returned home to discover his body (there is a suggestion that she had been admitted to hospital with a broken leg immediately prior to her husband's sudden death). Following the death of Brian, Michelle took an overdose with suicidal intent, reporting that she had not intended to be discovered. After assessment by the mental health liaison team at the Royal Blackburn Hospital, she was referred to the Lancashire Care NHS Foundation Trust (LCFT) Crisis Resolution / Home Treatment Team (CR/HTT). In their assessment of Michelle, they noted that she had experienced a number of traumatic life events and had taken overdoses on three known occasions.

5.7 Michelle was reported to have made good progress during her treatment but living in the place where her husband had died caused her some anxiety and she began talking of moving elsewhere. However, she took a further overdose – of epilepsy medication - in July 2013. She said she had not intended to take her own life and it was considered to have been an impulsive act.

5.8 After a brief relationship with Faruq, who frequented Address 1 but was not a resident there, Michelle began a relationship with Scott who had moved into Address

1 in January 2014. Both Michelle and Scott left Address 1 in April 2014 to move to Bolton, which is where Scott originated from.

5.9 Scott was forty one years old when he met Michelle and had a significant criminal history. He had inflicted domestic violence on two different partners and there had been a number of incidents involving violence or threats of violence to his father. None of the incidents of domestic violence against partners had been successfully prosecuted. He had been convicted of a number of other criminal offences largely relating to dishonesty. He had been sentenced to two years imprisonment for robbery when he had stolen money from a female at a cashpoint whilst armed with a knife. There was a warning on the Police National Computer (PNC) for firearms.

5.10 On 20th March 2014, Scott signed up to a tenancy with Bolton at Home at Address 2. During the following month, Bolton at Home provided support to Scott in accordance with their "sustainment and support" processes. This included ensuring Housing Benefit was in place as well as providing a decoration allowance and welfare provision for furniture.

5.11 On 3rd April 2014, a Bolton at Home Tenancy Support officer noted that Michelle was present at Scott's property. He explained that "she was just visiting."

5.12 On 8th April 2014, Michelle and Scott presented together to Bolton Integrated Drug and Alcohol Service (BiDAS) following their transfer from similar services in Blackburn. Assessment appointments were provided to them for later in the month. Two days later, Bolton at Home confirmed that drug treatment services for Scott were being transferred to Bolton but no contact was made with BiDAS at that time or subsequently.

5.13 On 10th April 2014, Scott registered as a new patient with Bolton GP practice 2. It was noted that Scott was being prescribed methadone, had recently moved from Blackburn, and was said to be "looking after mother and father" which seems likely to have been untrue. Scott was said to be a teetotaller and was provided with advice on smoking cessation. No previous GP records were obtained in respect of Scott as there is no requirement mandated by NHS England for gathering information at the point at which a patient first registers with a GP practice.

5.14 On 15th April 2014, Scott attended his BiDAS assessment appointment. He said he was using benzodiazepines 2-3 times per week, 20mg per occasion. He added that he was moving to Bolton for a "fresh start". He agreed to see a peer mentor and to access psychosocial interventions (PSI). No historical or current deliberate self-harm or suicidal ideation was disclosed. He said he had tested positive for Hepatitis C and disclosed he had previously had deep vein thrombosis. It is said that questions

regarding domestic abuse were asked and no risks identified. BiDAS has advised the review that Scott did not disclose the earlier instances of domestic abuse where he was the perpetrator.

5.15 Scott's assessment was followed by a medical review during which he disclosed he was released from custody in 2012 having served a sentence for 'armed' robbery. He disclosed no current issues in respect of his physical or mental well-being. A prescription of 65mls of methadone daily was agreed; the consumption of which was to be supervised due to Scott's illicit benzodiazepine (diazepam) use.

5.16 The following day, Michelle attended her assessment appointment with BiDAS. She said she had not used heroin since December 2013 and had not used benzodiazepine (diazepam) for one month. She disclosed she had attempted suicide six times previously with her most recent attempt taking place in July 2013. Mental health support was declined by Michelle. She said that all her children were over 18 which was untrue as Child 1 would have been eight years old at that time. She was also referred for PSI. The assessment disclosed past domestic abuse with a previous partner. No current domestic abuse was disclosed. BiDAS has advised the review that the assessments of both Michelle and Scott would have been informed initially by information provided by the client and that other information, including information provided by previous drug and alcohol service providers, would need to have been confirmed to be correct prior to being included in the assessments.

5.17 Michelle's assessment was followed by a medical review during which she disclosed using benzodiazepines (diazepam) once every two weeks and most recently on the previous day. This information was inconsistent with the information she provided during the earlier BiDAS assessment (see previous paragraph) but was not picked up on. Michelle provided a urine sample which tested positive for methadone and benzodiazepine. She said she had epilepsy which was well controlled.

5.18 Throughout April 2014, both Michelle and Scott began presenting together at Pharmacy 1 for daily supervised dispensing of methadone from Monday to Saturday.

5.19 During May 2014, both Michelle and Scott received medical reviews at BiDAS which recommended no change to their prescribing regime and both were advised to address their benzodiazepine use.

5.20 On 16th May 2014, Scott received a letter from Urban Outreach, which is a charity providing support to adults and young people living in Bolton who are disadvantaged, vulnerable or have complex-lifestyles, ending support due to his non-engagement.

5.21 Michelle left belongings behind at Address 1 and during May 2014 the owner contacted her to ask if she was still living at Address 1 and Michelle replied in the affirmative. Her rent continued to largely be paid direct by Blackburn with Darwen Council and Michelle paid a service top up charge of £7 per week. The owner says that after subsequently concluding that Michelle had no intention of returning to Address 1, he contacted the Council on 2nd June 2014 to stop Michelle's rent being paid and retained her belongings for 28 days before disposing of them.

5.22 On 6th June 2014, Michelle registered as a new patient with Bolton GP practice 3. She completed a new patient questionnaire which indicated a history of depression, also ticking a box to say she had bipolar disorder although there is no record of any such diagnosis. Michelle also wrote that she had attempted suicide six times following the death of Brian (she is known to have taken two overdoses following the death of Brian, whilst other overdoses took place earlier). Her history of epilepsy and short-term memory loss were also disclosed. She stated she was not receiving any current treatment and identified Scott as her next of kin. Scott had previously registered at Bolton GP practice 2 which shared the same site as GP practice 3 but is a separate practice.

5.23 Also on 6th June 2014, Scott and Michelle were crossing a road in Bolton when Scott kicked out at a passing vehicle causing a dent. The female driver alleged that when she stopped and attempted to speak to Scott, she was verbally abused and spat on by both Scott and then Michelle, who was encouraged by Scott. Michelle and Scott were arrested and Scott was charged with common assault, possessing an offensive weapon (knuckle duster), criminal damage and public order offences. Michelle was charged with conduct likely to cause a breach of the peace. They were bailed to appear at Bolton Magistrates Court on 19th June 2014.

5.24 On 7th June 2014, Michelle visited her GP complaining of insomnia. She was said to be "tearful". She talked about the death of Brian and the impact this had had on her and made mention of previous suicide attempts. She said her mood was now stable, she described her boyfriend as supportive and that they had moved to Bolton for a "fresh start". She said that her main problem was lack of sleep which adversely affected her mood. She said she had been taking mirtazapine (a sedating antidepressant) but had stopped taking this three months previously. Her GP agreed to re-start her on mirtazapine and review this after three weeks.

5.25 On 12th June 2014, Michelle had an interview with a life coach at Blackburn Jobcentre Plus during which she said she had left Address 1 and moved to an address in Preston. This information was not forwarded or received by Preston Benefit Centre and so mail from the Department of Work and Pensions (DWP) continued to be sent

to Address 1. However, the DWP mail sent to her at Address 1 appears to have been forwarded to her at Address 2.

5.26 During the night of 16th June 2014, Scott contacted the out of hours (OOH) GP service saying he had been suffering from insomnia for three months, had had thoughts of self harm for six weeks and had tried to hang himself one month earlier. He said he was on his own (it is assumed Michelle was with him – see following paragraph) After discussing options, Scott decided to make an urgent appointment to see his own GP in the morning. He said he had made contact with the "Crisis Team" and was awaiting a call back. He said he couldn't guarantee that he wouldn't self harm without a prescription of medication to help him sleep.

5.27 In the morning, Scott visited his GP in company with Michelle. He said he had tried to hang himself but the rope had broken. He said he was unable to sleep and was depressed. He had been taking mirtazapine but had stopped for two months. A prescription for mirtazapine was issued and arrangements made to see him again. The very similar presentation by Michelle on 7th June 2014 (see Paragraph 5.24) was not picked up on as they were registered at different GP practices and so the opportunity to adopt a more holistic approach was not available to GP services. It is understood that the assessment carried out by the GP on this occasion did not include consideration of the risk Scott might present to others. Michelle appears to have been perceived to be a protective factor.

5.28 On 24th June 2014, Michelle attended a one-to-one PSI session at BiDAS at which her mental well-being and mood were explored. The death of her husband was discussed and Michelle became tearful. Scott attended BiDAS with her but did not participate in the PSI session with her.

5.29 On 26th June 2014, Scott asked a Bolton at Home Tenancy Officer whether his girlfriend (Michelle) could move in with him. It was explained to him that Bolton at Home policy does not allow this as his tenure was classed as an "introductory tenancy". He was advised that he could make the request again after twelve months of positive tenancy conduct. There was said to be no objection to her staying with Scott a couple of nights each week. Michelle had given Scott's address to her GP and BiDAS and it is assumed she had been living with Scott since April 2014.

5.30 Scott went on to speak to the Tenancy Officer about how he felt he had really turned his life around and how far he had come. He said he was due to start an IT course via the UCAN centre. Scott was noted to be very engaging and appreciative of the support he had received. He was said to still be engaging with Urban Outreach and BiDAS. Scott said that BiDAS were looking to reduce his methadone prescription.

The latter appears to have been untrue as does the claim that he was engaging with Urban Outreach (see Paragraph 5.20).

5.31 On 8th July 2014, Michelle's GP saw her to review progress since her earlier presentation of insomnia. Michelle said that her mood remained low and that she felt a little paranoid about people and had done for some years. She remained on mirtazapine. She also complained of abdominal bloating and blood tests were arranged.

5.32 On the same date, Scott was seen by his GP to review progress following his earlier presentation with insomnia. Mirtazapine was to continue to be prescribed. NICE guidelines advise that "a person with depression started on antidepressants who is considered to present an increased suicide risk should normally be seen after one week and frequently thereafter as appropriate until the risk is no longer considered clinically important." Over three weeks had elapsed since Scott's presentation with insomnia during which he disclosed that he had attempted to hang himself (see Paragraph 5.26). Scott also presented with a urology problem and was referred for a scan (urology is concerned with the function and disorders of the urinary system).

5.33 On 9th July 2014, Scott attended a PSI appointment at BiDAS at which a detox was discussed which would necessitate a reduction in his diazepam usage. The BiDAS Case Manager was to be updated.

5.34 The following day, Bolton at Home made a 'no access' visit to Scott – the second such visit of his tenancy.

5.35 On 11th July 2014, the DWP decided that Michelle had had good cause for failing to attend a previous work capability assessment and a re-referral was to be made. She was advised of the outcome by letter sent to Address 1.

5.36 On 18th July 2014, Michelle had a medical review at BiDAS when anxiety and withdrawal were discussed. She agreed to keep withdrawal diary for two weeks to ascertain if an increase in the prescribed dose of methadone was required.

5.37 On the same date, Scott had a medical review at BiDAS at which a detox was further discussed. Scott is said to have agreed to stabilise by reducing diazepam to aid the detox and there was to be no change to methadone prescribing.

5.38 On 25th July 2014, Bolton at Home made a home visit to Scott when Michelle was noted to be present.

5.39 During July 2014, Scott failed to attend two further appointments with BiDAS and Michelle also missed her remaining appointment with BiDAS for that month.

5.40 On 31st July 2014, Michelle visited her GP for a review of treatment for her insomnia. She said she had "up and down days" but no longer felt depressed. However, her sleep was poor if she didn't take mirtazapine. Lowering the dosage to 15mg at the discretion of the patient was discussed. Her GP also reviewed her epilepsy and Michelle said she had last had a fit seven months ago.

5.41 The following day, Michelle had a medical review at BiDAS where it was agreed that her dosage of methadone should be increased from 45mls to 60mls daily.

5.42 On 4th August 2014, Scott was seen by his GP for review. Mirtazapine was prescribed again and it was said that BiDAS was aware of this. It is, however, unclear how BiDAS would be aware unless Scott was the conduit for informing them. There is no reference to suicidal ideation in the record of this visit to the GP.

5.43 On 8th August 2014, Scott appeared at Bolton Magistrates Court in respect of the offences committed on 6th June 2014. The court adjourned for sentencing on 8th September 2014 pending the preparation of a pre-sentence report to be completed by the National Probation Service (NPS). Michelle received a conditional discharge for twelve months for her part in the incident. This did not entail any involvement by the NPS.

5.44 On 12th August 2014, Michelle contacted BiDAS to cancel Scott's appointment saying that he was having a seizure as a result of stopping diazepam use. She was advised to call an ambulance but there is no record of Michelle doing this. The Case Manager was updated who attempted to contact Scott by telephone but was unable to get a reply

5.45 The outcome of Scott's urology scan was abnormal, and, on 19th August 2014, a letter was sent to his GP to advise of this. On 3rd September 2014, Scott attended an appointment at the Urology Outpatients' Department at the Royal Bolton Hospital (RBH).

5.46 On 26th August 2014, Scott was interviewed by the NPS for the preparation of a pre-sentence report. The report concluded that Scott posed a medium risk of serious harm to the public and made a sentence proposal for a Community Order with two requirements of nine months supervision and completion of the 'Thinking Skills Accredited Programme' (TSP). The following day, the NPS liaised with Scott's BiDAS Case Manager who recorded brief details of the offences. There is no evidence of further follow up from BiDAS.

5.47 On 29th August 2014, BiDAS conducted a case management review with Michelle. Reducing benzodiazepine usage was discussed as was her physical health and wellbeing. Michelle disclosed the death of her baby at 39 weeks in 2013. There was said to be no evidence of deliberate self harm or suicidal ideation and she was said to be settled with Scott. On 1st September 2014, Michelle again attended BiDAS, this time for a medical review. She provided a urine sample and tested positive for methadone metabolite and benzodiazepines. She said she had tried to self-detox from benzodiazepines – reducing from 120mg to 10mg daily – but had fitted on the third day of the reduced dosage. Michelle was referred to PSI to attempt to reduce benzodiazepines in a more controlled manner.

5.48 Michelle was again reviewed by her GP on 3rd September 2014 when she said she had tried, but had been unable, to reduce the dosage of mirtazapine. An unchanged amount was subsequently prescribed. During this appointment, Michelle disclosed a previous miscarriage at 32 weeks. All previous references to this pregnancy indicated that the child had been still born.

5.49 On 8th September 2014, Scott was sentenced by Bolton Magistrates Court to a twelve-month Community Order with supervision, attendance at the Thinking Skills Accredited Programme, and an electronically monitored curfew for twelve weeks. At that point, Scott's case was allocated to the Community Rehabilitation Company (CRC).

5.50 On the same date, Scott saw his GP. Weight loss and pain in his right arm was noted. His recent appointment with Urology was discussed. It was said that testicular cancer had not been excluded and another scan was pending. This was causing Scott increased stress. A further prescription of mirtazapine was issued. The next day Scott disclosed a "lump in his testicle" to his BiDAS case manager and that he was using cannabis. He added that his relationship with Michelle was going well.

5.51 On 10th September 2014, Scott attended an induction appointment with the CRC where the Order imposed by the Court was explained to him by his CRC Offender Manager. He provided his address, and said he had no children living with him. He did not appear to be asked about a partner. He said that he was unemployed as a result of health issues including a "metal plate in his elbow". He said he had not used illicit substances in the past 18 months, which was untrue as he had recently disclosed cannabis use to BiDAS (see Paragraph 5.50). Scott was prescribed 65mls of methadone daily and was under the care of BiDAS.

5.52 On 12th September 2014, Scott and Michelle attended BIDAS together for PSI. Detox was again discussed as were options to reduce benzodiazepine use. Scott agreed to keep a drug diary.

5.53 On 16th September 2014, Scott attended an appointment with his CRC Offender Manager. His electronic tag was fitted. He said that his partner Michelle was supportive of him.

5.54 On 18th September 2014, Scott shared his concerns about testicular cancer with a Bolton at Home officer making a home visit. They also discussed his welfare benefits and Scott disclosed that his Job Seekers Allowance had been stopped.

5.55 The same day, Michelle attended a PSI session at BiDAS and weekly one-to-one sessions were agreed to support a reduction in benzodiazepine use. She was advised to keep a diary. During the meeting, Michelle said that she had moved to Bolton for "a fresh start". Bereavement and mental health were also discussed.

5.56 On 23rd September 2014, Michelle attended an appointment with a work coach at Blackburn Jobcentre Plus. At this meeting, Michelle claimed that "they" were caring for their Grandma in Preston who was terminally ill. Although it was true that Michelle's grandmother was terminally ill, it was untrue to say that she (and by implication Scott) were caring for her.

5.57 On 24th September 2014, Scott met with his CRC Offender Manager and provided information to inform the Offender Assessment System (OASys), including the self-assessment.

5.58 On 26th September 2014, Scott again attended a Urology Out Patients appointment and his GP was advised by letter.

5.59 On 29th September 2014, Michelle was issued with a repeat prescription for antidepressants. No face-to-face review took place on this occasion, which was consistent with NICE guidance regarding recommended frequency of reviews.

5.60 On 3rd October 2014, Scott was seen by his GP and was said to be awaiting the outcome of his urology review. Mirtazapine continued to be prescribed. The same day Michelle visited her GP complaining of lower back pain following a fall onto her bottom. She was given strong analgesia.

5.61 On 8th October 2014, Scott attend his TSP induction at which programme goals were discussed. A brief history was taken of his drug use. He said that he began

smoking cannabis at the age of thirteen and this escalated at the age of twenty when he lost his job, became homeless and began smoking heroin.

5.62 The following day, Michelle phoned BiDAS to cancel her appointment for that day as she had fallen. No further details of the fall were recorded. It is not known if it was the same fall that she had reported to her GP six days previously (see Paragraph 5.60).

5.63 On 15th October 2014, Scott attended a CRC supervision appointment which focussed on relationships. Scott disclosed that many of the issues with his father stemmed from his drug use. His previous domestic abuse history with an ex-partner was discussed. Scott agreed that he needed to do some work on dealing with conflict in relationships.

5.64 On 22nd October 2014, Scott attended a further CRC supervision appointment. Given Scott's previous domestic abuse history, he was encouraged to consider putting "time out" in place as he was in a new relationship. Recognising when he was getting angry and doing something else, such as taking deep breaths, was also discussed. Scott was asked to monitor his aggression and note the signs he displayed and what has worked for him in calming himself down. He was due to commence the TSP on 1st November 2014.

5.65 Also on 22nd October 2014, Scott's GP received a letter from Royal Bolton Hospital (RBH) to say that he had been discharged after failing to attend an appointment.

5.66 Meanwhile, also on 22nd October 2014, Michelle returned to her GP with lower back pain and said she was unable to move her back and had been screaming in pain. She was again prescribed strong analgesia (tramadol and naproxen) and gabapentin – which is used to treat epilepsy and neuropathic pain - was added. Her methadone prescription was documented by her GP for the first time. Her GP had received no communication from BiDAS prior to this time.

5.67 A BiDAS medical review of Michelle on 27th October 2014 noted the medication prescribed by her GP, although Michelle was said not to be taking the tramadol. She continued on 60mls daily of methadone. Michelle said she had reduced benzodiazepine use from 120mg to 40mg daily and wished to continue to reduce on her own, rather than engage with PSI.

5.68 On 5th November 2014, Michelle was seen by her GP to review her lower back pain. The dose of gabapentin was gradually being adjusted. The following day, Scott

also saw his GP. He was awaiting the result of his urology review which appeared to be causing him some stress. A prescription of mirtazapine was issued.

5.69 On 25th November 2014, Scott attended a CRC supervision appointment at which he said he was upset as his partner (Michelle) had been told about the death of her sister's husband that morning and was also coping with her grandmother dying of cancer. Scott said that he was trying to be supportive of Michelle. He said that he was on a waiting list to have his elbow re-plated and pinned and awaited an appointment with a specialist regarding his testicular lump. Scott said that he was keen to commence TSP (it is unclear why he had not already started TSP which had been due to begin on 1st November 2014).

5.70 On 26th November 2014, Michelle saw her GP regarding her lower back pain. It appeared that she may have been taking gabapentin more frequently than was medically safe to do so. She explained that her brother had recently died which may have been a factor. The risk of overdose and addiction was discussed with her.

5.71 On 30th November 2014, Scott's curfew came to an end without any breaches taking place.

5.72 In early December 2014, Michelle and Scott attended her grandmother's funeral. This was the last time she was seen in person by her family. One family member commented that Michelle appeared to be affected by drugs.

5.73 On 1st December 2014, Scott attended the first TSP session which considered different frames of mind - aggressive, passive and assertive. Scott was said to have demonstrated an understanding of the consequences of being in each frame of mind.

5.74 On 3rd December 2014, Scott attended a further CRC programme session and engaged well until he was asked to speak about his partner at which point, he became withdrawn and refused to discuss it further.

5.75 When Michelle attended a BiDAS medical review on 8th December 2014, she disclosed recent family bereavements and a letter was sent by BiDAS to her GP but later returned stating that Michelle was not registered with the GP. However, Michelle's GP records recorded no correspondence from BiDAS at that time.

5.76 On the same date, Scott attended a BiDAS medical review at which he disclosed that he had attempted to hang himself three years previously.

5.77 On 10th December 2014, Scott rang his CRC Offender Manager to say that he was unable to attend his TSP session that evening as Michelle had taken the two

family deaths very badly and had attempted to self-harm. Scott was said to feel he could not leave her. Scott said that Michelle had sought medical help and that her GP was exploring bereavement counselling for her. There is no record of Michelle being offered bereavement counselling by her GP, although she did subsequently discuss her bereavements with her GP (see Paragraph 5.79). Scott was advised that, as he had missed two TSP appointments, he would be suspended from the programme until he could commit.

5.78 On 11th December 2014, BIDAS was made aware of Michelle's youngest child, Child 1, by Chorley Children's Services.

5.79 On 17th December 2014, Michelle saw her GP because of a heavy cough which she had had for four weeks and lost her voice as a result. She mentioned her recent bereavements. Smoking cessation advice was given and she was referred for an urgent chest x-ray. No discussion of her earlier back pain and the medication prescribed for that condition is recorded to have taken place.

5.80 On 19th December 2014, Scott attended a BiDAS medical review at which he again mentioned a previous attempt to hang himself. He agreed to start on prescribed benzodiazepines to aid stabilisation and reduction. A letter was sent to his GP which was the first contact his GP had received from BiDAS. The letter advised that Scott continued to be prescribed methadone and was embarking on a benzodiazepine reducing regime. Scott was said to have not used heroin for more than twelve months.

5.81 On 23rd December 2014, Scott attended a CRC supervision appointment and said that he had (unspecified) concerns about Michelle and had sought (unspecified) advice from the UCAN Centre. There is no record of any such contact with the UCAN Centre although the UCAN's record keeping is limited. Scott requested an appointment to re-start the TSP.

5.82 On 2nd January 2015, Scott's GP received a letter from Royal Bolton Hospital (RBH) Urology Department which indicated (unspecified) surgery was planned.

5.83 On 5th January 2015, Scott rang his Offender Manager to say that he was unable to re-start the TSP the following day because he was seeing a specialist at the 'Bolton One' Outpatient and Diagnostic Service regarding the lump in his testicle. Scott stated that he had a pre-operation appointment at RBH on 12th January with admission for surgery scheduled for three days later. His Offender Manager requested evidence of these appointments which Scott subsequently provided. The Offender Manager offered support to Scott (and Michelle) which was declined.

5.84 On 8th January 2015, Scott shared the details of the forthcoming operation with BiDAS. He was to continue with 14mgs benzodiazepines daily. Scott said that his relationship with Michelle had 'improved'. The context for this comment is unknown but may relate to the impact of bereavement on Michelle during November and December 2014.

5.85 On 19th January 2015, Michelle cancelled a BiDAS medical review as she had a chest infection. This may have been linked to the heavy cold she informed her GP about on 17th December 2014 (see Paragraph 5.79). Three days later, Michelle was well enough to attend a re-arranged BiDAS medical review during which she said she had reduced benzodiazepine use to 20mg daily. She also said she was having 'weekly assessments' with Children's Social Care to consider access to Child 1. Michelle did not attend any of these assessments. The plan with BiDAS was to continue with methadone at the current dosage and continue to reduce benzodiazepines.

5.86 On the same day, a query was raised within BiDAS as to why Michelle was not receiving a benzodiazepine prescription when Scott was. This was stated to be a 'medical decision'. In a telephone consultation that day, Scott advised BiDAS that he had reduced his benzodiazepine use to 10mg daily.

5.87 On 30th January 2015, a Bolton at Home officer visited Scott. Scott advised that his pre-operation procedure and operation had been rescheduled to 5th and 19th February 2015 respectively. Scott said he was struggling financially, was behind with his water payments and confused about how much he owed.

5.88 On 19th February 2015, Scott took an overdose of 'opium based' prescribed medication at home immediately prior to his scheduled hospital operation. RBH notified the police and the ambulance service and both services attended Scott's address. Scott refused to attend hospital. After examination by paramedics, he was left in the care of Michelle. The police also attended and decided to make no safeguarding referral as relevant medical staff were said to be aware. Scott said that he had made an appointment to see his GP later the same day but there is no record of this.

5.89 On 22nd February 2015, the DWP sent Michelle details of an appointment for a work capability assessment to Address 1 which she failed to attend.

5.90 On 25th February 2015, Scott attended a BiDAS medical review and said that fear had prevented him from attending the "testicle operation" which had been re-arranged for four weeks time. On the same date, Scott's GP received a letter from RBH Urology Department to advise that the planned operation had been cancelled as Scott had taken an overdose the day before. RBH had contacted the police and

ambulance services on the day of the overdose and notified his GP but do not appear to have considered any referral to mental health services. There was no follow up by Scott's GP.

5.91 During January and February 2015, Michelle's only contact with her GP was to obtain repeat prescriptions which did not require face-to-face contact.

5.92 On 16th March 2015, Scott saw his GP and discussed the missed operation because of his overdose. A new appointment was said to have been made for late April. No update to the risk assessment relating to suicidal ideation was clearly documented following Scott's overdose.

5.93 On 17th March 2015, Michelle attended a BiDAS medical review at which there was no change to the current prescribing regime. She was again referred to PSI. A case manager review was recommended. These should take place every twelve weeks, but this had not been happening in respect of Michelle. It is unclear why.

5.94 On 19th March 2015, Scott attended an appointment with his Offender Manager. This appears to have been the first appointment since 5th January 2015. Scott apologised for missed appointments saying that he had been in a poor emotional state because of the planned operation. He said he was receiving more support from his father. He also said he was stable on methadone and had not used illicit substances since December 2014. No contact was made with BiDAS to verify Scott's stated drug use.

5.95 On 23rd March 2015, Scott phoned BiDAS to say that he had testicular cancer and was receiving support from MacMillan and Christies (this was false – see Paragraph 5.117). He went on to say that he had overdosed on temazepam and pregabalin during the previous week. He added that he found the telephone consultations helpful and requested more of them. BiDAS carried out no checks with his GP regarding Scott's references to testicular cancer and did not follow up with his GP regarding the overdose disclosure.

5.96 On 30th March 2015, Michelle attended a BiDAS case manager review when she reported using 10mg benzodiazepines daily. Her fear of further reduction of benzodiazepines was discussed and PSI one-to-one support was agreed. Her risk assessment was reviewed.

5.97 During the early part of 2015, the Proprietor of Address 1 stated that he received a phone call from Michelle asking for her old room back. The proprietor said that he declined her request as he was no longer taking new tenants. It is not known what prompted Michelle's call.

5.98 During March 2015, Michelle sent a birthday card containing £10 to Child 1. His guardian, Sandra, passed the card to Children's Social Care who returned it to Sandra to hold for Child 1. In April 2015, a Special Guardianship Order was put in place for Child 1 which, according to Sandra, required Michelle to engage with Children's Social Care should she wish to contact her child.

5.99 On 10th April 2015, Michelle rang BiDAS to re-arrange an appointment which clashed with a CAFCAS appointment. This may have related to the Special Guardianship Order in respect of Child 1.

5.100 On 14th April 2015, Scott phoned his Offender Manager to say that he would miss the TSP session due to the need to support his sister whose husband had been taken to hospital (this may have been untrue).

5.101 On 15th April 2015, Scott contacted BiDAS to say that Michelle would be unable to attend appointments for later in April as her sister was in hospital. This was untrue as Michelle had no face-to-face contact with her family after December 2014.

5.102 On 17th April 2015, BIDAS attempted to contact Scott for a PSI telephone consultation but were unable to obtain a reply. Scott's case manager was advised that he was not engaging with the telephone consultations he had requested.

5.103 On 17th April 2015, DWP referred Michelle's failure to attend a Work Capability Assessment appointment on 31st March 2015 for a decision to be made about her Employment and Support Allowance (ESA) benefit. This benefit was subsequently stopped in the absence of evidence of good cause for for non-attendance being shown.

5.104 On 20th April 2015, Michelle made an unplanned visit to BiDAS and said that her benzodiazepine usage had increased to 20-30mg daily. The risks of stopping altogether such as seizures were discussed as was the impact on her epilepsy. On the same day, Scott contacted his BiDAS Case Manager to say that he was "working closely with a specialist team and MacMillan nurses". This was untrue.

5.105 On 22nd April 2015, Scott attended a BIDAS medical review. He said he had separated from Michelle three days previously. He added that he wanted to reconcile with her. He provided a urine sample which tested positive for opiates, methadone and benzodiazepines. Scott requested an inpatient detox. A letter was sent to Scott's GP requesting details of his medical history and current medication.

5.106 The following day Scott contacted the CRC to say that he was unable to attend the TSP session that day because of a hospital appointment. He was allowed to stay on the TSP module because of what was considered to be his high level of engagement.

5.107 On 24th April 2015, Scott's GP received a letter from RBH urology to advise that they planned to "repeat the scan". On the same date, Scott's GP received the letter sent by BiDAS on 22nd April requesting his medical history and current medication details. The letter also referred to Scott's intentional overdose prior to his planned operation in February 2015. It is unclear whether the GP actioned the request for information from BiDAS.

5.108 On 28th April 2015, Scott was suspended from the CRC TSP group after leaving the group early to attend hospital with stomach issues.

5.109 At some time after receiving the birthday card for Child 1, Sandra received a letter from Michelle asking if it would be possible to circumvent the requirement to engage with Children's Social Care so that she could have direct contact with Child 1. She also requested a photograph of him. Sandra did not reply to the letter.

5.110 On 8th May 2015, Scott attended a BIDAS medical review. He said his operation was due to take place in seven days and that he was now reconciled with Michelle.

5.111 On 11th May 2015, Michelle saw her GP complaining of dizziness which may have been viral labyrinthitis. A prescription for mirtazapine was issued. Over six months had elapsed since the last face-to-face review of medication prescribed to Michelle. No discussion took place about the stability of Michelle's mental health and her response to the medication as recommended by NICE guidance. This was the final face-to-face contact Michelle had with her GP. Thereafter, Michelle accessed fortnightly repeat prescriptions via her pharmacy.

5.112 On 14th May 2015, Michelle attended BIDAS where she presented as tearful as it was near the second anniversary of her husband's death.

5.113 On 15th May 2015, Scott attended an appointment with his Offender Manager who informed him that the Community Order would need to be returned to the Court owing to his two failed attempts at completing the TSP. On 22nd May 2015, the Offender Manager submitted a request to Bolton Magistrates Court to vary the Order.

5.114 On 21st May 2015, Michelle's GP practice sent her a letter to book an appointment to discuss her epilepsy. This was to arrange a routine epilepsy follow up review.

5.115 On 27th May 2015, Michelle telephoned DWP to dispute the decision to stop her ESA benefit and requested mandatory reconsideration of the decision. Michelle falsely confirmed that Address 1 remained her address but that she had been staying in Preston looking after a sick relative. The following day DWP contacted Michelle to gather further information and decided that there was good cause for failing to attend the work capability assessment and her ESA benefit was reinstated.

5.116 On 28th May 2015, Scott attended an appointment with his Offender Manager. He said that he remained drug free and on a daily 60mls methadone prescription. Scott asked to do work around anger management, goal setting and "positive self-talk". His Offender Manager completed some anger management work with Scott but didn't enquire why he wanted to focus on anger management.

5.117 On 28th May 2015, Scott attended a BiDAS medical review and stated that his right testicle had been removed but that the surgeon did not think the lump was cancerous. RBH has advised the review that, following Scott's abnormal urology scan in August 2014 (see Paragraph 5.45), it was concluded that the lump discovered on his testicle was unlikely to be cancerous. Scott was removed from the 'cancer pathway'. Follow-up care would include further scans. However, Scott was subsequently listed for an orchidectomy (removal of testicle) because he described discomfort and was experiencing anxiety about the lump. After this, Scott took an overdose on the day the procedure was due to take place (see Paragraph 5.88). There is no evidence that he attended for the procedure at a later date.

5.118 On 3rd June 2015, Bolton Magistrates Court revoked the Thinking Skills Programme which Scott had previously been required to complete.

5.119 On 8th June 2015, Michelle attended BiDAS and disclosed she was experiencing withdrawal symptoms. These were to be discussed with the Medical Team.

5.120 On 22nd June 2015, the CRC Offender Manager attempted to phone Scott but Michelle answered and said that Scott had suffered fits whilst detoxing over the last few days. As a result, it was agreed to rearrange his forthcoming appointment and to link him in with a health trainer. On the same date, Michelle phoned BiDAS to cancel her PSI appointment as Scott was said to be having seizures.

5.121 On 24th June 2015, Scott attended a BiDAS medical review and said he had completed a benzodiazepine detox three weeks previously.

5.122 On 24th June 2015, mail sent to Address 1 for Michelle by the DWP was returned. When no answer was received from the mobile phone number held for Michelle, her claim was suspended.

5.123 On 26th June 2015, Bolton at Home contacted Scott by phone after numerous messages had been left to in an attempt arrange a home visit to "sort out United Utilities". As Scott said he had felt unwell following his operation but now felt better, a home visit was to be arranged for early July.

5.124 On 30th June 2015, Scott attended an appointment with his Offender Manager in company with Michelle. Scott was introduced to a health trainer. A discussion took place around detox at home. Scott said he had had a testicular lump removed which turned out to be a benign cyst. This had been a relief to him but "has helped to bring his family back together". The Offender Manager and Scott then began work to look at aggression including different types of aggression and identifying his thoughts and feeling before during and after the offence.

5.125 On 6th July 2015, Michelle contacted the DWP to state that her address remained Address 1 which allowed her benefits to be reinstated. The following day she contacted DWP again to request a text message when her benefit was paid and provided her mobile phone number for this purpose.

5.126 On 6th July 2015, Scott saw his GP to complain of choking and the sensation of food becoming stuck when eating. There was also a reference to weight loss. An urgent referral to RBH Ear, Nose and Throat (ENT) Department was made (to exclude any physical cause for his symptoms) and a repeat prescription of mirtazapine issued. There was no reference to any urology operation.

5.127 On 15th July 2015, Scott attended a BiDAS case manager review during which he said he had used benzodiazepine twice since self-detoxing. He also disclosed cannabis use. He stated that he had no active criminal justice involvement which was untrue as he was still serving the twelve-month Community Order and being supervised by the CRC. He added that his relationship with Michelle was "good" and that she was supporting his recovery.

5.128 On 21st July 2015, Scott attended a supervision appointment with his Offender Manager. Scott said that he was clean of amphetamine (this was probably a recording error as Scott was not known to use amphetamine) and continued to work with BiDAS. The Offender Manager completed conflict resolution work with Scott.

5.129 On 22nd July 2015, Scott's GP received a letter from RBH Ear, Nose and Throat (ENT) Department advising that Scott had been referred for further investigation.

5.130 On 27th July 2015, Scott attended a BiDAS case manager review during which he disclosed smoking cannabis three times per week. He agreed to continue with PSI to help address his illicit use. However, he did not attend the next three PSI appointments.

5.131 On 3rd August 2015, Scott saw his GP and was said to be stable in mood and said he was feeling better on a "split antidepressant" dose.

5.132 On 6th August 2015, Michelle failed to attend a BiDAS appointment. Between 6th June and 1st September 2015, Michelle was seen only rarely by agencies.

5.133 On 10th August 2015, the BiDAS Case Manager telephoned Scott who said he had lapsed into benzodiazepine and had used heroin due to his GP investigating "throat cancer". He was encouraged to attend PSI. There is no reference to BiDAS contacting Scott's GP to verify the throat cancer remark. It is unknown whether BiDAS had yet received a reply to their request for information from Scott's GP sent on 22nd April 2015 or followed it up (see Paragraph 5.107).

5.134 On 10th August 2015, Scott's GP received a letter from RBH ENT Department to advise that Scott had been discharged having failed to attend two investigations and a clinic review.

5.135 On 12th August 2015, Scott attended a PSI group session at BiDAS which addressed anxiety management work. On 17th August 2015, Scott attended a BiDAS medical review during which he stated he had difficulty swallowing and had had an endoscopy with 'no appreciable disease' being the outcome.

5.136 On 18th August 2015, Bolton at Home made a 'no access' visit to Scott's property.

5.137 On 20th August 2015, Michelle did not attend a BiDAS PSI session which appears to have prompted a phone call to her on 28th August during which she said she was unwell. Michelle's mother, Linda, has contributed to this review and said that Michelle had told her that Scott had assaulted her in late August or early September 2015 (see Paragraph 6.10).

5.138 During September or October 2015, Michelle phoned her cousin, Amy, and told her that she was about to leave Scott but needed some money to travel back to Preston. She apparently said that Scott had told her he did not love her anymore and she had been sleeping on the sofa for a couple of nights. Some days later, Michelle again contacted Amy to say that "everything is now ok". It seems likely that this call

was made around the time Michelle disclosed to Linda that Scott had assaulted her (see previous paragraph).

5.139 On 28th August 2015, Scott saw his GP. His mood was described as stable. There was no discussion about his missed ENT appointments.

5.140 On 1st September 2015, Michelle attended a BiDAS medical review when it was agreed to continue with the current prescribing regime. This was the first time she had been seen by BiDAS since 8th June 2015, but this does not appear to have been noticed or enquired into.

5.141 On 7th September 2015, Scott's Community Order was terminated.

5.142 On the same day, Michelle phoned BiDAS to rearrange her PSI session as her mother was unwell. This was untrue. She was said to sound 'tearful.'

5.143 On 15th September 2015, Michelle attended a BiDAS medical review when detox was discussed as an option. She was encouraged to attend PSI appointments.

5.144 On 17th September 2015, Michelle attended a BiDAS PSI session at which her 'recovery capital' – the assets that can be used to initiate and sustain recovery from drug misuse – was explored. Michelle offered that she had a stable home and a supportive partner. This was the last occasion on which Michelle was seen by BiDAS. On the same date, Scott did not attend a BiDAS PSI and his Case Manager was informed.

5.145 On 18th September 2015, Scott's GP received a letter from RBH Urology Department to advise that he had failed to attend an appointment and had been discharged.

5.146 On 25th September 2015, a Bolton at Home officer texted Scott to ask if everything was "ok" as he had made no contact after a calling-card had been left at his property. Scott responded by text, advising that he has sorted things out with United Utilities, his bills were now being paid and he was stress free. On the same date, Scott saw his GP who prescribed a weaning dose of antidepressants. There was no discussion about the recent failure to attend the RBH Urology Department.

5.147 On 28th September 2015, Scott attended a BiDAS medical review during which he said he had used benzodiazepines on three occasions because his grandmother had been in hospital. This seems unlikely to have been true. BiDAS subsequently wrote to Scott's GP to advise that he remained on a methadone programme whilst continuing to use illicit benzodiazepine due to an inability to cope with life's ups and downs. The

letter stated that he continued to take mirtazapine. He was reported to be compliant and was not drinking alcohol.

5.148 On 29th September 2015, Michelle's last known text message was sent to her daughter Sarah. Sarah replied to the text but received no response. She also rang the phones of her mother and Scott but received no reply. No family or friends had any contact with Michelle after this date.

5.149 On 1st October 2015, Michelle did not attend a BiDAS PSI meeting. She was contacted by phone and said she had forgotten about the appointment. A letter was sent offering a further appointment on 22nd October 2015. BiDAS have advised the Review Panel that a three-week waiting time for a new appointment was as a result of staff capacity.

5.150 On 2nd October 2015, Scott phoned BiDAS to request a PSI session.

5.151 Both Michelle and Scott were attending Pharmacy 1 together each day from Monday to Saturday to collect their daily prescription of methadone which they were supervised to take whilst at the pharmacy. On each Saturday, they received two doses so that they could administer the Sunday dose at home when the pharmacy was closed. On Tuesday 6th October 2015, Michelle went to Pharmacy 1, accompanied as usual by Scott, for the last time. It had been understood that during a period of one or two weeks prior to 6th October 2015, Scott had been attending the pharmacy alone and (falsely) stating that Michelle had been admitted to hospital with double pneumonia during this period. The Qualified Pharmacy Dispenser, who was the source of the account that there had been an interruption of one or two weeks in Michelle attending the pharmacy prior to 6th October 2015, has since changed her account, and now believes that Michelle attended the pharmacy continuously up to and including 6th October 2015. On 6th October 2015, the Qualified Pharmacy Dispenser noticed that Michelle was looking very unwell and shivering "like she had flu". She spoke to Michelle who said that she would go home and have a lie down. As previously stated, Michelle did not attend Pharmacy 1 again nor was she seen alive again after this date.

5.152 A statement made to the police by Scott's friend has informed this Review. In his statement, the friend described calling at Scott's flat and finding Michelle lying on the couch obviously very unwell. The friend states that he told Scott that Michelle needed to go to hospital. Later that morning, the friend described how they managed to walk Michelle to the pharmacy to collect her prescription. The friend states that he drew the attention of the pharmacy staff to Michelle's condition and thinks they offered to call an ambulance which Scott declined. This was the last time the friend saw Michelle alive. Although Scott's friend does not have a precise recollection of dates, it

seems reasonable to assume that the circumstances he described took place on 6th October 2015.

5.153 From 7th October 2015, Scott attended Pharmacy 1 to obtain his methadone prescription alone. When pharmacy staff asked about Michelle he gave a number of broadly consistent accounts, in which he said that Michelle had moved to her mother's home in order to clean herself up and was doing really well. At one point he said that she was holding down a job in a care home. After persisting with this optimistic account, he later told a Pharmacy Technician that Michelle had died in his flat. He said they had gone to bed together at night and when he woke in the morning she was dead. He indicated that her death was linked to him having spent the night in police cells from which he had just been released. There is no record of Scott being detained in police cells during the relevant period. The Pharmacy Technician was unable to date this conversation and said she was surprised by this account as she had not realised that Scott and Michelle had resumed their relationship.

5.154 Scott is said to have told his friend that Michelle had been admitted to hospital and had then decided not to return to Scott as continuing to take drugs could make her seriously ill again. The friend noticed that Michelle's belongings remained in Scott's flat for some time after she had allegedly left.

5.155 After the discovery of Michelle's body in January 2017, a post-mortem was carried out which found fractures to her right and left nasal bones and her upper jaw which were consistent with blunt force injury. However, these fractures showed signs of healing consistent with the injury occurring *at least* 4-6 weeks prior to death. It is not known how Michelle came by these injuries, but an assault by Scott must be a possibility. If this was the case, this may be one explanation why Michelle appears not to have been seen by practitioners, other than the staff of Pharmacy 1, from 17th September 2015 until her final visit to the pharmacy on 6th October 2015. As stated in Paragraph 5.151, it had been understood that there had been an interruption of one or two weeks in Michelle's attendance at Pharmacy 1 prior to 6th October 2015. This period of absence would have begun on or around 23rd or 30th September 2015 and would have been broadly consistent with the period during which Michelle was not seen by other services. However, as previously stated, the Qualified Pharmacy Dispenser who was the source of this information has since changed her account to say that there was no interruption in Michelle's attendance at pharmacy 1 prior to 6th October 2015. Assuming the fractures to her nose and jaw had been visible, and the post-mortem report states that Michelle 'would have had a nose bleed and an obviously bruised and swollen face', then Scott may have been reluctant for her to be seen in public. However, it should be acknowledged that the injury noted in the post-mortem may have occurred earlier than 4-6 weeks prior to death. The post-mortem report states that the injury was 'possibly older' at one point and 'likely much older'

than 4-6 weeks prior to death at another point. Michelle's mother has said that Michelle told her that Scott assaulted her in late August or early September 2015 (see Paragraph 6.10).

5.156 On 8th October 2015, Michelle's GP issued her final repeat prescription.

5.157 On 14th October 2015, BiDAS telephoned Scott and arranged an appointment for the following day when he agreed to work towards unsupervised consumption of methadone. He agreed to attend PSI one-to-one sessions and said he had no issues with his physical or mental wellbeing. He added that his long term relationship with Michelle was "going strong".

5.158 Scott saw his GP on 19th October 2015 when a reducing dose of antidepressants was agreed.

5.159 Michelle failed to attend a BiDAS case manager review on 20th October, PSI meeting on 22nd October, and a medical review on 27th October 2015. A further case management review was due to take place on 3rd November 2015.

5.160 On 30th October 2015, Scott used Michelle's mobile phone to send text messages to her daughter, Sarah, to say that Michelle had left him three weeks previously. On 8th November 2015 Scott sent a final text message to Sarah from her mother's phone to say that Michelle had returned to Address 1 to live with her ex-boyfriend Faruq. This text angered Sarah because she believed her mother had betrayed the trust that they had gradually built up since Michelle's grandmother's funeral, by moving on in her life without bothering to let her daughter know. The text provided other family members with false reassurance that Michelle had managed to leave her relationship with Scott.

5.161 On 11th November 2015, Scott attended a BiDAS medical review during which he reported feeling "down" as he had split up from Michelle. This had contributed to lapsing back into using heroin once or twice a week. He was also using diazepam. Scott was said to be well presented with a good level of self care. BiDAS wrote to Scott's GP to advise that he was using heroin again after the end of his relationship with Michelle.

5.162 On 16th November 2015, BiDAS wrote to Michelle explaining that if no contact was made within seven days, her case would be closed. On 27th November 2015, her case was closed due to non-engagement. BiDAS then wrote to Michelle's GP to advise that she had "unsuccessfully completed prescribed treatment and case has now been closed." No contact was made with any other agency in respect of Michelle at that time.

5.163 Scott continued to access Michelle's ESA benefit by using her bank card to withdraw the benefit from her bank account via a nearby cash machine. The ESA benefit amounted to £200 each fortnight which Scott immediately withdrew until the benefit was stopped in December 2015 (see Paragraph 5.164). Scott's friend sometimes accompanied him to withdraw Michelle's benefits and described Scott's anger when he was no longer able to access her benefits. Scott had told his friend that Michelle had returned to her mother who was providing her daughter with financial support which meant that she had no need to access her benefits.

5.164 On 9th December 2015, DWP mail for Michelle was returned from Address 1. Attempts to make telephone contact with Address 1 were unsuccessful. Notes retained by DWP indicated that Address 1 was used as a correspondence address by Michelle because she was staying with, and caring for, her grandparent. Michelle's benefits were suspended until her whereabouts could be clarified. DWP guidance states that benefit should be suspended when post is returned from the last known address. It further states that the decision maker must take steps to ensure that they have tried to trace the customer, by checking to see if a new address is held, telephoning the customer, and arranging a visit to the last known address. Michelle's claim was finally terminated in August 2016, as she had made no contact since benefit suspension in December 2015.

5.165 On 20th January 2016, Scott advised Bolton at Home that he had split up from Michelle. He had taken no steps to add Michelle to the tenancy.

5.166 Throughout 2016, Scott's health appeared to deteriorate. He lost weight and his diet was said to be poor. His mental health appeared stable for a period before he began to complain of anxiety and said that he was unable to leave the house without using benzodiazepines. He stated that he took an intentional overdose in October 2016.

5.167 In February 2016, Sandra wrote to Michelle to seek permission to change Child 1's surname to assist in obtaining a passport. In March 2016, she received a reply purportedly from Michelle expressing upset at the request. The relevant permission slip had been signed, but Michelle purported to request the return of the £10 she had sent Child 1 for his birthday the previous year. It was later established that Scott composed and sent this reply to Sandra.

5.168 There were a number of occasions during 2016 when repair work at Scott's flat necessitated visits from various workers. On 28th April 2016, Scott reported a toilet leaking into the flat below and, on 13th May 2016, a blocked toilet. On 3rd November 2016, a damp inspection was carried out and, on 14th December 2016, the boiler was

repaired. There are no reports of workers noticing the smell of a decomposing body. Scott's friend states that he began to notice what he described as a "horrible" smell in the flat from around three or four months after Scott told him Michelle had left. He says he discussed the smell with Scott who suggested that the drains may have become blocked. The friend later noticed that Scott had kicked the bottom door panel out of an external door to the flat and wondered whether he had done this to allow for a greater circulation of air in order to try and get rid of the smell. He described Scott as someone who appeared somewhat obsessive about keeping his flat clean and tidy.

5.169 On 24th October 2016, Linda contacted Lancashire Constabulary to report her daughter Michelle missing. By this stage, almost a year had elapsed since Scott had used Michelle's phone to send texts to members of her family to say that Michelle had left him (see Paragraph 5.160). Linda explained that, whilst it was not unusual for her daughter to be out of contact with her family, this was the longest period without her either getting in touch or the family hearing about Michelle's whereabouts from a third party. Linda said that Michelle's daughter Sarah had been told by Scott that Michelle had returned to a previous boyfriend (Faruq) in Blackburn. Linda provided Michelle's telephone number to the police which they used to attempt to contact Michelle but received no reply. Linda also shared information about Michelle's health issues including epilepsy, long term use of drugs, alcohol, and previous overdoses.

5.170 Lancashire Constabulary created an incident log and commenced enquiries. These enquiries included contacting GMP to check their systems for any contact with Michelle and, if no recent contact had been made, GMP was requested to visit Address 2. Address 2 was visited by a Police Community Support Officer (PCSO) on 24th October 2016, who spoke to Scott. Scott told the PCSO that he had not seen Michelle for about 15 months and that he believed that she may have returned to Blackburn. Enquiries were also made with Address 1, where the hostel manager stated that Michelle had not been seen for the past two years, had moved to Bolton with a 'lad', and had not since returned. Efforts were made to trace Michelle's previous boyfriend Faruq, and it was established that he was currently in prison.

5.171 The following day (25th October 2015), the incident log was reviewed by a Police Inspector who decided that the disappearance of Michelle should not be classed as a 'missing from home' (MFH) at that time as there were a number of additional enquiries which could be made. The Inspector stated that it was not force policy to become involved in tracing lost relatives unless it was believed that they had come to significant harm. The author of Lancashire Constabulary's Individual Management Review (IMR) stated that this was an incorrect interpretation of force policy by the Inspector.

5.172 A further review the following day (26th October 2016) reiterated the Inspector's initial position. It appears that significant weight was attached to the fact that absence of contact with her family was not out of character for Michelle. The reviewing officers do not appear to have considered Michelle's vulnerabilities or Scott's extensive criminal history as part of their assessment of the risks faced by Michelle at this point.

5.173 The same day, Lancashire Constabulary re-contacted Linda who was said to be unhappy about the decision not to class Michelle's disappearance as a missing person investigation although she was said to have been reassured by the extent of enquiries conducted by the police. During this conversation, Linda advised the police that, prior to the loss of contact with Michelle, she had been staring to get in touch with family members more regularly. Telephone contact was also made with Sarah on this date who observed that it was unusual for her mother to have ceased claiming benefits. Also, on this day, the incident log in respect of Michelle was inadvertently closed, although this error had been identified and rectified by the following day.

5.174 On 28th October 2016, it appears that the classification of Michelle's case changed from 'concern for welfare' to a missing person investigation. It appears that the trigger for this change was that the DWP would not carry out certain checks if the case remained classified as 'concern for welfare'. Michelle was assessed as a 'standard risk' missing person. DWP checks were authorised by an Inspector.

5.175 On 3rd November 2016, Lancashire Constabulary sent an email to Greater Manchester Police (GMP) to request they check whether Michelle was at Address 2 in Bolton. The email explained that Michelle had been reported as a missing person by her mother who had not seen her during the previous year. After initial visits to Address 2 received no reply, Scott was seen by an officer the following day. Scott indicated that he last saw Michelle in June or July 2015 when they separated because of her drug misuse and he believed she had returned to Address 1 in Blackburn. Scott said that they had been together for ten months but he said he wanted to "get away" from drugs whilst Michelle wanted to continue. He said that Michelle usually contacted her sisters monthly. Michelle has one sister, but the review has not been advised of contact between Michelle and her. Lancashire Constabulary were advised of the outcome of the visit to Address 2.

5.176 Lancashire Constabulary appended the information from GMP to the missing person report. Initial enquiries had been made with the manager of Address 1 who said that Michelle had not returned to the address for two years. The discrepancy between this information and Scott's claim that he believed Michelle had returned to Address 1 in June or July 2015 was not picked up on at this stage.

5.177 On 5th November 2016, Lancashire Constabulary issued a media appeal for information about Michelle's whereabouts which generated contact from the paternal grandmother of Child 1 who said she had contacted Michelle via Chorley Children's Social Care in May 2015 to obtain a passport for the child.

5.178 Also on 10th November 2016, Lancashire Constabulary noted DWP policy that they would only release information to the police in respect of missing person cases which had been assessed as high risk. At that time Michelle continued to be assessed as standard risk.

5.179 Further enquiries began to cast doubt on the account provided by Scott to GMP, including the length of Scott and Michelle's relationship, Michelle's alleged return to Address 1 in June or July 2015, and evidence that Michelle's bank account was in use in Bolton after that date. However, confusion arose over earlier communication between Michelle and Sandra over access to Child 1. A letter had been sent to Sandra by Michelle requesting access to child 1, which suggested circumventing the involvement of Children's Social Care (see Paragraph 5.109). However, this letter, which was probably sent by Michelle in the spring of 2015, appears to have been placed in an envelope post-marked 31st March 2016 by mistake. It seems likely that the March 2016 envelope was the envelope in which Scott had written a letter to Sandra, purportedly from Michelle, to express upset at the decision to change Child 1's surname for a passport application (Paragraph 5.167). As a result of this confusion, it was incorrectly assumed that the letter from Michelle to Sandra requesting contact with Child 1 provided evidence of 'proof of life' for Michelle as late as March 2016. It also led to the incorrect theory that Michelle may have continued to use Address 2 as a correspondence address after she and Scott had apparently ended their relationship in 2015. Notwithstanding the confusion over the letter, Lancashire Constabulary re-contacted GMP on 10th November 2016 to request they visit Scott again and interview him regarding the discrepancies in the account he had provided.

5.180 In response, GMP made several visits to Address 2 and found no-one at home. On 20th November 2016, Scott was seen at Address 2 and said it was probably November or December 2015 when he last saw Michelle. He reiterated that she was heavily misusing drugs at that time and wanted to return to Blackburn. Their relationship ended and he said he believed she had returned to a former boyfriend Faruq. Lancashire Constabulary were made aware of this response by GMP.

5.181 On 22nd November 2016, Lancashire Constabulary issued a further media appeal this time in conjunction with GMP so that the appeal reached the latter force area where Michelle had been living prior to her disappearance. The appeal generated recent 'sightings' of Michelle which were investigated. On the same date it was decided to raise the risk level to 'medium'. Increasing the assessment of risk to 'high' had been

considered and discounted on the basis that if Michelle was at risk of significant harm then this was already likely to have occurred given the elapse of time since the last contact with her.

5.182 On 24th and 28th November 2016, Michelle's case was reviewed by Senior Detectives in Lancashire Constabulary which led to several high priority actions including:

- creating intelligence profiles for Michelle, Scott, Faruq, and the Proprietor of Address 1;
- scanning of open source media for the presence of Michelle;
- preparing an analytical timeline;
- obtaining a statement from Linda and establishing the family tree;
- making enquiries regarding Michelle's benefit withdrawal in Bolton.

5.183 It was agreed that the risk assessment would remain at 'medium' unless new information came to light. If this indicated that Michelle was alive but at risk of serious harm, the assessment of risk would be increased to 'high'. If Michelle was found to be alive and well, the assessment would be reduced to 'low'. A POLSA (Police Search Adviser) Officer reviewed the investigation and recommended raising the risk category to 'high' risk as this would allow the DWP to release information and mobile phone cell citing analysis to be commenced. However, the risk assessment remained at 'medium'. On 29th November 2016, the case was transferred from the MFH 'Sleuth' System to the 'Caseman' System and a Detective Inspector was identified as the supervisor of the case.

5.184 On 1st December 2016, a Senior Detective from Lancashire Constabulary made contact with a counterpart in GMP to discuss Michelle's case and it was agreed that Lancashire Constabulary would continue to gather evidence. On the same date, several hypotheses in respect of Michelle's disappearance were considered:

- Killed by a third-party;
- Died of natural causes and body not found (no third-party involvement);
- Died of natural causes and body concealed by a third-party;
- Found deceased but not identified;
- Alive and well but does not wish to be found;
- Alive and is unwell / hospitalised;
- Being held somewhere against her will.

5.185 The final hypothesis was considered to be highly unlikely owing to emerging facts such as Michelle stopping drawing benefits, stopping attending the pharmacy to collect prescriptions, and stopping attending drug rehabilitation. By this stage, it had been established that Scott had drawn Michelle's benefits over what was described as

a long period but had stopped doing so in December 2015 when Michelle's benefits had been suspended. The hypothesis agreed upon by Senior Officers was that Michelle was dead and had been for over twelve-months.

5.186 On 15th December 2016, a Detective Chief Inspector formally recorded that he suspected Scott had had involvement in the death of Michelle. The Officer believed that Scott had killed her or disposed of her body following a drugs-related death / overdose. Scott was afforded 'suspect status' which necessitated further contact with GMP to determine which Force would lead the investigation. It was recorded that when Scott was arrested this would necessitate a forensic search of Address 2. By this time, it had been clarified that Michelle's benefits had been drawn in Bolton until 9th December 2015.

5.187 On 19th December 2016, the Lancashire Constabulary Detective Chief Inspector briefed the GMP Detective Chief Inspector on the progress of the investigation to date. It was agreed that GMP would take primacy following a planned meeting between the two Forces which subsequently took place on 29th December 2016. GMP would run the enquiry as a 'suspicious death'. In the meantime, Lancashire Constabulary would continue to progress outstanding lines of enquiry and continue to provide family support. Records created by Lancashire Constabulary would be back recorded onto GMP's 'HOLMES' investigation system.

5.188 On 21st December 2016, Faruq was interviewed in prison where he was serving a sentence unconnected with this DHR. He claimed not to have seen Michelle since they broke up in early 2014. He also said that another prison inmate had told him four months previously that Michelle had died of a drug overdose in Bolton. During the same month, enquiries with Pharmacy 1 disclosed that Scott had told one of the Pharmacy Dispensers that Michelle had died in his flat after maintaining that she had left him and returned to her mother for many months.

5.189 On 3rd January 2017, the GMP Senior Investigating Officer (SIO) recorded his assessment of the case and the steps to be taken to progress the investigation. He concluded that Michelle was almost certainly deceased and decided that the controlled recovery of Michelle's body was essential in order to seek to establish the cause of her death. The SIO also considered that the recovery of Michelle's body would be of great importance to Michelle's family. Steps were then taken which included monitoring Scott's lifestyle and movements prior to the execution of a search warrant at Address 2.

5.190 On 16th January 2017 GMP executed a search warrant at Address 2. The body of a female, later identified as Michelle, was discovered in a boiler cupboard. Scott was arrested. During interview, Scott claimed that, on 6th October 2015, he and

Michelle had taken a substantial amount of drugs. He had woken up in the early hours and found Michelle dead. He panicked and decided to place her body in the boiler cupboard where it had remained until that date.

6.0 Contact with the family and friends of Michelle

6.1 Michelle's mother Linda contributed to this review. Michelle's daughter (Sarah) and cousin (Amy) were also approached but decided not to contribute.

6.2 Linda described Michelle as a bubbly, loving person who got on well with people. Although she did not maintain frequent contact with her family, Linda described her as very family-oriented. Michelle had a particularly close bond with her maternal grandparents. Her maternal grandfather died in 2006 and her maternal grandmother died in December 2014.

6.3 Linda said that Michelle had become involved in the 'drugs scene' through her partners and had experienced health problems as a result of taking drugs for many years. Linda later implied that Michelle's involvement with drugs had adversely affected her friendships and her move to Blackburn and later, Bolton, had further isolated her from friends.

6.4 Linda said that when Michelle visited the family they would all meet at her maternal grandmother's home. At some point in the second half of 2014, Michelle brought Scott with her to one of these family gatherings. This was the first time he had been introduced to the family. Linda recalled that Scott initially greeted family members with what she regarded as an excessive show of affection. She also noticed that Michelle appeared to be watching what she said in Scott's presence and when he said it was time to go, she immediately complied. Linda felt that Scott seemed to have some kind of 'hold' over Michelle which created a distance between her and her family on this occasion.

6.5 The next time Linda saw Michelle was when she and Scott attended Michelle's maternal grandmother's funeral in December 2014. This was the last time Linda saw Michelle. Linda said that Michelle was absolutely devastated by the death of her grandmother and was weeping at the funeral. She and Scott attended the wake after the funeral service, but they did not stay long. Linda felt that leaving so soon was out of character for Michelle and further convinced her that Scott had some kind of 'hold' over her.

6.6 Linda said that Michelle spoke to her daughter Sarah after the funeral and they agreed to meet. Michelle had lost contact with Sarah and had never met Sarah's children and seemed excited at the prospect of being introduced to them. Michelle was also going to meet Linda so that she could collect some personal items left to her by her maternal grandmother. It had been arranged that Michelle would travel to Preston to meet with Linda and Sarah in February 2015, but this fell through. Linda recalled that lack of money may have been said to have prevented Michelle travelling

to Preston but she wondered whether Scott was concerned that Michelle seemed to be bonding with her daughter Sarah.

6.7 Subsequently, Linda said that it was decided that she would pass on the items left to Michelle by her grandmother to Sarah, so that she could give them to Michelle when they met. However, this meeting never materialised. Linda reflected that Michelle's contact with her family diminished after she became involved with Scott. This contrasted with the earlier period when Michelle was living at Address 1 with her husband and her contact with her family was much more frequent.

6.8 Through 2015, Linda maintained telephone contact with Michelle. Michelle would usually text Linda to let her know she was free to take a call and Linda would ring her. These calls took place when Scott was not with Michelle. Linda said that she noticed that if she ever rang Michelle when Scott was present, Michelle would quickly hang up.

6.9 Linda recalled one unusual occasion when Michelle rang her to ask her to talk to Scott because he was worried about having testicular cancer. Michelle apparently wanted her mother to advise Scott because Linda worked in the care sector. Linda provided Scott with some verbal reassurance. She wondered whether Michelle had used Scott's personal health concerns as a pretext for being allowed to ring her mother.

6.10 Towards the end of August or the beginning of September 2015, Linda said she telephoned Michelle who told her that Scott had been violent towards her. She recalled Michelle saying that Scott "had gone for her" and that "he does it regularly, Mum". Linda says she advised her daughter to pack her things and get out. Michelle told her that she was arranging to go and stay with her cousin, Amy. Linda added that Michelle had shared more information about Scott's violence towards her with Amy, possibly because she didn't want to upset Linda. Linda said that Michelle had told Amy that Scott had been "very rough with her".

6.11 Linda said that Michelle did not go to stay with Amy. When she rang Michelle a short time later, in early September 2015, around the time of Michelle's birthday, Michelle's plan to stay with Amy appeared to have changed. Michelle told her that Scott had bought her a dress which she was going to wear when she went out with Scott and his family. Linda said that Michelle seemed quite excited as she never normally wore a dress. This was the last time she had telephone contact with Michelle.

6.12 Sarah later told Linda that she had been contacted by Scott to say that Michelle had left him and gone back to a former boyfriend and was living at Address 1. Linda said that she and other family members felt some relief on hearing this news, thinking

that Michelle had been able to extract herself from what they perceived to be a relationship in which Scott was 'domineering'.

6.13 By Christmas 2015, Linda said that she and her family were unable to contact Michelle by phone or text. She said she thought that Michelle was 'living her own life'. She added that it was not unusual for Michelle to go a few months without contact.

6.14 Linda said that the family became increasingly concerned about the lack of contact from Michelle during 2016 and began to make enquiries to try and locate her which included contacting Address 1. Linda said she would have expected Michelle to have rung her cousin, Amy, with whom she had a close relationship.

6.15 Linda described how she made contact with Lancashire Constabulary in October 2016 to say how worried the family were about not hearing from Michelle for so long. She added that she told the police that Scott had behaved very possessively towards Michelle, but that the family had been told by Scott that she had left the relationship. She said that the police began making enquiries, including visiting Address 1 where it was confirmed that Michelle had never returned. This contradicted the story Scott told Michelle's daughter Sarah. It was at this point that Amy became convinced that Scott had murdered Michelle.

6.16 However, Linda described how the sightings of Michelle, received by the police in response to an appeal in the local media, gave the family hope that Michelle was alive. Linda mentioned an apparently recent sighting by a security guard and said she kept asking the police if they had interviewed the security guard to get more information.

6.17 She said that Lancashire Constabulary later told her that GMP were taking over the investigation as Scott lived in their area. Linda described how she was visited by GMP detectives in December 2016. She said that they told her that they planned to search Scott's house in January 2017 and that they believed Michelle to be dead. Linda said that she was told to keep this information to herself and not share it with other members of the family which she said was "very, very hard work" particularly as the police didn't go to Scott's address and find Michelle until 16th January 2017.

6.18 Linda expressed some concerns about the police investigation, specifically why it took so long to search Scott's home and why checks on Michelle's benefits and prescribed methadone had not been checked on 'day one' of the investigation.

6.19 She said the GMP Family Liaison Officer was 'lovely' and put her in touch with Victim Support. The Family Liaison Officer advised her that it would be Lancashire Victim Support who would contact her. Linda expressed dissatisfaction with the

support she initially received from Lancashire Victim Support as the person they sent to see her was not trained to support people affected by homicide; did not know the details of the case; and provided incorrect advice about where to get help with funeral costs. However, she said that subsequent contact with Lancashire Victim Support was much better and that the member of staff who supported her thereafter had been trained to support people affected by homicide.

6.20 Linda also expressed concern about the actions of the pharmacy when Michelle visited there for the last time. She said that it "really grated on her" that no-one from pharmacy 1 had sent for an ambulance when Michelle was clearly very ill.

6.21 Linda has had the opportunity to read a late draft of this report. She expressed that she was satisfied with the thoroughness of the review. She was critical of the practices of several agencies involved in the review, particularly what she perceived to be the inaction of pharmacy 1 and BiDAS when Michelle disappeared after presenting as ill at pharmacy 1, and the ineffectiveness of Lancashire Constabulary's initial response when Linda reported Michelle missing. She added that Michelle came from a family who loved her and that she was not "just a drug addict".

6.22 From statements taken from family members by the police, the following is known.

6.23 Michelle's daughter, Sarah, hardly had a relationship with her mother until the funeral of Michelle's grandmother in December 2014. Although they did not speak at the funeral, Sarah took the decision to phone her mother afterwards. This led to an improving relationship between mother and daughter which was conducted exclusively by phone and text between December 2014 and September 2015. Sarah indicated that she was very pleased that she and her mother were getting on well and that her mother appeared to be being very open with her.

6.24 Michelle's cousin, Amy, kept in telephone contact with her and it is to her that Michelle reached out when she initially decided to leave Scott, probably in early September 2015.

6.25 Sandra, who is the guardian of Child 1 has contributed to the review.

6.26 Sandra described receiving the birthday card for Child 1 in March 2015 (see Paragraph 5.98); subsequent contact from Michelle to try and arrange informal contact with Child 1 (see Paragraph 5.109); and the response to a request to Michelle to agree a change of surname for Child 1 to facilitate a passport application (see Paragraph 5.167). This final contact took place after the death of Michelle.

6.27 Sandra commented that she initially assumed that the reply she received in March 2016 in respect of the passport name change had been sent by Michelle. She had only later realised that the handwriting was different to that of Michelle although at the time she had noticed that the tone of the letter she received was "nasty" which she considered to be out of character for Michelle.

6.28 When Sandra was asked whether there were any issues the DHR should explore, she wondered why the agencies involved with Michelle did not appear to notice that she had disappeared and wondered how it was possible for Scott to continue to obtain Michelle's benefits after her death.

6.29 A friend of Scott and Michelle who knew them whilst they were living together in Bolton was offered the opportunity to contribute to this review but declined. However, the statement he provided for the police investigation provides some valuable insights into the relationship between Scott and Michelle. It was decided to write to the friend to advise him that it was intended to make use of his statement to inform the review unless he had any objections. No objections were received.

6.30 In his statement, the friend described Scott's controlling behaviour towards Michelle. He also appears to have accompanied Scott and Michelle (whilst she was very unwell) to the pharmacy on 6th October 2015 which was the last time she was seen alive. The friend's account has been used to inform this report at various points.

6.31 Scott declined the opportunity to contribute to this review.

7.0 Analysis

7.1 The case specific terms of reference for this DHR are as follows:

- How effectively were any disclosures of domestic abuse by Michelle addressed?

- How effectively were the risks to others presented by Scott assessed and managed?

- If Scott had contact with his son, how effectively were any child safeguarding issues addressed?

- If Michelle had contact with Child 1, how effectively were any child safeguarding issues addressed?

- How effectively were any indications of Michelle's absence or that she may have come to harm responded to?

- After Michelle's family reported her as a missing person, how effective were efforts to locate her?

Each of these case specific terms of reference will be addressed below.

How effectively were any disclosures or indicators of domestic abuse by Michelle addressed?

7.2 This review has not been advised that Michelle made any disclosures to any agency of domestic abuse by Scott during their relationship which began between January and April 2014 and ended with her death which occurred on or after 6th October 2015.

7.3 However, it is clear that members of Michelle's family were concerned about what her mother Linda described as Scott's 'hold' over Michelle. Linda said that the pattern of contact between Michelle and her family changed during her relationship with Scott meaning that the family saw her less. Michelle visited her family with Scott just twice during their relationship and one of these visits was to attend Michelle's grandmother's funeral in December 2014 which they left early. Planned meetings with family members which appeared to be of importance to Michelle did not take place. For example, Michelle was said to be excited about meeting Sarah's children – Michelle's first grandchildren – but this meeting did not happen. Another example was the plan for Michelle to collect precious items left for her by her late grandmother, to whom

Michelle was said to have been very close. Returning to Preston to collect these items appears to have been discussed for some time, but again did not happen. Linda accepted that Michelle's contact with family had become very intermittent and that she had become completely estranged from her daughter, Sarah, and was not involved with Child 1. However, Linda felt that Michelle had had much more open contact with family members during her prior relationship with her husband Brian. Linda was adamant that her concerns about Michelle's relationship with Scott were concerns that she had felt at the time and had not been influenced by Michelle's subsequent death whilst she was living with Scott.

7.4 Linda also described how Michelle appeared to watch what she said in Scott's presence and, when with other people, if Scott decided it was time to leave, Michelle immediately complied. This observation is consistent with the account provided by Scott's friend which is set out below. Scott also appeared to exert influence over Michelle's telephone contact with her family. Linda described how Michelle would usually text her to let her know she was free to take a call and Linda would then ring her. These calls took place when Scott was not with Michelle. Linda said that she noticed that if she ever rang Michelle when Scott was present, Michelle would quickly finish the call.

7.5 Linda described how Michelle disclosed physical abuse by Scott in a telephone call towards the end of August or the beginning of September 2015. She recalled Michelle saying that Scott "had gone for her" and that "he does it regularly Mum". Linda says she advised her daughter to pack her things and get out. Michelle told her that she arranging to go and stay with her cousin, Amy. Linda added that Michelle had shared with Amy more information about Scott's violence towards her, possibly because she didn't want to upset Linda. Linda said that Michelle had told Amy that Scott had been "very rough with her".

7.6 In the event, Michelle did not go to stay with Amy. When Linda rang her daughter in early September 2015, Michelle told her that Scott had bought her a dress which she was going to wear when she went out with Scott and his family. Linda said that Michelle seemed quite excited as she never normally wore a dress. It seems possible that Scott had bought Michelle a dress and promised to take her out in order to encourage her to stay with him. However, given Scott's control of Michelle's movements, including regularly locking her in his flat (see below), it seems more likely that Michelle was prevented from leaving. Michelle may have been presenting a more reassuring picture to her mother in what turned out to be the final telephone call she had with her.

7.7 Further indications that Michelle was the victim of domestic abuse by Scott are derived from the statement provided to the police by Scott's friend; Scott's behaviour

in concealing Michelle's death; and the post mortem examination after the discovery of Michelle's body in Scott's flat.

7.8 In his statement to the police, Scott's friend said he had known Scott for around two to three years. He said he would often visit Scott in his flat at Address 2 and would sometimes stay over. He said he would lend money to Scott which was repaid when he drew his and Michelle's benefits. He said he got to know Michelle as well. He described the relationship between Scott and Michelle as one in which Scott was very controlling. The friend described how Scott, who had only one key to his flat, would lock Michelle in the flat when he went out. On one occasion the friend found Michelle locked in the flat alone and unable to go to Pharmacy 1 for her methadone prescription. The friend said Michelle told him she was "ok" with this situation but he added that he "could see in her eyes that she was not 'ok' with it". The friend offered to get a second key cut for Michelle but Scott declined this. Scott's friend described how Michelle was sometimes locked in the flat without very much food.

7.9 The friend said that he never saw Scott hit or threaten Michelle, nor did he see any bruises on her body, but that he controlled every aspect of her life. He always controlled the money, carried Michelle's 'card', and decided what their money should be spent on. When spending their money, the friend said Scott prioritised his own needs including the purchase of valium, for example, where he would keep the majority for his own use. The friend said that Michelle did not appear visibly afraid of Scott but went along with everything he said and never questioned anything. Research suggests that victims of domestic abuse who misuse substances may find it difficult to accurately assess risks posed to them as their perception may be 'dulled' (1). The friend said that Scott would inject heroin into Michelle's neck as she had no other suitable veins.

7.10 From the accounts provided by Michelle's mother Linda and Scott's friend, there is clear evidence of controlling behaviour by Scott towards Linda. Controlling behaviour is defined as "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" (2). In this case, Scott isolated Michelle from sources of support by limiting family contact to telephone and text communication only, exploited Michelle's resources for personal gain by taking control of her finances and using her money to prioritise his own needs, and deprived Michelle of the means of escape by routinely locking her in his flat.

7.11 Coercive behaviour is also in evidence. This is defined as "a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim" (3). In this case, there is evidence that

Scott used physical abuse to harm and intimidate Michelle as disclosed by her in her telephone conversation with Linda in which she said "he does it regularly, Mum". Regularly locking Michelle in his flat was both humiliating and intimidating.

7.12 The chronologies provided by agencies which were in contact with Michelle and Scott provide only hints of coercion and control. Michelle and Scott had regular contact with BiDAS from April 2014. Michelle declined involvement in group work from the outset. She did not attend, or ring to re-arrange, sixteen appointments. On two occasions she did not attend because she said she was unwell (on 28th August and 7th September 2015) but did not contact her GP at that time. Failing to attend appointments is unlikely to have been an unusual behaviour amongst BiDAS clients but in Michelle's case, may have been a consequence of being restricted in leaving Scott's flat on occasions. Whilst several of Michelle's BiDAS appointments coincided with those of Scott, there were nineteen appointments which did not, although he was noted to have accompanied her on one of these. In the GMP report to the Coroner Scott was said to have been described by BiDAS staff as "very controlling" towards Michelle but this view was not confirmed by the BiDAS IMR.

7.13 Michelle was always accompanied by Scott when they attended Pharmacy 1 six days a week for supervised dispensing of methadone. Pharmacy staff are said to have developed a professional relationship with both of them through daily interaction. Pharmacy staff described them as "lovey-dovey", "loved up" and "a wonderful couple". Michelle's mother has commented that she believes that this was the false impression that Scott was trying to create.

7.14 Scott and Michelle were registered with different GP surgeries (albeit co-located on the same site). It is not known whether Scott accompanied Michelle to her GP appointments.

7.15 In regards to further direct evidence of domestic abuse of Michelle by Scott, the post-mortem examination of Michelle's severely decomposed body disclosed bilateral thyroid horn fractures which raised the 'strong possibility' that Michelle died as a result of strong pressure to the neck. It was considered unlikely that these injuries had been sustained weeks prior to death and possible that they may have been caused at the time of death. Additionally, the post-mortem disclosed that Michelle had sustained a broken nose and fractured left cheek bone which could have been sustained at the same time as each other. Such injuries are often caused by very hard punches but can also be caused by a blunt weapon, stamping or kicking. These injuries would have caused a nose bleed and an obviously bruised and swollen face. The pathologist noted signs of healing which indicated that these facial injuries were at least several weeks old and were likely much older at the time of death. There is no evidence to suggest

that anyone other than Scott inflicted the injuries Michelle sustained prior to or at the time of her death.

7.16 There is no record of any practitioner noticing the facial injuries sustained by Michelle in the weeks prior to her death. As previously stated, Michelle would present at Pharmacy 1 every day except Sunday and she was seen regularly by BiDAS staff (although there were some not insubstantial gaps between face to face contacts with BiDAS).

7.17 Scott's actions in concealing the body of Michelle and lying to her family, his friend, Pharmacy 1, BiDAS, and Bolton at Home about what had happened to her demonstrated a desire to evade any scrutiny of the circumstances which led to Michelle's death including the possible presence of domestic violence.

7.18 There were other indications that all was not well in the relationship between Michelle and Scott which were not known to practitioners. Michelle appears to have contacted the Proprietor of Address 1 to enquire if she could have her old room back in early 2015. It is not known why she made this request. In the weeks before she died, Michelle contacted her cousin, Amy, to seek financial help to move to Amy's home in West Yorkshire as her relationship with Scott had broken down. However, when Amy re-contacted Michelle some days later, Michelle indicated that the relationship problems with Scott had been resolved. It seems likely that this contact with Amy, who has not contributed to this review, may have been around the time that Michelle disclosed domestic abuse by Scott to Linda in late August or early September 2015.

7.19 Michelle also appears to have experienced domestic abuse in a prior relationship in September 2011. Although no details of the abuse have been ascertained, the impact on Michelle was such that she felt impelled to leave her home in Preston and move to Blackpool at short notice. Discover Drug and Alcohol Services in Preston were providing support to her at the time and they appear to have made prompt arrangements for her to transfer to equivalent services in Blackpool. However, there is no record to suggest that a discussion or handover process took place when Michelle transferred to the Blackpool service which may have highlighted to them that Michelle was fleeing domestic abuse. Subsequently, when Michelle returned to the Discover Service at Preston, there is no record of any discussions about any support Michelle might have been receiving from any domestic abuse related service, or record of the Discover Service considering referring Michelle to any domestic abuse service.

7.20 Michelle was also provided with support by Blackburn with Darwen Wish Centre which supports victims of domestic abuse. In May 2013, after an argument with Brian which was reported to the police, she told The Wish Centre that she tended to be the

one who initiated arguments with Brian. She went on to disclose that she had been in an abusive relationship for twelve years and took out some of the anger she experienced as a result of that abusive relationship on Brian. The Wish Centre suggested that Michelle may want to attend a programme for women who find it difficult to communicate effectively and then retaliate in an argument with hostility and anger. Michelle expressed interest in this and asked for a referral which was made the following day. Michelle did not subsequently attend the programme and her file was closed. The Wish Centre would normally have contacted Michelle after she failed to attend the first session but decided that this was unnecessary as she had volunteered for the programme and the risks she faced were not considered to be significant. The Specialist Domestic Abuse Advisor to the DHR Panel indicates that there could have been merit in The Wish Centre contacting Michelle as this was an opportunity to engage her in work to enhance her safety through early intervention.

7.21 BiDAS were made aware of Michelle's previous experience of domestic abuse when she transferred to their service in April 2014. Thereafter, the question of whether Michelle may be experiencing, or be vulnerable to domestic abuse, did not appear to be considered by any of the BiDAS practitioners who came into contact with her. In part, this may have been because she presented her relationship with Scott in generally positive terms and, in common with Scott, repeatedly characterised their move to Bolton together as a 'fresh start'. However, the pattern of their engagement with the service was not consistent with the 'fresh start' narrative. Both she and Scott engaged only sporadically with the psychosocial interventions team, neither making significant progress towards any change in behaviour that would have supported long term abstinence.

7.22 Despite this, there appeared to be an absence of professional curiosity on the part of BiDAS staff. For example, when Scott disclosed that he and Michelle had split up in April 2015 (see Paragraph 5.105) this information did not appear to be passed to anyone working with Michelle to check on her wellbeing. When Scott disclosed serious self-harm and suicidal ideation, there seemed to be no consideration about how this might impact upon Michelle. In abusive relationships, the threat of suicide by an abuser is regarded as an indicator that the abuser might also harm their partner (4).

7.23 BiDAS appeared to work with Michelle and Scott as completely separate clients. Even the plans designed to help them reduce their drug dependence were different, despite their similar presentations, which BiDAS acknowledge was not good practice. There is no reference in either of their case records to the care/recovery plan of the other party. Whilst it is not expected that the individuals would be viewed as a single case, it is good practice to evidence where information has been shared internally that

relates to both parties. Both case records lack consistent evidence of liaison or information sharing within BiDAS.

7.24 Whilst it is good practice to provide individual service users with a confidential space to discuss their needs, there does not appear to have been any discussion with either Michelle or Scott regarding the impact they may or may not have had on each other's substance use and, therefore, recovery. Nor was the relationship between Michelle and Scott explicitly referenced during their treatment journeys. Acknowledgement of the relationship and discussions regarding the impact of the relationship, may have allowed BiDAS greater insight into the relationship dynamics and led to more detailed assessment of potential domestic abuse.

7.25 BiDAS also acknowledges that information provided by both Michelle and Scott at assessment and throughout treatment appeared to be taken at face value. For example, in the assessment notes of Michelle, it clearly states that she had not used benzodiazepines (diazepam) for one month, yet on the same day, during her medical assessment, she disclosed having used them on the previous day which was also corroborated by her urine test.

7.26 In respect of both Michelle and Scott, minimal evidence of partnership working was demonstrated by BiDAS; particularly with Criminal Justice Services, Children's Social Care and Mental Health Services. This further limited the opportunity to identify whether domestic abuse was present in the relationship.

7.27 The BiDAS IMR author points out that each case manager manages a case load of 80-120 service users at any one time. PSI and medical staff do not carry caseloads, so it is therefore possible for service users to see a different member of staff at medical reviews and psychosocial interventions. BiDAS acknowledges that this leads to a lack of continuity of care. Whilst their system assigns oversight to the case manager, BiDAS contends that the case manager lacks the time to review case progression on an individual level to ensure full oversight. Michelle's mother commented that this lack of continuity of care and the insufficiency of oversight of cases needs addressing by BiDAS. Achieve Recovery Service, which has replaced BiDAS, has advised the review that their service is undergoing structural change, with caseloads reduced and an outreach service commissioned.

7.28 When Michelle registered with her Bolton GP in June 2014 she completed a patient questionnaire. The practice experienced initial difficulty in obtaining Michelle's patient records from her previous GP practice which may have led to the disclosure of previous domestic abuse. Michelle's GP practice has subsequently become an IRIS (Identification and Referral to Improve Safety) practice. IRIS is a General practice domestic abuse training and referral programme, evaluation of which indicates a

substantially increased likelihood of victims having discussions about domestic abuse with their GP and being referred for support (5).

7.29 There appears to have been an almost complete absence of contact between BiDAS and Michelle's GP until November 2015 when BiDAS wrote to inform the GP that Michelle's case had been closed. This appears to contrast with Scott's experience of support via BiDAS, as BiDAS sent periodic letters to his GP. BiDAS records indicate that an earlier letter was sent to Michelle's GP after she disclosed the death of her grandmother and another family bereavement in December 2014, but there is no record of this letter being received by Michelle's GP. The general absence of contact with Michelle's GP prevented continuity and consistency of care, although Michelle made her GP aware of the fact she was on a methadone programme. Reviewing Michelle's contact with her GP, it seems that she was primarily prescribed medication for her epilepsy and an antidepressant. She was also prescribed analgesics on occasion which could have been a potential replacement for benzodiazepines, if she and Scott had been unable to obtain them. Michelle had just over seven GP consultations a year which the author of the CCG IMR did not consider excessive.

7.30 Although Scott had presented himself as single when first assessed by his CRC Offender Manager, the Offender Manager gradually became aware of Michelle. In December 2014, Scott disclosed to his Offender Manager that Michelle had self-harmed. No detail of the nature of the self-harm appears to have been recorded. Scott linked Michelle's self-harm to her distress at recent family bereavements. The disclosure prompted no enquiry or liaison with other agencies to verify this or check on Michelle's welfare.

7.31 Michelle wasn't really on Bolton at Home's radar as they were focussed on supporting Scott in his tenancy and they declined the request he made early in his tenancy for Michelle to be allowed to move in with him on the grounds that he needed to demonstrate a positive tenancy for a year before anyone could be allowed to share the property with him. Michelle was seen at the property by Bolton at Home staff on more than one occasion but was said to be "just visiting."

7.32 Both BiDAS and her GP recognised that Michelle had vulnerabilities, but their focus was primarily on vulnerabilities associated with her mental health, including previous suicide attempts and her use of illicit and prescription drugs. There appeared to be no consideration of how a person with her vulnerabilities might be faring in her most intimate relationship. Michelle's GP had very little knowledge of Scott but BiDAS knew Scott well and had the opportunity to gain an impression that he could attempt to manipulate others. However, BiDAS' general approach appeared to accept what Scott told them at face value which may have prevented them considering how his tendency to manipulate others might have played out in his relationship with Michelle.

7.33 Research suggests that victims of domestic abuse who misuse substances feel that they are constantly judged and stigmatised by agencies, with false assumptions made (6). In Michelle's case, it seems possible that stigma may have been a factor in the lack of professional interest in how Michelle – who had been a victim of domestic abuse, had a history of mental health problems including several suicide attempts and was a substance misuser – was coping in her relationship with Scott who also had mental health problems, was a substance misuser and was known to be manipulative. Scott's criminal history was known only to the CRC and Bolton at Home, and a partial appreciation of his history as a domestic abuser was apparently known only to the CRC. Stigma may also have been a factor in Lancashire Constabulary's initial handling of the missing person report by Linda. Much greater weight appeared to be placed on Michelle's lifestyle and estrangement from her family than on her vulnerability and the risks to her presented by Scott.

How effectively were the risks to others presented by Scott assessed and managed?

7.34 Scott had a history of domestic abuse of female partners although none of the incidents had resulted in criminal convictions.

7.35 In 1997, Scott was arrested for assaulting a previous female partner by punching and head-butting her causing bruising before dragging her upstairs and causing scratches to her chest, shoulder and legs with a kitchen knife. Scott was charged but the case was discontinued for unknown reasons.

7.36 In 2007, he argued with a female and grabbed her by the hair and swung her around before hitting her in the face with his hand. After initially making a complaint, the victim later decided not to pursue the matter. Scott was neither charged nor prosecuted.

7.37 In 2009, Scott argued with his female partner before pushing her onto a settee and grabbing her tightly around the throat and slapping her around the face. Scott was arrested but not charged due to a 'lack of credible evidence'. Days later, the same victim contacted the police to report receiving threatening and abusive telephone calls and texts from Scott which led the police to advise him to desist.

7.38 Additionally, there were five reported incidents of domestic abuse involving Scott and his father including threats to kill made by Scott in 2004. He also has a substantial non-domestic abuse related criminal history which relates primarily to offences of dishonesty although there was a warning for firearms recorded. Of particular concern was a robbery of cash from a female who was unknown to him whilst she was

withdrawing cash from an ATM. He threatened to "cut her". It is assumed he had a knife in his possession or claiming as such. He was sentenced to two years imprisonment for this offence in 2008.

7.39 The only agencies which were in contact with Scott during his relationship with Michelle which would have been aware of his offending history were GMP; the National Probation Service (NPS); the Community Rehabilitation Company (CRC); and Bolton at Home. Scott also disclosed his involvement in the aforementioned robbery in a BiDAS medical review.

7.40 The police had two contacts with Scott prior to Michelle's death. The first was when he and Michelle were arrested on 6th June 2014, and the second occasion was when Scott took an overdose on 19th February 2015 (see Paragraph 5.88). On the first occasion, the circumstances did not give rise to concerns about the relationship between Scott and Michelle. On the latter occasion, the focus of the police was on ensuring Scott was safe. The second event prompted consideration of an Adult Safeguarding referral, but the police decided against it as Scott was in contact with the Royal Bolton Hospital and he also advised them that he intended to see his GP later that day.

7.41 The NPS prepared a pre-sentence report in respect of Scott following his conviction for offences related to the incident on 6th June 2014 (see Paragraph 5.23). The NPS requested details of any 'police call-outs' for domestic abuse in respect of Scott from GMP and were provided with details of seven incidents. Neither the 1997 (see Paragraph 7.35) or 2007 (see Paragraph 7.36) domestic abuse incidents were included in the details provided by GMP. The explanation provided by GMP is that the 1997 incident was not transferred to a new GMP information management system, and the 2007 incident, although it included elements of stalking and harassing behaviour, did not involve an intimate relationship and was therefore not coded as domestic abuse.

7.42 Scott was assessed as posing a medium risk of serious harm in line with NPS risk policy which informed the sentence recommendation. To be assessed as a medium risk of harm, the offender must have demonstrated behaviour which had crossed the serious harm threshold. The NPS define serious harm as "an event which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, is likely to be difficult or impossible". Whilst the offences with which Scott was convicted by Bolton Magistrates Court in 2014 did not cross the serious harm threshold, Scott's previous offence of robbery committed in 2008 did.

7.43 The NPS went on to assess that seriously harmful behaviour was not imminent due to the protective factors evident at that time, which were stated to be stable

accommodation and drug treatment. The author of the pre-sentence report consulted with BiDAS who confirmed that Scott remained engaged with drug treatment and had not provided any recent positive tests for heroin.

7.44 The NPS risk assessment was supported by a Risk of Serious Harm (ROSH) analysis which did not include details of the police call-outs despite policy dictating that it should do so. However, the NPS IMR author concluded that the police call-out information would not have had any influence on the NPS sentence proposal for the following reasons:

- the June 2014 offences were not committed in the context of domestic abuse;
- there was no reference to Scott being in a relationship at the time the pre-sentence report was completed;
- the police call-outs had not resulted in a conviction and had taken place some years previously.

7.45 It is of concern that the author of the NPS pre-sentence report was unaware of Scott being in a relationship at that time the report was prepared. Scott committed the offences for which he was being sentenced in the company of Michelle which would have been made known to the pre-sentence report author who appears to have shown insufficient curiosity about Scott's female companion at the time of the offence. It is also possible that Scott may have wished to create the impression that he was single.

7.46 Following sentence, Scott's case was allocated to the CRC in Bolton to manage the Community Order imposed by the Court. The Offender Manager to whom Scott's case was allocated was required to complete an assessment of risk of re-offending and serious harm within ten working days of Scott's first contact with the service.

7.47 The CRC assessment was consistent with that of the NPS in concluding that Scott posed a medium risk of serious harm. Scott was considered to be capable of serious harm, but protective factors indicated that the likelihood of this happening was low. The protective factors stated were stable accommodation; engagement with BiDAS; no financial issues; Scott's engagement and motivation; and the absence of offending for three years.

7.48 However, the assessment did not link Scott's emotional wellbeing to re-offending even though Scott sought to mitigate his June 2014 offending by saying that he had been preoccupied with his own health issues at the time. Nor were Scott's attitudes linked to re-offending or harm which the CRC IMR author regarded as an omission given the previous call-outs regarding domestic abuse incidents. This information was

omitted from the assessment report which the CRC IMR author also regards as unsatisfactory.

7.49 From analysis of Scott's responses to a self-assessment, the Offender Manager noted that he had issues with:

- Understanding others' feelings;
- Taking drugs;
- Losing his temper;
- Doing things on the spur of the moment;
- Getting violent when annoyed;
- Worrying about things;
- Feeling depressed;
- Feeling stressed.

Scott's issues with controlling behaviour emerged from another element of the assessment.

7.50 During the self-assessment, Scott disclosed previous issues with heroin, cannabis and benzodiazepine but stated that he has been free of illicit substances for some time (this was a lie – see Paragraph 5.50) and was working with BIDAS on a methadone programme. Surprisingly, Scott's substance misuse was not linked to his risk of harm or re-offending. The CRC IMR author states that, given Scott's history of substance misuse and the offences which are associated with substance misuse, she would have expected this issue to have been further explored and linked to his risk of reoffending and possibly his risk of harm to others.

7.51 The CRC Offender Manager also completed a Spousal Assault Risk Assessment (SARA) as the police had notified two call-outs relating to an intimate partner, the last of which was in 2009. Scott was assessed as a low risk to intimate partners. At this stage, the Offender Manager appeared to be unaware of Michelle. Scott said he was living in his own tenancy alone. Again, one wonders why the Offender Manager was not aware of Michelle given that the offences he had just been sentenced for had been committed with Michelle present and she had initially been regarded as a co-offender (see Paragraph 5.23).

7.52 The Offender Manager did not place a "DV Perpetrator" flag on the CRC system for Scott as there had been no domestic abuse police call-outs within the preceding two years. However, given the previous domestic abuse call-outs, CRC policy required a 'DV History' flag to be applied, but this did not happen. The Offender Manager has contributed to this review and said that, at that time, there was some confusion

around the use of this flag and she had only recently started supervising those with a domestic abuse history.

7.53 The final part of the assessment is the construction of the Sentence Plan. This is completed with the service user and sets out the direction of travel of the Order. The plan for Scott consisted of the following three objectives:

- Improved awareness of consequences of behaviour;
- Improved ability to recognise victims' perspective/needs;
- Increased management of self-control.

7.54 Scott's compliance with his Order was as expected until November 2014 when there was an unexplained four-week gap in face-to-face contact. Appointments also needed to be rearranged whilst Scott claimed to be supporting Michelle through family bereavements in December 2014. Scott also had health concerns which appeared to require periods of hospitalisation for which his Offender Manager required verification. Thereafter, physical reporting to his Offender Manager appeared to diminish and no home visits took place.

7.55 Despite being offered numerous opportunities to complete the thinking skills programme, Scott made insufficient progress and ultimately the requirement to complete the programme was removed from his order by the Court. The programme consisted of the three modules of self-control; problem solving; and positive relationships.

7.56 However, Scott was said to have engaged well with one-to-one work with his Offender Manager on relationships; conflict management; self-talk; recognising anger and conflict; managing anger and aggression; and problem solving. In May 2015, Scott specifically requested to complete work on anger management. His Offender Manager did not record the reasons for this and was unable to recall them when interviewed for this review.

7.57 Scott's Offender Manager gradually became aware of Michelle as several appointments were rearranged in December 2014 due to Scott saying that he was supporting Michelle through family bereavements. Scott also referred to Michelle self-harming at that time. The author of the CRC IMR takes the view that, given these absences relating to Michelle, the concerns highlighted regarding her self-harming, and Scott raising concerns relating to anger, these issues should have prompted a home visit to verify the situation, but this did not occur.

7.58 Multi-agency working in respect of Scott's order was also limited, with no contact made with BiDAS which one would have expected to have been prompted when, for

example, the Offender Manager was told of Scott's overdose prior to his planned hospital procedure in March 2015. Scott's BiDAS Key-worker's details were noted in the CRC Risk Management Plan.

7.59 Scott's order terminated on 7th September 2015, which was a month prior to the date on which Michelle was last seen alive.

7.60 Prior to Scott beginning his Bolton at Home tenancy, appropriate references would have been required from Offender Advice Rehabilitation and Support (OARS) which supports homeless male offenders leaving HMP Forest Bank to obtain accommodation and achieve lifestyle change. Scott had been referred to OARS on his release from HMP Forest Bank in June 2009 and had remained in touch with that service despite moving to the Blackburn area in 2010. The references received in respect of Scott are no longer held by Bolton at Home so it is not known whether his past as a domestic abuse perpetrator was included.

7.61 Bolton at Home supported Scott to set up his tenancy and resettle. They were aware that he was being provided with support by BiDAS but initiated no contact with them or any other agency as Scott's tenancy was perceived to be progressing satisfactorily. Bolton at Home was not made aware of his Court Order by the CRC as CRC policy would only require such notification if Scott's offending risks were linked to his accommodation in any respect.

7.62 Bolton at Home became aware of Scott's mental health issues and state that this may have dissuaded them from closing his file. As previously stated, Bolton at Home were aware of Michelle but did not consider Scott's relationship with her whilst they were providing support to Scott.

7.63 As previously stated, Scott registered with a different GP practice to Michelle which limited the opportunity for their respective GP practices to consider them as a couple. There is no indication that Scott disclosed his past offending (including domestic abuse) when he registered with his GP practice on his return to Bolton in April 2014 and his previous GP records were not obtained.

7.64 Scott's GP practice became aware of his relationship with Michelle when she accompanied him to a GP appointment in June 2014 following a recent attempt to hang himself. His GP did not consider the risk Scott might present to others including Michelle who was perceived by the GP to be a 'protective factor'.

7.65 From August 2014, Scott's GP was aware that Scott began to experience stress as a result of a urology referral and subsequent scan which disclosed an abnormality. There was no immediate follow up when his GP was advised in February 2015 that

Scott had taken an overdose which prevented him attending surgery to remove the (non-cancerous) testicle. The issue was discussed with Scott at a subsequent GP appointment on 16th March 2015, but Scott's risk assessment for suicidal ideation was not updated. There was no consideration of the impact of Scott's mental health on others, including Michelle.

7.66 Scott's GP received some contact by letter from BiDAS but it is unclear whether the GP responded to the request from BiDAS for Scott's medical history following the February 2015 overdose (see Paragraph 5.107).

7.67 Scott's GP received some information from RBH in connection with the urology referral and a subsequent referral to RBH Ear, Nose and Throat Department but these do not appear to have been discussed in subsequent GP appointments.

7.68 The criticisms of the way BiDAS interacted with Michelle (see Paragraphs 7.21 to 7.27) largely also applied to their contact with Scott, except that BiDAS made periodic contact with Scott's GP. BiDAS also accepted Scott's 'fresh start' narrative despite his engagement with the service being inconsistent with this. As previously stated, BiDAS demonstrated a lack of professional curiosity when Scott disclosed relationship problems with Michelle and did not consider the impact of Scott's disclosure of self-harm and suicidal ideation on Michelle. BiDAS worked with Scott and Michelle as separate clients with an absence of information sharing between BiDAS Practitioners working with them. The impact each had on the other's substance misuse and recovery went undiscussed and no insights were gained into the dynamics of their relationship. Information provided by both Scott and Michelle was taken at face value.

7.69 As with Michelle, there was minimal evidence of partnership working by BiDAS in the support they provided to Scott. BiDAS acknowledge that improved liaison with primary and secondary care could have provided them with far greater insight into Scott's physical and mental health and allowed them to adapt his plan of care to more fully meet his needs. BiDAS were contacted by the NPS at the time of Scott's pre-sentence assessment.

7.70 There is also substantial evidence that Scott manipulated agencies by providing information which was untrue, for example, lying about recent illicit substance misuse at his initial CRC assessment; providing information which was probably untrue such as his various comments about supporting members of his family from whom he seems to have been estranged; and concealing pertinent information by presenting himself to the CRC as single. Scott was assisted in his manipulation by the general tendency of agencies to accept the information he provided at face value and the absence of communication between agencies.

If Scott had contact with his son, how effectively were any child safeguarding issues addressed?

7.71 Scott was believed to have a son on the basis of information he had previously provided to a number of services. During the course of this Review it became apparent that Scott had also claimed to be the father of two daughters in an assessment carried out by the CRC. However, no evidence of the existence of any of these children has been unearthed other than from information provided by Scott to various agencies.

7.72 The CRC acknowledge that they should have contacted Children's Services when Scott referred to his two daughters during their initial assessment but failed to do so.

7.73 In an attempt to clarify whether Scott actually had any children, contact was made with his father, with whom Scott had a conflicted relationship. Scott's father was adamant that his son had never had any children. Scott declined to contribute to this Review, so it has not been possible to put the question about children to him directly. As previously stated, the Review has noted a number of examples of Scott's dishonesty in his communication with agencies. It seems more likely than not that he lied to agencies about being the father of children. Certainly, the Review has received no evidence to indicate that he was in touch with a son or the two daughters he claimed to be the father of.

If Michelle had contact with Child 1, how effectively were any child safeguarding issues addressed?

7.74 During the period considered by this Review, there is no record of Michelle having any direct contact with Child 1. She sent a birthday card with money to Child 1 in March 2015 which his Guardian, Sandra, notified Lancashire Children's Social Care about (see Paragraph 5.97).

7.75 After Child 1 was formally made subject to a Special Guardianship Order in April 2015, Michelle wrote to Sandra asking if it would be possible to circumvent Children's Social Care so that she could have contact with Child 1. Michelle also requested a photograph of him. Sandra did not reply to the letter or accede to Michelle's request (see Paragraph 5.108).

7.76 Michelle did not disclose the existence of Child 1 when she first registered with BiDAS who only became aware of him in December 2014 when informed by Chorley Children's Services. (Paragraph 5.78) BiDAS did not further consider Child 1 or have any discussion with Michelle about Child 1.

How effectively were any indications of Michelle's absence or that she may have come to harm responded to?

7.77 Michelle attended Pharmacy 1 for the final time on 6th October 2015. As usual, she was accompanied by Scott. Scott's friend also appears to have been present. Michelle was evidently unwell. The Pharmacy Dispenser described Michelle as "looking awful" and "looking terrible". The Pharmacy staff may have been under the impression that Michelle had recently been admitted to hospital for pneumonia and advised her and Scott that she should return to hospital. The Pharmacy Dispenser has contributed to this review and has advised that she did not believe that Michelle's presentation was as a result of opiate withdrawal.

7.78 Given Michelle's presentation, the Pharmacy Dispenser could have contacted BiDAS or Michelle's GP or escalated her concerns about Michelle's presentation to the Pharmacist. None of these actions took place. Pharmacies are expected to report any events of concern to substance misuse service providers. Michelle's presentation was not considered to be an 'event of concern' and the presence of Scott, who was perceived by Pharmacy staff to be a caring and supportive partner, may have provided reassurance that he would ensure Michelle's ill-health was promptly addressed. The author of Pharmacy 1's IMR takes the view that it is difficult for a Pharmacy Dispenser to assess the risk of a person's health deteriorating during the brief episodes of limited contact they have with patients. The review has been advised that the appropriateness of dispensing methadone to a patient who appears unwell is clinical judgement by the pharmacist. Michelle's mother, Linda, is aware of how ill her daughter appeared to be when she visited Pharmacy 1 on 6th October 2015 from evidence given at the inquest and has told this review that it "really grated on her" that no-one from Pharmacy 1 had sent for an ambulance when Michelle was clearly very ill (see Paragraph 6.20).

7.79 Pharmacies are obliged to notify the substance misuse service provider (BiDAS in this instance) if the patient fails to attend for collection and supervision on three consecutive days. Michelle did not attend Pharmacy 1 after Tuesday 6th October 2015 and so Pharmacy 1 should have notified BiDAS on Friday 9th October 2015. Michelle's methadone prescription covered the period up to 14th October 2015.

7.80 Pharmacy 1 has reviewed their records which show that they dispensed consecutive supplies of methadone in the name of Michelle for the six-month period up to and including 6th October 2015. Pharmacy 1 recorded 7th, 8th, and 9th October 2015 as 'patient did not attend' and thereafter recorded that treatment against that prescription was to be cancelled. Pharmacy 1 advise that the cancellation of a substance misuse prescription is at the direction of BIDAS. However, a clear note that BiDAS was notified was not recorded. Apparently, this is consistent with usual practice.

7.81 Pharmacy 1's IMR states that notification to BiDAS of failure to collect methadone for three consecutive days is made by telephone. They would speak to the patient's designated support worker if they were available. More commonly, a message would be left with the receptionist who would advise the designated support worker when he or she was free. It is understood that the designated support worker at BIDAS would then be expected to discuss the situation with their medical team and a clinical decision made. The most common outcome is that the current prescription would be voided. This would be recorded on 'PharmOutcomes' which a pharmacy reporting system to which BiDAS does not have access.

7.82 It is acknowledged that patients failing to collect supplies of methadone, or other medicines for substance misuse, will be likely to exhibit withdrawal symptoms and to seek illicit substances to meet their needs. At the point that a pharmacist advises BiDAS of three consecutive days of non-collection, their contractual obligations and their duty to patient care is deemed to have been completed.

7.83 Pharmacy 1's IMR states that the decision of whether or not to cancel a prescription is based upon a range of factors including the reliability of the patient; any mitigating circumstances; the participation of the patient with their management programme; and the risks to the patient.

7.84 As stated in Paragraph 7.80, records from Pharmacy 1 demonstrate that consecutive supplies of methadone were dispensed to Michelle during the six months up to and including 6th October 2015. These records are inconsistent with the earlier account that Michelle had not attended Pharmacy 1 for a period of one or two weeks prior to 6th October 2015 (see Paragraphs 5.151 and 5.155) but appear to confirm the amended account provided by Pharmacy 1 that there was, in fact, no interruption in the attendance of Michelle at the pharmacy.

7.85 However, there are some concerns about the change in the account provided by Pharmacy 1. The original account provided by the Pharmacy Dispenser – that Michelle had not attended Pharmacy 1 for one or two weeks prior to her final attendance on 6th October 2015 – was first set out in a statement to the police and was believed to have been confirmed by the first IMR submitted to this review in respect of Pharmacy 1. The account appears to have changed only when the author of Pharmacy 1's IMR was asked to explore what action was taken by the pharmacy during this period of one or two weeks when Michelle was not attending. Members of the DHR Panel wondered whether Scott had been allowed to collect Michelle's prescription for her, on presentation of a note from Michelle. If this arrangement had not been in place, DHR Panel members questioned why the pharmacy had not notified BiDAS after three consecutive days of non-collection by Michelle. It was only after these queries were raised, and an amended second IMR had been submitted in respect of the pharmacy,

that the account provided by the pharmacy appeared to change. Repeated efforts were made to obtain a satisfactory explanation for the change to the second pharmacy IMR. The explanation eventually provided to the Review was that the first pharmacy IMR had not been intended to convey the impression that there had been any interruption in Michelle's attendance at the pharmacy prior to her final attendance on 6th October 2015, and that a single typing error in the first IMR had created confusion. The Independent Panel Chair /author is unable to accept this explanation as the first pharmacy IMR, although containing some ambiguity, appears to clearly confirm the account earlier provided in a police statement by the Pharmacy Dispenser that there had been an interruption for one or two weeks in Michelle's attendance at the pharmacy. On scrutinising the first pharmacy IMR, this is the view that the DHR Panel also came to.

7.86 However, it is also accepted that the account initially provided by the Pharmacy Dispenser to the police and the Pharmacy IMR author could have been mistaken. There is absolutely no criticism of the Pharmacy Dispenser in changing her account. Recalling the precise sequence of events which occurred more than a year earlier was not a straightforward matter, particularly as Scott had repeatedly attempted to deceive pharmacy staff about what had happened to Michelle.

7.87 Whilst the records of Pharmacy 1 appear to support the eventual account that there was no interruption in Michelle's attendance at Pharmacy 1 prior to her death, it should be noted that the pharmacy records were initially said to incorrectly indicate that the last date Michelle attended the pharmacy was Thursday 1st October 2015.

7.88 Greater Manchester Health and Social Care Partnership (GMHSCP) was responsible for the preparation, quality assurance and submission of the Pharmacy 1 IMRs to this Review. GMHSCP consists of 35 NHS and local authority organisations from across Greater Manchester, one of which is Bolton Council which directly commissions enhanced pharmacy services including the supervised consumption of methadone service provided to Michelle and Scott by Pharmacy 1. GMHSCP's position is that their first IMR was not intended to convey the impression that there had been any interruption in Michelle's attendance at Pharmacy 1 and that it was a single typing error which led the DHR Panel to conclude that the first pharmacy IMR indicated that there had in fact been such an interruption. As stated in Paragraph 7.85, the Independent Panel Chair is unable to accept this explanation. Regrettably, this issue must be classed as an unresolved disagreement as set out in Paragraph 31 of the Home Office DHR Guidance. Every effort has been made to resolve the disagreement through repeated contact with the Pharmacy 1 IMR author and subsequent contact with the GMHSCP DHR Panel Member and the GMHSCR Senior Manager who quality assured the two versions of the pharmacy IMR.

7.89 Because it has not proved possible to resolve this disagreement, Be Safe Strategic Partnership may wish to report this matter to Bolton Council as the local commissioners of the supervised consumption of methadone service in order that they (Bolton Council) can seek assurance about the manner in which the supervised consumption of methadone service is provided by pharmacies. Additionally, GMHSCP may wish to reflect on the manner in which they have engaged with this DHR in order to ensure that they communicate clearly with future statutory reviews.

7.90 Michelle was last seen by BiDAS on 17th September 2015 when she attended a PSI session (see Paragraph 5.143). Her final contact with BiDAS was on 1st October 2015 when she failed to attend a PSI meeting. When her non-attendance was followed up with a phone call on the same date, Michelle said she had forgotten about the appointment. BiDAS then wrote to her to offer a further appointment on 22nd October 2015 (see Paragraph 5.149).

7.91 BiDAS has advised the review that they have no record of Pharmacy 1 informing them of the non-collection of methadone by Michelle on 9th October 2015. They also advise that, if they had been notified, they would have cancelled Michelle's medical review scheduled for 27th October 2015 and advised her that she required a re-start. This is not an entirely convincing argument. If they were notified and failed to record the notification, then the medical review seems unlikely to have been cancelled.

7.92 Michelle failed to attend a BiDAS case manager review on 20th October 2015; the rescheduled PSI meeting on 22nd October; and the medical review on 27th October 2015 (see Paragraph 5.159).

7.93 Following this series of missed appointments, BiDAS wrote to Michelle on 16th November 2015 to explain that, if no contact was made within seven days, her case would be closed. On 27th November, her case was closed due to non-engagement. (see Paragraph 5.162) BiDAS then wrote to Michelle's GP to advise that she had "unsuccessfully completed prescribed treatment and case has now been closed".

7.94 Meanwhile, Scott continued to engage with BiDAS. During a medical review on 11th November 2015 he reported feeling 'down' as he had split up from Michelle. He said that this had contributed to him lapsing back into using heroin once or twice a week. BiDAS wrote to Scott's GP to advise that he had "recently split from partner and three weeks ago started using heroin again. Referred for 1:1 support". There is no record that BiDAS explored any aspect of the ending of Scott's relationship with Michelle with him, or enquired as to Michelle's whereabouts or welfare.

7.95 The response of BiDAS to Michelle's disappearance was extremely limited. There appears to have been no curiosity over what might have happened to her. BiDAS were

aware of Michelle's mental health issues including previous suicide attempts. (see Paragraph 5.16) They would also be aware that disengaging from their service could put her at risk of experiencing withdrawal symptoms and seeking illicit drugs to meet her needs. The absence of any contact from an alternative provider of substance misuse services to which Michelle might have been expected to turn seemingly went unnoticed. BiDAS did not appear to see Scott as a source of information about Michelle's welfare.

7.96 The BiDAS IMR acknowledges that there is no indication that any discussion took place with Michelle over previous issues regarding lack of engagement and failing to attend appointments. One could argue that their response to Michelle failing to attend appointments from 1st October 2015 onwards was consistent with their limited exploration of the earlier lack of engagement by Michelle. However, the absence of any curiosity about the disappearance of a service user with many known vulnerabilities is surprising. BiDAS has advised the review that of approximately 1200 service users, between 150 – 200 were classed as high-risk due to issues such as safeguarding concerns or domestic abuse including MARAC referrals. They state that any disengagement by high-risk service users would have been followed up immediately, but that Michelle was not considered to be high-risk. Michelle's mother takes the view that her daughter's sudden disappearance from Pharmacy 1, in circumstances in which she was clearly unwell, and from BiDAS should have "rung alarm bells".

7.97 Michelle's final appointment with her GP took place on 11th May 2015 when she complained of dizziness which the GP suspected may have been viral labyrinthitis. She was prescribed mirtazapine (see Paragraph 5.111).

7.98 Apart from repeat prescribing of her medication each fortnight, the final attempt to contact Michelle by her GP occurred on 21st May 2015 when she was sent a letter to book an appointment to discuss her epilepsy to which she did not respond. (Paragraph 5.114).

7.99 At the time of her disappearance in October 2015, Michelle was obtaining the medication prescribed by her GP (as opposed to the methadone prescribed via BiDAS) on a fortnightly basis. This was undertaken via a repeat prescribing process managed by Pharmacy 1 and her GP practice and which did not necessitate appointments with her GP. Patients considered suitable for repeat prescribing include those on stable therapy; those with long term conditions; those requiring multiple therapy e.g. for hypertension diabetes, asthma etc.; and those who can appropriately self-manage seasonal conditions. Michelle's final repeat prescription was issued on 8th October 2015. (Paragraph 5.156)

7.100 The repeat prescribing system prompts GPs and practice staff to recommend the patient attend an appointment to review, or have a telephone consultation, at least annually. In Michelle's case, the CCG IMR states that, if repeat prescribing had continued beyond six months without clinical review, she would have been contacted by the GP practice. This is because, continuing antidepressants beyond six months after remission should prompt a review of the patient to consider any residual symptoms; physical health problems; and psychosocial difficulties. However, at the time of her disappearance, just five months had elapsed since Michelle's most recent clinical review. However, Michelle's GP practice did not always conduct reviews in a timely manner.

7.101 As previously stated, BiDAS advised Michelle's GP by letter when they closed her case. This appears to be the only occasion on which BiDAS successfully communicated with Michelle's GP which is in contrast to the periodic contact they maintained with Scott's GP. Michelle's GP practice appears to have taken no action other than placing the letter in her file which was standard practice.

7.102 Michelle remained registered as a patient with the GP practice. The absence of further repeat prescribing after 8th October 2015 prompted no concerns about how she was managing without the prescribed medication and, as stated in the paragraph above, the closure of her case by BiDAS prompted no enquiry. The ending of repeat prescribing and the closure of her case by BiDAS does not appear to have been connected by practitioners in any way.

7.103 The only further action by the GP practice was to write to Michelle in August 2016 to recommend she attended for a health check.

7.104 Bolton at Home had no direct involvement with Michelle. They had declined Scott's request for her to move in with him in April 2014 (see Paragraph 5.29) although they advised Scott that he could make the request again after twelve months of positive tenancy conduct. Although his tenancy was seen as positive, Scott did not make any further request for Michelle to move in with him.

7.105 Bolton at Home Sustainment and Support Officers noticed Michelle's presence in Scott's flat on several occasions, but their focus was on delivering tenancy support to Scott as a sole tenant. In January 2016, Scott advised Bolton at Home that he had split up with Michelle over Christmas 2015 and this information was noted and recorded.

7.106 The Bolton at Home IMR acknowledges that had their officers engaged with Michelle, they may have become aware of the nature of the relationship including possible indicators of domestic abuse. Bolton at Home may also wish to reflect on

their policy of denying tenant's requests for partners to move in with them until one year of positive tenancy conduct has been demonstrated. This appears to be a defensible policy, but it is unclear how enforceable it is. Michelle appeared to live continuously with Scott from April 2014 until her death without Bolton at Home realising that this was the case. She used Scott's address as her address when registering with her GP and BiDAS. Additionally, the policy had the unintended consequence of making Scott's relationship with Michelle largely invisible to the Bolton at Home staff who provided support to Scott. This increased the likelihood of domestic abuse going unnoticed. Bolton at Home has added a review of their policy of refusing to add partners to an introductory tenancy to their Single Agency Action Plan – see Appendix B.

7.107 Michelle had given Address 1 as her permanent address to the DWP from March 2012 and did not disclose that she had moved to Bolton in 2014. The DWP was aware that Address 1 was a hostel. Michelle received Employment and Support Allowance (ESA) from April 2012 until 8th December 2015 (apart from a short gap in the spring of 2015). The DWP was in possession of medical evidence which indicated that Michelle's primary diagnosis was of depression. Michelle was designated as a vulnerable customer which is defined as having "mental health conditions or learning disabilities or conditions affecting communication/cognition".

7.108 The last contact DWP had with Michelle was on 7th July 2015 when she rang their benefit processing centre to request a text message when a benefit payment was made and provided her mobile phone number for this purpose (see Paragraph 5.125).

7.109 Correspondence the DWP sent to Michelle was returned from Address 1 on 9th December 2015 and her benefits were suspended (see Paragraph 5.164) The DWP has advised this review that their policy clearly requires every attempt to be made to contact the individual prior to suspending benefits.

7.110 DWP instructions state that, in the event of correspondence being returned, the claimant should be phoned. The DWP Benefit Centre made one recorded effort to contact Michelle by googling the telephone number for Address 1 and ringing that number. The outcome of this call is not known. It is not recorded whether the DWP rang the mobile phone number they had held on file for Michelle since July 2015. It is assumed that any phone call to Address 1 would have disclosed that Michelle had not lived there since early 2014. Had a call been made to Michelle's mobile phone number it seems likely that they would have received no reply or that Scott may possibly have answered.

7.111 DWP instructions also state that their system should be checked for any change of address. It was not recorded whether this was done. Had the system been checked, the additional address given by Michelle as the home of her the terminally ill grandmother would have been apparent. DWP instructions also require a visit to be requested to the last known address of the claimant. This was not done. There is no record of any decision making process to explain or justify this omission. The DWP has advised this review that, in Michelle's case, it would have been best practice to request visits to both the recorded correspondence address (Address 1) and to the alternative address (of Michelle's grandmother). Had a visit been made to Address 1, it is assumed that the DWP Official would have been advised that Michelle had not lived there since early 2014 and they may have been provided with details of Address 2. Had a visit been made to Michelle's grandmother's address, it would have been discovered that the grandmother had died a year earlier in December 2014.

7.112 It is concerning that the DWP did not fully comply with their own policies in carrying out checks deemed necessary prior to benefit suspension, particularly as Michelle was considered to be a vulnerable customer. However, Michelle's lack of openness with the DWP about her address undoubtedly complicated matters. Michelle may have been reluctant to give Scott's Bolton address to the DWP as she had no right to reside there. She may have been waiting until Scott took the steps necessary to include her on his tenancy after twelve months. Scott may have persuaded her not to declare their Bolton address to DWP. However, maintaining the fiction that she had been living with her terminally ill grandmother in order to care for her ultimately rebounded against Michelle's interests.

After Michelle's family reported her as a missing person, how effective were efforts to locate her?

7.113 Michelle's mother Linda contacted Lancashire Constabulary to report her daughter as a missing person on 24th October 2016. This was over a year since the family had last heard from Michelle and approaching two years since any member of the family had last seen her. Linda explained that whilst it was not unusual for her daughter to be out of contact with her family, this was the longest period of time they had not heard from her.

7.114 Linda shared information with the police about some of Michelle's vulnerabilities, specifically her epilepsy and her long-term misuse of alcohol and drugs including previous overdoses. In her contribution to this review, Linda said she shared her concerns about Michelle's relationship with Scott, but at that time was under the impression that Michelle had left Scott and was no longer at risk from him.

7.115 Lancashire Constabulary initially treated the report from Linda as a concern for the welfare of Michelle and did not record and investigate her disappearance as a missing person in the first instance. Lancashire Constabulary's Missing Persons Procedure adopts the Association of Chief Police Officers (ACPO) definition of a missing person which is "anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or others".

7.116 It was apparent to the police that Michelle had become somewhat estranged from her family and that fairly lengthy periods without substantial contact were not unusual. It was therefore not unreasonable for Lancashire Constabulary to initially treat the circumstances as a 'concern for safety/welfare' rather than as a missing person enquiry. This is allowed by the above-mentioned Missing Persons Procedure (Section 10.4) which advises that, if the initial categorisation is assessed to be a concern for safety/welfare, it is important to follow the missing person process if the person is subsequently considered to be a missing person.

7.117 Additionally, the Missing Persons Procedure also states (Section 10.3) that the force will not be operationally engaged in locating lost relatives as there are specialist organisations that are better placed to do this. This also appeared to be a factor in the initial decision not to treat Michelle as a missing person (see Paragraph 5.170).

7.118 Three days after the initial contact from Linda (on 27th October 2016), it was decided to change the categorisation of Michelle's case from 'concern for welfare' to missing person enquiry. It appears that the trigger for this change was that 'certain checks" could not be carried out if the case remained as a 'concern for welfare'. (see Paragraph 5.173). The Lancashire Constabulary IMR does not state which checks could not be carried out although the IMR states that certain (again unspecified) checks could not be carried out due to the data protection policies of (unnamed) organisations.

7.119 There were grounds for categorising Michelle as a missing person earlier. The author of the Lancashire Constabulary IMR concludes that "once the initial enquiries to trace FA1 were made, it was clear at this time that she was indeed missing". Additionally, when Lancashire Constabulary re-contacted Linda on 26th October 2016, she advised the police that, prior to the loss of contact with Michelle, she had been staring to get in touch with family members – particularly her daughter Sarah – more regularly (see Paragraph 5.172). This was quite significant information because, until that time, the police appeared to be of the opinion that Michelle's lengthy period without contacting her family was consistent with her previous behaviour. The disclosure that she had been in more regular contact with her family in the months

prior to her disappearance indicated that her loss of contact with her family was more out of character than previously assumed.

7.120 Once Michelle was categorised as a missing person, it was essential to ensure that the Missing Persons Procedure was followed from that point on. This would have necessitated a check of the actions which had been carried out during the period when Michelle's disappearance was treated as a 'concern for welfare' to identify whether there were any additional actions which needed to be carried out to ensure compliance with the Missing Persons Procedure. One important task which had not been completed was a search of Michelle's last known address: Address 2. The importance of this task is emphasised by the fact that the need to conduct such a search is referenced no less than four times in the Missing Persons Procedure (Sections 5.8, 6.3, 13.1 and 14.1). However, none of the supervisors who regularly reviewed the missing person record for Michelle appeared to pick up on this omission.

7.121 The categorisation of Michelle as a missing person also entailed recording all enquiries on the Sleuth information system from that point on. All previous enquiries and reviews had been recorded on an incident log, which were then back record converted onto the Sleuth system.

7.122 Michelle was assessed as a 'standard' risk missing person. 'Standard' risk is applied where there is no apparent threat of danger to either the subject or the public. The risk is assessed as medium if the risk is likely to place the subject in danger or they are a threat to themselves or others. High-risk is applied where the risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability; may have been the victim of a serious crime; or the risk posed is immediate and there are substantial grounds for believing that the public is in danger.

7.123 There was an absence of evidence at that time to indicate that Michelle faced any immediate risks and it may therefore have been inappropriate to assess her as a 'high' risk missing person at that time. However, as enquiries to establish that Michelle was alive were being made with negative results, and fears that she could have come to harm increased, she could have been assessed as 'high' risk on the basis that she "may have been the victim of a serious crime". However, the decision to assess Michelle as a 'standard' risk missing person at the outset appeared to take insufficient account of Scott's substantial criminal history, which included domestic abuse or the many factors in Michelle's life which increased her vulnerability to harm.

7.124 All missing persons assessed as 'standard' or 'medium' are investigated and managed at Divisional level whilst missing persons assessed as 'high' risk are overseen by the Force Major Incident Team (FMIT). If a 'standard' or 'medium' risk

missing person is still live on the Sleuth system after 72 hours, the Missing Persons Procedure requires that a formal review is carried out by a Detective Inspector. The 72 hour threshold would have been reached in respect of Michelle on 1st November 2016 but the Detective Inspector review does not appear to have taken place until 22nd November.

7.125 The bulk of the review activity was carried out by Divisional Sergeants and Inspectors. The responsibilities of the review officer are set out in the Missing Persons Procedure and include checking on outstanding and incomplete actions, quality assuring actions already taken and setting new actions and enquiries (Section 8.7.1). There are indications that review activity was not entirely effective in the earlier stages of the missing person enquiry for Michelle. Reference has already been made of the failure to action a search of Michelle's last known address. The Lancashire Constabulary IMR states that a Constable was allocated as a single point of contact (SPOC) and that this Constable was supported by a Sergeant. However, it is unclear when this took place and what impact the SPOC had.

7.126 It was clear from the outset that the missing person enquiry would require a degree of collaboration with GMP because Michelle's last known address was situated in the Greater Manchester force area. This issue is partially addressed in the Missing Persons Procedure, which sets out the arrangements for transfer of primacy for a missing person enquiry. Although primacy for the missing person enquiry regarding Michelle was eventually transferred to GMP, in the earlier stages of the enquiry primacy was not an active issue. However, it was necessary for Lancashire Constabulary and GMP to work closely together as the focus of the enquiry shifted towards Scott and the inconsistencies which began to emerge in the accounts he provided to the police. The Missing Persons Procedure does not reference how this type of cross-border collaboration should be managed.

7.127 The wording of the initial email dated 3rd November 2016 from Lancashire Constabulary to GMP to request a 'missing person check' at Address 2 indicated that little more than a routine enquiry was required. The email contained a hint of Michelle's vulnerability in a reference to her being a 'drug/alcohol misuser'. No request for a search of the property was made. The manner in which GMP responded to the request was equally routine. A GMP Officer visited the address on 4th November and had a conversation with Scott on his doorstep. The information he supplied to the Officer was relayed to Lancashire Constabulary. The GMP Officer who spoke to Scott was provided with no information which might have allowed her to challenge anything Scott said and so the account he provided appears to have been accepted without question.

7.128 The subsequent email dated 10th November 2016 from Lancashire Constabulary to GMP to request that Scott be revisited differed in tone and content from the first email. In this second email, Lancashire Constabulary stated that they were "beginning to become increasingly concerned" that their enquiries to trace Michelle were "all drawing a blank". The email highlighted a number of discrepancies in the account Scott provided to GMP on 4th November 2016, specifically that he had been in a relationship with Michelle for longer than he had originally said, Michelle had not returned to Address 1, and that Scott had told Michelle's family that he had last seen her in November 2015 and not June / July 2015 as stated to the GMP Officer who carried out the first visit.

7.129 The Lancashire Constabulary email also stated that Michelle's benefits had continued to be drawn in Bolton until December 2015 and that correspondence which purported to be from Michelle had apparently been received from Address 2 as recently as March 2016. The latter point was subsequently found to be incorrect.

7.130 The email concluded with the following request:

> "Please can an officer be asked to re-visit Scott and ask him again regarding when he last saw Michelle, or if he knows about her current whereabouts. He has clearly lied to the police thus far and needs to be challenged regarding the inconsistencies in his account".

7.131 The approach adopted by Lancashire Constabulary in making this request was unsatisfactory in a number of respects. Firstly, it contained an inaccuracy in that it stated that, whilst Michelle had not been seen by her family since December 2014 (which was correct), since this point she had not had any contact with them (incorrect). Secondly, the email set out no plan other than a request for a further conversation with Scott in which he was to be challenged on the "lies" he had previously told. Thirdly, there was again no request to conduct a search of Address 2. either with Scott's consent or under the appropriate authority. Fourthly, setting out such a request in the form of an email was inappropriate. It was clear from the content of the email that concerns for Michelle's welfare were increasing and that Scott had some difficult questions to answer. This situation required a substantive discussion between the two police forces and a co-ordinated plan of action agreed. Simply sending an email appeared to significantly diminish the chances of a satisfactory outcome to an important enquiry.

7.132 Lancashire Constabulary adopted a "transactional" approach to requesting that GMP revisit Scott in that a limited method of communication was chosen in which there was minimal emphasis on gaining the ownership and engagement of the other

police force. This had the effect of diminishing the importance of the task. Lancashire's approach was then mirrored by GMP who went on to further de-escalate the task.

7.133 It was open to GMP to express concern to Lancashire Constabulary about the content of their request and the method by which it was communicated and to suggest a more co-ordinated approach. This did not happen. As a result, it was left up to the GMP Officer who was ultimately allocated the task of revisiting Scott to do the best they could.

7.134 No GMP Officer spoke to Scott until ten days after receiving the 10th November email. The matter was initially allocated a Grade 3 response in accordance with GMP's graded response policy which required attendance by an officer within four hours. Competing priorities and resource challenges prevented this target being met and, on 12th November 2016, the call was downgraded to Grade 4 which required resolution within 48 hours. Given the concerns for the welfare of Michelle expressed in the Lancashire Constabulary email, this was an inappropriate decision and the GMP IMR Author considers that this decision was taken simply to remove the incident from the list of overdue incidents Bolton response officers were attempting to deal with at that time. Ultimately, the incident was allocated for attention by a Neighbourhood Beat Officer.

7.135 The interview by GMP with Scott on 20th November 2016 was largely ineffectual. Scott appeared to quickly pick up on the fact that discrepancies had been noted in the earlier version of events he had given to GMP on 4th November 2016 and amended his answers accordingly. The Officer who visited Scott on 20th November 2016 has advised this review that he was not made aware of the 4th November visit to Scott or that there were any concerns about Scott previously lying to the police. If this is the case, the Officer who saw Scott on 20th November was very poorly briefed indeed. In any event, Scott's revised account appears to have been recorded without challenge. The Officer has reflected on his interaction with Scott and says that he has amended his approach to thoroughly check the source of any such requests to ensure he is fully aware of the facts, particularly issues relating to vulnerability. This is valuable learning for the Officer which needs to be shared more widely.

7.136 However, even if the Officer who revisited Scott had fully understood the implications of the 10th November 2016 email request from Lancashire Constabulary, it was unrealistic to expect him to respond in the manner proposed by Lancashire Constabulary.

7.137 The ineffectual approach to questioning Scott on 4th and then not again until 20th November 2016 may have provided him with a window of opportunity to consider

disposing of Michelle's body prior to any further contact by the police. Fortunately, he did not do so.

7.138 The risk assessment for Michelle was subsequently increased from standard to 'medium' risk. At no time was Michelle assessed as a 'high' risk missing person. As previously stated, Michelle could have been assessed as 'high' risk on the basis that she "may have been the victim of a serious crime". The impression gained is that, in assessing the risk to Michelle, officers may have given greater emphasis to the the perceived absence of 'immediacy', as the likelihood that she was dead, and had been for some time, increased. The possibility that Michelle was alive and in immediate danger was not discounted but was regarded as an increasingly remote possibility.

7.139 However, one implication of not being considered a high-risk missing person was that this appeared to limit financial investigation, including enquiries with DWP. Indeed, the Missing Persons Procedure explicitly limits the involvement of Lancashire Constabulary's Financial Investigation Unit to high-risk missing persons. This seems unhelpfully restrictive. In Michelle's case, there were strong grounds for expeditiously conducting financial enquiries which could have helped to more promptly establish that indications that she was alive were absent.

7.140 There were at least two appeals via the media for information about Michelle's whereabouts on 5th and 22nd November 2016 (see Paragraph 5.177 & 5.181). The target audience of the second media appeal included the GMP area. The first media appeal generated contact from the paternal grandmother of Child 1 which was of value to the missing person investigation. However, both media appeals generated potential sightings of Michelle by members of the general public which necessitated follow up police contact. Arguably, the first media appeal was premature in that there were a number of outstanding enquiries which appeared to have greater priority including searching the place where Michelle was last known to have been, analysing the account provided by Scott the previous day and further contact with the Proprietor of Address 1. Additionally, Linda advised this review that being informed of the potential sightings of Michelle gave her and her family hope that she may still be alive. It seems possible that Linda was not advised that such sightings should be treated with caution until confirmed.

7.141 It is very noticeable that, once Michelle's case was reviewed by Senior Detectives in Lancashire Constabulary on 24th and 28th November 2016 (see Paragraph 5.182), much clearer oversight and direction of the missing person investigation was apparent. A number of high priority actions were identified and pursued; the management of the case was transferred from the Sleuth to the Caseman system; and, in a meeting with GMP counterparts, a range of hypotheses were tested against the evidence which had been gathered. The most likely hypothesis was that Michelle

was dead and had been for over twelve months. One could question the urgency with which matters were progressed during December 2016. Although the hypothesis that Michelle was being held against her will was considered unlikely, it had not been completely ruled out. There is also the concern that Scott was fully aware that Michelle's disappearance was being investigated – by this time he had been spoken to by the police on three separate occasions – and may have had the opportunity to dispose of her remains if he still retained control over them.

7.142 The Lancashire Constabulary Missing Persons Procedure provides comprehensive guidance in an important area of police work in which ensuring a consistent approach is very challenging to achieve. The Procedure was written in 2014 and was due to be reviewed in early 2017. This review has commenced and is currently ongoing. The Procedure contains brief guidance on domestic violence which helpfully points out that the abuser may fail, or be reluctant, to report the victim missing to avoid subsequent investigation. Overall, the Procedure appears to be stronger on highlighting child safeguarding as opposed to adult safeguarding issues and this may be an area which could be strengthened when the review of the Procedure takes place.

7.143 The GMP investigation between 29th December 2016 and 16th January 2017 focussed on achieving the controlled recovery of Michelle's body whilst preserving evidence in order to establish whether her death had been accidental or whether foul play had been involved. The GMP SIO had concluded that Michelle was almost certainly deceased taking into account the large number of enquiries carried out by Lancashire Constabulary which indicated she was no longer alive. The SIO also considered it necessary to monitor Scott's lifestyle and movements during this period including whether he had access to a vehicle which might have been used to move Michelle's body. This period was also used to research potential sites for the disposal of a body, prepare interview strategies and plan a forensic strategy.

8.0 Findings and Recommendations

8.1 This is an unusual DHR because it was not considered possible to prosecute the suspected perpetrator Scott, due to the difficulty in determining how the victim Michelle died. Nor had there been any complaint of domestic abuse by Michelle, or in respect of Michelle by any third party, during the course of her relationship with Scott.

8.2 However, it is clear from the post-mortem on Michelle's severely decomposed body that there is a strong possibility that foul play was a factor in her death as there was evidence of strangulation which may have coincided with the time of her death. However, it also possible that Michelle may have died of natural causes given how unwell she appeared to be on the last day she was seen alive. If Michelle died of natural causes it is difficult to reconcile this with Scott's behaviour in concealing her body and misleading her family, his friend and curious practitioners about Michelle's whereabouts.

8.3 The post mortem also disclosed facial fractures which Michelle sustained at least 4-6 weeks prior to her death.

8.4 Although no complaint of domestic abuse was made by Michelle, or on behalf of Michelle, the account provided by Michelle's mother to this review and the statement made by Scott's friend contain mutually reinforcing accounts of a relationship which was characterised by coercion and control by Scott. The level of control which Scott appeared to exert over Michelle seems likely to have been a factor in the absence of any complaint of domestic abuse by her to any agency.

8.5 Notwithstanding the absence of disclosures of domestic abuse to any agency in contact with Michelle and Scott, there is much learning in this case about the manner in which agencies worked with and engaged with them. In general, the agencies in contact with Michelle and Scott did not consider the possibility that domestic abuse was present in their relationship whilst rigid silo working severely limited opportunities for sharing those concerns which arose from time to time.

8.6 Another unusual feature of this DHR is that there is a focus on policy and practice following the assumed date of Michelle's death in order to identify learning from the manner in which agencies responded to her initial disappearance and how the two police forces involved responded once Michelle's family subsequently reported her as a missing person.

Absence of partnership working particularly communication and information sharing.

8.7 The agencies in contact with Michelle and Scott whilst they were in a relationship with each other and residing in Address 2 did not work in partnership and barely communicated with each other.

8.8 Bolton at Home provided support to Scott in his tenancy from March 2014 until April 2016. They were aware that he was being provided with support by BiDAS and became aware of his mental health issues to an extent but never made contact with BiDAS or his GP. BiDAS wrote to Michelle's GP on three occasions. The first occasion was to request bereavement counselling for her in December 2014 and the last occasion was when they closed Michelle's case following her disappearance. The first letter was not received by Michelle's GP. BiDAS wrote to Scott's GP slightly more frequently but there is no record of their letter to his GP to request his medical history after Scott's overdose in February 2015 being replied to by the GP practice or any non-reply being followed up. Michelle and Scott were registered with different GP practices and there is no indication that either GP practice communicated with each other despite the concerns about Scott's mental health. The CCG advises that this would never be done as it would breach patient confidentiality. The National Probation Service consulted BiDAS when preparing their pre-sentence report for Scott but the Community Rehabilitation Company (CRC) made no contact with BiDAS during the year in which they supervised Scott's Community Order. BiDAS made no contact with either the NPS or CRC. The CRC made no contact with Scott's GP despite concerns about his mental health or Michelle's GP when they were told that she had self-harmed.

8.9 The agencies which were in contact with Michelle and Scott from their arrival in Bolton in March/April 2014 until Michelle's disappearance in October 2015 worked almost exclusively in silos. There were a number of consequences of this silo working. Bolton at Home probably gained an over-optimistic view of Scott's tenancy and were unaware that Michelle was living permanently with him at Address 2 and had provided this address to her GP and BiDAS. The Care Plans prepared by BiDAS in respect of both Michelle and Scott were insufficiently informed by their physical and mental health issues. CRC efforts to support Scott to reduce his risk of harm were insufficiently informed about everything else that was happening in his life (although the CRC did require verification of hospital attendance). In particular, the CRC was not aware of how well or otherwise Scott was engaging with substance misuse services which was likely to have an impact on whether he continued to commit offences.

8.10 It is not known how widespread the silo working so evident in this case is. It was suggested by one IMR Author that silo working was partly a consequence of the

impacts of austerity which had led to practitioners turning inwards and focusing primarily, if not exclusively, on complying with internal policies and processes. This may be true, but there appeared to be other factors which contributed to silo working. For example, internal silo working appeared to be present in BiDAS in the entirely separate way in which they worked with Michelle and Scott, including not even considering whether a consistent approach should be taken to their individual Treatment Plans. The choice made by Scott and Michelle to register with different GP practices; the unintended consequence of Bolton at Home's policy of restricting partners from moving in with new supported tenants rendering Michelle as 'invisible' to them; and a general absence of professional curiosity were all factors which contributed to silo working.

8.11 Each agency involved in this review has identified single agency recommendations which are set out in Appendix B. Several agencies have included recommendations which are intended to challenge silo working as follows:

- Bolton at Home: "*Engage with relevant others where appropriate in the delivery of support interventions";*
- CCG: "*GP practices to encourage all members of a household to register with the same GP practice";*
- BiDAS: "*All three organisations within BIDAS should make greater efforts to work in partnership and to engage external agencies within assessment, risk assessment and review processes".*

8.12 It is therefore recommended that Be Safe Bolton Strategic Partnership takes a particular interest in those single agency recommendations which are intended to address silo working, as silo working limited partner agencies ability to potentially become aware of domestic abuse (see Paragraphs 8.13 to 8.18 below).

Recommendation 1

That Be Safe Bolton Strategic Partnership obtains assurance that the silo working evident in this DHR is addressed effectively by rigorously monitoring the outcome of relevant single agency recommendations.

Absence of focus on domestic abuse by individual agencies

8.13 Scott's history as a perpetrator of domestic abuse was not recent. The relevant recorded incidents had taken place in 1997, 2007 and 2009 (it should be noted that the 2007 incident, although including elements of stalking and harassing behaviour, did not involve an intimate relationship and was therefore not coded as domestic abuse). None of the incidents led to criminal convictions.

8.14 When Scott registered with GP practice 2 it appears that he did not disclose this domestic abuse via the new patient questionnaire and the practice did not appear to access his previous GP records which may, or may not, have included reference to the previous domestic abuse. Scott did disclose the term of imprisonment he had served following his conviction for robbery armed with a knife to BiDAS, but there is no indication that he disclosed the domestic abuse incidents or that BiDAS became aware of them through information shared by his previous substance misuse service. Bolton at Home was aware of the above-mentioned prison sentence served by Scott, but it is not known whether they were made aware of the domestic abuse incidents. The NPS and CRC were made aware of only the 2009 domestic abuse incidents by GMP to inform the assessments they completed following Scott's conviction in August 2014. It can therefore be concluded that BiDAS, GP practice 2, and possibly Bolton at Home were unaware of the previous incidents of domestic abuse and did not perceive Scott to be a potential perpetrator of domestic abuse. Although Scott's known domestic abuse history in respect of intimate partners was quite limited and had not resulted in any convictions (although the absence of convictions is not unusual), this case raises concern that the sharing of information about domestic abuse perpetrators as they transfer from one geographic area to another, and from one agency / service provider to another is far from watertight. This is an issue that Be Safe Bolton Strategic Partnership may wish to be mindful of given the impending introduction of the General Data Protection Regulation (GDPR) which will supersede the Data Protection Act (1998). The GDPR will expand the rights of individuals to control how their personal data is collected and processed. It will place a range of new obligations on organisations to be more accountable for data protection which may result in greater caution being exercised before personal information is shared.

8.15 However, the NPS and CRC were aware of the two domestic abuse incidents from 2007 but these incidents did not sufficiently inform their assessments of Scott. Nor did the NPS or the CRC appear to have noted that Scott committed the 2014 offences which he had pleaded guilty to in company with Michelle. It seems clear that Scott sought to portray himself as a single man to the CRC Offender Manager. It is unclear whether Scott adopted the same approach with the NPS Assessor. The NPS risk of serious harm assessment omitted reference to the domestic abuse incidents in contravention of NPS policy. The CRC Offender Manager omitted to flag Scott's domestic abuse history in contravention of CRC policy. The CRC assessment did not link Scott's attitudes to his risk of offending and harm. The CRC assessed him as at low risk to intimate partners. The CRC Offender Manager became aware of the existence of Michelle quite soon after the assessment but did not appear to query why Scott had presented himself as a single person or to consider this in any way suspicious. It therefore appears that Scott's potential risk to Michelle may have been under estimated in the assessments carried out by the NPS and CRC.

8.16 Whilst Scott was either not perceived by agencies to be a potential domestic abuser, or they assessed the risk he presented to an intimate partner as low, agencies were generally aware that Michelle had previously experienced domestic abuse as a victim. Although Michelle did not disclose domestic abuse when she registered with GP practice 3, the practice did receive her previous GP records which included a reference to domestic abuse victimisation. BiDAS also became aware of the domestic abuse Michelle had suffered when she first registered with them. However, this awareness did not inform the care the GP practice or BiDAS subsequently provided to Michelle.

8.17 GP's are expected to take the opportunity to sensitively question patients about domestic abuse. It appears that Michelle was never asked about domestic abuse by her GP. There may also have been an opportunity for Scott's GP to ask the domestic abuse question of Michelle, or arrange for the question to be asked after Michelle accompanied Scott to see his GP after Scott had attempted to hang himself. (The CCG has advised that a GP would never ask the domestic abuse question of a partner of a patient who had attempted suicide, where the partner was not their patient). As previously stated Michelle's Bolton GP practice has since become an IRIS practice (Paragraph 7.28) as has Scott's which increases the likelihood that, when appropriate, these practices would now enquire about domestic abuse in a safe manner.

8.18 BiDAS never appeared to consider the impact of Scott's mental health on his most intimate relationship after they became aware of his overdose immediately prior to his surgery. Nor did they check on Michelle's wellbeing after Scott disclosed relationship problems to them. These omissions are all the more surprising given the knowledge BiDAS had of Michelle's mental health issues, including previous attempts to take her own life and the impact that family bereavements had upon her in December 2014.

8.19 Scott disclosed to his Offender Manager that Michelle had self-harmed whilst affected by the above-mentioned family bereavements in December 2014, but the Offender Manager took no action. As previously stated, Bolton at Home gave no consideration to the relationship between Scott and Michelle because their exclusive focus was on Scott as a tenant. Scott and Michelle were seen most frequently by staff at Pharmacy 1 from which they were dispensed methadone on a near daily basis. Pharmacy 1 staff perceived their relationship in very positive terms which was the impression that Scott probably wished to create, and which Michelle also appears to have involved herself in perpetuating. Both Scott and Michelle repeatedly talked of the 'fresh start' that their move to Bolton represented. Practitioners do not appear to have

picked up on the gaps which began to emerge between the 'fresh start' narrative and reality.

8.20 There were a number of factors which prevented practitioners even considering whether Michelle could be at risk of domestic abuse from Scott. These included a lack of awareness of his previous history as a domestic abuser; an under estimation of the risk he could pose to an intimate partner; and a lack of professional curiosity over the impact that fluctuations in Scott's mental health, including an attempted suicide, might have on his relationship with Michelle who was known to be vulnerable herself. Indeed, on one occasion, Michelle was perceived by Scott's GP to be a 'protective factor' for Scott. The silo working documented in paragraphs 8.7 to 8.12 resulted in key issues such as Michelle allegedly self-harming and this not being communicated by the CRC to her GP.

8.21 This case indicates a general absence of awareness of, and curiosity about, domestic abuse within a range of professional disciplines. The case also indicates a lack of awareness of specific aspects of domestic abuse including the risk that a suicidal person could present to their intimate partner; the subtlety of coercion and control within relationships which Michelle's mother and Scott's friend appeared to notice but escaped practitioner's attention; and the particular risks victims of domestic abuse who are also substance misusers face.

8.22 It is therefore recommended that Be Safe Bolton Strategic Partnership obtains assurance from the agencies involved in this review about their plans to enhance the awareness of managers and practitioners in respect of domestic abuse, with particular reference to coercion and control;, the potential impact of mental health issues including attempts to commit suicide on the intimate partner of the person affected; and the particular risks experienced by victims of domestic abuse who are also substance misusers. It may also be of value to review public awareness materials in the light of this DHR, as Michelle's family clearly had concerns about Scott's behaviour towards Michelle (described by her mother as having a 'hold' over Michelle) but may not have appreciated that this behaviour could constitute domestic abuse. The review has been advised that Be Safe Bolton Strategic Partnership has initiated such a review as a result of a recommendation from an earlier DHR. It is therefore recommended that the learning from this current DHR also informs the review of public awareness materials.

Recommendation 2

That Be Safe Bolton Strategic Partnership obtains assurance from the agencies involved in this review in respect of their plans to enhance practitioner and management awareness of domestic abuse.

Recommendation 3

That Be Safe Bolton Strategic Partnership develops a case study based on this DHR in order to widely disseminate learning.

Recommendation 4

That Be Safe Bolton Partnership makes use of the learning from this DHR to contribute to their ongoing review of domestic abuse public awareness materials to gain assurance that such materials explain coercion and control in terms the general public can easily understand and relate to.

The response of agencies to Michelle's disappearance.

8.23 The ease with which Scott was able to conceal Michelle's death is a matter of concern. Clearly, Michelle had become isolated after moving into Address 2 with Scott and he appears to have greatly contributed to this isolation by restricting Michelle's movements, limiting access to her family to telephone calls and text messages, and exercising control over their money and decision making generally.

8.24 BiDAS closed Michelle's case without making any enquiries after she did not attend a number of appointments. It has not been possible to definitively establish whether Pharmacy 1 notified BiDAS when Michelle failed to collect her methadone prescription for three consecutive days after she was last seen on 6th October 2015. However, it is assumed that BiDAS must have become aware of Michelle's non-attendance at Pharmacy 1 at some stage because her prescription was cancelled. The absence of any contact by BiDAS with Pharmacy 1 in order to make any enquiries once Michelle failed to collect her prescription and subsequently failed to attend scheduled BiDAS appointments is concerning. BiDAS did not enquire with Scott about what had happened to Michelle, simply accepting at face value his assertion that their relationship had come to an end. As previously stated, BiDAS has advised the Review that, as Michelle was not considered to be a high- risk service user, there was no requirement for them to make enquiries and that it is far from unusual for service users to disengage without warning. The staff at Pharmacy 1 did not share their concerns about how unwell Michelle appeared to be on the last day she was seen alive with her GP or BiDAS or call for an ambulance. These omissions appear consistent with the silo working observed within so many agencies which were in contact with Michelle and Scott. Michelle had not been seen by her GP for several months and when she stopped ordering her fortnightly prescription no action was considered necessary.

8.25 The DWP suspended Michelle's benefits without completing all the checks required or considered good practice in respect of a customer regarded as vulnerable, although these checks may not have highlighted concerns about Michelle's welfare as she had not declared her residence at Address 2. Bolton at Home accepted Scott's explanation that his relationship with Michelle had ended and workers who subsequently attended Address 2 to deal with various maintenance issues did not notice any smell of Michelle's decomposing body which Scott's friend described as "horrible". The GMP Senior Investigating Officer has advised the review that on the date on which Michelle's body was discovered in Scott's flat there was no discernible odour, adding that, in his experience, the smell of decomposition is at its worst in the first few weeks before gradually diminishing as the body mummifies.

8.26 The failure of agencies in contact with Michelle and Scott to enquire about and share concerns in respect of Michelle's sudden disappearance contributed to the delay in discovering Michelle's body. The delay in discovering Michelle's body meant that it was not possible to determine the cause of her death. If Scott did in fact murder her, the delay in finding her body enabled him to evade justice.

8.27 Since this DHR commenced, the commissioning arrangements for pharmacy services in Greater Manchester have changed and BiDAS is no longer the provider of substance misuse services in Bolton. However, the CCG, the new substance misuse service provider, and the commissioners of pharmacy services have begun work on an action plan to ensure improved information sharing between the three agencies in the event of a service user/patient going missing in the future. Be Safe Bolton Strategic Partnership may wish to monitor the outcome of this action plan.

The response of the police to the concerns raised by Michelle's family.

8.28 When Michelle's mother reported the lengthy absence of contact with her daughter to Lancashire Constabulary in October 2016, the early stages of the missing person enquiry were handled unsatisfactorily.

8.29 Lancashire Constabulary's Missing Person Procedure repeatedly stresses the importance of conducting a search of the place where the missing person was last seen. The place where Michelle was last seen was Address 2 which was in a different police force area – Greater Manchester Police – but this does not adequately explain why this important initial step was repeatedly overlooked.

8.30 Several days passed by before Lancashire Constabulary decided to investigate the concerns about Michelle as a missing person. Initial risk assessments gave insufficient weight to Michelle's vulnerability, the risks that Scott, with his well

documented criminal history, could present to her and the increasing likelihood that Michelle had been the victim of a serious crime. The missing person enquiry was reviewed by a series of different supervisors, not all of whom appeared to be completely conversant with the Missing Person Procedure. Whilst 24-hour policing requires different teams to contribute to ongoing enquiries, the missing person enquiry for Michelle may have benefitted from a more consistent approach.

8.31 Enquires gradually disclosed a number of discrepancies in the account initially provided by Scott to GMP which necessitated a further interview. This was a task which required a carefully thought through and co-ordinated plan. Unfortunately, the task was inadequately communicated to GMP who did not progress it with sufficient urgency or ensure that the task was well completed.

8.32 There was a substantial delay in the case being reviewed by senior detective in accordance with the Missing Person Procedure. Once the matter was escalated to senior detectives, the management of the enquiry was much more assured and effective collaboration between Lancashire Constabulary and GMP ultimately led to the recovery of Michelle's body and the arrest of Scott. However, this only took place after quite a lengthy delay during which Scott could have disposed of Michelle's body and frustrated the course of justice still further.

8.33 Lancashire Constabulary has generated a comprehensive action plan in response to this Review. However, Lancashire Constabulary is not directly accountable to Be Safe Bolton Strategic Partnership, so it may be more appropriate for this DHR to be shared with the relevant Community Safety Partnership in Lancashire so that they can receive and scrutinise a future report from Lancashire Constabulary to obtain assurance that the deficiencies noted in the Force's response to this missing person enquiry have all been satisfactorily addressed. It is therefore recommended that Be Safe Bolton Strategic Partnership liaise with the relevant Community Safety Partnership in Lancashire, share this DHR report with them, and request that they then scrutinise any report(s) describing the outcome of the Lancashire Constabulary action plan.

Recommendation 5

That Be Safe Bolton Strategic Partnership share this DHR report with the relevant Community Safety Partnership in Lancashire so that they can obtain assurance that Lancashire Constabulary has satisfactorily addressed the deficiencies this Review disclosed in their handling of the Michelle missing person enquiry.

8.34 Michelle's mother expressed concern about the support provided to her by Victim Support Lancashire following the death of her daughter. In particular, she was

concerned that the Support Worker who contacted her initially was not homicide trained, did not appear to be fully briefed about the details of the case and provided inaccurate advice about the financial support in respect of funeral costs. Be Safe Bolton Strategic Partnership may wish to write to Victim Support Lancashire to draw their attention to Linda's concerns and invite any comments Victim Support may wish to make. Alternatively, the Partnership may wish to share Michelle's mother's concerns about Victim Support Lancashire with the relevant Community Safety Partnership in Lancashire so that they can consider what action to take locally.

8.35 As stated in Paragraph 7.89, Be Safe Strategic Partnership may wish to report the issue of whether or not there was any interruption in Michelle's attendance at Pharmacy 1 to Bolton Council as the local commissioners of the supervised consumption of methadone service in order that they (Bolton Council) can seek assurance about the manner in which the supervised consumption of methadone service is provided by pharmacies. Additionally, as stated in Paragraph 7.89, GMHSCP may wish to reflect on the manner in which they have engaged with this DHR in order to ensure that they communicate clearly with future statutory reviews.

Appendix A -References

(1) Retrieved from https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf

(2) Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

(3) ibid

(4) Retrieved from http://www.dashriskchecklist.co.uk/wp-content/uploads/2016,/09/One-Page-High-Risk-Factor-Definitons-for-Domestic-Abuse.pdf

(5) Retrieved from http://www.irisdomesticviolence.org.uk/iris/about-iris/about/

(6) Retrieved from https://www.adass.org.uk/adassmedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf

Appendix B - Single Agency Recommendations

Bolton at Home				
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**
1	Ensure all operatives report any signs of vulnerability through to appropriate teams	Deliver enhanced safeguarding training (including DAV) to all R&M operatives	Training materials and records	Increased awareness of vulnerability and referral routes
2	Ensure all relevant information regarding relevant others (family/ friends/ partners) is recorded	Include in workflow a 'relevant others' section and include in staff support planning training the need to consider 'whole household/ relevant others'	Relevant others prompt in case view/ workflow	Inclusive robust information and support plans/ Increased awareness/ engagement with relevant others
3	Engage with relevant others where appropriate in the delivery of support interventions	Include in staff support planning training the importance of engaging with relevant others (permission required from client)	Training materials and records	Increased awareness/ engagement with relevant others
4	Ensure cases are closed using a robust process	Re issue new operational guidance to staff regarding case closures	Guidance note	Consistent practice
5	Ensure periodic contacts with other partner agencies for updates.	Revisit training with staff on case notes.	Training materials and records	Consistent practice
6	Review current practice of refusing additional occupants at introductory tenancy stage	Revisit existing practice and review objectives/ risk with a view to amended processes.	Meeting minutes/ processes guidance	Amended practice as appropriate
7	Ensure additional Police checks where offences/ risk is known	Ensure all checks are made to identify risk.	Staff guidance material	Consistent practice

Joint Achieve Bolton and Bolton Clinical Commissioning Group

No	Recommendation	Key Actions	Evidence	Key Outcomes
8	Systems and processes are in place between Bolton pharmacies and GMMH regarding the non-collection of methadone after 3 days.	Achieve Bolton (GMMH) to ensure that a robust procedure is in place with Bolton pharmacies for the communication of missed collection of medications at pharmacies.	Bolton Pharmacies/GMMH to ensure that email is used to communicate this information from Bolton pharmacies to Achieve Bolton. Achieve Bolton has recently issued new service specifications to Bolton Pharmacies relating to supervised consumption. The standard requirement that substance misuse services are notified if service users fail to collect three days of medication is included in the specification (section 20). Monitor progress through future clinical incidents reported through Bolton Achieve and take	Commissioned substance misuse contracts to include a requirement for the recording of communications by GMMH and the dispensing pharmacist. Protocol to be reinforced with local pharmacies by the LPC and NHS England.

			appropriate action and learning. Specific incidents will be reported to the commissioner of the service through contract monitoring and they must have a route for sharing and dissemination. *Service Specification for Pharmacists and Appropriately Qualified and Trained Pharmacy Technicians 2018.* *Supervised Self Administration of Methadone, Buprenorphine, Opiates and Suboxone®*	
9	Substance misuse provider to liaise with pharmacy contractors to ensure effective processes are in place.	GMMH/CCG/LPC/NHS England to ensure that all Bolton pharmacy contractors are aware of the requirements set out in action 1. Bolton Pharmacies must ensure that the procedure for the reporting of missed collections is adhered to at all times.	The use of the electronic recording email system for missed collections for three days will be added to the newly agreed pharmacy specifications: *Supervised Self Administration of Methadone, Buprenorphine, Opiates and Suboxone®*	Addendum will be made to the newly agreed pharmacy specifications for local pharmacies.
10	GMMH to confirm the instruction to cancel or to continue the patient's	Achieve Bolton (GMMH) to ensure that this is written into	This will be actioned by Administration,	A full, auditable record will be available to

	prescription electronically by email enabling any authorised party may see clearly when that message was provided to the pharmacy.	the Standard Operating Procedure (SOP). Email address list of all pharmacies to be created.	Practitioners or Case Managers by replying to the notification of missed collections email that is received from pharmacies.	demonstrate communication between pharmacies and Achieve Bolton.
11	An additional system for messages to be transmitted between pharmacies and Achieve Bolton in relation to concerns for the health and well-being of service users.	Pharmacies will communicate by email to allow identification of the message with a date and timestamp. Dissemination of the above email contact to be circulated to all pharmacies.	The requirement for Bolton pharmacies to contact Achieve Bolton when a service user presents as unwell is included in section 20 of the Supervised Consumption Service Specification 2018. *Service Specification for Pharmacists and Appropriately Qualified and Trained Pharmacy Technicians 2018 Supervised Self Administration of Methadone, Buprenorphine, Opiates and Suboxone®*	Staff will have a better understanding of the benefits of identifying relations / associations between service users and will take this into account during risk assessment and care planning.”
12	Staff should seek to identify relations / associations which may exist between service users in order to acknowledge such relationships in terms of risk assessment and care planning, including assessing the risk of the	Shared learning regarding this DHR, in particular the findings which support this recommendation, to be carried out in staff meetings and staff briefings	Records of meetings and briefings conducted	Staff will have a better understanding of the benefits of identifying relations / associations between service users and will take this into account during risk

	relationship, of each individual to each other and therefore, the risk of DAV			assessment and care planning.”
13	Achieve Bolton will work with GP’s to improve information sharing and develop a clear procedure for the communication of concerns relating to service users.	Achieve Bolton will review the existing local procedures with GP’s in relation to the communication channels between general practice and substance misuse services. Achieve BST communications strategy includes liaison with GP’s in relation to the new Treatment and Recovery Service. Awareness sessions to be included through the CCG weekly learning sessions (North and South) Review of primary care pathways included in wider service action plan.	GP’s will communicate by email to allow identification of the message with a date and timestamp. This contact address will be disseminated through the CCG weekly learning sessions.	Management of specific action plan for the development of Achieve Bolton Treatment and Recovery Service. Monitor progress through future clinical incidents reported to Achieve Bolton and take appropriate action and learning. Specific incidents will be reported to the commissioner of the service and they must have a route for sharing and dissemination.
14	All staff should be encouraged to question the information they receive, validate and clarify to ensure the information they have is accurate enough to inform robust risk assessment and care planning	Development of new GMMH model to include a review of staff training regarding assessment, risk assessment and risk management. Standard GMMH templates within PARIS will be used to ensure consistency and	All staff to undertake GMMH risk assessment training. Supervision documents to evidence encouragement of professional questioning	Effective care planning and risk assessment plans to be in place. Regular audit of assessment and risk assessment through supervision and formal audit.

		accuracy in the collection and evaluation of information. Review of clinical and managerial supervision.		
15	Previous BIDAS Action's - All three organisations within BIDAS (previously commissioned service) should make greater efforts to work in partnership and to engage external agencies within assessment, risk assessment and review processes. All 3 organisations within BIDAS need to demonstrate improved levels of information sharing and joint working	Under the new GMMH lead provider model the entire treatment system in Bolton is currently under review. Previous systems and processes across clinical, case management and PSI elements of the service are subject to a period of significant change relating service delivery which will replicate GMMH's outstanding rated substance misuse services in other areas. As GMMH are the lead provider of substance misuse services there will no longer be three organisations providing care.	A specific action has been drawn up with commissioners and is monitored through a joint steering group and GMMH operational management group. This action plan includes partnership working and engagement with external agencies through the assessment, risk management and case management functions.	Management of specific action plan for the development of Achieve Bolton Treatment and Recovery Service.
16	Previous BIDAS action – Lack of engagement in elements of the service provided by BIDAS should prompt timely intervention and review from Case Management and other areas of the service as appropriate. This should be a joint approach from all 3 organisations	GMMH are now the lead provider for each part of the treatment system. Staff who are providing PSI interventions will ensure that feedback to case managers is given within 24 hours of a service user failing to attend an appointment.	Audit Case records to demonstrate timely feedback and response to lack of engagement	Timely response to lack of engagement from all areas of the treatment system. Improved risk management Improved service user engagement

		Re-engagement planning to be clearly documented in case notes, risk management plans and care plans		

Bolton Clinical Commissioning Group

No.	Recommendation	Key Actions	Evidence	Key Outcomes
		Pharmacy		
17	A more robust additional system for messages to be transmitted between the pharmacy and substance misuse services). This may be by email or other electronic system to allow identification of the message with a date and timestamp. The message may be from a preselected list i.e. patient failed to collect for 3-consecutive days.	To develop pathways.	Copy of pathways	To improve systems and processes between pharmacy and substance services.
		CCG		
18	NHS commissioners seek assurance from providers, Bolton Foundation Trust and GMMH as to the immediate response to a patient disclosing recent suicide attempts and suicidal ideation	To confirm mental health pathways	Copy of specification from GMMH.	To ensure appropriate suicide prevention pathways are in place.
19	GP practices should consider the benefits of obtaining more medical, psychological and social information when patients register	practice managers newsletter – information following the DHR recommends gathering of more information about a	PM newsletter	Patients background will be better understood by their new GP practice following registration

	with their service, although this cannot be mandated as National Guidance precludes this. Consideration should be given as to the pertinence of the social and medical history to on-going care and "Coded" on the significant past history screen in the records accordingly.	patients background on registration		
20	GP and clinical practice staff to enquire regarding suicidal ideation self-harm and risk of harm to self at every contact regarding mental health. GP practices to gain and document a clearer understand of a patient's psychosocial protective and risk factors when assessing mental health.	To be discussed at Governance and Safety Committee CCG. Work planned to refresh GPs knowledge of NICE guidance regarding the management of anxiety and depression in primary care and will also recommend routine enquiry of risk of self-harm and harm to others at every mental health contact. This work will also remind GPs of the importance of biopsychosocial enquiry with patients presenting with emotional health issues.	Minutes of Quality and safety committee – will determine actions for CCG and evidence required. This will include safeguarding audits and GP education. Summary of key points of NICE guidance issued to GPs via PM newsletter.	GPs will improve their assessment of risk and protective factors when consulting with patients with mental health issues. Patients with mental health needs will have those needs met more appropriately.
21	GP practices to encourage all members of a household to register with the same GP practice.	practice managers newsletter – information following the DHR recommends encouraging all members of a household to register at same GP	PM newsletter – sent out in May's safeguarding newsletter.	Patients in one household will access care from the same GP practice

22	GP practices to have a repeat prescribing policy which indicates the frequency of medication review for certain conditions. The Policy should make reference to the cross provider process when a patient does not attend for Methadone prescribing and a practice's action when repeated attempts to contact a vulnerable patient regarding their medication fail and there are concerns about the patient's safety.	Each practice own internal policy	Presentation at clinical leads – feedback to all practices.	GP practices to have a repeat prescribing policy.
23	In particular, where a patient fails to attend for their methadone there should be a liaison between the 3 providers to agree a plan of action to ensure the patient is safe and on-going prescribing is appropriate.	Need to develop a did not attend protocol.	4/5 practices prescribe method. CCG to meet with practices and seek assurance.	To develop a Did Not Attend policy specific to this recommendation.
24	GP practices to continue to engage with the IRIS programme and enquire regarding DAV (in a safe manner) when appropriate.	IRIS is currently being recommissioned by the Local Authority and the new contract requires the provider to continue to deliver IRIS training and advocacy to all 50 GP practices in Bolton and also to act as a conduit for information sharing between MARAC and primary care	Report to be provided by IRIS at the GP Safeguarding Lead Event in January 2018 regarding coverage of training and advocacy and plans for delivery of MARAC information sharing	Continued improvement in GP and their staff's knowledge around DAV. Improved support services for victims within primary care GP practice knowledge of high risk victims to be raised

Cheshire & Greater Manchester CRC

No.	Recommendation	Key Actions	Evidence	Key Outcomes
25	Information Sharing Agreement with GMP regarding Domestic Abuse Call Outs is not functional and reliant on requests from CGM CRC to GMP.	CD1 to liaise with GMP to confirm ongoing arrangements for requesting and supplying DV call out information.	• Information Sharing Agreement in place with GMP.	Receiving regular DV call out information in a timely manner is key to swift risk assessment and management of service users. This protects victims and the public.
26	CRC (Bolton) needs to ensure that all relevant issues identified are communicated to all practice staff.	IM to design and deliver a practice Development / Staff Awareness session to practice staff which summarises the issues of concern raised and ensure that lessons are learned.	• practice Development Input / Presentation materials and associated training exercises.	CRC (Bolton) will have an increased awareness of the relevant issues identified by the DHR process.

Department for Work and Pensions

No.	Recommendation	Key Actions	Evidence	Key Outcomes
27	DWP will look to strengthen the instructions when ESA claims are suspended.	Policy lead to review current instructions and ensure revision covers situations where a claimant has given an alternative address where they could reasonably be traced.	Revised instructions.	Clarity for staff when claims to ESA are suspended.

No.	Recommendation	Key Actions	Evidence	Key Outcomes
28	To disseminate the anonymised details of the case to other NHS Contractors to consider their own operational systems for resilience and response to concerns in relation to Domestic Abuse	Contractors to note the details of the case and to review their own policies, procedures and training. To be completed within the next 12 months and to support the annual Contractor Performance Assurance Framework (CPAF)	Minutes of the decision taken within GMHSCP Confirmation of the case outline and supporting correspondence to NHS contractors	Increased awareness of the risks from domestic abuse, and multi-agency referrals.
29	To update Safeguarding training for community pharmacies that provide Drug and Alcohol services.	This training builds on the existing training provided to community pharmacy on Safeguarding. To be completed within the next twelve months.	Pharmacy contractors will be signposted to Level 2 Safeguarding Training, free of charge, which will be available to all Pharmacists and Technicians and will be further supported by the GM Health Academy	Increased awareness of Safeguarding responsibilities
30	To develop standards for the administration, prescribing and dispensing of controlled drugs by community pharmacy across Greater Manchester	To bring together Providers and Commissioners of Drug and Alcohol services to develop a framework. To be completed in next twelve months	The Controlled Drug Accountable Officer for GMHSCP has identified issues with the administration, supply and prescribing of controlled drugs that require a multi-disciplinary approach to resolve.	Standards developed for notification of non-attendance, pre and post-dated dispensing of prescriptions

Greater Manchester Police

No.	Recommendation	Key Actions	Evidence	Key Outcomes
31	The issues revealed by this IMR in relation to internal and external communication the recognition of vulnerability in missing person cases and prioritisation of FWINS where vulnerability is a factor are to be reported to GMP's Organisational Learning Board for assessment. Relevant learning from that assessment to be disseminated across GMP	1. IMR author to submit a report to the GMP Organisational Learning Board. 2. The Organisational Learning Board will assess the issues raised by this IMR and will disseminate relevant learning across GMP.	1. Submission of a report to the GMP OLB 2. Evidence of assessment and dissemination of learning across relevant departments and divisions in GMP	Raised awareness in GMP in relation to: • Internal and external communication; • The recognition of vulnerability associated with missing person enquiries; • Measures to mitigate further breaches of GMP's graded response policy.

Lancashire Constabulary

No.	Recommendation	Key Actions	Evidence	Key Outcomes
32	Training to Contact Management staff on the importance of correctly classifying incidents from the outset or amending the classification as further information comes to light.	• Training and workforce development resources will be identified and commissioned to carry out training to the appropriate staff • Team Leaders; Sergeants; Inspectors will QA all missing	Missing person logs will be audited to ensure that the policy is adhered to.	Missing Person logs will be correctly risk assessed, graded and reviewed. Golden Hour actions are identified and acted upon, ensuring that all opportunities are identified to locate and trace the missing person.

		person logs, and ensure that incidents are correctly classified from the outset or amend the classification as further information comes to light.		
33	Golden hour tasks required to be undertaken on receipt of a Missing Person's Report to be conducted expeditiously.	• Overt supervision of Missing Person Investigations by supervisors and Missing Person Co-ordinators will ensure that searches will be carried out in all cases when a person is reported missing. • Supervisors will ensure that searches have been conducted in accordance with the policy, and correctly recorded. • This action will be re-iterated in training for all	Audit of Missing persons logs/reports showing that that overt supervision of Missing Person Investigations by supervisors and Missing Person Co-ordinators is being carried out and that the policy is adhered to.	Ensuring the safeguarding of missing persons and gathering evidence to locate the person or ascertain their likely whereabouts as soon as possible to reduce the risk of harm to such persons.

		front line staff and supervisors.		
34	Cross border missing person investigations and more complex investigations be allocated a SPOC on initial transfer.	• Cross-border missing person investigations are now subject to national best practice. • It is intended that this recommendation will be implemented into policy for missing person investigations. • The outcome of the review of missing person's policy and procedures will be embedded into new policy documents • New policy will be implemented into training of all front line staff and supervisors, including Missing Person Co-ordinators who will drive the policy within divisions.	• The existence of new amended policy documents covering cross-border missing person investigations. • Audit of Missing persons logs/reports showing that that new policy on cross-border missing person investigations is being adhered to	Effective communication will take place between police forces enabling them to efficiently co-ordinate cross border investigations into missing persons, reducing the risk of missed opportunities to locate and safeguard missing persons.
35	Full and concise information be gathered upon deployment to a Missing Persons incident.	• The question set used by Corporate Communications Staff in response to calls reporting missing	• Audit of Missing persons logs/reports showing that that overt supervision of Missing Person	The outcome will ensure that more in depth information is obtained relating to the missing person so that investigations are

		persons will be reviewed within the current missing persons review. This will be incorporated within new MFH Policy and Procedures • Investigative skills are part of the training for front line Police Officers. Training will be delivered to Officers to incorporate the findings of the current review into the investigation of missing persons. • IT solutions will ensure consideration to all golden hour tasks is evidenced.	Investigations by supervisors and Missing Person Co-ordinators is being carried out and that the policy is adhered to.	effective in identifying the location of a person reported missing from home and the level of any risks they are subject to.
36	Training be delivered to all staff involved in Missing Person enquiries and this to be tailored to their role. For example-: Contact management, DRU, PC, Sgt, DRI and DI.	Training package to be devised and delivered to all roles connected to Missing Persons investigations.	Training delivered.	All staff will be proficient in their role. Quality of investigations will improve. Effective investigations will be evidenced.
37	Undertake a review of the current procedures to review a missing persons record, taking into account	• Current review of Missing Persons	• Audit of Missing Persons	• Reviews are an integral part of the

	both timescales and role of the reviewer and ensure future IT systems running Missing Persons investigations have the capability to incorporate review timescales tailored to the specific investigation.	Investigations will address and include this recommendation. • The implementation of an IT based Case Management System in Collaboration with Northgate Managed Services Limited which facilitates the automatic highlighting to supervision that action is required on a particular case.	Investigations to show that review timescales are tailored to the specific investigation based upon information known at the time. • IT specification is capable of highlighting to supervision that action is required on a particular case. • The report on the force's review into Missing Person Investigations	missing person investigation procedure. • Effective investigations ensure missing people are located as soon as possible. • Reviews timescales will be tailored to the specific investigation based upon information known at the time.
38	Ensure specialist skills and knowledge are available to Officers undertaking Missing Persons investigations so they can request the correct resource, to aid the investigation. For example-: POLSA; Missing Persons Manager; Digital Media Officer, in order to incorporate specific	• Specialist staff are readily identifiable. • Sufficient training is delivered to these staff. • Specialist staff are readily available for reference.	• Register of staff and skills is available. • Training is delivered.	Investigations that require specialist support are able to utilise them as and when required.

	actions when and where necessary.			
39	The Constabulary to adopt a Missing Persons management IT solution that assists in the delivery of an effective investigation.	• The implementation of an IT based Case Management System in collaboration with Northgate Managed Services Limited which facilitates the automatic highlighting to supervision that action is required on a particular case and provides an effective and practical investigation tool.	Case management system incorporates recommendation.	An unencumbered solution for case management of missing person investigations.
40	Clear ownership of each investigation and an officer in the case allocated to the family	• Each investigation has a dedicated Officer in case. • Training package to all staff involved in Missing persons Investigations to cover assessment of risk. • Families have a dedicated point of contact.	• Ownership of investigation. • Audit of Missing persons Investigations • Training delivered	• Staff members are easily identifiable to each investigation. • There is responsibility for all actions and continuum of enquiries. • Risk is properly assessed. • Effective information

		• IT case management system to incorporate this recommendation.		gathering and recording to influence all decision making and investigation enquiries

National Probation Service				
No.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcomes**
41	A short term piece of work should be undertaken to develop existing practice which ensures that all PSR (pre sentence report) writers in the Bolton NPS Court Team are briefed and reminded of the need and importance of recording all relevant historical information in the ROSH analysis document, regardless of it's inclusion or not within the PSR document	A review of current working practices to develop and reinforce existing policy and practice. This will be completed within an NPS Court Team briefing for PSR writers, following which a 'dip sample' will be completed to monitor this practice.	Confirmation that the briefing has been completed by the NPS Court Team manager (Senior Probation Officer) via the team briefing minutes. A dip sample of 10 ROSH (risk of serious harm) analysis documents completed following the preparation of a PSR, to ensure that all historical information available relating to previously harmful behaviours are included in the ROSH analysis document	Increased awareness of the need to record all relevant historical information in the ROSH analysis document and for this to be evidenced via the dip sample.

42	To improve the focus of ‘Domestic Abuse’ when report writers are preparing sentencing reports, despite the index offence not including any evidence of domestic abuse. To increase professional curiosity when preparing reports in terms of an individuals relationship status.	To complete a training/briefing session with court report writing staff using a case study to help improve awareness regarding professional curiosity in terms of domestic abuse and relationship status.	Confirmation that the briefing has been completed by the NPS Court Team manager (Senior Probation Officer) via the team briefing minutes. A dip sample of 10 reports to be audited 6 weeks following completion of the training/briefing using the case study, with specific focus on relationship status and domestic abuse history.	Increased/improved awareness and professional curiosity with regard to domestic abuse and relationship status when preparing sentencing reports.

Appendix C - Be Safe Bolton Strategic Partnership Multi-Agency Action Plan

Recommendation One

That Be Safe Bolton partnership obtains assurance that the silo working evident in this DHR is addressed effectively by rigorously monitoring the outcome of relevant single agency recommendations.

Key Actions	Evidence	Key Outcomes	Lead Officer
1.1 Review of all relevant Single Agency Action Plans to ensure that they address the themes of silo working and absence of partnership working using SMART principles **1.2** Agree reporting channels to enable Be Safe to effectively monitor progress of the relevant Single Agency Action Plans **1.3** Be Safe Bolton Strategic Partnership Board quarterly meetings to monitor progress of relevant Single Agency Action Plans	• Amended Single Agency Action Plans following review • Progress reports from agencies • Minutes from Be Safe Bolton Strategic Partnership Board Minutes	The specific issues identified within this DHR indicating silo working and the absence of partnership working are effectively addressed so that partner agencies increase their ability to potentially become aware of domestic abuse.	**Nick Maher** **LOCAL SCOPE**

Recommendation Two

That Be Safe Bolton Partnership obtains assurance from the agencies involved in this review in respect of their plans to enhance practitioner and management awareness of domestic abuse.

Key Actions	Evidence	Key Outcomes	Lead Officer
2.1 Develop a Case Study as set out in Actions 3.1 & 3.2 and make available to agencies **2.2** Agencies to identify forums for sharing learning amongst their management and practitioners and inform Be Safe of their plans to disseminate the Case Study **2.3** Use the Case Study to embed the learning into the Multi Agency DA Training provision **2.3** Agree reporting channels to enable Be Safe to obtain assurance of dissemination of the Case Study and effectiveness of learning **2.4** Be Safe Bolton Strategic Partnership Board quarterly meetings to receive reports on dissemination of the Case Study	• Case Study package • Report from DA Coordinator re Multi Agency DA Training • Reports from agencies to Be Safe • Minutes from Be Safe Bolton Strategic Partnership Board Minutes	Agencies will develop an enhanced awareness of, and curiosity about, domestic abuse at both practitioner and management levels especially in relation to the risk that a suicidal person could present to their intimate partner, the subtlety of coercion and control within relationships and risks to domestic abuse victims who are also substance misusers.	**Nick Maher** **LOCAL SCOPE**

Recommendation Three

That Be Safe Bolton Partnership develops a case study based on this DHR in order to widely disseminate learning.

Key Actions	Evidence	Key Outcomes	Lead Officer
3.1 Identify the events which support the findings that there was an absence of focus on domestic abuse within individual agencies **3.2** Develop a Case Study package written in accessible language which delivers key messages with particular reference to coercion and control, potential impact of mental health issues, potential impact of attempts to commit suicide on the intimate partner of the person affected and particular risks experienced by victims of domestic abuse who are also substance misusers **3.3** Use the Case Study as a vehicle for disseminating learning across partner agencies.	• Case Study package	Agencies have access to a Case Study which will provide a foundation for the dissemination of learning to enable partner agencies to enhance practitioner and management awareness of domestic abuse.	**Nick Maher** **LOCAL SCOPE**

Recommendation Four

That Be Safe Bolton Partnership makes use of the learning from this DHR to contribute to their ongoing review of domestic abuse public awareness materials in order to gain assurance that such materials explain coercion and control in terms the general public can easily understand and relate to.

Key Actions	Evidence	Key Outcomes	Lead Officer
4.1 Review content of public awareness materials from Mohammadi and Ahmedi DHR **4.2** Consider relevant learning from Michelle DHR **4.3** Where appropriate revise content of public awareness materials to amalgamate all learning	Report by Be Safe Panel member. Revised public awareness materials where appropriate	**P**ublic awareness materials include particular reference to coercion and control in terms which the general public can easily understand and relate to.	**Nick Maher** **LOCAL SCOPE**

Recommendation Five

That Be Safe Bolton Partnership shares this DHR report with the relevant Community Safety Partnership in Lancashire so that they can obtain assurance that Lancashire Constabulary has satisfactorily addressed the deficiencies this review disclosed in their handling of the FA1 Missing Person Enquiry.

Key Actions	Evidence	Key Outcomes	Lead Officer
5.1 Review of Lancashire Single Agency Action Plan to ensure that it addresses the deficiencies in their handling of the FA1 Missing Person Enquiry using SMART principles **5.2** Agree reporting channels to enable Be Safe to obtain assurance from the Preston Community Safety Partnership that the Lancashire Constabulary Single Agency Action Plan is being progressed effectively **5.3** Preston Community Safety Partnership to monitor progress of the Lancashire Constabulary Single Agency Action Plan **5.4** Preston Community Safety Partnership to provide quarterly reports to Be Safe on the progress of the Single Agency Action Plan	• Amended Single Agency Action Plans following review • Quarterly reports Preston Community Safety Partnership on the progress of the Single Agency Action Plan	Staff awareness of Missing Person Investigation policy will be enhanced so that the correct actions will be taken including classification and grading of incidents, Golden Hour actions, safeguarding considerations, collaboration between police forces in cross border investigations, responsibility and reviews of ongoing investigations, and effective information gathering.	**Nick Maher** **LOCAL SCOPE**

Appendix D

Process by which DHR completed and membership of DHR Panel

The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016).

Individual Management Reviews (IMR) were completed by

- Bolton at Home
- Bolton Integrated Drug and Alcohol Service (now known as Achieve Recovery Service)
- Department for Work and Pensions
- Greater Manchester and Cheshire Community Rehabilitation Service
- Greater Manchester Health and Social Care Partnership
- Greater Manchester Police
- Lancashire Constabulary
- National Probation Service
- NHS Bolton Clinical Commissioning Group

Summary reports were provided by Blackburn with Darwen Council; Blackburn with Darwen Wish Centre; Greater Manchester Mental Health NHS Foundation Trust; and Lancashire Care NHS Foundation Trust.

Michelle's mother Linda contributed to this review as did Sandra who is the Special Guardian of Child 1. The perpetrator – Scott – declined to contribute to the review.

The DHR was overseen by an independently chaired Panel which ultimately approved the DHR Overview Report and submitted it to Be Safe Strategic Partnership.

Appendix E - Membership of the DHR panel

The Domestic Homicide Review Panel consisted of;

Independent Chair and Author	David Mellor	
Be Safe Bolton Strategic Partnership	Tony Kenyon	Neighbourhood Crime and Justice Co-ordinator, Bolton Council
Preston City Council	Alison Hart	Head of Community Safety
Lancashire Constabulary	Det Insp Jane Newton	PPU Development
Fortalice Ltd (DA Services)	Gill Smallwood	Chief Executive
Greater Manchester Police	Det Sergeant DS Alison Troisi	Specialist Protective Services
National Probation Service	Suzanne Earnshaw	Senior Probation Officer
Greater Manchester and Cheshire Community Rehabilitation Company	Joe Long	Senior Probation Officer
NHS Bolton Bolton Clinical Commissioning Group	Kaleel Khan	Specialist Safeguarding Adults Practitioner
Greater Manchester Health and Social Care Partnership	Karen O'Brien	Deputy Medical Director and Controlled Drugs Accountable Officer
Bolton integrated Drug and Alcohol Service (BiDAS) Substance Misuse Service until 15th January 2018	Isobel Mann	Services Manager
Greater Manchester Mental Health FT (GMMH) 'Achieve Bolton' Substance Misuse Service from 15th January 2018	Ann McKernan	Service Manager
Bolton at Home	Gemma Parlby	Head of Support & Safeguarding
Blackburn with Darwen Council	Rebecca Leach	DHR Lead
Administrative support was provided by Marion Griffin, Bolton Council Business Support		

Appendix F - Statement of Independence

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

Since 2006, David has been an independent consultant. He has variously held the role of Independent Chair for Cheshire East Local Safeguarding Children Board (2009-2011); Stockport Local Safeguarding Children Board (2010-2016); and Stockport Safeguarding Adults Board (2011-2015).

Since 2012, he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews; Safeguarding Adults Reviews; and Domestic Homicide Reviews.

David has no current or previous connection to any agency in Bolton.