Manchester Community Safety Partnership

Domestic Homicide Review in the Case of Louise

(Died May 2020, aged 67 years)

Period Reviewed: 1st January 2018 to date of death in May 2020

Final Report

Independent Chair/Author: Maureen Noble

16th September 2022

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1 Introduction

1.1 This Domestic Homicide Review report is about Louise, who died in May 2020. Louise was 67 years old at the time of her death. In April 2021 Louise's son was found guilty of manslaughter and is currently serving a prison sentence. The review panel offer condolences to Louise's family on their tragic loss.

1.2 The people referred to in this report are:

1.3 Louise (Victim – deceased)

1.4 Michael (Perpetrator)

1.5 These are not their real names, but are pseudonyms chosen by the family.

1.6 The period reviewed is from January 2018 to the date of Louise's death. Whilst there were no specific events or agency contacts associated with this start date, the panel chose this period for review as witness statements shared with the review indicated that Michael was experiencing symptoms of mental ill health at this time and had mentioned this to a colleague at work.

1.7 Incident Leading to the DHR

1.8 On a date in May 2020 Greater Manchester Police (GMP) were contacted by Louise's nephew who reported concern for his auntie and his cousin (Michael) as he had not heard from either of them, which was unusual. He had last seen both the previous day and he later told police that Michael had been suffering with mental health issues recently, but when he had last seen him (the day before the incident) he had seemed ok.

1.9 While waiting for the police to attend, he and Louise's brother went to the property and entered via the kitchen door (which was not locked). He looked around the house and on entering the bathroom found Louise's body in the bath.

1.10 He then re-contacted the police and paramedics were called. On arrival at the property paramedics found Louise deceased. She was face down in the bath and when she was moved blood was apparently coming from her face and neck. (Pathology reports later confirmed that this was not Louise's blood) The time of Louise's death was given as 21:15.

1.11 The officers in attendance also found that there was blood staining across the landing, which united Louise's bedroom with Michael's, and also found blood in the bathroom. Two knives were discovered in Michael's bedroom with apparent bloodstaining: one being a Stanley knife (on the bed), the other, a kitchen knife on the top of a chest of drawers.

1.2 Louise's sister last spoke to her at 8.30pm that same day on her landline phone. She had also spoken with Michael at this time. Michael had stated he had felt depressed, and she urged him to see his GP. Family members told police officers that they had been concerned about Michael's mental health recently and that he had said that he wanted to self-harm.

1.13 Police began to look for Michael and at 0912hrs the following day, GMP received a call from a member of the public reporting a concern for a male who was standing next to a bench in a public space. The informant stated he first spotted the male there the previous day and he was still there and appeared to have not moved.

1.14 The description passed to police fitted the description of Michael, and he was subsequently located in the park and arrested on suspicion of the murder of his mother and taken into police custody. He was in a confused state and had superficial cuts to his arms.

1.15 Parallel Processes

1.16 A Post Mortem was carried out and two causes of death were listed

1a Asphyxia

1b Upper airway obstruction and pressure to the neck

1.17 Police Investigation

1.18 When questioned Michael gave a prepared statement to police in which he said that he did not remember anything in detail in the last few days but accepted that it must be true that he had killed his mother.

1.19 He confirmed that he had been very depressed in the weeks and months leading up to the incident, and that he had deteriorated recently. He told police that he had made a call to the Samaritans and searched for help online, although he could not remember this clearly. He said that all he wanted to do was isolate himself. He said he had tried to talk to family members about how bad he felt and that they advised him to pray as they believed in the power of prayer. He said that this wasn't helpful to him and made him feel worse. NB Michael later confirmed this in an interview with the DHR Chair.

1.20 At 2020hrs on 9th May 2020, Michael received a mental health assessment, and was detained under S2 of the Mental Health Act and transported to a local psychiatric hospital for further assessment.

1.21 Between 9th May 2020 and 1st September Michael was detained under Section 3 of the Mental Health Act. Initially he was closely supervised due to a potential suicide risk. However, his symptoms improved following medical treatment. During this time Michael's mental health was being assessed and police were maintaining contact with hospital staff in relation to the criminal investigation.

1.22 On 1st September 2020 Michael was discharged from detention under Section 3 of the Mental Health Act and was transferred to a local prison pending trial, which was scheduled for 17th March 2021. NB There were delays to Michael's schedule trial date due to the Covid-19 pandemic.

1.23 On 26th February Michael offered a plea of guilty to the charge of manslaughter due to diminished responsibility. On 9th April 2021 Michael was sentenced to 6 years 8 months in prison for the manslaughter of Louise.

1.24 At the time of writing this report no inquest has taken place. The Coroner has been updated regarding progress of the DHR and, should it be required for inquest, copy of the DHR report will be provided to the Coroner.

1.25 Pen Picture of Louise

1.26 Louise was 67 years of age at the time of her death. Louise was born in Jamaica. She came to England with siblings and made her home in Manchester. She met her partner in Manchester and set up home with him and their only son Michael. The relationship sadly broke down when Michael was a young child, following which Michael lived with Louise.

1.27 Louise met a new partner when Michael was around 7 years of age. Information provided in a witness statement to police by Louise's partner indicates that the relationship was not permanent and that it had been 'on/off over the years. Louise and her partner did not live together, and her partner did not take on any parental responsibilities for Michael. Her partner did not spend time at Louise's house and said in a witness statement that Louise felt more comfortable at his home which is mostly where they spent time together. Following Louise's retirement three years ago Louise spent more time at her partner's house, probably around once per week. They also kept in touch by phone. From the onset of Covid-19 pandemic (around March 2020) they did not see each other and occasionally spoke on the phone. Louise's partner did not know of Louise's death until he was informed by a member of her family.

1.28 Louise lived close to her siblings, and they were a close and tight knit family who saw each other frequently. Louise's extended family also spent time together and offered each other support.

1.29 Louise had a long-established friendship with a female friend which began more than 30 years ago. Louise's friend had moved away from the local area 26 years ago, but the friendship continued. Louise's friend spoke to her on the phone every month or two, and they took a holiday abroad together in August 2019. Louise confided in her friend that Michael had taken a large amount of money from her bank account and that, although she had given him access, she was upset that he had taken all the money without informing her. Louise's friend last spoke to her at the end of April 2020, when they had talked about the Covid-19 pandemic and life in general.

1.30 Louise's brother told the DHR Chair that Louise was an outgoing and sociable person who was kind and devoted to her son.

1.31 Louise was an active member of the local church and participated in services and church events.

1.32 Pen Picture of Michael

1.33 Michael was 39 years old when he was arrested and charged with the murder of his mother.

1.34 Following the breakdown of his parents' relationship Michael and his mother set up home together.

1.35 Michael and his father were estranged since Michael was around 12 years old. Michael's father maintained contact with Louise, although it appears that they had not been in touch with each other since 2017.

1.36 In a witness statement to police Michael's father said that, as far as he was aware, the relationship between Louise and Michael was 'fantastic' and that Michael looked after Louise.

1.37 Michael lived with Louise throughout his childhood and adult life. Michael confirmed in an interview with the DHR Chair that they had a good relationship and worked together to maintain the home, sharing responsibility for bills, and looking after the house. Michael worked at a local private hospital in a support role.

1.38 Michael was described by his family as a person who kept himself to himself.

1.39 Information provided in a psychiatric report (conducted for the criminal investigation) indicates that Michael suffered from a major depressive illness, and it was likely that he had done so for many years.

1.40 It appears that some members of Michael's family were aware that he experienced problems with his mental health. Some family members encouraged him to seek support from the local church, however Michael did not do so. (He later reported in the psychiatric assessment that he did not feel the church could help him). He also confirmed this in an interview with the DHR Chair.

1.41 He told a colleague at work that he was experiencing mental health difficulties in the form of anxiety and depression. Michael's employer was aware that he was experiencing mental health difficulties and advised him to speak to his GP. Michael confirmed to the DHR Chair that he did not consult his GP regarding his mental health.

1.42 In a statement made to police Michael reported that in the weeks prior to Louise's death his mental health had deteriorated, and he felt that he wanted to isolate himself. Michael continued to work during the Covid 19 pandemic. He told the DHR Chair that during this period he noticed that his mental health was deteriorating. He said that when he was going to work and coming home, he was aware of how strange the world had become and that he felt very isolated and separate from other people.

1.43 Equality and Diversity

1.44 The panel considered the nine characteristics set out in the Equality and Diversity Act 2010[1] and made the following observations.

1.45 The panel noted Louise's gender as a protected characteristic in relation to disproportionate representation of female victims and male perpetrators of domestic abuse.

1.46 The panel also noted that both Louise and Michael are of Jamaican heritage. The panel agreed that the key lines of enquiry for the review should examine the relevance of heritage, in terms of impact on Louise and Michael's daily lived experience, and in terms of services and professional involvement with them.

1.47 The panel also noted that Michael had experienced mental health problems over many years. The panel noted that Michael's cousin provided information that Michael had been diagnosed with clinical depression by his GP in October 2018. The review has found no record of this diagnosis and Michael confirmed to the DHR Chair that he had never sought help from his GP regarding his mental health. The review is also mindful that Michael

[1] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about/equality-and-diversity#our-duties-under-the-equality-act-2010

underwent mental health assessment prior to entering a plea of guilty for manslaughter. Information from the psychiatric report is included in this report.

1.49 Further the panel agreed to involve relevant community and third sector organisations who may be able to assist and inform the review in relation to matters of race and culture.

1.50 The panel also sought expertise from local and regional specialist mental health and domestic abuse services to inform its discussions and conclusions.

1.51 Family Involvement in the Review

1.52 At the start of the review the Chair made enquiries with the police panel representative regarding support to the family and established that a Family Liaison Officer (FLO) had been assigned to the family. The Chair contacted the FLO who provided contact details for Louise's brothers. The DHR Chair also provided written information via the FLO in relation to the requirement for a DHR and further information on the conduct of the review. The family were provided with leaflets produced by AAFDA and the Home Office.

1.53 Louise and Michael were members of a large extended and close-knit family (although Michael was described in a witness statement made to police as an insular man who kept himself to himself and who didn't have a lot to say). Louise's brother and sister lived nearby to her, whilst other family members were in another part of the country. They kept in frequent touch with each other, and Louise saw her brother and sister on a frequent basis.

1.54 The family said that they wished to nominate one of Louise's brothers to act as the key point of contact for the review. The Chair wrote to him to arrange an initial conversation. Included in the letter was further background information on DHR's and a draft of the terms of reference and key lines of enquiry for the review. NB Due to Covid-19 restrictions the Chair was unable to conduct face to face meetings at any time during the review.

1.55 The Chair's first one to one contact with Louise's brother was by telephone. During this conversation Louise's brother said that the family were shocked at what had happened (at this time Michael was still detained under the Mental Health Act and no criminal charges had been brought). He said that the relationship between Louise and Michael had been loving and caring, and that there was never any indication of animosity between them. He said that there was no sign of domestic abuse in the relationship. Louise's brother confirmed that the family had expressed concerns regarding Michael's mental health.

1.56 Louise's brother said that they were happy with the questions posed by the review and that the family would like to be kept informed of progress. The Chair asked if it would be helpful for her to write to Louise's brother again with more detail about the areas of interest for the review. Louise's brother agreed to this. A time was arranged for Louise's brother to ring the Chair to discuss the questions further, however he did not make contact. The Chair sent a text message to Louise's brother to ensure that there weren't any difficulties in making contact, however no reply was received. The Chair then sent a final text message informing Louise's brother that he could re-establish contact by phone, letter or through the FLO whenever he wished to do so.

1.57 Due to the criminal proceedings being delayed (firstly because of Michael being sectioned and subsequently due to delays in processes related to Covid 19) the DHR was pended, and the family were informed in writing that the review would resume once the criminal proceedings had been completed. At this time the family were continuing to receive support from the FLO and were advised that they could contact the DHR Chair directly at any time should they wish to do so.

1.58 In April 2021, following a plea of guilty to manslaughter, Michael was sentenced to imprisonment (as set out above). Michael's sentencing was delayed due to lockdown regulations following an outbreak of Coronavirus in the prison where Michael was remanded.

1.59 Following Michael's sentence the DHR resumed, and the Chair contacted the police FLO to request a meeting with Louise's brother. The Chair telephoned Louise's brother at a pre-arranged time, however there was no reply. The Chair then sent two further messages to Louise's brother advising that he could make contact if he wished to have any further involvement in the review. The Chair did not receive any response.

1.60 A copy of the final draft report was shared with the family prior to submission to the Home Office for quality assurance. The family did not submit any comments for consideration by the review panel, however Michael contacted the DHR Chair via his Offender Manager and asked if he could receive a copy of the report. This request was approved and Michael will be sent a copy of the report when approved by the Community Safety Partnership.

1.61 Michael's Involvement in the Review

1.62 Michael agreed to be interviewed by the Chair of the Review, in the presence of his Offender Manager. The interview took place via a 'Team's link' to the prison where Michael is serving his sentence.

1.63 The Chair asked Michael about his mental health, other aspects of his day-to-day life, his relationship with Louise and any observations that he had about how a tragedy like this could be prevented from occurring in the future. Michael gave permission for key points from the interview to be included in this report.

1.64 Michael said that he had been unable to recall anything about the fatal incident, nor can he remember very much about the few days beforehand. He said that his family members have told him that he contacted the Samaritans, but he doesn't remember anything about the call or the conversation. NB The criminal investigation did not confirm any contact with the Samaritans.

1.65 He also said that he had been told that his employer had suggested to him that he go to see his GP (he had taken some time off work) but he doesn't recall that either.

1.66 Michael said that he had experienced periods of low mood and depression from a very young age. He said that by the time he reached adolescence he had begun to self-harm by cutting, which was a release for his anxiety, rather than an attempt to hurt himself. He said that he had been very aware as a child that his father was not present in his life, although he was known in the local community as Michael's father, which Michael found difficult.

1.67 Michael said that he had always 'bottled up' his feelings rather than talking about how he felt. He said that is 'just the way he is'. He also said that whilst Louise was more able to discuss problems, she tended to just get on with life and accept difficulties, rather than dwelling on them. She would often say 'we just have to get on with it'. He felt her coping mechanism was keeping busy, particularly with housework. He said she was a strong person who didn't ask anyone for anything but would help anyone if they needed her.

1.68 Throughout his adult life Michael said he had experienced periods of low mood and depression. He said that this improved when he was in a relationship, but when that broke down the depression returned, and he began self-harming again. He did not talk to anyone about this. Michael said that he didn't seek any medical help for his mental health as he just expected that it would always be the same. He said he didn't feel there was any point in seeking help.

1.69 He said that his family supported him and that, being a religious family, they believed very strongly in the power of prayer and encouraged him to go to church. Michael said that he didn't feel the same way as them, but that he did read the bible. He felt that the church doesn't always understand the problems that people go to them with, and that there can be a judgmental and stigmatised approach to mental health within both the church and the community. Michael felt that more could be done to educate pastors and others associated with the church so that they can offer help to people without imposing 'conditions' on them.

1.70 Michael said that he knew that bottling up feelings and not seeking help was not good for him. He has had time to think about this and he said he would advise anyone who is having mental health difficulties to talk to someone, although he said that when you are naturally reserved and believe that you shouldn't bother people, this is very difficult to do. He felt that schools have a role to play in encouraging young people, from all cultures, to have the confidence to share their problems and speak out when they need help to do so.

1.71 Michael reflected on his relationship with his mother. He said she was lovely, strong and had always been there to support him. He said they worked as a team and looked after each other; things weren't perfect but 'that is just normal life'. She was a loving, caring mother and he in turn loved her and wanted to care for her.

1.72 Michael offered no insight into what had lead to the fatal incident.

2 Conduct of the Review

2.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004)[2]. This provision came into force on the 13th of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

2.2 This Domestic Homicide Review was commissioned by the Manchester Community Safety Partnership, following a screening meeting held in July 2019. The Home Office were notified and endorsed this course of action.

2.3 The DHR has been completed in accordance with the regulations set out in the Act and with the revised guidance issued by the Home Office to support the implementation of the Act. The Home Office definition of domestic abuse and homicide has been used in this case.

2.4 Following the publication of the Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to "review the effectiveness of the statutory guidance on Domestic Homicide Review"), guidance on the conduct and completion of DHRs has been updated.[3]

2.5 The panel noted the revised definition of domestic abuse to ensure that all aspects of domestic abuse were addressed in the terms of reference and in the reports provided by agencies.

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

- Establish what lessons are to be learned from a domestic homicide, regarding the way in which professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Use learning from the DHR to prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children.
- Draw up and implement a co-ordinated multi-agency action plan that ensures that learning in relation to domestic abuse is acted upon at local, regional, and national level.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

[2]https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004

[3] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

2.7 The rationale for a DHR is to ensure that the review process derives learning about the way agencies responded to the needs of the victim.

2.8 It is the responsibility of the panel to ensure that the daily lived experience of the victim is reflected in its considerations and conclusions.

2.9 Wherever possible and practicable, family and friends of the victim should participate in reviews to enable the panel to gain a deeper understanding of the victim's wishes and feelings.

2.10 The review aims to understand how agencies respond to domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions with an aim to avoid future incidents of domestic homicide and violence.

2.11 Learning from the review will help to improve services to victims of domestic abuse. A multi-agency action plan is appended that sets out the actions that agencies should undertake to improve services to victims.

2.12 Terms of Reference:

1. To establish what contact agencies had with the victim and perpetrator; what services were provided and whether these were appropriate, timely and effective.
2. To establish whether agencies knew about domestic abuse and what actions they took to safeguard the victim and risk assess the perpetrator.
3. To establish whether the victim's family and/or significant others knew about domestic abuse and whether they sought or received help.
4. To establish whether there were other risk factors present in the lives of the victim and perpetrator (e.g. mental health issues, substance misuse, adverse childhood experiences).
5. To establish whether other safeguarding issues (including safeguarding children and/or adults at risk were appropriately identified and acted upon.
6. To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways.
7. To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
8. To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan.
9. To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.
10. To consider specific issues relating to diversity.

2.14 The Panel agreed the following key lines of enquiry:

2.15 KLOE1: Was any agency aware that Louise may be a victim of domestic abuse? If so, what action did they take and how effective was this?

2.16 KLOE 2: Did Louise make any disclosures of abuse to family members? Were family members aware of (or did they suspect) any form of domestic abuse within the relationship between Louise and her son?

2.17 KLOE 3: Did family members ever address concerns regarding domestic abuse with Louise or her son? If not, what were the reasons for this?

2.18 KLOE 4: Did family members seek support or advice in relation to domestic abuse from any agency in the community, third sector or public/private sectors?

2.19 KLOE 5: Were there any barriers in agencies that might have stopped the victim from seeking help for domestic abuse or mental health issues? If yes, what were they and how can they be addressed in the future?

2.20 KLOE 6: What knowledge did the GP have of the relationships within the family that could help the DHR Panel understand what was happening in their lives?

2.21 KLOE 7: Did Michael discuss mental health issues with agencies, family members or community organisations? What was their response?

2.22 KLOE 8: Did Michael discuss drug use with agencies, family members or community organisations? If so, what was their response?

2.23 KLOE 9: Did agencies take account of any racial, cultural, linguistic, faith or other diversity issues when providing services to Louise or members of her family?

2.24 KLOE 10: Are agencies 'culturally competent' in working with people of Caribbean heritage?

2.25 KLOE 11: Are there aspects of diversity/heritage that Louise's family feel needs to be addressed by the review?

2.27 KLOE 12: What is the role of local community-based organisations/services in working with individuals, families, and agencies in relation to cultural competence[4] and responding to diverse communities. How did they respond in this case?

2.28 KLOE 13: Did the Covid-19 pandemic impact on any aspect of the case

2.29 A DHR Panel was established and met on four occasions to oversee the review. The Panel received reports from agencies and dealt with all associated matters such as family engagement, media management and liaison with the Coroner's Office. In addition, the panel liaised with the police Senior Investigating Officer in relation to disclosure of relevant material.

[4] Cultural competence is loosely defined as the ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own

2.30 The Community Safety Partnership appointed Maureen Noble as independent Chair and Author to oversee and direct the Review, and to write the overview report. Maureen Noble was previously employed by Manchester City Council as Head of Crime and Disorder. Maureen left this role in September 2012. She has not been employed in any capacity by Manchester City Council since that time and has worked as an independent consultant since leaving the authority. Maureen has extensive knowledge and experience in conducting DHRs and undertakes pro-bono work with NICE in relation to domestic abuse.

2.31 A panel of senior representatives from relevant agencies was appointed as set out below.

Name	**Role/Agency**
Maureen Noble	Independent Chair and Author
Zylla Graham	Greater Manchester Police
Sarah Khalil	Manchester Foundation Trust
Ian Halliday	Manchester City Council
Leanne Conroy	Manchester City Council
Delia Edwards	Manchester City Council
Advisors to the Panel:	
Priya Chopra	Chief Officer, Saheli Domestic Abuse Service
Charles Kwaku-Odoi	Chief Officer, Caribbean, and African Health Network (CAHN)[5]
Faye Bruce	Chair of the Board of Directors, CAHN
Tom Woodcock	Director, Greater Manchester Mental Health Trust

2.32 The Community Safety Partnership sought information from a range of agencies at screening for the DHR. This screening confirmed that the only agencies that Louise and Michael were known to were their respective general practitioners, who provided chronologies of their contacts which are shown in section 3 of this report.

2.33 Neither Louise nor Michael had any contact with Greater Manchester Police regarding domestic abuse or other matters at any time prior to or during the period being reviewed. Neither Louise nor Michael had any convictions or contacts with criminal justice agencies.

2.34 The review made further enquiries of local non-statutory services, specifically those providing support to victims of domestic abuse and mental health services. On checking their records none had had any contact with either Louise or Michael.

2.35 Although the review heard that Michael told police he had contacted Samaritans he had no recollection of this and it did not form part of the criminal investigation. The review

[5] CAHN is a Black-led organisation set up to address the wider social determinants to reduce health inequalities for people of Caribbean & African in Greater Manchester and beyond. We work with the Black community and cross-sector organisations to build community resilience, relationships, and a social movement to reduce health inequalities. https://www.cahn.org.uk/

has concluded that it is not possible to analyse this event as it is not clear whether this call ever actually took place.

2.36 The Review sought expert opinions from Greater Manchester Mental Health Services (GMMH) in relation to mental health services for Black and Minority Ethnic (BAME) communities.

2.37 The Review also sought expert opinions from a specialist Domestic Abuse Service, Saheli, in relation to possible barriers to Louise seeking support.

2.38 The review was aware that Louise attended a local church and raised this with the family, however the family felt that for reasons of privacy, it was not desirable to contact the local church.

2.39 The Panel therefore sought guidance from the organisation CAHN (Caribbean and African Health Network)[6] in relation to the current and future role and position of faith[7] organisations in supporting victims of domestic abuse and people experiencing mental health difficulties.

2.40 Michael was employed in a support role by a local private hospital. The Chair wrote to the organisation's HR department to seek their involvement in the review. Despite several approaches and contacts with the organisation, they ultimately did not agree to participate in the review.

2.41 Michael was subject to psychiatric assessment under Section 3 of the Mental Health Act. The review was provided with an abridged version of a psychiatric report that had been prepared for the criminal trial. Permission was given by the psychiatrist to reproduce the key findings of the psychiatric review. The findings of this report are provided later in this report.

2.42 Given the very limited agency information available to the review, and the fact that no disclosures of domestic abuse were made or known to Louise's family or friends, the panel decided to invite Michael to contribute to the review. The Chair thanks Michael for his contribution which appears above and throughout this report.

2.43 Information from Witness Statements Seen by the Chair

2.44 Several witness statements had been gathered by police during the criminal investigation. These statements were made available to the Chair of the panel. The panel

[6] CAHN is a Black-led organisation set up to address the wider social determinants to reduce health inequalities for people of Caribbean & African in Greater Manchester and beyond. We work with the Black community and cross-sector organisations to build community resilience, relationships, and a social movement to reduce health inequalities. https://www.cahn.org.uk/

[7] https://www.cahn.org.uk/wp-content/uploads/2019/05/MS-Developing-Health-Literacy-among-Caribbean-and-African-Faith-Leaders-to-Influence-Decision-Making-at-Strategic-Levels.pdf

recognises that witness statements are gathered for purposes related to the criminal case and may not necessarily be factually correct. Based on information provided in witness statements the panel agreed to follow up several contacts as follows:

2.45 The Chair wrote to a close friend of Louise's to ask if they wished to participate in the review, however no reply was received.

2.46 The panel considered a witness statement made by a colleague of Michael's and discussed whether to ask them to participate in the review. The panel noted from the content of the witness statement that the colleagues' association with Michael had been the source of some concern to them and may have impacted their own relationship. It was decided by the panel that to safeguard the colleague no further contact should be made with them.

2.47 As indicated above Michael's employer had become concerned about his mental health and had spoken to him about seeking support (Michael told the DHR chair that he did not recall this). The review made contact with Michael's employer who initially indicated that they may provide information to the review. However, despite several further contacts from the Chair no further response was received by the review.

2.48 There were no other witness statements that the panel felt should be followed up for further information.

2.49 Information from the Psychiatric Report

2.50 The psychiatric report confirmed that Michael had had no previous contact with mental health services prior to being Sectioned under the Mental Health Act. The author of the psychiatric report has given the review permission to include the following analysis and conclusions:

2.51 The clinician's diagnostic view was that Michael suffered with a depressive illness and this was considered to be recurrent in nature.

2.52 The report stated that

'*There is compelling evidence to suggest this was present at the time of the offence and a number of weeks and months prior, with a deteriorating trend.*

Depressive symptoms also seemed to be evident intermittently, at varying levels of severity, for several years from his account. To support this view the following is relevant: evidence on admission of signs and symptoms consistent with a major depressive disorder including biological symptoms of depression concerns expressed by those around him that he was ill and urged to seek help prior to the offence; being unfit to be interviewed by the police and a Mental Health Act assessment which considered a diagnosis of depression with psychotic symptoms as the cause of the abnormal presentation on the day of arrest; text messages and internet searches which corroborate an account of inner turmoil, distress, despair and

decline prior to the offence consistent with an untreated depressed state; and evidence of a response to treatment in an inpatient setting, with a subsequent decline when medication was discontinued followed by improvement when recommenced.

The clinician completing the report concluded 'In my opinion ……. I do not think Michael fulfils the diagnostic criteria for schizophrenia based on the nature and time course of his presentation…….. There is no evidence to support Michael's amnesia being feigned or exaggerated on review of his records and consideration of the clinical picture…… If it is accepted that Michael was more likely than not, experiencing psychotic symptoms at the time of the offence and on arrest, then an abnormality of mental functioning may have substantially impaired his ability to form a rational judgement. It appears to me that this abnormality of mental functioning in isolation would have had more than a trivial impact upon his ability to exercise self-control. It is unlikely it substantially impaired his ability to understand the nature of his conduct based on the information available. …. Michael does have a recognised Mental Disorder within the meaning of the Mental Health Act of 1983 (as amended in 2007), namely a recurrent depressive disorder and his mental illness can be monitored and treated by primary care services.'

2.53 With regard to disclosure of relevant material, the panel liaised with the Senior Investigating Officer in the case to ensure that any new or additional material was made available that may be relevant to the criminal proceedings.

2.54 The review commenced in June 2020 with the final report being submitted to the Home Office QA panel in October 2021.

3 What Agencies Knew

3.1 As referenced in section 1 of this report, Louise and Michael had no contact with any agency other than their GPs in the period under review.

3.2 Between 10th September 2018 and 13th November 2019 Louise had seven contacts with her GP related to her physical health, unrelated to this review.

3.3 On 19th December 2019 at a consultation regarding a medication review at which Louise's blood pressure was raised, Louise was asked by the GP if there was any reason that this may be the case. Louise informed the GP that there was some stress at home as her son had been out of work. However, he had a new job, and this should now decrease.

3.4 The review made further enquiries with the GP regarding this contact. The GP observed that the information from Louise came 'out of the blue'. The GP confirmed that neither Louise nor Michael had ever raised concerns about domestic abuse, nor had Michael ever consulted the GP in relation to mental health issues or issues related to anger or aggression.

3.5 Louise had one further contact with her GP on 15th January 2020.

3.6 There is only one recorded contact on Michael's GP record where on 6th November 2019 Michael asked his GP for a medical summary in relation to a job application.

3.7 Analysis of Contacts

3.8 The panel concluded that both Louise and Michael's General Practitioners provided appropriate services. Neither was aware of, nor saw any indications that may have led them to enquire about domestic abuse.

3.9 On the one occasion that Louise mentioned stress at home related to her son, the GP noted this and made a further enquiry. The review cross-referenced whether a presentation with hypertension would trigger an enquiry under the HARKs prompt and established that it would not. [8] The GP also noted that Louise had said that the stress would improve now that he had another job. It was good practice by the GP to pursue the point with Louise and demonstrates professional curiosity. The GP in question has received IRIS training and has previously made referrals related to domestic abuse.

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[8] The four HARK questions were developed as a framework for helping identify people who have suffered domestic abuse, and found to be a sensitive tool.[12] This stands for:

- **H**umiliation: "In the last year, have you been humiliated or emotionally abused in other ways by your partner?" "Does your partner make you feel bad about yourself?" "Do you feel you can do nothing right?"
- **A**fraid: "In the last year have you been afraid of your partner or ex-partner?" "What does your partner do that scares you?"
- **R**ape: "In the last year have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"
- **K**ick: "In the last year have you been physically hurt by your partner?" "Does your partner threaten to hurt you?"

4 Learning from the Review

NB Due to Louise and Michael's limited contact with agencies, the key lines of enquiry were also addressed with specialist advisors to the review, to ensure that learning in the wider context was captured.

4.1 Learning from the Key Lines of Enquiry

4.2 KLOE1: Was any agency aware that Louise may be a victim of domestic abuse? If so, what action did they take and how effective was this?

4.3 Neither Louise nor Michael's General Practitioner was aware that Louise may be a victim of domestic abuse. There were no indications in Louise's presentations that might have led her GP to make routine or targeted enquiry, although the GP might have considered enquiring further about Louise's report of stress at home.

4.4 KLOE 2: Did Louise make any disclosures of abuse to family members? Were family members aware of (or did they suspect) any form of domestic abuse within the relationship between Louise and her son?

4.5 Louise did not make any disclosures of domestic abuse to family members. Family members told the review that there were no indicators of domestic abuse in the relationship between Louise and Michael. Some family members noted that Michael experienced mental health difficulties but there was no indication that this resulted in domestic abuse in the relationship.[9] NB: It should not be assumed that there is a direct link between mental ill health and domestic abuse. The national charity Safelives notes that there are associations between domestic abuse and mental health issues for both victims and perpetrators.

4.6 A friend of Louise's reported in a witness statement that they were aware that on one occasion Michael had taken a large amount of money from Louise's bank account. It was reported that Louise had told Michael that he could use money from her account if necessary, however she was said to have been upset that he had taken such a large amount without consulting her.

4.7 Michael did not talk directly about this matter in his interview. He did however say that he and his mother shared financial responsibilities.

4.8 KLOE 3: Did family members ever address concerns regarding domestic abuse with Louise or her son? If not, what were the reasons for this?

[9] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

4.9 Family members did not observe, hear about, or perceive domestic abuse in the relationship between Louise and Michael.

4.10 KLOE 4: Did family members seek support or advice in relation to domestic abuse from any agency in the community, third sector or public/private sectors?

4.11 As above at 4.9. The family did not see any need to contact services.

4.12 KLOE 5: Were there any barriers in agencies that might have stopped the victim from seeking help for domestic abuse or mental health issues? If yes, what were they and how can they be addressed in the future?

4.13 The case itself does not indicate any barriers to services. However, the wider context and consultation with advisors to the review, as well as national research, indicate that there are several barriers to some communities accessing services that should be taken into consideration. These are described throughout this report and a recommendation is made in relation to raising awareness of domestic abuse in family and community settings.

4.14 KLOE 6: What knowledge did the GP have of the relationships within the family that could help the DHR Panel understand what was happening in their lives?

4.15 The General Practitioners had minimal contact with Louise or Michael and therefore had little knowledge about their daily lives. On one occasion Louise spoke to her GP in relation to family stresses but said that these had now alleviated because her son had found employment.

4.16 KLOE 7: Did Michael discuss mental health issues with agencies, family members or community organisations? What was their response?

4.17 Until Michael was sectioned under the Mental Health Act no agency was aware that he was experiencing mental health difficulties.

4.18 Family members were aware of Michael's mental health difficulties. Some members of the family advised him to seek support from the local church, however Michael confirmed that he was reluctant to do this.

4.19 In the period immediately prior to Louise's death, one family member advised Michael that he should seek help from his GP.

4.20 Michael disclosed mental health difficulties to a work colleague and to his employer. The review contacted Michael's employer several times to seek their involvement in the review, however, they did not agree to participate in the review.

4.21 The review invited contributions to increase understanding of Mental Health Services from GMMH, a large provider organisation that has developed a programme of building community capacity and developing cultural competency in relation to the provision of mental health services.

4.22 In 2019 The Race Equality Foundation published a report entitled 'Racial Disparities in Mental Health',[10] the review was commissioned by NHS England. The review found that the evidence on prevalence suggests that black and minority ethnic communities are at comparatively higher risk of mental ill health, and disproportionately impacted by social detriments associated with mental illness. The review also found that there is a wide range of different barriers for black and minority ethnic communities accessing mental health care.

4.23 The Foundation has also conducted research into the relationship between race and mental health and concluded that African and Caribbean men are both disproportionately represented in the population entering mental health services via the criminal justice system but are also less likely to recognise their mental health needs and less likely to seek support.

4.24 The panel commends this report as essential reading to guide the development of responses to the mental health needs of BAME communities.

4.25 KLOE 8: Did Michael discuss drug use with agencies, family members or community organisations? If so, what was their response?

4.26 There has been no information provided to the review that suggests that Michael used drugs or alcohol. In interview with the Chair Michael volunteered that he did not use drugs (other than experimenting with cannabis when younger) and that he was not interested in alcohol.

4.27 KLOE 9: Did agencies take account of any racial, cultural, linguistic, faith or other diversity issues when providing services to Louise or members of her family?

4.28 The only agencies that Louise and Michael had contact with were their respective GP's. There is nothing to suggest that support from the GP was not culturally appropriate or competent.

4.29 KLOE 10: Are agencies 'culturally competent' in working with people of African/Caribbean heritage? How do agencies support the implementation of equality and diversity polices in practice?

4.30 As above there is no indication that agencies who had contact with Louise and Michael (General Practitioners) were not culturally competent.

4.31 Further information gathered by the review, not specific to Louise or Michael, indicates that, despite significant focus on developing cultural competence within statutory and non-statutory agencies, involving training and workforce development, there remains a gap in practice. This is particularly apparent in terms of practitioners applying knowledge and skills that impact outcomes for service users.

[10] https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

4.32 The Manchester Safeguarding Partnership has produced guidelines in relation to cultural awareness[11] and Greater Manchester SCB[12] provides an extensive guide to culturally appropriate practice.

4.33 KLOE 11: Are there aspects of diversity/heritage that Louise's family feel needs to be addressed by the review?

4.34 Louise's family did not request that any specific issues be addressed. They expressed the view that provided the review was open and transparent they would be satisfied with the findings.

4.35 KLOE 12: What is the role of local community-based organisations/services in working with individuals, families, and agencies in relation to cultural competence and responding to diverse communities. How did they respond in this case?

4.36 Other than General Practitioners, no other agencies had contact with Louise or Michael; it is therefore not possible to analyse how they might have responded. However, there is considerable evidence of work taking place in the local area to develop cultural competence to address the needs of people from the BAME community who present to services.

4.37 A local organisation, CAHN, was invited to contribute to the review as advisors given their community leadership role in Greater Manchester in relation to health and other social issues affecting members of local Caribbean and African communities. CAHN told the review that, through their work with local communities and organisations, they are aware that there are issues about the availability of racially sensitive, cultural, and religiously appropriate services.

4.38 The DHR was informed that in October 2018 the Chair of CAHN had published a research study supported by the Mary Seacole Trust[13] that concluded that health inequalities in Caribbean and African communities remained a concern and that community leadership, particularly within faith communities, needed to be strengthened. Specifically there needed to be more investment in Black faith leaders so that they are empowered with the tools and resource to improve the health literacy of their congregants.

4.39 CAHN told the review that the small number of local Black organisations mean that they struggle to deliver and to promote their service due to underinvestment, which leaves

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[11] https://www.manchestersafeguardingpartnership.co.uk/resource/cultural-awareness-advice-practitioners/

[12] https://greatermanchesterscb.proceduresonline.com/chapters/g_culturally_appropriate.html

[13] MS-Developing-Health-Literacy-among-Caribbean-and-African-Faith-Leaders-to-Influence-Decision-Making-at-Strategic-Levels.pdf

a small number of Black organisations that are challenged to deliver on evidence-based needs in their communities. There is some community led support but not much, peer to peer support is there but is disjointed. This is also true of helplines. CAHN promotes the national domestic abuse helpline as a means of reducing vulnerability but recognises there are limitations to the usefulness of helplines where other services are not in place or accessible.

4.40 CAHN felt that local people want to use services but that they are not staffed by the people who can relate to the users, e.g. of same heritage. They don't 'see themselves' in the services available and the organisation feels that members of the local community are 'suffering in silence'.

4.41 The organisation felt that there are concerns regarding trust and the cultural and racial sensitivities of the issues (domestic abuse) by the local community and that there was a need to work with other parts of the system, for example the police, to increase community confidence. They concluded that services are not meaningful to the Black community currently.

4.42 The organisation felt that there were not enough services to meet needs and that if people are to come forward for help and support there needs to be fundamental change and greater investment in local services to the BAME community. This also requires investment to focus on equity and fairness in workforce development to encourage Black staff to work in services.

4.43 In relation to the community response to domestic abuse it was felt that a conversation was needed with the Black community about what could make a difference.

4.44 It was noted by CAHN that there is a strong community affiliation with the church, this is a source that needs to be tapped into. Use of the church space. However, the organisation was not confident that the church leadership would know where to go to get help, also an issue of who they would trust. Greater training and financial support and system wide relationship building opportunities for faith leaders in the Black community would be beneficial and hopefully break down barriers.

4.45 In order to gain insight into domestic abuse in BAME communities, the review invited the Chief Officer of Saheli, a local well established domestic abuse charity to provide an overview of the barriers experienced by women from BAME communities to accessing domestic abuse services.

4.46 Saheli informed the review that, although the organisation provides services to women from Asian communities, the issues within other BAME communities were similar and could therefore help to inform the conclusions and recommendations of this review. The review was informed that Issues related to honour, the role of women in the community, religious, cultural and faith issues all provided potential barriers to access. It was noted that a lot of work has been done in Manchester to develop culturally appropriate and competent services, but that there is more work that can be done to improve access to services, particularly involving service users and potential service users in consultation about what

they need from services, and supporting them in participating in service developments, considering other social and cultural barriers experience by some women in BAME communities.

4.47 The review notes that there are several local organisations providing specific domestic abuse services and support to victims of domestic abuse. It may be that there is a need to raise the profile of these services and, whilst it is not the purpose of this review to promote services, the panel felt it important to reference the existence and work of services specifically available to women from BAME communities including Olive Pathway who provide a wide range of services and support (https://www.olivepathway.org.uk/) and the Sahara Project, providing support and services. Sahara Project sits within the Pankhurst Trust and is part of Manchester Women's Aid (https://pankhursttrust.org/get-help/sahara-bame-women). A copy of this report will be provided to these services.

4.48 KLOE 13: Did the Covid-19 pandemic impact on any aspect of the case

4.49 The Covid-19 pandemic impacted on the justice process in this case. Michael's sentencing was delayed due to an outbreak in the prison in which he was remanded.

4.50 The Chair was unable to meet with family members and other agencies due to Covid-19 restrictions and all meetings in the review were held 'virtually'.

4.51 Had Michael decided that he needed to see a GP during periods of 'lockdown', he would not have been able to see GP face to face.

4.52 In relation to whether the pandemic impacted on Michael's mental health, he reported to the Chair when interviewed that his sense of isolation had increased during the pandemic and that he felt 'separate' from other people. He felt his mental health deteriorated at this time.

4.53 Summary of Learning

4.54 There is very little information from agencies in this case as neither Louise nor Michael had contact with services, other than their General Practitioners. The very minimal contact with other health services may be somewhat unusual but may reflect a reticence within the local African and Caribbean community to access services.

4.55 Louise and Michael's family did not observe or perceive any form of domestic abuse in their relationship and had never considered that Louise may be at any risk from Michael, or that they needed to seek advice or support from specialist domestic abuse services. The family did become concerned about Michael's mental health and offered support and advice to him, however, there was never any indication that Michael's mental health issues caused him to abuse Louise in any way.

4.56 Psychiatric assessment and reports confirmed that Michael had experienced mental health difficulties from a young age. Michael confirmed that he had 'lived with' depression and did not think it was worthwhile trying to seek help. He said that he just got on with things. He did not attribute his unwillingness to seek help to any cultural factors.

4.57 The review has been unable to draw firm conclusions about culturally competent practice and the needs of the local BAME community (particularly those of African and Caribbean heritage) from the case itself because Louise and Michael did not present to services, however, specialist advisors to the review advised that more needs to be done to inform, support and develop services to meet the needs of the local BAME community.

4.58 The role of faith leaders and the influence of the church in African and Caribbean communities in Manchester was a recurring theme in the review. The review highlighted the importance of working with faith leaders to ensure that they have access to training and support in matters related to mental health and domestic abuse, and that they can work effectively with a range of agencies to support members of their congregations and the wider community.

5 Conclusions and Recommendations

5.1 The review identified five key themes and has formulated conclusions in relation to each of these themes as set out below:

5.2 Theme 1 Domestic abuse

5.3 In relation to Louise as a victim of domestic abuse from Michael, the review found only one reference to possible economic abuse.[14] This was in relation to Michael taking money from Louise's bank account. The review found no other episodes of possible economic abuse. The panel concluded that there may have been coercion and control and financial impropriety in relation to financial matters, however it should be noted that Louise had given Michael access to her bank account, which he may have misinterpreted.

The information regarding Michael withdrawing a large amount of money from Louise's bank account came from a third party source and was unsubstantiated (as they did not respond to a request to be involved in the review). In conversation with the DHR chair Michael did not confirm or deny withdrawing the money and said that he and his mum helped each other out financially. On that basis the review is unable to draw any conclusions regarding economic abuse.

5.4 Family members commented that Louise and Michael appeared to have a strong and supportive relationship. There were there no indications that Michael had previously been violent towards Louise, however it should not be assumed that he had not.

5.5 Panel members observed that some witness statements made specific reference to Louise not talking very much about Michael in conversation with friends. It would be speculative to suggest that there was anything untoward in this behaviour by Louise, but it did strike the panel as unusual that given the closeness of her relationship with Michael, she avoided questions about him and did not tend to bring him up in conversation.

5.6 Domestic abuse in any form does not appear to have been perceived by Louise's family or friends, nor does Louise appear to have felt the need to make disclosures to family, friends, professionals, or specialist support services about any aspect of her relationship with Michael.

5.7 Michael did not report any form of domestic abuse in his relationship with his mother when he spoke to the DHR Chair. He said they had a loving mother/son relationship.

5.8 Recommendation 1

5.9 As part of the refresh of the local domestic violence and abuse strategy, the CSP should develop a targeted domestic abuse education campaign to the local African and Caribbean community, this should involve community representatives in designing education and support.

5.10 Theme 2 Mental Health

5.11 Michael experienced mental health difficulties over many years. Michael's family were aware that he was experiencing difficulties. Michael never consulted his GP or any other

[14] https://www.co-operativebank.co.uk/values-and-ethics/ethical-campaigns/my-money-my-life/

service about his mental health and no diagnosis was ever sought. (NB It was not until Michael was detained under the Mental Health Act that a diagnosis of recurrent depressive disorder was made).

5.12 Michael's employer demonstrated good practice in speaking to Michael about his mental health and in encouraging him to seek help from his GP.

5.13 Whilst the case itself does not indicate barriers to mental health services, Michael experienced mental health issues for a long period of time without seeking help and support.

5.14 Michael himself said that he had 'normalised' his depressive episodes and therefore did not seek any help. Michael said that there might have been a cultural element to this, in that there is stigma and shame associated with mental health difficulties, but he felt that this crossed all cultures and communities.

5.15 Local and national research would suggest that members of the African Caribbean community may not recognise their own mental health needs and may feel stigma in seeking support from services. Initiatives such as IRIE-Mind[15] have been established to develop services but also to encourage local and national discussion about the mental health needs of the African Caribbean community.

5.16 The national mental health charity MIND has recognised the barriers to accessing mental health services across all groups and communities, and is campaigning to improve access following a review of the Mental Health Act. Their work in relation to the barriers experienced by 'racialised' communities is commended as excellent practice.[16]

5.17 Recommendation 2

5.18 The Community Safety Partnership (CSP) should work with local knowledgeable and creditable organisations to advise and support the development of appropriate domestic abuse and mental health training for BAME organisations, staff, community members and victims.

The CSP should share the findings of this review with local strategic partnerships who have responsibility for commissioning domestic abuse and mental health support services (Local Care Organisations/Integrated Care System Boards).

5.19 Theme 3 Cultural Competence in Agencies and the Workforce

5.20 The review noted that local safeguarding policy and practice is supported by resources to address cultural awareness and cultural competence. However, the review also noted that BAME organisations felt that cultural competence is not embedded in local agencies and that more needs to be done in this area.

5.21 Recommendation 3

5.22 The CSP should work with the local Safeguarding Partnership to develop methods for evidencing the impact on practice of cultural competence training.

[15] https://iriemind.org/about/
[16] https://www.mind.org.uk/news-campaigns/campaigns/

5.23 Theme 4 Leadership in faith communities

5.24 The role of faith and community leaders is seen to be key in encouraging an open discussion regarding topics that have traditionally been 'hidden' e.g. domestic abuse, mental health, and substance misuse. The review noted that there may be an opportunity to learn from organisations such as BCDAF (Black Churches Domestic Abuse Forum)[17] that offer free training and support to faith organisations in relation to domestic abuse.

5.25 Recommendation 4

5.26 The CSP should work with local community and faith organisations to develop a model of training and support (based on BCDAF) to be implemented locally

Appendix 1

Methodology by which DHR was completed

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

Chronologies were provided by the agencies set out above.

The authors of the IMRs had had no prior involvement in the case.

The DHR was overseen by an independently chaired Panel which ultimately approved the DHR overview report and submitted it to Manchester Community Safety Partnership.

Dissemination

It is intended that a copy of the DHR overview report will be shared with all the above agencies and to the following:

Louise's Family
Michael
Manchester Safeguarding Partnership
CAHN
Saheli
The Olive Pathway
Manchester Women's Aid (Sahara Project)

[17] https://www.bcdaf.org.uk/domestic-abuse-and-black-churches-a-research-overview/ **The BCDAF is a group of black Christians, social workers, psychologists, pastors, advocates and academics who are addressing the 'elephant' in our congregations that is domestic abuse. Silence and tacit acceptance of domestic abuse undermines our teachings of love and corrupts the emblem of the church as a place of safety and deliverance.**