Bolton Vision | Be Safe Bolton Strategic Partnership

BE SAFE BOLTON STRATEGIC PARTNERSHIP

DOMESTIC HOMICIDE REVIEW (DHR)

Andrew

Died January 2019

EXECUTIVE SUMMARY

14th May 2024

Chair and Author Paul Sharkey

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Section 1

1. Introduction and Background to the Review

1.1 This report of a Domestic Homicide Review (henceforth referred to as the review) examines agency responses and support given to Andrew; a resident of Bolton, prior to his death in January 2019.

1.2 In addition to agency involvement, which was in fact minimal, the review will also examine the past to identify any relevant background or trail of abuse before the death; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 This review concerns the tragic death of Andrew, a forty-nine-year-old male at the time of his death, and the circumstances of his demise, within the context of possible domestic abuse and violence. Andrew sustained a single stab wound to his chest on a morning in December 2018 following a party at the home (address 2) which he shared with his partner, Gemma in the Bolton area. He was taken by ambulance to a local hospital and treated for his injury. He survived for thirteen days but died in hospital in January 2019. The pathology evidence subsequently established that the cause of death was from a stab wound to his heart.

1.4 Andrew had, prior to his death, been in an eighteen-month relationship (from August 2017) with Gemma, a female in her thirties; albeit they had split up for two months between November 2017 and January 2018.

1.5 Whilst in hospital Andrew told his four daughters (Patricia, Susan, Jane, Mary) that he could not remember the stabbing incident and was unable to give an account of how he had come by his wound. He was twice visited in the hospital by Greater Manchester Police officers prior to his death. He was groggy from his pain medication and stated that he had no recollection of what had happened, saying that his last memory was being at the party. Subsequently, two different narratives emerged accounting for the incident. Gemma told a police officer, on scene shortly after the incident when Andrew was fatally injured, that there had been an argument which had turned into an altercation. Andrew had allegedly gone into the kitchen and on his return was striking himself in the chest with a knife. According to Gemma, her partner's injury was self-inflicted. She was arrested that morning on suspicion of a section 18 wounding (wounding with intent to cause grievous bodily harm) on Andrew.

1.6 Andrew's family (his parents, four adult daughters and brother, Bryan) challenged this narrative and asserted that he was highly unlikely to have stabbed himself. They formed the view that he had been stabbed by Gemma during the altercation and that she had killed him. The family told the subsequent Greater Manchester Police investigation that, in their view, the couple's relationship had been volatile, marked by a history of controlling and violent behaviour directed at Andrew from Gemma. In essence, this narrative characterised Andrew as the victim of domestic abuse, violence and controlling behaviour from his partner. This became the subsequent GMP investigative hypothesis that underpinned Gemma later being charged with the murder of Andrew.

1.7 In furtherance of this narrative, the family and some of Andrew's acquaintances told the police of three incidents when Gemma had allegedly been violent. Two incidents occurred in late 2017 and the third on 30th December 2018.

1.8 Despite the above alleged incidents and the death of Andrew, neither individual had a criminal history of any relevance regarding reported domestic abuse and violence, or any recent involvement with the police, or indeed, of any domestic abuse service. Apart from the occasional

GP attendance in 2018 by Andrew and Gemma, there had been no relevant involvement by either individual with any of the social care and health agencies.

1.9 The ensuing police enquiry sought early investigative advice in March 2019 from the Crown Prosecution Service (CPS). Following subsequent CPS advice, Gemma was re-arrested in September 2019 and interviewed. She said that Andrew had struggled with mental health issues and had previously threatened to kill himself. Gemma was charged with his murder on 7th May 2020 and spent the remaining time, prior to her trial in November 2020, on remand in custody. She was found Not Guilty in late November 2020 after a three-week trial.

1.10 Independently of the criminal process the Bolton Be Safe Partnership decided to commission a Domestic Homicide Review on 7th May 2019. Bolton Be Safe Core Screening Panel determined that the circumstances of Andrew's death fitted the criteria for a Domestic Homicide Review under primary legislation[1] and under paragraph 18 of the Home Office guidance (2016). An independent Chair/Author was duly appointed, and the Review commenced shortly after. However, for various reasons, the Chair's involvement was ended on 17th June 2021 and a new independent joint Chair/Author was appointed in late July 2021. The first panel met on 16th November 2021 and signed off the report in August 2022. Approval was given by the Bolton Be Safe Partnership on the 12 September 2022.

Key Persons

1.11	Andrew (deceased:	Subject of this Domestic Homicide Review
	Gemma:	Partner to Andrew (lived at address 2)
	Child 1:	Gemma's younger child
	Child 2:	Gemma's older child
	Bryan:	Andrew's brother
	Patricia, Susan, Jane, Mary:	Andrew's adult daughters
	Ian and Michael:	Andrew's friends at address 1 (Andrew's house)

2. Review: Purpose and Terms of Reference

2.1 Purpose

As per section 2, paragraph 7, Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; a) to f). See appendix 1

2.2 Terms of Reference

1. Did Gemma perpetrate domestic abuse and violence[2], and/or coercive control on Andrew. Conversely, did Andrew perpetrate domestic abuse and violence, and/or coercive control on Gemma? If so, what was the nature and extent of domestic abuse and violence, coercion and control in the couple's relationship?

[1] Under section 9(3) of the Domestic Violence Crimes and Victims Act 2004 (the 2004 Act) and section 18 of the Home Office guidance. See appendix 1 of this report.
[2] Also known as intimate partner violence

2. If domestic abuse and violence, and/or coercive control was prevailing in the relationship, what was the self-awareness of Andrew and /or Gemma as a victim of domestic abuse and violence or coercion and control?

3. Why was there no agency intervention prior to the death of Andrew?

4. Were there any barriers to reporting domestic abuse and violence, and coercive control? Were there any barriers to the reporting of any concerns, held by the family and friends of Andrew, about domestic abuse and violence or coercion and control within the relationship between Andrew and his partner.

5. What evidence, if any, was there to suggest that Andrew manifested thoughts of suicidal ideation?

6. To what extent, if at all, did substance misuse by either or both partners have an impact on the relationship?

7. Are there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

8. Is there sufficient local awareness of Domestic Abuse and Violence services for males and how to report it?

9. Is there sufficient service provision locally for male victims of domestic abuse and violence?

10. What support is available for anyone contemplating suicide and how easy is it to access?

Scope

a. The timeframe is from August 2017 (the start of the couple's relationship) to January 2019; Andrew's death

b. The DHR will not seek to establish who stabbed Andrew or any culpability issues. These were addressed by the trial.

c. The DHR will not seek to establish how Andrew died; this will be examined by any forthcoming Inquest, assuming one takes place.

d. Attempts will be made to include Andrew's family and friends and his partner in the DHR process.

3. Timescales

3.1 August 2017 to January 2019.

4. Confidentiality

4.1 The contents and findings of this review are confidential, with information being available only to participating officers/professionals and their line managers. It will remain confidential until approved for publication by the Home Office Quality Assurance Panel. Andrew and his partner,

Gemma, have been anonymised to protect their identities, as have family, friends and professionals, in line with data protection and confidentiality regulations.

5. Methodology

5.1 The Bolton Be Safe Partnership commissioned this DHR on 7th May 2019.

5.2 The DHR panel met on four occasions during the review. Terms of Reference, scope and key lines of enquiry were agreed at the first meeting (under the current chair) in November 2021. Andrew's family was encouraged to meet with the author, amongst other things, to contribute to the terms of reference; but signaled that they did not wish to take part in the process of the review.

5.3 The review was informed by.

- Summary reports from the relevant agencies
- All relevant documentation from the Bolton Be Safe Core Screening Panel
- Police documents such as witness statements and mobile telephone scripts
- The Judge's summing up of Gemma's trial
- Government and Home Office strategy and policy documents on Violence Against Women and Girls and Supporting Male Victims of Domestic Abuse and violence.
- Discussions with friends Ian and Gemma
- The use of a 'critical friend' from the Mankind Initiative[3]
- Legal advice from the local authority solicitor (acting as legal advisor to the panel)

6. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

6.1 The author was mindful of the need to involve the family and friends of Andrew and Gemma herself. Letters were sent to Andrew's parents and brother informing them of the decision to hold a DHR on the death of Andrew, what a DHR was, and a request from the Independent Chair/Author to contact them in order to ascertain whether they would like to have some involvement in the review. The letters followed previous contact between the family and the GMP family liaison officer (FLO) to prepare the way for their possible involvement in the DHR process. The family was provided with the Home Office DHR leaflet.

6.2 The issue of advocacy for the family was considered at the beginning of the review, with the National Homicide Service being willing to provide this. This option was made clear to the family in communications to them.

6.3 The family communicated to the Chair/Author that they did not wish to have any involvement with the DHR process, regarding the development of the terms of reference, inclusion of their views on agency involvement, advocacy or any other matter. It was left open to the family to contact the reviewer but to date, no contact has been made.

6.4 The family's decision not to have any involvement in the DHR resulted in the review author being unable to hear and include their views and perspectives on significant events regarding Andrew and Gemma's relationship and time together, in this report.

6.5 Contact was made with Ian, Andrew's friend, with whom he lived with prior to moving in with Gemma in May 2019. Ian very helpfully spoke with the author by telephone in line with his wishes.

[3] The Mankind Initiative is a specialist charity in the UK focussing on male victims of domestic abuse

He did not want to meet directly with the author because he was fearful of the emotional impact of such a meeting. Ian's answers to several e-mailed questions were recorded by the author and then sent to Ian for his approval, which was forthcoming.

6.6 Other friends and acquaintances of Andrew were written to and invited to meet or speak with the author, but no response was received.

6.7 The author met with Gemma in April 2022 to discuss relevant issues with her. Following advice, the Independent Chair arranged advocacy for Gemma via the AAFDA organisation (Advocacy After Fatal Domestic Abuse). The author met with Gemma in early July 2022 to share with her this report, and to gather her responses.

Andrew-A portrait

6.8 According to the trial Judge's summing up, Andrew grew up in a suburb of Bolton along with his brother (Bryan) and parents. There were no other siblings. He had a good relationship with his brother, who described him as a private person not given to talking about his feelings. Others described him as easy going, close to his children and grandchildren, a happy person, houseproud and tidy. Gemma described him as 'bubbly and very energetic and would do anything for anyone'. A work colleague said he was always upbeat and very positive.

6.9 Andrew was married and had three daughters, plus one stepdaughter from another relationship. The parents split up in 1999 but remained close, as Andrew did with his four daughters.

7. Contributors to the Review

7.1 The following agencies provided summary reports[4];

- Greater Manchester Police
- NHS Greater Manchester Integrated Care (Bolton Place) Bolton at Home [5]
- Fortalice[6]
- Endeavour[7]
- Bolton NHS Foundation Trust

8. The Review Panel Members

8.1 The panel meet four times between November 2021 and May 2022 and consisted of the following representatives, all who were independent of line management oversight in this case.

DS Alison Troisi	Greater Manchester Police Serious Case Review Unit
Dr (hc) Gill Smallwood	Chief Executive: Fortalice
Jill Caldwell	Chief Executive: Endeavour
Kaleel Khan	Head of Safeguarding Adults; NHS Greater Manchester Integrated Care (Bolton Place)
Karen Allsop	Head of Support and Safeguarding; Bolton at Home
Dr Ayesha Ali	Greater Manchester Mental Health FT; Forensic Psychiatrist

[4] IMRs were not required because of non or very minimal agency involvement with Andrew and Gemma prior to the former's death.
[5] Formerly, and at the time that the review was conducted, known as Bolton Clinical Commissioning Group (CCG)
[6] Fortalice Ltd is a third sector organisation based in Bolton providing frontline services for people who are, or have been, affected by DAV.
[7] Endeavour is a local third sector agency that provides a range of medium to high DAV services for people and their pets.

Mark Brooks	The Mankind Initiative
Anisa Patel	Bolton Council Children's Social Care

8.2 The review and panel were supported by Mr. Tony Kenyon, DHR Coordinator with Bolton Council Community Safety Services. Ms. Marion Griffin from Bolton Council provided the administrative support. Ms. Angela Hunt (solicitor) of Bolton Council Legal Services, provided legal advice to the panel

9. Author and Chair of the Review

9.1 Mr. Paul Sharkey was the joint Chair and Author of the DHR. He has over thirty years social work experience in multi-agency child/adult safeguarding and public protection services with the Leeds NSPCC and several large local authorities in West and South Yorkshire.

9.2 He has a Master in Public Administration (MPA- equivalent to a public sector MBA) from the University of Warwick Business School (2007) and an M.A in Child Protection Law and Practice (1993) from the University of Keele. He obtained a certificate in strategic management from the Kennedy School of Government (Harvard University USA) in 2001.

9.3 Mr. Sharkey has over twenty years experience in writing and chairing numerous children's Serious Case Reviews (latterly Child Safeguarding Practice Reviews), Adult Safeguarding Reviews and Domestic Homicide Reviews. [8]

9.4 He is independent of all agencies involved in this DHR and has had no previous involvement with any Bolton agency or the Community Safety Partnership (Bolton be Safe).

10. Parallel Reviews

10.1 The criminal trial concluded in late November 2020 with a finding of Not Guilty of murder for Gemma.

10.2 Regarding an Inquest, the review understands that, at the time of writing this report, in August 2022, the local Coroner has not yet decided whether to hold an Inquest.

10.3 GMP undertook a Post Acquittal Review. This was made available to the author who included its contents into this DHR.

11. Equality Issues

11.1 Andrew was an abled bodied forty-nine-year-old male (at the time of his death) of white British background, whose first; and only language as far as is known, was English.

12. Dissemination

12.1 The following individuals and organisations will receive copies of this report.

- Andrew's family, assuming they agree to any further contact
- Gemma
- Be Safe Bolton Strategic Partnership Board
- Bolton Domestic Abuse and Violence Partnership

[8] Over twenty-five reviews

- Bolton Safeguarding Adults Partnership
- Bolton Safeguarding Children Partnership
- Office of the Mayor for Greater Manchester
- Domestic Abuse Commissioner
- All agencies contributing to this review

Section 2

13. Background Information: The Facts

13.1 At the time of the incident when Andrew was fatally wounded in late December 2018, he was living with Gemma and her children at the latter's home (address 2) in the Bolton area. Andrew had been divorced for several years but had four adult daughters with whom he was in regular contact, as he was with his own parents who lived locally. Prior to joining Gemma and her children in May 2018, Andrew had lived at a separate address (address 3) in the Bolton area. Gemma was also from the Bolton area and divorced with two children: Child 1 and Child 2. The couple had been in a relationship for some eighteen months before Andrew's death. Both adults were of White British background and of unknown religion.

13.2 Andrew died in a local hospital in January 2019. The cause of death was a knife stab to the chest sustained in December 2018 at Gemma's home. Both of her children were in the house during the incident but did not witness it, albeit they did see the after effects. There were no safeguarding issues reported at the time and none since[9]. Gemma said that Andrew had stabbed himself during an altercation, however, his family maintained that it was highly unlikely that he had stabbed himself. In any event, Gemma was charged in May 2020 with her partner's murder and was subsequently found Not Guilty in late November 2020.

13.3 The manner and circumstances of Andrew's death are unascertained at the time of writing this report (July 2022). The author is currently unsure as to whether an Inquest into his death will take place.

14. Chronology

14.1 There was minimal agency involvement with the couple during the time under examination. The following table sets out the key events in the couple's relationship and the eighteen months leading up to Andrew's death.

August 2017	Andrew and Gemma begin their relationship
November 2017	(Incident 1); Andrew allegedly stabbed in the leg by Gemma.
November 2017	(Incident 2); The couple split up following an altercation when Gemma assaulted Andrew and damaged his house (address 3). Friends (Ian and Michael) became aware from others and Andrew about the incident.
27th January 2018	The couple reconcile and resume their relationship
April 2018	Gemma attends her GP for physical health problems
May 2018	Andrew moves in with Gemma and her two children
June 2018	Andrew consults his GP for sleep difficulties.
September 2018	The couple take a holiday in Egypt and announce their marriage intentions
December 2018	(Incident 3); Fatal wounding; Following a family party Andrew

[9] The children were removed from their mother's care and placed with a relative. They have since moved back to their mother's care with the agreement of Bolton Children's Social Care.

	is taken to local hospital. Gemma gives her account of the incident to attending police officers. Gemma is arrested.
Early January 2019	Andrew tells his children and police officers he cannot remember what happened
11th January 2019	Andrew dies in hospital
12th September 2019	Gemma is re-arrested
7th May 2020	Gemma is charged with murder
November 2020	Gemma's Trial
26th November 2020	Not Guilty verdict

15. Overview

15.1 There was no agency involvement with Andrew, his family or Gemma (within the relevant timeframe) prior to the incident of December 2018, save for routine GP and hospital contacts.

Definition of Terms

15.2 The Domestic Abuse Act 2021 defines domestic abuse as,

"Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if

(a) A and B are each 16 or over and are personally connected to each other, and
(b) The behaviour is abusive

Behaviour is abusive if it consists of any of the following-

(a) physical or sexual abuse.
(b) Violent or threatening behaviour
(c) Controlling or coercive behaviour
(d) Economic abuse[10]
(e) Psychological, emotional or other abuse

And it does not matter whether the behaviour consists of a single incident or a course of conduct.

15.3 Controlling behaviour[11] 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".

15.4 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". (Home Office, 2016, paragraph 15)

Gender and Prevalence Issues

[10] "Economic abuse", means any behaviour that has a substantial adverse effect on B's ability to -
(a) acquire, use or maintain money or other property, or
(b) Obtain goods or services.
[11] See Home Office, 'Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews', 2016, paragraph 15.

15.5 This review recognises that domestic abuse, violence and coercive control are forms of inter-personal violence mostly inflicted on women and girls by men (Home Office; March 2022, page 11)[12].

'Abuse should also be understood as a cause and consequence of gender inequality, and as a result, it impacts disproportionately on women and girls.' (Home Office, March 2022, 7)

15.6 It can impact at any stage of life on an individual's physical and mental health, damage to self-esteem, confidence, isolation, homelessness and reduces economic circumstance with varying degrees of harm, vulnerability and disadvantage. Over 27% of women had experienced domestic abuse since the age of 16 along with 14% of men. (Home Office; March 2022, 11)[13]

15.7 However, even though it is beyond dispute that victims of domestic abuse, violence and coercive control are predominately female (women and girls) there is a solid body of evidence and research to indicate that men and boys also experience domestic abuse and violence (H.M. Government March 2022; Bates et al, 2019)

15.8 The Office for National Statistics figures show every year that one in the three victims of domestic abuse are male, equating to 757,000 men (1.561m women)[14]. 6.1% of cases discussed at Multi-Agency Risk Assessment Conferences (MARACs) held between April 2020 and May 2021 involved male victims (likely to be an underestimate) with the remainder being female (93.9%). Out of 362 domestic homicides reported between March 2018 and March 2020, 86 (24%) were men (H.M. Government, March 2022) with 76% being female. Of those male homicides, 33 were due to an (ex) partner, 28 of whom were female and 5 males. The remainder of the 86 were from family members.

Government Policy and Key Documents Supporting Male (and Female) Victims

15.9 In recognition of the evidence of the male experience of domestic abuse and violence as victims, the Government has recently published (March 2022) its 'Supporting Male Victims' document (see note 9 below for the full reference). This sits alongside the 'Tackling Violence Against Women and Girls (VAWG) Strategy 2021 (see also, Home Office, 'Violence Against Women and Girls-National Statement of Expectations', March 2022)[15] and the Domestic Abuse Plan 2022 which aims to support all victims/survivors, including men and boys.

Section 3:

16. Conclusions

16.1 In relation to ToR 1

16.1.1 Accounts of the two altercations between the couple in November 2017 and 30th December 2018, together with additional trial and mobile transcript evidence, suggest that the couple's relationship was intense, volatile, insecure, unstable and prone to bouts of verbal and physical abuse.

16.1.2 The was insufficient evidence, on the balance of probabilities, to indicate that Andrew was stabbed by Gemma in late 2017.

[12] Home Office; March 2022; Violence Against Women and Girls Services; Commissioning Toolkit
[13] H.M. Government, 'Supporting male victims of crimes considered violence against women and girls', March 2022.
[14] Taken from the 'Mankind Initiative website (statistics)
[15] This document complements the Home Office commissioning toolkit cited above at note 8)

16.1.3 Andrew was struck in the face by Gemma during the November 2017 incident (2) at his house and can therefore be said (within the legal definition of domestic abuse) to have experienced domestic abuse by way of a physical assault. The incident occurred within the context of Andrew unexpectedly telling Gemma that he wanted to end the relationship. Gemma said that she acted not so much in anger but rather as an immediate emotional response to the situation.

16.1.4 There was negligible evidence to show that Andrew was violent towards Gemma, save in ejecting her from his house during incident 2 in November 2017.

16.1.5 It is noted that incident 2 occurred at a time of Andrew announcing unexpectedly, of his wish to end the relationship. It is well established that incidents of couple separation can heighten the risk of serious harm to the partner instigating the split.

16.1.6 The evidence from incident 3 (the night of 30th December 2018) indicated that there was a significant altercation between the couple.

16.1.7 Set against the legal definition, the evidence does not suggest that the couple's relationship was characterised by coercive control of Andrew by Gemma. There was no evidence to indicate that Gemma experienced coercive control from Andrew.

16.2 ToR 2

16.2.1 The available evidence suggests that neither individual had an understanding and self-awareness of being a victim of domestic abuse, violence and/or coercive control. The instances of verbal and physical (and possibly emotional) abuse seemed to be perceived as part of the volatile nature of the relationship.

16.3 ToR 3

16.3.1 Apart from the three contacts with universal health services, there was no involvement with second and third tier specialist health and public protection services such as mental health, substance misuse or police and domestic abuse and violence services.

16.3.2 A possible reason may have been that the couple's understanding of their volatile relationship seemed not to have been seen by them as existing within mental health or interpersonal violence frames of reference. Both individuals appear not to have seen themselves as, 'victims' of domestic violence/abuse and coercive control, and thus, not to have defined their situations as needing health and public protection solutions. Therefore, neither individual choose to go to the police and other public protection agencies in relation to issues of interpersonal violence, nor sought a GP referral to appropriate support/helping agencies.

16.3.3 There was no evidence that Andrew's friends recommended that he contact the police or an appropriate agency; nor that they contacted or looked for agencies themselves that could help Andrew.

16.4 ToR 4

16.4.1 Male victims of DAV can encounter significant barriers to reporting and receiving support and help, due in part to existing societal beliefs around masculine narratives of male strength, stoicism, self-reliance, shame and embarrassment in seeking help. This includes a lack of recognition (including self-recognition) that men (including LGBTQI+ and BAME males) can be and are victims of domestic abuse and violence.

16.5 ToR 5

16.5.1 There was minimal evidence to indicate that Andrew tried to kill himself, self-harmed or manifested suicidal ideation prior to the stabbing incident on 30th December 2018.

16.6 ToR 6

16.6.1 There was not enough information to establish with any certainty that substance misuse contributed to the couple's volatile relationship. Therefore, it can only be concluded that there was a possibility that substance misuse by either or both partners had an impact on the relationship, albeit it was not possible to determine the level of the impact.

16.7 ToR 7

16.7.1 There were no identified specific issues around the nine protected equality and diversity characteristics that impacted upon Andrew's situation, save, as a male, he was embarrassed to acknowledge being subjected to domestic abuse and not wanting to report this to the police or other domestic abuse agencies.

16.7.2 It is likely that male victims of DAV are under-represented in accessing DAV support services for the reasons given in section 16.4 above. It is also likely that LGBTQI+ and BAME people are under-represented in the DAV service offer.

16.8 ToR 8

16.8.1 There is insufficient local professional and public awareness of DAV services for males and how to report it.

16.9 ToR 9

16.9.1 There is insufficient local service provision for male victims of DAV.

16.9.2 There is a limited service offer, however, it is not well promoted, with limited data regarding the scale of the problem and numbers of males coming forward to the police, public protection, GPs, statutory health agencies and third sector organisations.

16.9.3 The current low numbers of male victims (including LGBTQI+and BAME males) accessing services are unlikely to reflect the real need, which is presently unknown. There is a need to understand how services for male victims are promoted within communities so that the 'hidden victims can start to come forward and access support. The lived experiences of male victims also need to be explored. The gap in knowledge needs to be addressed to inform future multi-agency policy, practice, service design and referral pathways for male victims.

16.10 ToR 10

16.10.1 This question is no longer relevant as there was minimal evidence to indicate that Andrew was prone to suicide ideation.

17. Key Lessons

17.1 There are no lessons arising from ToRs 1,2, 3, 5, 6 and 7.

17.2 Regarding ToRs 4, 8 and 9 appropriate actions need to be taken by the Bolton Be Safe partnership to.

- Increase local community and professional awareness of domestic abuse and violence towards males, including LGBTQI+and BAME males.
- Undertake a needs assessment[16] of service provision for male victims of domestic abuse and violence as part of its VAWG strategy and commissioning in line with HM Government and Home Office, 'Supporting male victims of crime considered violence against women and girls', and 'Violence against Women and Girls (VAWG)', National Statement of Expectations and accompanying Toolkit.

Section 4

18. Recommendations and Action Plan

18.1 The Be Safe Bolton Strategic Partnership (via the Bolton Domestic Abuse and Violence Partnership Board) should take steps to increase awareness across local communities of the domestic abuse and violence of males, including LGBTQI+ and BAME males.

18.2 The Be Safe Bolton Strategic Partnership (via the Bolton Domestic Abuse and Violence Partnership Board) should take steps to increase awareness by local professionals of the domestic abuse and violence of males, including LGBTQI+ and BAME males.

18.3 The Be Safe Bolton Strategic Partnership, via the Domestic Abuse and Violence Partnership Board, as part of the refresh of the Domestic Abuse and Violence Strategy, should undertake a review of the needs of male victims of DAV, including LGBTQI+ and BAME males. This should take account of the Safe Lives Whole System Review and the ongoing work within the Greater Manchester Working Group on male victims of domestic abuse and violence, to ensure they are supported as part of a whole system approach.

[16] In line with two significant pieces of work recently undertaken in Bolton, namely the Greater Manchester Male Victims Working Group and the Safe Lives Review (see appendix 2)

Be Safe Bolton Strategic Partnership – Multi- Agency Action Plan

Recommendation One

Be Safe Bolton Strategic Partnership (via the Bolton Domestic Abuse and Violence Partnership Board) to take steps to increase awareness of the Domestic Abuse and Violence of males across local communities.

Key Actions	Evidence	Key Outcomes	Lead Officer
1.1 Bolton DAV Partnership Board to take account of the Safe Lives Whole System Review on DAV in Bolton and the local system assessment under the Greater Manchester Working Group on male victims of domestic abuse and violence. **1.2** Bolton DAV Partnership Board to coordinate community communications activity and develop a new form of engagement. **1.3** Domestic Abuse and Violence Prevention Strategy to be refreshed, taking into account this recommendation	Safe Lives Whole System Review on DAV in Bolton Bolton system assessment on male victims (Greater Manchester Working Group on male victims of domestic abuse and violence) Minutes from DAV Partnership Board Meetings Domestic Abuse and Violence Prevention Strategy Communications activities	Increased recognition and awareness of signs of Domestic Abuse and Violence to male victims within local communities. More male victims encouraged to report Domestic Abuse and Violence Reduce barriers for males to access DAV services	Head of Community Safety & Neighbourhoods, Bolton Council

Recommendation Two

Be Safe Bolton Strategic Partnership (via the Bolton Domestic Abuse and Violence Partnership Board) to take steps to increase awareness of the Domestic Abuse and Violence of males within local professionals.

Key Actions	Evidence	Key Outcomes	Lead Officer
2.1 Bolton DAV Partnership Board to take account of the Safe Lives Whole System Review on DAV in Bolton and the local system assessment under the Greater Manchester Working Group on male victims of domestic abuse and violence. **2.2** Bolton DAV Partnership Board to coordinate awareness raising activities for professionals. **2.3** Domestic Abuse and Violence Prevention Strategy to be refreshed, taking into account this recommendation	Safe Lives Whole System Review on DAV in Bolton Bolton system assessment on male victims (Greater Manchester Working Group on male victims of domestic abuse and violence) Minutes from DAV Partnership Board Meetings Domestic Abuse and Violence Prevention Strategy Communications activities	Increased recognition and awareness of signs of Domestic Abuse and Violence to male victims by professionals. More male victims encouraged to report Domestic Abuse and Violence Reduce barriers for males to access DAV services	Head of Community Safety & Neighbourhoods, Bolton Council

Recommendation Three

Be Safe Bolton Strategic Partnership, via the Domestic Abuse and Violence Partnership Board, as part of the refresh of the Domestic Abuse and Violence Prevention Strategy, should undertake a review of the needs of male victims of DAV, taking account of the Safe Lives Whole System Review and the ongoing work within the Greater Manchester Working Group on male victims of domestic abuse and violence, to ensure male victims of DAV are supported as part of a whole system approach

Key Actions	Evidence	Key Outcomes	Lead Officer
3.1 Bolton DAV Partnership Board to take account of the Safe Lives Whole System Review on DAV in Bolton and the local system assessment under the Greater Manchester Working Group on male victims of domestic abuse and violence. **3.2** As referenced in the Safe Lives Whole System Review, Bolton DAV Partnership Board to clarify how the safe accommodation offer meets the needs of male victims within the Bolton Safe Accommodation Strategy 2022 - 2025 **3.3** MARAC steering group to track and monitor the percentage of male victim referrals, and to flag to the Domestic Abuse and Violence Partnership Board when and if this falls outside of the recommended range identified in the Safe Lives Whole System Review. **3.4** Domestic Abuse and Violence Prevention Strategy to be refreshed, taking into account this recommendation	Safe Lives Whole System Review on DAV in Bolton Bolton system assessment on male victims (Greater Manchester Working Group on male victims of domestic abuse and violence) Minutes from DAV Partnership Board Meetings Domestic Abuse and Violence Prevention Strategy MARAC data. Bolton Safe Accommodation Strategy 2022 - 2025	Reduce barriers for males to access DAV services	Head of Community Safety & Neighbourhoods, Bolton Council

Appendix 1

The purpose of a Domestic Homicide Review

The purpose of a DHR is to:

a) 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.

b) 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.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

Appendix 2

Greater Manchester Male Victims Working Group

Bolton is a member of the Greater Manchester Male Victims Working Group which was set up to meet the statutory duties under the new domestic abuse bill in ensuring a coordinated approach to supporting male domestic abuse victims across Greater Manchester. The work is being progressed in partnership with Greater Combined Authority, Greater Manchester Police, and other partners, including the Mankind Initiative

Local areas in the working group aim to encourage male victims to come forward, better recognition in both the public and professionals of signs of domestic abuse in male victims, ensuring all agencies work closer together and to improve quality and consistency of support.

As part of this work, Bolton is carrying out a whole system assessment of male domestic abuse support services, including mapping of services, volumes of male victims assessing services, victim referral routes, barriers in accessing domestic abuse services, safer accommodation arrangements, gaps in current male support provision, how best gaps can be addressed, and changes needed around current provision.

Safe Lives Full Review

This review has recently been concluded in Bolton and represents a whole system assessment for all victims of domestic abuse, including male victims. Be Safe is currently planning the next steps in implementing all the recommendations of the review

Bolton's DAV Partnership Board would like to respond to the recommendations from the 'Andrew' Domestic Homicide Review within the broader context of both the Safe Lives review together with the local results of the assessment carried out under the GM Male Victims Group, by ensuring that the findings of the DHR are incorporated into the work that the DAV partnership is progressing and to form part of their strategy and action plan.

The current recommendation requires that the 'whole system assessment' should be in line with the three HM and Home Office documents cited in paragraph 18.3). The Home Office Documents referred to are 1) HM Government and Home Office, 'Supporting male victims of crime considered violence against women and girls', 2) 'Violence against Women and Girls (VAWG)', 3) National Statement of Expectations and accompanying Toolkit.

Since the report was written, the government has now launched the Domestic Abuse Action Plan, and this is now considered to be the primary national policy document that areas need to work towards