EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

relating to the death of Penny

FINAL

on behalf of:

Safer Somerset Partnership

Report author; Liz Cooper-Borthwick

Independent Chair

December 2021

EXECUTIVE SUMMARY CONTENTS

1.0 INTRODUCTION

This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the Safer Somerset Partnership into the unexpected death of Penny. All the names in this review have been anonymised for the purpose of confidentiality.

2.0 OUTLINE OF THE INCIDENT

2.1 **Late October 2019**, the police received a 999 call from Penny's mother who had found Penny dead. The police and paramedics attended. The police considered Penny's death to be non-suspicious. Penny's phone was submitted to the police for analysis following a request from Penny's father around allegations that Tony (Penny's partner) had harassed her days prior to her death. The police analysed the phone but found nothing which would be considered as harassment.

2.2 The post-mortem took place **late October 2019** with the cause of death was defined by the pathologist, but the DHR Panel decided not to include the full details in the report as the anonymity of Penny and the family could be comprised. Toxicology tests were conducted and prescribed sertraline was found in Penny's blood and alcohol consistent with a level of a normal social drinker. The pathologist concluded however it was not possible to comment on the specific effects this may have had on the deceased, or her state of mind, at the time of death.

3.0 DOMESTIC HOMICIDE REVIEW

The review considered the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs), issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and aims to:

a. Establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims.
b. 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.
c. Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d. Prevent future domestic violence homicides wherever possible, through intra and inter agency working.

4.0 TERMS OF REFERENCE

Terms of Reference were agreed by the DHR Panel on March 2020 and were regularly reviewed and amended as further details of the incident emerged (see Appendix One).

5.0 INDEPENDENCE

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with several Serious Case Reviews. She has no connection with any of the agencies in this case.

6.0 PARALLEL AND RELATED PROCESSES

6.1 Inquest

An inquest was held in **February 2020** which determined that the cause of death (Please see paragraph 2.2).

7.0 METHODOLOGY

7.1 The Chair requested proportionate Individual Management Reviews (IMRs) from those agencies identified by the DHR Panel as potentially having contact with Penny and her family (Tony, Sam and Alex). The agencies were provided with a framework and guidance for the process including a chronological account of their contact with the victim and / or the alleged perpetrator covering a period from **1 June 2011 until late October 2019.** This covered the period from when Penny was pregnant with Alex subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events which agencies felt were relevant.

7.2 The Terms of reference detailed the specific areas of enquiry that an agency should consider in their IMR.

7.3 Contributors to the Review

The following agencies submitted IMRs detailing their contact with Penny, Tony and the children

- Avon and Somerset Constabulary (the police)
- Somerset Children's Social Care (CSC)
- Somerset Clinical Commissioning Group (on behalf of the GP)
- Somerset NHS Foundation Trust (a letter, contact out of scope but relevant)
- Somerset Integrated Domestic Abuse Services (SIDAS)
- South Somerset District Council (SSDC)
- Bristol, Gloucestershire, Somerset, Wiltshire Community Rehabilitation Company (BGSW CRC)

The IMRs were completed by senior staff who had no direct management involvement with the family or the incident.

The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

In addition, further information was provided from Sam and Alex's school.
The Independent Chair supplemented the IMR information by speaking with a local specialist drugs and alcohol service, housing professionals and the Crown Prosecution Service.

8.0 PANEL MEMBERSHIP

The Panel consisted of senior representatives from the following agencies:

- Liz Cooper- Borthwick -Independent DHR Chair/Overview Report Author
- Suzanne Harris - Somerset County Council (Public Health and SSP)
- Heather Sparks - Somerset NHS Foundation Trust
- Katia Maggs - Somerset Children's Social Care
- Melanie Munday - Somerset Clinical Commissioning Group
- DI Andy Sparks-Avon and Somerset Constabulary
- Peter Brandt- Bristol, Gloucestershire, Somerset and Wiltshire Community rehabilitation Company
- Leanne Tasker and Katie Bielec – The You Trust (current Somerset Integrated Domestic Abuse Service contracted provider)
- Melanie Thomson- Live West Housing Association (former Somerset Integrated Domestic Abuse Service contracted provider)
- Tim Cook-South Somerset District Council

Contact with family and friends.

Although Penny's family were invited to be part of the review, there was very little contact from them. The family did not want a review to take place. The Independent Chair did update the family on progress of the review, but the family finally stated that they did not want to read the draft DHR report or to receive a final copy.

The Independent Chair spoke with Tony who had been convicted of the offence of common assault and battery against Penny in **April 2019**. Tony was involved in the review as a perpetrator of domestic abuse and the father of Alex.

9.0 SUMMARY OF THE CASE

The DHR Panel received extensive information from the agency IMRs and the DHR panel utilised the SCIE model "Learning Together"[1] to identify the key practice episodes (KPE) in the lives of Penny, Tony and the children.

- **KPE One: Penny's Life before Tony (2001 - 2009)**

Penny suffered intermittent depression and received medical advice and treatment. Information provided highlights that Penny was overspending, in debt and had issues

[1] www.scie.org.uk/children/learningtogether/

with drug and alcohol misuse resulting in guilt and low moods. Police records confirmed that Penny had also experienced domestic abuse with previous partners.

- **KPE Two: Life with Tony and Penny's mental health (2009-2018)**

Penny continued to have mental health issues, had outstanding debts and was struggling to find a home but met Tony and started a relationship in around **2010,** with Alex being born in **2012.** Sam, Penny's child from a previous relationship lived with Penny and Tony. Evidence suggests that Tony and Sam had a difficult relationship which created additional pressure for Penny.

- **KPE Three: Incident of Domestic Abuse - physical abuse by Tony (2019)**.

Early March 2019 Alex called 999 reporting that Penny and Tony were arguing. The police attended and Penny told the police that Tony was struggling with alcohol. A second incident happened a few weeks later in **March 2019** when Tony twice put his hands around Penny's throat. Although Penny could breathe, she was very scared.[2] Tony had to be pulled off Penny by a friend and he was also making serious threats to Sam. Tony was arrested and convicted of Common Assault and battery and was sentenced in **April 2019** to an ORA Community Order[3].
Following the incident and sentence, Penny received support from Somerset Independent Domestic Abuse Service (SIDAS), including support from an Independent Domestic Abuse Advisor (IDVA). The IDVA was supporting Penny with several agencies e.g. housing, legal and liaison with Alex's school.

- **Key Practice Episode Four: Involvement with agencies**

Following the incident in late **March 2019** and the criminal conviction in **April 2019**, several agencies became involved with Penny, Tony and Alex including SIDAS, the Police, Health, Alex's school and Bristol, Gloucestershire, Somerset and Wiltshire Community Restorative Service (BGSW CRC).

Penny was supported by an Independent Domestic Violence Adviser (IDVA) from Somerset Integrated Domestic Abuse Service (SIDAS). The IDVA provided support to Penny especially in trying to secure housing and providing contact with legal services around custody of Alex and finances.

Extensive support was provided by the school for Alex, but Penny was struggling with the child's behaviour at home. It was agreed to proceed with a Team around the Child conference but for several reasons this did not take place before Penny died.

The GP met with Penny who was suffering from some physical issues as well as her continual mental health issues. The GP had not been made aware of the domestic

[2] The offence of non-fatal strangulation is set to be a separate offence DAB06.pdf (parliament.uk)
[3] ORA -Community Order-Offenders Rehabilitation Act - rehabilitation activity requirements

abuse that Penny was experiencing and therefore did not have the “full picture” of the trauma that Penny was experiencing.

Tony was involved with BGSW CRC whilst completing his rehabilitation requirements. The focus of contact was around Tony, how he was coping and about the completion of his rehabilitation requirements.

Although Penny, Tony and Alex were involved with several agencies it would appear that no agencies had a full picture of Penny the victim and her situation. Penny’s mental health was understood by the GP, but they were not aware of the domestic abuse that was taking place in all its forms, physical, emotional and financial. The IDVA was aware of the domestic abuse that Penny had and was still experiencing but did not appear to have knowledge of her mental health issues.

The Police did attend several incidents between Penny and Tony, but they were unaware of any mental health issues that Penny may have been experiencing.

- **KPE Five: Escalation of emotional abuse by Tony relating to custody of Alex.**

There is evidence to identify that Tony continued to control Penny and the situation via threats around custody arrangements for Alex and finances relating to the sale of the family home. Tony would say that “Penny was a bad mother” and Alex was struggling with what had happened between Penny and Tony.

Late September, Penny phoned the police as Tony had turned up at her house to see Alex and he was verbally abusive to Penny. Tony disclosed to the school that he wanted Alex to live with him and that Alex was not getting on with Penny. When the school informed Penny about the disclosure she said that Tony was filling Alex’s head with the nonsense about her. Penny was also worried that if Alex went to see Tony, he would not return Alex home.

Late October 2019, Tony called the police reporting that Alex had called him from Penny’s house claiming to have been assaulted by Penny. Tony said that when he went to collect Alex, Penny was intoxicated. The police call handler assessed that there were no immediate safeguarding issues as Alex had been removed by Tony and it was agreed that Alex could remain with Tony overnight. The following day, the police considered suitable lines of enquiry including liaison with Somerset Children’s Social Care, interviews with those present at Penny’s house and if appropriated to conduct an Achieving Best Evidence interview with Alex.

- **KPE Six: Death of Penny (Late October 2019)**

Three days after this incident, a 999 call was received from Penny’s mother who had found Penny dead.

10.0 KEY ISSUES ARISING FROM THE REVIEW.

The review identified several instances which may have contributed to Penny's unexpected death.

10.1 Information Sharing.

As found in many DHR reviews, gaps in information sharing prevented a whole picture of what was happening with Penny and the family being visible, the smallest piece of information can make a difference in judging risk and decision making. Penny and the family were involved with several agencies but the GP who was fully aware of Penny's long history of depression and anxiety was not made aware of the domestic abuse incidences that had happened between Penny and Tony and therefore was not able to provide further support or highlight to agencies the risks around Penny's mental health.

10.2 Lack of Understanding by professionals (and the wider community) of Coercive Controlling Behaviour.

Despite controlling and coercive behaviour being embedded in domestic abuse legislation, it is the least understood aspect of domestic abuse by professionals and the wider community. In the last few months of Penny's life, she experienced control by being undermined by Tony ("you are a terrible mother"), economic abuse about the family home and manipulation around custody of Alex. Professionals do not always use professional curiosity to explore the wider aspects of domestic abuse and if they can understand all aspect of abuse that a victim is experiencing, it enables better risk management and support for a victim.

10.3 Trauma informed approach to Domestic Abuse.

Professionals sometimes look at incidents of domestic abuse in isolation from what else a victim is experiencing. It does not allow professionals to build up a complete life story of a victim and shift the approach from "what's wrong with this person" to "what has happened to this person". Penny, in common with many other domestic abuse victims, experienced a series of events which were physically and emotionally harmful. Penny had experienced depression and anxiety for several years, she had experienced domestic abuse with several partners and was "homeless" following the ending of her relationship with Tony. If professionals can understand and implement a trauma -based approach[4] to supporting victims of domestic abuse it will provide a more coordinated response.

10.4 Professional Curiosity and understanding the need of the victim.

[4] Trauma-informed approach to DA Trauma informed work: the key to supporting women | Safelives

No single agency had a complete picture of Penny and her needs. The police responded to incidents following policy and procedure, the GP knew about Penny's mental health issues, SIDAS understood the controlling coercive behaviour that Penny was experiencing following her separation from Tony, and Alex's school had a vast amount of information about the family dynamics, but no agency had a complete picture. Evidence also showed that Tony was influencing Alex following the breakup with Penny. If professionals had been more curious, they may have been able to review the risks relating to Penny and Alex and provided more support.

Somerset Safeguarding Adults Board has produced a guidance document about professional curiosity, and this is a useful tool for the police, GPs, local authority housing departments and other professionals involved with families who need support.

10.5 Risk and Impact of Separation of Children and the Victim:

There is no doubt that Penny loved Sam and Alex. When Sam went to live with the birth father this would have impacted on Penny and Alex. Evidence shows that Tony used custody rights to control the situation between himself and Penny. Following the incident in late October 2019 when Penny allegedly hit Alex, Penny may have been very fearful of losing Alex. Three days later, Penny died.

Research identifies that parents often find it hard to seek support from Children's Social Care through a fear of being stigmatised. Several council children's social care services are now operating a Family Safeguarding model which focusses on the following:

- Working in partnership with families instead of 'doing to' families
- Enabling children to stay with their parents and their wider family.
- Enabling families to develop their own care plan to address their child's needs.

Somerset CSC implemented such a model in late 2020.

10.6 Impact of Children living with domestic abuse.

Although the TOR did not identify the children as a key line of enquiry, this review has given a detailed insight into the life of a child in a home where there is domestic abuse. This review may help professionals in schools when dealing with families and issues in the future. There is evidence to identify that Alex started to self-harm and "play up". Research shows that domestic abuse can have a devastating impact on children and young people which can last until adulthood including having flashbacks, becoming anxious, depressed and becoming aggressive. If professionals working with families have tools to listen and interpret the voice of the child, it could enable the whole family's needs to be better supported.

10.7 Post Review learning

- The updated DHR Statutory Guidance December 2016 advises that a DHR should be undertaken where someone has died unexpectedly in circumstances where there are concerns about domestic abuse, including controlling coercive

behaviour. The process is about learning and not blame. However, some families struggle to understand why a DHR is required as there was no homicide[5]. The family felt the terminology was unhelpful. In the only telephone conversation with Penny's father, he was angry that such a review was taking place as the family had just started to move on and come to terms with Penny's death. The process brought it all back.

Penny died in **late October 2019**, the family were not aware of the review until April 2020 when the Independent Chair contacted them to introduce herself and give information around the DHR process.

The Home Office Guidance is that a family should be contacted in the first instance by the Community Safety Partnership once it has agreed that a homicide/unexpected death meets the criteria for a DHR. It was noted by the Panel that the Safer Somerset Partnership should action the early learning and implement the process whereby they are responsible for contacting a family as soon as it is agreed to carry out a DHR.

- Following the death of Penny, Alex's school offered a comprehensive support programme not just for Alex but also Tony, including bereavement counselling for them both. Monthly support meetings have continued between the school, Alex and Tony for the past year which has helped, especially for Alex, to navigate grief, memories of Penny and life events such as birthdays and the anniversary of Penny's death.

It would be of benefit for the school to share the experience of supporting a child and the family following the death of a parent with other schools, via safeguarding training and the Safer Somerset partnership.

11.0 CONCLUSIONS

11.1 Penny's death was unexpected. Although Penny had attempted to take her own life many years earlier, she never spoke to professionals about her feelings, anxiety and depression in the last six months of her life. Penny was trying to arrange custody of Alex, finding a home for them both and trying to resolve financial issues. Penny engaged with professionals and was trying to carry out all she needed to do to get additional support and guidance.

11.2 *O*ne of Penny notes written in late July 2019 highlights the anxiety and despair that Penny appears to have been experiencing.

"*I am still in love with him, but the worst thing is our daughter would rather be with him and his new girlfriend playing happy families, this really hurts, and I feel as though I have lost a son as well and now for what. I hate my life at this moment".*

[5] Homicide the killing of one person by another - Oxford Dictionary of English

11.3 There is no doubt that Penny would have been devastated about the allegation of her assaulting Alex on 24 October 2019 and evidence stating she had been drinking. Following the incident, Penny may have considered that the impact of this might have on her having custody of Alex. Penny took her own life three days later having written notes for her children and parents.

11.4 The Review has identified the tragic cost of domestic abuse including coercive control and mental health issues. The agencies involved with Penny did not appear to consider Penny's mental health (the bigger picture). If Penny's GP had been aware of the domestic abuse incidents in March 2019, there may have been some further interventions which could have supported Penny.

11.5 Penny's notes detailed how fragile she was, but she was also trying to resolve many issues, finding a home for her and Alex, seeking financial support, getting a new job, trying to resolve custody around Alex whilst experiencing some elements of coercive control from Tony e.g., undermining, harassment and verbal abuse.

11.6 When abusive relationships are breaking down or when partners separate, there can be an increased risk of serious harm. Many professionals are aware of the risks, but this review also highlights the potential risk of losing a child through custody. Professionals need to consider the safeguarding risks to the parent and in future provide appropriate support.

11.7 Penny did receive support from specialist domestic abuse services, Alex's school, housing, her GP and the police but not all agencies fully understood what had happened and was ongoing in Penny's life, and therefore there was not a fully coordinated approach to the support that Penny received. The police, SIDAS and Alex's school were not aware of Penny's long history of mental health issues and the GP was not aware of the domestic abuse that Penny had suffered and was still experiencing including coercive controlling behaviour, being told she was a bad mother, using custody and finances to control and undermine Penny.

11.8 It is imperative that agencies work together to ensure that they fully understand the issues the person is experiencing and to understand what has happened in the past. This will enable professionals to "know the victim" better and enable the essential support they may need.

12.0 RECOMMENDATIONS

The following recommendations have been arrived at using a range of information sources:
IMR recommendations / learning from the Review / the Review Panel's discussion and deliberations.

The recommendations are regularly monitored by the Somerset Domestic Abuse Board a sub- group of Safer Somerset Partnership.

1. Training Local

Recommendation One

The Safer Somerset Partnership will provide a minimum curriculum and training for all staff working with vulnerable adults, children and families. This will include provides an in depth understanding of DA, including controlling, coercive behaviour, a trauma-based approach of supporting victims suffering DA, an understanding of the links between mental health issues, substance abuse and domestic abuse, professional curiosity, timeliness of interventions and the impact of the Domestic Abuse Bill 2020.

Ownership: Safer Somerset Partnership.

Recommendation Two

The Safer Somerset Partnership to seek assurance from public health (local) that all schools(state and private) are promoting Personal Social Health and Economic (PSHE) policies which support children living with DA to for all to understand healthy relationships.

Ownership: Safer Somerset Partnership

Recommendation Three

The Safer Somerset Partnership to request that Somerset District Councils include mandatory Induction Safeguarding training (including domestic abuse) for all front-line staff.

Ownership; Safer Somerset Partnership and Somerset District Councils Human Resources Dept.

2.Information Sharing/Referral Process

Recommendation Four

Safer Somerset Partnership and Somerset Safeguarding Children Partnership should consider whether a regional approach to domestic abuse notifications should be developed in collaboration with Avon and Somerset Strategic Safeguarding Partnership.

Implement a partnership approach to share information and analyse the needs of children living with domestic abuse.

Ownership: Chair of Partnership Business Group, Somerset Children partnership / Safer Somerset Partnership.

Recommendation Five

To review the Somerset CCG Domestic Abuse Information Sharing project between Police and Primary Care (GPs) during COVID-19 Pandemic 2020. Investigate its wider implementation.

Ownership: Avon and Somerset Police and Somerset CCG

3. Housing

Recommendation Six

The Safer Somerset Partnership to promote a Whole Housing Approach[6] to housing providers to enable the housing sector to improve housing options and outcomes for people experiencing domestic abuse, so they can achieve stable housing, live safely and overcome the abuse and its harmful impact.

Ownership: Safer Somerset Partnership - Somerset Strategic Housing Officers

4. Other Local

Recommendation Seven

Agencies to implement the recommendations identified within their IMRs and provide an update report to the Safer Somerset Partnership on a quarterly basis.

Ownership: The Safer Somerset Partnership and all agencies included in this report.

Recommendation Eight

Safer Somerset Partnership to review how it informs families of the deceased that a Domestic Homicide Review will take place. This will include protocols for homicides and unexpected deaths.

Ownership: Safer Somerset partnership

5. National

Recommendation Nine

Safer Somerset Partnership to request the Home Office consider updating the Multi-Agency Statutory Guidance for a Conduct of a Domestic Homicide Review 2016 to include specific guidance where a person may have taken their own life. This review to include recommended terminology to replace the DHR use of

[6] Whole Housing Approach www.dahalliance.org.uk

homicide/victim/perpetrator to make it more transparent to a family why a review is required.

Ownership; Safer Somerset Partnership

APPENDIX ONE
TERMS OF REFERENCE FOR REVIEW PANEL
DHR 028

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Penny. The death is believed to be suicide and is within the statutory parameters for a DHR because the deceased was understood to be up until her death in a domestically abusive relationship with her estranged husband.

1.2 All other responsibility relating to the review commissioners (The Safer Somerset Partnership) will be the collective responsibility of the Partnership namely:

- any changes to these Terms of Reference
- the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death on late October 2019 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

2.2 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.

2.3 To produce a report which summarises concisely the relevant chronology of events including:

- the actions of all the involved agencies.
- the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they have experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate:

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence, abuse homicide, and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from 01.06.2011 to late October 2019 (this is intended to cover the period from when Penny was pregnant with her youngest child) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews from each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events, taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- To consider the risk and impact on the separation of children and the victim
- Determine if there were any barriers Ms White or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a Review Panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. *(Consider Home Office leaflet for family members, plus statutory guidance (section 6).*
- Determine brief of, co-ordinate and request IMRs.
- Review IMRs – ensuring that they incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a Review Panel meeting to review IMR responses.
- Write report (including Action Plan) or appoint an independent overview report author and agree contents with the Review Panel.
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	**Representative**
Independent Chair	Liz Cooper
Avon and Somerset Police	DI Andrew Sparks
Children's Social Care (SCC)	Katia Maggs
Clinical Commissioning Group	Mel Munday
Community Rehabilitation Company	Peter Brandt
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Somerset Integrated Domestic Abuse Service	Leanne Tasker/Katie Bielic
Somerset Partnership NHS Foundation Trust	Heather Sparks
South Somerset District Council	Tim Cook

The above was confirmed at the first Review Panel meeting on 12 March 2020.

6.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website *before* joining the panel. (Online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

7 Liaison with Media

7.1 Somerset County Council, as lead agency for domestic abuse for the Safer Somerset Partnership will handle any media interest in this case.

7.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.