EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

relating to the death of Lily

FINAL

on behalf of:

Safer Somerset Partnership

Report author; Liz Cooper-Borthwick

Independent Chair

April 2022

EXECUTIVE SUMMARY CONTENTS

1.0 THE REVIEW PROCESS

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 Lily. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the victim, alleged perpetrators and family.

Name	**Relationship to the victim**
Lily	Victim
Peter	Partner of Lily and alleged perpetrator of domestic abuse.
Gary	Son of Lily and Gerry and alleged perpetrator of domestic abuse
Tom	Son of Lily and alleged perpetrator of domestic abuse
Gerry (deceased)	Husband of Lily and father of Gary.

1.3 Lily's death did take place in **mid- 2019** and at the time the SSP was not notified about a potential DHR. In 2020, following Somerset County Council Public Health reviewing deaths by suicide, and notifying the SSP of Lily's death to consider for a DHR, the SSP concluded that Lily's death did meet the criteria for a DHR, and an Independent Chair was commissioned to conduct a DHR.

1.4 The findings of the inquest are not known at the time of writing. (It's understood from previous correspondence with the Coroner that there'd been delays due to the covid-19 pandemic and other matters).

1.5 All agencies that potentially had contact with Lily and her family prior to the point of her death were contacted and asked to confirm any involvement with them.

2.0 CONTRIBUTERS TO THE REVIEW

2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the Safer Somerset Partnership.

2.2 The following agencies submitted IMRs detailing their contact with Lily, Tony and the Lily's adult sons.

- Avon and Somerset Constabulary (the police)
- Somerset Clinical Commissioning Group (on behalf of the GP)
- Somerset Partnership NHS Foundation Trust (SomFT)
- Somerset Adult Social Care (ASC)
- Somerset Integrated Domestic Abuse Services (SIDAS)
- Southwest Ambulance Foundation Thrust (SWAST)

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

2.3 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.

2.4 In addition, Somerset Drug and Alcohol Service (Turning Point) were requested to complete and IMR but on reviewing their records they found no details of Lily or any family members.

2.5 Lily and her family did live in social housing and information was provided by the registered housing provider who stated that Lily did contact them when there were issues with the property and that they had no anti-social behaviour report relating to the property although it the police did.

2.6 Somerset County Council Public Health mental health lead was invited to be a member of the DHR panel and provided specialist expert advice and challenge about death by suicide and suicide prevention.

2.7 The Independent Chair wrote to the Lily's two sons (Gary and Tom) but there has been no contact. Despite several efforts to obtain contact details for Peter, Lily's partner, no information was found and therefore no contact has been possible. Information provided did identify that Lily had a sister and the Independent Chair did contact Lily's sister, but she confirmed that she did not wish to participate in the review. Peter, Tom and Lily's sister were spoken to as part of the SomFT Root Cause Analysis Investigation and the final report, with their comments, was shared with the DHR Chair. Where appropriate, information from the family has been included in this report.

2.8 Lily had had a history of multiple attempts at self-harm and overdoses(totalling 42 overdoses from the age of 20 years old, a period of around 35 years) and to understand what support was available and is now available to support people who are vulnerable to suicide the Independent Chair spoke directly with Somerset's Public

Health Specialist (Public Mental Health and neighbourhood Programme) in order to understand the facts and figures around death by suicide in Somerset and to understand the support services that are now available in Somerset.

2.9 Although Lily did not engage with Somerset Drug and Alcohol Service(SDAS) directly, the SDAS Safeguarding Manager remained as a DHR Panel member to provide challenge and expertise about substance abuse which was relevant to this DHR.

3.0 THE REVIEW PANEL MEMBERS

3.1 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
- Louise Smailes-Somerset NHS Foundation Trust
- Louise White - Somerset Adult Social Care
- Andrew Tresidder - Somerset Clinical Commissioning Group
- Emma Read – Somerset Clinical Commissioning Group
- DCI Samuel Williams -Avon and Somerset Constabulary
- Louise Finnis- Somerset County Council Public Health
- Natalie Giles - Somerset Integrated Domestic Abuse Service
- Melanie Thomson- Live West Housing Association
- Jane Harvey Hill- Somerset Drug and Alcohol Service (Turning Point).

3.2 The Review Panel met on six occasions, all virtually and agency representatives were of the appropriate level of expertise.

4.0 CHAIR OF THE DHR AND AUTHOR OF THE OVERVIEW REPORT

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 is a member of AAFDA DHR Chairs Network and Liz has also been involved with several Serious Case Reviews. She has no connection with any of the agencies in this case.

5.0 TERMS OF REFERENCE

Terms of Reference were agreed by the DHR Panel, **February 2021** and were regularly reviewed and amended as further details of the incident emerged. The primary aim of the DHR was defined as examining how effectively the agencies involved with Lily and her family worked together to support them. A full copy of the TOR is attached in Appendix One but of particular note that has been considered in this DHR;

a) 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 following are fully explored:
    - the dynamics of coercive control
    - the understanding of domestic abuse and links with mental health and substance misuse
    - knowledge and awareness of familial abuse (rather than between intimate partners)
b) To discover if all relevant civil or criminal interventions were considered and/or used.
c) Determine if there were any barriers Lily 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.
d) To discover whether agencies complete safety plans for people who are self-harming/suicide risk and to what extent people are encouraged and /or supported to complete self-held safety plans.
e) To consider professionals perceptions around a victim/perpetrator behaviour which may have impacted on support for the victim (Confirmation bias).
f) Did professionals use their "professional curiosity "skills to understand the needs and know the victim better?

6. SUMMARY CHRONOLOGY

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 Lily, Tony and the children.

6.1 Overview of Family life

6.1.1 Information provided by an agency indicates that Lily's childhood experience could have been quite difficult, her mother was diagnosed with schizophrenia and her father allegedly died by suicide. Lily was seen as a vulnerable person and was well

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

known in her community. Lily's husband (of 30 years) died by suicide in 2016 and she told everyone how much she missed him , how sad and lonely she was without him.

6.2 KPE One: Allegation of familial abuse between Lily and Peter (2016)

6.2.1 Lily called 999 to report that Gary had repeatedly punched her in her face. When the police arrived, they found Lily very intoxicated with no visible injuries. Lily told the police she had taken some of Gary's rum and he was angry. When the police spoke to Gary, he stated that he had suggested to his mother it was unwise to drink any more as she was intoxicated. An officer led Domestic Abuse Stalking and Honour Based Violence Risk Identification Assessment Model (DASH)[2] was completed and rated as medium, Lily was referred to the Lighthouse Safeguarding Unit (LSU) as was standard practice, but the referral was not progressed as there was no evidence of assault and no identified victim.

6.3 KPE Two: Allegation of Sexual Assaults on Lily (Autumn 2016)

6.3.1 Lily called the police, early **Autumn 2016** to report a historic sexual assault which had happened some months prior, Lily also reported a second sexual assault, both by a man Lily only knew by a nickname. Lily told the police she was too drunk to have given consent. The police investigated the incidents, but Lily would not engage and stated she no longer wanted to pursue a complaint.

6.3.2 A referral was made by the Police to Adult Social Care (ASC), but no outcome was noted on the case file. ASC did contact the police and arranged to see Lily. An assessment was not completed until three months after the incident as Lily had missed several appointments. ASC referred Lily to the Somerset Village Agents[3] for support and inclusion . (Somerset Village and Community Agents provide confidential, practical community -based solutions and can be contacted directly or via a GP or ASC).

There was no evidence as to whether Lily was referred to Somerset and Avon Rape and Sexual Abuse Support (SARSAS) or the Sexual Assault Referral Centre (SARC).

6.4 KPE Three: Escalation in Lily's mental health and substance abuse. (Early 2017)

6.4.1 Tom contacted the police to say Lily was drunk, had taken pills and was threatening to cut herself. The police visited Lily's home to find her drifting in and out of consciousness and an ambulance was called and she was taken to Accident

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[2]Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and management Model DASH (2009) www.dashriskchecklist.co.uk

[3] www.somersetagents.org

&Emergency(A&E) . Following her discharge, Lily was assessed by ASC and again referred to the Village Agents.

6.4.2 **Early 2017**, Lily phoned the police to say Tom had threatened her a few months earlier stating he would take her to some local hills and burn her. Lily also stated that Tom had assaulted her. SomFT contacted the police to share their concerns about Lily.

6.4.3 A month later, Lily called the police again to say that Gary was banging on her bedroom door and accusing her of taking drugs. During the conversation Lily said that Gary controlled her including how she spent her money**.**

6.4.5 **Late autumn in 2017**, the police received a 999 call from a newsagent reporting that Lily had attempted to buy alcohol and she was refused as she had been banned for a previous alleged theft. Lily had thrown a bottle and made threats to the news agent. Lily was arrested, taken into custody and seen by a nurse and then released overnight. The police contacted the mental health team, and they confirmed that Lily was not seeking treatment at that time. Lily was charged with common assault and was given a conditional discharge of a year.

6.4.6 Not long after this incident, Lily went to A&E as she felt disturbed and was hallucinating. Lily was referred to a psychiatric team for a Mental Health Act Assessment.

6.4.5 A week later the police received a further 101 call, reporting a concern for Lily who was trying to jump into a river. The police did attend, and Lily was quite calm but did state she had been drinking all day.

6.5 Key Practice Episode Four: Further deterioration in Lily's mental health and further allegations of familial abuse. (Mid 2018)

6.5.1 **Early summer 2018**, Lily phoned the police to say she was being held against her will by Peter and Gary. The call handler spoke with Peter and Gary who stated that they thought Lily was having a breakdown and they denied the accusation that Lily was be held against her will. The police shared their concerns for Lily with SomFT.

6.5.2 A couple of days after this incident, Lily called the police again and said that Gary had pushed her over and stopped her seeing friends. Despite Lily not making any sense to the police, a DASH was completed and rated as medium. Gary was interviewed under caution, and he denied assaulting Lily. Gary stated that he received a call saying Lily was causing a scene in the street and that he found her lying in the road and pulled her from the road as he was afraid that Lily would get run over. Lily later told the police

she felt she had had a mental health episode but that she had an appointment with SomFT a few days later.

6.6 KPE Five: Escalation of reports of domestic abuse by Peter and Gary. (Late 2018).

6.6.1 Lily contacted the ambulance service, **late Autumn 2018** and stated that she had been punched in the face, but she would not say by whom or disclose any domestic abuse. A few weeks later, an ambulance was called as Lily had taken amphetamines and had fallen out with Peter. Lily did disclose domestic abuse to the ambulance service who made a referral to the police.

6.6.2 A couple of days later, Lily phoned the police again to say that Gary had been aggressive to her as one of the dogs she was walking had run off. The police visited lily, but she did not want to complete a DASH, so the police completed an officer perceived DASH which noted Lily's mental health and that she was more vulnerable and a potential victim of domestic abuse including controlling coercive behaviour.

6.6.3 **Near the end of 2018**, Lily phoned 999 and the call handler heard a disturbance, but Lily abandoned the call. The police went to Lily's home, and she stated that there had been an argument with Peter, she had called him a name, he poked her cheek and in response Lily struck his thigh with a frying pan.

6.6.4 Two days later, the police received another call from Lily and the police attended the home and Lily alleged that Peter had put a cigarette out on her arm and gave details of a further assault two months earlier. Lily also reported sexual abuse by Peter. Lily and Peter where interviewed (separately) by the police and concluded that both accounts were plausible and that there was insufficient evidence and therefore the police took no further action. A DASH was completed for Lily, and it was rated as medium.

6.6.5 Lily disclosed that Gary was present during the arguments and that she was regularly subjected to verbal and physical abuse from Gary. Lily disclosed an incident in **late autumn 2018** where Gary had punched her head and that she was taken to hospital. The police did try to arrest Gary at his workplace (information provided by Lily) but there was no record of Gary ever being employed at the address given.

6.6.7 The police believed that Lily changed her account as to who the perpetrator was and as there was no conclusive evidence as to who the perpetrator was, so no Multi Agency Risk Assessment Conference (MARAC) took place.

6.6.8 **Mid Spring 2019**. Lily was arrested for common assault following a scene in the street with another female. Lily was drunk and erratic. The following day, Lily made a disclosure that she had had sex with a young boy. The boy's father was interviewed and explained that Lily was under the influence of drink and had asked for sex with his son, but nothing had happened.

6.6.9 Following this incident, Lily phoned the police to say she had been called a paedophile and had stones thrown at her house.

6.6.10 **Late Spring 2019**, Lily was admitted to hospital due to an intentional overdose saying she wanted to kill herself.

6.7 KPE Six: Lily's admission to hospital (Late Spring 2019)

6.7.1 Tom called the mental health team to say that Lily's health was deteriorating. Lily was admitted to hospital, being placed on the same ward as where her husband had ended his life a few years earlier. Lily did say that this was disturbing her.

6.7.2 Whilst in hospital, Lily's antidepressant programme was reviewed, and a detox programme was advised. Professionals noted that Lily was bright, polite and exercising.

6.7.3 A few days later, Lily had a meeting with her consultant about her discharge. Lily did say she felt she was not in control of her life and that she would return to drinking and taking drugs. Tom also contacted the hospital to say he was concerned about Lily being discharged. Later that day it was reported by professionals that Lily was acting in an odd manner.

6.7.4 The following day , Lily was discharged from hospital and later that day, Tom phoned 999 as he was concerned about Lily 's drinking and psychotic episodes on returning to her home. Tom tried to contact the hospital but could not speak with anyone at that time but later in the day he spoke with a professional who explained that in the future Somerset Drug and Alcohol Service and SomFT would provide support.

6.8 Key Practice Episode Seven -Lily's death (Early summer 2019)

6.8.1 The day following Lily's discharge, the police received a 999 from Peter saying Lily had jumped from a window. The ambulance arrived and Lily was pronounced dead. Peter gave an account under caution, and investigation was carried out and the police were satisfied that Lily's death was not suspicious.

7. CONCLUSION/ KEY ISSUES ARISING FROM THE REVIEW.

7.1 Lily's death was unexpected by professionals, but the risks of her death were documented with numerous attempts at self- harm. Lily was a very vulnerable person. Her childhood experiences may have impacted on her ability to make decisions, to assess risks and to manage her safety in adult life. Lily suffered from mental health issues from her late teens. Lily was married for over 25 years and although the relationship was volatile with Lily as a victim and a perpetrator of domestic abuse, but when Gerry , her husband took his life in 2016, she suffered a lot of grief and sadness. Lily also suffered with her physical health with chronic back pain, suffered from alcohol and drug misuse(why she did was never identified) and Lily was allegedly a victim of domestic abuse, both IPV and AFV.

7.2 This review identifies that Lily was involved with several agencies, with each trying to help Lily with one aspect of her needs, e.g. mental health, physical health with only the Police considering domestic abuse and her mental health. There was no consideration about the impact of grief on Lily's life and any exploration by professionals of why Lily drank and took drugs. No one agency saw the bigger picture or background to what Lily had experienced and was experiencing.

7.3 Lily's case, although referred to a MARAC was never listed and therefore never discussed. Lily had multiple issues and a MARAC or a multi- agency meeting (using the "What to do if it's not Safeguarding" process) would have provided an opportunity for professionals to have all the information about Lily, which would have described a very vulnerable person who needed support and guidance to navigate services which could have helped her. e.g. drug and alcohol services. A multi-agency approach may also have helped the family navigate support for Lily's needs.

7.4 There are examples of agencies being supportive of Lily, especially the police who considered several safeguarding measures for Lily but often each contact was managed in isolation from another. A case management approach by the police may have helped Lily with a more integrated approach to what she was experiencing.

7.5 Lily, due to her complex needs would have benefitted from a multi-agency approach in trying to address the support that she needed. Agencies need to use the MARAC and if not appropriate another multi agency model to support a victim of domestic abuse who has very complex needs to be able to navigate what support is available and how to access it. Lily was always seen as having mental capacity and was included in decision making (a strength in Lily) but also one IMR author noted that her impression of Lily was that she was lonely, she missed her husband and often worried of how she was perceived by others.

7.6 In the absence of any family or friend input into the voice of the victim, the DHR Panel would wish to say that Lily did engage with professionals, she understood what domestic abuse was, she attended appointments and did appear to miss her husband who she lived with for over 30 years. Lily, despite her vulnerabilities did show strength when trying to deal with her complex issues. It was also noted that no one ever asked what Lily's aspirations for the future were? This may have helped professionals to understand Lily in a holistic way.

8 LESSONS TO BE LEARNT

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

8.1 Multi -agency response for victims of DA with complex needs.

8.1.1 Lily was involved with several agencies over many years, especially mental health and primary care. Lily had over fifty contacts with the police of which fifteen related to domestic abuse. Lily was a vulnerable adult having several attempts at self-harm including attempts to end her own life. Although Lily did have support from many agencies and referrals between agencies did happen there appear to have been no comprehensive approach to her care and support.

8.1.2 Lily was referred to a MARAC in **2016** but the case was not considered. If it had been it could have provided the opportunity to understand the complex nature of Lily's needs and the risk and safety planning required to best protect her.

8.1.3 Lily did not reach the threshold for an adult safeguarding enquiry under section 42 of the Care Act 2014, but Lily could have been considered under the guidance " What to do if it's not Safeguarding"[4], Somerset Safeguarding Adult Board. The guidance provides a protocol for a multi-disciplinary approach for an adult with complex mental health issues , long term physical health needs and chronic self-neglecting behaviour.

8.1.4 It is important that agencies understand what multi agency responses there are available to best support a vulnerable victim of domestic abuse. In Somerset, there are two models which can support a victim of domestic abuse and the DHR Panel welcome the review of the MARAC in Somerset which will be based on good practice and the promotion to professional of the adult social care multi agency approach for

[4] What to do if it is not Safeguarding, Somerset Safeguarding Adults Board. www.ssab.safeguardingsomerset.org.uk

vulnerable adults who do not meet the safeguarding threshold under the Care Act 2014.

8.2 Management of risk and safety planning for victims of domestic abuse who have complex needs.

8.2.1 Lily had complex needs, mental health, domestic abuse, drug and alcohol misuse and several recorded attempts to self-harm. There were examples within the review that agencies did carry out risk and safety planning with lily for example the police carrying out a perceived DASH on several occasions and increasing the risk level based on professional judgement.

8.2.3 As there was no multi agency response to Lily's needs this did mean that there was no overall plan for her safety.

8.2.4 The Local Government Association and Directors of Adult Social Care Safeguarding and Domestic Abuse " A guide to support practitioners and managers (2015) highlights the need for an assessment of risk in all situations where an adult with care and support needs is experiencing domestic abuse. The guide focuses on being personalised and uses tools to assess the risk for a victim.

8.2.5 A MARAC or a multi-agency safeguarding meeting would also provide a coordinated response to safety planning and management of risk.

8.3 Mental capacity and Lily

8.3.1 Despite Lily having known mental health issues, substance misuse and suffering interpersonal violence and adult family violence, Lily was always considered to have mental capacity to make her own choices and decisions and therefore she could make her own decision. Evidence within the review indicates that Lily's decision making was sometime impaired due to substance misuse, her mental health and due to the fact, she was suffering abuse within the home.

8.3.2 Lily may have benefitted from an independent advocate who could have helped her with decision making, especially around her discharge from hospital.

8.4 An understanding by professionals about the impact of Adverse Child Experiences (ACEs)

8.4.1 Information shared at the DHR Panel meetings indicate that Lily may have experienced ACEs. Information provided indicates that Lily's mother was a schizophrenic and her father's death from suicide.

8.4.2 There are many examples of ACEs including all forms of abuse, living with someone who is abusing alcohol/drugs, exposure to domestic abuse, living with someone with serios mental health issues and losing a parent through divorce, death or abandonment. Information identifies that Lily was living with someone who had a severe mental health issue and allegedly lost a parent to suicide.

8.4.3 ACE's can have an impact on future physical and mental health including;

- An increased risk of certain problems in adulthood, physical and mental health risks including becoming a victim of violence. (Lily)
- An increased risk of mental health issues such as anxiety, depression. (Lily)

8.4.5 Professionals need to understand the impact of ACEs on a victim, how it can make someone like Lily very vulnerable. If professionals take time to understand a victims life story, then they are more likely to develop a robust risk assessment and safety plan and be better able to support that person.

8.5 Understanding of Intimate partner Violence (IPV) and Adult Family Violence by Professionals and the wider community.

8.5.1 Lily was a victim of IPV (Peter) and AFV (Peter and Tom) including psychological, emotional, physical abuse and allegedly economic abuse. Although AVF falls within the UK government definition of domestic abuse and the remit of it associated the legislative instruments, existing practice and guidance is geared to IPV and not always suitable for AFV such as the DASH.

8.5.2 To date there has been limited research about AFV but what research has been carried out has identified that mothers and sisters continue to be the victims of violence from their sons and brother, mental health issues were a common feature for the majority of perpetrators of AFV and the caring relationship was also highlighted as a risk. Evidence suggests that Peter and Tom abused Lily, and they shared a caring responsibly for Lily.

8.5.3 It is important that professionals understand the dynamics of AVF and the DHR Panel would wish to highlight Standing Together briefing sheet about AFV as an aid to help better understanding and an understanding of the risks.
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.

8.6 Discharge planning from hospital for a known victim of domestic abuse.

8.6.1 Lily died a day after she was discharged from hospital. SomFT carried out an RCA and the actions have been implemented. One of the recommendations within the RCA is that family members are offered a family liaison meeting prior to discharge when there is a difference of opinion about treatment and timeliness of discharge.
Although the DHR Panel welcomed the recommendation there is concern that if it is known that partner/children were abusing the person being discharged then there should be an independent advocate (DA expert) involved whenever there is an allegation of intimate partner of familial abuse.

8.7 Routine enquiry about domestic abuse by health and social care professionals.

8.7.1 The review highlighted that there appeared to be no routine enquiry with Lily as to whether she was suffering any domestic abuse despite being involved with several agencies over a long period of time.

8.7.2 Health and Social Care professionals should be given the tools to feel comfortable to make a routine enquiry about domestic abuse with a patient/client and if there is a disclosure then provide the relevant signposting/support.

8.8 The understanding by professionals of unconscious bias when supporting a vulnerable victim of domestic abuse with complex needs.

8.8.1 Lily did have complex needs, had suffered a number of traumas in her life, loss of a parent and husband by suicide, grief, mental health including self-harm, substance abuse and domestic abuse. Lily also admitted that her 2story 2 was not as it should be and sometimes the story was changed, and Lily's credibility was undermined. Professionals do need to understand that unconscious bias can have a considerable influence on attitudes and behaviours and how professionals deal with a victim, including victim blaming. Professionals do need to make decisions based on evidence and they need to be able to justify and challenge their decision making.

9. 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.

9.1 DHR Recommendations

Recommendation One

To carry out a review of the MARAC, its procedures , referrals by agencies and identification of support /safety planning offered to victims of domestic abuse.

Ownership: Safer Somerset Partnership

Recommendation Two

As part of SSP communication strategy to the wider community to communications which include information about adult family violence (AFV), what it is (how to identify it) and to identify what support there is for a victim of AFV.

Ownership; Safer Somerset Partnership

Recommendation Three

The Police, SomFT and CCG to identify /promote to relevant professionals and practitioners training and guidance on adopting a trauma informed approach to supporting a victim of domestic abuse. This to include identification of trauma relating to family background, grief, mental health and substance abuse . This training should also include unconditional bias , knowing how it manifests and what professionals can do to challenge it and how this impact on support to a victim of domestic abuse**.**

Ownership; Police, SomFT and CCG

Recommendation Four

SSP to review its training to professionals and practitioners to include all definitions of domestic abuse relating to interpersonal violence but also adult family violence.

Ownership; Safer Somerset Partnership

Recommendation Five

Health practitioners, police and adult social care to understand the suicide risk and links to domestic abuse and the impact of grief when a family member has experienced a death by suicide. Professionals within the mentioned organisations to also understand what support is available to families with this experience.

Ownership; CCG, Police, SomFT and Adult Social Care

Recommendation Six

Somerset Safeguarding Adult Board(SSAB) to review "What to do if it is not Safeguarding" guidance and how it interacts with a MARAC. Also, SSAB to promote to agencies and practitioners in Somerset the model to support a vulnerable individual who may not meet the threshold of an adult safeguarding referral or a MARAC.

Ownership; Somerset Safeguarding Adult Board

Recommendation Seven

All agencies to be reminded via the SSP newsletter the importance of recording ethnicity of victims and perpetrators of domestic abuse on records e.g. Patient records/user records and crime records.

Ownership; Safer Somerset Partnership

Recommendation Eight

All agencies involved in this review, implement agency recommendations, and report the outcomes to the Safer Somerset Partnership within six months of publication of this DHR.

Ownership ; Safer Somerset Partnership and agencies involved in this review.

9.2 Single Agency Recommendations.

9.2.1 Avon and Somerset Police (ASP)

The following recommendations are already in progress by ASP ;
a)The Police to review its Procedural Guidance for Deployment and Crime Allocation to support case management approach for vulnerable individuals.

b)The police to take steps to ensure officers recognise coercive control more readily and take time to pursue further lines of enquiry when indicators of coercive control more readily and take time to pursue further lines of enquiry when indicators of coercive control are evident when dealing with domestic incidents.

Further recommendations.

I. The police identified that each incident was investigated as a discrete and unconnected case. If a case management approach had been implemented, then this should have allowed for improved professional curiosity.

II. The police have also recognised that further training and support for officers in recognising and investigating coercive behaviour as a learning point for the police and this is already a recommendation to improve practice.

The DHR Panel would also identify the need for the police to review its referral to MARAC procedures to ensure someone with multiple needs and suffering domestic abuse is considered by a multi-agency panel to ensure they receive the support they need.
The DHR Panel would also recommend that IAU staff are reminded of the process to make referrals to LSU.

9.2.2 Somerset Clinical Commissioning Group

I. If a person shares with a GP practice that they have been taken advantage of with the suggestion that the sexual activity was not consensual then the GP should refer to SARSAS and SARC.
II. Details of SARSAS including Welcome SARSAS Survivor Pathways (including a list of sexual violence services) should be included in the new CCG Safeguarding Service directory being developed by SCCG for GP Practices.
III. SARSAS and SARC to be invited to a GP learning event.
IV. If a person has contact with a GP service about their mental wellbeing and /or alcohol substance misuse /or chronic pain and there is no clear medical cause a GP practice should include a routine enquiry about domestic abuse.
V. The DHR Panel question whether the GP considered the chronic pain could have been related to domestic abuse injuries.
VI. This recommendation has been identified in previous DHR's and the action is already in process to employ a Domestic Abuse Advocate to provide GP practices with training, advice and support about having such conversations with a patient.
VII. A further action is underway by SSP in developing a health module as part of the domestic abuse training. *Since the commencement of this DHR, this module has been developed and implemented.*

The DHR Panel would also request that the CCG remind GPs of the importance of routine DA enquiry when seeing a patient.

9.2.3 Somerset NHS Foundation Trust (SomFT)

i. Mental health services should always explore domestic abuse when relationship difficulties are mentioned and or in cases where there is a coexistence of relationship difficulties and suicide ideation.

The DHR Panel would want this lesson identified to be enhanced by the inclusion of a DASH to be completed when a patient mentions relationship difficulties so risk can be identified.

ii. Psychiatric Inpatients Units should always complete a DASH with clients who have been admitted to a ward when domestic abuse has been reported including reports of historical abuse to ensure robust risk /safety planning.

iii. To liaise with SomFT Safeguarding Service when domestic abuse has been identifies through the completion of a DASH.

iv. Domestic Abuse Awareness raising with the Mental Health Teams to embed routine enquiry in domestic abuse in clients who present suicidal ideation or relationship difficulties.

v. To act upon the recommendations within the RCA relating to mental health and impatient processes of which all have been actioned and completed.

The DHR Panel would recommend that SomFT review their discharge policy for victims of domestic abuse, especially if the discharge is potentially to a setting where domestic abuse has happened.

9.2.4 Adult Social Care (ASC)

I. MHSC to ensure that case recording on individual case records is accurate. MHSC teams to have monthly audit focussing on accuracy.

II. MHSC to communicate the assessment outcomes to the person involved.

III. MHSC to ensure relevant documents relating to the person are saved to their records.

IV. MHSC professionals to ensure risk assessments are completed in full and guidance is given to staff when this has not been possible.

V. MHSC to review assessment templates to ensure;

- -they are fit for purpose
- -Still relevant
- -Staff know when to apply them
- -Review effectiveness of the tools
- -MHSC to ensure that all relevant and appropriate timescales for onwards referrals are made.

VI. -MHSC and SOMFT to review their working together arrangements specifically information sharing arrangements. (To note- at the time of the incident , MHSC staff would have had access to SOMFT's electronic record system and would have recorded on the same system. Each agency would have seen each other's notes.

VII. SCC to review MHSC attendance at DA training.

VIII. SCC to ensure MHSC staff know how to recognise , respond ,report and record concerns about domestic abuse.

9.4.5 Somerset Integrated Domestic Abuse Service (SIDAS)

I. To understand the MARAC referral pathway so high-risk DA cases (whether actual score or professional judgment) should always go to a MARAC and even where there is more than one perpetrator.

Terms of Reference Domestic Homicide Review

DHR 033

Version 3

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR learning review in response to the death of Lily. The death is believed to be suicide and is within the statutory parameters for a DHR because the deceased was understood to have experienced domestic abuse within her relationship with her intimate partner and her son.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in June 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 and abuse homicide and improve service responses for all domestic violence and abuse victims and their children (or other dependents), 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 01.05.2016 to 12.05.2019 (this is intended to cover the period from a police recorded incident between Lily and her son up until her death) 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 by 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 any proceedings in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the DHR (Covid pandemic permitting) 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 following are fully explored:
    - the dynamics of coercive control
    - the understanding of domestic abuse and links with mental health and substance misuse
    - knowledge and awareness of familial abuse (rather than between intimate partners)
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Lily 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.
- To discover whether agencies complete safety plans for people who are self-harming/suicide risk and to what extent people are encouraged and /or supported to complete self-held safety plans.
- To consider professionals perceptions around a victim/perpetrator behaviour which may have impacted on support for the victim(Confirmation bias).
- Did professionals use their "professional curiosity " skills to understand the needs and know the victim better?

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 IMR's.
- Review IMR's – ensuring that 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 representatives from these agencies:

Agency
Independent Chair
Avon and Somerset Police
Adult Social Care
Clinical Commissioning Group
Safer Somerset Partnership (SCC Public Health)
Somerset Drug and Alcohol Service
Somerset Integrated Domestic Abuse Service
Somerset NHS Foundation Trust

This is subject to discussion at the first Review Panel meeting

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.