Domestic Homicide Review

EXECUTIVE SUMMARY

On behalf of Safer Somerset Community Safety Partnership

Report into the death of David in September 2017

Report produced by Peter Stride – Foundry Risk Management Consultancy Ltd.

September 2021

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1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Somerset Community Safety Partnership Domestic Homicide Review panel in reviewing the suicide of David who was a resident in the area.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of her family members. The age of the children has been left blank to protect identities.

Name	Involvement	Ethnicity	Age (at the time of Death)
David	Deceased	Black	29yrs
Tracey	Partner	White British	27yrs
Child 2	Eldest child (of David and Tracey)	Dual Heritage	Blank
Child 3	Youngest child (of David and Tracey)	Dual Heritage	Blank
Child 1	Child of Tracey	White British	Blank
Jill	David's sister	Unknown	Unknown

1.3 There were no criminal proceedings in this matter as this was not a homicide. The reason for this review is that David died as a result of taking his own life and there was a history of domestic abuse in the relationship.

1.4 The process began following discussions with the Home Office between 15th December 2017 and 16th July 2018, whereby the type and scope of review was discussed. When a decision to hold a domestic homicide review was agreed, all agencies that potentially had contact with David and the family prior to the point of his death, were contacted to confirm whether they had any involvement with them.

1.5 Eight of the 20 agencies that were contacted confirmed they had engagement with the deceased and his family, and they were asked to secure their files.

2. Contributors to the Review

2.1 Individual Management Reviews and Chronologies were requested from the following agencies, all of whom were invited to form the panel.

Agency	Contribution
Somerset Partnership NHS Foundation Trust	Chronology and IMR
Avon and Somerset Constabulary	Chronology and IMR
Sedgemoor District Council	Chronology and IMR
Taunton and Somerset NHS Foundation Trust	Chronology and IMR
Children's Social Care	Chronology and IMR
Somerset Independent Domestic Abuse Service – LiveWest Housing	Chronology and IMR
The GP practice facilitated by Somerset CCG	Chronology and IMR
South Western Ambulance Service NHS Foundation Trust	IMR

2.2 Each of the chronologies and IMR's were prepared by an author who was independent of the matter. They had no direct line management responsibilities or involvement with these individuals prior to this review being called.

3. The Review Panel Members

3.1 The review panel consisted of:

Name	Agency
Peter Stride	Independent Chair and Overview Report Author
Mark Wolski	Co-Chair
Julia Burrows and Heather Sparks	Somerset Partnership & Taunton and Somerset NHS Foundation Trusts

Dr Andrew Tresidder and Charlotte Brown	Somerset Clinical Commissioning Group
Roger Fawsett	Avon and Somerset Constabulary
Dave Baxter	Sedgemoor District Council
Emma Martin	Children's Social Care
Leanne Tasker	Somerset Integrated Domestic Abuse Service
Suzanne Harris	Somerset County Council (Safer Somerset Partnership)

3.2 Each panel member confirmed their independence from any previous involvement with any of the parties in this review.

3.3 During the period of this review the Somerset Partnership NHS foundation Trust (SOMPAR) and the Taunton and Somerset NHS Foundation Trust (TST) worked as separate organisations however since the 1st of April 2020 these two agencies have now merged to form the Somerset NHS Foundation Trust.

4. Author of the Review

Independent Chair and Overview Report Author – Peter Stride

4.1 In September 2018 Peter Stride was appointed the chair and author of this DHR along with Mark Wolski who is the co-chair. Peter is a former Senior Detective in the Metropolitan Police, with 30 years operational service. He policed mainly within the arena of public safety, including Domestic Abuse and Child Sexual exploitation. Whilst working in the Metropolitan Police they were responsible for securing the first three DVPO's, in London and this success typified their passion and enthusiasm for supporting Domestic Abuse victims.

4.2 Since retirement Peter Stride along with Mark Wolski (below) have established their own consultancy business which focuses upon chairing Domestic Homicide Reviews and Serious Case Reviews for Community Safety Partnerships across the country as well as training and mentoring those in the public safety arena.

Co- Chair – Mark Wolski

4.3 Mark Wolski was appointed by Safer Somerset Partnership as Independent Co-Chair of the DHR Panel. He is a former Metropolitan police officer with 30 years

operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander across several London boroughs.

During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding. Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a MARAC Steering Group and as a DHR chair/co-chair.

4.4 Peter and Mark have both completed Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse.

4.5 Neither Peter nor Mark have any connection with Safer Somerset Partnership or any of the agencies involved in this review.

5. Terms of Reference

5.1 The full Terms of Reference are included in Appendix 1. The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death of David in the county by Somerset Partnership NHS Foundation Trust. The review aims to identify the learning from this death and for action to be taken in response to that learning, with a view to prevent similar circumstances occurring again in the future and ensuring that individuals and families are supported.

5.2 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in the statutory guidance and identified and considered the following case specific issues:

- Set out the facts of their involvement with David, Tracey and their three children.
- Critically analyse the service they provided to Tracey, David and Family in line with the specific terms of reference.
- Identify any recommendations for practice or policy in relation to their agency
- Consider issues of agency activity in other areas and review the impact in this specific case.

5.4 At the first meeting, the Review Panel shared brief information obtained from a 'summary of engagement' exercise about agency contact with the individuals

involved. At this early stage it was clear that there had been a variety of contacts with agencies since the family moved from the Midlands in 2012. As a result, the panel agreed that a review period from when they moved to Somerset was most appropriate.

6. Summary of the Chronology

David

6.1 David had various contacts with statutory services, which primarily related to the police and health. There were also various contacts with Sedgemoor District Council regarding rent arrears.

6.2 In relation to contact with the police early in the review period, David was arrested for assaulting a male and this appeared to have a significant impact upon his emotional state. As subsequently he made several visits to the GP surgery with regards to his depression and feeling that the matters would never come to an end. Eventually he was prescribed with a course of antidepressants and encouraged to engage with the "Talking Therapies" service.

6.3 In relation to health, David had contact with a range of health services primarily the GP surgery and the South West Ambulance Service NHS Foundation Trust. The chronology records four incidents where David collapsed at home. The medical reason for the collapses varied but invariably had domestic issues either at the core, or as a contributory factor. During visits to the GP surgery David recorded feeling depressed and discussed issues of self-harming.

6.4 David had several contacts with Sedgemoor District Council mostly relating to rent arrears and subsequent settlement of them. He also applied to move to a new house as the family size increased. Financial problems at the beginning of the review process meant that the family's applications to move did not progress.

General

6.5 David's relationship with Tracy has been at the core of this review. Therefore, it is worthy of mention that the chronology discusses several incidents where the police and - Children's Social Care (CSC) were contacted following various arguments and disputes.

6.6 These contacts were particularly focused once David had left the family home and the relationship appeared to come to an end, with Tracy making several calls to CSC following arguments between the two.

6.7 It also appears the relationship between Tracey and David's sister Jill was at times difficult. Indeed, at one point Tracy contacted the police to inform them that she had been assaulted by Jill, however no subsequent arrest or prosecution ever took place.

7. Key issues arising from the Review

7.1 Domestic Abuse/Violence

7.1.1 David had died as a result of deliberately suspending himself by the neck but his intentions at that time were not determined.

7.1.2 Considering the government definition of domestic violence and abuse which describes a pattern of incidents of controlling coercive or threatening behaviour the review panel was not able to determine whether a broader history or a result of a single act caused David to take this action.

This conclusion is based on information gathered by this review panel. The collation of the IMR's and chronologies by individual agencies has identified there were problems and issues within the relationship between David and Tracey. There were several incidents reported of David self-harming. However, these could be generalised as being superficial and potential cries for help. While there were several reported incidents to Avon and Somerset Police often these were recorded as a domestic incident requiring little police intervention.

David did however visit his GP on several occasions and reported feelings of depression financial worries and difficulties in meeting the expectations of his family. On several occasions he was prescribed antidepressant medication and referred to support agencies in order to treat or minimise this condition.

7.1.3 There are also several reported incidents of David collapsing either at home or at work. As a result of speaking with health services he made similar disclosures about his anxieties.

7.1.4 Regardless as to whether there was any wider pattern of domestic violence or abuse or not, it is clear there was an increasing amount of tension as well as relationship conflict between Tracey and David. The couple had separated in

February 2017 although David remained on the tenancy of the family home and had keys to the premises. On occasion this caused Tracey some anxiety and anger resulting in calls to the police.

7.1.5 Tragically it is not possible to build a picture of David's perspective in this relationship however he appeared to be juggling family life, with financial expectations, with work commitments and this appeared to be a difficult balancing act for him to achieve. David appeared to struggle with this over several years.

7.1.6 However if David did have wider concerns about his relationship or experienced domestic violence or abuse from Tracey, he appeared keen to have kept them to himself. While it was not possible to know either way if David did have concerns, that he did not share, it could be for many reasons including embarrassment, or shame, or feeling that he should be able to cope. The potential barriers to reporting these issues are considered further in relation to gender perception (See Section 7.3) and equality and diversity.

7.1.7 One explanation for David's act may be to focus upon his mental health and feelings of depression, specifically on whether this would account for his decision to take his own life. David was never diagnosed as having any mental health issues although he had been prescribed an anti-depressant.

7.1.8 However it is also possible to explore this suicide through another lens specifically the gender of those involved. Research by NHS England[1] identifies suicide is the leading cause of death for men under the age of 50. It is hard to convey the devastation with just numbers; a suicide is like a rock thrown into the water with the ripples spreading outwards affecting all those who knew him.

7.1.9 Both men and women are expected to conduct themselves in certain ways, socially constructed and include behavioural activities and attributes that a given society considers appropriate. Using a gender framework, it is possible to explore how David's ideas of masculinity might feature in the circumstances leading to his death.

7.1.10 Academic research and statistical analysis show the complex issue of suicide and in a report carried out by the Samaritans organisation in 2018[2] men talked about their relationships breaking down, separation from their children, loss,

[1] https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/
[2] https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/

addiction, a lack of close family friendships, loneliness and being unable to open up to anybody as root causes of suicidal feeling.

7.1.11 David visited the GP to discuss the pressures he felt. Rightly and reasonably, the GP sought to provide David with support including those from statutory and voluntary agencies. This included the Samaritans, the local Talking Therapies programme and the Mental Health Home Treatment Team[3] as well as prescribing medication.

7.1.12 Recent research[4] into suicide has explored the importance of suicide triggers, in simple terms suicidal thoughts and behaviours start when vulnerable individuals encounter stressful events. They can then become overwhelmed by situation and decide, that suicide is the only reasonable way to stop the pain they are experiencing. Determining what makes events stressful is difficult because everyone copes in different ways and from different perspectives.

7.1.13 Both positive and negative events can be sources of great significant stress for example, losses related to health, significant relationship and job problems, debt and humiliation. The Office of National Statistics record that in the year up to September 2019 three quarters of deaths from suicide were men[5].

7.1.14 The limited information in this case means it is difficult to be certain as to the presence of these markers. The prospective separation or rejection has been mentioned throughout the combined chronology, and the deceased speaks of financial expectations placed upon himself. Also, the combined chronology appears to present a picture of potential homelessness immediately prior to his death. There were also recorded events of significant rent arrears and the expectation is that David will accept responsibility for them.

7.2 Male Victims of Domestic Abuse

7.2.1 The author wishes to point out that the research and analysis on this subject in no way seeks to draw a line between David's death and any domestic abuse which was occurring in the family home.

[3] Referrals to the Mental Health Home Treatment Team fall into two categories. High Risk matters are referred by the GP and lower risk matters can be referred by any other of agency. This method allows for suitable prioritisation

[4] https://www.gulfbend.org/poc/view_doc.php?type=doc&id=13740&cn=9

[5]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

7.2.2 The chair has researched the issue of male victims of domestic abuse and specifically the subject of ethnicity. In the summer of 2019 Safelives carried out a programme to gather voices of men and boys, from all backgrounds who been the victims of domestic abuse[6]. There were over 200 respondents from across the UK and a number of key findings included that the main dynamics of abuse included, being made to feel small, being blamed for something that was not their fault.

7.2.3 The impact of domestic abuse can be long lasting and leave the victim with many damaging emotions including:

- Anxiety or continuously feeling on edge
- Loss of confidence
- Loneliness and/or isolation
- Embarrassment of shame
- Low self-esteem or worthlessness.

7.2.4 In terms of the Safelives program mentioned above, over 90% of the responders reported a combination of these emotions. Almost two thirds of the responders reported having suicidal thoughts and one third had self-harmed. 80% of the responders reported that the behaviour they experienced 'affected their mental health a lot'.

7.2.5 In terms of how these statistics translate into this review it would be wrong and inaccurate to try and offer a specific and direct link between the relationship problems David and Tracey were having and his death. However, it is worth noting some of the impacts that the Safelives programme highlights when considering some of the emotions that David reported during the period of time that this review covers i.e.

- There were a number of occasions where David's emotional and physical health caused an ambulance to be called suggesting high levels of anxiety.

- On more than one occasion David reported struggling to cope with the expectations placed on him by others.

- There were a number of occasions when David expressed feelings of having dark thoughts and depression but confirmed that Tracey and the children were supportive of him.

[6]https://safelives.org.uk/sites/default/files/resources/Men%20and%20boys'%20experience%20of%20domestic%20abuse.pdf

- It was shortly before David's death that plans were put in place to repossess the family home due to rent arrears. It seems natural that he would have had feelings of shame and embarrassment that he was unable to prevent this from happening.

- Throughout the period of this review there are reports of David self-harming including the incident the night before his death when David took a knife from the kitchen and threatened the same in front of police officers.

7.2.6 The author of this report has carried out extensive research into the links between Domestic Abuse, suffered by BAME male victims. The Office of National Statistics detail that 3.9% of white men experienced domestic abuse compared with 3.5% of men identifying themselves as from a mixed ethnicity and 3.3% of men who are black.[7] However, "the heterosexual male, BME, and LGBT victims of domestic and sexual violence are in different ways 'hard-to-reach' groups (Gadd, 2002; Batsleer et al., 2002; McCarry et al., 2008)" and this is suggests that with 1 in 3 victims on Domestic Abuse being male more needs to be done to raise this as a national issue in order its causes and symptoms may be explored and solutions found.

7.2.7 It might be easy to suggest that there is a national knowledge gap on the subject of men being victims of Domestic Abuse in the BAME community however the simple fact is that men seem unwilling to come forward and discuss their experiences and this may be reflective (as mentioned above) of men generally being unwilling to discuss their experiences and feelings, particularly on such a sensitive subject.

7.3 Equality and Diversity

7.3.1 The chair of the review and the review panel considered whether the protected characteristics of age, disability, gender realignment, marriage and civil partnership, pregnancy and maternity, race, religion (or belief) and sex, wherever relevant to this report.

7.3.2 In identifying the relevant equality and diversity issues for David the review panel noted that, David was a heterosexual male aged 29 at the time of his death. He was a British, black male who had been in a relationship with Tracey

[7] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019#ethnicity

for 9 years. His religion was unknown, and he had no known or diagnosis of any disability.

7.3.3 The panel found no concerns over barriers to reporting and accessing services, in this case. Each agency also considered the wider issue of whether any service delivery was impacted by these characteristics, the conclusion drawn by each was that, with one exception this was not the case.

7.3.4 Due to domestic abuse consisting predominantly of violence by men towards women gender was a relevant protected characteristic.

7.3.5 The review panel considered the fact that in this relationship, where domestic abuse had been an issue, it was the male partner who had ultimately died and therefore was the subject of this review.

7.3.6 Analysis from the Office of National Statistics[8] record that in 74% of Domestic Homicides the victim were women and therefore a quarter (26%) were men. Also, that 7.5% of women are victims of Domestic Abuse as against 3.8% of men.

7.3.7 Issues of equality and diversity are referred to in this report. However, this was raised to individual agencies and the collective as part of the review process, and the panel felt that this was not an issue of concern with regards to services available or provided.

7.3.8 The panel considered whether or not their agencies recognised that 1 in 4 (as per paragraph 1.11.6) victims of domestic abuse were men and whether front line practitioners were aware of this and whether they were suitably trained and experienced. Panel agencies have reviewed their own policies, procedures and training to confirm that, indeed, when dealing with cases of domestic abuse it is recognised that men can be victims as well as women.

8 Conclusions

8.1 David was a loving and caring father and a devoted family man. He worked hard to provide a home and loving environment in order that his family could develop and flourish. His death was a tragedy and affected all his family, and it will impact on them for the rest of their lives.

[8] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

8.2 For those close to David this tragedy is made more difficult because it appears to be completely unexpected. Those closest to him knew that he'd had problems with his emotions and had previously been diagnosed with depression. His relationship with Tracey was often challenging to the point where it broke down early in 2017. However, his loving devotion for his three children never wavered. David never ceased in his desire to bring the three children up in a caring environment and it was Tracy who reported that shortly before his death the two of them had rekindled their relationship with a view to re-establishing the family home.

8.3 There has been a challenge for the review panel to fully understand the nature of the relationship between David and Tracey as they often sought to remain private when engaging with agencies in Somerset. One panel agency referred to their relationship with David and Tracy as being that of "disguised compliance" leading to ultimate avoidance ideology. This appears to sum up things very neatly. The review panel members noted there were times when agencies had opportunities to demonstrate more respectful uncertainty or professional curiosity, when seeking to understand any challenges or issues the family faced.

8.4 The couple would use agencies in Somerset, in what appeared to be part of a coping mechanism. For example, David would visit the GP in order to discuss his emotional vulnerability and the stresses and strains he felt with home life. Various pathways of support were offered to David however, there is no evidence to suggest that he ever explored these avenues. Reports to the police were mainly made by Tracy however these were often of a comparatively minor nature, being referred to as "police incidents" whereby no crimes were alleged or identified.

8.5 However ultimately, due to David's apparent emotional fragility he was offered a wide array of services in order to support him and his family. These opportunities for support included agencies such as the GP surgery, local hospital services, SHAL housing, and the police however, for reasons that tragically this review will never understand they were never seized upon.

8.6 As has been pointed out during this review, suicide is a human condition, can occur without the presence or independently of a mental health disorder. Depression is often interpreted as a sub-category of mental health and this review has considered responses, where appropriate, through this lens.

8.7 The review panel considered whether there were periods, or moments, in time during this review where there were obvious triggers that should have warned

professionals of his intention to take his own life. The panel is taking a holistic view in order to try to understand whether there were obvious failings which, had they been identified, could have saved David's life or diverted him away from this path. Despite incidents whereby David collapsed, demonstrated evidence of self-harming, or discussed emotional lows the review cannot positively say that there were circumstances where had agencies acted in a different way this tragic outcome would have been averted. Having said that every review of this nature allows agencies to reflect upon their own performance, methodologies, policies and procedures.

8.8 In approaching learning and recommendations, the review panel has sought to do two things. First, to try and understand what happened and consider the issues in the lives of David and, to an extent Tracey, that might help to explain the circumstances of the death. Secondly to use this case to consider a wide range of issues locally including provisions for victims of domestic violence and abuse, both male and female.

8.9 The review panel wishes to extend its sympathies to all those affected by David death.

9 Lessons to be Learned

9.1 The review process allowed individual agencies to review their own performance and processes. This enabled not only these agencies, but the panel to identify opportunities to enhance the services provided to individuals and families in situations similar. The learning points have been drawn from the overview report and have been accompanied with recommendations which are recorded in section 10.

9.2 These learning points have been categorised into each individual agency and as 'General' learning points where multiple agencies or the Partnership as a whole is impacted.

9.2.1 Children's Social Care

Learning Point. The review process has identified a lack of documented supervision and little in the way of strategy setting or support for the allocated worker. There's a clear inference of missed opportunities at various stages. These may have been more easily identified and resolved with regular focused documented professional discussions between frontline practitioner and supervisor.

Learning Point. When carrying out any form of assessment with relation to the safeguarding of children and their safety it's vital to hear the child's voice. In preparing for this review the independent author of the CSC IMR can find no details of any interviews conducted with any of the three children particularly away from their parents. The details from such an interview could have played a vital role in deciding how best to support them and their parents.

Learning Point. An NSPCC fact sheet prepared in March 20109 gives some guidance in relation to disguised compliance, this involves a parental carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions to allay professional curiosity and ultimately to diffuse professional intervention. In the Victoria Climbié inquiry, Lord Laming (2003)[10] suggested social workers needed to practice "respectful uncertainty", applying critical evaluation to any information they receive and maintaining an open mind. It appears that in both Child and Family assessments, David and Tracey were keen to present their family in the light which would satisfy frontline staff that they weren't in need of any support or help.

9.2.2 General

Learning Point. It is important that professionals have a better understanding of how to identify those likely to be at risk of Domestic Abuse. Also knowing what actions of those professionals or local partnerships can take to reduce the likelihood of future suicide of this nature. Additionally, a key purpose of DHR's is to reduce the likelihood of future cases like this. As the Home Office has access to all DHR's, as part of the quality assurance process it can review learning across cases in a way that a single agency cannot.

9.2.3 Taunton and Somerset NHS Foundation Trust

Learning point. The panel takes the view that there is an opportunity for the staff at the Musgrove Hospital Emergency Department to demonstrate more professional curiosity when dealing with victims of assault (in accordance with paragraph 5.3.1.4 of the Overview Report). David had disclosed to staff, that he had been pushed down the stairs at home and there were concerns for David's mental well-being, raised by the ambulance crew upon arrival at the hospital.

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[9] https://lrsb.org.uk/uploads/nspcc-fact-sheet-disguised-compliance.pdf

[10] Laming, Lord, (2003) The Victoria Climbie inquiry: report of an inquiry by Lord Laming (PDF). Norwich: TSO P205.

9.2.4 Somerset Partnership NHS Foundation Trust

Learning Point. The panel recognised there were opportunities here for David to receive potential support prior to leaving the hospital. For example, being provided with a leaflet explaining the role of the Psychiatric Liaison Team and to be provided with contact details for community support including mental health services.

This has been raised by the IMR author, as an action and recommendation, on behalf of their own agency and the TST, the panel and the chair support this recommendation.

9.2.5 GP Surgery

Learning Point. There was an opportunity to make enquiries during a couple of consultations, such as when he alleged, he was pushed down the stairs. This is a learning point for the surgery about recognising someone, particularly a male who is experiencing Domestic Abuse.

Learning Point. A variety of effective interventions can make it easier for GP and NHS services to play their part in reducing domestic abuse and identifying the vulnerable. This should include access to training and a referral programme in order to support them asking about and responding to domestic violence and abuse. This has already been implemented by the CCG over the past three years and is monitored through the annual safeguarding report that GP practices are required to return to the CCG. This annual safeguarding report includes information about Domestic Abuse.

9.2.6 Safer Somerset Domestic Abuse Board

Learning Point. The review recognises the principles of taking a holistic view when dealing with assessments such as these and need to maximise the skill of professional curiosity and to seek every opportunity to understand the issues and challenges faced by all families in these circumstances. There were various missed opportunities here including, the lack of interviews of the children 'independent' of their parents, the use of a DASH risk assessment and referrals to Somerset Drug and Alcohol Agency following disclosures about her use of controlled substances following her brother's death. There have been recommendations, made during previous DHR's, with regards to professional curiosity and this review seeks to support them i.e. from DHR 022

Learning Point. The review raises the issue of information sharing and this has been a subject of concern during many previous DHR's. It seems to be a crucial function of all assessments including Children and Families processes, that those engaging with families have access to all reasonable pieces of information and can share it appropriately. This will often involve consent of the parents and be subject to all suitable safeguarding measures.

9.2.7 SWAST NHS Foundation Trust

Learning point. Often domestic abuse incidents are because of or have an outcome of violence. Therefore, perpetrators are reluctant to contact the police directly, thus ambulance services are often the first point of call. It seems reasonable that, where circumstances allow, efforts should be made to complete a DASH risk assessment. Particularly if patients are removed from the scene of the incident, and the injuries allow for this conversation to take place.

9.2.8 SHAL Housing

Learning Point. In order to support families and uplift SHAL's reputation as an agency who supports the reduction in domestic abuse the chair feels that it would benefit from formal Domestic Abuse accreditation.

Learning Point. SHAL encourages all staff and those with active engagements with families to be proactive in identifying and reporting concerns of Domestic Abuse, the review feels that this process needs an element of protection and formalisation.

Learning Point. Agencies like SHAL have, potentially, a good deal of contact with families suffering domestic abuse problems and the previous learning point encourages reporting of these matters. It appears to be a missed opportunity for the information, which they identify, not to be shared with other involved agencies. Similarly, there must be available information which could support SHAL et al in assisting families as well as allowing employees in assessing risk prior to making home visits.

Learning Point. SHAL recognises that there is a need for all agencies to take seriously the subject of professional curiosity. They report that prior to death of David there were reports to staff about problems in the home, including shouting and violence. There is a need to encourage staff to 'investigate' such reports, with

their tenants, however, this should be done sensitively and with regards to suitable safeguarding guidelines.

9.2.9 Avon and Somerset Police Constabulary

Learning point. There is potentially an issue with officers failing to identify that all domestic abuse investigations, however small or apparently low-level should have a DASH risk assessment completed during the initial stages. This will allow subsequent investigations to identify continuing concerns over escalation of risk.

"It's worth noting the Safe Lives MARAC process encourages referrals where has been 3 domestic abuse reports over 12 months[11]".

It may be the case that the weaknesses identified in this learning point have already been rectified. However, the panel seeks to be reassured that this is the case.

10 Recommendations

Single Agency Recommendations

During the process of preparing their Individual Management Reviews. The reviewers/authors have been invited identify recommendations of their own. These are listed below.

Children's Social Care

1. Improve social workers ability to be more robust in the triangulation of information

Avon and Somerset Police

1. Avon and Somerset Police should consider how existing processes can be used to develop a prompt system that reminds officers of their training in relation to

[11] It is common practice to start with 3 or more police callouts in a 12-month period, but this will need to be reviewed depending on local volume and level of police reporting. https://safelives.org.uk/sites/default/files/resources/MARAC_FAQs_for%20MARAC%20practitioners_2013%20FINAL.pdf

dealing with mental health crisis that does not meet these section 136 criteria and is not volatile potentially a reminder of tactical options available to manage a situation

SOMPAR, Taunton and Somerset NHS Foundation Trust

2. Improve knowledge of domestic abuse awareness in Emergency Department

Sedgemoor District Council

3. Strengthen housing options team's understanding of when to share information with social landlords (eg SHAL and similar) around risk to child neglect.

4. Strengthen housing options team's understanding of when to share information with social landlords (eg SHAL) and similar around risk to joint tenancy issues

Somerset NHS Foundation Trust

5. Improve consistency of community mental health staff always clearly documenting source of disclosure of historic domestic abuse relevant details, whether or not the information can be substantiated.

6. Change how Patient Liaison Team (with A&E) follow up to patients referred to the PLT but leave the hospital without being seen

SIDAS – Livewest

7. **Improve the effectiveness and robustness of referral intake procedures within SIDAS**

DHR Panel Recommendations

Recommendation 1: Safer Somerset CSP to seek reassurance that training and Continuous Professional Development strategies reflect:

- Gender dynamics when dealing with incidents of domestic abuse.
- Identify 'triggers' associated with the escalation of domestic abuse.

Recommendation 2: The Safer Somerset Partnership to write to the Home Office with the findings of this DHR suggesting that they undertake further research into cases of suicide

with a reported history of domestic abuse where the perpetrators are male, in order to develop a profile of potentially vulnerable men.

Recommendation 3: Home Office to undertake further research into male victims of domestic abuse in the BAME community and to raise awareness of referral pathways for all men who are victims of domestic violence.

Recommendation 4: Ensure that training packages are prepared and delivered in accordance with the guidance and directions provided within the SOMPAR DA policy.

Recommendation 5: Improve monitoring of reports to identify domestic abuse trigger's and, if appropriate, carry out further enquiries and possible onward referrals to GP Surgeries.

Recommendation 6: Safer Somerset Partnership in support with the Domestic Abuse Board to seek assurance in asking all agencies to provide evidence that they include professional curiosity in their safeguarding training.

Recommendation 7: Somerset Domestic Abuse Board to improve the effectiveness of relevant information sharing pathways in relation to domestic abuse and ensure that frontline staff are aware of the opportunities available to them and the ethical and legal ways all sharing information that they receive..

Recommendation 8: The CSC to reinforce the need for the interview of children in domestic abuse circumstances..

Recommendation 9: Improve the availability of training for frontline practitioners and managers about their responsibilities and the principles in managing situations where disguised compliance is apparent..

Recommendation 10: The CSC to improve governance protocols and if necessary, introduce a review framework that details, current risk and plans, going forward.

Recommendation 11: Reinforce the necessity to record contemporaneous notes at the scene of domestic abuse incidents and a referral is made to Trust Safeguarding Team within the 48-hour time scales which SWASFT policy requires.

Recommendation 12; Ensure that information sharing procedures are effective so that there's engagement with external and internal partners, whenever safeguarding issues are raised, in timely and proportionate manner.

Recommendation 13: SWASFT NHS Trust, to develop the training available to staff so that they are aware of how to complete DASH risk assessments

Recommendation 14: The CSP should consider providing funding to support SHAL and other housing providers bid to receive formal Domestic Abuse accreditation in order to raise its profile, provide reassurance to the vulnerable and discourage perpetrators.

Recommendation 15: SHAL Housing should develop a policy to support a 'See something Say something' style of reporting by those in frontline services.

Recommendation 16: The Somerset Domestic Abuse Board should review their information protocols in order that agencies like SHAL are able, to provide, and have access to, details from other agencies within the Community Safety Partnership.

Recommendation 17: SHAL Housing and similar housing providers to promote the availability of resources and training to improve understanding of "professional curiosity"

Recommendation 18: Avon & Somerset Police to ensure current procedures are promoted so that all staff are aware of the need to complete DASH risk assessment at the initial stage of all domestic abuse cases.

Appendix 1

Terms of Reference
Domestic Homicide Review (case 021)

1 Commissioner of the Domestic Homicide Review

1.1 The chair of the Safer Somerset Partnership has commissioned this review, following notification of the death of David in the county

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

1.3 The resources required for completing this review will be secured by the chair of the Safer Somerset Partnership.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from this domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of David.

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've experienced.

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

3 Timescale

3.1 Aim to complete a final overview report within 6 months acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair. Additionally, the criminal justice process will impact on timescales so that key relatives and friends can be contacted for involvement without prejudicing the criminal proceedings, although the statutory guidance is clear a DHR should be commenced and concluded as soon as possible – and the Review Panel should be mindful of paragraphs 90 to 96 of the guidance.

4 Scope of the review

4.1 To review events up to the domestic abuse related death of David in September 2017.

4.2 Events should be reviewed by all agencies for 5 years (i.e. September 2012) preceding the domestic abuse related death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 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.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers David faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the Review and Overview Report can

maximise opportunities for learning to help avoid similar deaths occurring in future.

5 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)

6 Domestic Homicide Review Panel

6.1 Membership of the panel will comprise:

Name	Agency
Peter Stride	Independent Chair and Overview Report Author
Mark Wolski	Co-Chair
Julia Burrows	Somerset Partnership & Taunton and Somerset NHS Foundation Trust
Dr Andrew Tresidder	Somerset Clinical Commissioning Group
Roger Fawsett	Avon and Somerset Constabulary
Dave Baxter	Housing Health and Wellbeing, Sedgemoor District Council.
Heather Sparks	Taunton and Somerset NHS Foundation Trust
Emma Martin	Children's Social Care
Leanne Tasker	Somerset Independent Domestic Abuse Service
Suzanne Harris	Somerset County Council Senior Commissioning Officer

The above was confirmed at the first DHR Review Panel Meeting held on 5 November 2018.

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.

Appendix 2 – see separate document