Safe Somerset Partnership

Multi- Agency Domestic Homicide Review

Into the death of Mr A in February 2021

Contents

Safer Somerset Partnership

Multi- Agency Domestic Homicide Review

Overview Report

Into the death of Mr A in February 2021

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Tribute to Mr A

The Independent Chair and Domestic Homicide Review Panel offer their sincere condolences to all who have been affected by the death of Mr A, who is remembered for his pride and commitment to serve his country in the British Army. Mr A joined the Armed Forces in 1959 as a Private and left the army in 1996 as a Lieutenant Colonel, however immediately moved into a Retired Officer role until 2002 when he did retire fully.

Mr A travelled many countries whilst he served his country in the British Army and therefore embraced the different cultures. Mr A spent a significant amount of time living in Germany and France in his career with his wife Mrs B and daughter Mrs C. Even after he retired Mr A still enjoyed travelling and holidays overseas. Family members shared with the Panel his love of travelling, socialising with friends, and having garden parties most summers which would often continue until the early hours.

Mr A's death is a very sad loss to many but is felt particularly by his daughters and grandson who all contributed to this review. The Independent Chair and Domestic Homicide Review Panel thank all who have contributed to the deliberations of this review, for their time, patience, honesty, and cooperation.

Contents

Appendices

1. Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship or
b) A member of the same household as himself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term which has been adopted by the Safer Somerset Partnership.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the death of Mr A, regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide, domestic abuse related deaths and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

2. Introduction

2.1. This review examines the circumstances surrounding the death of Mr A who was 78 years of age when he died, White British and had lived in the county of Somerset for the last seven years of his life.

2.2 Mr A was a very proud man who served in the Army for many years and had a very rewarding career beginning as a Private and retired as a Lieutenant Colonel

in 1996. After this time he continued employment as a retired officer until 2002 when he retired fully. He was a father to three daughters and one son. As a result of his career he lived in several different countries during his lifetime before settling in Somerset in August 2013 with Mrs B.

2.3 Mr A and Mrs B met through work, Mr A worked in the Army and Mrs B worked for the Ministry of Defence, they got married in 1996. Mr A was not the biological father of Mrs B's third child but was legally adopted by him and it was described by family members as part of this review that they had a close relationship.

2.4 Mr A had limited contact with agencies during the timeframe of this review from 2016-2021. However, it was recorded in his medical records that he had a number of medical conditions over the years. This included prostate cancer for which he had surgery in 2012. He also had rectal cancer which was diagnosed in 2015. In addition in 2013 he had a deep brain stimulator inserted owing to issues relating to a benign essential tremor. A Medtronic battery was in place in his abdomen.

2.5 There was only one incident reported to any agency relating to domestic abuse, and this was Mrs B who contacted the police in December 2020 reporting that she had been assaulted by Mr A. No formal complaint or arrest was made in relation to this one incident.

2.6 Incident summary:

2.6.1 Mr A and Mrs B had spent the evening in February 2021 on a zoom call with their daughter, Mrs C and son in law celebrating Mrs B's 66th Birthday, this was due to Covid 19 Lockdown restrictions. The family had all enjoyed food and drinks separately in their homes. It was reported that the evening had been going well until an argument had started between Mr A and Mrs B over an iPad charger that appeared not to be working so the call ended.

2.6.2 Later that same night, Mr A called 999 however seconds after this was answered, Mrs B advised that she had attempted to kill her husband, Mr A, by stabbing him with a knife. She also added that Mr A had teased her after the stabbing so she stabbed him twice further.

2.6.3 It was recorded by agencies that Mrs B had refused to provide first aid when requested to do so by the ambulance call handler. Mrs B also advised as part of the call that Mr A had been abusing her for months and she had reached breaking point.

2.6.4 Mr A died as a result of several stab wounds to his chest, sides and groin areas on that night, and despite attempts made by emergency services to

resuscitate him on arrival he was pronounced deceased at his home address that evening.

3. Timescales

3.1 On 17th February 2021 Safer Somerset Partnership received a Domestic Homicide Review Referral relating to Mr A from Avon and Somerset Constabulary. A decision was made by the Chair of the Safer Somerset Partnership to undertake a review on 17th March 2021. The rationale for this decision was based on the information that the couple were married, had lived together for many years and there had been a death of a person aged over 16 that had resulted from violence.

3.2 An Independent Chair and Report Author was commissioned by the Chair of the Safer Somerset Partnership in May 2021 with the aim of completing this review by December 2021, as per statutory guidance. It was noted at the first panel meeting in July 2021 that the case was subject of a criminal investigation and that the trial was listed for October 2021. Individual Management Reviews were still undertaken swiftly by agencies to identify single agency learning, and some contact was made with family members prior to the trial. A more realistic timeframe of Autumn 2021 was set to conclude the enquiries and write the Overview Report during Winter 2021/22 after the criminal investigation had concluded. Further enquiries were undertaken after the Panel meeting in February 2022 relating to witness statements and contact the couple had with North Bristol NHS Trust. The final draft was agreed in July 2022.

3.3 As per the Terms of Reference, see Section 6, this review therefore examines the circumstances surrounding the death of Mr A in the county of Somerset in February 2021 and is called a Domestic Homicide Review. The principles underpinning the review process have been followed in accordance with the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews- Revised Version-December 2016.

3.4 The key purpose of this review is to enable lessons to be learned from Mr A's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of this happening in the future.

3.5 The Review has considered all contacts/involvement agencies had with Mr A during the period of February 2016-February 2021 as well as any events, prior to this date which are relevant to mental health, violence and abuse.

3.6 Owing to their serving career in the Army and relatively short period of time spent living in Somerset, contact was made with the Wiltshire Community Safety Partnership to understand whether there was any relevant information known by key statutory agencies in that location, as they'd lived their immediately prior to Somerset. This partnership responded advising that they did not have any relevant information to share.

4. Confidentiality

4.1 The findings of this Review are restricted to only participating professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel. See section 11 for information on publication.

4.2 As recommended within the 'Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identity of the deceased, and her family, the following pseudonyms have been used throughout this report.

4.3 The name Mr A is used for the deceased, who was 78 years at the time of his death and identified as a White British Male. The Independent Chair liaised with the deceased's youngest child and the name Mr A was chosen by her. The name Mrs B was agreed by the Review Panel to represent the offender. Mrs C was also agreed by the Review Panel to represent Mr A's youngest child who Mr A spent the most time with during the timespan of this review (2016-2021).

4.4 The sharing of information between agencies in relation to the DHR was all underpinned by a Confidentiality Statement which each Panel member read and signed at the beginning of the review (Appendix B). An information sharing protocol was and currently is in place which all local agencies represented on this panel are signatories to, this agreement is underpinned by the Crime and Disorder Act 1998 which the Safer Somerset Partnership have in place.

5. Multi- Agency Domestic Homicide Review Panel

5.1 The Domestic Homicide Review Panel consists of senior managers, from both the statutory and voluntary sector, listed below in 5.2. All of the agencies who have been part of the Review have assisted in the identification of lessons and committed to implementing action plans to address the lessons. All Panel members have also undertaken the Home Office DHR Panel training and signed confidentiality statements.

5.2 The membership of the Domestic Homicide Review Panel included the following;

- Faye Kamara LLB MSc, Independent Chair,
- Suzanne Harris, Senior Commissioning Lead-Domestic Abuse, Somerset County Council
- Heather Sparks, Adult Safeguarding Lead, Taunton and Somerset NHS Foundation Trust
- Samuel Williams, Detective Chief Inspector, Avon and Somerset Constabulary
- Emma Read, Deputy Designated Nurse for Safeguarding Adults, Somerset Clinical Commissioning Group
- Mark Brooks, Chair, Mankind Initiative
- Suzanne Cornford, Principal Safeguarding Officer, SSAFA (Armed Forces Charity)
- Chloe Day, Paragon (Service) Manager, Somerset Integrated Domestic Abuse Service (The You Trust)

5.3 The Review Panel was also supported with contributions from;

- Ministry of Defence, Army Welfare/Personal Support

5.4 The Independent Chair and the Review Panel members offer their deepest sympathy and condolences to Mr A's family. The Chair would also like to thank the Review Panel and Specialist advisers who have contributed to the Review, for their time, transparency and cooperation.

5.5 The Chair of the Panel possesses the qualifications and experience required of an Independent Review Chair, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She is not associated with any of the agencies involved in the Review nor had she had any dealings with Mr A and is totally independent. She has undertaken the AAFDA (Advocacy after Fatal Domestic Abuse) DHR Chair Training and is an experienced DHR Independent Chair and Report Author.

5.6 As per the Home Office guidance letters together with the Leaflet on 'Domestic Homicide Reviews' were sent to Mr A's three daughters and his sister. The independent Chair met with Mr A's family, collectively and individually in some cases, via Microsoft Teams on multiple occasions to seek their views and experiences and provide updates on progress relating to this statutory review. The Independent Chair also sent numerous letters to Mrs B via her solicitor and to Her Majesty's Prison Service inviting her to share experiences of agencies and her relationship with Mr A. However, Mrs B declined this invitation whilst she appealed her conviction.

5.7 Mr A's family were given the opportunity to influence the Terms of Reference by making suggestions for additional key lines of enquiry, however they felt that what the Panel had drafted was comprehensive. As per family's request and Home Office Statutory Guidance the family have also had sight of this report and provided comments, factual amendments and queried points of accuracy.

6. The Terms of Reference

6.1 Commissioner of the Domestic Homicide Review

6.1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Mr A. Mrs B was also convicted of Mr A's murder in October 2021.

6.1.2 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.

6.2. Aims of The Domestic Homicide Review Process

6.2.1 Establish the facts that led to the death of Mr A in February 2021 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.

6.2.2 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.

6.2.3 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.

6.2.4 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 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.

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

6.3 Scope of the review

The review will:

- Consider the period from February 2016 to February 2021 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 Mr A's family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse, coercive or controlling behaviour 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, neighbours and statutory and voluntary

organisations. This is to also ensure that the dynamics of coercive control are also fully explored. Explore whether communities would know what action to take if they suspected domestic abuse.

- Scope whether any support was offered to the family by military related organisations given Mr A's occupation and how they identify signs of domestic abuse.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Mr A or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively. This is to include the impact that the Covid-19 pandemic may have had on agencies from March 2020 to Mr A's death in February 2021.

7. Schedule of the Domestic Homicide Review Panel Meetings

First Panel Meeting- July 2021

Second Panel Meeting- November 2021

Third Panel Meeting- February 2022

Fourth Panel Meeting- June 2022

8. Methodology

8.1 This Report has been compiled using information and facts from the following:

- Individual Management Reviews as per statutory guidance from the following agencies;
    - Avon and Somerset Constabulary
    - Somerset Clinical Commissioning Group
    - Somerset Partnership NHS Foundation Trust

- A chronology of events leading up to the death of Mr A, coordinated and produced by Safer Somerset Partnership

- Information shared by family members of Mr A's character and their experiences and observations of his relationships.

- Information provided by North Bristol NHS Trust

- Discussions during the Review Panel Meetings

- Summary of information from Witness Statements held by Avon and Somerset Constabulary.

9. Contributors to the Review

9.1 Whilst there is a statutory duty that specific bodies including, the police, local authority, probation and health authorities must participate in a DHR; in this case eight agencies were involved in this review. These are listed in Section 5 of this report,

9.2 Family members did respond to the invitation made by the Independent Chair to contribute to this review as previously advised in para. 3.2.

9.3 Contact was also made with Mrs B through the solicitor, prison service and an outreach service to contribute to this review. Mrs B responded advising that she felt unable to contribute at this time due to legal advice.

10. Parallel Reviews

10.1 There was a criminal investigation undertaken into the death of Mr A, and Mrs B was found guilty of murder on 29th October 2021 and sentenced to life imprisonment for the minimum term of 18 years based on aggravating factors. In the sentencing remarks "Having inflicted fatal injuries you then spent 18 minutes talking to the emergency services during which time you refused all their pleas to go to Mr A's aid. He was alive for much of that 18 minute period and would have been able to hear what you were saying. At one stage in response to an enquiry as to whether he was still alert you called out to him by way of enquiry, but did so in a mocking fashion and with no thought of helping him. At other points you even contemplated stabbing him again and said so. Your behaviour during that call evidences a shocking level of callousness on your part".

10.2 The Coroner will not be undertaking an Inquest following the outcome of the criminal investigation and an Indefinite Adjournment was agreed on 19th November 2021.

11. Dissemination

11.1 Each of the Panel members (see para. 5.2), the Chair and members of the Safer Somerset Partnership, the Avon and Somerset Police Crime Commissioner will receive copies of the Report. The Domestic Abuse Commissioner's Office will also receive a copy of this report. The report will be published on the local

Somerset domestic abuse website www.somersetsurvivors.org.uk. Redactions maybe requested by Panel members or family members prior to the publication through contact with the Independent Chair.

11.2 A redaction may be the removal of personal and sensitive details about an individual, i.e. medical information. Redactions will not be used to protect the identities of the agencies participating in the Review.

12. The Facts

12.1 Mr A was a father to three daughters and one son and had multiple grandchildren. Mr A had been married three times, his third marriage was to Mrs B 25 years ago in 1996. Mr A's son sadly died in 1998 and it was reported, as part of the criminal trial and this review by family members, that during that time Mr A experienced low mood and was prescribed some medication. There is no record of this in his GP records in Somerset because at that time he did not live in the area.

12.2 In 2012, owing to a benign essential tremor, Mr A had a deep brain stimulator inserted to treat the tremors. A Medtronic battery was also inserted into his abdomen; this was done in France which was his residence at the time. There are no indications in his medical records that this ever caused any issues for him- in terms of his physical health. There was evidence in his records that there were yearly reviews of this stimulator with review letters sent to the GP for their records.

12.3 The next record any agencies had significant to this review was when Mr A was diagnosed with Rectal Cancer in July 2015. Correspondence was shared with the Neurological team in North Bristol NHS Trust at this time to ensure that no treatment or surgery would affect his deep brain stimulator. It is understood by the Panel that surgery was undertaken and that he also underwent a period of chemotherapy which ended in February 2016.

12.4 On 18th May 2016, it was reported to the police by Mrs B that they had been burgled following a 2 week holiday, where watches had been taken. This was investigated but no prosecution was made. It was recorded that the couple were provided with Victim Support information.

12.5 Mr A was in regular contact with the Nursing team at Musgrove Park Hospital in the summer of 2016 and it was recorded that he was struggling to manage emotionally with his ileostomy and couldn't wait to have a reversal. It is understood from family members as part of this review that he did have a reversal procedure.

12.6 On 24th October 2016, a further report was made by Mrs B and Mr A to the police of a burglary whilst staying in a hotel where a high value watch was stolen from the guest room via a window. This was investigated but no prosecution was made.

12.7 Mr A had a routine appointment to check blood pressure and routine observations in November 2016. There were no records of any contact with Mr A then until October 2017, when following a telephone consultation with the GP practice, Mr A expressed how unhappy he was that they were discussing his risk of diabetes over the phone instead of a face to face appointment. Mr A was advised to eat a healthy diet and regular exercise to prevent progression to full diabetes.

12.8 Mr A was in touch again with the GP Practice one week later complaining of erectile dysfunction which he was very upset about and had been an issue since his prostate surgery in 2012. There were no other records in this consultation of his relationship with his wife.

12.9 In March 2018, Mr A had further contact with the GP practice regarding gallstones where he was assessed and provided with treatment. There were no further records of contact with Mr A until September 2019 when he attended the GP Practice for routine blood pressure tests and observations, and his medications were reviewed.

12.10 There were no further records of Mr A until December 2020 when it was recorded by the GP Practice that Mr A had attended as an outpatient to North Bristol NHS Trust. Mr A attended an Outpatients appointment at Bristol Brain Centre during December 2020, following a battery replacement for the deep brain stimulator for the essential tremor in 2012. This battery change at Southmead hospital took place on 21st December 2020.

12.11 On the evening of 23rd December 2020 Mrs B called Avon and Somerset Constabulary to report that she had been assaulted by Mr A at their home following an argument concerning the tv remote. It was recorded that Mr A had said to Mrs B that she was controlling him and he was leaving. Mrs B reported that Mr A was angry, grabbed and shook her arms leaving bruises, and in response, because she was frightened, she locked Mr A in the conservatory to calm down. She further reported that Mr A smashed the conservatory window with a fire poker to exit and threatened her with violence if she did not get out of his way. Mr A then left the home voluntarily and was picked up walking towards town by Mrs C, they then returned home and Mr A waited in the car whilst Mrs C supported Mrs B. Mr A and Mrs B sat in separate room until the Police arrived. Officers attended and spoke to Mr A and Mrs B separately. Whilst officers spoke with Mr A he remarked ‘did she tell

you what she did to me', and this was recorded as such on the risk assessment. Officers perceived the Domestic Abuse, Stalking and Honour Based Abuse (DASH) risk assessment for Mrs B as the victim to be medium. Mrs B advised that Mr A had had some surgery two days prior and questioned whether this could explain his behaviour. Officers suggested that Mr A should leave the property with his daughter, Mrs C, that night; who had attended the property after hearing about the incident from Mrs B. Officers also advised Mrs B that she should contact North Bristol NHS Trust for advice on whether Mr A's minor surgery could have impacted on his behaviour.

12.12 The same evening Mrs B also contacted North Bristol NHS Trust and left a message on the nurse telephone clinic answering machine advising that Mr A had become aggressive and left the home that evening and that the police were in attendance. The following day on 24th December 2020 North Bristol NHS Trust returned a call to Mrs B who reported that Mr A had experienced an episode of becoming verbally aggressive the night before, which was out of character for him, and he had left the house. She also advised that she had called the police at the time. She stated that Mr A had not been physically aggressive and that his behaviour had since returned to normal. She said that both Mr A and herself were embarrassed by the incident.

12.13 Following this conversation, direct contact was made with Mr A by North Bristol NHS Trust to encourage him to attend the clinic that afternoon, Mr A refused stating that it was Christmas Eve. Mr A advised that he remembered the sequence of events leading up to his verbally aggressive behaviour, resulting in the police having to be called and reported that he was very embarrassed about the incident. He did not report any pain however a form of pressure sensation to the right frontal part of his head. An assessment was carried out over the phone by the clinician with Mr A to determine if there were any signs or symptoms of an infection. As a precaution Mr A was instructed to reduce his stimulation voltage for Channel 1 (his right side of body). Mr A was familiar with this process and confirmed on the call that this had been undertaken.

12.14 It was reported by family members as part of this review that things had calmed down and they all had a nice Christmas together.

12.15 On 29th December 2020, Officers followed up with Mrs B who advised that she did not want to pursue a complaint nor have any contact from the Lighthouse Safeguarding Unit who could offer help, advice and support. She also advised the police that she had sought medical advice from North Bristol NHS Trust who had advised that the slight adjustment to his battery could have had an impact on his behaviour but that all had settled now. The Police considered an evidence led prosecution but the evidence did not support this. On 30th

December 2020, Mr A visited North Bristol NHS Trust, this was following the incident that occurred on 23rd December 2020 and his refusal to be seen in person on 24th December 2020. His battery was checked and a discussion took place with him about the sequence of events that led to his change in behaviour. It was recorded that he was vague with his answers and he was advised that his GP would be notified of his attendance at clinic and a nurse would follow up with him 4 weeks later.

12.16 On 31st December 2020, Mr A attended the GP Practice to have the stitches removed following the battery replacement that was undertaken on 21st December 2020.

12.17 On 5th January 2021, a letter detailing the contact Bristol Brain Centre/North Bristol NHS Trust had had with Mr A since the battery replacement on 21st December including details of the incident and behavioural changes Mr A felt. Within the letter, it was recorded that Mr A would be reviewed again by the team in February 2021 and that they had reiterated to Mr A that if he had any other experiences or any feelings of change in his behaviour that he must contact the service.

12.18 It was reported as part of this review and criminal investigation by some family members that Mr A and Mrs B had enjoyed a family meal, cocktails and games via zoom, owing to Covid 19 pandemic lockdown on an evening in February 2021. However, that the call had come to an abrupt ending because Mr A and Mrs B had argued over an iPad charger.

12.19 Later that evening Mr A called 999 and seconds later the call was taken over by Mrs B who stated that she had attempted to kill her husband by stabbing him. The ambulance service alerted the police. Whilst both services were travelling to the address, Mrs B advised that Mr A had teased her after the stabbing so she stabbed him a further two times. Mrs B refused to provide first aid when requested to do so by the call handler and it was recorded as part of the criminal investigation by the ambulance service that during this 18minute period of emergency services traveling to the address Mrs B called out to Mr A but did so in a 'mocking fashion with no thought of helping him'.

12.20 Police Officers and Ambulance Crew attended the address shortly after the call. Officers found Mr A on the floor having been stabbed a number of times and despite numerous attempts by the emergency services to resuscitate Mr A he was pronounced dead at the scene. Mrs B was arrested and subsequently charged with murder.

12.21 As per para 10.1, Mrs B was later convicted of murdering Mr A on 29th October 2021 after a 13 day trial. Mrs B was sentenced to serve a life imprisonment

sentence set as a minimum of 18 years due to several aggravating factors including the use of a weapon.

13. Overview

13.1 The Panel have been committed to the Review, within the spirit of the Equalities Act 2010, and have demonstrated an ethos of fairness, equality, openness and transparency. The Panel have worked as a partnership in ensuring that the Review has been conducted in line with the Terms of Reference.

13.2 The Review has been cognisant of Mr A's family, their privacy and have been very grateful of the contributions made by the family members. The family members have provided the Review Panel with an insight into the type of person that Mr A was; caring, hard-working and very private in terms of his relationships and health conditions. This intelligence has been invaluable given the little information known by agencies in Somerset.

13.3 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010 i.e. Age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, face and religion and belief, sex or sexual orientation.

13.4 In line with the Terms of Reference, the Panel considered these protected characteristics and concluded that Mr A was a 78 year old male, who had battled several serious medical conditions. Therefore, although family members recognised that he had aged, and one family member reported that his words on occasion sounded more slurred as a result of his deep brain stimulator they did not describe him as frail. Instead, he was a very proud man who had served his country in the British Army for many years and was enjoying his well-deserved retirement. The Panel however did acknowledge his age and gender and explored as a Review Panel the experiences he had from agencies and whether these protected characteristics played a part in how he was seen, understood and responded to by organisations.

13.5 As per section 5 of this report, the following agencies were involved in this review either because they had involvement with Mr A or Mrs B or their expertise was relevant to this case.

- Somerset County Council- (Safer Somerset Partnership- Commissioner of Review)
- Somerset NHS Foundation Trust (previously Taunton and Somerset NHS Foundation Trust/Somerset Partnership NHS Foundation Trust)
- Avon and Somerset Constabulary

- Somerset Clinical Commissioning Group
- Mankind Initiative
- SSAFA (Armed Forces Charity)
- Ministry of Defence- Army Welfare Service
- Somerset Integrated Domestic Abuse Service (The You Trust)
- North Bristol NHS Trust

13.6 Somerset County Council are one of the main agencies involved in the Safer Somerset Partnerships who have the statutory responsibility for commissioning Domestic Homicide Reviews under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Therefore their involvement in this review was to ensure that the Statutory Guidance was followed and to offer support and information on the commissioning of domestic abuse services.

13.7 Somerset NHS Foundation Trust is the newly merged services of secondary acute care, community and mental health services provided in Somerset. Mr A had very limited contact with this service which was at the time known as Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust where he received treatment for Rectal Cancer. No disclosures of domestic abuse or references to his home life were recorded in his medical records by this provider.

13.8 Avon and Somerset Constabulary provide the police service to the county of Somerset. Mr A was only known to this organisations in relation to two reports of burglary which Mrs B had reported and one domestic abuse related incident in December 2020, where Mr A was recorded as the alleged offender. Although Mr A did express at the time of the incident 'has she told you what she did to me' which implied that there had possibly been some abusive behaviour from Mrs B towards Mr A.

13.9 Somerset Clinical Commissioning Group (CCG) is the main commissioner of health services within the Somerset area. The CCG have been included as part of this review in order to incorporate what was known by Mr A's GP about his physical and mental health. The GP Practice were informed of Mr A's various illnesses over the years and also received annual updates from North Bristol NHS Trust about the review of Mr A's deep brain stimulator.

13.10 Mankind Initiative are a well-respected national initiative which offers support to male victims of domestic abuse. The charity also advocates for this cohort and has undertaken extensive research with the support of other academics into the experiences male victims of domestic abuse face from organisations. The Panel felt it would be valuable to have this expertise incorporated into the discussions.

13.11 SSAFA is a nationally recognised Armed Forces charity. They provide support and help to serving military families and veterans. As previously indicated both Mr A served in the Army in various officer roles, and Mrs B worked for the Ministry of Defence; they lived in various countries and therefore as part of this review the Panel wanted to understand what support is available for military families who experience domestic abuse. In addition, how are staff working in these charitable roles trained to spot the signs of domestic abuse etc..

13.12 Ministry of Defence- Army Welfare/Personal Support. This division of the Ministry of Defence have a responsibility to ensure that appropriate training, support and supervision is in place to manage personal issues that officers might face. The Panel sought advice from this service for the same purposes as above- to seek assurance on what support is available to military families, and what is the training, policy and awareness internally of this subject.

13.13 Somerset Integrated Domestic Abuse Service is the specialist domestic abuse support service in Somerset commissioned by the local authority (Somerset County Council) to provide the core services of IDVA (Independent Domestic Violence Adviser), outreach and accommodation. This service is provided by The You Trust which is the name of the organisation. Mr A did not have any contact with this agency prior to his death.

13.14 North Bristol NHS Trust provides hospital and community healthcare, and is also as specialist regional centre for neurosciences, plastics, burns, orthopaedics and renal. Mr A had some contact with this organisation from June 2015 after having a Deep Brain Stimulator implant was fitted in France a few years earlier. Mr A was seen on numerous occasions (June November 2015, June 2016, March 2017, June 2017, June 2018, July 2019 and December 2020) to have his Deep Brain Stimulator checked, battery changed and further programmed. No disclosures of domestic abuse or sensitive information about his relationship with Mrs B that might give cause for concern of additional questioning were shared at any of these consultations. However, detailed information from this organisation was provided to us in relation to the contact they had with Mr A and Mrs B in December 2020.

13.15 A chronology was compiled as part of this review given the number of contacts Mr A had had with these agencies. A brief summary of this is captured in 'The facts' section of this report.

13.16 Individual Management Reviews were also undertaken by three agencies as already listed in section 8; Avon and Somerset Constabulary, Somerset Clinical Commissioning Group and Somerset NHS Foundation Trust. However

additional information was sought from North Bristol NHS Trust. All reports and presentations were completed by professionals who were independent, and had no contact with either Mr A, Mrs B or any direct line management of any professional who had contact with them.

13.17 In addition to the information provided above, the summary of witness statement provided to the court included some other insights into the relationship between Mr A and Mrs B. As already indicated Mr A was described by many in witness statements as a proud and traditional man who was thoughtful and considerate. He liked order and expected certain standards of behaviour. He was also described as stubborn. Mrs B was described as a strong character with firm opinions, loud and gregarious, often the centre of attention and sometimes enjoyed antagonising/doing things others found uncomfortable.

13.18 According to witness statements, both Mr A and Mrs B were strong minded and opinionated individuals who found it difficult to admit if they were wrong. Many witness statements reported that they would sometimes observe bickering and frostiness over a difference of opinion between them with neither admitting they were wrong or wanting to back down. These arguments were usually resolved quickly within the same day or following day was also what was reported by witnesses as part of the criminal trial. Witnesses commented that Mr A would calm Mrs B if she got too loud by placing his hand over hers. Other witnesses said that they observed verbal abuse between the couple who argued and berated each other. It was mentioned that Mrs B would berate and belittle Mr A (this was in the context of Mrs B stating her money paid for things). Witnesses also stated that Mr A would be embarrassed by Mrs B's behaviour at times and that it appeared that she seemed to enjoy his discomfort.

13.19 Mrs B was also described by some of the witnesses as being unsympathetic to Mr A when suffering from the effects of the deep brain stimulator to control his tremors. As a result of this, one friend disclosed that Mr A had reported that he wanted his friend to 'find him a flat as he want(ed) to get out of this' at the time, this was just after his initial operation to stop his tremors in 2012. The same friend also commented that the couple bickered and on one occasion Mr A loudly told Mrs B to 'shut the f*** up' which was out of character.

13.20 Most friends who provided witness statements stated that they had never witnessed any physical aggression or violence between the couple. They said they were often happy together in each other's company.

13.21 As previously reported in this review in para 12.1, it is understood that Mr A found the death of his son extremely difficult and this affected his mood. Witnesses statements compiled for the criminal investigation included references to Mr A not being able to grieve for this death because Mrs B didn't want to support him with his grief and believed that he should just get over it. However, to the contrary other family members commented that Mrs B supported Mr A to grieve, taking flowers to his son's grave in Scotland every year and supporting him in any way she could.

13.22 There was also commentary within the witness statements that Mr A had reported before he married Mrs B that he didn't want to get married but felt he could not back out for fear of the consequences for his career and reputation. This supports the kind of character Mr A was. Another witness stated that Mrs B disclosed that she was not happy in the marriage to Mr A but could not afford to financially leave the marriage. Another witness said that Mrs B would often say she loved her third husband and did not love Mr A, and this would be said in front of him but Mr A would not react.

13.23 Although there was only one reported domestic incident in the United Kingdom, as a result of the criminal investigation into Mr A's death it was advised by witnesses and Mrs B that there were incidents that occurred in the late 1990s whilst living in Germany. The first mentioned in statements was in June 1999, where following a day out with Mr A's family a physical incident occurred where witnesses described both Mr A and Mrs B shouting and pushing each other, with Mrs B goading Mr A to fight. Mr A headbutted Mrs B and then returned with a knife. Family members that were present reported in their witness statement that they were able to remove the knife from Mr A. The police were not called, and witnesses believed that Mr A received counselling after this incident.

13.24 Mrs C, as part of the criminal investigation advised of two further incidents in Germany in the late 1990s, one where Mr A smashed a mug bought by her as a Mother's Day present in front of both her and Mrs B. Another was where she had returned home to Mrs B and Mr A arguing and witnessed Mr A hit Mrs B against a barometer on the wall. Mrs B's nose was bleeding and both her and Mrs C left the house for the night and returned the next day. Mrs C also documented in her witness statements that she was told that Mr A had made threats to Mrs B that she would tell Mrs C the truth about her birth father.

13.25 Two further alleged incidents were also recalled by Mrs B as part of the criminal trial, one where Mr A had kicked Mrs B down the stairs in Germany and another where Mrs B was strangled whilst on a cruise following an argument over coffee.

13.26 The above information provided the Panel with some context from those closest to the couple, in terms of what Mr A's and Mrs B's relationship appeared to be like. Although there was only one reported domestic incident to the police in the United Kingdom and no other disclosures made to any other agencies within the timeframe of this review, there is clear evidence from these sources that both Mr A and Mrs B exhibited domestic abuse behaviours towards each other for a significant period of their marriage.

14. Analysis

14.1 The Panel has considered all of the Individual Management Reviews through the viewpoints of both Mr A and Mrs B, to ascertain whether the contact made had been appropriate and that the agency acted in accordance with their set procedures and guidelines. This was with the aim of establishing whether any lessons needed to be learnt. In addition, the Panel explored with the support of Mankind Initiative, SSAFA and Ministry of Defence- Army Welfare/Personal Support what the response might have been had the couple still been working and disclosures had been made to their employer.

14.2 The authors of the Individual Management Reviews have followed the Review's Terms of Reference and addressed the points within it. The agencies undertook the Internal Reports in an honest, thorough and transparent fashion, ascertaining information from a number of sources. The following is the Review Panel's view on the appropriateness of the intervention undertaken by each agency and/or whether their policy and procedures are adequate in protecting and supporting victims of domestic abuse.

Avon and Somerset Constabulary

14.3 As previously articulated within this report, there were only three contacts that this organisation had with either Mr A or Mrs B; two of which were reports of burglary. The third contact was a domestic incident reported by Mrs B on 23rd December 2020 where she stated that the two of them had argued over a television remote. It was reported that Mr A had thrown the remote stating that Mrs B was controlling him and grabbed and shook Mrs B by the arms leaving bruises and frightening her. Mr A advised that he had packed a bag and was leaving. Mrs B then locked Mr A in the conservatory to calm down and prevent him from leaving. Mr A subsequently smashed the glass in the conservatory internal door with a fire poker to enable him to exit the conservatory and threatened Mrs B with violence if she didn't get out of his way. Mr A left the property on foot. Mrs B called the police and her daughter Mrs C to advise what had happened. Mrs C made contact with Mr A and arrived at the property with Mr A. Officers then attended about 20 minutes later and found that the situation had diffused with Mr A and Mrs B in separate rooms and with both Mrs C and her husband present.

14.4 It was highlighted in the IMR that Officers were professionally curious with Mrs B when she advised that Mr A had undergone an operation two days previously to change a battery in his brain implant and had not been the same person since. The officer probed further to understand what their relationship was like, it was recorded that Mrs B advised that Mr A could be vindictive and have a bad temper but that he had not displayed this behaviour previously. The IMR highlighted that this was managed in accordance with the Constabulary's procedural guidance and empathy and sensitivity was demonstrated by the officer in how the incident was recorded on the police system.

14.5 Nevertheless, the second officer, who spoke separately to Mr A, did not undertake thorough enquiries with him about his experiences of the relationship. It was recorded in the IMR that Mr A remarked to the officer 'has she told you what she did to me' but this was not explored further with Mr A at the time of the incident nor later on. The Panel felt that this was a potential missed opportunity to better understand the dynamics of the relationship because it appeared as though following Mr A's comment above he may have made a disclosure of abuse. However, to the contrary, the Panel were informed by Mr A's family that he was a very proud man and they advised it was probably unlikely he would have disclosed any abuse he had been subjected to in detail due to feeling embarrassed.

14.6 The Panel agreed that policy and procedure were not followed adequately for this incident, because there was a lack of professional curiosity with Mr A. Mrs B was asked if she wished to be supported by a specialist domestic abuse service, the parties were separated and spoken to individually and Mrs B was encouraged by the police to seek medical advice for Mr A given the change in behaviour since the minor operation two days prior.

14.7 A few days after the incident, Mrs B was contacted by the police as part of a follow up, once again this was recognised by the Panel and IMR author as standard but good practice. Mrs B had sought medical advice and reported that Mr A had since adjusted the settings which had made a different to his demeanour. She also added that Mr A had not recalled the incident and was ashamed of what had happened. Mrs B also added that she did not want any further police action. There was no additional follow up contact made with Mr A. It was highlighted in the IMR that a further direct conversation with Mr A driven by professional curiosity during the investigative process could have led to a disruption in the events that preceded Mr A's death.

14.8 It was also acknowledged by the IMR author and the Panel that the officers did not appear to be open minded to the possibility that it was Mr A who was

the primary victim, even though the initial report for this domestic related incident came from Mrs B. This was because Mr A was not asked to account for specifics of the incident at the time nor asked to voluntarily attend later to explain the incident and his involvement, which have may have enabled the officer to understand more details about the relationship as has already been stated above. The Panel discussed the barriers that male victims face when reporting domestic abuse to agencies, and therefore how well this is understood by practitioners who come across these situations. It was concluded that further awareness raising of this issue would be helpful to ensure that approaches to supporting male victims and encouraging disclosures of domestic abuse are appropriate.

14.9 Within the IMR and Panel discussions, the police action on reviewing the incident was also considered. The Panel concluded similarly to the police that there was limited evidence to support an evidence-led prosecution owing to no formal complaint being made by either party about one another. Therefore, the internal police processes in place to review these incidents was sound.

14.10 The Police IMR did recognise the importance of reviewing their Domestic Abuse Procedure Guidance which had already been identified in a previous Domestic Homicide Review. The updates needed to reflect how domestic abuse in an older population should be managed. This was also discussed as a wider learning point- see para 15.12 below. In support of this change, the police Panel representative also advised that a new force wide training programme would commence in Autumn 2022 called Domestic Abuse Matters provided by Safe Lives. This is an evidence based cultural, attitudinal and practice transformation programme, specifically for police forces, included within this work is a localised element of domestic abuse and older victims. The programme aims to effect mass cultural change through; a force health check to ensure the cultural change can be maintained, enhanced training on domestic abuse; creating Domestic Abuse Matters Champions who will sustain the change and support colleagues particularly around compassion fatigue, and; a train the (local) trainers programme so that training can be ongoing. The programme focuses particularly on controlling and coercive behaviour and the dynamics of domestic abuse including specific cohorts like those aged over 60, male victims and LGBTQ victims.

North Bristol NHS Trust

14.11 Mr A was referred to this organisation via his GP, in June 2015 following the Deep Brain Stimulator fitting in France the previous year. A full IMR was not requested at first from this organisation because it was believed that their contact was purely clinical and extremely limited. However, a thorough report

was shared with the Panel in April 2022 to provide clarity on what contact and actions were taken by this organisation in particular relation to the time period December 2020.

14.12 Within this report, the Panel were advised of what the usual policy and pathway would be for a patient with a Deep Brain Stimulator implant and this was that contact would be made with the patient 6months post activation, at 1 year and at 2 years. In addition, patients would be encouraged to self-refer to the service if they had any queries or concerns in relation to the programming of their stimulator. Patients are not discharged from the service. However, in this instance, because Mr A's deep brain stimulator was fitted elsewhere, he did not follow the usual patient pathway but was seen regularly to check programming etc. This was regarded as good practice by the Panel and by the organisation. He also had previously had some surgery for a replacement Implantable Pulse Generator incorporating a battery at North Bristol NHS Trust and therefore was seen by a sister team, the Movement Disorder team also. Assurances were sought from the organisation in relation to safeguarding policies and practices, in order that had Mr A made any disclosures to these specialist teams that pathways to safeguard him would have been followed.

14.13 The safeguarding actions taken following Mrs B's call to this organisation on 23rd December 2020 were scrutinised by the Panel. The Panel concluded that they had followed good practice in seeking the latest position from Mrs B by returning her call as soon as possible, and making direct contact with their patient Mr A to understand how he was feeling. This was also fully documented and provided an excellent audit trail for this review and the court witness statements.

14.14 In addition to the above, the Panel also upheld the excellent practice in insisting that they physically met with Mr A after the incident on 23rd December 2020. As we know from 'The Facts' chapter, Mr A refused to visit the clinic on the 24th December 2020 after the incident to have his battery checked and meet with the Nursing team, therefore he was invited and attended on the 30th December 2020. His battery was checked and it was recorded as part of this review that probing questions were asked to establish the sequence of events and full picture of what had happened. However, it was documented in the records that Mr A was very embarrassed about the whole situation and was very vague with his answers. He said that it was a misunderstanding with Mrs B and all was now resolved. It was upheld by the Panel that professional curiosity was used in this situation and that the nurse could only work with the information available to them by what and how Mr A was presenting. The Panel felt assured that had there been more indicators

from Mr A suggesting he might be at risk that safeguarding procedures would have been followed and his GP would have been notified immediately.

14.15 In summary, there was some good evidence presented by this organisation that they followed up concerns and documented information well; this was also supported by the Panel discussions. Given the period of time this happened, there were some minor delays in letters being written and distributed to the GP Practice about Mr A's attendance at the clinic. The Panel debated how much of an impact this might have had on any missed opportunities. The Panel concluded that had the GP Practice known more about the incident on the 23rd December 2020, and the follow up consultation with North Bristol Trust on 30th December 2020, when Mr A did attend on 31st December to have his stitches removed a more thorough conversation could have been undertaken to establish how he was feeling etc. Nevertheless, based on the information recorded during his consultation on 30th December 2020 with this organisation, and information from his family about his personality, the Panel thought it was unlikely that he may have shared any further information about his situation. On that basis and reassurances sought from North Bristol NHS Trust, there were no recommendations suggested.

Somerset Clinical Commissioning Group

14.16 Mr A had contact with his GP Practice in Somerset 6 times between early 2016 and his death in 2021. None of these contacts were in relation to domestic abuse. Instead, they were due to his medical conditions which included prostate cancer, rectal cancer and the deep brain stimulator which was fitted in France in 2012. This stimulator was checked annually owing to the Medtronic battery which was placed in his abdomen, and therefore correspondence was shared regularly between North Bristol NHS Trust and the GP practice about this.

14.17 Following analysis of the contacts made by Mr A to the GP Practice in October 2017, it appeared to the Panel that when he called the Practice to discuss the risk of diabetes and requested a face to face appointment but this was declined that he may have wanted to discuss something more sensitive with the GP in person. This is because one week later when Mr A was seen in person, he expressed to the GP his concerns of erectile dysfunction following his prostate surgery in 2012. However, the Panel discussed processes related to booking an appointment, and unless a reason is articulated by the patient for the preference of a face to face conversation then it would not have occurred to the individual handling the telephone conversation the possible significance of a face to face consultation.

14.18 When Mr A attended the GP Practice and disclosed his concerns over erectile dysfunction following prostate surgery the next week there was no evidence within the records that a conversation took place with him about the impact this was having on his relationship with this wife. The IMR author and Panel felt that this might have been a missed opportunity for the GP to show professional curiosity and explore more directly with Mr A his marital relationship. A more open conversation may have led to a disclosure of any difficulties within the relationship and perhaps domestic abuse. A recommendation to encourage GPs to be professionally curious when patients disclose sensitive information that might have an impact on a relationship was endorsed by the Panel.

Somerset NHS Foundation Trust

14.19 Mr A had very limited contact with this agency in 2016 to support the management of his medication port whilst receiving Chemotherapy from North Bristol NHS Trust in February and March 2016. Mr A received 3 visits for care of his medication port, none were related to domestic abuse.

14.20 As the contact by this agency was extremely limited, a Panel discussion took place relating to what might have been the actions taken if Mr A had disclosed that he was experiencing domestic abuse at any of these visits, recognising that those visiting him at home would have been district nurses. Somerset NHS Foundation Trust advised the Panel that at the time of these visits the organisation would have been Somerset Partnership and district nurses received safeguarding training which did not explicitly reference domestic abuse, therefore had there been a disclosure by Mr A it is unclear how professionals might have responded. However, the representative from this organisation has provided assurances on what actions have been taken in the last two years to improve the agency's response to domestic abuse. More recently, an additional domestic abuse awareness raising e-learning module has been created which all professionals must complete and is an addition to their core safeguarding modules. It is anticipated that this will be rolled out over Summer 2022. For those clinicians requiring more detailed safeguarding training, domestic abuse features in this module too in significant detail using a case study, sexual exploitation and financial abuse. In addition to this there are also three other domestic abuse modules; one of these is about 'Domestic Abuse and Older Persons'.

14.21 Furthermore to this, the Trust has a dedicated Safeguarding Duty Team who advise on processes regarding domestic abuse concerns and all Duty Team members have regular domestic abuse bespoke training. There is also a Domestic Abuse Coordinator who supports clinical staff in the completion of DASH (Domestic Abuse, Stalking and Harassment and Honour Based Abuse

Risk Assessment), helps to deliver training and coordinates the Domestic Abuse Link Worker (DALs) Network. The DAL network is a group of staff members who have an interest in developing their knowledge and expertise when it comes to tackling domestic abuse both to support staff internally and patients who attend the Trust. The vision for the DAL network is to upskill the workforce to become more domestic abuse literate through developing specialists within individuals teams, so far the Trust has 60 staff members signed up to the DAL network. Finally, the Duty team also provide safeguarding supervision to Trust staff which enables the discussion of domestic abuse case work and learning from DHR's. The Trust's Safeguarding Service intranet pages also includes links to Somerset Survivors, 7 minute briefings (including professional curiosity and coercive control). Plus published DHR reports and associated learning are also shared via Staff newsletters.

15. Themes

In addition to the IMRs summarised above and some of the learning, Panel discussions also took place in relation to;

1. What research tells us about how we better respond and work with male victims and how does this relate to the county of Somerset
2. If Mr A had still been serving in the military, what might the response have been of his employer to respond to disclosures of domestic abuse
3. What work is being undertaken in Somerset to improve the identification and responses to older victims of domestic abuse
4. What the impact might have been given the Covid-19 pandemic and numerous lockdowns

15.1 Firstly, Mankind Initiative as articulated in paragraph 13.10 are a national charity based in Somerset that support male victims of domestic abuse. Their representative has been extremely valuable in exploring as a Panel how we can improve identification, responses and services for male victims of domestic abuse in Somerset. Panel discussions took place during the life course of this review to better understand the reasons why men do not disclose to services what they are experiencing. Hine (2019) tells us that this is because often men do not understand or recognise it themselves that what they are experiencing is wrong and that they are a victim. This research led the Panel to explore thoroughly how and what more could be done to combat the stigma that males can be victims too.

15.2 The Panel also discussed a more recent study undertaken in 2021 by University of Cumbria (Hope et al, 2021) which analysed 22 Domestic Homicide Reviews where the victims were males. The outcome of this research

found that opportunities were missed due to gender bias and outdated stereotypes. Similarly in this case, where there were missed opportunities to use professional curiosity to better understand the relationship from Mr A's point of view by the Police and GP Practice; the only two agencies which had any contact with him in the five years preceding his death. It was also found in this research that support services lacked guidance to help identify and treat male victims. The Panel explored this finding challenging their own policies and practices as well as one another on what training they deliver to combat the gender bias within this learning point. It was found that learning from this DHR as a case study example would add additional impact given it's media coverage.

15.3 In specific relation to this review, the Panel explored the phenomenon of male status within the military and how that might have impacted how Mr A felt about sharing what he was experiencing within his relationship. Research tells us (Taylor, Bates, Colosi et al, 2021) that male victims of Intimate Partner Violence are less likely to seek help for their victimisation than female victims. This is because of barriers to seeking help (status and credibility, health and wellbeing) as well as responses to the act of initially seeking help (discreditation, exclusion, isolation and helpfulness). For example, the social status of men being powerful and able to protect themselves- specifically those serving in the forces, whose role is to protect the country, does not align itself in the general narrative to the 'victim' label which has implications of references to weak, passive and trapped. The inferred synonymy between 'victim' and 'weakness' is particularly salient for male victims as was found by Allen-Collinson (2009) in A marked man: A case of female-perpetrated intimate partner abuse. This therefore suggests that 'to request help may therefore challenge internally and externally held beliefs around masculinity, where men are supposed to be strong, independent and self-sufficient individuals' (Walker et al, 2019). The Panel explored this alongside the views of family members who all concurred how Mr A was a very proud man and masculine in how he led his life owing to his career choices and experiences. The Panel concluded that they felt Mr A was certainly an individual who may have struggled with the inferred synonymy as described above between 'victim' and 'weakness'. Therefore, further work is needed in Somerset to ensure that male victims know where to go for help and how to de-stigmatise seeking help in these circumstances.

15.4 Furthermore to what is described above, the Panel also explored language and communications and how when raising the awareness of domestic abuse, as strategic leaders and commissioners we should consider what imagery is used to not reinforce gender bias but recognise that anyone can be impacted by domestic abuse regardless of gender. The Panel explored the term 'gender-informed', this describes the approach that should be adopted when

raising the awareness of these issues- being cognisant of the different audiences, cohorts and intersectionality that exists within today's society. The Panel agreed to adopt this approach in their communications plan to address domestic abuse over the coming years with the campaigns planned for the future. Likewise, when a campaign is targeted specifically at male victims, taking from the research noted above, any communications should be male-friendly and therefore be based around the following five factors; masculinity messaging, design, location, methods and case studies and third party endorsement.

15.5 The second area which the Panel had a focussed discussion on was in relation to military responses to domestic abuse, exploring what might have been the response had Mr A ever disclosed that he was experiencing domestic abuse whilst serving in the army. At first this was explored with SSAFA, as described above in paragraph 13.11 a national charity working with and supporting military families and veterans on a range of issues. SSAFA provided assurances to the Panel on what their policies, protocols and expected responses would be to any disclosures of domestic abuse. These included that all volunteers and case workers are trained in safeguarding and therefore are familiar with the signs of domestic abuse. Policies are also clear stating that when there are any concerns they will discuss with the Principal Safeguarding Officer. The representative from SSAFA advised that the organisation's ethos is to work in partnership with other agencies to mitigate against the risk escalating and that they are able to support individuals and their families indefinitely. This was recognised as good practice by the Panel and endorsed.

15.6 In addition to this, the Panel considered a report titled 'Experiences of Intimate Partner Violence and Abuse among Civilian Partners of UK Military Personnel: Perception of the Impact of Military Life and Experiences of Help-seeking and Support'. This report was published in October 2021 by Kings College London and reveals complex issues of 'culture, stereotypical gendered roles and behaviours, hierarchy, social isolation and separation, extra-relationship and family pressures associated with housing and finance, and complex victim-survivor dynamics'. It also highlighted the importance of training, awareness, data sharing, appropriate pathways for those experiencing intimate partner violence especially for those transitioning from military life into civilian support avenues.

15.7 The Panel recognised that Mr A and Mrs B's situation was different to many of the case studies included in this review. However, the transition of military to civilian life is relevant and how cultural changes might influence behaviours, attitudes and actions by individuals. The study found that cultural change is needed in the military community to engender attitudes which are more conductive and supportive of health relationships among personnel. The Panel

reflected that this was also true of this review in that organisations must recognise the gender differences and adopt a gender informed approach as discussed already above. The research also highlighted that further research is needed to investigate the experiences of male victim-survivors within the military personnel which the Panel would also support.

15.8 In addition to the above, the Panel also sought advice and information from the Army Welfare Service. As articulated already in paragraph 13.12 this service supports serving army personnel and veterans for a limited period upon leaving the service on all aspects of welfare issues including domestic abuse. Some excellent best practice was highlighted as a result of this engagement including the following;

- The Army consistently briefs that Domestic Abuse behaviours are contrary to core values and standards of being a solider and over the next 18 months, utilising a theatre production, workshops will be delivered across the Army to enhance awareness of domestic abuse.
- The personnel that work in the Army Welfare Service have undertaken a 7 months comprehensive course to become an Army Welfare Worker and this course includes specific training on Domestic Abuse.
- The Army Welfare Service also links with independent specialist domestic abuse charities to seek advice, consultation and supervision on complex domestic abuse matters.
- The Army Welfare Service is also informed of any reported incident of domestic abuse in order that data can be collated and appropriate services offered.

15.9 The above list is a handful of examples provided to the Panel on what actions have and continue to be undertaken by the Army and Army Welfare Service. As part of this engagement it was also advised that the above actions are part of a wider Ministry of Justice Domestic Abuse Strategy which includes the Royal Air Force and the Marines, where there is a Domestic Abuse Board in place to support the implementation of the strategy and share best practice and ideas on what work is being undertaken to reduce the harm caused by these issues.

15.10 The third area explored by the Panel was what actions and work had been undertaken to help identify older victims of domestic abuse in Somerset and what further work needed to be undertaken to improve this and provide assurances to the Partnership. The Panel advised that during the pandemic, a range of communications and networks were created and established to support the coordinated response to tackle domestic abuse, especially for the older population who were likely to feel even more isolated. This included a newsletter which was circulated every month to agencies that might come

into contact with victims of domestic abuse- reminding colleagues of the signs to look for and specialist support services available.

15.11 In addition to this, Safer Somerset Partnership also launched a specific campaign on the issue of older people and domestic abuse in December 2021 which lasted for 4 months. This included a press release, social media campaign, posters, an TV advert, BBC radio Somerset interview with the Chair of the Community Safety Partnership, magazine adverts and briefing for local elected councillors. Furthermore, sadly since Mr A's death a series of training programmes digitally hosted online have been created specifically to raise awareness of domestic abuse and coercive control which all agencies represented in the partnership can access. None of the modules are specifically related to older people and domestic abuse, although the core message throughout all modules is that domestic abuse can affect anyone of any age. The Panel did conclude that Safer Somerset Partnership should consider if a specific module for older people and domestic abuse should be created.

15.12 The Panel concluded that during the last two years and specifically since the pandemic began a significant amount of work has been undertaken to improve the pathway for older victims of domestic abuse, and raise the awareness amongst this cohort. Nevertheless, there is growing research that has indicated that the older population has been significantly affected as a result of the pandemic; owing to further isolation from support networks. Therefore, to that end, the Panel concluded that further exploration of pathways, commissioned services and training for staff was needed to improve the responses to older victims of domestic abuse. A report written by the Home Office together with a number of other agencies titled 'Domestic Homicide and Suspected Victim Suicides during the Covid19 Pandemic 2020-21' researched the typologies of victims and suspects and found that 18% of homicide victims were aged 65 or over in their study. When compared to previous years, there has been a small but significant increase in older victims of intimate partner homicide (especially aged 65 and over) with a decrease in younger intimate partner homicide in 2020/21. The Panel agreed that further work is required in this area because they did not feel assured that colleagues would be able to identify the differences between 'elder abuse' and all forms of domestic abuse including coercive and controlling behaviour. Bows (2021) notes the differences between these two concepts advising that with the former there is no agreed definition of elder abuse, it is gender neutral and usually these cases are considered closely by a health and social care model. Whereas domestic abuse is gender informed, it has a clear definition and is comprehensive in its description. There are specialist pathways for those affected once it has been identified. Therefore, it is argued by various studies that further work should be undertaken to help agencies identify when there

might be domestic abuse not elder abuse, and respond appropriately with services for this cohort.

15.13 Similarly to the above point, the Chair shared with the Panel some guidance information created by Dewis Choice Initiative in Wales and amended by Cambridgeshire and Peterborough Partnership, which aims to improve agencies' responses to older victims of domestic abuse. As part of this guidance Dewis Choice Initiative adapted the Duluth Power and Control Wheel to reflect their research examining the lived experience of over 90 older victims and survivors- a tool the Panel thought would be extremely valuable. Further to this their research has also helped to shape additional questions relating to caring needs and isolation that have been used in an adapted Cambridgeshire Partnership Older Person's DASH risk assessment. A Panel discussion took place about this and Avon and Somerset Constabulary advised that they are awaiting the final evaluation of a national pilot in relation to Domestic Abuse risk assessments and how this tool might be simplified and uploaded onto systems differently which is currently with the National Policing Lead for consideration. This national pilot is reflective of a change to how all victims, regardless of age or gender would be risk assessed. In the interim as already mentioned in paragraph 14.10 their internal Domestic Abuse Procedural Guidance has been updated with specific references to domestic abuse in the older population, taking the learning from research mentioned within this review and the Domestic Abuse Matters comprehensive force-wide training programme will reinforce these messages in Autumn 2022. The Panel also were assured by Avon and Somerset Constabulary that the DASH is also used to risk assess familial incidents of domestic abuse.

15.14 The Panel also discussed whether they felt the Covid-19 pandemic had had an impact on Mr A and Mrs B's relationship. The Panel concluded that they felt it had. There was evidence from conversations with family members and the witness statements provided for the criminal investigation that the couple took great joy from travelling and socialising, spending time in bigger groups with family and friends which they had not been able to do due to Covid 19 restrictions. The Panel concluded that the impact of less social interaction with others, and focus on one another may have contributed to escalations in abusive behaviours towards one another.

16. Conclusions

16.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the draft chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

16.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Mr A's death in February 2021.

16.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the theme discussed.

16.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points.

16.5 The first key learning point relates to the identification, response and communication about, for and to male victims of domestic abuse and the importance of getting this right to encourage more males to disclose and take those opportunities to seek help and support. The Panel felt that more should be done by the Partnership to consider this when preparing communications and campaigns.

16.6 The second key learning point similar to the above paragraph is how the Covid 19 pandemic has had a huge impact on the older population, their confidence to socialise like they did before, their access to services and how hidden domestic abuse. This is aside from the debate the Panel endured around whether domestic abuse amongst the older population is identified correctly in Somerset. Greater training and awareness for those services engaging and working with this cohort and supplementary to this greater coordination of these services once domestic abuse has been disclosed or identified by an organisation so that specialist services can offer appropriate support and correct risk assessments can be undertaken.

16.7 The final key learning point to include in this conclusion relates to the importance of professional curiosity. There was some good evidence of this with some agencies who had some contact with Mr A. However, there wasn't a consistent approach to professional curiosity. For example, this wasn't always adopted by the GP Practice when some sensitive information was shared by this couple. In addition, similar to the points raised above, professional curiosity wasn't evidenced by the police officers who attended the incident on the 23rd December 2020 either. The Panel discussed how a practitioner's

mindset has a role to play in whether professional curiosity is adopted consistently. For example, the one domestic abuse related incident reported to the police was made by Mrs B and therefore officers were attending with the knowledge that Mrs B was the potential victim. However, where an open mindset is used consistently to assess the situation based on the information available, professional curiosity is more likely to be used effectively. The Panel recognised that this should also be highlighted as another key concluding recommendation to improve the response to victims of domestic abuse, and encourage safe spaces for disclosure and rapport building.

17 Recommendations

Avon and Somerset Constabulary

17.1 The review has identified the need for Avon and Somerset Constabulary to reinforce the importance of spotting the signs of abusive behaviour in the older population and to be professionally curious with both parties to better understand the relationship. This has duplicated the findings of an earlier unrelated DHR from (May 2021) where a recommendation was made to update procedural guidance for frontline officers who are attending domestic abuse related incidents to include specific reference to how domestic abuse in an older population should be managed. This guidance has been revised and is awaiting final authorisation from the Legal Department before a communications plan across the Constabulary is implemented to launch the new guidance.

Somerset Clinical Commissioning Group (now NHS Somerset ICB)

17.2 If a patient attends the GP Practice and is discussing something sensitive that may impact intimacy during a sexual relationship it would be appropriate for the GP to explore further with sensitive and open discussion to understand if it has led to relationship tensions.

Safer Somerset Partnership

17.3 This review to be used as a case study within multi agency domestic abuse training, coordinated by the partnership to emphasise the importance of professional curiosity, having courageous conversations with individuals and other professionals, and challenging stigma.

17.4 The Partnership to take a gender-informed approach to any domestic abuse awareness campaigns in order that they have the greatest impact. Consider what imagery and communications should be best used for a campaign if the target

audience is to increase the awareness of male victims of domestic abuse and coercive and controlling behaviour in Somerset.

17.5 The Partnership to support a roll out of Masterclasses- supported by the Mankind Initiative to empathise how practitioners can better support male victims of domestic abuse; recognising the barriers they face to reporting and disclosing abuse.

17.6 The Partnership to further explore the pathways and commissioned services for older victims of domestic abuse in Somerset and develop training for services about this, in order that it is identified at the earliest opportunity so that specialist services can risk assess and offer support and early intervention. As part of this the Partnership should consider the use and adoption of the Dewis Choice Initiative Procedural Guidance for Older victims of domestic abuse.

17.7 The Partnership to evaluate the success and use of the digital e-learning suite created to raise awareness of domestic abuse and consider if a specific module on older people and domestic abuse should be created.

Appendix A

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Pieces of legislation

Adoption and Children Act 2002

Crime and Disorder Act 1998

Domestic Violence, Crime and Victims Act 2004

Equalities Act 2010

Serious Crime Act 2015

Care Act 2014

Protection from Harassment Act 2002

Appendix B

Confidentiality Statement

Somerset Domestic Homicide Review into the Death of
Mr A

CONFIDENTIALITY AGREEMENT

– PLEASE READ THIS DOCUMENT CAREFULLY

This document must be read and signed by all members of the DHR Panel.

If you have any questions concerning this document, please contact your manager before signing. You should retain your own-signed copy for future reference.

Many of the services that agencies in the Somerset area provide for its clients are confidential and to enable them to perform these services, its clients disclose confidential and personal information to those involved in their care and assistance.

The goodwill and respect of these agencies depends amongst other things upon keeping such services and information confidential. You may have access to such information, see or hear information of a confidential nature during your involvement in the DHR Panel.

You are not permitted at any time during or after your involvement in the DHR Panel to disclose any such personal or business information whatsoever including to colleagues and line managers. In holding information, you occupy a position of trust which you are required to respect. Any breach of confidentiality will be viewed seriously and could result in termination of your contract.

You will need to observe the very basic rule that information revealed, and Panel discussions are confidential. It should not be discussed with anyone except when written permission has been sought from and granted by the Chair. In no circumstances should you discuss it with family, friends, other clients, the general public or in any public place. In addition, you are not permitted to or allow any

unauthorised person/s to examine or to make copies of any reports documents or business information to do with clients or the business of this DHR. Any information you hold should be deleted or handed back to the Chair at the end of the Review. Disclosure may be in breach of the Data Protection Act and may give rise to irreparable injury to the clients as the owner of such information; and they may seek remedy against the agency where you employed.

If you are in any doubt about the disclosure of any information **you should consult the Chair**.

I confirm that I have read and understand the above. I understand that any breach of this confidentiality will be regarded as a serious matter by the Chair and Somerset CSP and may result in legal proceedings.

NAME:

SIGNATURE:

AGENCY:

DATE:

Safer Somerset Partnership

Multi Agency Domestic Homicide Review

Executive Summary

Into the death of Mr A (pseudonym) in February 2021

Faye Kamara LLB, MSc
Independent Domestic Homicide Review Chair and Report Author

Report Completed: July 2022

A Tribute to Mr A

The Independent Chair and Domestic Homicide Review Panel offer their sincere condolences to all who have been affected by the death of Mr A, who is remembered for his pride and commitment to serve his country in the British Army. Mr A joined the Armed Forces in 1959 as a Private and left the army in 1996 as a Lieutenant Colonel, however immediately moved into a Retired Officer role until 2002 when he did retire fully.

Mr A travelled many countries whilst he served his country in the British Army and therefore embraced the different cultures. Mr A spent a significant time living in Germany and France in his career with his wife Mrs B and daughter Mrs C. Even after he retired Mr A still enjoyed travelling and holidays overseas. Family members shared with the Panel his love of travelling, socialising with friends, and having garden parties most summers which would often continue until the early hours.

Mr A's death is a very sad loss to many but is felt particularly by his sister and daughters who all contributed to this review. The Independent Chair and Domestic Homicide Review Panel thank all who have contributed to the deliberations of this review, for their time, patience, honesty, and cooperation.

Contents

1. Preface

1.1 Domestic Homicide Reviews (DHRs) came in to force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

c) A person to whom she was related or with whom she was or had been in an intimate personal relationship or
d) A member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term 'domestic abuse' is used in reference to 'domestic violence' as this is the term which has been adopted by the Safer Somerset Partnership.

1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the death of Mr A, regarding the way in which local professionals and agencies work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply those lessons to service response, including changes to policies and procedures as appropriate, and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide, domestic abuse related deaths and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

2. Introduction

2.1 This review examines the circumstances surrounding the death of Mr A who was 78 years of age when he died, White British and had lived in the county of Somerset for the last seven years of his life.

2.2 Mr A was a very proud man who served in the Army for many years and had a very rewarding career beginning as a Private and retired as a Lieutenant Colonel

in 1996. After this time he continued employment as a retired officer until 2002 when he retired fully. He was a father to three daughters and one son. As a result of his career he lived in several different countries during his lifetime before settling in Somerset in August 2013 with Mrs B.

2.3 Mr A and Mrs B met through work, Mr A worked in the Army and Mrs B worked for the Ministry of Defence, they got married in 1996. Mr A was not the biological father of Mrs B's third child but was legally adopted by him and it was described by family members as part of this review that they had a close relationship.

2.4 Mr A had limited contact with agencies during the timeframe of this review from 2016-2021. However, it was recorded in his medical records that he had a number of medical conditions over the years. This included prostate cancer for which he had surgery in 2012. He also had rectal cancer which was diagnosed in 2015. In addition in 2013 he had a deep brain stimulator inserted owing to issues relating to a benign essential tremor. A Medtronic battery was in place in his abdomen.

2.5 There was only one incident reported to any agency relating to domestic abuse, and this was Mrs B who contacted the police in December 2020 reporting that she had been assaulted by Mr A. No formal complaint or arrest was made in relation to this one incident.

2.6 Incident summary:

2.6.1 Mr A and Mrs B had spent the evening of 13th February 2021 on a zoom call with their daughter, Mrs C and son in law celebrating Mrs B's 66th Birthday, this was due to Covid 19 Lockdown restrictions. The family had all enjoyed food and drinks separately in their homes. It was reported that the evening had been going well until an argument had started between Mr A and Mrs B over an iPad charger that appeared not to be working so the call ended.

2.6.2 Later that same night, Mr A called 999 however seconds after this was answered Mrs B advised that she had attempted to kill her husband, Mr A, by stabbing him with a knife. She also added that Mr A had teased her after the stabbing so she stabbed him twice further.

2.6.3 It was recorded by agencies that Mrs B had refused to provide first aid when requested to do so by the ambulance call handler. Mrs B also advised as part of the call that Mr A had been abusing her for months and she had reached breaking point.

2.6.4 Mr A died as a result of several stab wounds to his chest, sides and groin areas on 13th February 2021, and despite attempts made by emergency services to

resuscitate him on arrival he was pronounced deceased at his home address that evening.

3. The Terms of Reference

3.1 Commissioner of the Domestic Homicide Review

3.1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Mr A. Mrs B was also convicted of Mr A's murder in October 2021.

3.1.2 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.

3.2. Aims of The Domestic Homicide Review Process

3.2.1 Establish the facts that led to the death of Mr A on 13th February 2021 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.

3.2.2 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.

3.2.3 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.

3.2.4 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 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.

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

3.3 Scope of the review

The review will:

- Consider the period from 01.02.2016 to 13.02.2021 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 Mr A's family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse, coercive or controlling behaviour 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, neighbours and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored. Explore whether communities would know what action to take if they suspected domestic abuse.

- Scope whether any support was offered to the family by military related organisations given Mr A's occupation and how they identify signs of domestic abuse.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Mr A or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively. This is to include the impact that the Covid-19 pandemic may have had on agencies from March 2020 to Mr A's death in February 2021.

3.4 The Chair of the Panel and Report Author is the same individual, who was commissioned by the Safer Somerset Partnership to undertake this review. They possess the qualifications and experience required of an Independent Review Chair and author, as set out in section 5.10 of the Home Office Multi- Agency Statutory Guidance. She is not associated with any of the agencies involved in the Review nor had she had any dealings with Mr A and is totally independent. She has undertaken the AAFDA (Advocacy after Fatal Domestic Abuse) DHR Chair Training and is an experienced DHR Independent Chair and Report Author.

4. Involvement of family, friends, work colleagues, neighbours and wider community.

4.1 As per the Home Office guidance, letters together with the Leaflet on 'Domestic Homicide Reviews' were sent to Mr A's three daughters and his sister. The independent Chair met with Mr A's family, collectively and individually in some cases, via Microsoft Teams on multiple occasions to seek their views and experiences and provide updates on progress relating to this statutory review. The Independent Chair also sent numerous letters to Mrs B via her solicitor and to Her Majesty's Prison Service inviting her to share experiences of agencies and her relationship with Mr A. However, Mrs B declined this invitation whilst she appealed her conviction.

4.2 Mr A's family were given the opportunity to influence the Terms of Reference by making suggestions for additional key lines of enquiry, however they felt that what the Panel had drafted was comprehensive. Mr A's family members were updated periodically during this review and as per family's request and Home Office Statutory Guidance the family also had sight of this report and provided comments, factual amendments and queried points of accuracy.

5. Summary of agencies involved and their contact

5.1 The following agencies were participants in this review either because they had involvement with Mr A or Mrs B or their expertise was relevant to this case.

- Somerset County Council- (Safer Somerset Partnership- Commissioner of Review)
- Somerset NHS Foundation Trust (previously Taunton and Somerset NHS Foundation Trust/Somerset Partnership NHS Foundation Trust)
- Avon and Somerset Constabulary
- Somerset Clinical Commissioning Group
- Mankind Initiative
- SSAFA (Armed Forces Charity)
- Ministry of Defence- Army Welfare Service
- Somerset Integrated Domestic Abuse Service (The You Trust)
- North Bristol NHS Trust

5.2 Somerset County Council are one of the main agencies involved in the Safer Somerset Partnerships who have the statutory responsibility for commissioning Domestic Homicide Reviews under Section 9 of the Domestic Violence, Crime and Victims Act (2004). Therefore their involvement in this review was to ensure that the Statutory Guidance was followed and to offer support and information on the commissioning of domestic abuse services.

5.3 Somerset NHS Foundation Trust is the newly merged services of secondary acute care, community and mental health services provided in Somerset. Mr A had very limited contact with this service which was at the time known as Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust where he received treatment for Rectal Cancer. No disclosures of domestic abuse or references to his home life were recorded in his medical records by this provider.

5.4 Avon and Somerset Constabulary provide the police service to the county of Somerset. Mr A was only known to this organisations in relation to two reports of burglary which Mrs B had reported and one domestic abuse related incident in December 2020, where Mr A was recorded as the alleged offender. Although Mr A did express at the time of the incident 'has she told you what she did to me' which implied that there had possibly been some abusive behaviour from Mrs B towards Mr A.

5.5 Somerset Clinical Commissioning Group (CCG) is the main commissioner of health services within the Somerset area. The CCG have been included as part of this review in order to incorporate what was known by Mr A's GP about his physical and mental health. The GP Practice were informed of Mr A's various illnesses over the years and also received annual updates from North Bristol NHS Trust about the review of Mr A's deep brain stimulator.

5.6 Mankind Initiative are a well-respected national initiative which offers support to male victims of domestic abuse. The charity also advocates for this cohort and has undertaken extensive research with the support of other academics into the experiences male victims of domestic abuse face from organisations. The Panel felt it would be valuable to have this expertise incorporated into the discussions.

5.7 SSAFA is a nationally recognised Armed Forces charity. They provide support and help to serving military families and veterans. As previously indicated both Mr A served in the Army in various officer roles, and Mrs B worked for the Ministry of Defence; they lived in various countries and therefore as part of this review the Panel wanted to understand what support is available for military families who experience domestic abuse. In addition, how are staff working in these charitable roles trained to spot the signs of domestic abuse etc..

5.8 Ministry of Defence- Army Welfare/Personal Support. This division of the Ministry of Defence have a responsibility to ensure that appropriate training, support and supervision is in place to manage personal issues that officers might face. The Panel sought advice from this service for the same purposes as above- to seek assurance on what support is available to military families, and what is the training, policy and awareness internally of this subject.

5.9 Somerset Integrated Domestic Abuse Service is the specialist domestic abuse support service in Somerset commissioned by the local authority (Somerset County Council) to provide the core services of IDVA (Independent Domestic Violence Adviser), outreach and accommodation. This service is provided by The You Trust which is the name of the organisation. Mr A did not have any contact with this agency prior to his death.

5.10 North Bristol NHS Trust provides hospital and community healthcare, and is also as specialist regional centre for neurosciences, plastics, burns, orthopaedics and renal. Mr A had some contact with this organisation from June 2015 after having a Deep Brain Stimulator implant was fitted in France a few years earlier. Mr A was seen on numerous occasions (June November 2015, June 2016, March 2017, June 2017, June 2018, July 2019 and December 2020) to have his Deep Brain Stimulator checked, battery changed and further programmed. No disclosures of domestic abuse or sensitive information about his relationship with Mrs B that might give cause for concern of additional questioning were shared at any of these consultations. However, detailed information from this organisation was provided to us in relation to the contact they had with Mr A and Mrs B in December 2020.

5.11 A chronology was compiled as part for this review given the number of contacts Mr A had had with these agencies.

5.12 Individual Management Reviews were also undertaken by three agencies; Avon and Somerset Constabulary, Somerset Clinical Commissioning Group and Somerset NHS Foundation Trust. However additional information was sought from North Bristol NHS Trust. All reports and presentations were completed by professionals who were independent, and had no contact with either Mr A, Mrs B or any direct line management of any professional who had contact with them.

5.13 In addition to the information provided above, the summary of witness statement provided to the court included some other insights into the relationship between Mr A and Mrs B. As already indicated Mr A was described by many in witness statements as a proud and traditional man who was thoughtful and considerate. He liked order and expected certain standards of behaviour. He was also described as stubborn. Mrs B was described as a strong character with firm opinions, loud and gregarious, often the centre of attention and sometimes enjoyed antagonising/doing things others found uncomfortable.

5.14 According to witness statements, both Mr A and Mrs B were strong minded and opinionated individuals who found it difficult to admit if they were wrong. Many witness statements reported that they would sometimes observe bickering and frostiness over a difference of opinion between them with neither admitting they were wrong or wanting to back down. These arguments were usually resolved quickly within the same day or following day was also what was reported by witnesses as part of the criminal trial. Witnesses commented that Mr A would calm Mrs B if she got too loud by placing his hand over hers. Other witnesses said that they observed verbal abuse between the couple who argued and berated each other. It was mentioned that Mrs B would berate and belittle Mr A (this was in the context of Mrs B stating her money paid for things). Witnesses also stated that Mr A would be embarrassed by Mrs B's behaviour at times and that it appeared that she seemed to enjoy his discomfort.

5.15 Mrs B was also described by some of the witnesses as being unsympathetic to Mr A when suffering from the effects of the deep brain stimulator to control his tremors. As a result of this, one friend disclosed that Mr A had reported that he wanted his friend to 'find him a flat as he want(ed) to get out of this' at the time, this was just after his initial operation to stop his tremors in 2012. The same friend also commented that the couple bickered and on one occasion Mr A loudly told Mrs B to 'shut the f*** up' which was out of character.

5.16 Most friends who provided witness statements stated that they had never witnessed any physical aggression or violence between the couple. They said they were often happy together in each other's company.

5.17 As previously reported in this review, it is understood that Mr A found the death of his son extremely difficult and this affected his mood. Witnesses statements compiled for the criminal investigation included references to Mr A not being able to grieve for this death because Mrs B didn't want to support him with his grief and believed that he should just get over it. However, to the contrary other family members commented that Mrs B supported Mr A to grieve, taking flowers to his son's grave in Scotland every year and supporting him in any way she could.

5.18 There was also commentary within the witness statements that Mr A had reported before he married Mrs B that he didn't want to get married but felt he could not back out for fear of the consequences for his career and reputation. This supports the kind of character Mr A was. Another witness stated that Mrs B disclosed that she was not happy in the marriage to Mr A but could not afford to financially leave the marriage. Another witness said that Mrs B would often say she loved her third husband and did not love Mr A, and this would be said in front of him but Mr A would not react.

5.19 Although there was only one reported domestic incident in the United Kingdom, as a result of the criminal investigation into Mr A's death it was advised by witnesses and Mrs B that there were incidents that occurred in the late 1990s whilst living in Germany. The first mentioned in statements was in June 1999, where following a day out with Mr A's family a physical incident occurred where witnesses described both Mr A and Mrs B shouting and pushing each other, with Mrs B goading Mr A to fight. Mr A headbutted Mrs B and then returned with a knife. Family members that were present reported in their witness statement that they were able to remove the knife from Mr A. The police were not called and witnesses believed that Mr A received counselling after this incident.

5.20 Mrs C, as part of the criminal investigation advised of two further incident in Germany in the late 1990s, one where Mr A smashed a mug bought by her as a Mother's Day present in front of both her and Mrs B. Another was where she had returned home to Mrs B and Mr A arguing and witnessed Mr A hit Mrs B against a barometer on the wall. Mrs B's nose was bleeding and both her and Mrs C left the house for the night and returned the next day. Mrs C also documented in her witness statements that she was told that Mr A had made threats to Mrs B that she would tell Mrs C the truth about her birth father.

5.21 Two further alleged incidents were also recalled by Mrs B as part of the criminal trial, one where Mr A had kicked Mrs B down the stairs in Germany and another where Mrs B was strangled whilst on a cruise following an argument over coffee.

5.22 The above information provided the Panel with some context from those closest to the couple, in terms of what Mr A's and Mrs B's relationship appeared to be like. Although there was only one reported domestic incident to the police in the United Kingdom and no other disclosures made to any other agencies within the timeframe of this review, there is clear evidence from these sources that both Mr A and Mrs B exhibited domestic abuse behaviours towards each other for a significant period of their marriage.

6. Conclusions

6.1 In reaching their conclusions the Review Panel have focussed on the following questions;

- Has the Panel fulfilled the Terms of Reference for this review by undertaking a variety of lines of enquiry, including discussing the draft chronology and entering broader more strategic discussions about cross authority working?
- Will the actions and suggestions for improvement improve the response domestic abuse victims have in the future?
- What are the key themes or learning points from this review?

6.2 The Review Panel are satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Mr A's death in February 2021.

6.3 The Panel is of the opinion that the agreed recommendations appropriately address the points raised throughout the review, particularly in relation to the lessons learnt and the theme discussed.

6.4 The Panel felt that there were a number of key issues which were fundamental to the discussion and therefore key learning points.

6.5 The first key learning point relates to the identification, response and communication about, for and to male victims of domestic abuse and the importance of getting this right to encourage more males to disclose and take those opportunities to seek help and support. The Panel felt that more should be done by the Partnership to consider this when preparing communications and campaigns.

6.6 The second key learning point similar to the above paragraph is how the Covid 19 pandemic has had a huge impact on the older population, their confidence to socialise like they did before, their access to services and how hidden domestic abuse. This is aside from the debate the Panel endured around whether domestic abuse amongst the older population is identified correctly in Somerset. Greater training and awareness for those services engaging and working with this cohort and supplementary to this greater coordination of these services once domestic abuse has been disclosed or identified by an organisation so that specialist services can offer appropriate support and correct risk assessments can be undertaken.

6.7 The final key learning point to include in this conclusion relates to the importance of professional curiosity. There was some good evidence of this with some agencies who had some contact with Mr A. However, there wasn't a consistent approach to professional curiosity. For example, this wasn't always adopted by the GP Practice when some sensitive information was shared by this couple. In addition, similar to the points raised above, professional curiosity wasn't evidenced by the police officers who attended the incident on the 23rd December 2020 either. The Panel discussed how a practitioner's mindset has a role to play in whether professional curiosity is adopted consistently. For example, the one domestic abuse related incident reported to the police was made by Mrs B and therefore officers were attending with the knowledge that Mrs B was the potential victim. However, where an open mindset is used consistently to assess the situation based on the information available, professional curiosity is more likely to be used effectively. The Panel recognised that this should also be highlighted as another key concluding recommendation to improve the response to victims of domestic abuse, and encourage safe spaces for disclosure and rapport building.

7. Lessons to be learnt

In addition to the key learning points summarised in the conclusions, Panel discussions also took place in relation to;

5. What research tells us about how we better respond and work with male victims and how does this relate to Somerset county
6. If Mr A had still been serving in the military, what might the response have been of his employer to respond to disclosures of domestic abuse
7. What work is being undertaken in Somerset to improve the identification and responses to older victims of domestic abuse
8. What the impact might have been given the Covid-19 pandemic and numerous lockdowns

7.1 Firstly, Mankind Initiative as articulated in paragraph 14.6 are a national charity based in Somerset that support male victims of domestic abuse. Their representative has been extremely valuable in exploring as a Panel how we can improve identification, responses and services for male victims of domestic abuse in Somerset. Panel discussions took place during the life course of this review to better understand the reasons why men do not disclose to services what they are experiencing. Hine (2019) tells us that this is because often men do not understand or recognise it themselves that what they are experiencing is wrong and that they are a victim. This research led the Panel to explore thoroughly how and what more could be done to combat the stigma that males can be victims too.

7.2 The Panel also discussed a more recent study undertaken in 2021 by University of Cumbria (Hope et al, 2021) which analysed 22 Domestic Homicide Reviews where the victims were males. The outcome of this research found that opportunities were missed due to gender bias and outdated stereotypes. Similarly in this case, where there were missed opportunities to use professional curiosity to better understand the relationship from Mr A's point of view by the Police and GP Practice; the only two agencies which had any contact with him in the five years preceding his death. It was also found in this research that support services lacked guidance to help identify and treat male victims. The Panel explored this finding challenging their own policies and practices as well as one another on what training they deliver to combat the gender bias within this learning point. It was found that learning from this DHR as a case study example would add additional impact given it's media coverage.

7.3 In specific relation to this review, the Panel explored the phenomenon of male status within the military and how that might have impacted how Mr A felt about sharing what he was experiencing within his relationship. Research tells us (Taylor, Bates, Colosi et al, 2021) that male victims of Intimate Partner Violence are less likely to seek help for their victimisation than female victims. This is because of barriers to seeking help (status and credibility, health and wellbeing) as well as responses to the act of initially seeking help (discreditation, exclusion, isolation and helpfulness). For example, the social status of men being powerful and able to protect themselves- specifically those serving in the forces, whose role is to protect the country, does not align itself in the general narrative to the 'victim' label which has implications of references to weak, passive and trapped. The inferred synonymy between 'victim' and 'weakness' is particularly salient for male victims as was found by Allen-Collinson (2009) in A marked man: A case of female-perpetrated intimate partner abuse. This therefore suggests that 'to request help may therefore challenge internally and externally held beliefs around masculinity, where men are supposed to be strong, independent and self-sufficient

individuals' (Walker et al, 2019). The Panel explored this alongside the views of family members who all concurred how Mr A was a very proud man and masculine in how he led his life owing to his career choices and experiences. The Panel concluded that they felt Mr A was certainly an individual who may have struggled with the inferred synonymy as described above between 'victim' and 'weakness'. Therefore, further work is needed in Somerset to ensure that male victims know where to go for help and how to de-stigmatise seeking help in these circumstances.

7.4 Furthermore to what is described above, the Panel also explored language and communications and how when raising the awareness of domestic abuse, as strategic leaders and commissioners we should consider what imagery is used to not reinforce gender bias but recognise that anyone can be impacted by domestic abuse regardless of gender. The Panel explored the term 'gender-informed', this describes the approach that should be adopted when raising the awareness of these issues- being cognisant of the different audiences, cohorts and intersectionality that exists within today's society. The Panel agreed to adopt this approach in their communications plan to address domestic abuse over the coming years with the campaigns planned for the future. Likewise, when a campaign is targeted specifically at male victims, taking from the research noted above, any communications should be male-friendly and therefore be based around the following five factors; masculinity messaging, design, location, methods and case studies and third party endorsement.

7.5 The second area which the Panel had a focussed discussion on was in relation to military responses to domestic abuse, exploring what might have been the response had Mr A ever disclosed that he was experiencing domestic abuse whilst serving in the army. At first this was explored with SSAFA, as described above in paragraph 14.7 a national charity working with and supporting military families and veterans on a range of issues. SSAFA provided assurances to the Panel on what their policies, protocols and expected responses would be to any disclosures of domestic abuse. These included that all volunteers and case workers are trained in safeguarding and therefore are familiar with the signs of domestic abuse. Policies are also clear stating that when there are any concerns they will discuss with the Principal Safeguarding Officer. The representative from SSAFA advised that the organisation's ethos is to work in partnership with other agencies to mitigate against the risk escalating and that they are able to support individuals and their families indefinitely. This was recognised as good practice by the Panel and endorsed.

7.6 In addition to this, the Panel considered a report titled 'Experiences of Intimate Partner Violence and Abuse among Civilian Partners of UK Military Personnel: Perception of the Impact of Military Life and Experiences of Help-

seeking and Support'. This report was published in October 2021 by Kings College London and reveals complex issues of 'culture, stereotypical gendered roles and behaviours, hierarchy, social isolation and separation, extra-relationship and family pressures associated with housing and finance, and complex victim-survivor dynamics'. It also highlighted the importance of training, awareness, data sharing, appropriate pathways for those experiencing intimate partner violence especially for those transitioning from military life into civilian support avenues.

7.7 The Panel recognised that Mr A and Mrs B's situation was different to many of the case studies included in this review. However, the transition of military to civilian life is relevant and how cultural changes might influence behaviours, attitudes and actions by individuals. The study found that cultural change is needed in the military community to engender attitudes which are more conductive and supportive of health relationships among personnel. The Panel reflected that this was also true of this review in that organisations must recognise the gender differences and adopt a gender informed approach as discussed already above. The research also highlighted that further research is needed to investigate the experiences of male victim-survivors within the military personnel which the Panel would also support.

7.8 In addition to the above, the Panel also sought advice and information from the Army Welfare Service. As articulated already in the previous section, this service supports serving army personnel and veterans for a limited period upon leaving the service on all aspects of welfare issues including domestic abuse. Some excellent best practice was highlighted as a result of this engagement including the following;

- The Army consistently briefs that Domestic Abuse behaviours are contrary to core values and standards of being a solider and over the next 18 months, utilising a theatre production, workshops will be delivered across the Army to enhance awareness of domestic abuse.
- The personnel that work in the Army Welfare Service have undertaken a 7 months comprehensive course to become an Army Welfare Worker and this course includes specific training on Domestic Abuse.
- The Army Welfare Service also links with independent specialist domestic abuse charities to seek advice, consultation and supervision on complex domestic abuse matters.
- The Army Welfare Service is also informed of any reported incident of domestic abuse in order that data can be collated and appropriate services offered.

7.9 The above list is a handful of examples provided to the Panel on what actions have and continue to be undertaken by the Army and Army Welfare Service. As part of this engagement it was also advised that the above actions are part

of a wider Ministry of Justice Domestic Abuse Strategy which includes the Royal Air Force and the Marines, where there is a Domestic Abuse Board in place to support the implementation of the strategy and share best practice and ideas on what work is being undertaken to reduce the harm caused by these issues.

7.10 The above is also supported by a Policy which states that when a unit becomes aware of Domestic Abuse then this should be referred to Army Welfare Service (AWS) who provide the Army's specialist welfare outputs. All specialist welfare workers must either have completed the MOD 6 months Level 7 Defence Specialist Welfare Worker Course or be qualified and registered social workers. Additionally, it is mandatory for all Army Welfare Service personal support workers to undertake a 4 day specialist DA Course utilising the Safe & Together Model (LINK), in addition the Army fund specialist and independent support via Aurora New Dawn (LINK) for those individuals who do not feel comfortable approaching Army Welfare Service. In addition the Aurora New Dawn CEO is a full member of the Army's Domestic Abuse Group which reviews Army policy, processes and services across all Army departments eg. Service Police, Medics, Padres etc. This information was provided to the Panel by the Army Welfare Service, which provided a level of assurance to the review on what support is available to couples working in the military where domestic abuse may be a factor or cause for concern.

7.11 The third area explored by the Panel was what actions and work had been undertaken to help identify older victims of domestic abuse in Somerset and what further work needed to be undertaken to improve this and provide assurances to the Partnership. The Panel advised that during the pandemic, a range of communications and networks were created and established to support the coordinated response to tackle domestic abuse, especially for the older population who were likely to feel even more isolated. This included a newsletter which was circulated every month to agencies that might come into contact with victims of domestic abuse- reminding colleagues of the signs to look for and specialist support services available.

7.12 In addition to this, Safer Somerset Partnership also launched a specific campaign on the issue of older people and domestic abuse in December 2021 which lasted for 4 months. This included a press release, social media campaign, posters, an TV advert, BBC radio Somerset interview with the Chair of the Community Safety Partnership, magazine adverts and briefing for local elected councillors. Furthermore, since Mr A's death a series of training programmes digitally hosted online have been created specifically to raise awareness of domestic abuse and coercive control which all agencies represented in the partnership can access. None of the modules are

specifically related to older people and domestic abuse, although the core message throughout all modules is that domestic abuse can affect anyone of any age. The Panel did conclude that Safer Somerset Partnership should consider if a specific module for older people and domestic abuse should be created.

7.13 The Panel concluded that during the last two years and specifically since the pandemic began a significant amount of work has been undertaken to improve the pathway for older victims of domestic abuse, and raise the awareness amongst this cohort. Nevertheless, there is growing research that has indicated that the older population has been significantly affected as a result of the pandemic; owing to further isolation from support networks. Therefore, to that end, the Panel concluded that further exploration of pathways, commissioned services and training for staff was needed to improve the responses to older victims of domestic abuse. A report written by the Home Office together with a number of other agencies titled 'Domestic Homicide and Suspected Victim Suicides during the Covid19 Pandemic 2020-21' researched the typologies of victims and suspects and found that 18% of homicide victims were aged 65 or over in their study. When compared to previous years, there has been a small but significant increase in older victims of intimate partner homicide (especially aged 65 and over) with a decrease in younger intimate partner homicide in 2020/21. The Panel agreed that further work is required in this area because they did not feel assured that colleagues would be able to identify the differences between 'elder abuse' and all forms of domestic abuse including coercive and controlling behaviour. Bows (2021) notes the differences between these two concepts advising that with the former there is no agreed definition of elder abuse, it is gender neutral and usually these cases are considered closely by a health and social care model. Whereas domestic abuse is gender informed, it has a clear definition and is comprehensive in its description. There are specialist pathways for those affected once it has been identified. Therefore, it is argued by various studies that further work should be undertaken to help agencies identify when there might be domestic abuse not elder abuse, and respond appropriately with services for this cohort.

7.14 Similarly to the above point, the Chair shared with the Panel some guidance information created by Dewis Choice Initiative in Wales and amended by Cambridgeshire and Peterborough Partnership, which aims to improve agencies' responses to older victims of domestic abuse. As part of this guidance Dewis Choice Initiative adapted the Duluth Power and Control Wheel to reflect their research examining the lived experience of over 90 older victims and survivors- a tool the Panel thought would be extremely valuable. Further to this their research has also helped to shape additional questions relating to caring needs and isolation that have been used in an adapted

Cambridgeshire Partnership Older Person's DASH risk assessment. A Panel discussion took place about this and Avon and Somerset Constabulary advised that they are awaiting the final evaluation of a national pilot in relation to Domestic Abuse risk assessments and how this tool might be simplified and uploaded onto systems differently which is currently with the National Policing Lead for consideration. This national pilot is reflective of a change to how all victims, regardless of age or gender would be risk assessed. In the interim as already mentioned, their internal Domestic Abuse Procedural Guidance has been updated with specific references to domestic abuse in the older population, taking the learning from research mentioned within this review and the Domestic Abuse Matters comprehensive force-wide training programme will reinforce these messages in Autumn 2022. The Panel also were assured by Avon and Somerset Constabulary that the DASH is also used to risk assess familial incidents of domestic abuse.

7.15 The Panel also discussed whether they felt the Covid-19 pandemic had had an impact on Mr A and Mrs B's relationship. The Panel concluded that they felt it had. There was evidence from conversations with family members and the witness statements provided for the criminal investigation that the couple took great joy from travelling and socialising, spending time in bigger groups with family and friends which they had not been able to do due to Covid 19 restrictions. The Panel concluded that the impact of less social interaction with others, and focus on one another may have contributed to escalations in abusive behaviours towards one another.

7.16 Lastly, the Panel also discussed, given some of the disclosures in the witness statements whether situational couple violence was also present in their relationship. Situational Couple Violence (SCV) was defined by Johnson (2008) as a type of intimate partner violence which is enacted as a means of controlling a specific situation or context and is often a disagreement that escalates into violence, as opposed to being about exerting power and control from one person onto another. SCV is relevant here because incidents referred to in Germany suggested that these may have been as a result of disagreements escalating.

7.17 There have been a number of pieces of research undertaken to understand more about what the difference is between the power and control model of intimate partner violence and SCV, as well as the impact. A study by Leone, Johnson and Cohan (2007) found that those experiencing SCV are more likely to seek help from family and friends informally, in the hope that they can 'fix' the problem which causes the conflict and remain in the relationship. This is fundamentally different to an abusive relationship focussed on a power and control phenomenon where victims seeking help are often looking for an escape route to leave the relationship due to fear of violence, abuse and

sometimes death. This is useful to note in this review because some of the additional information has come to light through witness statement and evidence at court b family and friends. However, the Panel did conclude that although there may be some indication of SCV, there was a domestic homicide that took place.

8. Recommendations

Avon and Somerset Constabulary

8.1 The review has identified the need for Avon and Somerset Constabulary to reinforce the importance of spotting the sings of abusive behaviour in the older population and to be professionally curious with both parties to better understand the relationship. This has duplicated the findings of an earlier unrelated DHR from (May 2021) where a recommendation was made to update procedural guidance for frontline officers who are attending domestic abuse related incidents to include specific reference to how domestic abuse in an older population should be managed. This guidance has been revised and is awaiting final authorisation from the Legal Department before a communications plan across the Constabulary is implemented to launch the new guidance. The change to Procedural Guidance authorised was the following;

Diversity of DA victims
Research indicates that women disproportionately experience domestic abuse predominantly by male perpetrators, but it is important to remember that anybody can be a victim or perpetrator of DA.

The abuse may not always be obvious and our unconscious biases can lead to the abuse being overlooked. As with attending any incident, it is important to keep an open mind and an investigative mind-set.

The below links provide useful information when dealing with a diverse range of victims:
A number of links have been included that provide useful information when dealing with a diverse range of victims. This includes:

• Familial abuse - Abuse of older people – the procedure links to the College of Policing, Domestic Abuse Authorised Professional Practice 'Abuse of older people' which itself has links to Action on Elder Abuse and the CPS DA Guidelines for Prosecutors, Older people.

Somerset Clinical Commissioning Group

8.2 If a patient attends the GP Practice and is discussing something sensitive that may impact intimacy during a sexual relationship it would be appropriate for the GP to explore further how the patient feels about the relationship, being professionally

curious, sensitive and open to whether there are any signs of domestic abuse, coercive control or controlling behaviour.

Safer Somerset Partnership

8.3 This review to be used as a case study within multi agency domestic abuse training, coordinated by the partnership to emphasise the importance of professional curiosity, having courageous conversations with individuals and other professionals, and challenging stigma that anyone can be affected by domestic abuse, regardless of race, gender, ethnicity, age etc…

8.4 The Partnership to take a more gender-informed approach to any domestic abuse awareness campaigns in order that they have the greatest impact. Consider what imagery and communications, most importantly language should be best used for a campaign if the target audience is to increase the awareness of male victims of domestic abuse and coercive and controlling behaviour in Somerset.

8.5 The Partnership to support a roll out of Masterclasses- supported by the Mankind Initiative to empathise how practitioners can better support male victims of domestic abuse; recognising the barriers they face to reporting and disclosing abuse.

8.6 The Partnership to further explore the pathways and commissioned services for older victims of domestic abuse in Somerset and develop training for services about this in order that it is identified at the earliest opportunity so that specialist services can risk assess and offer support and early intervention. As part of this the Partnership should consider the use and adoption of the Dewis Choice Initiative Procedural Guidance for Older victims of domestic abuse.

8.7 The Partnership to evaluate the success and use of the digital e-learning suite created to raise awareness of domestic abuse, and consider if a specific module on older people and domestic abuse should be created.

Appendices

a. Action Plan

Please note, this action plan is a live document and will be subject to changes as outcomes are delivered.

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Avon and Somerset Constabulary to update procedural guidance for frontline officers who are attending domestic abuse related incidents, to reinforce the importance of stopping the signs of abusive behaviour in the older population and to be professionally curious with both parties to better understand the relationship	Local	Update policies and implement training programme	Avon and Somerset Constabulary	ASCs internal DA guidance / policy has been updated and APP hyperlinks have been included for diverse types of DA victims along with a section on unconscious bias / elder abuse. Avon & Somerset Constabulary has signed up to The Domestic Abuse (DA) Matters Change Programme, launched Autumn 2022, which will cover the issue of unconscious bias, including elder. The overarching aim of the DA Matters Change programme is to provide a programme of events which builds on and enhances the policing response to those experiencing domestic	*complete*	Completed

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				abuse and those responsible for domestic abuse. Its aim is to assist Police to act before someone harms or is harmed, identify and stop harmful behaviour, increase safety for those at risk and support people to live the lives they want after harm occurs. The DA Matters Change Programme elements: The programme is made up of seven elements: • Critical Friend Health Check • Train the Trainer Event • First Responder Training • Champions Training • Sustain the Change workshop • Evaluation • Ongoing support		

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				DA Matters SafeLifes attended ASC on 18th July to conduct a pre health check assessment. They will then reattend once the training has been delivered for a post health check. This will provide us with assurance that we have made the necessary change in our organisation and it has had a positive effect		
If a patient attends the GP and is discussing something sensitive that may impact intimacy during a sexual relationship it would be appropriate for the GP to explore further with sensitive and open discussion.	Local	There is already a recommendation from previous DHRs where two Domestic Abuse health advocates to provide GP practices with training, advice and support about how to have conversations which may explore further the relationship and wellbeing of a patient.	NHS Somerset ICB (formerly Somerset CCG)	Pilot project for health advocates ran for 1 year from April 2021- March 2022 whereby part of their role was to provide training to GPs both formally and through ad hoc support conversations. DHR learning also promoted in GP Safeguarding Leads level Safeguarding training provided twice	30.9.22	30.9.22 Training and awareness completed with GPs

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
		A Health Module has been developed as part of Domestic Abuse Training by SSP.		in 2022. Health modules within SSP training suite have been promoted to GPs through ICB Safeguard DA specific newsletter in July 2022.		
This review to be used as a case study within multi agency domestic abuse training, coordinated by the partnership to emphasise the importance of professional curiosity, having courageous conversations with individuals and other professionals, and challenging stigma.	Local	Somerset County Council to review current domestic abuse training programme and determine where to utilise this case study and add	Safer Somerset Partnership	Review training programme – both online modules and also face-to-face training Update training content to include this case study	30.6.2023	
The Partnership to take a gender-informed approach to any domestic abuse awareness campaigns in order that they have the greatest impact. Consider what imagery and communications should be best used for a campaign if the target audience is to increase the awareness of male victims of	Local	Somerset County Council Public Health as part of its Domestic Abuse awareness strategy to review to ensure that enacts this recommendation	Safer Somerset Partnership	Domestic abuse communications and awareness strategy to be reviewed Amendments made to communications strategy if needed	31.1.2023	December 2022 Complete, domestic abuse communications strategy encompasses this recommendation

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
domestic abuse and coercive and controlling behaviour in Somerset.				Deliver media/comms to reflect the recommendation		
The Partnership to support a roll out of Masterclasses- supported by the Mankind Initiative to empathise how practitioners can better support male victims of domestic abuse; recognising the barriers they face to reporting and disclosing abuse	Local	Somerset County Council Public Health to contact Mankind Initiative to organise these masterclasses	Safer Somerset Partnership	Mankind Initiative and SCC Public Health to agree programme of training Training masterclasses to be delivered and evaluated	31.3.2023	
The Partnership to further explore the pathways and commissioned services for older victims of domestic abuse in Somerset and develop training for services about this in order that it is identified at the earliest opportunity so that specialist services can risk assess and offer support and early intervention. As part of this the Partnership should consider the use and adoption of the Dewis Choice Initiative Procedural Guidance	Local	Somerset County Council Public Health to review its service specifications as part of its procurement of the Somerset Integrated Domestic Abuse Service and ensure older victims of domestic abuse are positively enabled to access –through professional awareness and training to be organised for professionals as part of	Safer Somerset Partnership	Review service specifications as part of Summer 2022 procurement Ensure contracts for Somerset Integrated Domestic Abuse Service starting 1.4.2023 enable training and awareness both within service and with other professionals Monitor referrals and service uptake within new SIDAS	31.3.2023	

Recommendation	Scope of recommendation (Local, Regional, National)	Action to Take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and outcome
for Older victims of domestic abuse.		multi agency programme				
The Partnership to evaluate the success and use of the digital e-learning suite created to raise awareness of domestic abuse, and consider if a specific module on older people and domestic abuse should be created.	Local	Somerset County Council Public Health to review the takeup and evaluations from the digital domestic abuse learning suite at Somerset Survivors website and consider adding a new module on older people and domestic abuse if required.	Safer Somerset Partnership	Review evaluations and takeup Decision on whether to include in planned programme of revisions to modules for 2023/24	31.3.2023	

b. Home Office QA Panel Feedback Letter

Home Office

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Suzanne Harris
Senior Commissioning Officer
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28 December 2023

Dear Suzanne,

Thank you for resubmitting the report (Mr A) for Safer Somerset Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in December 2023.

The QA Panel is grateful for sight of your report into what is clearly a challenging and complex case. The Panel notes the sensitivity shown to both the victim and their family in the report, including in the pen portrait. A full range of relevant agencies and charities were involved in the review. It is also noted that limited agency contact, and the couple living overseas for some years, may make it difficult to put together a full picture of events.

The QA panel noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel