SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Report into the death of Louise

May 2023

Contents

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Into the death of Louise

In May 2023

OVERVIEW REPORT

Independent Chair and Author: Michelle Baird MBA, BA.
Review Completed: 11 June 2024

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Tribute written by Louise's Mum

"Louise, looking for the words to say, knowing they are here inside with all the thoughts and memories …

Louise touched the hearts of so many people, she had a multitude of friends, and yet in many ways was alone. She could be funny, annoying, or loving and giving, but to me she was my 'little girl'.

Louise was one of life's givers, often going without herself to give to others. There are so many stories I could tell, about her selflessness and thoughtfulness. One of my favourites of her is:

"Louise would get paid of a Tuesday, and so she could give me flowers on a Saturday, she would buy them then. When Saturday arrived, so would Louise with the 4 days old drooping flowers, but I loved them".

Louise felt the pressures of a social system that should have been there to protect her. A 50 year asthmatic lady trying to survive the best she could, yet the benefit system forced her to seek employment, while so many young, fit and healthy sat in pubs reaping the rewards of a failed system. Was Louise bitter? No, she turned it to her favour. She got a job and had actually just gained a position in a school as a cleaner when she was taken from us.

That's who Louise was. A smile that was infectious and a heart so full of love".

1. PREFACE

1.1 The Safer Somerset Partnership Domestic Homicide Review panel wish to express their deepest sympathy to Louise's[1] family and all who have been affected by Louise's untimely death.

1.2 The Review Chair thanks the panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review. She is joined by the panel in extending specific thanks to Suzanne Harris for her efficient administration of the Review.

1.3 This Review was commissioned by the Safer Somerset Partnership following notification of Louise's death in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

1.4 Domestic Homicide Reviews (DHRs) are not disciplinary inquiries nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.5 This Review was held in compliance with Legislation and followed Statutory Guidance. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Louise and Daniel[2] entering into the process from their viewpoint. This has ensured that the Review panel has been able to consider the circumstances of Louise's death in a meaningful way and address with candour the issues that it has raised.

1.6 The term domestic abuse will be used throughout this Review as it reflects the range of behaviours and avoids the inclination to view domestic abuse in terms of physical assault only.

2. INTRODUCTION

2.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Louise and Daniel, both residents in an area in Somerset to the point of Louise's death in May 2023.

2.2 In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Louise's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review seeks to identify appropriate solutions to make the future safer.[3]

2.3 The key purpose for undertaking this Review is to enable lessons to be learned where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for lessons to be learned

[1] Pseudonym for the deceased.
[2] Pseudonym for the perpetrator.
[3] Home Office Guidance for Domestic Homicide Reviews December 2016.

as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change to reduce the risk of such tragedies occurring in the future.

2.4 **The Domestic Abuse Act 2021 defines Domestic Abuse as**:

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

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

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

(a) physical or sexual abuse
(b) violent or threatening behaviour
(c) controlling or coercive behaviour
(d) economic abuse (see sub-section (4))
(e) psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct. https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

2.5 **The Home Office defines Controlling and Coercive behaviour as:**

- **Controlling behaviour is:** A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- **Coercive behaviour is:** An act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

2.6 Legislation does not provide a definition on strangulation. Strangulation is defined as asphyxia by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck. There are three main categories: hanging, ligature strangulation and manual strangulation. Non-fatal strangulation (NFS) is where the person has not died.

2.7 A standalone offence of non-fatal strangulation and suffocation under the Domestic Abuse Act 2021 was introduced in England and Wales on 07 June 2022.[4]

2.8 Strangulation is now widely recognised as a particularly high-risk element of domestic abuse, usually within the context of controlling/coercive behaviour. In a different context, the normalisation of strangulation, or what is often

[4] https://www.cps.gov.uk/legal-guidance/non-fatal-strangulation-or-non-fatal-suffocation

erroneously referred to as 'choking' during sex is rising (with particular impact on younger women) and bringing with it, complex questions of consent.[5]

2.9 A summary of the circumstances that led to the Review being undertaken in this case:

2.10 During an evening in May 2023, Daniel, called 999 to inform the Police that he had just tried to kill Louise by strangulation at his home address. Little more than 12 hours after the assault, Louise went into a coma and was rushed to hospital. Sadly, Louise died 10 days later. (See Section 14 for further details).

3. TIMESCALES

3.1 A referral was made by Avon and Somerset Police on 28 June 2023 for a Domestic Homicide Review to be considered. A decision to undertake a Domestic Homicide Review was taken by the Chair and Members of the Safer Somerset Partnership on 28 June 2023, and the Home Office were informed of this decision the same day.

3.2 The Independent Domestic Homicide Review Chair was appointed on 08 August 2023 and a pre-meeting of the DHR was held on 31 August 2023 to agree process, timescales and Terms of Reference. A further update was provided to the Home Office by the Review Chair regarding timescales. The first Panel meeting was held at the earliest opportunity on 26 September 2023, during which the Panel members were instructed to secure their records relating to any contact made with either Louise, Daniel or Nicky and appoint an IMR author.

3.3 Normally such Reviews, in accordance with National Guidance[6], would be completed within six months of the commencement of the Review. However, in this case, due to the ongoing criminal investigation and court proceedings this was not possible and the Home Office authorised additional time.

3.4 The Review considered the contact and involvement that agencies had with Louise, Daniel or Nicky from 01 January 2021 to the date of Louise's death in May 2023. These dates were chosen, as the relationship between Louise and Daniel commenced in January 2021.

3.5 In consultation with the Police Investigating Officer, it was decided to delay certain aspects of the Domestic Homicide Review until the criminal investigation had concluded. However, permission was given for the Review Chair to contact family members and friends as they were not listed as witnesses in the court case. Once the court proceedings had been concluded, further meetings of the Review took place.

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[5] https://www.counselmagazine.co.uk/articles/non-fatal-strangulation-one-year-on-why-it-matters

[6] The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance (14.162 and 14.63)

3.6 After an initial pre-meeting on 31 August 2023, the DHR Panel met formally four times via 'Teams'.

- 26 September 2023
- 18 January 2024
- 19 March 2024
- 26 April 2024

3.7 The Review was concluded on 11 June 2024.

4. CONFIDENTIALITY

4.1 In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel members and IMR authors. The findings of this Review are restricted to only participating Officers / Professionals and their Line Managers until after this report has been approved for publication by the Home Office Quality Assurance Panel.

4.2 As recommended within the Guidance, to protect the identity of the deceased, the perpetrator, her family and friend, pseudonyms have been used throughout this report. In the case of Louise, Charlie[7] and Cathy[8], these names were chosen; Nicky[9] and Daniel[10] was chosen by the Review Chair and agreed by the Panel.

4.3 Louise was 50 years of age at the time of her death, Daniel was aged 43 and Nicky aged 16. All three were white British nationals.

5. TERMS OF REFERENCE

5.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant statutory guidance for the conduct of Domestic Homicide Reviews.

5.2 **Statutory Guidance states the purpose of the Review is to:**

- Establish what lessons are to be learned from the Domestic Homicide Review regarding the way in which local professionals and organisations 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.

[7] Louise's middle child.
[8] Louise's friend.
[9] Louise's younger child
[10] Perpetrator

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

5.3 **Specific Terms of Reference for this Review:**

- Consider the period from 01 January 2021 and the date of Louise's death in May 2023, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events relating to domestic abuse, violence, non-fatal strangulation, substance abuse or mental health.

- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events, taking account of the criminal justice proceedings in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the Domestic Homicide Review being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control and non-fatal strangulation are fully explored.

- Determine if there were any barriers for Louise or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:

  - Against the Equality Act 2010's protected characteristics.
  - In regard to children and any potential impact this had ensuring the safeguarding of any children during the Review.

- 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 how interventions designed to manage perpetrators were implemented (including registered sex offenders), and the impact this had on Louise.

- 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.

6. METHODOLOGY

6.1 The method for conducting this Domestic Homicide Review is prescribed by Legislation and Home Office Guidance. As previously stated, upon receiving notification of Louise's death from Avon and Somerset Police in May 2023, a decision to undertake the Review was taken by the Chair of the Safer Somerset Partnership.

6.2 Agencies in the Somerset and Plymouth area were instructed to search for any contact they may have had with Louise, Daniel or Nicky and asked to secure their records. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Louise's circumstances in the future.

6.3 The Domestic Homicide Review panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums
- Discussions with members of Louise's family
- Information from Cathy, Louise's friend

- Discussions during Review panel meetings
- Pathologist Report / Post-Mortem
- Expert advice in relation to Non-Fatal Strangulation from the Institute for Addressing Strangulation (IFAS)

7. INVOLVEMENT OF FAMILY AND FRIENDS

7.1 At the commencement of the Review, the Review Chair contacted Louise's mother and Charlie, (Louise's middle child) by formal letter on the 31 August 2023. They were provided with a copy of the draft Terms of Reference, the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA) leaflets explaining DHRs and available support. During the first of the telephone conversations, the Review Chair explained the purpose of the Review and why it was being held.

7.2 Louise's mother and Charlie declined the support of an AAFDA Advocate, as Louise's mother had already built a rapport with her Family Liaison Officer and Charlie was receiving support privately.

7.3 The family requested that no contact be made with four of Louise's children. The Review Chair respected their wishes. Louise's mother and Charlie provided information relating to Louise which has been included in this Report.

7.4 Louise's mother, Charlie and Cathy were invited to attend the final meeting of the Review which they declined.

7.5 The Review Chair endeavoured to contact Charlie's father, two of Louise's friends and partners from Louise's previous relationships and with the exception of one friend, (Cathy), others declined to contribute to the Review. It is acknowledged that this has resulted in a lack of information relating to Louise and the relationships with her previous partners.

7.6 On 31 August 2023, the Review Chair wrote to Louise's partner Daniel, via his Solicitor, to notify him of the Review but did not receive any response. Nevertheless, the Review Chair tried again to contact Daniel through his probation officer after the criminal proceedings had been completed. Daniel declined to participate in the Review and did not give consent for his medical records to be made available to the Review.

8. CONTRIBUTORS TO THE REVIEW

8.1 Whilst there is a statutory duty on bodies including the police, local authority, probation, and health bodies to engage in a Domestic Homicide Review, other organisations can voluntarily participate; in this case the following agencies were contacted by the Review:

- **Avon and Somerset Police:** This Police Force had relevant contact with Louise and Daniel, and an Individual Management Review (IMR) was completed. A senior member of this Force is a Review panel member.

- **Children's Social Care:** This service had relevant contact with Nicky and the family on three occasions. An Individual Management Review (IMR) was completed. A senior member from this service is a panel member.

- **Devon and Cornwall Police:** This Police Force had relevant contact with Daniel prior to the timeframe of the Review and a report was completed.

- **Harbour Drug and Alcohol Service:** This service had relevant contact with Daniel prior to the timeframe of the Review and an Individual Management Review (IMR) was completed.

- **NHS Somerset Integrated Care Board (ICB) on behalf of GPs:** This organisation had contact with Louise and an Individual Management Review (IMR) was completed. A senior member of this organisation is a panel member.

- **Plymouth Probation Service:** This service had regular contact with Daniel prior to the timeframe of the Review and a report was completed.

- **South Western Ambulance Service NHS Foundation Trust (SWAST):** This service had relevant contact with Louise and Daniel. A report was completed, and a senior member of this service is a panel member.

- **Somerset Council Housing (formerly Sedgemoor):** This organisation had Contact with Louise and Daniel and an Individual Management Review (IMR) was completed. A senior member of this organisation is a panel member.

- **Somerset Drug and Alcohol Service:** This service had contact with Daniel. A senior member of this service is a Panel member, an Individual Management Review (IMR) was completed.

- **Somerset NHS Foundation Trust:** This Trust had limited contact with Louise. A report was completed, and a senior member of this Trust is a panel member.

8.2 In addition to the above agencies, family members and a close friend also contributed to the Review.

8.3 The following agencies were contacted and reported having no contact with Louise or her children:

- Adult Social Care
- Next Link / Safe Link ISVA
- Somerset Integrated Domestic Abuse Service (SIDAS)
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS)
- Victim Support
- Sanctuary Supported Living

9. REVIEW PANEL

9.1 The Domestic Homicide Review panel consists of senior officers from statutory and non-statutory agencies who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. All Panel members were independent of any direct involvement with or supervision of services involved in this case.

Membership of the Panel:

Michelle Baird	Independent Chair
Suzanna Harris	Senior Commissioning Officer - Safer Somerset Partnership (Somerset Council Public Health)
Dave Marchant	Detective Inspector - Avon and Somerset Police
Kelly Brewer	Head of Help and Protect - Somerset Council Children Social Care
Julia Mason	Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team - NHS Somerset Integrated Care Board (ICB) on behalf of GPs
Rob Semple	Community Safety & Resilience Manager - Somerset Council Housing (formerly Sedgemoor)
Jane Harvey-Hill	Safeguarding Manager - Somerset Drug and Alcohol Service
Vicky Hanna	Domestic Abuse Lead -Safeguarding Advisory Service Somerset NHS Foundation Trust
Jody Gallagher	Safeguarding Named Professional - South Western Ambulance Service NHSFT
Jayne Hardy	Assistant Director - Somerset Integrated Domestic Abuse Service (SIDAS) The YOU Trust

9.2 Expert advice was sought from Professor Cath White, a former GP and now a key expert in the area of fatal strangulation at the Institute for Addressing Strangulation (IFAS). Professor White and a colleague were invited to attend a Panel meeting and a presentation on strangulation was provided to the Panel. Much of the research done by IFAS has been developed in consultation with survivors of non-fatal strangulation.

9.3 **Key points taken from the presentation were as follows:**

- Strangulation can happen as part of any domestically abusive relationship, and not only as part of sexual violence, e.g. it is part of coercion and controlling behaviour. Strangulation is so very easy to have a significant impact, that is why as part of coercive control the threat alone can be very effective for the perpetrator to control.

- Those who perpetrate strangulation can be involved in other abusive and/or criminal activities.

- Victims of strangulation can be confused, unsure of what has happened and may not be able to give coherent account of what has happened - due to the physical effects, including lack of oxygen intake. No oxygen equals no memory.

- Lack of external physical injury does not mean that strangulation has not happened.

- Pressure required to cause damage on the neck through strangulation is less than that of opening a can of soda or an adult male's handshake.

- Analysed Domestic Homicide Reviews have found that:

  - 19% had a clear history of non-fatal strangulation.
  - 97% of perpetrators were male and 81% of the victims were female.
  - 53% of non-fatal strangulation perpetrators went on to kill the victim.
  - 59% reported incidences of non-fatal strangulation to the police.

9.4 IFAS has collaborated with major royal colleges and associated professional groups to develop comprehensive guidelines for clinical management of non-fatal strangulation in acute and emergency care services, aiming to provide victims with optimal care promptly and mitigate potential harm[11]. This was published in February 2024.

10. CHAIR AND AUTHOR OF THE REVIEW

10.1 The Independent Chair and author of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Safer Somerset Partnership and is independent of all the agencies involved in the Review. She has had no previous dealings with Louise, Daniel or Nicky.

10.2. Her qualifications include three degrees: Business Management, Labour Law, and Mental Health and Wellbeing. She has held directorship positions within companies and has trained numerous managers, supervisors, and employees in both charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health, and Bereavement. She also holds a diploma in Criminology, Cognitive Behavioural Therapy, and Emotional Freedom Techniques (EFT).

10.3 She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.

10.4 In June 2022, she attended a 2 day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. She has also attended a

[11] https://ifas.org.uk/guidelines-for-clinical-management-of-non-fatal-strangulation-in-acute-and-emergency-care-services/

number of online courses provided by the Institute for Addressing Strangulation (IFAS).

11. PARALLEL REVIEWS

11.1 A police investigation was conducted following Louise's death and Daniel was subsequently charged. Daniel submitted a guilty plea to intentional strangulation and assault on Louise. A court date was scheduled for November 2023.

11.2 In line with standard policy/procedure an Independent Office for Police Conduct (IOPC)[12] referral was made by the Professional Standards Department (PSD), due to officers attending a reported domestic incident between Louise and Daniel in May 2023. No further action by the IOPC or by PSD was deemed necessary.

11.3 At the time of concluding this Review, the Coroner had not yet listed Louise's death for inquest.

12. EQUALITY AND DIVERSITY

12.1 The Panel and agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered.

12.2 Section 4 of the Quality Act 2020 defined 'protective characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

12.3 There is no information within records provided by any agency or organisation to indicate that any incident mentioned within this report was motivated or aggravated by age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/belief or sexual orientation.

[12] Independent Office for Police Conduct (IOPC) exists to increase public confidence in the police complaints system in England and Wales. It also investigates serious complaints and allegations of misconduct against the police and handles appeals. IOPC is an executive non-departmental public body, sponsored by the Home Office.

Sex was a protected characteristic in this Review. Statistically women are at greater risk from domestic violence and abuse than men.[13]

12.4 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if -
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on a P's ability to carry out normal day-to-day activities[14]

12.5. There was no indication from agency records, or from the information available to the Review, that Louise had any known issues, support needs, or vulnerabilities. There was no history of mental health, disability, or known substance misuse.

12.6. Louise was not known to domestic abuse services or support agencies prior to the single incident reported to police in May 2023. While the absence of such markers suggests limited visibility to services, it also highlights the hidden nature of domestic abuse and the challenges in identifying coercive or controlling behaviour, particularly in cases where there has been no prior engagement with support services.

12.7. It was recorded that Daniel suffered from ADHD and mental health issues. As Daniel did not give consent for access to his medical records, this limited the ability to fully explore whether any protected characteristics may have been relevant, particularly in relation to mental health or disability. The absence of consent created a gap in understanding and restricted the ability to assess whether factors such as mental health or neurodivergence may have contributed to his behaviour toward Louise.

13. DISSEMINATION

13.1 Until this report has been approved for publication by the Home Office Quality Assurance Panel, dissemination of the findings of this Domestic Homicide Review has been restricted.

13.2 Each of the Panel members, the Chair and members of the Safer Somerset Partnership have received copies of this report. A copy will also be sent to the Avon and Somerset Police and Crime Commissioner, the Coroner and the Domestic Abuse Commissioner for England and Wales.

13.3 Louise's mother contacted the Review Chair at the conclusion of the Review, thanked her for the work put into the Review and requested that the family not be sent a copy of the report as it would be too harrowing to read. The Review Chair respected her wishes.

[13] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023

[14] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability.

14. BACKGROUND INFORMATION (THE FACTS) [15]

14.1 Louise and Daniel had been in an on/off relationship for around two years prior to Louise's death. They had separate addresses in an area in Somerset however, it was confirmed by Cathy, that Louise spent most of her time living at Daniel's address. At times, Nicky, Louise's younger child who lived with Louise would spend time with Louise at Daniel's address.

14.2 There had been no previous reports of domestic abuse made by Louise to the police, however on the day of the non-fatal strangulation, Louise gave a written statement of the abuse that she had previously endured at the hands of Daniel.

14.3 On an evening in May 2023, Daniel called 999 to inform police that he had just tried to kill his partner, Louise, at his home address. Daniel's opening words on the call were *"Yeah, hi there I need to report a crime, I just tried to kill my missus",* followed by *"I just lost my temper and I reacted, and I strangled her. I tried to strangle her with a t-shirt round her neck, punch her face in".* Daniel passed the phone over to Louise who was able to talk to the call handler. It was established that Louise had no problems breathing, no serious bleeding and was not injured in any other way other than a sore neck. The call handler dispatched officers to the address and contacted South Western Ambulance Service (SWAST). A colleague remained on the phone to Louise for around 29 minutes until police officers arrived at the scene.

14.4 On the information provided to the Emergency Medical Dispatch (EMD) and the call handler confirming that the police were providing an urgent response, the EMD informed the call handler that the call had been prioritised as a category 3 (urgent but not life threatening) and requested that the Police provide an update when on the scene. An ambulance was directed to the address (arriving some 6 hours later). No update/information was provided to indicate that a more urgent response was required.

14.5 Daniel, on opening the door to the police officers was behaving aggressively holding a large kitchen knife. Officers deployed their PAVA spray[16] and a police dog confronted Daniel. He was arrested for intentional strangulation as well as offences linked to his violent behaviour towards the officers. Photos were taken of Louise's neck and the officer's report stated that *"[she] clearly had a large red mark to her neck area and appeared to be frightened. However [she] was all in order and needed no medical attention".*

14.6 The police, after satisfying themselves that Louise was sufficiently able to do so, took a written statement from Louise. Contact details were provided by Louise including her full name, date of birth, home address and mobile number. Louise told the officer that Daniel had started to argue with her and when the argument escalated, she decided to leave Daniel's home address.

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[15] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

[16] PAVA spray is an incapacitant spray similar to pepper spray.

He then pushed her onto the bed and started to wrestle with her. He grabbed the top of her t-shirt and twisted it around her neck to the point where she was struggling to breathe. Whilst Daniel was doing this, he was shouting *"I'M GOING TO ……. STRANGLE YOU".*

14.7 Louise described their relationship as "toxic", saying that when Daniel had been drinking alcohol, he would be malicious and always found something that she had done wrong. On the afternoon prior to the assault, Daniel had been drinking cider and spirits. Louise also disclosed that there had been another incident a few months previously where Daniel had punched her in the eye, but she had not reported this to the police at the time. She added that Daniel *"is very controlling and doesn't let me be friends with other males and is always making false accusations against me".*

14.8 After taking Louise's statement, the officer completed a DASH with Louise which rated the risk as 'medium'. This was reviewed 3 working days later by the Lighthouse Safeguarding Unit (LSU) as 'high-risk' domestic abuse which is in line with procedure where non-fatal strangulation has been used. Referrals were made to MARAC[17] and Children Social Care regarding Louise's child, Nicky. A "treat as urgent marker" was placed on Louise's home address. There was no "treat as urgent marker" placed on Daniel's address, which was where the incident occurred.

14.9 At the police station following Daniel's arrest, he was seen by the NHS Trust's Advice and Support in Custody and Court (ASCC) for assessment of his mental health. He was subsequently charged and remanded in custody until his court appearance in May 2023.

14.10 When the paramedics arrived at Daniel's address approximately 6 hours after the incident, they got no answer at the door and it was not clear if Louise had left and gone to her home address. Police were called to ascertain if they had any further contact details for Louise, no address or mobile number was recorded for Louise. It is however noted in paragraph 14.6 that Louise had provided details. Enquiries were made with the hospital to check if Louise had self-presented. She had not but based on information from the police that Louise had stated that she had no problems breathing and only had a sore neck, forced entry was not requested at Daniel's address and Louise was recorded as not located.

Subsequent deterioration of Louise's health from the time of the assault to her date of death in May 2023:

14.11 Three days after the non-fatal strangulation assault, Charlie made a 101 call to the police informing them that Louise had been taken to hospital in a coma, and that she had a bleed on the brain. Charlie further explained that little more than 12 hours after the assault from Daniel, the family (Louise's mother and

[17] MARAC - Multi-Agency Risk Assessment Conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

her younger child Nicky) had been having breakfast with Louise at a pub. They noticed that Louise had her head in her hands, when asked what was wrong, Louise said she was hot and complained that she had a headache and did not feel well. According to Louise's mother, Louise was known to suffer from migraines (which were not severe enough for GP attention). Louise went outside to get some fresh air and when the family went out to check that she was okay, they found Louise collapsed on the pavement unresponsive.

14.12 Paramedics attended, and on arrival there was no obvious signs of injury. Louise had urinary incontinence, was shaking and unresponsive. A possible intracranial bleed[18] was recorded by the paramedics and Louise was taken to hospital. Following a CT scan, Louise was transferred to another hospital. On arrival at the hospital, a doctor initially viewed Louise's collapse as not suspicious, being a spontaneous bleed on the brain. However, after learning more about the assault from the previous evening, the Doctor agreed that specialists should review the CT scan images. Later that day Louise had surgery to seal the ruptured blood vessel and drain fluid from her brain to release pressure. Following these procedures, Louise required breathing apparatus to sustain her life and remained in a coma. Avon and Somerset Police remained in constant contact with the hospital, obtaining regular updates, whilst undertaking a full police investigation.

14.13 Seven days later, a doctor in the Intensive Care Unit called the police to inform them of a significant deterioration in Louise's condition. It was reported that part of Louise's brain had died, and that if she did not improve over the next few days she would be moved to end-of-life care. Two days later, a further call was made by the hospital to the police, informing them that Louise's condition had taken a significant downturn overnight and that once all family members had been notified, they would be withdrawing life support and would expect Louise to die within a few hours of this happening. Sadly, Louise died within a few hours.

14.14 A forensic post-mortem was completed in May 2023 at the request of the Coroner. The pathologist placed importance on finding out if Louise had any symptoms in the period between her assault and the collapse, mentioning nausea and headaches as typical precursors. (Louise did cite a headache as a reason she went outside at the pub to get some air).

14.15 The Pathologist's findings stated:

1) Louise was found to have suffered bleeding around the brain (subarachnoid haemorrhage) from a ruptured aneurysm within one of the blood vessels at the base of the brain (anterior communicating artery). Subarachnoid haemorrhage is known to have an irritant effect on blood vessels and can cause vasospasm; sudden contraction of the blood vessels restricting blood flow to the brain. Neuropathological examination confirmed the presence of ischaemic (stroke) damage within the front of the brain consistent with this.

[18] A brain bleed (intracranial haemorrhage) is *a type of stroke*. It causes blood to pool between your brain and skull.

2) The apparent presentation of the symptoms on the morning that Louise collapsed, strongly suggests that the aneurysm ruptured at that time. There is, therefore, no reason to believe that the physical act of neck compression directly caused the rupture. It is recognised, that emotionally stressful events can result in cardiovascular effects such as increased heart rate and blood pressure as part of an adrenaline-related response within the body. This can occur at the time of a stressful incident or when reliving/recounting the event at a later stage. It is conceivable that Louise may have had a physiological stress response that precipitated the rupture of the aneurysm, but it is also entirely possible that this was an entirely coincidental timing of the spontaneous rupture of the pre-existing vascular weakness.

14.16 Cause of death:

1) Subarachnoid haemorrhage with vasospasm associated ischaemic brain injury and secondary bronchopneumonia.

2) Ruptured aneurysm of anterior communicating cerebral artery (operated).

14.17 Daniel appeared in court in November 2023, and found guilty of assault by beating and intentional strangulation. He was sentenced to 20 months imprisonment.

15. CHRONOLOGY

15.1 The events described in this section explain the background history of Louise and Daniel, prior to the key timelines under Review as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with Louise and Daniel, and from information provided by Louise's family.

15.2 Louise had minimal contact with agencies prior to the timeframe of the Review. In relation to her health, records show that Louise was diagnosed with glaucoma[19] in January 2016. She was also known to suffer from asthma.

15.3 Louise's mother informed the Review that Louise was the eldest of four siblings, who had a happy childhood in a family that she loved and who loved her. She described Louise as a very caring person, always putting others first. She went further to say that at times, being a mother prevented Louise from finding employment, but would always endeavour to find work whenever she could. She stated that Louise was an avid "church goer" for many years before meeting Daniel and could only speculate that Daniel was the reason for Louise's relationship with the church ending. She also mentioned that Louise was never a "drinker" before meeting Daniel.

[19] Glaucoma is a common eye condition where the optic nerve, which connects the eye to the brain, becomes damaged.

15.4 Charlie described Louise as a hopeless romantic and stated that all Louise ever wanted was to be loved. Charlie informed the Review that Louise fell into relationships very quickly and had 5 children, each with a different partner. Charlie left home at the age of 16 and moved to another county but stayed in contact with Louise.

15.5 Daniel, a “registered sex offender” was convicted in November 2012, of a contact sexual offence against a child, the daughter of someone he was in a relationship with at the time. He served two and a half years in custody and on his release, was directed by probation service to reside in the Plymouth area. Daniel was managed as a “registered sex offender” by Devon and Cornwall Police.

15.6 On 13 February 2017, Devon and Cornwall Police were informed that Daniel was wanted for prison recall. He had been drinking and became aggressive, verbally abusive and threatening violence to staff and residents at his accommodation. He was arrested following this notification and released from prison in September 2018.

15.7 Devon and Cornwall Police were called to a pub on 28 May 2019, following an incident where Daniel was found in possession of a knife by staff who had to remove it from him. Daniel lost his temper and punched a window breaking a pane of glass and cutting his hand in the process. On police attendance, Daniel was obstructive and used abusive language towards the officers. He was arrested, charged and remanded for possession of a bladed article and criminal damage and received a Suspended Sentence Order of 24 months with 6 months custody with an alcohol treatment requirement for 9 months.

15.8 Devon and Cornwall Police received a call on 09 September 2019 regarding concerns from an ex-resident, who stated that Daniel was carrying knives and that he wanted to murder someone to go back to prison. He was very upset and not coping, calling prison home. Mental health services were called but were not willing to engage as Daniel was deemed to have capacity. Officers called Daniel who did not disclose his location. Daniel stated he was fine and that he had an appointment the following day with his probation officer and a support worker from Harbour. A decision was made by the police that their attendance was not required.

15.9 From 30 October 2019 to 21 October 2020, Daniel received support from Harbour, a drug and alcohol service for problematic alcohol consumption. This was subsequent to Daniel receiving an alcohol treatment requirement in May 2019. He was not treated for alcohol dependency whilst under the care of Harbour.

15.10 During an appointment on 13 November 2019 with his key worker from Harbour, Daniel disclosed that he had experience of being involved with gang culture from the age of 16 years old. He disclosed that he liked the "look of fear" on people's faces and liked people being "fearful" of him. He stated that he did not feel any remorse for any of his previous offences. It was noted that Daniel could become violent and aggressive when under the influence

of alcohol and also be a volatile individual when not under the influence of substances. He had a history of carrying weapons particularly knives. Daniel reported a history of self-harm by cutting but declined to discuss this with professionals.

15.11 On 29 January 2020, Daniel attended an appointment with his probation officer. He was asked to leave the appointment as he was "heavily intoxicated and aggressive". The incident was relayed to his key worker at Harbour. On a number of occasions, Daniel would present at appointments with both probation service and Harbour heavily intoxicated.

15.12 During an appointment with Harbour on 05 February 2020, Daniel disclosed that he felt that the murder of his father had impacted on both his forensic history and substance use. He stated that a certain date in December was always a difficult day for him as this was the anniversary of his father's death. He acknowledged that he may have experienced some Adverse Childhood Experiences (ACEs)[20] including physical abuse by his stepmother and the breakdown of his family situation.

15.13 Daniel's treatment with Harbour was closed on 21 October 2020. Prior to closure, Daniel stated that he was planning to move to an area in Somerset. It was noted that Daniel had no family connections in Somerset. Following the closure of his treatment, staff at Harbour had no further recorded contact with Daniel.

15.14 On 22 October 2020, Daniel's police offender manager conducted a home visit. Daniel presented well and stated that he was looking at moving to an address in the Somerset area and gave a possible address. This address was checked by the local Management of Sexual Offender & Violent Offenders Officers (MOSOVO) and had shown that two registered sex offenders resided in flats within this property along with other concerning factors. Daniel was strongly recommended by his police offender manager to look for alternative accommodation and this information was shared with his probation officer. It was at that time believed that neither the police nor the probation service had the authority to stop Daniel moving into the address. Daniel was given a copy of his Sexual Harm Prevention Orders (SHPO) and Sex Offender Register (SOR) notification requirements and was aware that he would need to register his new address, should he move, within three days of doing so.

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[20] Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity." (Young Minds, 2018).

15.15 On 28 October 2020, during the absence of Daniel's probation officer, questions were raised regarding Daniel's move. An email was sent to Daniel by a probation support officer (PSO), who was unaware of what action had previously been taken. The PSO advised Daniel, that as he had followed the requirement of the Suspended Sentence Order by informing them of his proposed move, he would inform the senior probation officer in Somerset of his proposed move and an officer from the management of sexual offenders would contact him. The PSO advised Daniel that he would be expected to report to the Somerset Probation Office within 4 weeks of arrival and depending on what is agreed, Plymouth Probation may continue to contact him by phone.

15.16 On 03 November 2020, Daniel was informed by his probation officer that due to the information received by police, the Somerset Probation Team had refused his move to the address that he had proposed. Therefore, it was believed that should he move, he would be in breach of his probation conditions. Daniel had previously had the go ahead from a probation support officer for his move and as such, even with the knowledge of the breach he decided to move.

15.17 On 06 November 2020, Daniel moved to the Somerset area. He notified Avon and Somerset Police of his move on 13 November 2020 and his management was transferred. A police offender manager was allocated to Daniel. Daniel's risk of sexual offending was rated as 'medium', but his propensity for violent offending was rated as 'very high'. It was also noted that Daniel was suffering from ADHD, mood swings and was alcohol dependent.

16. OVERVIEW

16.1 This section documents the key contacts agencies and professionals had with Louise, Daniel and Nicky, together with information received from family and friends.

16.2 Louise's mother informed the Review Chair that Louise met Daniel in early 2021, and after a few months of meeting Daniel, Louise announced that she was going to marry him. Louise gave up her home to move in with him. Shortly before Christmas of that year (2021), Louise's mother was informed by Charlie that Daniel had assaulted Louise and thrown her out. Homeless, Louise went and stayed with a friend. Louise's mother contacted Louise's previous landlord requesting her to find Louise a place to stay, agreeing to pay the deposit and advance rental. Shortly after this, Louise and Daniel were back together again.

16.3 Louise's mother stated that Louise had informed her that Daniel would often drink and become aggressive towards her. She went further to say that when Daniel was taken to hospital with pancreatic problems, Louise was there for him, borrowing money for bus fares which she knew that Louise could not repay. When Daniel was discharged from hospital, Louise took care of him, collecting his prescription medication and adhering to his requests to buy alcohol for him.

16.4 In early 2021, Charlie became aware of Louise's relationship with Daniel and was initially excited that Louise had found someone to finally settle down with. Charlie had only met Daniel once, and immediately had concerns as he had consumed a large amount of alcohol on the day they met. Charlie did not say anything to Louise because Louise was happy. Charlie was unaware at this stage that Daniel was a registered sex offender.

16.5 Charlie informed the Review Chair that in 2021, Louise had discussed sending Charlie money as a birthday gift for driving lessons. This did not happen as Daniel had taken the money and used it for alcohol.

16.6 Cathy stated that Louise hardly ever stayed at her place of residence and lived with Daniel on a regular basis. She went further to say that Louise had a discussion with her landlord, requesting permission for Daniel to move in with her as he was due to be evicted from his home for being in arrears with his rent. Louise's landlord was aware of Daniel's past as being a "high-risk sex offender" and already in place were restricted times for Daniel to visit Louise, due to children living in close proximity to Louise's address. Louise's request was denied. Cathy informed the Review that Daniel was a heavy drinker and that Louise never drank alcohol before meeting Daniel.

16.7 Cathy informed the Review Chair, that during Louise and Daniel's relationship she had never witnessed Daniel physically or verbally abuse Louise but did notice bruising, which Louise explained was due to her being clumsy and falling. Cathy recalls seeing Louise with a black eye (she could not recall the date) and Louise confided to Cathy that this was caused by Daniel, and that he had broken her glasses during the assault. Louise told Cathy that she was done with the relationship and was going to leave Daniel.

16.8 On 16 August 2021, paramedics attended Daniel's address. On arrival they found Daniel unconscious. Electronic patient clinical records (EPCR) recorded that Daniel was alcohol dependent. Daniel was at home with friends, he stood up and friends witnessed one side of his face go rigid and he collapsed. Daniel became more alert during assessment and examination, able to converse with the paramedics and answer questions, however he was reluctant to give information as to how much alcohol he had consumed. Friends at the scene told the paramedics that Daniel who regularly drinks throughout the day, had drunk no more than usual. A single convulsion was recorded, and Daniel declined to be conveyed to hospital despite multiple people on the scene trying to convince him to go to hospital. It was recorded that Daniel was capacitated and able to retain all information given.

16.9 On 15 October 2021, a BRAG[21] rated amber was submitted by Avon and Somerset Police to Lighthouse Safeguarding Unit (LSU)[22], highlighting concerns that Daniel was in a relationship with Louise who had a 16 year old

[21] BRAG - A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies.

[22] A team with joint function of supporting victims/witnesses of crime including onward referral to other agencies and, where appropriate, being a point of contact during a CJS process.

child. LSU reviewed the BRAG and made onward safeguarding referrals to Children Social Care (CSC).

16.10 On 19 October 2021, Children Social Care received a referral from Lighthouse Safeguarding Unit (LSU) for an assessment to be conducted with Nicky as Daniel had previously had a contact sexual offence against a minor who was the child of his previous partner. It was reported that Louise called Nicky and told Nicky to deny she was Nicky's mother if the police should call.

16.11 On 27 October 2021, a Multi-Agency Safeguarding Hub (MASH)[23] discussion was held at the Family Front Door[24]. This was partly as the police at this time had made the decision not to make a formal disclosure to Nicky's father, as Louise had shared this information with him in a telephone call and there was no reported contact between Nicky and Daniel. However, within the MASH discussion, it was agreed that a disclosure was required to Nicky along with an assessment.

16.12 A Children and Families assessment was completed but Louise was not spoken to as part of the assessment. Nicky's father was present when the disclosure was made to Nicky, so he was fully aware and confirmed his initial worries. Once Nicky's father was alerted to the fact that Louise was in a new relationship with a sex offender, he made a Sarah's Law[25] application and Nicky then moved in with him. The assessment concluded that Nicky who was safe in the father's care, was having no contact with Daniel and was informed of the potential risk from Daniel. It was agreed that Nicky would only be having contact with Louise and not Daniel. There was no further role identified for Children Social Care.

16.13 On 28 October 2021, Louise called Charlie to say that Daniel had attacked her and kicked her out. Charlie offered to buy Louise a coach ticket so that she could come and stay with Charlie for a while. A few hours later, after not hearing back from Louise, Charlie called her and found out that Louise had gone back to Daniel's flat. Charlie went further to state that it was around this time that Charlie found out about Daniel being a sex offender, Charlie and Louise had little contact after this.

16.14 Louise was seen at her GP surgery on 03 November 2021, due to her legs giving way. This was occurring 2-3 times a day. Louise also reported chronic back and leg pain and that she trips, falls and stumbles easily and self-reported being 'very clumsy'. There were no injuries resulting from these falls, no suspicions of domestic abuse or Louise disclosing domestic abuse articulated in the GP records. There was also no record of any diagnosis given as to the reason for Louise's legs giving way.

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[23] The purpose of a MASH is to bring together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.
[24] The Family Front Door, Initial Contact and Referral Team is the central point for all referrals for children and young people aged 0 to 18 years.
[25] Child Sex Offender Disclosure Scheme, or "Sarah's Law", allows parents to ask police if someone with access to their son or daughter has been convicted or suspected of child abuse.

16.15 On 25 December 2021, Louise contacted Charlie, they had a short conversation and Daniel could be heard in the background. Louise continued her relationship with Daniel despite the abuse perpetrated by him and Louise being aware that he was a registered sex offender.

16.16 On 29 December 2021, Somerset Drug and Alcohol Service (SDAS) received a professional referral from Seetec Pluss[26] for Daniel. Apart from drinking related risks, there were no other risks identified on the referral. The referral stated that Daniel was drinking more than 10 units of alcohol daily.

16.17 Contact Point, who manage referrals and take general enquiries for SDAS called Daniel on 30 December 2021 to complete his referral by using the contact and screening tool. Daniel reported that he was drinking 2 x 2 litre bottles of cider, 2 x 70ml bottles of Amaretto and sometimes brandy daily. An alcohol audit was completed to determine the frequency of alcohol use, with a score of 12 (possible dependency). Daniel reported a family history of alcohol dependency, he also disclosed that he has ADHD and mental health issues. Daniel answered 'yes' to having thoughts of harming himself, others or taking his own life and stated he had made no attempts and had no intent to act on his thoughts. Daniel was identified as a priority during the call, and the case was handed over to the Somerset Drug and Alcohol Service (SDAS) to assess.

16.18 An assessment appointment was not given to Daniel at the time the contact and screening tool was completed. Daniel had highlighted he did not have any flexibility with his work pattern to attend appointments and could be contacted on Fridays after 16:30hrs. Mutual Aid Support[27] numbers were emailed to Daniel.

16.19 On 31 December 2021, a worker from SDAS called Daniel to discuss an assessment appointment. Daniel was advised that to engage with the service, he would need to attend clinic or group sessions Monday - Friday between 09:00 - 17:00hrs. This clashed with his working hours and Daniel advised that he would not be attending as he did not want his employer to be aware of his alcohol use.[28] As a result, Daniel was again signposted to Mutual Aid Support and closed to the service.

16.20 Toward the end of February 2022, Charlie received a phone call from Nicky stating that Daniel had once again attacked Louise. Charlie offered Louise a place to stay but Louise did not take up the offer, and at the beginning of March, Louise was back in a relationship with Daniel.

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[26] Seetec Pluss is a leading provider of work and wellbeing services that inspires thousands of people to find and progress in work.

[27] Groups for people who are thinking about stopping and/or actively trying to stop their drug and alcohol use.

[28] There was no confirmation whether Daniel was in employment. (Para.16.8 stated he regularly drinks throughout the day).

16.21 On 05 May 2022, Children Social Care received an anonymous call. Concerns were raised that Nicky was in contact with Louise when Daniel was present. The caller stated that they were aware that Children Social Care were previously involved, but at that time Nicky was not having contact with Daniel and was meeting Louise in public places. They raised concerns that Nicky had stayed with Louise and Daniel over the Easter holidays and reported that Nicky would often pop in and see Louise and Daniel when Nicky was in the area.

16.22 The social worker spoke with Nicky's father and stepmother who confirmed that Nicky was seeing Daniel when Nicky was visiting Louise. This worried Nicky's father, but he felt that he had limited control as Nicky was 16 years old. However, he shared that he felt Nicky was able to keep safe and was aware of the risk from Daniel. When Nicky was spoken to, Nicky stated that there was little interaction with Daniel and felt that Louise would keep Nicky safe. Nicky also identified a safe person at school for accessing support and shared that there has been education in school around grooming and did not require any further support. A letter was sent to Louise to call into Children Social Care, as contact with Louise could not be made via telephone. There was no evidence on Children Social Care files that Louise called into Children Social Care to discuss the concerns. Nicky was closed to the service on 05 May 2022.

16.23 On 21 June 2022, Daniel called 999 reporting an injury to Louise's head and arm. It was recorded that Louise had a fall down the last 3 steps on the stairs injuring the left side of her head and her left arm when trying to protect her head. Daniel also reported that Louise had broken her glasses during the fall. It is noted in paragraph 16.7 that Louise confided to Cathy that Daniel had broken her glasses during an assault. No loss of consciousness was reported, and Louise was alert and able to converse with paramedics on arrival. Louise reported to the paramedics that she had poor mobility since she was a child, however had no diagnosis, and that she had been generally more unsteady on her feet the last two weeks.

16.24 Paramedic records stated that Louise was 'happy to remain on the scene with her partner'. Louise was advised that if her condition worsened, she was to seek further medical attention immediately. This was understood by both. Louise had her own address, however, spends a lot of time at her partner's address where she was 'staying for the next couple of days'. Louise's electronic record was sent to her GP surgery on the date of attendance. Louise did not attend a GP appointment in this regard.

16.25 Charlie informed the Review Chair, that the last contact had with Louise was after the incident on 21 June 2022. This was a choice made by Charlie to protect Charlie's mental health.

16.26 On 26 July 2022, after receiving a notice for rental arrears, Daniel attended the Somerset Council Housing Office as homeless and was interviewed. He advised that he relapsed with his alcohol dependency and was spending his money on alcohol rather than paying his bills and rent. There was mention

of his mental health deteriorating due to a family member recently passing away. Daniel was offered a referral to Somerset Drug and Alcohol Service (SDAS) for his alcohol use but refused. He was also referred to Citizens Advice Bureau. Following this meeting, on 25 August 2022, Daniel's notice was revoked due to Somerset Council Housing paying off his arrears and liaising with the landlord to allow him to stay if referrals were in place and further rent was being paid.

16.27 On 10 August 2022, paramedics attended Daniel's home address after receiving a 999 call from Daniel, reporting diarrhoea, vomiting and abdominal pain. Daniel informed the Paramedics that he had been drinking alcohol (brandy) heavily over the last 7 days, combining this with Nurofen, up to 24 a day. Assessment and observations were taken, a significant gastro-intestinal bleed, was identified. Paramedics advised that Daniel needed to go to hospital, he declined. Both Daniel and his partner told the paramedics that they would self-present at the emergency department the following day as 'they were too stressed at the moment'. Daniel's refusal to be conveyed to hospital was recorded, witness signature signed by 'Louise'. A further call was made by Daniel to 999 that evening. Daniel reported to be feeling worse and was conveyed to hospital. Alcohol excess, ADHD and anxiety was recorded under his medical history.

16.28 Paramedics attended Daniel's address on two further occasions, 14 October 2022 and 08 November 2022. Both these attendances were related to his pancreatitis [29]and Daniel was conveyed to hospital.

16.29 Daniel contacted Somerset Council Housing on 11 April 2023, as he had fallen into arrears again. He stated that he had some money which he could pay. The Council advised that enquiries would be made regarding a Discretionary Housing Payment[30] (DHP) for any arrears. The Housing Sustainment Team made contact with Daniel the same day.

16.30 On 17 April 2023, the Housing Action Trust (HAT) team contacted Daniel as he had not paid what was agreed to his landlord. He stated that he did not want to pay rental as he was concerned that the landlord would still serve notice. Daniel felt that Housing should pay his rental - it was explained that his universal credit covers his rent. Due to being unable to prevent his homelessness situation, the case was passed to a housing officer. Work was attempted with the landlord to keep Daniel at the property, but due to a number of noise complaints and police attendance at the property they would not let Daniel remain. The housing officer made numerous attempts to contact Daniel, but Daniel never responded.

16.31 Daniel attended Somerset Council Housing in May 2023, to hand in information required for his Discretionary Housing Payment (DHP). He had

[29] Inflammation of the pancreas usually caused by gallstones or alcohol.
[30] DHPs provide financial support towards housing cost.

also now been given a Section 21 notice[31] with an eviction date in June 2023. This was triaged by the Housing Team the same day and a call was made to Daniel to discuss the eviction notice. Daniel was sent a personal housing plan but did not respond.

16.32 Following the non-fatal strangulation incident in May 2023, Children Social Care received a referral from LSU. A social worker from the Family Front Door spoke with Nicky and Nicky's stepmother. Nicky's father was unable to speak with the social worker due to work commitments. Nicky reported being on the phone to Louise when the assault occurred and felt that if Louise remained in a relationship with Daniel, Nicky would not be having any further contact with Louise. Following these discussions with Nicky and the stepmother, it was agreed that there was no role for Children Social Care as Nicky had adequate support from the family.

17. ANALYSIS

17.1 The Review panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

17.2 Ten organisations have provided Individual Management Reports (IMRs) / reports detailing relevant contacts with Louise, Daniel and Nicky. The Review panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

17.3 The lessons learned and recommendations / action plans to address them, are listed in Section 19 and 20 in this report.

17.4 The following is the Review panel's analysis of the agencies' interventions:

Avon and Somerset Police

17.5 Avon and Somerset Police had no reported incidents between Louise or Daniel prior to May 2023. However, Daniel was known to Avon and Somerset Police as a 'registered sex offender' and was being managed by their Offender Management Team.

17.6 There were six contacts with Louise and Daniel during the timeframe of the Review. One detailing the management of Daniel as a registered sex offender, one relating to domestic abuse and four that have not been included in the report as they are not relevant to the Review.

17.7 The IMR author acknowledged that disclosure was not made to Nicky's father regarding Daniel being a registered sex offender. The rationale for no

[31] A section 21 notice starts the legal process to end an assured shorthold tenancy.

disclosure was due to the fact that Louise had already alerted him during a phone call she had with him. The IMR author considered the response to be appropriate and proportionate, and agencies worked together to ensure the safeguarding of Nicky, Louise's younger child.

17.8 The Lighthouse Safeguarding Unit is in the process of creating a Disclosure Team who will hold responsibility for both Domestic Violence Disclosure Scheme (DVDS) and Child Sex Offender Disclosure Scheme (CSODS) processes. Part of this will see training and communication across the constabulary and extending into partner organisations around the scope for professionals in any role to trigger a disclosure process. It is hoped this will begin to become operational in April 2024.

17.9 On the day of the non-fatal strangulation assault, officers followed standard domestic abuse procedure by completing a DASH assessment. Louise engaged with the DASH process, disclosing there had been previous domestic abuse between Daniel and herself. It was noted that there was no reported domestic abuse to police prior to this incident. The officer rated Louise's DASH as 'medium' and submitted this to the LSU. Non-fatal strangulation is seen as a high-risk indicator within domestic abuse, therefore upon review the LSU increased the level to high.

17.10 The officer completing the DASH should have assessed the risk as "high" originally. The LSU did make suitable onward referrals; therefore, this did not affect the support which would have been offered to Louise. The IMR author acknowledged that a more concerned approach to this incident could have been taken by the attending officer, and this to be fed back for individual learning.

17.11 It was acknowledged by the IMR author that Louise's contact details (full name, date of birth, home address and mobile number) were recorded on Niche (crime recording system), which would have been visible had it been checked by the police call handler at the time the paramedics called. Due to the call handler no longer working for the organisation, the incident was assessed and found to be an individual error, in either assuming the phone number used to make the call was Louise's and/or failure to check the linked crime report/Niche where all the necessary details for Louise could have been found.

17.12 There was no "treat as urgent" marker placed on Daniel's address which is where the NFA incident occurred. The IMR author acknowledged that the Force's policy around Information Markers is up to date and fit for purpose. This incident was assessed as an individual error which has been fed back for individual learning. Furthermore, a reminder regarding Information Markers has been included in the Forcewide weekly internal bulletin.

17.13 The IMR author acknowledged that further training is needed on non-fatal strangulation from a medical perspective. The Domestic Abuse Matters Editorial Board is further enhancing training content with materials from the

Institute for Addressing Strangulation (IFAS) which will be included in future versions.

17.14 In addition, a multi-agency recommendation has been made by the Safer Somerset Partnership, who will lead on gaining assurance that all agencies embed learning/training on non-fatal strangulation, primarily from a medical perspective.

17.15 The IMR author is satisfied that the lessons learned have been actioned, therefore no recommendations will be made.

Children Social Care (CSC)

17.16 Between January 2021 and prior to Louise's death in 2023, Children Social Care had referrals for Nicky, Louise's youngest child on 3 occasions, 1 of which related to domestic abuse between Louise and Daniel. However, on these 3 occasions there was no evidence of direct contact between Children Social Care with Louise or Daniel.

17.17 It was unclear why in the MASH form it was not agreed for a disclosure to be made by the police to Nicky's father and also to Louise. It is highly likely that Louise was aware of Daniel's conviction, but it could not be confirmed through the MASH minutes. Both parents needed to have the information required to be able to keep Nicky safe.

17.18 It would have been expected for Louise and possibly Daniel to be party to the assessment that was completed with Nicky, despite there being no contact between Nicky and Daniel at the time, as the likelihood of contact happening in the future was high. This may have given Louise more insight into Daniel's convictions and the risks that he may continue to pose. This would have also enabled Louise to be party to safety planning for Nicky.

17.19 Good practice was identified on the 05 May 2022 by the social worker from the Family Front Door. Checks were made with Nicky, the stepmother and the school to readdress the potential risks. It was recognised that Louise was not spoken to as part of the previous assessment and identified gaps in that there had been no keep safe work completed with Nicky. These matters were explored with the family, and Nicky reported having recently completed work around grooming at school. The social worker tried to make contact with Louise via telephone and then via letter, but Louise did not respond.

17.20 This was a very traumatic experience for Nicky, however, at the time Nicky was supported by the father and stepmother and did not want CSC support. Nicky was three months away from being 18 at the time and was assessed as being Gillick competent[32].

[32] Children who are 16 or 17 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment.

17.21 The IMR author acknowledged that it was not clear from the contact if there were any other agency involved with Nicky that CSC could have spoken with to widen the support net for Nicky, and questions if there could have been signposting for Nicky to domestic abuse services for Young People.

17.22 Recommendations have been made by the IMR author.

Devon and Cornwall Police

17.23 Devon and Cornwall Police had no contact with Louise prior to or during the timeframe of the Review. They did however have contact with Daniel on a number of occasions, following his conviction of a sexual offence in 2012.

17.24 Daniel was managed as a registered sex offender (RSO) by Devon and Cornwall Police's Offender Manager team until his transfer to Avon and Somerset Police in November 2020. After this date, Devon and Cornwall Police had no further contact with Daniel.

17.25 Up until November 2020, regular visits were made to Daniel by his police offender manager. Good communication was identified between Daniel's police offender manager, the support worker at his accommodation and probation service.

17.26 No recommendations were made by the IMR author.

Harbour Drug and Alcohol Service (HDAS) - Plymouth

17.27 Harbour Drug and Alcohol Service had no contact with Louise. No contact was had with Daniel during the timeframe of the Review however, they did have a number of prior contacts with Daniel, the most recent being between October 2019 - October 2020.

17.28 Whilst with Harbour, Daniel received support for problematic alcohol consumption following receiving an alcohol treatment requirement in October 2019. Daniel was not treated for alcohol dependency whilst under the care of Harbour.

17.29 Due to Daniel's forensic history, he was seen at the probation service office by Harbour staff. However, due to COVID 19 restrictions during his treatment, the majority of Daniel's appointments with Harbour staff took place over the telephone.

17.30 Daniel was known to be violent and aggressive when under the influence of alcohol and even when not, Daniel would become volatile. Good practice was identified when Daniel presented heavily intoxicated at meetings and was asked to leave by his key worker so as to ensure the safety of staff.

17.31 Following Daniel's closure to the service in October 2020, no further contact was had with Daniel.

17.32 The IMR author acknowledged, that there was good communication from Harbour staff to probation service and is satisfied with the service provided to Daniel. Therefore, the IMR author has no recommendations to make.

NHS Somerset Integrated Care Board (ICB) on behalf of GPs

17.33 During the timeframe of this Review, there was a mixture of face to face and telephone contacts between Louise and her GP. Louise attended 11 out of 13 appointments with the surgery.

17.34 Louise was known to suffer from asthma and glaucoma. She did not attend for routine reviews for both these on a number of occasions in the year proceeding her death and did not respond to reminders for tests.

17.35 Louise did report concerns regarding her mobility to her GP in 2021, and in 2022, Daniel called 999 when she fell at his home. Louise sustained injuries from the fall on 21 June 2022 which was recorded by the paramedics on her electronic patient clinic record and sent to the GP. Louise did not attend a GP appointment in this regard.

17.36 Louise did not disclose domestic abuse at any time, and there were no other known risk factors which would have prompted targeted enquiries into domestic abuse by the GP.

17.37 The IMR author acknowledged that there was no additional information recorded in Louise's records to prompt the GP to undertake targeted enquiries and therefore, the response from the GP was appropriate. The IMR author does not wish to make any recommendations.

Probation Service - Plymouth

17.38 Probation service had contact with Daniel prior to the timeframe of the Review. Their dealings with him were for a sexual offence against a 13 year old child of a previous partner. During this time, Daniel was dealt with by a number of probation officers, and problems identified where Daniel would show aggression and threaten violence.

17.39 Good communication was evidenced between Daniel's probation officer and his police offender manager - of note, the incident on the 13 February 2017 for prison recall, when Daniel became aggressive, verbally abusive and threatening violence to staff and residence at his accommodation.

17.40 In October 2020, Daniel's probation officer advised him that Somerset Probation Service would not accept transfer for his move to a proposed address in the Somerset area, due to 2 registered sex offenders residing in the same building. In her absence, conflicting information was provided to Daniel by a number of temporary probation officers regarding his move. This resulted in Daniel moving to the address in November 2020 without permission.

17.41 Whilst it was acknowledged by the Report writer that Daniel was given conflicting information regarding his move to an address that had not been approved, she confirmed that there have been significant changes since the reunification of probation service in June 2021 and is satisfied with the updated transfer policy that was implemented in October 2022, and therefore does not wish to make a recommendation.

Somerset Alcohol and Drug Service (SDAS)

17.42 Somerset Alcohol and Drug Service had no contact with Louise, they did however have contact with Daniel on two occasions during the timeframe of the Review. During these contacts, there was no mention of domestic abuse or Daniel being in a relationship with Louise.

17.43 After receiving a professional referral for Daniel on 29 December 2021, Daniel was contacted the following day to complete an online assessment. During his assessment he was identified as a high-risk priority, referred to management and given support numbers for his mental health and sign posted to community and online Mutual Aid Support. No assessment appointment was given to Daniel, when he highlighted that he could not attend appointments during the day as he did not want his employer to be aware of his alcohol use.

17.44 The IMR author acknowledged that SDAS were not offering late night key working appointments, and Daniel could have been offered the SDAS online platform which he could access in his own time for support, to learn skills and coping strategies to address his alcohol use.

17.45 A recommendation has been made by the IMR author.

Somerset Council Housing (formerly Sedgemoor)

17.46 Somerset Council Housing had contact with Louise and/or Daniel on 15 occasions. These contacts ranged from letters sent to face-to face interactions around tenancy for Daniel.

17.47 There had been no interactions that evidenced any concerns around domestic abuse or missed opportunities to identify domestic abuse. All interactions followed departments guidance and procedures.

17.48 The IMR author acknowledged that whilst there are opportunities for the service to improve, these were mainly around professional curiosity and signposting for support around mental health and bereavement.

17.49 When Daniel mentioned struggling with his mental health and a recent bereavement, there was no indication that any support was offered around this. This has resulted in one recommendation being made by the IMR author.

Somerset NHS Foundation Trust

17.50 Minimal contact was had with Louise during the timeframe of the Review, none of which were related to domestic abuse. There were seven clinical appointments made between March 2021 and November 2022 relating to glaucoma, two of which were not attended despite being sent reminders.

17.51 The Trust followed procedure when appointments were missed by Louise, therefore, no recommendations were made by the IMR author.

South Western Ambulance Service NHS Foundation Trust (SWAST)

17.52 Between January 2021 and May 2023, SWAST had contact with Louise and Daniel on seven occasions. Two of those emergency calls were for Louise, none of which were recorded to be related to domestic abuse. Five of those contacts were emergency calls for Daniel.

17.53 The two contacts with Louise were for a fall down three stairs on 21 June 2022 and when Louise collapsed in May 2023 which sadly, she did not recover from and died soon after.

17.54 Four out of the five contacts with Daniel were for abdominal pain, one contact was for a possible fit/seizure.

17.55 The paramedics who met with and assessed Louise on 21 June 2022 acted appropriately. Louise's medical history, presenting condition and a full set of observations were recorded. Louise, who was happy to stay with Daniel and was advised that if her condition worsened, she was to seek further medical attention immediately. A copy of Louise's electronic patient clinical records was sent to her GP.

17.56 The electronic patient clinical records (EPCR) for contact with Louise on the day she collapsed, reported that there was no known recent head injury or trauma or obvious sign of injury or trauma. The recent non-fatal strangulation assault was not recorded as being reported to the paramedics on the scene. The paramedics, however, refer to the fall and head injury on 21 June 2022 nearly a year prior. It was recorded that when the paramedics arrived on the scene (the day Louise collapsed), Louise had been incontinent of urine, and known to suffer with migraines, however, was not a known epileptic. It was unclear whether Louise migraines were hemiplegic[33] in nature. The Paramedics would assess and treat based on what they see, and information known to them.

17.57 The IMR author acknowledged, that with the information now known pertaining to the abuse perpetrated by Daniel, the contact with Louise on 21 June 2022 could have been a cause for concern. However, at the time, South Western Ambulance Service had no previous contact or information regarding Louise being a victim of domestic abuse. The injuries sustained seemed to be consistent with that of a fall, and the paramedics were able to talk to Louise

[33] Rare type of migraine involving temporary weakness on one side of the body as part of the attack.

who herself stated that she had fallen and that she had suffered a deterioration in her mobility over the past few weeks. There was no further information reported as to why Louise's mobility had declined.

17.58 The IMR author confirmed that South Western Ambulance Service have reviewed their safeguarding training. This training commenced in April 2024 and includes the importance of using professional curiosity, to recognise safeguarding concerns for all patient facing frontline staff.

17.59 The IMR author listened to the emergency call made on the day of the non-fatal strangulation incident, to gather information and then requested for the call to be audited.

17.60 It was acknowledged by the IMR author that the audit of the call had been deemed as partially compliant. In essence the outcome reached was correct, with the information given. However, although the EMD's reason for not trying to make the call a 1st or 2nd party call by speaking with Louise directly can be understood, in that police were on the phone to Louise. This does sit outside Standard Operating Procedure EOC44 Management of 3rd/4th party callers. Therefore, the EMD should have advised the police that contact with Louise was needed to further triage and provide instructions/advice. Whether the police would have cleared the line at that point it is not known based on safety and risk. It was also not known if Louise had a personal number that she could have been contacted on separate to Daniel's mobile number.

17.61 The police call handler reported that police were providing the immediate response. The police did not call South Western Ambulance Service back when on the scene to report a change or deterioration in the physical presentation of Louise. Police could have called the ambulance service to have given an update and to have asked for any advice/guidance whilst waiting for an ambulance.

17.62 South Western Ambulance Service arrived at the location of the incident approximately 6 hours post the emergency call from the police call handler. This does not meet the expectation of the Department of Health guidelines. This delay was due to service pressures, the demand on the South Western Ambulance Service at that time and hospital/ hand over delays. No further emergency calls were made to the South Western Ambulance Service to prompt reprioritisation of the initial call/response time.

17.63 Consideration has been given as to whether South Western Ambulance Service should have gained entry to the address, to have sited Louise and to have offered her an assessment.

17.64 The IMR author confirmed that there is guidance in relation to forced entry for the South Western Ambulance Service. They have no statutory provision or legal power to forcefully gain access to premises. SWAST do however have a duty of care to patients and must uphold its Article 2 Right to Life

responsibilities[34]. In this instance there was no evidence that there was a risk to Louise's life once Daniel had been arrested, based on Louise's physical presentation reported by police.

17.65 The IMR author informed the Review that there are no clinical guidelines within South Western Ambulance Service on what to do if a patient is unable to be located. This is the decision of the paramedics and operations officer providing clinical leadership to them. The decision would be made based on information available and risk to a person, considering not only risk factors, but the patients right to private and family life.

17.66 A recommendation has been made by the IMR author.

18. KEY ISSUES AND CONCLUSIONS

18.1 The Review panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contact with Louise and Daniel.

18.2 Louise did not report domestic abuse to the police prior to the non-fatal strangulation assault or seek help from a support agency. There is considerable academic research relating to domestic abuse and the difficulties faced when experiencing trauma, which can often make reporting such crimes extremely difficult. It is estimated that less than 24% of domestic abuse is reported to the police (Domestic Abuse Statistics UK). Whilst there are laws to protect against domestic abuse, there are several factors that could prevent those affected from coming forward to have their voice heard.[35]

18.3 Daniel was alcohol dependent and was known to both the police and probation service as someone who could be violent and aggressive when intoxicated towards professionals and members of the public. Charlie and Louise's mother have confirmed to the Review, that Louise had confided in them that she was afraid of Daniel when he was intoxicated as he had been violent towards her on several occasions and Louise refused to report it to the police. Whilst alcohol is not a cause of domestic abuse and is never an excuse, there are however, many ways in which alcohol and domestic abuse are related. Many abuse incidents occur when one or both people involved have been drinking, and alcohol is more commonly involved in more aggressive incidents.[36]

18.4 The Review panel acknowledges that this Review highlights the importance of professional curiosity by practitioners. The paramedics recorded no

[34] https://www.equalityhumanrights.com/human-rights/human-rights-act/article-2-right-life
[35] https://swaca.com/why-is-domestic-abuse-often-not-reported/

[36] https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Alcohol-and-Domestic_Abuse_Oct2021.pdf

suspicion of accidental injury during their contact with Louise in June 2022, however, could have talked to Louise in more depth regarding her fall and the previous stumbles that day, including the deterioration in her mobility. The discussion with Louise may have been different if more information was known about Louise and her situation, however the paramedics had no information regarding previous or current domestic abuse at that time.

18.5 The paramedics who attended Daniel's address in August 2022, could have attempted to speak to Daniel in more depth regarding why he was stressed and declining to go to hospital, in order to gain a better understanding of his situation.

18.6 When police attended on the day of the non-fatal strangulation assault, it was recorded that Louise needed no medical attention. Experts in the field emphasise the importance of all victims of strangulation to be medically assessed, as this omission puts victims at further risk. Even if the victims initially survive the strangulation, they could die in the coming days or weeks after the strangulation as a result of blood clots, arterial complications, respiratory issues or other reasons.[37]

18.7 It was acknowledged by the Review, that all agencies interacting with victims of strangulation need to be aware of post incident complications and ensure that they know what signs and symptoms they need to look for in the following hours/days. Subsequently, guidance around this has recently been published by the Institute for Addressing Strangulation which will assist agencies in this regard.

18.8 On the day in May when Louise collapsed, paramedics stated that there was no sign of visible injury. The types of serious harm caused by strangulation are often externally invisible and sometimes delayed. A 2021 study (Bichard et al, 2021), neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence identified a range of serious impacts including hypoxic brain injury and stroke.[38] In a recent study of 204 women presenting following an assault in which they had been strangled, over 86% had symptoms which lasted after the assault, (White et al, 2021).

18.9 Louise had been described by Charlie as a "hopeless romantic" who fell quickly into relationships. On this occasion, Louise had fallen for a troubled individual with a violent nature and could not bring herself to leave the relationship. According to Charlie, Louise found it difficult to leave the relationship as Louise feared being alone after so many failed relationships.

19. LESSONS LEARNED

[37] https://www.biausa.org/public-affairs/media/strangulation-domestic-violence-and-brain-injury-an-introduction-to-a-complex-topic#:~:text=Even%20if%20the%20victims%20initially,respiratory%20issues%2C%20or%20other%20reasons.

[38] https://www.counselmagazine.co.uk/articles/non-fatal-strangulation-one-year-on-why-it-matters

19.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Appendix A of this report.

Avon and Somerset Police

19.2 A more proactive approach should be taken by police officers, by ensuring that victims of non-fatal strangulation understand the severity of the situation, encouraging them to seek urgent medical assistance and getting them to A&E to be assessed.

19.3 When adding information markers to locations involved in incidents, police officers are to ensure consideration is given to all addresses of those involved, this is vital if parties live separately. This will prompt an effective response and ensure the appropriate safeguarding is in place.

Children Social Care (CSC)

19.4 The assessment that was completed following the potential risk Daniel posed to Nicky, both Louise and Daniel should have been party to the assessment, despite at the time there being no contact between Nicky and Daniel, as the likelihood of contact happening in the future was high.

19.5 Following the risk of Nicky having contact with Louise when Daniel was present, both Louise and Daniel should have been spoken to, especially Louise who should have been party to safety planning for Nicky.

19.6 It was not clear if there was any other agency involved with Nicky that CSC could have spoken with to widen the support net for Nicky. CSC could have signposted Nicky to domestic abuse services for Young People.

Probation Service (Plymouth)

19.7 Due to Daniel being supervised by several temporary probation officers in the absence of his probation officer, he received conflicting information relating to his proposed move to an address in an area in Somerset. The lack of communication between probation officers resulted in Daniel contracting to move to an inappropriate address where two registered sex offenders were already residing in the building.

Somerset Council Housing (formerly Sedgemoor)

19.8 When Daniel mentioned struggling with his mental health and a recent bereavement, there was no indication that any support was offered around this. Further questioning around who he had lost may have helped to signpost Daniel to his doctor or a bereavement charity.

Somerset Drug and Alcohol Service (SDAS)

19.9 When Daniel disclosed that he was unable to attend an assessment appointment during working hours, SDAS could have considered a late assessment appointment at 16:30hrs to establish a treatment plan. They could have also offered Daniel the SDAS online platform which he could access in his own time for support, to learn skills and coping strategies to address his alcohol use.

South Western Ambulance Service NHS Foundation Trust

19.10 More information could have been obtained from Louise in relation to her fall in June 2022. It was evidenced that the fall was explored with Louise, telling the paramedics that she had become more unsteady on her feet over the last few weeks, and that she had two previous stumbles that day. However, more information could have been gathered in relation to the fall, previous falls/stumbles, and deterioration in her mobility. There was no information recorded as to why Louise's mobility had declined.

19.11 When Paramedics attended Daniel's property on the 10 August 2022, Daniel made the decision not to be conveyed to hospital as he reported that he was too stressed. This could have been explored further with Daniel, as to why he was feeling stressed, to ascertain if any further advice or support could have been offered. A recommendation has been made by the IMR author.

20. RECOMMENDATIONS

20.1 The Domestic Homicide Review panel's up to date action plan, at the time of concluding the Review is set out in Appendix A of this report.

Multi-Agency Recommendations

20.2 Somerset Council Public Health on behalf of Safer Somerset Partnership to liaise with Gloucestershire Community Safety Partnership to develop a multi-agency protocol on how to deal with incidences of non-fatal strangulation.

20.3 Safer Somerset Partnership should lead on gaining assurance that all agencies embed learning/training on non-fatal strangulation, as all could have NFS disclosure made to them and need to equally be aware of the domestic abuse safeguarding and medical concerns due to this.

National Recommendation

20.4 Safer Somerset Partnership to write to the Domestic Abuse Commissioner for England and Wales, Minister with responsibility for Home Office and Minister with responsibility for Department of Health to suggest a high-profile campaign to raise awareness around the risks relating to NFS (primarily from a medical welfare perspective), given that evidence shows the majority of domestic abuse is not reported.

Agency Recommendations

Children Social Care

20.5 It is recommended that when a disclosure needs to be made to keep a child safe, personnel must clearly evidence who needs to be party to the information in order to act in the best interest of the child.

20.6 Staff should be reminded when an assessment is being completed and the potential risk is around a child's contact with one particular parent, that parent should be included in the assessment to widen the safety net for the child.

20.7 Where there are children living in a domestic abuse environment, consideration should be given for referrals to be made to domestic abuse services for Young People.

Somerset Council

20.8 Somerset Council Public Health to improve public understanding on the course of action to take if a 3rd party witnesses or hears an incidence of domestic abuse occurring to victims who may be male or female.

Somerset Council Housing (formerly Sedgemoor)

20.9 Officers at Somerset Council Housing to improve around professional curiosity and signposting for support around mental health and bereavement.

Somerset Drug and Alcohol Service (SDAS)

20.10 Somerset Drug and Alcohol Service to consider alternative ways to engage with clients who highlight at referral that they are unable to engage in their standard treatment options; Mon-Fri 09:00 - 17:00.

South Western Ambulance Service (SWAST)

20.11 South Western Ambulance Service to ensure that frontline, patient facing staff are aware of the importance of professional curiosity and the need to look at and understand the holistic picture.

APPENDIX A

The following information has been provided by the Institute for Addressing Strangulation (IFAS)

The Institute for Addressing Strangulation (IFAS) was established in October 2022 following the introduction of strangulation as a standalone offence under the Domestic Abuse Act 2021. IFAS is funded by the Home Office to increase awareness of strangulation amongst the public and professionals, conduct and disseminate research into strangulation, and improve the response to victims, survivors, and their supporters.

Strangulation can be defined as obstruction or compression of blood vessels and/or airways by external pressure to the neck impeding normal breathing or circulation of the blood. Non-fatal strangulation is where such strangulation has not directly caused the death of the victim and fatal strangulation is where death ensues.

Strangulation is an act usually perpetrated by males towards females within the context of domestic and sexual violence. Research has shown the presence of non-fatal strangulation to be indicative of an escalation in intimate partner violence and heightened risk that the victim will be seriously injured or killed. An analysis of Domestic Homicide Reviews by the Home Office between October 2019 to September 2020 found that strangulation was the method of killing in a quarter of the DHRs in that year. A further analysis of 396 DHRs by IFAS found that 1 in 5 DHRs had a history of non-fatal strangulation.

Strangulation, risks brain injury, cardiac arrest and death as well as other adverse outcomes. The neck contains vital structures including blood vessels, which lie close to the surface. These can be blocked by strangulation, affecting the brain's blood supply, resulting in brain damage. That damage can result in life-changing physical and psychological difficulties, and even death. This can happen in seconds and does not require significant pressure. Strangulation can damage blood vessels in the neck, leading to blood clots forming which may result in a stroke. The stroke can happen anything up to a year after the strangulation. Evidence suggests strangulation is the second most common cause of stroke in young women. There is increased awareness that even gentle pressure to the neck, for example during medical procedures, can have devastating consequences. At IFAS we have a clear message that there is no safe way to strangle someone.

One key recommendation from the Domestic Homicide Review analysis conducted by IFAS in 2023, is for the DHR process to highlight the high-risk nature of strangulation within the context of domestic abuse. Subsequently, such information should be cascaded to local services through the dissemination of the learning from both individual and collective DHRs. We were therefore encouraged by the invitation to share research on strangulation to the Domestic Homicide Review Panel in this case.

APPENDIX B

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Safer Somerset Partnership

Feel Safe, Be Safe

SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the death of Louise

In May 2023

EXECUTIVE SUMMARY

Independent Chair and Author: Michelle Baird MBA, BA.
Review Completed: 11 June 2024

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Safer Somerset Partnership in reviewing the death of Louise (pseudonym) who was a resident in their area.

1.2 To protect the identity of the deceased, perpetrator, family and friend, pseudonyms have been used throughout this report.

- Louise - Deceased
- Daniel - Perpetrator
- Charlie - Louise's older child
- Nicky - Louise's younger child
- Cathy - Louise's friend

1.3 Louise aged 50 years of age at the time of her death, lived in an area in Somerset with her younger child, Nicky aged 16. Daniel at the time of Louise's death was 43 years of age. All were white British nationals.

1.4 Criminal proceedings were completed in November 2023, and Daniel was found guilty of assault by beating and intentional strangulation. He was sentenced to 20 months imprisonment.

1.5 The process began with an initial meeting of the Community Safety Partnership on 28 June 2023 when the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with Louise, Daniel and Nicky prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.6 Ten of the sixteen agencies contacted confirmed contact with Louise, Daniel and/or Nicky and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

2.1 Whilst there is a statutory duty on bodies including the police, local authority, probation, and health bodies to engage in a Domestic Homicide Review, other organisations can voluntarily participate; in this case the following agencies were contacted by the Review:

- **Avon and Somerset Police:** This Police Force had relevant contact with Louise and Daniel, and an Individual Management Review (IMR) was completed. A senior member of this Force is a Review Panel member.

- **Children's Social Care:** This service had relevant contact with Nicky and the family on three occasions. An Individual Management Review (IMR) was completed. A Senior Member from this service is a Panel member.

- **Devon and Cornwall Police:** This Police Force had relevant contact with Daniel prior to the timeframe of the Review and a report was completed.

- **Harbour Drug and Alcohol Service:** This service had relevant contact with Daniel prior to the timeframe of the Review and an Individual Management Review (IMR) was completed.

- **NHS Somerset Integrated Care Board (ICB) on behalf of GPs:** This organisation had contact with Louise and an Individual Management Review (IMR) was completed. A senior member of this organisation is a Panel member.

- **Plymouth Probation Service:** This service had regular contact with Daniel prior to the timeframe of the Review and a report was completed.

- **South Western Ambulance Service NHS Foundation Trust (SWAST):** This service had relevant contact with Louise and Daniel. A report was completed, and a senior member of this service is a Panel member.

- **Somerset Council Housing (formerly Sedgemoor):** This organisation had Contact with Louise and Daniel and an Individual Management Review (IMR) was completed. A senior member of this organisation is a Panel member.

- **Somerset Drug and Alcohol Service:** This service had contact with Daniel. A senior Member of this service is a Panel member, an Individual Management Review (IMR) was completed.

- **Somerset NHS Foundation Trust:** This Trust had limited contact with Louise. A report was completed, and a senior member of this Trust is a Panel member.

2.2 In addition to the above agencies, family members and a close friend also contributed to the Review.

2.3 The following agencies were contacted and reported having no contact with Louise or her children:

- Adult Social Care
- Next Link / Safe Link ISVA
- Somerset Integrated Domestic Abuse Service (SIDAS)
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS)
- Victim Support
- Sanctuary Supported Living

3. REVIEW PANEL

3.1 The Domestic Homicide Review Panel consists of senior officers from statutory and non-statutory agencies who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. All Panel members were independent of any direct involvement with or supervision of services involved in this case.

Membership of the Panel:

Michelle Baird	Independent Chair
Suzanna Harris	Senior Commissioning Officer - Safer Somerset Partnership (Somerset Council Public Health)
Dave Marchant	Detective Inspector - Avon and Somerset Police
Kelly Brewer	Head of Help and Protect - Somerset Council Children Social Care
Julia Mason	Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team - NHS Somerset Integrated Care Board (ICB) on behalf of GPs
Rob Semple	Community Safety & Resilience Manager - Somerset Council Housing (formerly Sedgemoor)
Jane Harvey-Hill	Safeguarding Manager - Somerset Drug and Alcohol Service
Vicky Hanna	Domestic Abuse Lead -Safeguarding Advisory Service Somerset NHS Foundation Trust
Jody Gallagher	Safeguarding Named Professional - South Western Ambulance Service NHSFT
Jayne Hardy	Assistant Director - Somerset Integrated Domestic Abuse Service (SIDAS) The YOU Trust

3.2 Expert advice was sought from Professor Cath White, a former GP and now a key expert in the area of fatal strangulation at the Institute for Addressing Strangulation (IFAS). Professor White and a colleague were invited to attend a Panel meeting and a presentation on strangulation was provided to the Panel. Much of the research done by IFAS has been developed in consultation with survivors of non-fatal strangulation.

3.3 **Key points taken from the presentation were as follows:**

- Strangulation can happen as part of any domestically abusive relationship, and not only as part of sexual violence, e.g. it is part of coercion and controlling behaviour. Strangulation is so very easy to have a significant impact, that is why as part of coercive control the threat alone can be very effective for the perpetrator to control.

- Those who perpetrate strangulation can be involved in other abusive and/or criminal activities.

- Victims of strangulation can be confused, unsure of what has happened and may not be able to give coherent account of what has happened - due to the physical effects, including lack of oxygen intake. No oxygen equals no memory.

- Lack of external physical injury does not mean that strangulation has not happened.

- Pressure required to cause damage on the neck through strangulation is less than that of opening a can of soda or an adult male's handshake.

- Analysed Domestic Homicide Reviews have found that:

  - 19% had a clear history of non-fatal strangulation.
  - 97% of perpetrators were male and 81% of the victims were female.
  - 53% of non-fatal strangulation perpetrators went on to kill the victim.
  - 59% reported incidences of non-fatal strangulation to the police.

3.4 IFAS has collaborated with major royal colleges and associated professional groups to develop comprehensive guidelines for clinical management of non-fatal strangulation in acute and emergency care services, aiming to provide victims with optimal care promptly and mitigate potential harm[39]. This was published in February 2024.

4. CHAIR AND AUTHOR OF THE REVIEW

4.1 The Independent Chair and Author of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Safer Somerset Partnership and is independent of all the agencies involved in the Review. She has had no previous dealings with Louise, Daniel or Nicky.

4.2 Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of directorship within companies and trained a number of managers, supervisors and employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Emotional Freedom Techniques (EFT).

4.3 She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.

4.4 In June 2022, she attended a 2 day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. She has also attended a number of online courses provided by the Institute for Addressing Strangulation (IFAS).

5. TERMS OF REFERENCE

5.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous

[39] https://ifas.org.uk/guidelines-for-clinical-management-of-non-fatal-strangulation-in-acute-and-emergency-care-services/

manner in accordance with the relevant statutory guidance for the conduct of Domestic Homicide Reviews.

5.2 **Statutory Guidance states the purpose of the Review is to:**

- Establish what lessons are to be learned from the Domestic Homicide Review regarding the way in which local professionals and organisations 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 these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

- To seek to establish whether the events leading to the homicide could have been predicted or prevented.

5.3 **Specific Terms of Reference for this Review:**

- Consider the period from 01 January 2021 and the date of Louise's death in May 2023, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events relating to domestic abuse, violence, non-fatal strangulation, substance abuse or mental health.

- Seek the involvement of the family, employers, neighbours and friends to provide a robust analysis of the events, taking account of the criminal justice proceedings in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the Domestic Homicide Review being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control and non-fatal strangulation are fully explored.

- Determine if there were any barriers for Louise or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:

- Against the Equality Act 2010's protected characteristics.
- In regard to children and any potential impact this had ensuring the safeguarding of any children during the Review.

♦ 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 how interventions designed to manage perpetrators were implemented (including registered sex offenders), and the impact this had on Louise.

♦ 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.

6. SUMMARY CHRONOLOGY

6.1 The synopsis of the case has been informed by chronologies of the contact agencies in Somerset and Plymouth had with Louise, Daniel and Nicky as well asinformation provided by Louise's family and friend.

6.2 Louise and Daniel had been in an on/off relationship for around two years prior to Louise's death. They had separate addresses in an area in Somerset, however, it was confirmed by Cathy that Louise spent most of her time living at Daniel's address. At times, Nicky, who lived with Louise would spend time with Louise at Daniel's address.

6.3 There had been no previous reports of domestic abuse made by Louise to the police, however on the day of the non-fatal strangulation, Louise gave a written statement of the abuse that she had previously endured at the hands of Daniel.

6.4 Louise had minimal contact with statutory services, with this relating to health providers and Avon and Somerset Police.

6.5 In relation to health, Louise had contact with her GP relating to asthma and glaucoma and on one occasion she reported concerns regarding her mobility. South Western Ambulance Service had contact with Louise on two occasions. These contacts were for a fall down 3 stairs, and when Louise collapsed, which sadly, she did not recover from and died soon after. There were no suspicions of domestic abuse articulated in the GP or South Western Ambulance Service records, and Louise did not disclose experiencing domestic abuse.

6.6 Avon and Somerset Police had contact with Louise on one occasion. This was on the day that Daniel reported to police that he had tried to kill Louise by strangulation.

6.7 Daniel had contact with South Western Ambulance Service on five occasions, four of which were for abdominal pain and one for a possible fit/seizure. He had several historical contacts with criminal justice agencies. Daniel, a “registered sex offender” was convicted in November 2012 of a contact sexual offence against a 13 year old child, the daughter of someone he was in a relationship with at the time. He served two and a half years in custody.

6.8 Daniel who was alcohol dependent, was known to be violent and aggressive when under the influence of alcohol. Devon and Cornwall Police attended a number of incidents between 2017 and 2019 in relation to Daniel’s alcohol use, violence and being in possession of a bladed object. It was noted in police records that Daniel wanted to murder someone to go back to prison, as he was struggling to come to terms mentally with living alone in a new area and was calling prison his home.

6.9 On 13 February 2017, Daniel was recalled to prison. He had been drinking and became aggressive, verbally abusive and threatening violence to staff and residents at his accommodation. Daniel was released from prison in September 2018.

6.10 On 28 May 2019, Daniel was arrested, charged and remanded for possession of a bladed article and criminal damage, receiving a Suspended Order of 24 months with 6 months custody and an alcohol treatment requirement for 9 months. Harbour Drug and Alcohol Service supported Daniel with this requirement.

6.11 During a meeting in August 2019 with Harbour, Daniel disclosed that he had experience of being involved with gang culture from the age of 16 years old. He disclosed that he liked the "look of fear" on people's faces and liked

people being "fearful" of him. He advised that he did not feel any remorse for any of his previous offences.

6.12 Daniel had advised his police offender manager during a home visit on 22 October 2020 that he was looking to move to the Somerset area. A proposed address was provided and checked by the local Management of Sexual Offender & Violent Offenders Officers (MOSOVO) and had shown that two registered sex offenders resided in flats within this property along with other concerning factors. Daniel was strongly recommended by his police offender manager to look for alternative accommodation and this information was shared with his probation officer. It was at that time believed that neither the police nor probation had the authority to stop Daniel moving into the address. Daniel was given a copy of his Sexual Harm Prevention Orders (SHPO) and Sex Offender Register (SOR) notification requirements and was aware that he would need to register his new address, should he move, within three days of doing so.

6.13 On 28 October 2020, during the absence of Daniel's probation officer, questions were raised regarding Daniel's move. An email was sent to Daniel by a probation support officer (PSO), who was unaware of what action had previously been taken. The PSO advised Daniel, that as he had followed the requirement of the Suspended Sentence Order by informing them of his proposed move, he would inform the senior probation officer in Somerset of his proposed move and an officer from the Management of Sexual Offenders would contact him. The PSO advised Daniel that he would be expected to report to the Somerset probation office within 4 weeks of arrival and depending on what is agreed, Plymouth probation may continue to contact him by phone.

6.14 On 03 November 2020, Daniel was informed by his probation officer that due to the information received by police, the Somerset Probation Team had refused his move to the address that he had proposed. Therefore, it was believed that should he move, he would be in breach of his probation conditions. Daniel had previously had the go ahead from a probation support officer for his move and as such, even with the knowledge of the breach he decided to move.

6.15 On 06 November 2020, Daniel moved to the Somerset area. He notified Avon and Somerset Police of his move on 13 November 2020, and his management was transferred. A police offender manager was allocated to Daniel. Daniel's risk of sexual offending was rated as 'medium', but his propensity for violent offending was rated as 'very high'. It was also noted that Daniel was suffering from ADHD, mood swings and was alcohol dependent.

6.16 On 15 October 2021, a BRAG[40] rated amber was submitted by Avon and Somerset Police to Lighthouse Safeguarding Unit (LSU)[41], highlighting concerns that Daniel was in a relationship with Louise who had a 16 year old child. LSU reviewed the BRAG and made onward safeguarding referrals to Children Social Care (CSC). A separate occurrence was created to document any safeguarding concerns and a decision was made, following a Child Sex Offender Disclosure Scheme (CSODS) strategy meeting, that disclosure would be made to Nicky, regarding Daniel. Daniel's registered sex offender management (RSO) was ongoing.

6.17 On 19 October 2021, Children Social Care received a referral from Lighthouse Safeguarding Unit (LSU) for an assessment to be conducted with Nicky as Daniel had previously had a contact sexual offence against a minor who was the child of his previous partner. It was reported that Louise called Nicky and told Nicky to deny she was Nicky's mother if the police should call.

6.18 On 27 October 2021, a Multi-Agency Safeguarding Hub (MASH)[42] discussion was held at the Family Front Door[43]. This was partly as the police at this time had made the decision not to make a formal disclosure to Nicky's father, as Louise had previously shared this information with him in a telephone call, and there was no reported contact between Nicky and Daniel. However, within the MASH discussion, it was agreed that a disclosure was required to Nicky along with an assessment.

6.19 A Children and Families assessment was completed but Louise was not spoken to as part of the assessment. Nicky's father was present when the disclosure was made to Nicky, so he was fully aware and confirmed his initial worries. Once Nicky's father was alerted to the fact that Louise was in a new relationship with a sex offender, he made a Sarah's Law[44] application and Nicky then moved in with him. The assessment concluded that Nicky who was safe in the father's care, was having no contact with Daniel and was informed of the potential risk from Daniel. It was agreed that Nicky would only be having contact with Louise and not Daniel. There was no further role identified for Children Social Care.

6.20 Louise was seen at her GP surgery on 03 November 2021, following a history of her legs giving way. This was occurring 2-3 times a day. Louise also reported chronic back and leg pain and that she trips, falls and stumbles easily and self-reported being 'very clumsy'. There were no injuries resulting from these falls, suspicions of domestic abuse or Louise disclosing domestic

[40] BRAG - A tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies.
[41] A team with joint function of supporting victims/witnesses of crime including onward referral to other agencies and, where appropriate, being a point of contact during a CJS process.
[42] The purpose of a MASH is to bring together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children.
[43] The Family Front Door, Initial Contact and Referral Team is the central point for all referrals for children and young people aged 0 to 18 years.
[44] Child Sex Offender Disclosure Scheme, or "Sarah's Law", allows parents to ask police if someone with access to their son or daughter has been convicted or suspected of child abuse.

abuse articulated in the GP records. There was also no record of any diagnosis given as to the reason for Louise's legs giving way.

6.21 On 29 December 2021, Somerset Drug and Alcohol Service (SDAS) received a professional referral from Seetec Pluss[45] for Daniel. The referral stated that Daniel was drinking more than 10 units of alcohol daily. Contact Point who manage referrals for SDAS, called Daniel on 30 December 2021 and completed his referral using the contact and screening tool. He was identified as a priority during the call and the case was handed over to the SDAS. An assessment appointment was not given to Daniel at the time the contact and screening tool was completed. Daniel had highlighted he did not have any flexibility with his work pattern to attend appointments and could be contacted on Fridays after 16:30hrs. Mutual Aid Support[46] numbers were emailed to Daniel.

6.22 On 31 December 2021, a worker from SDAS called Daniel to discuss an assessment appointment. Daniel had highlighted he did not have any flexibility with his work pattern to attend appointments and could be contacted on Fridays after 16:30hrs. Daniel was advised that to engage with the service, he would need to attend clinic or group sessions Monday - Friday between 09:00 - 17:00hrs. This clashed with his working hours and Daniel advised that he would not be attending as he did not want his employer to be aware of his alcohol use.[47] As a result, Daniel was again signposted to Mutual Aid support and closed to the service.

6.23 On 21 June 2022, Daniel called 999 reporting an injury to Louise's head and arm. It was recorded that Louise had a fall down the last 3 steps on the stairs injuring the left side of her head and her left arm when trying to protect her head. Daniel also reported that Louise had broken her glasses during the fall. No loss of consciousness was reported, and Louise was alert and able to converse with paramedics on arrival. Louise reported to the paramedics that she had poor mobility since she was a child, however had no diagnosis, and that she had been generally more unsteady on her feet the last two weeks. Paramedic records stated that Louise was 'happy to remain on the scene with her partner'. Louise was advised that if her condition worsened, she was to seek further medical attention immediately. This was understood by both. Louise's electronic record was sent to her GP surgery on the date of attendance. Louise did not attend a GP appointment in this regard.

6.24 On 26 July 2022, after receiving a notice for rental arrears, Daniel attended the Somerset Council Housing office as homeless and was interviewed. He advised that he relapsed with his alcohol dependency and was spending his money on alcohol rather than paying his bills and rent. There was mention

[45] Seetec Pluss is a leading provider of work and wellbeing services that inspires thousands of people to find and progress in work.

[46] Groups for people who are thinking about stopping and/or actively trying to stop their drug and alcohol use.

[47] There was no confirmation whether Daniel was in employment. (Para.16.8 stated he regularly drinks throughout the day).

of his mental health deteriorating due to a family member recently passing away. Daniel was offered a referral to Somerset Drug and Alcohol Service (SDAS) for his alcohol use but refused. He was also referred to Citizens Advice Bureau. Following this meeting, on 25 August 2022, Daniel's notice was revoked due to Somerset Council Housing paying off his arrears and liaising with the landlord to allow him to stay if referrals were in place and further rent was being paid.

6.25 On 10 August 2022, paramedics attended Daniel's home address after receiving a 999 call from Daniel, reporting diarrhoea, vomiting and abdominal pain. Daniel informed the paramedics that he had been drinking alcohol (brandy) heavily over the last 7 days, combining this with Nurofen, up to 24 a day. Assessment and observations were taken, a significant gastro-intestinal bleed was identified. Paramedics advised that Daniel needed to go to hospital, he declined. Both Daniel and his partner told the paramedics that they would self-present at the emergency department the following day as 'they were too stressed at the moment'. Daniel's refusal to be conveyed to hospital was recorded, witness signature signed by 'Louise'. A further call was made by Daniel to 999 that evening. Daniel reported to be feeling worse and was conveyed to hospital. Alcohol excess, ADHD and anxiety was recorded under his medical history.

Incident Summary

6.26 On an evening in May 2023, Daniel called 999 to inform police that he had just tried to kill his partner, Louise, at his home address. Daniel's opening words on the call were *"Yeah, hi there I need to report a crime, I just tried to kill my missus",* followed by *"I just lost my temper and I reacted, and I strangled her. I tried to strangle her with a t-shirt round her neck, punch her face in".* Daniel passed the phone over to Louise who was able to talk to the call handler. It was established that Louise had no problems breathing, no serious bleeding and was not injured in any other way other than a sore neck. The call handler dispatched officers to the address and contacted South Western Ambulance Service (SWAST). A colleague remained on the phone to Louise for around 29 minutes until police officers arrived at the scene.

6.27 On the information provided to the Emergency Medical Dispatch (EMD) and the call handler confirming that the police were providing an urgent response, the EMD informed the call handler that the call had been prioritised as a category 3 (urgent but not life threatening) and requested that the police provide an update when on the scene. An ambulance was directed to the address (arriving some 6 hours later). No update/information was provided to indicate that a more urgent response was required.

6.28 Daniel, on opening the door to the police officers was behaving aggressively holding a large kitchen knife. Officers deployed their PAVA spray[48] and a police dog confronted Daniel. He was arrested for intentional strangulation as well as offences linked to his violent behaviour towards the officers. Photos

[48] PAVA spray is an incapacitant spray similar to pepper spray.

were taken of Louise's neck and the officer's report stated that *"[she] clearly had a large red mark to her neck area and appeared to be frightened. However [she] was all in order and needed no medical attention".*

6.29 The police, after satisfying themselves that Louise was sufficiently able to do so, took a written statement from Louise. Contact details were provided by Louise including her full name, date of birth, home address and mobile number. Louise told the officer that Daniel had started to argue with her and when the argument escalated, she decided to leave Daniel's home address. He then pushed her onto the bed and started to wrestle with her. He grabbed the top of her t-shirt and twisted it around her neck to the point where she was struggling to breathe. Whilst Daniel was doing this, he was shouting *"I'M GOING TO ……. STRANGLE YOU".*

6.30 Louise described their relationship as "toxic", saying that when Daniel had been drinking alcohol, he would be malicious and always found something that she had done wrong. On the afternoon prior to the assault, Daniel had been drinking cider and spirits. Louise also disclosed that there had been another incident a few months previously where Daniel had punched her in the eye, but she had not reported this to the police at the time. She added that Daniel *"is very controlling and doesn't let me be friends with other males and is always making false accusation against me".*

6.31 After taking Louise's statement, the officer completed a DASH with Louise which rated the risk as 'medium'. This was reviewed 3 working days later by the Lighthouse Safeguarding Unit (LSU) as 'high-risk' domestic abuse which is in line with procedure where non-fatal strangulation has been used. Referrals were made to MARAC[49] and Children Social Care regarding Louise's child, Nicky. A "treat as urgent marker" was placed on Louise's home address. There was no "treat as urgent marker" placed on Daniel's address, which was where the incident occurred. This has been assessed as an individual error and fed back for individual learning. Furthermore, a reminder regarding information markers has been included in the Forcewide weekly internal bulletin.

6.32 At the police station following his arrest, Daniel was seen by the NHS Trust's Advice and Support in Custody and Court (ASCC) for assessment of his mental health. He was subsequently charged and remanded in custody until his court appearance in May 2023.

6.33 When the paramedics arrived at Daniel's address approximately 6 hours after the incident, they got no answer at the door and it was not clear if Louise had left and gone to her home address. Police were called to ascertain if they had any further contact details for Louise, no address or mobile number was recorded for Louise. It is however noted in paragraph 6.29 that Louise had

[49] MARAC - Multi-Agency Risk Assessment Conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

provided details. Enquiries were made with the hospital to check if Louise had self-presented. She had not but based on information from the police that Louise had stated that she had no problems breathing and only had a sore neck, forced entry was not requested at Daniel's address and Louise was recorded as not located.

Subsequent deterioration of Louise's health from the time of the assault to her date of death in May 2023:

6.34 Three days after the non-fatal strangulation assault, Charlie made a 101 call to the police informing them that Louise had been taken to hospital in a coma, and that she had a bleed on the brain. Charlie further explained that little more than 12 hours after the assault from Daniel, the family (Louise's mother and her younger child Nicky) had been having breakfast with Louise at a pub. They noticed that Louise had her head in her hands, when asked what was wrong, Louise said she was hot and complained that she had a headache and did not feel well. According to Louise's mother, Louise was known to suffer from migraines (which were not severe enough for GP attention). Louise went outside to get some fresh air and when the family went out to check that she was okay, they found Louise collapsed on the pavement unresponsive.

6.35 Paramedics attended, and on arrival there was no obvious signs of injury. Louise had urinary incontinence, was shaking and unresponsive. A possible intracranial bleed[50] was recorded by the paramedics and Louise was taken to hospital. Following a CT scan, Louise was transferred to another hospital. On arrival at the hospital, a doctor initially viewed Louise's collapse as not suspicious, being a spontaneous bleed on the brain. However, after learning more about the assault from the previous evening, the doctor agreed that specialists should review the CT scan images. Later that day Louise had surgery to seal the ruptured blood vessel and drain fluid from her brain to release pressure. Following these procedures, Louise required breathing apparatus to sustain her life and remained in a coma. Avon and Somerset Police remained in constant contact with the hospital, obtaining regular updates, whilst undertaking a full police investigation.

6.36 Seven days later, a doctor in the Intensive Care Unit called the police to inform them of a significant deterioration in Louise's condition. It was reported that part of Louise's brain had died, and that if she did not improve over the next few days she would be moved to end-of-life care. Two days later, a further call was made by the hospital to the police, informing them that Louise's condition had taken a significant downturn overnight and that once all family members had been notified, they would be withdrawing life support and would expect Louise to die within a few hours of this happening. Sadly, Louise died within a few hours.

[50]A brain bleed (intracranial haemorrhage) is ***a type of stroke***. It causes blood to pool between your brain and skull.

7. KEY ISSUES AND CONCLUSIONS

7.1 The Review Panel has formed the following conclusions after considering all of the evidence presented in the reports from those agencies that had contacts with Louise and Daniel, as well as information gathered from Louise's family and friend.

7.2 Louise did not report domestic abuse to the police prior to the non-fatal strangulation assault or seek help from a support agency. There is considerable academic research relating to domestic abuse and the difficulties faced when experiencing trauma, which can often make reporting such crimes extremely difficult. It is estimated that less than 24% of domestic abuse is reported to the police (Domestic Abuse Statistics UK). Whilst there are laws to protect against domestic abuse, there are several factors that could prevent those affected from coming forward to have their voice heard.[51]

7.3 Daniel was alcohol dependent and was known to both the police and probation service as someone who could be violent and aggressive when intoxicated towards professionals and members of the public. Charlie and Louise's mother have confirmed to the Review, that Louise had confided in them that she was afraid of Daniel when he was intoxicated as he had been violent towards her on several occasions and Louise refused to report it to the police. Whilst alcohol is not a cause of domestic abuse and is never an excuse, there are however, many ways in which alcohol and domestic abuse are related. Many abuse incidents occur when one or both people involved have been drinking, and alcohol is more commonly involved in more aggressive incidents.[52]

7.4 The Review Panel acknowledges that this Review highlights the importance of professional curiosity by practitioners. The paramedics recorded no suspicion of accidental injury during their contact with Louise in June 2022, however, could have talked to Louise in more depth regarding her fall and the previous stumbles that day, including the deterioration in her mobility. The discussion with Louise may have been different if more information was known about Louise and her situation, however the paramedics had no information regarding previous or current domestic abuse at that time.

7.5 The paramedics who attended Daniel's address in August 2022, could have attempted to speak to Daniel in more depth regarding why he was stressed and declining to go to hospital, in order to gain a better understanding of his situation.

7.6 When police attended on the day of the non-fatal strangulation assault, it was recorded that Louise needed no medical attention. Experts in the field emphasise the importance of all victims of strangulation to be medically assessed, as this omission puts victims at further risk. Even if the victims

[51] https://swaca.com/why-is-domestic-abuse-often-not-reported/

[52] https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/Alcohol-and-Domestic_Abuse_Oct2021.pdf

initially survive the strangulation, they could die in the coming days or weeks after the strangulation as a result of blood clots, arterial complications, respiratory issues or other reasons.[53]

7.7 It was acknowledged by the Review, that all agencies interacting with victims of strangulation need to be aware of post incident complications and ensure that they know what signs and symptoms they need to look for in the following hours/days. Subsequently, guidance around this has recently been published by the Institute for Addressing Strangulation which will assist agencies in this regard.

7.8 On the day in May when Louise collapsed, paramedics stated that there was no sign of visible injury. The types of serious harm caused by strangulation are often externally invisible and sometimes delayed. A 2021 study (Bichard et al, 2021), neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence identified a range of serious impacts including hypoxic brain injury and stroke.[54] In a recent study of 204 women presenting following an assault in which they had been strangled, over 86% had symptoms which lasted after the assault, (White et al, 2021).

7.9 Louise had been described by Charlie as a “hopeless romantic” who fell quickly into relationships. On this occasion, Louise had fallen for a troubled individual with a violent nature and could not bring herself to leave the relationship. According to Charlie, Louise found it difficult to leave the relationship as Louise feared being alone after so many failed relationships.

8. LESSONS LEARNED

8.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Appendix A of the Overview Report.

Avon and Somerset Police

8.2 A more proactive approach should be taken by police officers, by ensuring that victims of non-fatal strangulation understand the severity of the situation, encouraging them to seek urgent medical assistance and getting them to A&E to be assessed.

8.3 When adding information markers to locations involved in incidents, police officers are to ensure consideration is given to all addresses of those involved, this is vital if parties live separately. This will prompt an effective response and ensure the appropriate safeguarding is in place.

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[53] https://www.biausa.org/public-affairs/media/strangulation-domestic-violence-and-brain-injury-an-introduction-to-a-complex-topic#:~:text=Even%20if%20the%20victims%20initially,respiratory%20issues%2C%20or%20other%20reasons.

[54] https://www.counselmagazine.co.uk/articles/non-fatal-strangulation-one-year-on-why-it-matters

Children Social Care (CSC)

8.4 The assessment that was completed following the potential risk Daniel posed to Nicky, both Louise and Daniel should have been party to the assessment, despite at the time there being no contact between Nicky and Daniel, as the likelihood of contact happening in the future was high.

8.5 Following the risk of Nicky having contact with Louise when Daniel was present, both Louise and Daniel should have been spoken to, especially Louise who should have been party to safety planning for Nicky.

8.6 It was not clear if there was any other agency involved with Nicky that CSC could have spoken with to widen the support net for Nicky. CSC could have signposted Nicky to domestic abuse services for Young People.

Probation Service (Plymouth)

8.7 Due to Daniel being supervised by several temporary probation officers in the absence of his probation officer, he received conflicting information relating to his proposed move to an address in an area in Somerset. The lack of communication between probation officers resulted in Daniel contracting to move to an inappropriate address where two registered sex offenders were already residing in the building.

Somerset Council Housing (formerly Sedgemoor)

8.8 When Daniel mentioned struggling with his mental health and a recent bereavement, there was no indication that any support was offered around this. Further questioning around who he had lost may have helped to signpost Daniel to his doctor or a bereavement charity.

Somerset Drug and Alcohol Service (SDAS)

8.9 When Daniel disclosed that he was unable to attend an assessment appointment during working hours, SDAS could have considered a late assessment appointment at 16:30hrs to establish a treatment plan. They could have also offered Daniel the SDAS online platform which he could access in his own time for support, to learn skills and coping strategies to address his alcohol use.

South Western Ambulance Service NHS Foundation Trust

8.10 More information could have been obtained from Louise in relation to her fall in June 2022. It was evidenced that the fall was briefly explored, with Louise telling the paramedics that she had become more unsteady on her feet over the last few weeks and had two previous stumbles that day. There was no further information reported as to why Louise's mobility had declined.

8.11 When paramedics attended Daniel's property on the 10 August 2022, Daniel made the decision not to be conveyed to hospital as he was 'too stressed at the moment'. This could have been explored further as to why he was feeling stressed and ascertain if any further advice or support could have been offered.

9. RECOMMENDATIONS

Multi-Agency Recommendations

9.1 Somerset Council Public Health on behalf of Safer Somerset Partnership to liaise with Gloucestershire Community Safety Partnership to develop a multi-agency protocol on how to deal with incidences of non-fatal strangulation.

9.2 Safer Somerset Partnership should lead on gaining assurance that all agencies embed learning/training on non-fatal strangulation, as all could have NFS disclosure made to them and need to equally be aware of the domestic abuse safeguarding and medical concerns due to this.

National Recommendation

9.3 Safer Somerset Partnership to write to the Domestic Abuse Commissioner for England and Wales, Minister with responsibility for Home Office and Minister with responsibility for Department of Health to suggest a high-profile campaign to raise awareness around the risks relating to NFS (primarily from a medical welfare perspective), given that evidence shows the majority of domestic abuse is not reported.

Agency Recommendations

Children Social Care

9.4 It is recommended that when a disclosure needs to be made to keep a child safe, personnel must clearly evidence who needs to be party to the information in order to act in the best interest of the child.

9.5 Staff should be reminded when an assessment is being completed and the potential risk is around a child's contact with one particular parent, that parent should be included in the assessment to widen the safety net for the child.

9.6 Where there are children living in a domestic abuse environment, consideration should be given for referrals to be made to domestic abuse services for Young People.

Somerset Council

9.7 Somerset Council Public Health to improve public understanding on the course of action to take if a 3rd party witnesses or hears an incidence of domestic abuse occurring to victims who may be male or female.

Somerset Council Housing (formerly Sedgemoor)

9.8 Officers at Somerset Council Housing to improve around professional curiosity and signposting for support around mental health and bereavement.

Somerset Drug and Alcohol Service (SDAS)

9.9 Somerset Drug and Alcohol Service to consider alternative ways to engage with clients who highlight at referral that they are unable to engage in their standard treatment options i.e. Mon-Fri 09:00 - 17:00

South Western Ambulance Service (SWAST)

9.10 South West Ambulance Service to ensure that frontline, patient facing staff are aware of the importance of professional curiosity and the need to look at and understand the holistic picture.

Appendix A: Action Plan (please be aware this is a working document and subject to change)

Children Social Care (CSC)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
It is recommended that when a disclosure needs to be made to keep a child safe, personnel must clearly evidence who needs to be party to the information in order to act in the best interest of the child.	Local	To be discussed at MASH steering group which includes partner agencies and those who would be involved in MASH and strategy discussions. Discuss action at County Managers Meeting where all Team Managers who chair strategy discussions attend where disclosures will be agreed.	Children Social Care	MASH steering group arrange for the 14th February 2024. County Managers Meeting 19th February 2024.	February 2024	**Completed** This will ensure that all parties concerned are aware of the potential current / future risks that the child may face if appropriate strategies are not put in place to safeguard the child.
Staff should be reminded when an assessment is being completed and the potential risk is around a	Local	Discuss action at County Managers Meeting where all Team Managers	Children Social Care	County Managers Meeting 19th February 2024.	February 2024	**Completed** This will enable concerns to be raised with that

child's contact with one particular parent, that parent should be included in the assessment to widen the safety net for the child.		and operations Managers attend who sign off Children's and Families Assessments to ensure both parents are included in the assessment process.				parent around the potential risks to the child, and to be part of, and agree with the safeguarding plan put in place.
Where there are children living in a domestic abuse environment, consideration should be given for referrals to be made to domestic abuse services for Young People.	Local	Discuss action and County Managers Meeting within CSC. Complete Quality Assurance Activity on whether referrals are made for children to domestic abuse services.	Children Social Care	County Managers Meeting 19th February 2024	May 2024	**Completed** This enables the service to work closely with agencies supporting the family, to coordinate a plan of support that places the child's safety and wellbeing at the forefront and an individual support plan put in place based on individual needs.

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Somerset Council Public Health on behalf of Safer Somerset Partnership to liaise with Gloucestershire Community Safety Partnership in the development of a multi-agency protocol on how to deal with incidences of non-fatal strangulation.	Local	Embed training for all professionals interacting with victims of non-fatal strangulation. Ensure that accurate and timely assessments are made by all professionals and that urgent medical assistance is sought for the victims. Convey victims to hospital - NHS pathway to take over in terms of CT scans etc. Protocol to be taken forward to the South West group for consideration of wider adoption.	All agencies country wide Somerset Council Public Health / GCSP	Clear multi-agency guidance on how to respond to NFS across statutory and voluntary sector agencies (e.g. MARAC agencies) These professionals interacting with NFS victims to attend relevant NFS related training, for example provided by the Institute for Addressing Non-Fatal Strangulation.	31.3.25	**In progress** Awareness around risks relating to NFS, primarily from a medical welfare perspective. June 2024, Somerset Council met with Institute for Addressing Strangulation who advised further guidance due out later in year. To see how any national guidance can be promoted locally/ regionally, and if local/ regional protocol would be beneficial

Improve public understanding on the course of action to take if a 3rd party witnesses or hears an incidence of domestic abuse occurring.	Local	Somerset Council Public Health wide campaign involving family, friends and communities to raise public awareness on what to do if they are aware of domestic abuse taking place to victims who may be male or female.	Somerset Council Public Health	Bystander awareness training circulated by Nighttime Economy Promote updated public online learning – what to do and how to report domestic abuse	31 March 2025	**In progress**
SSP should lead on gaining assurance that all agencies embed learning/training as all could have NFS disclosure made to them so need to equally be aware of the DA safeguarding and medical concerns due to this.	Local	Include within Somerset Domestic Abuse Board self-assessment for all agencies to complete. Somerset public health to include NFS in training programmes specifically around domestic abuse and in other PH training courses as appropriate.	Somerset Council Public Health on behalf of SSP	NFS included in online learning for professionals – this includes resources NFS information included in domestic abuse board briefs to raise awareness	31 Dec 2024	**In progress**
SSP to write to Domestic Abuse Commissioner for England and Wales, Minister with responsibility for Home Office and	National	Letters to be sent.	Domestic Abuse Commissioner/Home Office/Ministe	Letter drafted and to be sent when report published	31 August 2024	**In progress**

Minister with responsibility for Department of Health to suggest a high-profile campaign to raise awareness around the risks relating to NFS (primarily from a medical welfare perspective) given that evidence shows the majority of DA is not reported.			r for Department of Health			

Somerset Council Housing

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Somerset Council Housing to improve around professional curiosity and signposting for support around mental health and bereavement.	Local	Housing staff trained to signpost for bereavement support and show curiosity when customers discussing elements causing issues sustaining tenancy. Support document produced with relevant support agencies listed.	Somerset Council Housing	Staff meeting and training sessions set for 31 January 2024. Further sessions to be held for those who cannot attend. Training to be completed by March 2024.	March 2024	**Completed** Appropriately trained staff will provide a more informed service to vulnerable tenants.

		If bereavement is raised, then this document and advice to be written into Personal Housing Plan (PHP's) letter.				

Somerset Drug and Alcohol Service (SDAS)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
Somerset Drug and Alcohol Service to consider alternative ways to engage with clients who highlight at referral that they are unable to engage in their standard treatment options ie. Mon-Fri 09:00 - 17:00	Local	Introduce weekly late night opening hours. Senior Management team to remind Team leaders/Managers to signpost clients who cannot engage in treatment to online/out of hours psychosocial intervention.	SDAS	Discussions held with Management. After hours appointments now in place on a Wednesday evening between 17:00 - 19:00.	January 2024	**Completed** This has enabled clients who work or have other commitments during the day to attend treatment.

South Western Ambulance Service NHS Foundation Trust (SWAST)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
SWAST to ensure that frontline, patient facing staff are aware of the importance of professional curiosity and the need to look at and understand the holistic picture.	Local	An action from the commissioned safeguarding review recommended that the SWAST annual education day will include an increase in safeguarding training for all frontline, patient facing staff. This will include 9 learning outcomes to be taught on Safeguarding. Number 8 is "State the importance of using professional curiosity to recognise safeguarding concerns" and will be taught to all patient facing frontline staff.	SWAST	The annual education day will be part of the learning and development offer 2024/2025 starting in April 2024.	April 2025	**Completed** Frontline, patient facing staff will receive 4.5 hours of face-to-face safeguarding training by the end of the academic year. Trust compliance target is 85%.