Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Sarah

Date of death: June 2021

Contents

Domestic Abuse Related Death Overview Report of:

Sarah

Date of death: June 2021 (Aged 28)

Report initially produced by Colin Wilderspin (Independent Chair) and edited/finalised by Safer Somerset Partnership post Home Office Quality Assurance feedback

October 2025

Table of Contents

Introduction:

1.1. This report of a death by suicide of an individual who experienced domestic abuse will follow the principles of a Domestic Homicide Review (DHR) which examines agency responses and support given to 'Sarah', a resident of the Somerset area, prior to her death in June 2021.

1.2. Domestic Homicide Reviews will be renamed Domestic Abuse Related Death Reviews following calls to better recognise domestic abuse related suicide as announced in February 2024. This review will follow this format. This means that a Domestic Homicide Review can be commissioned whenever there is a death that has, or appears to have, resulted from domestic abuse. As well as physical abuse, this includes controlling or coercive behaviour and emotional and economic abuse. It will help to ensure that lessons are learned from fatal domestic abuse cases[1].

1.3. From this point forward this review will be defined as a 'Domestic Abuse Related Death Review', as it recognises a death from domestic abuse related suicide rather than an act of homicide, however the current DHR process and statutory guidance will be followed.

1.4. In addition to agency involvement, the review will also examine (from 2015 until Sarah's death,) any relevant background or experience of abuse, 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 and aim to reduce the chances of another tragic loss of life.

1.5. Sarah was only 28 years old when she took her life by hanging herself. She was a woman who had experienced a difficult and traumatic life, including being a looked after child from the age of 13. Sarah had been with her most recent partner only a few months, who she met within the temporary accommodation she was residing in.

1.6. In the 12 months leading up to her death Sarah had lost her mother, and this appears to have had a huge impact on her, in addition to other factors in her life including housing difficulties. We are not aware of the identity of her paternal father.

1.7. Sarah had three children from separate relationships; she also had a history of experiencing multiple instances of domestic abuse. At the point of her death Sarah was of the belief that she was in early pregnancy.

1.8. It was on an evening in June 2021 that the police received a call from the accommodation where Sarah was residing. Police attended and recorded death by hanging. They were satisfied her death was not suspicious and the investigation was closed.

[1] Fatal domestic abuse reviews renamed to better recognise suicide cases - GOV.UK (www.gov.uk)

1.9. It is within this context that this review is set.

1.10. The review will consider, in detail, agency contact and involvement with Sarah and her partner. It will also draw upon and reference other relevant incidents or life events prior to her death. The period from 2015 was chosen because it contained significant events leading up to Sarah's death, which reflected ongoing issues in her life.

1.11. The key purpose for undertaking a DHR is to enable lessons to be learned from homicides or other deaths. Furthermore, whether domestic abuse may have been a contributory factor or a key factor in the person's life. For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each death, and most importantly, what needs to change to reduce the risk of such tragedies happening again in the future.

2 Domestic Abuse Related Death Review Introduction:

2.1 This Domestic Abuse Related Death Review is commissioned by the Safer Somerset Partnership in response to the death of Sarah. On an evening in June 2021, a call was made to police by residents of a homeless hostel stating that Sarah had been found hanged in her room, by a ligature made of her own dressing gown. Despite the best efforts of residents, paramedics and police officers Sarah was pronounced deceased at 23.47.

2.2 Sarah had several mental health issues. These included depression and Emotionally Unstable Personality Disorder (EUPD) documented from adolescence into adulthood. Sarah was known to GP surgeries, more through safeguarding concerns with her children and mental health needs than through a domestic abuse context. Her mental health appears to have significantly declined in the last 8 months of her life.

2.3 There is clear evidence that Sarah had a history of experiencing domestic abuse and wider trauma recorded by other agencies. She was a victim of domestic abuse by at least three individuals in the last six months of her life, and there is historical domestic abuse going back to at least 2015. She was a Looked After Child from the age of 13 until she was 21, although she had kept in contact with her mother who we can assume had an impact on Sarah's life until her death in October 2020.

2.4 The Safer Somerset Partnership approved the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and initiated the DHR process in November 2021.

2.5 A Domestic Homicide Review Panel was established with relevant partners and was led by Colin Wilderspin as an Independent Chair. The panel's role involves supporting the collation of Individual Management Reviews (IMR), producing timelines and analytical reports of their organisation and encourages learning to be identified.

2.6 The guidance states: A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over that has, or appears to have had, resulted from violence, abuse or neglect by:

- a person to whom they were related or with whom they were or had been in an intimate personal relationship, or

- a member of the same household as them, held with a view to identifying the lessons to be learnt from the death.

2.7 The purpose of the DHR/Domestic Abuse related suicide is to: establish what lessons are to be learned from the death linked to domestic abuse regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2.8 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.9 Apply these lessons to service responses including changes to policies and procedures as appropriate; prevent domestic violence and abuse deaths and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

2.10 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice. *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)*

2.11 The government has also announced that the name of these reviews will be changed from 'Domestic Homicide Review' to 'Domestic Abuse Related Death Review', to better reflect all deaths which fall within their scope.

3. The Review Process

3.1 The independent chair was appointed in November 2021, with the initial review panel meeting taking place on 17 January 2022. An initial trawl for information identified 8 agencies who had significant contact with Sarah.

3.2 Independent Management Reviews (IMR's) and chronologies of their contact with Sarah and connected individuals were requested from these agencies addressing the agreed Terms of Reference for this review. (Appendix A)

3.3 The key lines of enquiry for the review included:

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

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

- Determine if there were any barriers for Sarah 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 regards to children and pregnancy 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.

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

- 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.

3.4 The full List of Panel Members and the Agencies contributing to the review are listed in Appendix A

3.5 Agencies contributing to the review are listed below:

- Avon and Somerset Police
- Sedgemoor District Council
- Somerset Integrated Domestic Abuse Service (SIDAS) (Livewest)
- Somerset Integrated Domestic Abuse Service (SIDAS) (The You Trust)
- Somerset County Council
- Somerset Children Social Care
- Somerset NHS Foundation Trust
- Somerset Public Health Nursing
- NHS Somerset ICB
- YMCA Dulverton Group

3.6 All IMR authors and Review Panel members were independent of any direct contact with Sarah or other parties relevant to this review.

3.7 The Safer Somerset Partnership appointed an independent chair to conduct the review including to author the overview report. He is an independent trained DHR Chair. He had extensive experience in the statutory sector specifically around community safety and safeguarding and has undertaken internal reviews for organisations throughout the UK. He never previously worked in Somerset and was independent from all the agencies involved in this case.

Through quality assurance, the Home Office noted that their overview report template has not been followed. Unfortunately, despite extensive efforts by the Safer Somerset Partnership the independent chair did not provide a revised report in response to this feedback. Due to resource pressures, the Safer Somerset Partnership have been unable to revise the report to fit the template and acknowledge this feedback for any future DHRs that are commissioned to ensure they meet the template requirements.

3.8 There have been lengthy delays with the completion of this review, initially there was a delay of 4 months to commission the review due to resource pressures within the Council who operate on behalf of the Safer Somerset Partnership in commissioning DHRs. During the review itself the independent chair then had significant health and personal factors that led to delays with its progress.

3.9 Attempts were made to contact members of Sarah's family to consult with them as part of this review process. Sarah's next of kin was contacted but did not engage with the process. Sarah's mother sadly passed away in October 2020. Her Father is unknown and therefore was unable to be contacted.

3.10 Attempts were made to contact Sarah's brother who was also notified of the DHR and the Chair wrote to him inviting him to contribute to the review. However, he did not take up the opportunity during the review process period. He was also notified when the review had concluded and advised that there was still opportunity to contribute to the review if he so wished. At the time of writing, he has made no contact with the chair.

3.11 The review has sought to understand Sarah and life from her perspective. This has been difficult because there has been no engagement from family and friends. We fully respect their decision to cope with Sarah's death in the way best suited to them. As a result, our knowledge of Sarah 'as a person', has been drawn from professionals' records.

3.12 It was decided by the panel that due to the ages of the children and their current care arrangements that they should not be part of the review. In addition, Sarah had not seen her children for a considerable time before her death and the children were not living with her.

3.13 During the COVID pandemic, people were residing in the hostel who may have otherwise been homeless or sleeping rough. Due to the restrictions coming to an

end many of these people left the hostel. It was agreed that contact with Sarah's most recent partner prior to her death - Michael (pseudonym) - would have been challenging due to these circumstances and could potentially pose a risk to him from others connected with the hostel at this time**.** Additionally, as Michael had a chaotic lifestyle and there were considerations regarding his own mental health and general wellbeing, it was agreed for these reasons by the panel not to approach Michael who was her partner at the time of her death, or others at her residence. Sarah was living in temporary accommodation at the time of her death.

3.14 The Review Panel expresses its sympathy to anyone who knew Sarah with their loss in such tragic circumstances.

4 Parallel Reviews

4.1 The Coroner confirmed that his inquest took place in October 2021, whereby Sarah's cause of death following postmortem was confirmed as: -

a) Compression of the Neck

b) Suspension by a Ligature.

The death was recorded at inquest as that of suicide, with "Sarah deliberately suspending herself by the neck with the intention of ending her life."

4.2 No other reviews were understood to have been completed by another agency or official body.

5 Confidentiality

5.1 The content and findings of this review are confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

5.2 To protect the anonymity of the deceased, and her family, the subject of the review will be known as Sarah.

5.3 There are three significant (ex)partners during the scoping period of this review and pseudonym names are given below.

- Partner 1: David (father of middle child)
- Partner 2: Peter (father of youngest child)
- Partner 3: Michael (most recent partner and likely partner to her unborn child)
- Her eldest child was with a different ex-partner and is not referenced further in this document, so a pseudonym has not been given.

5.4 These pseudonyms were chosen by the Review Chair.

6 Dissemination

6.1 This report will be disseminated to:

- Review panel
- Somerset Domestic Abuse Board
- Safer Somerset Partnership
- Avon and Somerset Police Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Home Office DHR Team

7 Equalities:

7.1 The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

7.2 The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance to the DHR. The characteristics of Age, Disability, Race, Religion or belief, and Sex, were discussed by the DHR, and the potential vulnerabilities of mental health, ill health and domestic abuse were recognised by agencies working with Sarah. Sarah was female, she had been working with mental health services since a young age through CAMHS and adult mental health services, and her mental health needs towards the end of her life would probably be considered a disability. Sarah was a white female.

7.3 1 in 4 women in England and Wales will experience domestic abuse in their lifetime[2]. In the year ending March 2022, the victim was female in 74.1% of domestic abuse-related crimes. Additionally for the same year ending March 2022, the Crime Survey for England and Wales (CSEW) estimated that 1.7 million women and 699,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 7 in 100 women and 3 in 100 men.[3]

7.4 There is evidence amongst some agencies that Sarah was from a Jehovah Witness family, although we are unable to confirm her interaction with her faith during the period of time this review covers, her religion could have played a big part of her life and as a victim of domestic abuse, however as we have not been

[2] https://refuge.org.uk/what-is-domestic-abuse/the-facts/#:~:text=Fact%3A%201%20in%204%20women,partner%20in%20England%20and%20Wales.

[3] file:///C:/Users/cwild/Downloads/Domestic%20abuse%20victim%20characteristics,%20England%20and%20Wales%20year%20ending%20March%202022%20(1).pdf

able to speak to a family member we are unable to ascertain if her religion had any influence on her daily life or if it could have impacted her decision making.

7.5 With regards to her adolescent years, we must also factor in that Sarah was a child in care from 13 years of age and therefore may not have a close affiliation with her religion. However, we should ensure that as a protective characteristic the review considers the potential challenges this could have had on her, although perhaps not a significant factor.

7.6 There is some very critical thinking regarding the religion of Jehovah Witness and domestic abuse and there are various examples of female individuals who have left the religion who portray a negative views of this religion and its views on domestic abuse, for example '*A Former Jehovah's Witness Shares Her #MeToo Story*'[4] This report outlines an individual (Georgia Browne) who was an active member of the church as she describes "growing up in a congregation you're always aware that you are seen as a lesser being, that you have a position underneath men. Women have no position of authority in the congregation". The article later reveals that she was sexually assaulted by her Jehovah Witness boyfriend and following a year of serious abuse she approached the Jehovah Witness Church:

"It's a common lesson taught, the story of Dinah. They teach about it in the Bible. [It's] about a young girl who was raped by a fella and the whole thing they teach about that is, well, if she hadn't been doing that, if she hadn't been there it wouldn't have happened to her. That puts women in the position where if they are victimized, they blame themselves.

[My boyfriend and I] ended up making the decision to get married. I look back now and I'm like, "Bloody hell! Nobody in their right mind would do that!" But I know for a fact that I was not in my right mind, you're a brainwashed individual; you will make decisions like that, and I know that I'm not the only woman who's been in that position and made that decision. It happens and it's still happening.

I stayed with him for a year and the rapes continued. In this time I'm thinking, "I want to get out of this. I need to go talk to the elders in our congregation."

I went to Kingdom Hall and I met with a group of four men in their mid-60s. I'm 24 years old and I'm terrified. So I'm trying to explain what has happened, and they want me to write out a letter, so I write down what I can, to the best of my ability. They said, "Well if you're saying that your ex did these things we need to bring him in so we can ask him to his face." I said, "No don't. Don't do that. Forget it." And they said, "We need to deliberate." So I stepped outside, and I went back in the room and they let me know that they were going to disfellowship me or excommunicate me for fornication".

7.7 Georgia later states that following this interaction and outcome that she considered taking her life. This is not an unusual scenario and there are many women with similar criticism of the religion and how they dealt with cases of domestic abuse.

[4] A Former Jehovah's Witness Shares Her #MeToo Story | KQED

7.8 However, it is important to note that there is an international site specifically for Jehovah Witnesses that provides both bible readings and other context against domestic abuse [5], as part of this review we are unable to assume Sarah's religion was a barrier, and she did not always disclose the fact that she had an affiliation with the religion nor how committed she was to it. However, it is helpful context as to potentially why she didn't always engage with professionals and agencies which will be discussed later in the report.

7.9 There is no further information mentioned within this report that any activity of events were motivated or aggravated by age, disability, gender reassignment, marriage/civil partnership, race or sexual orientation. However, due to domestic abuse consisting (in the majority of cases) of violence by men towards women, gender was a relevant protected characteristic particularly when considered alongside her religious belief.

7.10 There is some evidence through the chronology that when Sarah was pregnant her vulnerability of Domestic Abuse increased and incidents appear to have escalated, although this is likely more to do with the fact that agencies were more involved with her at these points and therefore it was recognised by professionals, rather than her being more at risk.

7.11 This review supports the findings of a recent independent review of children's social care, commissioned by the Government, which reported that Government should include care-experienced people in the protected characteristics listed in the Equality Act[6].

7.12 Such a move would make care experience a 'protected characteristic' in the same way as the law treats discrimination against age, disability, race, religion, gender reassignment, sex, sexual orientation, pregnancy and maternity and marriage and civil partnerships.

7.13 It is important that we acknowledge the additional barriers care-experienced young adults may face, and how these affect their ability to lead happy and fulfilled lives. Sarah was in care from 13 years of age. Care leavers are often vulnerable young adults: they are more likely to be in prison, homeless and suffering from mental health difficulties than their peers, and less likely to be in education, employment or training. Specifically, to this report it should also be recognised that care-experienced young adults are at an increase likelihood to be in an abusive relationship.

7.14 Sarah was in care from 13 years of age, as she went through her adolescent years she suffered homelessness, mental health issues, and struggled to maintain regular employment in addition to being a victim of Domestic Abuse.

[5] https://www.jw.org/en/library/series/more-topics/domestic-abuse/

[6] https://edm.parliament.uk/early-day-motion/60528/careexperience-and-protected-characteristics-under-the-equality-act-2010

8 Scope of the Review:

8.1 The scope of the review was agreed from January 2015 to date of death in June 2021 which represents the period from when agencies became involved in an escalation of domestic abuse, deteriorating mental health and concerns for her children's welfare.

8.2 There are 9 events identified within the review that will be analysed:

Event 1 – 26/07/2016 evidence of new relationship starting and previous partners (paternal fathers) raising concerns over her ability to be a mother around this time. Sarah requested to use Clare's Law (significant as records suggest that conversations were had with Sarah at the time outlining concerns and appropriate action to take).

Event 2 - 05/06/2018 Incident relating to Sarah's deteriorating Mental Health, suicide ideation and continued reporting focussing on her ability to be a mother by ex-partners. Also issues of agencies getting hold of Sarah post hospital discharge.

Event 3 - Event 3 – 29/10/2018 - 08/12/2019 - Evidence of coercive behaviour, increase in Sarah getting involved in altercations including a physical assault on a neighbour and her mother and threatening behaviour towards others which is potentially due to social media and other forms of communication from ex-partners and females connected to them. Also, DASH Assessment based on a police 2017 assessment of Standard Risk as Sarah refused to support assessment following this incident[7].

Event 4 – 01/03/2020 - 16/12/2020 Sarah faced significant challenges during this period. In March 2020 Sarah attempted an overdose and at the same time she lost her stable housing and her children when to live with their fathers, in addition she terminated a pregnancy and lost her employment, her Mum also passed away during this period. These 'events' are significant, and chronologies clearly show a decline in her mental health and increase in her vulnerability.

Event 5 – 27/01/2021 Sarah was significantly assaulted by a new partner, they were not living together and had been together for 1 week, although they had known each other longer.

Event 6 – 22/03/2021 Sedgemoor District Council Housing Officer requests an urgent housing placement for Sarah at hostel, due to having to leave her brothers accommodation.

Event 7 – 31/05/2021 Domestic Incident between Sarah and Michael, neither wanted to support police investigation. Sarah stated that the current accommodation was affecting her mental health, and she was looking for alternative accommodation.

[7] Frontline officers attending an incident both identify risk and apply an initial risk grade of. 'standard', 'medium' or 'high' risk. Risk-led-policing-2-2016.pdf (college.police.uk)

Event 8 – 05/06/2021 Sarah is a victim of assault by Michael whereby she sustained a cut to her hand by a knife from the communal kitchen. Referred to IDVA and MARAC.

Event 9 – 09/06/2021 Report from a member of the public of a male (Michael) assaulting a female (Sarah) outside a shop. Both had caused common assault injuries to each other although Sarah did not want to press any charges. Michael's placement had now ended at the hostel at the time of this event.

8.3 In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

9 Review Summary:

Background Information:

9.1 At the time of her death, Sarah was living in temporary accommodation in a hostel, she moved to this premise on the 22 March 2021 at the easing of the second lockdown of COVID 19 as a phase 1 return set out by Central Government[8]. During this period before her death Sarah started a relationship with Michael who was also a resident at the hostel and had been provided accommodation as part of the Governments support for homelessness during the Covid Pandemic.

9.2 Sarah had three children from three different ex partners: between the ages of 5 and 11 years. All three children were no longer living with her at the time of her death. During the timeframe of the review, Sarah's custody and access arrangements with her children seems to have changed. All 3 children were living with Sarah in 2016 but by the time of her death, Sarah was not with her children. Significantly this change seems to occur at the same time as changes to Sarah's housing, in addition ex-partners had concerns about her parenting and the children were staying with paternal family from each of the fathers' sides at the time of her death.

9.3 Sarah had been a Looked After Child in Care since she was 13 until her 21st birthday[9].

9.4 At the time of entering the hostel in March 2021, Sarah had concerns that she was pregnant, whilst this is unable to be proven, we are aware that she was telling professionals and friends that she was, and Michael was the likely Father.

9.5 There is a history, within the timeframe of this review, of multiple terminations following pregnancy and several short-term partners. Health agencies had regularly discussed her use of contraception and encouraged her to use multiple sexual health and contraceptive options.

9.6 Sarah was registered with a GP Practice in the Somerset area, she had several mental health issues which included depression and Emotional Unstable

[8] Coronavirus action plan: a guide to what you can expect across the UK - GOV.UK (www.gov.uk)

[9] A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care. Looked after children | NSPCC Learning

Personality Disorder, she also suffered with pelvic inflammatory disease. At the time of her death Sarah was under treatment from mental health services.

9.7 In the months leading up to her death there is evidence of heavy drinking of alcohol and a high use of prescribed painkillers, including diazepam. Throughout the timeframe of this review there is regular information to suggest Sarah took cocaine. It is likely that the increase in these activities before her death were related to a number of incidents linked with traumatic experiences including housing, loss of her mother and her access to her children.

9.8 Sarah had received significant mental health support and had been treated for drug overdoses in the past. Sarah had regular suicide ideation recorded by agencies throughout the timeframe of this review.

9.9 One of Sarah's critical factors is the loss of her mother, who passed away in October 2020; in her adult life her mother had been supportive and looked after Sarah's children when needed, she would have been a person Sarah would have shared concerns with based on agency notes.

9.10 As previously stated, Sarah was known to Mental Health, Police, Children's Services and Domestic Abuse services with sporadic engagement at various crisis points. Sarah would regularly not pick up calls or attend pre-agreed appointments, and agencies found it difficult to contact her. There are examples of Sarah losing her temper or becoming threatening to staff when she felt she was not listened to or receiving the medication she wanted.

9.11 Homelessness plays a key part during this period; Sarah had a large debt with a housing provider and, throughout the timeframe of this review, had been in a mixture of housing solutions including staying with family. Sarah's housing situation seemed to be very unsettled; Police logs suggest that Sarah's housing situation was stressful for her and a factor in her worsening mental health, particularly when she lost her home in around April 2020 before moving in with her brother and later when she moved to the hostel.

9.12 The lack of consistent housing and financial control over possessions within the property by an ex-partner suggests a financial coercion that was little considered at the time, although there is little evidence to build on this, and therefore should be a small consideration but, alongside other evidence that we do know around Sarah and her exposure to Domestic Abuse, cannot be ruled out of this review.

9.13 It has been established through research that mental health conditions including suicide ideation have an established patten with intimate partner violence.

9.14 It is reasonable to suggest that Sarah had significant trauma due to a range of historical and ongoing experiences and her treatment by men in multiple short-term relationships. It is significant that throughout reports from agencies there is no direct mention regarding the impact of trauma on Sarah.

10 Timeline of Significant Events (Chronology):

10.1 Event 1 – 26/07/2016 evidence of new relationship starting and previous partners (paternal fathers' raising concerns over her ability to be a mother around this time. Sarah requested to use Clare's Law (significant as records suggest that

conversations were had with Sarah at the time outlining concerns and appropriate action to take)

10.1.1 Prior to this first event the review has already outlined a number of vulnerable factors that Sarah had from adolescence into adulthood and the trauma that she would have gone through up until this timeline. Sarah admitted that she had been a victim of domestic abuse before when approached about Clare's Law.

10.1.2 In the build up to this event there were multiple episodes of ex-partners and their families having concerns for Sarah and her parenting of her two children. Her eldest was already living with her father. The period leading up to this event also saw heavy use in social media with open criticism of Sarah from ex-partners, these were not deemed to be a criminal offence, although a DASH was completed and rated medium. Sarah was referred to victim support, there were reports of counter allegations of the use of social media.

10.1.3 Sarah had recently given birth to her third child and was being seen by Health Visitors, although contact was inconsistent. On one contact with the Health Visitor Sarah openly claimed that she now recognised that her past relationships had been controlling and abusive, and this provided the first time that domestic abuse is recorded by agencies. Sarah also admitted that she had a new boyfriend although the father of her recently born child was supportive. Sarah is encouraged by the Health Visitor to consider 'Clare's Law for the new relationship. This period provides a positive time where Sarah was supported following disclosure of previous domestic abuse and entering a new relationship.

10.1.4 Although Sarah may have felt supported at this time with agencies, in the background she would have likely felt attacked by her ex-partners that she had children with, criticising her parenting and continually raising concerns about her. We do know now looking at agency reports that some of these reports were substantiated, however others were not, and it is likely that these constant accusations would have affected Sarah and ultimately her mental health.

10.1.5 During this period and prior to Event 2, one significant report to police in September 2017 detailed her ex-partner 'Peter' (father of her youngest child) assaulting her whilst she was holding their child and then used a knife to cut up the furniture. No further action was taken following this as Sarah did not want to support an investigation. A DASH was completed by the police and rated as medium risk, Sarah had told the police she was not in a relationship, however to other partners Sarah claimed that following this incident her relationship ended with that individual.

10.1.6 Around the time of this chronology period Children Social Care also received a 111 report and police reports regarding concerns for Sarah's mental health.

10.2 Event 2 - 05/06/2018 Incidents relating to Sarah deteriorating Mental Health and admittance to hospital, suicidal Ideation and continued reporting focussing on her being a bad mother by ex-partners. Also issues of agencies getting hold of Sarah post-hospital discharge.

10.2.1 This is a period where there was an escalation of one of the fathers raising concerns about the welfare of their children when with Sarah, In addition other reports in to partner agencies show an increase in reports challenging her

capability as a mother. The review also notes that engagement starts to become challenging for partner agencies to meet with Sarah during this point in the timeline and starts to regularly miss appointments for her children. Sarah experiences some notable traumatic events including David keeping their child longer than they had agreed, the following day of Sarah reporting this she is admitted to the acute mental health ward.

10.2.2 Whilst at the Acute Mental Health ward Sarah disclosed domestic abuse from Peter regarding stalking, harassment, blackmailing with nude pictures and suicide ideation thoughts. There were already police reports primarily around domestic abuse incidents regarding this disclosure, including a non-molestation order for Peter from September 2017 event outlined above in paragraph 8.6. This was breached within the first hour with the individual attending the property, he was arrested for the breach and charged for an assault on Sarah in March 2018. Peter was also due in court on the 12 June for a physical assault against her, so this would have likely added to her anxiety at this time. Peter was subsequently sentenced to a 12 month Community Order of 200 hours unpaid work.

10.2.3 A MARAC referral was made by Somerset Partnership Foundation Trust (as it was at the time) following her inpatient admission and a DASH was completed, however this was completed without Sarah as she had subsequently left the ward before this form was completed. The MARAC was held on the 22 June and allocated to SIDAS Livewest to work alongside Children' Social Care. Sarah did not engage and it was difficult to get hold of her. Contact was made by the Health Visitor on the 4 July in person and partner agencies had spoken with her during June – October 2018 period. Whilst communication and working together is covered later in this report it is worth highlighting the positive joint working and sharing of information to make contact with Sarah. However, by October 2018 the case was closed by SIDAS due to Sarah not engaging with the service. During this period however there is nothing reported by any agency between June and October 2018.

10.3 Event 3 - Event 3 – 29/10/2018 - 08/12/2019 - Evidence of coercive behaviour, increase in Sarah getting involved in altercations including a physical assault on a neighbour and her mother and threatening behaviour towards others which is potentially due to social media and other forms of communication from ex-partners and females connected to them. Also, DASH Assessment based on a police 2017 assessment of Standard Risk as Sarah refused to support assessment following this incident[10].

10.3.1 David made a report to the police regarding malicious texts being sent from Sarah which included derogatory comments being posted on a social media platform in December 2018. The use of social media is prevalent throughout the review, with both Sarah and ex-partners using this to provide a platform for expressing feelings and looking to agitate individuals and get a response from each other. David did not want to take any further action regarding this incident. There were further incidents following social media activity in November where

[10] Frontline officers attending an incident both identify risk and apply an initial risk grade of. 'standard', 'medium' or 'high' risk. Risk-led-policing-2-2016.pdf (college.police.uk)

Sarah was an involved party and was given a dispersal notice preventing her from attending a property of a female where Sarah confronted her regarding the sending of an inappropriate image and harassment with threats of violence. This investigation was considered to not be in the public interest.

10.3.2 Following this incident with the females, Sarah reported David for malicious messages by text and posting derogatory comments on a social media platform. Police recorded this as malicious communications and looked to investigate. Police arranged to see Sarah, but she failed to attend the meeting and return a follow up call. It can be assumed that this activity of malicious communication was a regular occurrence between December 2018 and December 2019 although not reported by any agency. Malicious communication could be considered a form of coercive control and a weapon to continue domestic abuse even after the relationship has ended.

10.3.3 For perpetrators, social media can be a powerful weapon, and social media abuse takes many different forms on these platforms. For most of the survivors interviewed in a 2022 Refuge report[11] (65%), of abuse on social media was their former partner. A quarter (24%) experienced abuse from their current partner. The large proportion of survivors who experienced abuse from a former partner illustrates how technology has allowed abusers to continue to harass survivors after separation, often at distance, great volume and for many months or years. Many perpetrators enlist the support of others in the abuse - 35% of survivors we interviewed reported that the friends of family of their partner or former partner conducted abuse. In this case Sarah had been a victim from her ex-partner and others connected with him also used this platform.

10.3.4 It is likely that had there been more attempts to make contact with Sarah, and professional curiosity to recognise previous social media concerns 12 months earlier that this could have been mitigated and managed through a multi-agency or criminal justice process. However, due to her non-attendance, a DASH was completed and rated standard based on a 2017 police assessment, as that was the last police recorded incident regarding Sarah the police had at that time. There is a question here as to whether the incident of malicious communication was connected to the report 12 months earlier where David reported Sarah, but this does not appear to have been included in the DASH. Sarah engaging would likely have affected the DASH assessment, which could have been deemed as high. Should this DASH have taken place it may have affected future housing assessment as a more recent record of domestic abuse may have been on housing file via MARAC records. Overall, this is important to note that agency records did not hold information regarding recent domestic abuse at the time of her placement and therefore was not a primary consideration in decision making for housing assessment 16 months later when placed into a hostel.

10.3.5 These incidents and the use of social media by Sarah, her ex-partner and other individuals would have only increased Sarah's mental health resilience. During this period, we also are aware of two incidents where Sarah had been physical towards her mother and a neighbour. We are also aware that Srah had both been verbally threatened and threatened others of violence following the use of social media. This perhaps demonstrates Sarah's mindset and her mental

[11] https://refuge.org.uk/wp-content/uploads/2022/11/Marked-as-Unsafe-FINAL-November-2022.pdf

resilience to these events during this period and would undoubtedly start her further downfall of her mental health.

10.4 Event 4 – 01/03/2020 - 16/12/2020 Sarah faced many significant challenges. In March 2020 Sarah attempted an overdose and at the same time she lost her stable housing and her children went to live with their fathers, in addition she terminated a pregnancy and lost her employment, her Mum also passed away during this period. These 'events' are significant and chronologies clearly show a decline in her mental health and increase in her vulnerability.

10.4.1 It is important to note that Sarah at this point had attempted to take her life in March 2020 and was self-harming in the build up to this incident, her drinking had become more noticeable and her mental health decline is obvious to note within agency records, including diagnosis of depressive disorder; her housing was an issue having had to leave what would be her last permanent home. Contact with her children was now limited and her youngest child was permanently living with his paternal grandparents. Notes show that she sometimes did not always attend appointments to see her son, and there were discussions had around joint custody. There was also continued issues around her mental wellbeing, and also behaviour of the children following a visit with Sarah. In particular her overdose in March 2020 and in February 2020 she had entered some nearby woods with a knife intending on suicide, she highlighted to friends her concern that the children will not return to live with her. Her mother had also passed away recently in October 2020. It is at this point that Sarah had many challenges and on top of previous trauma it is important that we recognise this within the context leading up to her death.

10.4.2 During this period in March 2020 Sarah was admitted under section 136 assessment to the acute mental ward, she was discharged a few days later but continues to express her desire to kill herself. Her Mother appears on agency reports to be heavily supporting her up until her death in October 2020.

10.4.3 There is during this event period concerns around the children, the youngest children schools and submitted concerns regarding the children when in their mother's care including her mental health, housing situation, domestic violence, frequent changes in partners, and mothers' chaotic and unpredictable lifestyle. Although all three children were now living with their respective father's or their family.

10.4.4 During this period Sarah also lost her stable housing and alongside losing her children to their fathers' families, she was evicted in February 2020. These events during this time would have had devastating effect on her, alongside notes suggesting that she had a termination and lost her employment as a carer. Sarah was on a personal housing plan in March 2020 and was scheduled to move into emergency accommodation. She was staying in a hotel and then moved to a hostel for a short period, however frequent missed appointments and poor communication with housing resulted in a discharge of duty, Sarah had not put in a housing benefit claim. Sarah had also handed the keys back to the hostel about the same time of the discharge of duty. During April and November 2020 Sarah moves into private rented accommodation.

10.4.5 In November 2020 whilst Sarah was living in private rented accommodation the landlord gave her notice as he was selling the property, and she was told to move out by the end of November 2020. At this time, she was still open to mental health services with increased thoughts of harm and anger and reported not having money for food. There were no concerns of domestic abuse reported. This would have been the second time in 12 months where she has been evicted from her rented accommodation. It also came at a time when she was dealing with grief from losing her mother. Sarah moves in with her brother at this point.

10.4.6 Sarah had also reported to her GP that she had likely had a miscarriage as she reported heavy bleeding whilst claiming to be pregnant in November 2020. Medical records show that in January 2021 she had a termination.

10.4.7 During this event period, Sarah had a number of complex needs, Sarah was leading a chaotic lifestyle including the reporting of taking cocaine and excessive alcohol, alongside some ill health and her poor mental wellbeing, inconsistent housing, poor and inconsistent relationship with her children and her consistent reluctance to engage with support services, although there was engagement when she wanted to; such as discussions with her GP around prescribed medication for her health condition and depression. This context for the review is important to highlight, as in this period, the 12 months leading up to her death in 2021 her challenges were significant and must be considered in the context of her death.

10.4.8 During this event period there is limited evidence of any reported domestic abuse, however on the 16th December 2020 Sarah was the victim of a fight with an ex-partner in the street, Sarah described it as pushing and pulling, although public reports to the police reported she appeared frightened and crying, Sarah stated she was not prepared to make a statement and she refused to complete a DASH, the police in her absence recorded a DASH as Standard risk.

10.5 Event 5 – 27/01/2021 Sarah was significantly assaulted by a new partner, they were not living together and had been together for 1 week, although they had allegedly known each other longer.

10.5.1 Sarah was badly assaulted by an assumed new partner whilst living at her brother's address. Sarah was falsely imprisoned and was physically assaulted, both were under the influence of alcohol and cocaine use and Sarah was unwilling to press charges. Police ascertained that the relationship was a week old, however they had allegedly known each other longer as it was one of her brother's friends.

10.5.2 Police considered an evidence-led prosecution but lacked enough evidence to pursue. A DASH was completed as a medium risk Sarah accepted a referral to SIDAS (The YOU Trust).

10.6 Event 6 – 22/03/2021 Sedgemoor District Council Housing Officer requests an urgent housing placement for Sarah at hostel, due to having to leave her brothers accommodation.

10.6.1 Referral from Sedgemoor District Council to hostel for urgent accommodation. From the point of referral questions were raised around the risk of Sarah for her and others due to her mental health. From this point forward there are regular concerns raised by the hostel and other agencies around this accommodation and its suitability for Sarah up until her death.

10.6.2 There appears to be little evidence that trauma and domestic abuse history were considered with this placement. It needs to be recognised that accommodation pressures due to Covid made it harder to find suitable accommodation, however if all information was better available it is likely that an assessment may have deemed this placement inappropriate. It is worth highlighting at this point that Housing noted as part of this review process they had no recent records of domestic abuse and Sarah on file and therefore was not considered as part of a risk assessment as to whether a mixed gender facility was appropriate.

10.6.3 It was confirmed during this review that historical information was not available at the point Sarah was referred to the hostel, and if it was Sarah would not have been accepted due to her vulnerability. Housing Act requirements state that victims of domestic abuse should be appropriately housed. The hostel was of a mixed gender setting and likely if Sarah's history been known this placement would not have been seen as 'appropriate'. The review does accept that escalation of Sarah's suitability at the hostel was raised on a number of occasions by the hostel to housing and other agencies, with particular concern on her mental wellbeing. COVID also created a large demand for housing and this would have likely had some effect on finding appropriate accommodation during that time of the pandemic.

10.6.4 During Sarah's time at the hostel, Sarah regularly stated she was looking for alternative accommodation where her children could come and stay with her, alongside Michael. Sarah wanted to get her children back and in her opinion was a realistic possibility, the reality however was that she had not seen her children for a considerable amount of time and any housing move away from the hostel would not have assessed this as a need for her housing. However, Sarah was of the opinion that she would get housing and it is recorded in agency notes only a few days before her death that she thought a move was going to happen.

10.7 Event 7 – 31/05/2021 Domestic incident between Sarah and Michael, neither wanted to support a police investigation. Sarah stated that the current accommodation was affecting her mental health, and she was looking for alternative accommodation.

10.7.1 At the point of this event Sarah was living at the hostel and this is the first-time police were involved in an incident involving Sarah and Michael. Police were called to reports of Sarah and Michael arguing with each other. Michael denied any fighting had taken place, but he had a small cut on his neck. Both Sarah and Michael refused to give statements, therefore the police recorded this incident as an assault on Michael as he had the wounds. A DASH assessment was refused by both individuals and police recorded this incident as a medium risk.

10.7.2 During police response to this incident Sarah mentioned 'she wanted to end it all' and had attempted to swallow a large amount of tablets, which officers were able to remove and an ambulance was called; Sarah attended hospital that evening but was discharged the same day.

10.7.3 Police were called to the hospital as Sarah refused to leave the hospital after being discharged. She was arrested following an assault on a Doctor and the police felt it was necessary to arrest her to protect the public from further in injury and, as she was a vulnerable person, to prevent further injury to herself. Sarah spent the night in police custody where she repeated her desire to end her life. Sarah was assessed whilst in custody by Advice and Support in Custody and Courts (ASCC) and no acute mental health symptoms were evident. She was released with no further action taken regarding the arrest.

10.8 Event 8 – 05/06/2021 Sarah was a victim of assault by Michael whereby she sustained a cut to her hand by a knife from the communal kitchen. Referred to IDVA and MARAC.

10.8.1 Police were called following a disclosure to hostel staff by Sarah reporting that Michael had threatened her with a knife, during an altercation between the two individuals, and Sarah had suffered a cut to her hand. Hostel staff witnessed the two individuals arguing with each other. Police attended and arrested Michael. There was not enough evidence to pursue a prosecution. Whilst a DASH was refused police deemed the risk as High and Sarah was referred to MARAC and SIDAS (You Trust) on 22 June 2021, attempts were made on the 24 June but SIDAS were unable to get hold of Sarah.

10.8.2 Michael was due to find alternative accommodation and was not at the hostel for a number of nights. However, Michael returned a few days later to the hostel and nothing was put in place regarding any conditions or a development of a multi-agency safety plan, although conversations had taken place between police and the hostel and both Sarah and Michael. Staff at the hostel advised they should stay apart but no further action was taken by agencies to consider any immediate accommodation considerations. It was not until 22 of June 2021 that Avon and Somerset Police Force Lighthouse Safeguarding Unit contacted Sarah following this incident. Sarah's case was due to be heard at the June 2021 MARAC.

10.8.3 The MARAC delay was the result of two factors; a data input issue, resulting in incorrect decision making and volumes of work within LSU (LSU is a dedicated police department for victim and witness care and safeguarding). On discussion with the LSU team, the author has ascertained that these incidents occurred during a period of significant volumes of work, which resulted in backlogs, and staffing challenge within the LSU. This amounted to exceptional circumstances for the team and resulted in delays in victim contact for victims of many different crime classifications; up to two weeks in some cases.

10.9 Event 9 – 09/06/2021 Report from a member of the public of a male (Michael) assaulting a female (Sarah) outside a shop. Both had caused common assault injuries to each other although Sarah did not want to press any charges. Michael's placement had now ended at the hostel at the time of this event.

10.9.1 A member of the public called police to report that a male and female were fighting outside a shop, police attended and found that Sarah and Michael were both drunk and had caused common assault injuries to each other. Both declined to prosecute, and no further action was taken. A DASH was refused and police in attendance deemed this medium risk. This DASH was only conducted 4 days after the High-Risk DASH, whilst the couple had been living in the same hostel.

10.9.2 Sarah claimed at this incident that they were no longer a couple. However, it is clear from agency information that after this event they remained in a relationship. When Sarah was discussing alternative accommodation with housing services, she had asked for Michael to be able to come with her, which at this point was refused by relevant agencies as not deemed appropriate.

10.9.3 By the time off her death, Michael was no longer a tenant of the hostel as he was part of the Government's Covid response to supporting homelessness and his placement was no longer funded, he left the hostel on the 20 June 2021. Despite this Michael was regularly in the hostel, despite staff attempts to refuse entry. Sarah would try and support Michael getting entry post his exit from the hostel. The evening in June 2021 when Sarah took her life followed an argument with Michael within the hostel, where he was able to gain entry.

11 Themes:

It is important that a number of themes are outlined as part of this review process:

Covid 19:

11.1 To give context to this review it is important to remind ourselves that the last year before her death and a considerable part of the timeframe of this review, everyday life was very different for workers and service users alike due to the pandemic. Front line services were working in a different way often using online communication or telephone appointments instead of face-to-face contact appointments. This affected all service delivery that Sarah used regularly and would have potentially been frustrating for her, especially where Sarah had multiple factors affecting her including the challenges of living a chaotic lifestyle.

11.2 People experiencing homelessness faced unique challenges during the COVID-19 pandemic, including changes to accommodation availability, societal restrictions impacting access to essentials like food, and services moving to online and remote access[12]. For the users of vital services COVID-19 pandemic led to changes in service delivery across health and social care services, with many adopting virtual or telephone support for service users.

11.3 Mental health and substance use support for people experiencing homelessness during the COVID-19 pandemic as mentioned drastically changed during Covid 19. A Qualitative research was conducted in North East England on people between the (ages 25 to 71) who self-identified as experiencing homelessness in North East England between February and May 2021. From the

[12] The Impact of the COVID-19 Pandemic and Associated Societal Restrictions on People Experiencing Homelessness (PEH): A Qualitative Interview Study with PEH and Service Providers in the UK https://www.mdpi.com/1660-4601/19/23/15526

findings barriers to access included: physical locations, repetition of recovery stories, individual readiness, and limited availability. Participants suggested creating services reflective of need and opportunities for choice and empowerment. Community mental health and substance use support for people experiencing homelessness should ensure the support is personalised, responsive to need, inclusive, and trauma-informed[13].

11.4 The research also highlighted that one of the most evident ways people felt overlooked was the fact that many providers only offered support between normal business hours; yet, people frequently felt that late at night was when they most needed support as 'no one is awake' and that was often when they hit 'rock bottom'[14]. Although this was not necessarily unique to COVID-19, individuals explained they wanted to be able to access some type of support during non-business hours. Additionally, the research also highlighted the rapid transition to remote care provision care suited some people, however due to the history of non-engagement with agencies this remote contact was inconsistent and challenging for agencies during this time. We are unable to assume if a change in operating hours would have increased Sarah's engagement, as her engagement was inconsistent before COVID-19.

11.5 Throughout the timeframe of this review there is a high number of agencies who struggled to get hold of Sarah or where she missed appointments. The pandemic would have made it much harder, and this is seen throughout agency chronologies. Mental Health Services maintained a weekly phone appointment which appears to have been relatively successful, but there are times where potentially a face-to-face appointment would have been more appropriate, however this was not possible at that time.

11.6 There are 2 other significant findings within this research which are important to consider;

- "During COVID-19, support offered remotely often took place while individuals were in their shared accommodation. Individuals highlighted the importance of space and place during recovery and shared that their ideal location would be reflective of their current recovery stage, have ample space, and be supportive and welcoming".
- "With a push to house everyone sleeping rough during the pandemic, individuals reflected on their experiences of being provided with accommodation. Group accommodation was often provided to both current and ex-substance users. This group offering was often a negative experience and sometimes resulted in past users being targeted by drug dealers and facing behaviours they had moved on from. Participants also expressed frustration around experiencing this when accessing support in person".[15]

11.7 Both bullet points are a reflection on Sarah's situation; her new partner Michael would have likely been a constant presence, with limited access outside of the hostel due to COVID-19, it is likely she spent a considerable amount of time with him. This would have also meant limited time with professionals as there

[13] A Qualitative Study Exploring Access to Mental Health and Substance Use Support among Individuals Experiencing Homelessness during COVID-19 - https://www.mdpi.com/1660-4601/19/6/3459

[14] A Qualitative Study Exploring Access to Mental Health and Substance Use Support among Individuals Experiencing Homelessness during COVID-19 - https://www.mdpi.com/1660-4601/19/6/3459

[15] A Qualitative Study Exploring Access to Mental Health and Substance Use Support among Individuals Experiencing Homelessness during COVID-19 - https://www.mdpi.com/1660-4601/19/6/3459

would have been limited face to face arrangements and therefore agencies who were frequently contacting largely by phone, which with Michael present would have likely reduced the freedom for Sarah to discuss issues around abuse etc.

11.8 Whilst both bullet points above are more specifically around substance misuse which Sarah struggled with, a similar context can be considered alongside mental health also. The challenge during COVID-19 to accommodate homeless individuals appropriately alongside other individual vulnerabilities was very difficult.

11.9 As outlined previously; housing was a significant issue for Sarah with her residing in multiple places of accommodation during the timeframe of the review. Emergency measures were put in place to protect tenants and homeowners during the coronavirus pandemic, including extended notice periods and a stay on evictions. Sarah's landlord sold the property she was living in and so was 'evicted' during this time. It is unclear of the process her landlord at the time but is very likely that it was not compliant with the guidance and legislation with measures put in place by the government due to Covid[16].

11.10 This period of homelessness was a key contributory factor in Sarah's life and her placement in the hostel and this made her more vulnerable, however accommodation was urgently required for Sarah and as highlighted previously not all relevant information was available to housing. In hindsight the panel determined this was not suitable provision for Sarah and her vulnerabilities, however the panel notes that due to COVID-19 options were very limited, especially challenging when you consider, domestic abuse, substance misuse and mental health issues. The homelessness response to COVID-19 saw Government action taken across the country to get everyone into safe accommodation during the pandemic, Michael was part of this programme and would likely have not been in this accommodation if it was not for Covid.

11.11 When Sarah was assessed for housing any history of domestic abuse was not considered as it was not known to housing and therefore the temporary housing provider was not made aware of the risk management. It is likely that had they known about domestic abuse at the point of referral that the identified housing option would have been deemed inappropriate and different housing advice offered. Guidance for victims of domestic abuse states that they should not be placed in mixed gender occupancy due to their vulnerabilities and the housing duty states that temporary accommodation should be suitable. However, at the point of the referral this vulnerability was not known and therefore the acceptance of Sarah was based on information available at that time and not on her mental health or domestic abuse experience.

11.12 Overall homelessness is a major issue for many victims of domestic abuse 'If someone experiencing domestic abuse becomes homeless, they may find it difficult to care for and protect themselves and cope with existing life challenges. Lacking safety, security, privacy and the support networks of friends and family, they may become particularly vulnerable to violence, abuse, crime and exploitation'[17]. Fear of losing housing and finding suitable accommodation was a scenario that faced Sarah on numerous occasions. The

[16] https://england.shelter.org.uk/professional_resources/legal/housing_options/coronavirus_covid-19_and_housing

[17] Homelessness - Preventing Exploitation Toolkit

inconsistency of maintaining secure housing pre COVID-19 should not be ignored for Sarah, and whilst the key reason for her housing issues was often debt, it cannot be ignored that evidence highlights that domestic abuse is a substantial cause of homelessness. Wider evidence suggests that the true numbers of individuals made homeless as a result of domestic abuse is much higher than any figures provided by numerous organisations, particularly for women.

Professional curiosity:

11.13 Practitioners need to apply professional curiosity, as it offers individuals' a framework that can be used to foster an understanding of how interlocking oppressions manifest in the lived experiences for the people. Agencies working in the front line must be proactive with professional curiosity and must actively acknowledge the multiple inequalities people experience as a result of oppressive behaviours of others especially in regard to domestic abuse[18].

11.14 It is important to consider the lived experience of Sarah and the impact of her complex life from her adolescent years through to adulthood. There is limited evidence from agency records to demonstrate how the information relating to her unresolved traumatic experiences including being a 'looked after child', trauma and not being with her children, mental ill health, several terminations, history of domestic abuse and inconsistent housing arrangements were shared and used in assessing and supporting Sarah.

11.15 In reviewing the extensive history of domestic abuse and mental health in Sarah's case it is important to recognise that her lived experience had many facets, and yet there are a number of occasions where these were not linked including her religion which was disclosed to some agencies. Sarah was assessed (often without her being present, due to non-engagement) yet the interconnectedness of her in-equalities and history were often seen in isolation rather than from a whole system approach. This can be seen during DASH risk assessment process where previous assessments were not considered.

11.16 Although there was evidence of escalation and issues relating to Sarah and domestic abuse most incidents had been viewed as medium risk level. Incidents were considered in isolation rather than clusters which would have escalated the domestic abuse she was experiencing to potentially meet the MARAC threshold criteria earlier, had historical reports from wider partnership information been incorporated also. There should be an expectation where DASH are completed without the individual present that the history of that person is considered before deciding the level of any risk by a trained police officer or other professional, this does not appear to have occurred every time and whilst it can be said police were consistent, other partners may have been in a better position to complete it as they were in contact with Sarah more frequently throughout the review period. Although

[18] Why intersectionality matters for social work practice in adult services - https://socialworkwithadults.blog.gov.uk/2020/01/31/why-intersectionality-matters-for-social-work-practice-in-adult-services/

the review recognises that DASH are an immediate risk, there should be consideration around how these are shared with partner agencies. This will be highlighted as a recommendation, it is recognised that medium risk outcome was not always appropriate and highlights the challenges frontline officers have with making an assessment around Domestic Abuse, particularly repeat victims under different partners and with complex needs.

11.17 In respect of the last few DASH completed for Sarah there is some inconsistency whilst in the hostel with one DASH being recorded as medium, followed by a high risk 5 days later, the last DASH was medium which was also only a few days after the high risk highlighting that inconsistencies can occur and previous assessments not always being referred to at that initial assessment by front line staff. In this scenario however the high risk had already been put in process to be heard at MARAC, although it is accepted that the last DASH should have been recorded as high.

11.18 In addition, when a victim refuses a DASH it misses the opportunity to gain some unknown answers to key questions In terms of the DASH assessment it highlights risk and on certain questions if identified for example best practice is to ask further supplementary questions. In the standard 24 DASH tool question five asks 'Are you feeling depressed or having suicidal thoughts? In the context of this review this is important as Sarah may have provided an answer which would have changed agency approaches, however based on the fact that she had previously tried to commit suicide this should have been considered as part of the DASH even though Sarah was not present or engaged with the process. This is more important in the few weeks before her death where police attended multiple times and as outlined in 10.5 where multiple DASH assessments were conducted although on one occasion Sarah was recorded as high risk in her absence, but this is not consistent.

11.19 The panel noted that concerns around Sarah's inability to maintain professional relationships and continuous non engagement should have been recorded and challenged better. Non engagement can be a sign for a number of things including domestic abuse and chaotic lifestyles. Additionally, there are multiple records that show Sarah went through a number of termination processes. Multiple terminations should raise curiosity for professionals. Whilst there is an example of a health professional discussing birth control, there is nothing mentioned during this period of terminations potentially linked with controlling and sexual abusive behaviour from partners.

Looked After Children as a protected characteristic:

11.20 Looked-after children and young people in care are a vulnerable group; their issues feature prominently in the United Nations Convention on the Rights of the Child (UNCRC), where it is noted that youth vulnerability runs into adulthood.

11.21 Many looked after children have previous experiences of violence, abuse or neglect. This can lead to them displaying behaviour that challenges and having

problems forming secure relationships. Some find it hard to develop positive peer relationships[19], and this experience can continue into adulthood.

11.22 According to a 2017 report by ONS revealed that "More than half (51%) of adults who were abused as children experienced domestic abuse in later life … A higher proportion of survivors of child abuse went on to experience domestic abuse in adulthood, compared with those who suffered no childhood abuse"[20]. Whilst we do not know the reasons for Sarah to be in care, it is a fair assumption that she faced some form of abuse as a child to have been put in the care system, and therefore this is a key part of her life that likely contributed to her experiences in later life.

11.23 Sarah experienced a number of issues related to the research of those in care as a child; such as mental health and homelessness and substance misuse. Care leavers are often vulnerable young adults: they are more likely to experience time in prison, homelessness and suffer from mental health difficulties than their peers, and less likely to be in education, employment or training. Specifically, to this report it should also be recognised that looked after children in care are at an increased likelihood to be in an abusive relationship when an adult, Sarah experienced most of these during her life, in addition to having mistrust for authority specifically around her children and Children Social Care.

Trauma (Lived experience)

11.24 Sarah suffered homelessness, mental health and struggled to maintain regular employment, experienced not seeing her children regularly in addition to being a victim of domestic abuse with various partners over a long and sustained period. This review considers whether organisations viewed Sarah's life through the lens of a person affected by both historical and recent trauma.

11.25 One in every 20 women have experienced extensive physical or sexual violence and abuse across their life course, compared to one in every 100 men. This equates to 1.2 million women in England alone. These women face very high rates of problems like mental ill health, addiction, homelessness, and poverty. More than half have a common mental ill health condition, one in five have experienced homelessness and one in three have an alcohol problem.[21] Sarah at some point in her life experienced all of these: mental ill health, addiction to prescribed diazepam, homelessness and due to her high debts with a housing provider we know she faced poverty, and during her last few months we know that she often came across as drinking excessive alcohol.

[19] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children#:~:text=Peer%20violence%20and%20abuse,to%20develop%20positive%20peer%20relationships.
[20] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/peoplewhowereabusedaschildrenaremorelikelytobeabusedasanadult/2017-09-27
[21] Scott, S, McManus, S, DMSS research for Agenda (2016), Hidden Hurt: Violence, Abuse and Disadvantage in the Lives of Women.

11.26 Sarah was only 28 years old when she died. She was a woman who had experienced a difficult and short traumatic life. Sarah had been a Looked After Child and research tells us that this often can lead to wider emotional and mental wellbeing issues into adult life. Research demonstrates that trauma is known to affect how survivors relate to others, particularly when the trauma was caused by other people (abuse etc) person rather than a natural disaster. Additionally, to this however, Sarah also experienced the loss her mother in the year before taking her life.

11.27 Many people experiencing homelessness have faced traumatic events, such as being exposed to violence, experiencing losses, and dealing with severed relationships. The experience of homelessness itself is traumatic, as it involves a lack of stability, a loss of safety and the disconnection from one's community/family at large.

11.28 Sarah had not seen her children for some time leading up to her death, as whilst there was no court order preventing Sarah seeing her children, they were residing with their father's and their paternal families, and this potentially made it challenging for Sarah. During the timeframe of this review, we are aware of a number of reports to Children's Social Care from the children's father and grandparents around Sarahs' competency as a mother. Some of this was ascertained from medical notes showing that Sarah failed to attend some medical appointments for her children. However, primarily the concern for Sarah was around her mental health and her ability to parent her children alongside the risk of being exposed to domestic abuse. This issue is prevalent particularly in the first part of this review period. There is some evidence that concerns were raised by organisations regarding the safeguarding for the children. For example, South West Ambulance Service attended in 2017 following calls from David regarding Sarah's welfare. Children Social Care had confirmed that they were already involved with the family. This referral however was instigated by David's call.

11.29 In addition to this Sarah reported that David had kept her child longer than agreed in June 2018, but this was deemed as a private law matter. This led to a spiral of traumatic sequences including admission into a mental health ward only a few days later and subsequently was a pivotal point and the beginning of the demise to her access to seeing her children overall. During the same period Sarah also reported regular issues of Peter sending controlling abusive texts to her.

11.30 From agency records we also are aware that within a few days prior to her taking her life she disclosed to the Community Mental Health Team that she was pregnant, when it was suggested that a pre birth assessment was to take place it is recorded that she refused stating she 'didn't want the social getting involved'. This suggests that alongside her own experiences and that as a parent that her distrust of services was present in her thinking.

11.31 Accusations and threats of children being removed can create anxiety. Alongside Sarah's other trauma she now faced questions from professionals around her ability to be a parent with the additional threat of having them removed. This review has not been able to ascertain how this made her feel although we can

see through organisation notes that she did care about her children, and we can assume that this would have been another issue on her mind to contend with. Sarah reported to the police in July 2017 that David had sent a threatening text message. Police were satisfied that it did not contain any direct threats but that it did criticise Sarahs' parenting.

11.32 As complicated as domestic abuse is on its own, it becomes even more complex when children are involved. Not only can they be affected by the abuse, they are sometimes used as an abusive mechanism by the perpetrator(s).

11.33 Whilst there was never any formal arrangement through Children Social Care regarding the children's arrangements, there is some evidence to suggest that Sarah had her access to her children restricted and controlled by others particularly by her ex-partners and their families. Reports from grandparents to Children Social Care and recorded by the Health Visitor suggest behaviour concerns of one of her children when they returned following a night with Sarah. Although this was a report made by the paternal grandparent there are cases where David and Peter expressed their concerns to the authorities. With the knowledge known by this review and organisations at that time there should be some consideration around how children could be used as a form of emotional and coercive control.

11.34 Abusive partners exert power and control over their significant others through many different tactics; using children can become a tactic or an abusive mechanism to gain control. Many times, abusive partners will threaten their significant others by telling them that if they leave the relationship, they'll take custody of the children. This threat is a form of emotional abuse that the abusive partner uses to keep the victim in the relationship[22] or under their control after a relationship. The panel do not know how much this was the case for Sarah, but it is an important area to highlight as part of this review.

11.35 Domestic violence and abuse are included in the Care Act 2014 as a specific category of harm/abuse. The Care Act specifies that freedom from abuse and neglect is a key aspect of a person's wellbeing, and the statutory guidance outlines that abuse takes many forms, and local authorities should not be constrained in their view of what constitutes abuse or neglect. 'Controlling behaviour' is a range of acts designed to make a person subordinate and/or dependent by isolating them. There is a criminal offence under Section 76 of the Serious Crime Act 2015 in relation to coercive and controlling behaviour within the context of domestic abuse. This sets out the importance of recognising the harm and cumulative impact on the victim caused by patterns of behaviour such as accusations and potentially a form of control over previous partners, alternatively this could have equally have been a Father acting in the best interest of their children and safety concerns for them or a little bit of both, and it would have been important for professionals to have explored and ascertained this at the time.

11.36 Although prior research has established that domestic abuse often leads to increased depression, anxiety and post-traumatic stress disorder (PTSD), little is

[22] https://www.thehotline.org/resources/children-as-an-abusive-mechanism/

known about how often abusive partners and ex-partners use survivors' children as an abuse tactic, nor whether this form of abuse is detrimental to survivors' mental health and trauma. It appears to be quite prevalent against survivors who are parents, where the abusive partner's use of the children to control or harm their current or former partner (Bancroft et al., 2011; Beeble et al., 2007)[23].

11.37 Domestic abuse appears to have been a regular feature of Sarah's life, but yet it is not included in information shared when Sarah is referred to stay in a homeless hostel. Information sharing is discussed later in this report. The panel with the information it gathered for this review does accept that the hostel Sarah was placed in was not suitable for her with her multiple vulnerabilities and her experiences. It recognises that had all information been available at that time this placement would not have taken place. Although with the issue of Covid options would have been limited at that point.

11.38 The hostel did follow up on the referral raising a number of questions however, domestic abuse was not mentioned although ongoing support was however, and this was in relation to her mental ill health and suicide ideation. The placement of Sarah in a mixed gender facility alongside a number of chaotic individuals including males who would not have normally been in the accommodation (but due to Covid were housed there) was not a place for a vulnerable multiple domestic abuse victim like Sarah who had other vulnerabilities.

11.39 Lastly regarding trauma is the ongoing and long-term health issue that Sarah was experiencing. Throughout this review period there are multiple mentions of pain relief particularly the use of diazepam. It is noted that Sarah suffered multiple health related issues including Emotional Unstable Personality Disorder, depression, pelvic inflammatory disease, regular concerns with cervix pain and multiple terminations. All of these would add to a long list of other traumas faced by Sarah, with a particular focus on the terminations potentially caused through abuse from partners.

Engaging with Services:

11.40 Within the timeframe of this review, it has to be acknowledged that for a significant proportion of time services and interactions had adapted to working within the restrictions of a pandemic. The impact of the pandemic however small can't be ignored as a factor in reducing access to help seeking for both her mental health, housing and the impact of domestic abuse.

11.41 However, there were challenges with contact pre pandemic, with all agencies recording missed appointments, with agencies either being unable to get her via phone or Sarah not calling back agencies This led to agencies recording that Sarah did not respond or engage on a number of occasions throughout the review period. On some occasions there is evidence that Sarah also could become aggressive towards GP staff if she did not get what she wanted with prescriptions for diazepam.

[23] https://link.springer.com/article/10.1007/s10896-021-00330-0

11.42 We are unable to clarify what impact if any her religion of being a Jehovah Witness had on her and her ability to report domestic abuse and her wider engagement with agencies. Therefore, whilst it must be a consideration overall, it cannot be treated as a matter of fact that this was a barrier, rather that it could have been.

11.43 Sarah was often reluctant to give formal statements to police and would frequently disengage after a call to agencies including the police. This would result in DASH forms being completed without input from Sarah, which ultimately lead to possibly inaccurate assessments, and not linking in with previous or historical incidents with previous partners. This lack of engagement may have been due to the fear of repercussions of disclosure, impact of ongoing mental ill health needs, stability of housing or her experienced trauma and the risk of losing her children, or at some point all of them.

11.44 Sadly, this is a regular occurrence for many DHR's as highlighted in a Home Office Domestic Homicide Review where engagement was discussed:
"With victims the most common theme was not wanting to continue with police action, often reporting violence but then withdrawing allegations or denying violence occurred when police arrived. There may be a number of barriers to victims engaging with services, which will be unique to each individual but may include their age, cultural beliefs, fear of the perpetrator, previous experiences, not being offered the service they want or not understanding what services are available".[24]

11.45 In the context Sarah's life, the above summary from this Home Office report from 2016 is unfortunately still prevalent. Sarah may not have engaged for all the reasons within this summary including but not exhaustive of the barriers of being raised as a Jehovah Witness, and her experiences of being Looked After Child.

11.46 We will not be able to determine the specific reason that there are multiple times within this period as to why Sarah did not engage with multiple services. Additionally like many similar reviews have noted Sarah frequently accessed services at a point of crisis. Often in these scenarios a holistic approach is not always followed as these contacts are based on the information available at that moment. A prime example of this in Sarah's case was the placement in the hostel which was based on financial grounds and the eviction of her brother from his property where she was staying during the pandemic. We also know that during this period at her brother's house Sarah was a victim of alleged severe abuse from a partner who she had allegedly known for some time previously. None of which formed part of the referral information sent to the hostel.

11.47 The lack of consistent engagement from Sarah also would have ultimately led to a lack of continuity of relationship with agencies, due to timeframes different individuals would be assigned. This potentially created more instability and lack of

[24] https://assets.publishing.service.gov.uk/media/5a81b1c5e5274a2e87dbf034/HO-Domestic-Homicide-Review-Analysis-161206.pdf

trust, whilst staffing allocation and changes in commissioned services and other staff turnover is inevitable but it still would have impacted on Sarah.

11.48 The health visitors who visited during the period of her youngest child clearly built up a rapport and were able to have positive challenging conversations with her. It appears from agency notes that Sarah was forthcoming with information to them, and it is noted that Clare's Law had been discussed with her and also other mechanisms of domestic abuse safety.

11.49 We can assume that the trauma Sarah experienced resulted in an inability to trust people and would likely have impacted on how she was able to engage with agencies.

11.50 It is not clear if professionals who had difficulty engaging with Sarah shared these difficulties with other agencies, although it can be seen in stages over short periods where there is evidence of escalation, it did not go as far as ensuring information was known to all partners. This is clear when considering housing knowledge when making an assessment around housing that domestic abuse was not a factor considered before her going into a hostel. There were 15 DASH recorded by the police in the timeframe of the review, 8 were assessed as medium or high risk. We are aware that the last DASH in June 2021 should have been assessed as high risk, however due to the DASH previously which was high risk Sarah was referred, although sadly Sarah had taken her own life before the June 2021 MARAC so the case was sadly never discussed. In 2018 Sarah was discussed at MARAC with an action of encouraging her to engage with SIDAS and this should be seen positively, yet by October her case was closed by the IDVA without engagement from Sarah.

11.51 We are unable to say if Sarah would have engaged had she been discussed at MARAC after 2018, but this review should consider that had she been discussed it would be a reasonable assumption that housing records may have been updated and therefore would likely have been a consideration for her vulnerability and essentially her housing allocation. There are questions around this review that with Sarah's complex lifestyle whether MARAC which is primarily focussed on domestic abuse was the right forum to manage her risk. In addition, between 2018 and 2021 there are limited records of recorded domestic abuse. Domestic abuse was an issue for Sarah through her adult years, but the review recognises that this was just one factor it what was a complex individual.

11.52 This review accepts that engaging with victims of domestic abuse is challenging and often relies on voluntary engagement, however in this specific case Sarah repeatedly did not engage or where she did, she quickly disengaged unless she needed something such as medication. All agencies did take steps to follow up and encourage where there was a lack of engagement. However, information sharing is key and whilst there is some evidence of this being shared it was on a short-term basis and not considered holistically over a period of time. This ultimately resulted in increasing Sarah's vulnerability particularly in the earlier part of this review period

and it non engagement is a regular theme for Domestic Abuse victims and particularly those with multiple trauma, mental ill health and substance misuse.

Information Sharing:

11.53 Previous Home Office DHR reviews have concluded that communication and information sharing between agencies was identified as an issue in 76% of reviews[25]. Fundamentally leading up to her death the referral to the hostel could not consider her domestic abuse vulnerability as this information was not shared/known, and the referral was based on Sarah's current situation around her brothers eviction where she was temporary residing and subsequently her eviction and her mental ill health, The review accepts that Sarah's history of domestic abuse should have formed part of the referral and risk management, particularly as it was a mixed gender hostel. Domestic Abuse was recorded historically on housing records but not in recent records.

11.54 Although there are some good practices of information sharing in Somerset and in particularly at MARAC level, it should be noted that there is a distinction between an information exchange and effective communication. In many cases, important information is shared between agencies, however it is either not actioned or else its significance, particularly in terms of risk to the adult, is not appreciated by the receiving agencies, unless an individual is discussed at MARAC. This appears to have occurred in Sarah's case. One example of this is her suicide ideation which Sarah raised intermittently with her GP during the period of this review. There is little evidence that this was shared beyond health partners and if it was little action would appear to have been taken, highlighting a need to ensure GP information is available for MARAC, and exploration as to how some of this information can be shared when an assessment does not meet MARAC.

11.55 It should be noted that the hostel did raise concerns around the suitability of the placement of Sarah to housing on receipt of her referral and expressed concerns with her escalation of behaviour and her mental ill health that the hostel was likely not a suitable accommodation on numerous occasions. Unfortunately, this was a short window of opportunity and although communication between partners took place, housing accommodation was limited due to COVID and concerns were not primarily based around her domestic abuse vulnerability as the current risk was not known to housing. Sarah was due to be heard at the next MARAC before her death, and it is likely that her vulnerability and suitability of the accommodation would have been disclosed and discussed and no doubt acted upon.

11.56 Organisations should seek to have systems/processes in place that allow those to be provided with previous history to enable them to provide the best support to the victim and assess holistically the incident in the light of the current situation.

[25] https://assets.publishing.service.gov.uk/media/5a81b1c5e5274a2e87dbf034/HO-Domestic-Homicide-Review-Analysis-161206.pdf

11.57 Domestic homicide review analyses frequently cite the failure of health services to effectively share information between other health agencies and with wider services. (e.g., Sharp-Jeffs and Kelly, 2016)[26]. National guidelines give subtly different advice on when sharing without consent can happen. Generally, such sharing can happen in the 'public interest' or when there is risk of 'serious crime' or 'serious harm'. But these terms are broad and ambiguous. In this review the issue is around access to information which could have changed the outcome of Sarah's placement at an inappropriate hostel including domestic abuse knowledge and suicidal ideation.

11.58 Very little research explicitly explores whether and how healthcare professionals share information about domestic violence/abuse within healthcare and with other agencies/services (Pitt et al. (2020)[27] particularly the link between GP and wider health agencies. This review highlights an inconsistent approach with how such information was shared with partners. Another study on the health visitor response to domestic violence/abuse (McFeely, 2016) showed that health visitors have little interaction with other agencies aside from occasional joint visits to families with social workers.

11.59 It is noted that with stronger information sharing of the history of vulnerabilities there was potential opportunities to have a greater understanding of the context of Sarah and services received from agencies. A key agency in her lived experience throughout were health services and research highlights their role in identifying those who have been abused and providing mental health support[28] is crucial alongside GP contributions which are inconsistent at MARAC.

11.60 The guidelines from the suicide prevention strategy[29] for England addresses issue around information sharing about domestic violence/abuse in the health service by Dr Sandi Dheensa. The statement emphasises to practitioners that, they should use their professional judgement to determine what is in the person's best interest. It is important that the practitioner records their decision and information sharing on their records.

Understanding Domestic Abuse and impact on Mental Health:

11.61 Research undertaken in the UK and internationally regarding understanding domestic abuse and the impact on Mental Health demonstrates that there is a casual link between attempted or completed suicide and concurrent experience of domestic abuse. In 2022 research suggested that women who suffer domestic abuse were three times as likely to attempt suicide[30]. A report from the Home Office

[26] FINAL_REPORT_Recording_and_sharing_DVA_information_in_healthcare.pdf (bris.ac.uk)
[27] FINAL_REPORT_Recording_and_sharing_DVA_information_in_healthcare.pdf (bris.ac.uk)
[28] https://www.local.gov.uk/case-studies/kent-and-medway-highlighting-relationship-between-domestic-abuse-and-suicide
[29] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)
[30] https://www.theguardian.com/society/2023/feb/22/women-who-suffer-domestic-abuse-three-times-as-likely-to-attempt-suicide

focused around the pandemic also recorded evidence of a sizeable number of suspected victim suicides with a known history of domestic abuse.[31]

11.62 The Office for National Statistics estimates that 27 women per week die as a result of suicide. The rate of females who die by suicide has increased by 8.9% (from 4.5 to 4.9 deaths per 100,000 women) between 2016 and 2019 [32]. Extrapolating from various statistics, Walby (2004) estimates that a third of female suicides are women who have experienced domestic abuse – between 4 and 10 per week [33]. Suicidality is more prevalent amongst women who are domestically abused than those women who are not abused[34]. A recent report conducted by the National Police Chief's Council released in March 2024 shows the scale of domestic homicides and for the first time recorded an increase in suspected suicides by domestic abuse victims, the report also suggests that the number of suspected victim suicides following domestic abuse has overtaken intimate partner homicides for the first time[35].

11.63 Further research has demonstrated a strong and negative relationship between intimate partner abuse and mental health consequences for survivors. Victimisation through physical and emotional abuse (Ahmadabadi et al., 2020; Ellsberg et al., 2008; Mapayi et al., 2013; Rivera, 2018) have all been shown to lead to increased depression, anxiety and post-traumatic stress disorder[36]. Throughout the timeframe of the review we are able to track the deterioration in Sarah's mental health and depression, culminating in anxiety regarding her concerns and perceptions of the hostel surroundings and her volatile relationship with Michael.

11.64 This sets out the importance of recognising the harm and cumulative impact on the victim caused by continued and historic domestic abuse alongside a current context. Sarah sustained regular domestic abuse from previous partners and the relationship with Michael at the time of her death was clearly unhealthy for both individuals.

11.65 Other abusive activity such as text messaging, social media posts and the pressure of reports to Children Social Care from ex partners over this period may not have appeared to be life threatening, the constant emotional and physical

[31] Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf (publishing.service.gov.uk)

[32] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf

[33] The Cost of Domestic Violence, Walby S, 2004, London: Women and Equality Unit.

[34] Reviere, S., Farber, E., Tworney, H., Okun, A., Jackson, E. & Zanville, H. (2017) 'Intimate Partner Violence and Suicidality in Low-Income African American Women: A Multimethod Assessment of Coping Factors.' Violence Against Women 13: 1113-1129; Pico-Alfonso, M., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C, Echeburua, E. & Martinez, M.(2006) 'The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety and Suicide.' Journal of Women's Health 15(5): 599-611. Cited in Domestic abuse and suicide, Refuge and Warwick Law School, 2018.

[35] Scale of homicide and suicides by domestic abuse victims revealed (npcc.police.uk)

[36] https://link.springer.com/article/10.1007/s10896-021-00330-0

abuse Sarah faced combined with behaviours that could be described as coercive control contributed to a pattern of phycological distress.

11.66 In March 2020 agencies were growing concerned around Sarah and her ability to be a parent, included at this time was a concern raised by the school where her children attended, who made a referral to Children Social Care outlining concerns about Sarah's mental health and domestic abuse, at this time the children were all under the primary care of the Fathers, this is a significant period as it potentially compounds her vulnerability further and increases her risk of mental health deterioration that is linked to her being a victim of domestic abuse alongside losing the maternal element of caring for her children. Alongside this it should also be connected to a continual criticism from ex partners and their families on her role as a parent and the challenges outlined above. We do know that some of these accusations were substantiated, and others were not, however as a review we recognise that this would have been significant alongside other factors to her mental wellbeing.

11.67 In practice, assessment of suicide risk in an individual is not precise. Combinations of risk factors for suicide may be more important in determining an outcome than individual characteristics. In Sarah's case the risk factors for suicide ideation changed rapidly over short periods (for example, from changing life events and experience of domestic abuse, long term pain, anxiety, and moving into temporary accommodation, alongside an extreme and a fast-moving serious relationship with Michael.)

11.68 Physical violence towards Sarah is also relevant, there are some examples where it is recorded where she was both the instigator and victim. The review highlights that her relationship with Michael was massively focussed around domestic violence on a frequent and regular basis. The review notes that this relationship was not a healthy one. The panel also feel that throughout most of Sarah's relationships that there was always an element of coercive behaviour and the panel would like to make it clear for this review that Sarah was a victim of Domestic Abuse, and not just violence.

11.69 Additionally, when action was taken and Michael left the hostel he continued to enter the accommodation. This would have also had an impact on her perception of and reality of her safety and potentially lead to a fear that the abuse could not be stopped and could also demonstrate that coercive behaviour from Michael in the relationship as outlined above.

11.70 We do not know the specifics to Sarah taking her life but her mental health and her experience of the recent domestic abuse from the relationship with Michael would have undoubtedly been factors which contributed to lead to Sarah taking the decision to end her life.

Prevalence of Suicide/Mental Health and Domestic Abuse:

- Analysis undertaken by Kent and Medway Suicide Prevention Team of the 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator.
- The most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health, found that between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence – 9% of all patients during this time, 104 deaths per year. The average number in 2016 – 17 was 101 per year but in 2018 – 19, this had increased to 149 per year. The majority (73%) were female – an average of 76 per year.
- Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone, and unemployed. The majority (81%) had a history of self-harm and previous alcohol (61%), and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.
- More women with a history of domestic violence had experienced adverse life events in the previous 3 months (115, 50% v. 351, 32%) – the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%), and loss of job, benefits, or housing (19% v. 12%).[37]

11.71 The last bullet point is a significant in the build up to Sarah taking her life she experienced the loss of her mother, not seeing her children, homelessness, loss of her job and entered into a new and abusive relationship and recent attempts to take her life before her death.

11.72 Refuge, in their research, explain that Weaver, et al. and Williams developed understanding about suicidality through what they called a 'cry of pain' hypothesis[38]. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible. It is suggested further that this constellation of feelings and beliefs can lead anyone, irrespective of psychiatric diagnosis, to consider, and even enact, suicide. A key finding, from wider research suggests that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide, with some research indicating that completed attempt often follows an uncompleted attempt within an average of one year. Therefore, to dismiss suicidality and attempts as 'merely a cry for help', risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future.

Suicide Ideation:

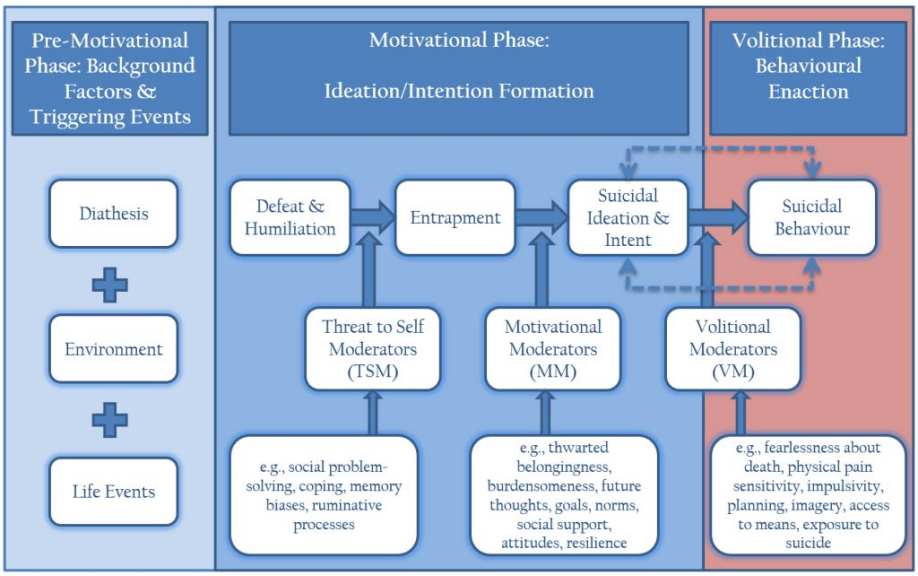
11.73 Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional model aims to synthesise, distil, and extend our knowledge

[37] The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report 2022: UK patient and general population data 2009-2019, and real-time surveillance data, University of Manchester, 2022

[38] Domestic abuse and suicide, Refuge and Warwick Law School, 2018.

and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind.

11.74 The Integrated Motivational-Volitional Model of Suicidal Behaviour was first proposed in 2011 by Rory O'Connor (IMV; O'Connor, 2011) and it was refined in 2018 (O'Connor & Kirtley, 2018). Its aim was to synthesize, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind. The model was developed from the recognition that suicide is characterised by a complex interplay of biology, psychology, environment, and culture (O'Connor, 2011), and that we need to move beyond psychiatric categories if we are to further understand the causes of suicidal malaise[39].



11.75 This model has been suggested to be an effective tool to help map a story of suicide and highlight specific points or factors, of which the review should take note.

11.76 **Pre-motivational phase**

This first phase sets the context for suicidal ideation, and Sarah experienced many vulnerability factors and stressors (some of which have been discussed in the previous section), as well as environmental influences that should be noted when considering suicide risk:

11.77 The below are a list of Pre-Motivational phase of Sarah

- Relationship difficulties (new and short-term relationships alongside historical relationships with the fathers of her children)
- Substance misuse
- Domestic abuse (ongoing and historic)
- Criminal issues (recent arrests and other assaults within the review time)
- History of suicide behaviour (attempted suicide in the hostel, discussion of suicidal ideation)

[39] https://suicideresearch.info/the-imv/

- Severe mental health conditions
- Discussions of long-term physical health issues (chronic pain)
- Sexual abuse
- Adverse Childhood Experiences (Looked After Child)
- Homelessness and debt

Motivational phase: Ideation/Intention formulation

11.78 The centre column of the table highlights the key drivers: defeat, humiliation, and unbearable entrapment for the emergence of suicidal ideation. Whilst many of Sarah's experiences will highlight these drivers, we focus on the incidents in the last 2 weeks of her life where multiple reports were made to the police and records show that a DASH assessment was high and reports that Sarah was worsening within her surroundings and her mental health was suffering. Although there is a question as to why a High-Risk DASH was conducted on 5 June 2021, but by the 9 June a new DASH was completed as medium risk.

11.79 Positive action however was taken by the police and the hostel to protect Sarah during this period including requesting urgent mental health support and arresting Michael. The review considers if more support and information sharing should have been in place to support Sarah during this time in the hostel and provided in a timelier manner. The hostel wanted to explore alternative accommodation and the logs recorded by night staff at the hostel evidence an individual in a chaotic episode. Records show that mental health failed to make contact with Sarah for over a week following the request by the hostel.

11.80 It is clear that from the end of May 2021 Sarah was on a spiralling downward cycle through attempting suicide, being assaulted and attending hospital multiple times.

11.81 Sarah continued to not press charges and even wanted Michael to move in with her when she got a house, and this may have been partly due to Sarah being pregnant with Michael's baby. We also are aware that despite Michael no longer being a resident in the hostel that he continued to attend, and ultimately on the day Sarah dies she had an argument with Michael shortly before she went to her room where she took her own life.

11.82 This moves into the last column where action is sadly enacted, and in late June Sarah took her life.

11.83 Eight-stage domestic homicide and Suicide Timeline pattern:

11.84 The Suicide Timeline provides an eight-stage timeline for domestic abuse related suicide. It is another practical tool, for use by professionals, developed through research and analysis of case studies to understand the interactions between perpetrators of coercive control and their victims, and how these interactions may be linked to escalating and de-escalating risk of serious harm or homicide.

11.85 The behavioural data gathered through this research was organised into a sequence of stages that represent potential escalating risk. The further along the stages, the higher the risk of serious harm, with opportunities at every stage to cease the progression. Each stage provides indicators of perpetrator and victim characteristics. Although the stages are arranged sequentially, they are not

necessarily mutually exclusive, they can and do overlap and may not occur in order with 'circling' through the stages occurring in some cases.

Stage	Alleged perpetrator characteristics	Victim characteristics
1. History	History of domestic abuse, coercive control, stalking, routine jealousy, violence, history of criminal behaviour	History of vulnerability. Previous domestic abuse, coercive control or sexual assault, away from home (student), previous local authority care
2. Early Relationship	Speed and intensity	Speed and intensity
3. Relationships	Dominated by controlling patterns, violence in many cases	Subject to violence, drugs and alcohol, sexual violence
4. Disclosure	Control escalating, violence may escalate, persistent harassment	Starts to tell other about the abuse
5. Help-Seeking	Alleged perpetrator may use victims mental health against them, may make threats to family/friends, counter allegations	Mental health services, GP for mental health, A&E, child services, social services, police
6. Suicidal Ideation	Alleged perpetrator may encourage suicide, persistent contact, threats	Suicide attempts, self-harm, may so they 'can't go on', may be convinced they will be killed, may have lost custody of the children
Complete Entrapment	Stalking, threats, persistent contact, threats to others, violence	May say 'I will never be free' or similar,
Suicide	Common for alleged perpetrators to find body, in some cases abuse transferred to victim's family	Most common to be at home with ligature, other methods also noted

12 Conclusions and Lessons identified:

12.1 This part of the report will summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. This has been a particularly sad case to review. It is based upon the death of a mother of three children. Despite the fact that those children were informally not within her care at the point of her death, they have still lost their mother. Sarah was also pregnant when she took her life.

12.2 Research by the National Vulnerability Knowledge and Practice Programme identify suspected victim suicide is strongly characterised by intimate partner domestic abuse, it is heavily gendered to female victims, and victims are most commonly in their mid-20s to mid-40s the age group Sarah was in, confirmed recently in a National Police Chief's Council (NPCC) report 'Victim and suspect demographics remained consistent with previous years, with the majority of victims being female aged 25-54 years old'[40].

12.3 There has recently been an increase in awareness of the links of suicide and links to domestic abuse, and this can only be a positive thing to ensure that the link is better identified and recognised by agencies not just in Somerset but across the United Kingdom and wider. Recent awareness has been based on recent survivors speaking out, such as the lady in this article[41]where she has told of the "horrific" abuse that she claims led to her trying to take her own life.

12.4 There are a number of current practices in place to prevent suicides where there is a link with domestic abuse. Some of the most recognised activity is highlighted within the NPCC and the National Vulnerability Knowledge and Practice Programme review from 2022 where some police force areas are trying to recognise the link between domestic abuse and prevent further suicides:

- Real Time Suicide Surveillance Systems (RTSSS) RTSSS bring together reports of suicides in a local area with information held by partner agencies in police, health, social services, and sometimes domestic abuse services. RTSSS track the number of completed and attempted suicides locally, but also capture information such as the location and method to help identify patterns for preventive interventions. We heard several examples of applied use of RTSSS to identify suicide cases involving domestic abuse. For instance, one force added questions to its RTSSS to capture the victim's history of domestic abuse. Where a suicide occurred, the RTSSS could be consulted to see if there was knowledge of prior domestic abuse unknown to police. Moving towards prevention, another force has implemented a process whereby an attempted suicide of a domestic abuse victim is reported to the local Independent Domestic Violence Advocate (IDVA) service, who contacts that individual to provide additional support.
- Dedicated suicide prevention posts and partnerships Several forces described investing strategically in posts and multi-agency partnerships to prevent suicide related to domestic abuse. One force implemented a Suicide Prevention and Vulnerability Officer post. As well as monitoring and identifying relevant deaths, this person runs safeguarding events for police and partners, and established

[40] Scale of homicide and suicides by domestic abuse victims revealed (npcc.police.uk)

[41] Domestic abuse: Mother says violence led to suicide attempt - BBC News

training as part of police officer continued professional development. Another force enshrined domestic abuse as a priority within their local Suicide Prevention Strategy, whilst another established a dedicated multi-agency Domestic Abuse Suicide Prevention Working Group; another conducts a weekly review of all suspected suicides to learn lessons about prevention, trends and support needs.[42]

12.5 These points above highlight some evolving practices alongside community safety partners that should be explored across every police force area in order to further prevent suicides relating to domestic abuse.

12.6 It is known that family involvement and engagement can be key to recovery for individuals diagnosed with mental illness. Previous studies have found that people using mental health services are more likely to stick to their treatment plans and have better outcomes when they have supportive family members involved in their care. Sarah lost her support network in October 2020, there is very little evidence of a wider supportive network. During the review, there is evidence of some good practice within several agencies who supported Sarah and it is equally important to develop learning from this good practice.

12.7 Sarah lost her mother 8 months before taking her life, there is no evidence that Sarah was offered any bereavement support, we know that the loss affected Sarah. Her loss of her mother is just one of a number of traumas Sarah faced and agencies should consider when putting plans in place or referring if wider support is necessary and this is fundamental to professional curiosity.

12.8 It is apparent that sharing of information needs to be improved particularly between health agencies and from wider health agencies. GP involvement in MARAC may have mitigated some of this information sharing. It is also to understand where and how appropriate information is shared alongside any historical domestic abuse, we know that it is sadly not uncommon for survivors to become victims again, so a consideration of historical information needs to be considered. It is likely that Sarah may not have been placed in the hostel she went to if all relevant historical information had been shared.

12.9 The current process for DASH is based on the immediate risk to an individual, and historical information should be considered, however limited partnership information means that often the DASH is based on the agency completing it and the rapport they have with the victim. There is an argument to be had nationally and locally on how historical context should be included in DASH assessments, and defining what that should look like. Had this been the case it could be argued that more would have been known about Sarah by wider partner organisations.

12.10 However, the impact of Covid-19 cannot be underestimated, this pandemic put further pressure on an already challenging housing service that was struggling to meet demand as per the landscape nationally and at a local level. This also made

[42] VKPP-DHP-Suspected-Victim-Suicides-following-Domestic-Abuse-Spotlight-Briefing-December-2022.pdf

it harder to interact with Sarah who was pre pandemic a difficult person to maintain engagement with, Covid increased this challenge. A challenge for all agencies is what can we do differently to encourage engagement with services when it is a voluntary process for the individual?

12.11 There is also an area of development to understand suicide and domestic abuse and the recognition that many females who do commit suicide have often experienced domestic abuse.

12.12 As a summary it should be concluded that whilst domestic abuse was a regular and consistent risk for Sarah, it was a wider complexity of issues including mental health, housing, limited finances and reduced access to her children, that undoubtedly contributed to her death, and whilst there is no doubt that she was a victim of domestic abuse it was not the sole reason in her taking her own life. This review is primarily focussed around domestic abuse and any conclusions should not just look at domestic abuse in isolation to the decision for Sarah to end her own life.

13 Areas of concern identified.

13.1 It is acknowledged that there was some impact of the pandemic on how agencies and services interacted with Sarah.

13.2 The police and specialist domestic abuse services used the DASH- RIC risk assessment to identify level of harm experienced by Sarah. It is dependent on the information provided primarily by the identified victim with limited opportunity to verify details. This is a strength in that a first-hand account of an incident is captured from source, however the flaw is that it can also be a deficit because traumatised victims may minimise, confuse incidents leading to an inaccurate impression of the level of risk or as in a number of scenarios Sarah refused to engage with the DASH process. Therefore, DASH may have not been reflective (for example one DASH was based on a review 2 years prior although appropriate to consider as it was the last report they had, engagement from Sarah would have provided a more informed DASH rather than one based on a different instance with a different partner. There should be some consideration around whether other partner agencies should have completed a DASH during the period of this review and whether this would have provided a different outcome regarding Sarah engaging.

13.3 During Sarah's time in the hostel a DASH risk was recorded as high, however 4 days later a DASH was conducted and recorded as medium, therefore demonstrating an inconsistency when completing DASH forms as the situation between Sarah and Michael had clearly not improved. There is no clear record recorded by partners as to how this immediate risk was managed, police requested that alternative housing should be sought for either resident, this was not an immediate mitigation, it is accepted that the DASH should have remained as high risk. However a referral had been made for Sarah to be discussed at the next

MARAC. There appears to have been limited risk assessment carried out over this short period on how to support Sarah. Michael was banned from the hostel, and we do know that on the night Sarah took her life Michael was able to get access to the hostel.

13.4 Pursuing issues around non- contact or responding – More could have been done by agencies on some occasions particularly from the local Domestic Abuse Commissioned Service.

13.5 Delayed referral in early June 2021, incident and referral received in late June 2021. This may have allowed partner agencies to discuss Sarah earlier.

13.6 Information sharing particularly linking in with housing services and health information.

13.7 Risk management and identification of suitable accommodation.

13.8 No clear evidence of Multi Agency Management Meeting following incidents in the Hostel – meant things were not joined up and services were often late to contact Sarah, however there were some good practices, but these were working in isolation particularly the hostel and the police.

13.9 Agency recognition between Domestic Abuse and suicide – lack of evidence of multi-agency safety plans particularly from 31.05.2021 or individual multi agency meeting to discuss Sarah.

13.10 Minimum evidence of professional curiosity and understanding Trauma and Lived experience and the affects this had on Sarah; although the review appreciates that this would have been harder to understand with Sarah not engaging with services:

- Multiple pregnancies/terminations/poor birth control practices.
- Loss of Mother (and her network.)
- Potential impact of not seeing her children frequently.
- Looked After Child.
- Homelessness.
- Substance and alcohol use.
- Long term illness affecting daily life.

13.11 Professionals need to understand the impact of Adverse Childhood Experiences and other trauma on a victim, how it can make someone like Sarah very vulnerable. If professionals take time to understand a victim's life story, then they are more likely to develop a robust risk assessment and safety plan and be better able to support that person.

14 Recommendations

14.1 There had been significant prior agency involvement with Sarah, and we have identified a number of areas where we feel lessons should be learned from this case. We note and welcome the work that is ongoing in Somerset to make

others safer. We make a total of 20 recommendations that we feel will support that work.

14.2 The review would like to thank agencies for their single agency learning and individual recommendations for their agency, specific recommendations from each agency. The review would ask that Safer Somerset Partnership monitor action plans and that outcomes are impact assessed within the organisations.

14.3 The following multi-agency recommendations are made to Safer Somerset Partnership:

- That when agencies screening and/or making assessments of domestic abuse cases (DASH) professionals look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident.
    - **Safer Somerset gains assurance that this should be included as part of future DASH training.**
    - **Safer Somerset should consider appropriate training for all staff who would be expected to complete DASH training**
    - **Current factors surrounding an individual to be considered alongside DASH to ensure any recent trauma such as bereavement, housing or family issues contribute to the assessment outcome.**
- The need for trauma informed approaches to practice, Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of historical and present trauma, such as Looked After Child, loss of network and children understanding and compassion of the affect it could have on individuals.
    - **Safer Somerset Partnership gains assurance that agencies provide Trauma informed practice training to all relevant frontline staff.**
    - **Safer Somerset should gain assurances and seek evidence that adults who were Looked After Children is a protective characteristic locally in any assessments.**
    - **To recognise and consider mitigation to protect current and past Looked After Children (LAC) and the increased risk of their vulnerability into adulthood of being a victim of domestic abuse. This could include the provision of the freedom programme to all LAC for example.**

- Review domestic abuse multi-agency training and awareness in the below areas:
    - **Safer Somerset Partnership to ensure domestic abuse training covers the topic of children being used as an emotional abuse mechanism. All agencies should promote this training as learning from this review.**
    - **To ensure that Trauma informed approaches form part of domestic abuse training.**

- Safer Somerset Partnership to highlight to all partner agencies the eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are aware of the benefits of incorporating them practically in assessments and its interpretation and similarities of risks to those with suicidal ideation.
    - **Safer Somerset Partnership to adopt this model as best practice and ensure training reflects the eight-stage domestic homicide and suicide timeline to professionals.**

- Safer Somerset Partnership with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies.
    - **Safer Somerset Partnership to gain assurance that domestic abuse is included in local suicide prevention strategy and action plan.**
    - **Ensure suicide prevention and trauma informed approaches forms part of any future commissioned service provision of domestic abuse and support services**
    - **Consideration should be given to a County wide awareness campaign of the link between suicide and domestic abuse for professionals and public.**

- Terminations and link to sexual abuse should form part of a DASH assessment as it can be a sign of sexual abuse.
    - **To be considered alongside training.**

- Organisations should seek to have systems in place that allow those responding to incidents to be provided with the previous history to enable them to provide the best support to the victim and assess the incident in the light of a developing and current pattern of behaviour.
    - **Ensure an effective process where GPs are involved in MARAC cases where they have significant involvement with an individual.**
    - **Explore the feasibility of a holistic partnership database to improve information sharing.**
- There should be an expectation with agency policies that; where DASH are completed without the individual present that the history of that person is considered before setting any risk even if recorded with a previous partner as research highlights individuals will often be victims on multiple occasions.
    - **Revise training to incorporate professional judgement of historic knowledge to consider as part of DASH. Particularly where the individual refuses to engage in the process and they have previously been high risk or partner agency involvement specifically around domestic abuse.**

- Local partners to ensure that domestic abuse training considers religious barriers.

    - **Safer Somerset Partnership ensure domestic abuse training specifically covers religious barriers within existing training and all agencies promote as part of learning from this review.**

- Historical domestic abuse should be a factor when assessing need.
    - **That housing providers consider historical domestic abuse as part of their assessment, and where it is historic that attempts are made with MARAC partners to understand current risk.**
    - **Where historic domestic abuse is recorded that the individual is asked if domestic abuse is still a factor to be considered.**

- Safer Somerset Partnership ensure that all local agency recommendations on Appendix B from IMR's are completed.

- *(added following Home Office Quality Assurance feedback*) – All agencies subject to this review should review their procedures around non-engagement. A common theme for this case, was that Sarah's case was closed without thorough consideration of her intersecting needs and minimal multi-agency working to try and better respond to her needs.

Report End ----------

Appendix A

TERMS OF REFERENCE FOR REVIEW PANEL
DHR 042

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Sarah. The death was determined to be suicide, with the person causing harm being her ex-partner(s).

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

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in June 2021 and whether there are any lessons to be learned from the case about the way in which local

professionals and agencies worked together to safeguard the family

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

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

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

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

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

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

3. Scope of the review

The review will:

- Consider the period from 01.01.2016 to 26.06.2021, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers for Sarah 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 regards to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.

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

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

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

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

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

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

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

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

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

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

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.

- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	Representative
Independent Chair	Colin Wilderspin
Avon and Somerset Police	DI Dave Marchant
Clinical Commissioning Group	Emma Read
Children's Social Care	Kelly Brewer
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Sedgemoor District Council	Rob Semple
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Sam Sandy
Somerset Integrated Domestic Abuse Service (Livewest Housing – 2015 to 2020)	Mel Thomson
Somerset NHS Foundation Trust	Heather Sparks
YMCA	Jonica Walkinshaw

This was confirmed at the first Review Panel meeting on 17th January 2022

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

6 Liaison with Media

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

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

Domestic Abuse Related Death

Executive Summary

Sarah

Date of death: June 2021 (Aged 28)

Report initially produced by Colin Wilderspin (Independent Chair) and edited/finalised by Safer Somerset Partnership post Home Office Quality Assurance feedback

October 2025

Contents

2. Introduction:

2.1. This report of a death by suicide of an individual who experienced domestic abuse will follow the principles of a Domestic Homicide Review (DHR) which examines agency responses and support given to 'Sarah', a resident of the Somerset area, prior to her death in June 2021.

2.2. Domestic Homicide Reviews will be renamed Domestic Abuse Related Death Reviews following calls to better recognise domestic abuse related suicide as announced in February 2024. This review will follow this format. This means that a Domestic Homicide Review can be commissioned whenever there is a death that has, or appears to have, resulted from domestic abuse. As well as physical abuse, this includes controlling or coercive behaviour and emotional and economic abuse. It will help to ensure that lessons are learned from fatal domestic abuse cases[43].

2.3. From this point forward this review will be defined as a 'Domestic Abuse Related Death Review', as it recognises a death from domestic abuse related suicide rather than an act of homicide, however the current DHR process and statutory guidance will be followed.

2.4. In addition to agency involvement, the review will also examine (from 2015 until Sarah's death,) any relevant background or experience of abuse, 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 and aim to reduce the chances of another tragic loss of life.

2.5. Sarah was only 28 years old when she took her life by hanging herself. She was a woman who had experienced a difficult and traumatic life, including being a looked after child from the age of 13. Sarah had been with her most recent partner only a few months, who she met within the temporary accommodation she was residing in.

2.6. In the 12 months leading up to her death Sarah had lost her mother, and this appears to have had a huge impact on her, in addition to other factors in her life including housing difficulties. We are not aware of the identity of her paternal Father.

2.7. Sarah had three children from separate relationships; she also had a history of experiencing multiple instances of domestic abuse. At the point of her death Sarah was of the belief that she was in early pregnancy.

2.8. It was on an evening in June 2021 that the police received a call from the accommodation where Sarah was residing. Police attended and recorded death by hanging. they were satisfied her death was not suspicious and the investigation was closed.

[43] Fatal domestic abuse reviews renamed to better recognise suicide cases - GOV.UK (www.gov.uk)

2.9. It is within this context that this review is set.

2.10. The review will consider, in detail, agency contact and involvement with Sarah and her partner. It will also draw upon and reference other relevant incidents or life events prior to her death. The period from 2015 was chosen because it contained significant events leading up to Sarah's death, which reflected ongoing issues in her life.

2.11. The key purpose for undertaking a DHR is to enable lessons to be learned from homicides or other deaths. Furthermore, whether domestic abuse may have been a contributory factor or a key factor in the person's life. For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each death, and most importantly, what needs to change to reduce the risk of such tragedies happening again in the future.

3. Domestic Abuse Related Death Review Introduction:

3.1. This Domestic Abuse Related Death Review is commissioned by the Safer Somerset Partnership in response to the death of Sarah. On an evening in June 2021, a call was made to police by residents of a homeless hostel stating that Sarah had been found hanged in her room, by a ligature made of her own dressing gown. Despite the best efforts of residents, paramedics and police officers Sarah was pronounced deceased at 23.47.

3.2. Sarah had several mental health issues. These included depression and Emotionally Unstable Personality Disorder (EUPD) documented from adolescence into adulthood. Sarah was known to GP surgeries, more through safeguarding concerns with her children and mental health needs than through a domestic abuse context. Her mental health appears to have significantly declined in the last 8 months of her life.

3.3. There is clear evidence that Sarah had a history of experiencing domestic abuse and wider trauma recorded by other agencies. She was a victim of domestic abuse by at least three individuals in the last six months of her life, and there is historical domestic abuse going back to at least 2015. She was a Looked After Child from the age of 13 until she was 21, although she had kept in contact with her mother who we can assume had an impact on Sarah's life until her death in October 2020.

3.4. The Safer Somerset Partnership approved the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and initiated the DHR process in November 2021.

3.5. A Domestic Homicide Review Panel was established with relevant partners and was led by Colin Wilderspin as an independent Chair. The panel's role involves supporting the collation of Individual Management Reviews (IMR),

producing timelines and analytical reports of their organisation and encourages learning to be identified.

3.6. The guidance states: A Domestic Homicide Review (DHR) must be undertaken when the death of a person aged 16 or over that has, or appears to have had, resulted from violence, abuse or neglect by:

- a person to whom they were related or with whom they were or had been in an intimate personal relationship, or
- a member of the same household as them, held with a view to identifying the lessons to be learnt from the death.

2.12 The purpose of the DHR/Domestic Abuse related suicide is to: establish what lessons are to be learned from the death linked to domestic abuse regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2.13 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.14 Apply these lessons to service responses including changes to policies and procedures as appropriate; prevent domestic violence and abuse deaths and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

2.15 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice. *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)*

2.16 The government has also announced that the name of these reviews will be changed from 'Domestic Homicide Review' to 'Domestic Abuse Related Death Review', to better reflect all deaths which fall within their scope.

4. The Review Process

3.15 The independent chair was appointed in November 2021, with the initial review panel meeting taking place on 17 January 2022. An initial trawl for information identified 8 agencies who had significant contact with Sarah.

3.16 Independent Management Reviews (IMR's) and chronologies of their contact with Sarah and connected individuals were requested from these agencies addressing the agreed Terms of Reference for this review. (Appendix A)

3.17 The key lines of enquiry for the review included:

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including

family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

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

- Determine if there were any barriers for Sarah 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 regards to children and pregnancy 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.

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

- 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.

3.18 The full List of Panel Members and the Agencies contributing to the review are listed in Appendix A

3.19 Agencies contributing to the review are listed below:

- Avon and Somerset Police
- Sedgemoor District Council
- Somerset Integrated Domestic Abuse Service (SIDAS) (Livewest)

- Somerset Integrated Domestic Abuse Service (SIDAS) (The You Trust)
- Somerset County Council
- Somerset Children Social Care
- Somerset NHS Foundation Trust
- Somerset Public Health Nursing
- NHS Somerset ICB
- YMCA Dulverton Group

3.20 All IMR authors and Review Panel members were independent of any direct contact with Sarah or other parties relevant to this review.

3.21 The Safer Somerset Partnership appointed an independent chair to conduct the review including to author the overview report. He is an independent trained DHR Chair. He had extensive experience in the statutory sector specifically around community safety and safeguarding and has undertaken internal reviews for organisations throughout the UK. He never previously worked in Somerset and was independent from all the agencies involved in this case.

Through quality assurance, the Home Office noted that their overview report template has not been followed. Unfortunately, despite extensive efforts by the Safer Somerset Partnership the independent chair did not provide a revised report in response to this feedback. Due to resource pressures, the Safer Somerset Partnership have been unable to revise the report to fit the template and acknowledge this feedback for any future DHRs that are commissioned to ensure they meet the template requirements.

3.22 There have been lengthy delays with the completion of this review, initially there was a delay of 4 months to commission the review due to resource pressures within the Council who operate on behalf of the Safer Somerset Partnership in commissioning DHRs. During the review itself the independent chair then had significant health and personal factors that led to delays with its progress.

3.23 Attempts were made to contact members of Sarah's family to consult with them as part of this review process. Sarah's next of kin was contacted but did not engage with the process. Sarah's mother sadly passed away in October 2020. Her Father is unknown and therefore was unable to be contacted.

3.24 Attempts were made to contact Sarah's brother who was also notified of the DHR and the Chair wrote to him inviting him to contribute to the review. However, he did not take up the opportunity during the review process period. He was also notified when the review had concluded and advised that there was still opportunity to contribute to the review if he so wished. At the time of writing, he has made no contact with the chair.

3.25 The review has sought to understand Sarah and life from her perspective. This has been difficult because there has been no engagement from family and friends. We fully respect their decision to cope with Sarah's death in the way best suited to

them. As a result, our knowledge of Sarah 'as a person', has been drawn from professionals' records.

3.26 It was decided by the panel that due to the ages of the children and their current care arrangements that they should not be part of the review. In addition, Sarah had not seen her children for a considerable time before her death and the children were not living with her.

3.27 During the COVID pandemic, people were residing in the hostel who may have otherwise been homeless or sleeping rough. Due to the restrictions coming to an end many of these people left the hostel. It was agreed that contact with Sarah's most recent partner prior to her death - Michael (pseudonym) - would have been challenging due to these circumstances and could potentially pose a risk to him from others connected with the hostel at this time**.** Additionally, as Michael had a chaotic lifestyle and there were considerations regarding his own mental health and general wellbeing, it was agreed for these reasons by the panel not to approach Michael who was her partner at the time of her death, or others at her residence. Sarah was living in temporary accommodation at the time of her death.

3.28 The Review Panel expresses its sympathy to anyone who knew Sarah with their loss in such tragic circumstances.

4. Confidentiality

4.1 The content and findings of this review are confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

4.2 To protect the anonymity of the deceased, and her family, the subject of the review will be known as Sarah.

4.3 This pseudonym was chosen by the Review Chair.

5. Equalities:

5.1 Equalities are set out in more detail within the main overview report.

5.2 The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance to the DHR. The characteristics of Age, Disability, Race, Religion or belief, and Sex, were discussed by the DHR, and the potential vulnerabilities of mental health, ill health and domestic abuse were recognised by agencies working with Sarah. Sarah was female, she had been working with mental health services since a young age through CAMHS and adult mental health

services, and her mental health needs towards the end of her life would probably be considered a disability. Sarah was a white female.

5.3 Sarah had on occasions stated she was a Jehovah Witness, although we were unable to ascertain if she was active in her religion post adolescent years. However as part of this review her religion is considered as part of a barrier to reporting domestic abuse.

5.4 In addition Sarah was a Looked After Child (LAC) and there was an agreement by the panel that this affected Sarah, and that this should be considered a 'protective characteristic' in its own right as often LAC become vulnerable adults and at higher risk of multiple issues including domestic abuse.

5.5 This review supports the findings of a recent independent review of children's social care, commissioned by the Government, which reported that Government should include care-experienced people in the protected characteristics listed in the Equality Act[44].

6. Scope of the Review and summary chronology:

6.1 The scope of the review was agreed from January 2015 to date of death in June 2021 which represents the period from when agencies became involved in an escalation of domestic abuse, deteriorating mental health and concerns for her children's welfare.

6.2 There are 9 events identified within the review that will be analysed:
Event 1 – 26/07/2016 evidence of new relationship starting and previous partners (paternal fathers) raising concerns over her ability to be a mother around this time. Sarah requested to use Clare's Law (significant as records suggest that conversations were had with Sarah at the time outlining concerns and appropriate action to take).

Event 2 - 05/06/2018 Incident relating to Sarah's deteriorating Mental Health, suicide ideation and continued reporting focussing on her ability to be a mother by ex-partners. Also issues of agencies getting hold of Sarah post hospital discharge.

Event 3 - Event 3 – 29/10/2018 - 08/12/2019 - Evidence of coercive behaviour, increase in Sarah getting involved in altercations including a physical assault on a neighbour and her mother and threatening behaviour towards others which is potentially due to social media and other forms of communication from ex-partners and females connected to them. Also, DASH Assessment based on a police 2017 assessment of Standard Risk as Sarah refused to support assessment following this incident[45].

[44] https://edm.parliament.uk/early-day-motion/60528/careexperience-and-protected-characteristics-under-the-equality-act-2010

[45] Frontline officers attending an incident both identify risk and apply an initial risk grade of. 'standard', 'medium' or 'high' risk. Risk-led-policing-2-2016.pdf (college.police.uk)

Event 4 – 01/03/2020 - 16/12/2020 Sarah faced significant challenges during this period. In March 2020 Sarah attempted an overdose and at the same time she lost her stable housing and her children when to live with their fathers, in addition she terminated a pregnancy and lost her employment, her Mum also passed away during this period. These 'events' are significant and chronologies clearly show a decline in her mental health and increase in her vulnerability.

Event 5 – 27/01/2021 Sarah was significantly assaulted by a new partner, they were not living together and had been together for 1 week, although they had known each other longer.

Event 6 – 22/03/2021 Sedgemoor District Council Housing Officer requests an urgent housing placement for Sarah at hostel, due to having to leave her brothers accommodation.

Event 7 – 31/05/2021 Domestic Incident between Sarah and Michael, neither wanted to support police investigation. Sarah stated that the current accommodation was affecting her mental health and she was looking for alternative accommodation.

Event 8 – 05/06/2021 Sarah is a victim of assault by Michael whereby she sustained a cut to her hand by a knife from the communal kitchen. Referred to IDVA and MARAC.

Event 9 – 09/06/2021 Report from a member of the public of a male (Michael) assaulting a female (Sarah) outside a shop. Both had caused common assault injuries to each other although Sarah did not want to press any charges. Michael's placement had now ended at the hostel at the time of this event.

6.3 In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

7. Review Summary:

Background Information:

7.1 At the time of her death, Sarah was living in temporary accommodation in a hostel, she moved to this premise on the 22 March 2021 at the easing of the second lockdown of COVID 19 as a phase 1 return set out by Central Government[46]. During this period before her death Sarah started a relationship with Michael who was also a resident at the hostel and had been provided accommodation as part of the Governments support for homelessness during the Covid Pandemic.

7.2 The review recognises that agencies had raised numerous concerns around Sarah, this is particularly recognised by the hostel she was residing in with regards to the suitability of the accommodation and concerns around her mental wellbeing. There was limited alternative provision and we must also recognise that meetings were taking place to explore alternative housing provision up until the day of her death. Additionally that Sarah was due to be discussed at the next MARAC.

[46] Coronavirus action plan: a guide to what you can expect across the UK - GOV.UK (www.gov.uk)

7.3 Sarah had three children from three different ex partners; between the ages of 5 and 11 years. All three children were no longer living with her at the time of her death. During the timeframe of the review, Sarah's custody and access arrangements with her children seems to have changed. All 3 children were living with Sarah in 2016 but by the time of her death, Sarah was not with her children. Significantly this change seems to occur at the same time as changes to Sarah's housing, in addition ex-partners had concerns about her parenting and the children were staying with paternal family from each of the fathers' sides at the time of her death.

7.4 There are three significant (ex)partners during this time and pseudonym names are given below.
Partner 1: David (father of middle child)

Partner 2: Peter (father of youngest child)

Partner 3: Michael (most recent partner and likely partner to her unborn child)

Her eldest child was with a different ex-partner and is not referenced further in this document so a pseudonym has not been given.

7.5 Sarah had been a Looked After Child in Care since she was 13 until her 21st birthday[47].

7.6 At the time of entering the hostel in March 2021, Sarah had concerns that she was pregnant, whilst this is unable to be proven, we are aware that she was telling professionals and friends that she was, and Michael was the likely Father.

7.7 There is a history, within the timeframe of this review, of multiple terminations following pregnancy and several short-term partners. Health agencies had regularly discussed her use of contraception and encouraged her to use multiple sexual health and contraceptive options.

7.8 Sarah was registered with a GP Practice in the Somerset area, she had several mental health issues which included depression and Emotional Unstable Personality Disorder, she also suffered with pelvic inflammatory disease. At the time of her death Sarah was under treatment from mental health services.

7.9 In the months leading up to her death there is evidence of heavy drinking of alcohol and a high use of prescribed painkillers, including diazepam. Throughout the timeframe of this review there is regular information to suggest Sarah took cocaine. It is likely that the increase in these activities before her death were related to a number of incidents linked with traumatic experiences including housing, loss of her mother and her access to her children.

[47] A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care. Looked after children | NSPCC Learning

7.10 Sarah had received significant mental health support and had been treated for drug overdoses in the past. Sarah had regular suicide ideation recorded by agencies throughout the timeframe of this review.

7.11 One of Sarah's critical factors is the loss of her mother, who passed away in October 2020; in her adult life her mother had been supportive and looked after Sarah's children when needed, she would have been a person Sarah would have shared concerns with based on agency notes.

7.12 As previously stated, Sarah was known to Mental Health, Police, Children's Services and Domestic Abuse services with sporadic engagement at various crisis points. Sarah would regularly not pick up calls or attend pre-agreed appointments, and agencies found it difficult to contact her. There are examples of Sarah losing her temper or becoming threatening to staff when she felt she was not listened to or receiving the medication she wanted.

7.13 Homelessness plays a key part during this period; Sarah had a large debt with a housing provider and, throughout the timeframe of this review, had been in a mixture of housing solutions including staying with family. Sarah's housing situation seemed to be very unsettled; Police logs suggest that Sarah's housing situation was stressful for her and a factor in her worsening mental health, particularly when she lost her home in around April 2020 before moving in with her brother and later when she moved to the hostel.

7.14 The lack of consistent housing and financial control over possessions within the property by an ex-partner suggests a financial coercion that was little considered at the time, although there is little evidence to build on this, and therefore should be a small consideration but, alongside other evidence that we do know around Sarah and her exposure to Domestic Abuse, cannot be ruled out of this review.

7.15 It has been established through research that mental health conditions including suicide ideation have an established patten with intimate partner violence.

7.16 It is reasonable to suggest that Sarah had significant trauma due to a range of historical and ongoing experiences and her treatment by men in multiple short-term relationships. It is significant that throughout reports from agencies there is no direct mention regarding the impact of trauma on Sarah.

8. Themes:

Themes considered as part of the review included:

8.1 Covid 19

To give context to this review it is important to remind ourselves that the last year before her death and a considerable part of the timeframe of this review, everyday life was very different for workers and service users alike due to the pandemic. Front line services were working in a different way often using online communication or telephone appointments instead of face-to-face contact

appointments. This affected all service delivery that Sarah used regularly and would have potentially been frustrating for her, especially where Sarah had multiple factors affecting her including the challenges of living a chaotic lifestyle.

8.2 Professional curiosity:

Practitioners need to apply professional curiosity, as it offers individuals' a framework that can be used to foster an understanding of how interlocking oppressions manifest in the lived experiences for the people. Agencies working in the front line must be proactive with professional curiosity and must actively acknowledge the multiple inequalities people experience as a result of oppressive behaviours of others especially in regard to domestic abuse[48].

8.3 Looked After Children as a protected characteristic

Looked-after children and young people in care are a vulnerable group; their issues feature prominently in the United Nations Convention on the Rights of the Child (UNCRC), where it is noted that youth vulnerability runs into adulthood. Many looked after children have previous experiences of violence, abuse or neglect. This can lead to them displaying behaviour that challenges and having problems forming secure relationships. Some find it hard to develop positive peer relationships[49], and this experience can continue into adulthood.

8.4 Trauma (Lived experience)

Sarah suffered homelessness, mental health and struggled to maintain regular employment, experienced not seeing her children regularly in addition to being a victim of domestic abuse with various partners over a long and sustained period. This review considers whether organisations viewed Sarah's life through the lens of a person affected by both historical and recent trauma.

8.5 Engaging with Services

Within the timeframe of this review it has to be acknowledged that for a significant proportion of time services and interactions had adapted to working within the restrictions of a pandemic. The impact of the pandemic however small can't be ignored as a factor in reducing access to help seeking for both her mental health, housing and the impact of domestic abuse. However, there were challenges with contact pre pandemic, with all agencies recording missed appointments, with agencies either being unable to get her via phone or Sarah not calling back agencies This led to agencies recording that Sarah did not respond or engage on a number of occasions throughout the review period.

---

[48] Why intersectionality matters for social work practice in adult services - https://socialworkwithadults.blog.gov.uk/2020/01/31/why-intersectionality-matters-for-social-work-practice-in-adult-services/

[49] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children#:~:text=Peer%20violence%20and%20abuse,to%20develop%20positive%20peer%20relationships.

8.6 Information Sharing

Previous Home Office DHR reviews have concluded that communication and information sharing between agencies was identified as an issue in 76% of reviews[50]. Fundamentally leading up to her death the referral to the hostel could not consider her domestic abuse vulnerability as this information was not shared/known at the time.

8.7 Understanding Domestic Abuse and impact on Mental Health

Research undertaken in the UK and internationally regarding understanding domestic abuse and the impact on Mental Health demonstrates that there is a casual link between attempted or completed suicide and concurrent experience of domestic abuse. In 2022 research suggested that women who suffer domestic abuse were three times as likely to attempt suicide[51]. A report from the Home Office focused around the pandemic also recorded evidence of a sizeable number of suspected victim suicides with a known history of domestic abuse.[52]

8.8 Suicide Ideation

Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. There has been a significant increase nationally of domestic abuse related suicides in recent years.

9. Conclusions and Lessons identified

9.1 This part of the report will summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action. This has been a particularly sad case to review. It is based upon the death of a mother of three children. Despite the fact that those children were informally not within her care at the point of her death, they have still lost their mother. Sarah was also pregnant when she took her life.

9.2 Research by the National Vulnerability Knowledge and Practice Programme identify suspected victim suicide is strongly characterised by intimate partner domestic abuse, it is heavily gendered to female victims, and victims are most commonly in their mid-20s to mid-40s the age group Sarah was in, confirmed recently in a National Police Chief's Council (NPCC) report 'Victim and suspect demographics remained consistent with previous years, with the majority of victims being female aged 25-54 years old'[53].

---

[50] https://assets.publishing.service.gov.uk/media/5a81b1c5e5274a2e87dbf034/HO-Domestic-Homicide-Review-Analysis-161206.pdf

[51] https://www.theguardian.com/society/2023/feb/22/women-who-suffer-domestic-abuse-three-times-as-likely-to-attempt-suicide

[52] Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf (publishing.service.gov.uk)

[53] Scale of homicide and suicides by domestic abuse victims revealed (npcc.police.uk)

9.3 There has recently been an increase in awareness of the links of suicide and links to domestic abuse, and this can only be a positive thing to ensure that the link is better identified and recognised by agencies not just in Somerset but across the United Kingdom and wider. Recent awareness has been based on recent survivors speaking out, such as the lady in this article[54]where she has told of the "horrific" abuse that she claims led to her trying to take her own life.

9.4 There are a number of current practices in place to prevent suicides where there is a link with domestic abuse. Some of the most recognised activity is highlighted within the NPCC and the National Vulnerability Knowledge and Practice Programme review from 2022 where some police force areas are trying to recognise the link between domestic abuse and prevent further suicides:

- Real Time Suicide Surveillance Systems (RTSSS) RTSSS bring together reports of suicides in a local area with information held by partner agencies in police, health, social services, and sometimes domestic abuse services. RTSSS track the number of completed and attempted suicides locally, but also capture information such as the location and method to help identify patterns for preventive interventions. We heard several examples of applied use of RTSSS to identify suicide cases involving domestic abuse. For instance, one force added questions to its RTSSS to capture the victim's history of domestic abuse. Where a suicide occurred, the RTSSS could be consulted to see if there was knowledge of prior domestic abuse unknown to police. Moving towards prevention, another force has implemented a process whereby an attempted suicide of a domestic abuse victim is reported to the local Independent Domestic Violence Advocate (IDVA) service, who contacts that individual to provide additional support.
- Dedicated suicide prevention posts and partnerships Several forces described investing strategically in posts and multi-agency partnerships to prevent suicide related to domestic abuse. One force implemented a Suicide Prevention and Vulnerability Officer post. As well as monitoring and identifying relevant deaths, this person runs safeguarding events for police and partners, and established training as part of police officer continued professional development. Another force enshrined domestic abuse as a priority within their local Suicide Prevention Strategy, whilst another established a dedicated multi-agency Domestic Abuse Suicide Prevention Working Group; another conducts a weekly review of all suspected suicides to learn lessons about prevention, trends and support needs.[55]

[54] Domestic abuse: Mother says violence led to suicide attempt - BBC News

[55] VKPP-DHP-Suspected-Victim-Suicides-following-Domestic-Abuse-Spotlight-Briefing-December-2022.pdf

9.5 These points above highlight some evolving practices alongside community safety partners that should be explored across every police force area in order to further prevent suicides relating to domestic abuse.

9.6 It is known that family involvement and engagement can be key to recovery for individuals diagnosed with mental illness. Previous studies have found that people using mental health services are more likely to stick to their treatment plans and have better outcomes when they have supportive family members involved in their care. Sarah lost her support network in October 2020, there is very little evidence of a wider supportive network. During the review, there is evidence of some good practice within several agencies who supported Sarah and it is equally important to develop learning from this good practice.

9.7 Sarah lost her mother 8 months before taking her life, there is no evidence that Sarah was offered any bereavement support, we know that the loss affected Sarah. Her loss of her mother is just one of a number of traumas Sarah faced and agencies should consider when putting plans in place or referring if wider support is necessary and this is fundamental to professional curiosity.

9.8 It is apparent that sharing of information needs to be improved particularly between health agencies and from wider health agencies. GP involvement in MARAC may have mitigated some of this information sharing. It is also to understand where and how appropriate information is shared alongside any historical domestic abuse, we know that it is sadly not uncommon for survivors to become victims again, so a consideration of historical information needs to be considered. It is likely that Sarah may not have been placed in the hostel she went to if all relevant historical information had been shared.

9.9 The current process for DASH is based on the immediate risk to an individual, and historical information should be considered, however limited partnership information means that often the DASH is based on the agency completing it and the rapport they have with the victim. There is an argument to be had nationally and locally on how historical context should be included in DASH assessments, and defining what that should look like. Had this been the case it could be argued that more would have been known about Sarah by wider partner organisations.

9.10 However, the impact of Covid-19 cannot be underestimated, this pandemic put further pressure on an already challenging housing service that was struggling to meet demand as per the landscape nationally and at a local level. This also made it harder to interact with Sarah who was pre pandemic a difficult person to maintain engagement with, Covid increased this challenge. A challenge for all agencies is what can we do differently to encourage engagement with services when it is a voluntary process for the individual?

9.11 There is also an area of development to understand suicide and domestic abuse and the recognition that many females who do commit suicide have often experienced domestic abuse.

9.12 As a summary it should be concluded that whilst domestic abuse was a regular and consistent risk for Sarah, it was a wider complexity of issues including mental health, housing, limited finances and reduced access to her children, that undoubtedly contributed to her death, and whilst there is no doubt that she was a victim of domestic abuse it was not the sole reason in her taking her own life. This review is primarily focussed around domestic abuse and any conclusions should not just look at domestic abuse in isolation to the decision for Sarah to end her own life.

10. Areas of Concern Identified

10.1 It is acknowledged that there was some impact of the pandemic on how agencies and services interacted with Sarah.

10.2 The police and specialist domestic abuse services used the DASH- RIC risk assessment to identify level of harm experienced by Sarah. It is dependent on the information provided primarily by the identified victim with limited opportunity to verify details. This is a strength in that a first-hand account of an incident is captured from source, however the flaw is that it can also be a deficit because traumatised victims may minimise, confuse incidents leading to an inaccurate impression of the level of risk or as in a number of scenarios Sarah refused to engage with the DASH process. Therefore, DASH may have not been reflective (for example one DASH was based on a review 2 years prior although appropriate to consider as it was the last report they had, engagement from Sarah would have provided a more informed DASH rather than one based on a different instance with a different partner. There should be some consideration around whether other partner agencies should have completed a DASH during the period of this review and whether this would have provided a different outcome regarding Sarah engaging.

10.3 During Sarah's time in the hostel a DASH risk was recorded as high, however 4 days later a DASH was conducted and recorded as medium, therefore demonstrating an inconsistency when completing DASH forms as the situation between Sarah and Michael had clearly not improved. There is no clear record recorded by partners as to how this immediate risk was managed, police requested that alternative housing should be sought for either resident, this was not an immediate mitigation, it is accepted that the DASH should have remained as high risk. However a referral had been made for Sarah to be discussed at the next MARAC. There appears to have been limited risk assessment carried out over this short period on how to support Sarah. Michael was banned from the hostel, and we do know that on the night Sarah took her life Michael was able to get access to the hostel.

10.4 Pursuing issues around non- contact or responding – More could have been done by agencies on some occasions particularly from the local Domestic Abuse Commissioned Service.

10.5 Delayed referral in early June 2021, incident and referral received in late June 2021. This may have allowed partner agencies to discuss Sarah earlier.

10.6 Information sharing particularly linking in with housing services and health information.

10.7 Risk management and identification of suitable accommodation.

10.8 No clear evidence of Multi Agency Management Meeting following incidents in the Hostel – meant things were not joined up and services were often late to contact Sarah, however there were some good practices, but these were working in isolation particularly the hostel and the police.

10.9 Agency recognition between Domestic Abuse and suicide – lack of evidence of multi-agency safety plans particularly from 31.05.2021 or individual multi agency meeting to discuss Sarah.

10.10 Minimum evidence of professional curiosity and understanding Trauma and Lived experience and the affects this had on Sarah; although the review appreciates that this would have been harder to understand with Sarah not engaging with services:

- Multiple pregnancies/terminations/poor birth control practices.
- Loss of Mother (and her network.)
- Potential impact of not seeing her children frequently.
- Looked After Child.
- Homelessness.
- Substance and alcohol use.
- Long term illness affecting daily life.

10.11 Professionals need to understand the impact of Adverse Childhood Experiences and other trauma on a victim, how it can make someone like Sarah very vulnerable. If professionals take time to understand a victim's life story, then they are more likely to develop a robust risk assessment and safety plan and be better able to support that person.

11. Recommendations

11.1 There had been significant prior agency involvement with Sarah, and we have identified a number of areas where we feel lessons should be learned from this case. We note and welcome the work that is ongoing in Somerset to make others safer. We make a total of 20 recommendations that we feel will support that work.

11.2 The review would like to thank agencies for their single agency learning and individual recommendations for their agency, specific recommendations from each agency. The review would ask that Safer Somerset Partnership monitor action plans and that outcomes are impact assessed within the organisations.

11.3 The following multi-agency recommendations are made to Safer Somerset Partnership:

- That when agencies screening and/or making assessments of domestic abuse cases (DASH) professionals look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident.
    - **Safer Somerset gains assurance that this should be included as part of future DASH training.**
    - **Safer Somerset should consider appropriate training for all staff who would be expected to complete DASH training**
    - **Current factors surrounding an individual to be considered alongside DASH to ensure any recent trauma such as bereavement, housing or family issues contribute to the assessment outcome.**
- The need for trauma informed approaches to practice, Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of historical and present trauma, such as Looked After Child, loss of network and children understanding and compassion of the affect it could have on individuals.
    - **Safer Somerset Partnership gains assurance that agencies provide Trauma informed practice training to all relevant frontline staff.**
    - **Safer Somerset should gain assurances and seek evidence that adults who were Looked After Children is a protective characteristic locally in any assessments.**
    - **To recognise and consider mitigation to protect current and past Looked After Children (LAC) and the increased risk of their vulnerability into adulthood of being a victim of domestic abuse. This could include the provision of the freedom programme to all LAC for example.**

- Review domestic abuse multi-agency training and awareness in the below areas:
    - **Safer Somerset Partnership to ensure domestic abuse training covers the topic of children being used as an emotional abuse mechanism. All agencies should promote this training as learning from this review.**
    - **To ensure that Trauma informed approaches form part of domestic abuse training.**

- Safer Somerset Partnership to highlight to all partner agencies the eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are aware of the benefits of incorporating them practically in assessments and its interpretation and similarities of risks to those with suicidal ideation.
    - **Safer Somerset Partnership to adopt this model as best practice and ensure training reflects the eight-stage domestic homicide and suicide timeline to professionals.**

- Safer Somerset Partnership with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies.
    - **Safer Somerset Partnership to gain assurance that domestic abuse is included in local suicide prevention strategy and action plan.**
    - **Ensure suicide prevention and trauma informed approaches forms part of any future commissioned service provision of domestic abuse and support services**
    - **Consideration should be given to a County wide awareness campaign of the link between suicide and domestic abuse for professionals and public.**

- Terminations and link to sexual abuse should form part of a DASH assessment as it can be a sign of sexual abuse.
    - **To be considered alongside training.**

- Organisations should seek to have systems in place that allow those responding to incidents to be provided with the previous history to enable them to provide the best support to the victim and assess the incident in the light of a developing and current pattern of behaviour.
    - **Ensure an effective process where GPs are involved in MARAC cases where they have significant involvement with an individual.**
    - **Explore the feasibility of a holistic partnership database to improve information sharing.**
- There should be an expectation with agency policies that; where DASH are completed without the individual present that the history of that person is considered before setting any risk even if recorded with a previous partner as research highlights individuals will often be victims on multiple occasions.
    - **Revise training to incorporate professional judgement of historic knowledge to consider as part of DASH. Particularly where the individual refuses to engage in the process and they have previously been high risk or partner agency involvement specifically around domestic abuse.**

- Local partners to ensure that domestic abuse training considers religious barriers.
    - **Safer Somerset Partnership ensure domestic abuse training specifically covers religious barriers within existing training and all agencies promote as part of learning from this review.**

- Historical domestic abuse should be a factor when assessing need.
    - **That housing providers consider historical domestic abuse as part of their assessment, and where it is historic that**

attempts are made with MARAC partners to understand current risk.

- **Where historic domestic abuse is recorded that the individual is asked if domestic abuse is still a factor to be considered.**

- Safer Somerset Partnership ensure that all local agency recommendations on Appendix B from IMR's are completed.

- *(added following Home Office Quality Assurance feedback*) – All agencies subject to this review should review their procedures around non-engagement. A common theme for this case, was that Sarah's case was closed without thorough consideration of her intersecting needs and minimal multi-agency working to try and better respond to her needs.

Report End ----------

Appendix A

TERMS OF REFERENCE FOR REVIEW PANEL
DHR 042

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Sarah. The death is believed to be suicide, with the person causing harm being her ex-partner(s).

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

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in June 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

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

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

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate

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

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

3. Scope of the review

The review will:

- Consider the period from 01.01.2016 to 26.06.2021, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers for Sarah 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 regards to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.

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

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

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

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

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

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

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

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

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

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

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

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Agency	Representative
Independent Chair	Colin Wilderspin
Avon and Somerset Police	DI Dave Marchant
Clinical Commissioning Group	Emma Read
Children's Social Care	Kelly Brewer
Safer Somerset Partnership (SCC Public Health)	Suzanne Harris
Sedgemoor District Council	Rob Semple
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Sam Sandy
Somerset Integrated Domestic Abuse Service (Livewest Housing – 2015 to 2020)	Mel Thomson
Somerset NHS Foundation Trust	Heather Sparks
YMCA	Jonica Walkinshaw

This was confirmed at the first Review Panel meeting on 17th January 2022.

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

7.3 to assist the Chair in analysis.

8 Liaison with Media

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

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

Appendix A: Action Plan DHR 042 (working document subject to changes)

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
That when agencies screening and/or making assessments of domestic abuse cases (DASH) professionals look at the clusters of incidents taking account of historical dynamics of abuse not just the current incident. • Safer Somerset gains assurance that this should be included as part of future DASH training. • Safer Somerset should consider appropriate training for all staff who would be expected to complete DASH training • Current factors surrounding an individual to be considered alongside DASH to ensure any recent trauma such as bereavement, housing or family issues contribute to the assessment outcome.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review: 1. The content of the current domestic abuse training offer and it to be updated if required 2. Responses to the 2024 SDAB self-assessment around training, and determine the uptake of domestic abuse training across partner agencies 3. Content of DASH training to determine if incorporates other factors in a victims lives as to be considered.	Safer Somerset Partnership	SSP to ensure Somerset Domestic Abuse Board (SDAB) are aware of this recommendation SDAB to review current training offer (and/or seek assurance from Somerset Council who lead on training) SDAB (to receive assurance that training is updated)	31/12/24	Ongoing

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
				SDAB to consider self-assessment findings All in progress, Somerset Council are in progress of updating domestic abuse training offer (summer 2024) SDAB self-assessment to be completed by agencies August 2024 and findings to SDAB meeting thereafter		

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
The need for trauma informed approaches to practice, Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' recognise the relevance of the abuse within a victim's relationship and the broader social context in which they find themselves, are key. Additional complexity in terms of historical and present trauma, such as Looked After Child, loss of network and children understanding and compassion of the affect it could have on individuals. • Safer Somerset Partnership gains assurance that agencies provide Trauma informed practice training to all relevant frontline staff. • Safer Somerset should gain assurances and seek evidence that adults who were Looked After Children is a protective characteristic locally in any assessments. • To recognise and consider mitigation to protect current and	Local	Safer Somerset Partnership to obtain assurance from agencies that trauma informed practice training is in place. This is to be either part of the SDAB self-assessment 2024 or a separate audit SSP to seek assurance and evidence across its partner agencies that looked after children are considered as a protected characteristic and risks and vulnerabilities understood. SSP to request that Somerset Council domestic abuse commissioners work with the specialist domestic abuse service to understand what support is being offered to those who were looked after children now,	Safer Somerset Partnership	Feb 2025 – SDAB brief included a link around trauma informed approaches. August 2025: https://traumainformedsomerset.org/ new website shared with partners around trauma informed approaches in Somerset. Children's counselling offer increased in DA service in Summer 2025	31/3/25	Completed

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
past Looked After Children (LAC) and the increased risk of their vulnerability into adulthood of being a victim of domestic abuse. This could include the provision of the freedom programme to all LAC for example.		and increase awareness of this priority within service.				
Review domestic abuse multi-agency training and awareness in the below areas: • Safer Somerset Partnership to ensure domestic abuse training covers the topic of children being used as an emotional abuse mechanism. All agencies should promote this training as learning from this review. • To ensure that Trauma informed approaches form part of domestic abuse training.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required	Safer Somerset Partnership	23.12.2024 - Contents of training reviewed. Included in 'Identifying the signs - Listen and believe' 23.12.2024 - Include trauma informed practice and link to professional support in SDAB brief	31/3/25	Completed

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
				August 2025: https://traumainformedsomerset.org/ used to promote trauma informed approaches		
Safer Somerset Partnership to highlight to all partner agencies the eight-stage domestic homicide and Suicide Timeline pattern models and ensure that they are aware of the benefits of incorporating them practically in assessments and its interpretation and similarities of risks to those with suicidal ideation. • Safer Somerset Partnership to adopt this model as best practice and ensure training reflects the eight-stage domestic homicide and suicide timeline to professionals.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required to include the eight stage domestic homicide and suicide timelines.	Safer Somerset Partnership	Aug 2025 - Add timeline to future SDAB brief, add link to homicide timeline and Ted Talk. https://youtu.be/sQ0W4ZT5ju4 Will be included in future updates on online training	31/3/25	Completed

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
Safer Somerset Partnership with all partners promote awareness around suicide prevention in line with the National Suicide Prevention Alliance best practice guidance. Consider domestic abuse in local and national suicide prevention strategies. • Safer Somerset Partnership to gain assurance that domestic abuse is included in local suicide prevention strategy and action plan. • Ensure suicide prevention and trauma informed approaches forms part of any future commissioned service provision of domestic abuse and support services • Consideration should be given to a County wide awareness campaign of the link between suicide and domestic abuse for professionals and public.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required. Subgroup not created but SDAB involved in training updates and discussions.	Safer Somerset Partnership	Feb 2025 - Suicide information linked to DA in SDAB brief Aug 2025 - Blog post linked to domestic abuse and suicide 10th September on social media and added to website SDAB member sits on suicide prevention group so links are made with strategies	31/3/25	Completed

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
Terminations and link to sexual abuse should form part of a DASH assessment as it can be a sign of sexual abuse. • To be considered alongside training.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required	Safer Somerset Partnership	Online training updated		Completed
Organisations should seek to have systems in place that allow those responding to incidents to be provided with the previous history to enable them to provide the best support to the victim and assess the incident in the light of a developing and current pattern of behaviour. • Ensure an effective process where GPs are involved in MARAC cases where they have significant involvement with an individual. • Explore the feasibility of a holistic partnership database to improve information sharing.	Local	SSP to review the agencies participating in MARAC and work with the NHS Somerset ICB to increase GP involvement SSP to oversee improvement in information sharing system for MARAC	SSP	SSP and NHS Somerset ICB to meet to develop improvements in GP participation In progress, with NHS Somerset ICB improving information sharing for GPs and MARAC This MARAC database/syste	31/12/24 01/10/22	Completed

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
				m is in place and utilised by trained MARAC representatives Somerset Council Public Health commission a new information system for MARAC (manta) 13.3.2025 update: There is a process now in place where GP's are made aware of cases discussed at MARAC. There is no resource to expand this currently to		

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
				further engage GP's with MARAC. A police and crime grant is being applied for to support this. But no guarantee that this will be successful.		
There should be an expectation with agency policies that; where DASH are completed without the individual present that the history of that person is considered before setting any risk even if recorded with a previous partner as research highlights individuals will often be victims on multiple occasions. • Revise training to incorporate professional judgement of historic knowledge to consider as part of DASH. Particularly where the individual refuses to engage in the process and they have previously	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required Somerset's domestic abuse training offer to be promoted to all agencies	SSP	Dec 24 - Modules have been updated. Promotion to agencies 2025-2026 Dec 24 - Reinforce the use of a DASH is best practice and added to SDAB brief Feb 25 - Outcome of	31/3/25	Completed

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
been high risk or partner agency involvement specifically around domestic abuse.				Needs Assessment to prioritise policies		
Local partners to ensure that domestic abuse training considers religious barriers. • Safer Somerset Partnership ensure domestic abuse training specifically covers religious barriers within existing training and all agencies promote as part of learning from this review.	Local	The Safer Somerset Partnership to request that its subgroup the statutory Somerset Domestic Abuse Board (SDAB) to review the content of the current domestic abuse training offer and it to be updated if required Somerset's domestic abuse training offer to be promoted to all agencies	SSP	Training reviewed to determine how religion is considered If required, training content updated Aug 2025 - promote learning when published using learning brief (with a focus on religion as barrier to reporting)	31/3/25	Completed

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
Historical domestic abuse should be a factor when assessing need. • That housing providers consider historical domestic abuse as part of their assessment, and where it is historic that attempts are made with MARAC partners to understand current risk. • Where historic domestic abuse is recorded that the individual is asked if domestic abuse is still a factor to be considered.	Local	SSP to contact Somerset Council Housing to determine current practice and if any improvements need to be made to understand impact of historical abuse on an individual	SSP	SSP to write to Somerset Council housing to understand practice Letter to be sent on publication	31/12/24	
Improve data accuracy to help support better decision making. An error in the occurrence type in the Niche record for this incident contributed to inappropriate prioritisation of victim contact and onward referrals to domestic abuse services		Training and awareness to staff to improve data recording and accuracy.	Avon and Somerset Police ASC Crime Data Integrity Task Force	ASC Crime Data Integrity Task Force Action closed by police as individual performance reviews include personal responsibility to ensure data	March 2023	Completed

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
				integrity and accurate data recording plus LSU regional managers are on data quality task and finish group		
Officers to show curiosity and consider if contact is appropriate.	Local	Review of internal Safeguarding procedure. Where safeguarding referrals received with threats to self-harm or harm others the Safeguarding officer should when safe either contact the customer or insure a more relevant agency makes contact.	Sedgemoor District Council SDC Safeguarding officer	Procedure reviewed Procedure promoted to staff, to highlight this	31.03.2022	Completed 31.3.22. Procedure reviewed* **Sedgemoor DC ceased to exist 1.4.23 due to new unitary Somerset Council forming*
SDC to test the professional curiosity of its workforce.	Local	Team session to be held within community safety to review and understand areas for improvement.	Sedgemoor District Council Communit		30.04.2022	Completed 30.4.22 **Sedgemoor DC ceased to exist*

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
		To seek assurances that the quality of practice is as required within the service.	y safety team.			*1.4.23 due to new unitary Somerset Council forming*
All future references of DV to give information if victim or perpetrator plus location of behaviour. All information to be clear and concise.	Local	Training to Housing Staff and relevant partners to highlight the importance of accurate record keeping. Some records of DV not clear when being reviewed.	Sedgemoor District Council - Housing Advice Team	Training content developed Training delivered	30.04.2022	Completed March 2022 **Sedgemoor DC ceased to exist 1.4.23 due to new unitary Somerset Council forming*
Personnel Housing Plans to be completed at beginning of process to allow involvement in goal setting.	Local	Internal training to remind staff of responsibility. PHP should be completed within 14 days of initial interview.	Sedgemoor District Council - Housing Advice Team	Training content developed Training delivered	30.04.2022	Completed March 2022* **Sedgemoor DC ceased to exist 1.4.23 due to new unitary Somerset Council forming*

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
Clear and concise records in relation to DV. Consider training for staff in relation to DV and record keeping.	Local	Training to Housing Staff and relevant partners to highlight the importance of accurate record keeping. Discrepancy between different records in relation to DV.	Sedgemoor District Council - Housing Advice Team	Training content developed Training delivered	30.04.2022	Completed March 2022* **Sedgemoor DC ceased to exist 1.4.23 due to new unitary Somerset Council forming*
All staff to be reminded of the referral and intake policy and best practice in relation being proactive to engage with clients and liaising with referrers.	Local	SIDAS Management Team General learning for staff	SIDAS	Staff briefing at team meeting	Immediately	January 2022
Link with adult safeguarding if/when concern arises.	Local	Feedback to be provided to the Front door teams. Ensure that multi agency approach is taken and relevant services are informed	CCG	Staff briefing at team meeting	March 2022	Completed
For patient's awaiting a termination of pregnancy there could be more professional curiosity and conversation	Local	Apart from signposting by GP's the raising awareness of the emotional impact of having a termination of	CCG - SSAB led with all	Briefing developed and utilised in various forms to	June 2022	Completed June 2022

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
around emotionally how the patient is feeling by the GP.		pregnancy with GP practices would be a benefit. Article to be added to GP newsletter. Subject matter taken to GP Supervision. To add subject matter to GP best Practice leads agenda. Professional Curiosity Rapid read developed Professional Curiosity Webinar	agencies input.	improve understanding by GPs		
Needs Assessments for Placements	Local	To contain all relevant and required information for placement requests, including any risk information for review. No area of the Needs Assessment to be left blank	SDC Housing Team and YMCA if not complete to push back.		June 2022	

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
		and no responses to be ambiguous. To ensure all required information is known to accommodation provider so risk is known and can be safeguarding against.				
A multi agency meeting with relevant involved or required agencies to be called if concerns are raised by an agency to another regarding suitability of placement or a domestic situation has taken place between two residents within the one setting.	Local	To ensure all services involved with individuals have a clear understanding and guidance provided for working with individual and are aware of each services approach and availability	All agencies involved in this review	Review process The agency raising concerns or Police if attendance has been required. 13.03.2025 Would suggest this can be covered through the work the SSAB have done to promote and embed the multi	Immediately.	Completed

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
				agency risk management process (MARM) SSAB-MARMv1.2-july-2024-fv-.docx		
Refresh training to staff of warning process to be followed in temporary accommodation and all warnings to be shared with SDC Housing.		Training day for staff who work with TA settings. Ensure boundaries are clear and behaviours are monitored within setting.	Assistant head of Housing – YMCA		June 2022	
Domestic Violence Policy to be created		Creation of Domestic Violence Policy to be implemented Ensure that all staff of YMCA are aware of response required for Domestic Violence incidents, covering all aspects of DV.	Head of Risk and Resource – YMCA		June 2022	

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
Refresh training to staff on Domestic Violence and completion of DASH.		Training for staff who work within TA settings. Link to Somerset County Councils Domestic Violence online Training Staff have been trained to respond to Domestic Violence and Abuse Reminder required about completions of DASH without consent.	Assistant Head of Housing – YMCA		June 2022	
All agencies subject to this review should review their procedures around non-engagement. A common theme for this case, was that Sarah's case was closed without thorough consideration of her intersecting needs and minimal multi-agency working to try and better respond to her needs.	Local				Ongoing	

Appendix B: Home Office Quality Assurance Feedback Letter

Home Office

Interpersonal Abuse Unit Tel: 020 7035 4848 2
Marsham Street www.homeoffice.gov.uk
London
SW1P 4DF

Heidi Hill
Project Change & Improvement Officer
Somerset Council
County Hall
Taunton
TA1 4DY

1st April 2025

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Sarah) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 19th February 2025. I apologise for the delay in responding to you.

The QA Panel felt that overall, this was a sensitively written report, with good recommendations and use of references and research. The recommendation around housing, the links drawn between suicide and domestic abuse and the way the lessons learnt are linked to the recommendations are also good.

The QA Panel commended the significant attempts made to engage the victim's family, and felt the report reflected the struggles the victim faced despite the lack of contribution from the victim's family or friends. They also felt that significant events were identified well and commended the consideration around whether to include the children in the review.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- The Home Office statutory guidance template was not followed which affects the flow of the report and means there are sections and headings missing from the report. Please review the layout accordingly.

- There should be further consideration of the issues regarding information sharing and the need for an effective process for involving the

GP/primary care in the MARAC process when they have had significant involvement with an individual.

- Sarah's voice could have been stronger in the report, though the Panel noted that this was likely due to the lack of tribute or contribution from family or friends.

- There was a 5-month delay between the victim's death and the decision to commission a DHR, which then took three years to complete. These delays should be explained.

- There is no mention of whether any parallel reviews were undertaken or shared, for example by the coroner. There is also no mention of liaison with the coroner, postmortem or inquest results, which should be included if available.

- There is no dissemination list or analysis section, which should be added.

- The sex of the victim's children should be redacted at paragraphs 8.19, 8.3 and 12.6 for confidentiality.

- Pseudonyms should be explained earlier in the report to make clearer who is who.

- Michael is mentioned at 3.10 but no context is given. This paragraph could be restructured to make clear he was Sarah's partner at the time of her death. It should also note whether Michael is a pseudonym or his real name.

- There is no independence statement relating to IMR authors or panel members within the report, which should be added.

- The information on the author's independence is too brief; there is no information on locations of previous jobs or DHR Chair training undertaken.

- The key lines of enquiry set out in Appendix A should be more specific to the circumstances of this case. They should also be in the main body of the report.

- The list of panel members and agencies contributing to the review should also be in the main body of the report rather than in Appendix A.

- The front title page contains details of the victim's month and year of birth which is unnecessary.

- There is no date shown for when the Panel was established by the Safer Somerset Partnership.

- The panel felt the reference to ‘Pursuing issues around non engagement’ at
18.4 should be a recommendation as it is a common theme.

- The report requires a thorough proofread for typos, grammar, tenses and formatting.

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

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

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

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

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

Home Office DHR Quality Assurance Panel