

Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Henrietta

Date of death: December 2022

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Safer Somerset Partnership

Domestic Homicide Review Overview Report

Henrietta died in December 2022

Independent Author – David Mellor BA QPM

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1.0 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Henrietta (a pseudonym), a resident of Somerset at the time of her death which took place in December 2022.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before Henrietta's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 Henrietta died at her ex-partner Lee's address in December 2022. She was 44 years of age. Henrietta had lived independently in social housing for a number of years. She had been in an intimate relationship with Lee for over a decade and although the relationship had become intermittent, Lee was a frequent visitor to Henrietta's home and as her health declined he began presenting himself to partner agencies as her informal carer. Henrietta had become dependent on alcohol but appeared reluctant to acknowledge the issue or seek help. She regularly experienced seizures and her mobility was adversely affected by the amputation of some of her toes after contracting sepsis. She began to experience falls more frequently and in March 2022 sustained a fracture of the neck of her femur which further reduced her mobility and increased her dependence on Lee. There was a significant escalation in domestic abuse incidents involving Henrietta and Lee during 2020 and again in 2022. Henrietta was almost always perceived to be the victim and Lee the perpetrator, and he was imprisoned after breaching a Domestic Violence Protection Order which prohibited him from molesting Henrietta. Henrietta appeared to be dependent on Lee for support, but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered.

1.4 On 7th January 2024 the Safer Somerset Partnership decided to commission a Domestic Homicide Review (DHR) on the grounds that Henrietta was a victim of domestic abuse from Lee, possibly including coercion and control, and his apparent neglect of her care and support needs may have contributed to Henrietta's death.

1.5 The review considered agency contact/involvement with Henrietta from 1st January 2020, when reports of domestic abuse incidents began to markedly escalate, and Henrietta's death in December 2022.

1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed, dies in circumstances in which neglect appears to be a factor or takes their own life as a result of neglect as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide or apparent suicide and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

DHR Timescales

1.7 This review began in April 2024 and was concluded in June 2025. DHRs should be completed, where possible, within six months of their commencement. The notification was received by the Safer Somerset Partnership at the end of January 2023. The Safer Somerset Partnership Chair decided a review should be commissioned but sought confirmation of whether a Safeguarding Adults Review (SAR) was to be commissioned by the Safeguarding Adults Board. Between March and December 2023 there was extensive liaison between both strategic groups, and it was at the beginning of January 2024 that a DHR was commissioned after it was decided that there was to be no SAR or joint SAR/DHR. After the review commenced, further delay arose because of the need to analyse the volume of chronological information held by partner agencies.

Confidentiality

1.8 The findings of each DHR are confidential. Information is available only to participating officers/professionals and their line managers. The pseudonym was chosen by Henrietta's family and used in the report to protect the identity of the individual involved. At the time of her death, Henrietta was 44 years of age. She was White British.

1.9 All Domestic Homicide Reviews involve the loss of a cherished life leaving devastation in its wake. Henrietta leaves her parents, sister and a niece. Safer Somerset Partnership therefore wishes to express sincere condolences to the family and friends of Henrietta.

Pen portrait

1.10 Henrietta was a White British woman who was born in 1978. She and her younger sister were brought up by their parents in a Somerset town.

1.11 Henrietta's family described her as a very intelligent person who had a degree in business studies and could speak 3 additional languages – French, Spanish and Italian. They said that, as a girl growing up, she was very popular and got on well with her many cousins and friends from school. Her mother said that she never needed to chastise Henrietta and that her daughter “never gave her a day of trouble”.

1.12 Her family said that after graduating, for the next 5 years Henrietta lived and worked in Ibiza during the summer months – running a bar – and worked in an Italian ski resort during the winter months. At that time her family said that she was a very fit and active person who was “very, very sociable”. When, later in life, she experienced significant mobility problems, her family said she became “terribly frustrated” after previously being such an active person.

1.13 Henrietta's sister described her as a ‘meticulously organised’ person and that this helped her to keep appointments with professionals.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

1. Establish what lessons are to be learned from Henrietta's death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
3. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-

ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

5. Contribute to a better understanding of the nature of domestic violence and abuse;
6. Highlight good practice.

2.2 The case specific terms of reference are as follows:

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Henrietta faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.
- 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.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice. In particular, explore the extent to which opportunities to safely make routine enquiry were taken by professionals.
- Given that agencies frequently struggled to engage with Henrietta, explore any barriers to accessing support she may have experienced, including the possibility that Henrietta may have been the victim of coercion and control. Is there any learning to be derived from Henrietta's contact with agencies which were more successful in working with her?
- Henrietta was frequently noted to be affected by alcohol use. Explore how professionals responded to this including the extent to which Henrietta was offered or encouraged to access support.

- 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.
- Whether the offer and/or provision of services to Henrietta was impacted by the restrictions introduced as a result of the Covid-19 pandemic.

3.0 Methodology

3.1 Following a referral from Somerset Council Adult Safeguarding, the Safer Somerset Partnership decided to commission a DHR on 7th January 2024.

3.2 The DHR was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016). Individual Management Review (IMR) reports were requested from all agencies who had had relevant contact with Henrietta, her family and her partner and ex-partners. The authors of the IMRs had the discretion to interview members of staff if this was required.

3.3 The IMRs were scrutinised by the DHR Panel and further information was requested where necessary.

Contributors to the DHR

3.4 The following agencies provided Individual Management Reviews to inform the review:

- Abri (Housing Provider)
- Avon and Somerset Police
- Oaklands Surgery
- Probation Service
- Somerset Council Adult Social Care
- Somerset Council Housing
- NHS Somerset Integrated Care Board
- Somerset NHS Foundation Trust
- South West Ambulance Service NHS Foundation Trust
- West Coker Surgery
- You First (provider of Somerset Domestic Abuse Service)

After Lee consented to relevant information from his medical records being used to inform the DHR, Somerset Council Adult Social Care, NHS Somerset Integrated Care Board and Somerset NHS Foundation Trust provided additional summary reports.

3.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

The DHR Panel Members

3.6 The DHR Panel consisted of:

David Mellor	Independent Chair of DHR Panel and Independent Author
Community Safety Manager	Somerset Council
Deputy Designated Nurse for Safeguarding Adults	NHS Somerset Safeguarding Team, Integrated Care Board
Detective Chief Inspector	Avon and Somerset Police
Group Community Safety Manager	Abri
Head of Somerset Probation Delivery Unit	HM Prisons and Probation Service
Service Manager	Somerset Domestic Abuse Service
Principal Social Worker/Strategic Manager Safeguarding & DOLS	Somerset Adult Social Care
Project Change and Improvement Officer	Somerset Council
Housing Specialist	Somerset Council
Safeguarding Manager	Somerset Drug & Alcohol Service
Safeguarding Specialist	South West Ambulance Service NHS Foundation Trust
Strategic Lead & Named Professional Safeguarding Adults; Prevent Lead/Domestic Abuse & Sexual Violence Lead	Somerset NHS Foundation Trust

3.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on six occasions – 25th June, 10th September, 16th October and 4th December 2024, 30th January, 1st April and 7th May 2025.

3.8 Following the decision to commission a DHR, Safer Somerset Partnership wrote to Henrietta's parents and her sister to advise them that the DHR had been commissioned and to invite them to contribute to the review, and the Home Office

and AAFDA leaflets were shared with Henrietta's family. The terms of reference questions were shared with the family, and they were invited to comment upon them. Henrietta's parents and sister's views are documented in Section 4 of this report. Henrietta's partner Lee was also invited to contribute to this DHR. His views have informed the report.

Author of the overview report

3.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has thirteen years' experience as an independent author of DHRs and other statutory reviews. He has completed the Home Office training for DHR chairs.

Statement of independence

3.10 Since 2006 he has been an independent consultant. He was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

3.11 He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

3.12 He has no connection to services in Somerset.

Parallel reviews

3.13 It is understood that no inquest is to be held.

Equality and diversity

3.14 The protected characteristics of 'sex' and 'disability' apply to Henrietta.

Sex:

3.15 Women are around twice as likely to have experienced domestic abuse than men. From the year ending March 2018 to the year ending March 2020, the majority of victims aged 16 and over of domestic homicides were female (76%). This contrasts with non-domestic homicides where the majority of victims were male (86%). Almost all those convicted for controlling or coercive behaviour in England and Wales in the year ending March 2023 were male – 553 out of 566. Henrietta disclosed non-fatal strangulation which is also a highly gendered crime.

Disability:

3.16 Henrietta had a physical disability in that the amputation of her toes was a physical impairment which had a substantial and long-term effect on her ability to carry out normal day-to-day activities. Her hip fracture in March 2022 was not technically a disability because it was anticipated that she would eventually make a recovery although this fracture had a substantial effect on the remainder of her life. Her disability may have been a factor which hampered her ability to attend in-person appointments. There is limited evidence of reasonable adjustments being considered by professionals with the exception of the decision to change the location of a Neurology Clinic appointment. Hospital transport could have been considered although Henrietta was able to use public transport fairly frequently prior to her March 2022 hip fracture.

Intersectionality

3.17 Henrietta's needs were complex and intersected with each other to a large extent. Her mobility issues were already significant before her March 2022 hip fracture. Her reliance on Lee therefore increased which he may have further exploited given that Henrietta's family found that the front wheels of her walking frames had been removed. Although Henrietta's alcohol dependence pre-dated her relationship with Lee, she may have been using alcohol as a coping mechanism for her abusive relationship. She was at serious risk from falls arising from her seizures which may have been linked to her alcohol use. She was often seen with unexplained bruising which may, or may not, have been caused by falls. Her alcohol dependence may have impaired her mental capacity at times. It is not known why Henrietta was underweight, but this may have been an element of the self-neglecting behaviours which became increasingly prominent.

3.18 It is possible that there may have been a degree of unconscious bias¹ by professionals in relation to Henrietta's alcohol dependence. However, she was offered assessments of her care and support needs on at least 3 previous occasions which challenges the view that assumptions may have been made about her alcohol use being a 'lifestyle choice'.

Dissemination

The following will receive copies of the DHR overview report:

- Avon and Somerset Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Safer Somerset Partnership
- Somerset Safeguarding Adults Board
- Somerset Domestic Abuse Board

¹ Unconscious (or implicit) bias is a term that describes the associations we hold, outside our conscious awareness and control. Unconscious bias affects everyone. Unconscious bias is triggered by our brain automatically making quick judgments and assessments. They are influenced by our background, personal experiences, societal stereotypes and cultural context. It is not just about gender, ethnicity or other visible diversity characteristics - height, body weight, names, and many other things can also trigger unconscious bias.

4.0 Views of Henrietta's family

4.1 Her family said that Henrietta was a very intelligent person who had a degree in business studies and could speak 3 additional languages – French, Spanish and Italian. As a young girl growing up her family said that she was very studious. They said that she was also a very popular girl who got on well with her many cousins and friends from school. Her mother said that she never needed to chastise Henrietta and that her daughter 'never gave her a day of trouble'.

4.2 Her family said that after graduating, Henrietta lived and worked in Ibiza during the summer months – running a bar – and worked in an Italian ski resort during the winter months. She did this for 5 years. At that time her family said that she was a very fit and active person who was very, very sociable.

4.3 She later moved to London with her then partner and ran a public house for a time. Her family said that Henrietta's relationship with her partner deteriorated and she started to drink – which her parents described as 'her demon'. Her parents said that they tried to help Henrietta with her drinking but said that their daughter appeared unwilling to accept help or acknowledge that her drinking was problematic. Her family were also critical of what they perceived to be a lack of support available to people who were becoming dependant on alcohol. During this period running a pub in London, they said that Henrietta had some kind of accident whilst cooking in the pub kitchen which may have caused her burn injuries. After her relationship with her partner broke down she moved back to Somerset from London. This would have been around 2005.

4.4 Her family said that Henrietta's relationship with Lee began in 2008 or 2009. Her family said that Henrietta had not experienced domestic abuse in previous intimate relationships although they described the ending of previous relationships as 'betrayals' by the males involved, adding that Henrietta was 'extremely giving' in her relationships. After her relationship with Lee began, her family said that he began to physically abuse her and that it was not unusual to see her with a black eye.

4.5 Henrietta's relationship with Lee ended for a time and she returned to live with her parents but they (Henrietta's parents) insisted that she did not drink alcohol in the house. Her family said that she ended up returning to Lee and that Henrietta and Lee then lived with Lee's parents for a time. Henrietta and Lee later moved in with Henrietta's parents and her family said that on the second night after moving in, they (the family) had to ring the Police as Lee was 'kicking the living daylights' out of Henrietta, leaving her 'black and blue'. The family added that the Police had to 'pepper spray' Lee to get him down the stairs.

4.6 Following Lee's arrest, Henrietta remained at her parent's address for a time, but her family said that Lee repeatedly rang her. They recalled that Henrietta received around 80 missed calls over one 2-hour period. Her parents described Lee as the most persistent, controlling person they had ever met.

4.7 Her family said that Henrietta then had a relationship with someone else, but she eventually returned to Lee because they said he was so persistent that he eventually 'wore her down'. After their relationship resumed, her family said that Lee 'completely stopped' her having contact with her family.

4.8 Her family say that they resumed contact with Henrietta around 2016 or 2017 when she was in crisis. She was admitted to hospital with sepsis. Her family said that she was dangerously ill at that time and was at risk of her limbs being amputated. Her family said that Henrietta remained in hospital for 9 weeks and they became very involved in supporting her at that time. She eventually lost the tips of her toes which seriously affected her mobility. Her family said that she was able to walk but only slowly, tentatively and with a degree of pain. She predominantly used crutches to mobilise. Her balance was also adversely affected. Her family said that this loss of mobility left Henrietta 'terribly frustrated' as she had been such an active person prior to this.

4.9 It was clear that her family held Lee responsible for not seeking medical help before Henrietta became so ill with sepsis, but they said that Lee claimed to have 'saved her life' by calling an ambulance.

4.10 Her family said that Lee's relationship with Henrietta ended at that time and she again lived with her family. However, Henrietta's relationship with Lee resumed once more although her family described the relationship as 'back and forth'. They said that Lee told Henrietta that she 'couldn't be with anyone else'.

4.11 Her family said that when she first moved to her new address in December 2020 Henrietta was engaging with services and signed a behavioural agreement which stated that Lee was not allowed in her property (Paragraph 5.53). Her sister described Henrietta as a 'meticulously organised' person and that this helped her to keep appointments with professionals.

4.12 Henrietta's family said that their access to her became extremely limited and that they had very little contact with her after 2021. They said that if they tried to ring

her, Lee would interrupt the calls, and he would then make phone calls to her family in the small hours of the morning which they described as 'horrific' and almost led to her parents suffering 'breakdowns'.

4.13 Henrietta's family said that on the evening of Friday 9th December 2022 Lee rang Henrietta's father and told him that Henrietta was dying, that she was at his flat and that he couldn't care for her anymore and as it was too much for him. Henrietta's parents and sister visited her at Lee's flat which they described as 'really squalid', with bottles, dishes, mouldy food and cannabis on the floor and holes in all the doors which they assumed had been caused by Lee punching them. Henrietta was lying on Lee's 'filthy sofa' and did not appear to have been bathed or washed. Her family state that they could see faeces under her fingernails. Her sister said that Henrietta was so thin that she could put her fingers fully round her wrist. They said that Henrietta was completely immobile by this time and so her family assumed that Lee must have transported her to his flat from her home. Her family said that this was the first time they had seen Henrietta for a long time as a result of Lee's behaviour.

4.14 Her family state that Henrietta asked them to get her out of Lee's flat and so they decided to try and move Henrietta back to her home and obtain support for her there. They said that Henrietta gave them her house keys, which they said that Lee accused them of stealing. The family said that they began contacting 'social services' on the morning of Saturday 10th December 2022 to try and arrange for support to be put in place at Henrietta's home but they said that they were unable to obtain any support for Henrietta despite making further phone calls to 'social services' on the Sunday, Monday and the morning of Tuesday 13th December 2022 (Paragraphs 5.161 and 5.162 summarise Adult Social Care's documented contact with Henrietta's family over the days immediately prior to her death).

4.15 Her family said that when they were clearing Henrietta's belongings out of her flat after her death, they found that the front wheels of her walking frames had been removed, her bed had been broken and there were several broken TV sets.

4.16 Reflecting on Henrietta's death, her family said that when they saw her on the evening of Friday 9th December 2022, they feel that she no longer had 'any fight in her', that she seemed to be aware that 'it was over' and they feel that dying was Henrietta's only way out of the relationship. They described Lee as being obsessed with Henrietta and said that he isolated her from family and her friends and that her only friends were his friends. They said that he even intimidated neighbours who she struck up friendships with.

4.17 Henrietta received support from a neighbour who encouraged her to accept support from Somerset Integrated Domestic Abuse Service (SIDAS)² (Paragraph 5.89) and accompanied to a GP appointment when she disclosed that she had been kicked on the shin (Paragraph 5.92). Unfortunately, the identity of the neighbour is not known by agencies who were in contact with Henrietta at that time and so it has not been possible to invite the neighbour to contribute to the DHR.

4.18 Henrietta's parents and sister read a late draft of the DHR report. They said that they were very satisfied with the report and supported all of the recommendations.

4.19 Henrietta's family made the following comments:

- They felt that their contacts with Adult Social Care in an effort to obtain help for Henrietta during the final days of her life had not been fully recorded.
- They felt that there was a lack of joined up thinking at times. They cited the missed opportunities for agencies to cross reference information held by them in respect of both Henrietta and Lee.
- They felt that it should be easier to mount an evidence-led prosecution where the victim does not feel able to support a prosecution.
- They felt that the "breathing spaces" arising from the DVPO and from Lee's imprisonment were opportunities for agencies to work more effectively in partnership to support the victim. In Henrietta's case they felt that agencies could have made greater effort to intervene at these times as Henrietta may have been even more vulnerable given that her access to alcohol (via Lee) would have been interrupted and she may have experienced increased isolation and anxiety in Lee's absence. Her family also felt that on his return when the "breathing spaces" ended, Lee would have been able to present himself as Henrietta's "saviour" and reinforce his control over her.
- They commented that there was no support for families bereaved in these circumstances. (The families of victims of domestic abuse who die by suicide or where their death results in part from a combination of neglect and coercion and control by the perpetrator are not eligible for support from the Victim Support Homicide Service).

² Somerset Integrated Domestic Abuse Service is now known as Somerset Domestic Abuse Service and is provided by the You Trust.

- They said that partner agencies should give greater attention to the impact of coercive and controlling behaviour on the victim. They felt that the contrast between how Henrietta presented at the time the witness statement was taken from her in 2017 (Paragraphs 6.28 to 6.32) and how she presented during the period covered by the DHR (2020-2022) was telling and was an indication that Henrietta had been completely “worn down” by Lee.
- The family said they would be very interested in the progress of the multi-agency action plan developed to implement the DHR recommendations and would welcome an update on progress made in due course.

5.0 Chronology/Overview

Background information (Paragraph 5.1 to 5.4)

5.1 Henrietta was a White British woman who was born in 1978. She and her younger sister were brought up by their parents in a Somerset town. After graduating, Henrietta worked abroad in the hospitality sector for a number of years before returning to the UK. After contracting sepsis in 2017, Henrietta had the big toe and the second toe on both her left and right feet amputated which adversely affected her mobility and left her 'terribly frustrated' (Paragraph 4.8). Over time Henrietta appeared to become dependent on alcohol although there is no indication that she accessed support from substance services. She also suffered seizures which were under investigation but may have been secondary to alcohol withdrawal. She appeared to have been very underweight for several years although she had not been diagnosed with an eating disorder. She also began to sustain injuries from falling and fractured her knee in 2019 or 2020.

5.2 Lee is a White British male who was born in 1985. From his childhood years he behaved in a violent and aggressive manner towards his parents and was supported by CAMHS from the age of 10. As an adult he disclosed childhood sexual abuse. It is not clear from information held by agencies whether this was formally investigated. His first contact with Adult Mental Health services was in 2008 and he subsequently received support from the community mental health team (CMHT) and the Dual Diagnosis team. He was diagnosed with ADHD (attention deficit hyperactivity disorder)³ and conduct disorder⁴ during his childhood years. As an adult he was diagnosed with mental and behavioural disorders due to multiple drug use and use of other psychoactive substances. Later assessment indicated probable traits aligned with antisocial personality disorder, although this was not formally diagnosed. Lee (or his mother who often contacted agencies on his behalf) frequently requested prescriptions of Diazepam⁵, which his GP practice prescribed cautiously given the risk of misuse and addiction.

5.3 Henrietta and Lee's relationship began in 2008. During the earlier years of their relationship, Henrietta made several disclosures of domestic abuse by Lee to the Police. Lee was prosecuted for an offence of assault by beating against Henrietta

³ ADHD is a neurodevelopmental disorder and refers to a pattern of behaviour that affects a child in most situations, is evident from an early age and can persist into adolescence and adulthood. Core symptoms of ADHD are difficulty concentrating, hyperactivity, and acting impulsively (such as doing things without thinking through the consequences).

⁴ Conduct disorders' describes persisting disruptive or dissocial behaviour.

⁵ Assault by beating is the charge relating to the offence of battery which is committed by the intentional or reckless application of unlawful force to another person (Section 39 Criminal Justice Act 1988).

which took place in December 2017, and he received a Conditional Discharge for 18 months. Henrietta became increasingly isolated from her family. Factors which contributed to this isolation appear to have primarily been Lee's aggressive and controlling behaviour and parental disapproval of Henrietta's alcohol use to an extent.

5.4 Lee's relationship with his parents became increasingly fraught and professionals became concerned about the risk to his parents from Lee's aggression and violence. Lee appeared to live between his parent's and Henrietta's address and as her health declined began presenting himself as her carer.

2020

5.5 During the evening of 2nd February 2020 Henrietta called police via the 999 system to report that her 'ex-partner' Lee was refusing to leave her address. Shouting could be heard in the background. The call handler spoke to Lee and advised him to leave the property, which he apparently did. Officers visited Henrietta the following day, as the incident had been initially dealt with by phone. She said that a verbal argument had taken place. No offences were disclosed. Henrietta did not wish to complete a DASH (Domestic Abuse, Stalking and Honour Based Violence)⁶ risk assessment and so a standard risk DASH was completed by an officer on the basis of their own observations. The incident was discussed at a Somerset Domestic Abuse Triage (DAT) meeting two days later. No referrals were made.

5.6 During the afternoon of 5th March 2020 Henrietta contacted the Police via the 999 system to report that Lee had stolen her bank card. Shouting could be heard in the background, but signal strength was very weak and the call cleared. The police comms operator attempted to recall Henrietta several times but was unsuccessful. Due to the previous domestic abuse history officers were dispatched and spoke to Henrietta who stated that Lee had called at her address asking for money. When Henrietta refused his request, Lee picked up her bank cards and attempted to leave. Henrietta locked the doors and Lee pushed her when trying to get out. Henrietta did not wish to support any further action by the Police. A medium risk DASH was completed. The officers noted that Henrietta was recovering from a fractured knee (Henrietta sustained a knee fracture, apparently caused by a fall, in late 2019/early 2020), and, as stated, had previously had some of her toes amputated. The officers felt that Henrietta required the support of a care package, noting that she did not have anyone other than Lee for support. A BRAG (which stands for Blue, Red,

⁶ The DASH risk assessment is a nationally implemented tool used to identify and assess risks when a potential victim discloses domestic abuse, honour based violence or stalking.

Amber and Green)⁷ assessment rated amber, was completed. The Police Lighthouse Safeguarding Unit (LSU)⁸ reviewed the incident, which was also discussed at a DAT meeting, and a referral was made to Adult Social Care. Due to insufficient evidence, no further police action was taken.

5.7 On 12th March 2020 Adult Social Care considered the Police referral which outlined concerns that Henrietta was dependant on Lee for care and support and was at risk of financial and physical abuse. The history of domestic abuse in her relationship with Lee was not included. The SCCC (Somerset County Council Contact Centre) phoned Henrietta to gather more information. She shared her health and mobility difficulties – describing herself as ‘housebound’, the help and support she received from Lee and her housing and benefits situation. She also said she had seen her GP in respect of depression and mental health. The Police referral was sent to the Adult Social Care community team who phoned Henrietta and offered her a Section 9 Care Act assessment⁹, which she decided not to avail herself of. The SCCC number was shared with her in case she changed her mind.

5.8 Lee had been supported by the Somerset NHS Foundation Trust (SFT) Dual Diagnosis team in relation to his mental health and substance use presentations. During a late March 2020 mental health assessment Lee disclosed that he had been a victim of childhood sexual abuse, which was later confirmed by his mother although this had not been independently verified. He also disclosed a significant level of debt (£20,000) which was thought to be gambling and/or drug related. He said that this was causing him stress. The psychiatrist conducting the assessment described Lee as ‘strongly solipsistic’ (self-centred) although he was noted to have a sense of duty which seemed at odds with this. Lee stated that his frustration levels arising from the ‘current crisis’ could increase the risk of verbal abuse or aggression to others.

5.9 On 23rd March 2020 the first national lockdown began in response to the Covid-19 pandemic. The unprecedented demands of the pandemic led to partners adopting

⁷ The BRAG is a tiered assessment tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies.

⁸ The LSU is a team with joint function of supporting victims/witnesses of crime including onward referral to other agencies and, where appropriate, being a point of contact during a CJS process.

⁹ Section 9 of the Care Act assessment states that local authorities must carry out an assessment of anyone who appears to have needs for care and support, regardless of whether those needs are likely to be eligible; focus the assessment on the person’s needs and how they impact on their wellbeing, and the outcomes they want to achieve; involve the person in the assessment and, where appropriate, their carer and/or someone else they nominate; provide access to an independent advocate to support the person’s involvement in the assessment, if required and consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support).

alternative service delivery models which significantly limited in-person contact with citizens.

5.10 Shortly after midnight on 20th May 2020 Henrietta called the Police via the 999 system to report that Lee was intoxicated and screaming. Lee took the phone from Henrietta and told the call handler Henrietta was intoxicated and causing a disturbance. Officers attended and spoke to Henrietta and Lee separately. Lee stated that Henrietta had hit him on the head with a TV remote but had no visible injuries and did not wish to make a complaint. Lee's father attended and took his son back to his parents' address. Neither Henrietta nor Lee wished to complete a DASH and so a medium risk DASH and a (green) BRAG were completed based on officer observations. When the Police LSU reviewed the incident they noted that support agencies would not accept a referral for Lee (who was perceived to be the victim) without a 'victim-led' DASH unless the 'officer completed' DASH is graded as high risk. (Without the consent of the victim, SIDAS would be unable to progress a referral, unless the incident was assessed as high risk, in which case victim consent was not required for SIDAS to progress the referral). There was felt to be insufficient evidence to consider an evidence-led prosecution¹⁰.

5.11 During the afternoon of 26th May 2020 the Police were called to reports of a disturbance between Lee and Henrietta. Officers attended. Henrietta reported that following a verbal argument, Lee had thrown eggs at her window. A standard risk DASH was completed but officers did not feel that Henrietta was able to answer all of the questions truthfully. A (red) BRAG was completed which documented that Henrietta was unable to look after herself and relied on Lee, who she was afraid of. Officers also spoke with Lee and his father, who stated that his son had issues with alcohol and his mental health and completed an (amber) BRAG in respect of Lee and advised him to contact his GP for support. The Police added an information marker to Henrietta's address for 12 months. The Police LSU reviewed the risk assessments and made referrals to Adult Social Care, the Multi-Agency Risk Assessment Conference (MARAC)¹¹ and IDVA¹² services. A Victim and Witness Care officer (VWCO) attempted to discuss other available support with Henrietta which she did not feel able to accept. No further police action was taken due to insufficient evidence to proceed.

¹⁰ Evidence-led prosecutions are prosecutions that enable the prosecution team to deliver justice without requiring the support of the victim.

¹¹ MARAC is a meeting where information is shared on the highest risk domestic abuse cases and is attended by representatives from police, health, child protection, housing, independent domestic violence advisors (IDVAs), probation and other specialists from the statutory or voluntary sectors. They share all relevant information they have about a victim, discuss options for increasing the victim's safety and create a co-ordinated action plan

¹² An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members, with the aim of securing their, and their children's, safety.

5.12 On 26th May 2020 SIDAS received a high-risk Police referral in respect of Henrietta for MARAC listing and IDVA support. SIDAS made 4 attempts to ring Henrietta and on the 4th call spoke to her and explored support options which she felt unable to accept.

5.13 On 27th May 2020 Adult Social Care considered the Police report of the domestic abuse incident which had taken place the previous day. The report outlined Henrietta's care and support needs which were being met by Lee who Henrietta appeared to be "scared of". The report also mentioned Lee's mental health issues and that there had been numerous incidents, including domestic abuse incidents potentially linked to his mental health. The SCCC sent the report to the Adult Social Care community triage team to request a Section 9 assessment of Henrietta's care and support needs. The triage team phoned Henrietta and discussed available support options such as direct payments and community agent referral which Henrietta did not feel able to accept at that time and so the referral was closed. Henrietta was advised to make contact if and when she required support.

5.14 Also on 27th May 2020 Lee's mother contacted his GP on her son's behalf to report that he had been stabbed in the top of his leg during an assault but had not attended hospital or reported the matter to the Police. Lee was advised to attend hospital immediately. There is no indication that he did so.

5.15 On 23rd June 2020 Henrietta was discussed at MARAC following which SIDAS contacted her GP to request that her patient records were flagged as at that time there was no primary care engagement with the MARAC process. MARAC noted that Adult Social Care had received 2 contacts from the Police, but Henrietta had declined an assessment of her care and support needs. It was stated that her (unassessed) care and support needs could increase her vulnerability (This MARAC information largely taken from Somerset NHS Foundation Trust (SFT) records).

5.16 On 4th July 2020 many of the restrictions introduced as part of the first Covid-19 lockdown began to be lifted although partner agencies continued to provide services in accordance with the revised service delivery models implemented at the outset of the pandemic.

5.17 On 24th July 2020 the Ambulance Service were contacted via the 999 system by a shop assistant who had seen Henrietta fall to the floor shaking inside the shop. Henrietta said that she had been investigated for epilepsy whilst living abroad and had had previous seizures. The crew asked her about bruises on her arms, and she initially said that she had 'done it' on a gas stove and later said she had fallen against a wall. The crew established that she lived alone but spent time with her

friend Lee. She was asked about safety concerns and stresses in the relationship but said there were none. The crew did not have any doubts about Henrietta's mental capacity.

5.18 Henrietta was later discharged from Yeovil District Hospital following 'an alcoholic seizure' and her GP informed. Yeovil District Hospital documented the attendance/admission as 'unwell cough for 3 days'.

5.19 During the early hours of 27th July 2020 Henrietta flagged down a Police patrol vehicle and reported an argument between herself and Lee. Henrietta stated that during the argument, a glass TV stand had been smashed after Lee fell on it whilst intoxicated. Both Henrietta and Lee were described as intoxicated. Lee had sustained injuries from the glass but declined medical attention. Henrietta said that she did not want Lee in her property, and his mother was asked to collect him. No offences were considered to have taken place at that time. Officers completed a DASH and a BRAG based on officer observations. The Police LSU made referrals to MARAC and SIDAS.

5.20 On 29th July 2020 Lee was sentenced to a 24-month Community Order with 30 days of Rehabilitation Activity Requirement (RAR)¹³ for the offence of possession of a bladed article in a public place. The victim of the offence was a neighbour of his parents. Lee was supervised by a Community Rehabilitation Company until such entities were disbanded following the reunification of Probation Services which took place in June 2021. The Probation Service then assumed responsibility for supervising Lee until the Community Order was terminated on 2nd November 2021 as a result of further offending.

5.21 During the early hours of 2nd August 2020 the Police were called to reports of a verbal disturbance at Henrietta's address. Officers attended and spoke to Henrietta and Lee separately. Henrietta disclosed that Lee had assaulted her causing visible bruising to her left shoulder within the last couple of days and had also hit her on the head causing a lump. Lee had also caused damage at her address, smashing a window, Henrietta's phone and a TV. Lee was arrested and transported to custody. An (amber) BRAG was completed highlighting Henrietta's use of drugs. A medium DASH was completed with the officer noting the relationship appeared to be 'abusive from both sides' and 'neither could leave due to their vulnerabilities'. The Police LSU reviewed the incident and upgraded the risk to high due to a previous MARAC

¹³ The RAR is one of the requirements that can be included within a community order or suspended sentence order. The main purpose is to secure someone's rehabilitation, restoring service users to a purposeful life in which they do not reoffend.

referral within the previous 12 months and a further referral to MARAC was made. The LSU also made a referral to SIDAS.

5.22 On 24th August 2020 Yeovil District Hospital documented a 'safeguarding concern patient alert' due to concerns Lee's parents raised about his aggression.

5.23 On 25th August 2020 Henrietta was discussed at MARAC following which SIDAS contacted her GP to request that her patient records were flagged. Henrietta's GP was informed that MARAC was concerned that she lacked support, and the GP was requested to share the contact details for SIDAS with her, should she contact the GP Practice. Her GP records were appropriately coded. MARAC was informed that a charging decision was awaited from the Crown Prosecution Service (CPS). Concern that Henrietta was at risk of homelessness were raised (MARAC information largely taken from Somerset NHS Foundation Trust (SFT) records).

5.24 On 26th August 2020 an Abri¹⁴ community safety officer (CSO) visited Henrietta. Also present was a male who was initially identified by the name of a former partner of Henrietta, who the CSO later established was Lee. Henrietta disclosed that she had fled abuse from Lee 2 years previously, but they had resumed contact during the first Covid-19 lockdown so that Lee could help her with her shopping. She said that Lee had subsequently assaulted her and smashed her window (Paragraph 5.21). She added that Lee had stolen money from her which had put her in debt. Henrietta said that she was no longer seeing Lee. She went on to say that she struggled with daily tasks such as cooking, taking a bath and shopping. The Abri CSO referred Henrietta to SIDAS and Adult Social Care. (There is no indication that a DASH was completed).

5.25 On 27th August 2020 SIDAS received an email from Abri housing advising that Henrietta would like support. SIDAS attempted to contact both Henrietta and Abri Housing without success and so the contact was closed.

5.26 On the same date (27th August 2020) the SCCC considered the Abri referral which stated that Henrietta was currently in temporary housing and set out her medical issues, possible care and support needs and included concerns relating to financial and domestic abuse. Lee was said to be an informal carer who was present during their visit although Abri had been introduced to him using the name of a former partner. The referral also stated that Henrietta had been very emotional during the visit, 'forgetting and repeating things. Abri advised that they had also referred Henrietta to IDVA and for financial support. The SCCC followed this up in the first instance by

¹⁴ Abri is a housing association based in the South of England. Abri was Henrietta's landlord.

phoning Henrietta to gather further information. She said that her former partner, who she said was not Lee, visited her daily to provide support and when asked to clarify the identity of her informal carer, she said that Abri must have got them muddled up. Henrietta expressed interest in finding out what support could be available for future reference. The ASC community triage team then phoned Henrietta who felt unable to accept an assessment, advising that she had support from her friends and neighbour. No further action was taken and the referral closed.

5.27 On 28th August 2020 Henrietta attended Yeovil District Hospital. Three fungal wounds were noted on her back. It was noted that Henrietta looked underweight. Bruising to her wrists and back were noted. When asked about how the bruising was caused, Henrietta denied that she had been a victim of domestic abuse. On 1st September 2020 the Police received a call from the Yeovil District Hospital Safeguarding Team raising concern after Henrietta attended Accident and Emergency (A&E) following a seizure and was found to have bruising. When questioned, Henrietta disclosed that the bruising had been caused by a friend who attended her address every other day to help her around the house. Henrietta disclosed that she was frightened and could not bear the situation, which had been going on for years, any longer. Henrietta declined to speak to the Police or an IDVA as they were 'already involved'. It is unclear whether a DASH was completed by the Yeovil District Hospital Safeguarding Team.

5.28 The Police investigated the above incident, but Henrietta did not feel able to provide a statement, consent to her medical records being accessed or support a prosecution. An evidence-led prosecution was considered and as a result of Lee's denials in relation to Henrietta's injuries and his admission that he had caused the criminal damage in his police interview he was dealt with by way of a community resolution and was given a conditional caution for the offence of criminal damage. The condition required Lee to complete a CARA course (Cautioning and Relationship Abuse) by the 3rd of March 2021. A CARA course is a diversionary course for domestic abusers providing 'awareness training and a reflection journey'.

5.29 Also on 1st September 2020 Henrietta's GP was advised of current domestic abuse concerns about Henrietta by the Yeovil District Hospital safeguarding team. On the same day the GP carried out a phone review of Henrietta's health following her recent hospital admission and referred her to dietetic services as she was 'very underweight'. The earlier MARAC request to share details of SIDAS with her was not actioned and domestic abuse was not explored with her. It is not known whether the GP was concerned that Henrietta may not be alone. The GP arranged for a health coach to contact Henrietta. The health coach phoned her on 7th September 2020 and noted that Henrietta 'did not have much of a voice' and appeared to be struggling to speak. Henrietta agreed to further contact but there is no indication that any subsequent phone call was made.

5.30 On 9th September 2020 a dietetic triage of Henrietta was carried out by phone. She was noted to have a very low BMI. She was said to have denied that she had an eating disorder. She said that she ate protein and vegetables but not carbohydrates. A clinic appointment was arranged for 19th October 2020.

5.31 During the evening of 15th September 2020 Henrietta called the Police to report that she had been locked out of her house by Lee. Officer attended and spoke to Henrietta and Lee separately. No offences were disclosed. Henrietta did not wish to complete a DASH having completed one recently and said that she was happy for the officer to use the same answers in completing a medium risk DASH. The officer noted that Henrietta depended on Lee due to her mobility issues and whilst they were no longer in a relationship (they both were said to have new partners) Lee spent a lot of time at her address helping her. It was noted Lee drank heavily, had diagnoses of ADHD and Asperger's¹⁵ (No diagnosis of Aspergers is recorded for Lee) and struggled to control his temper at times and there appeared to be some jealousy around Henrietta's new partner. The Police LSU reviewed the incident and made a referral to SIDAS. No further police action was taken.

5.32 During the morning of 17th September 2020 the Abri CSO visited Henrietta's address and received no reply. Lee was heard to be shouting and swearing very loudly and the sound of items being thrown around could be heard. The CSO was concerned for Henrietta's safety but then saw her returning to the flat. Lee then appeared naked at the window of the flat shouting and swearing. Abri called the Police who attended promptly and arrested Lee for public order offences and removed him from the scene. Henrietta 'refused to engage' with the Police and following the investigation there was insufficient evidence to seek a charging decision for an evidence-led prosecution. However, Lee was prosecuted for public order offences. A high-risk DASH was completed on the basis of officer observations which documented that Henrietta was at risk of serious harm due to her vulnerabilities regarding her health and reliance on support from Lee. An amber BRAG was completed noting that Henrietta was not taking her medication or engaging with Adult Social Care and was thought to be drinking a litre of vodka a day. The officer noted Henrietta was in 'desperate need of help' but was reluctant to involve any support services. Henrietta was documented to be reliant on Lee helping her with bathing, shopping and cleaning and Lee was said to believe that Henrietta would die if she did not seek help. The Police LSU reviewed the incident and made referrals to SIDAS, Adult Social Care and MARAC.

¹⁵ Asperger syndrome (often shortened to Asperger's) is no longer used as a diagnostic term for autism and is considered controversial due to the history of Hans Asperger. Historically, Asperger syndrome was used as a diagnostic term for some autistic people who did not also have a diagnosis of a learning disability. Broadly, it is now agreed that what was referred to as Asperger syndrome is part of the autism spectrum and there is no need for a separate term.

5.33 The Abri CSO noted that the flat was dirty and untidy. The CSO also advised Henrietta that if she allowed Lee to stay in her flat this could put her tenancy at risk and a further visit was arranged so that Henrietta could sign an acceptable behaviour contract (ABC)¹⁶ which would include a clause to prevent Lee from visiting.

5.34 During the evening of 19th September 2020 the Police received an abandoned 999 call which was traced to Henrietta and officers visited her. She disclosed that Lee had kicked her in the back leaving no visible injuries. Henrietta did not feel able to make a statement or support a prosecution. A medium risk DASH was completed which noted Henrietta's reliance on Lee 'due to her disabilities'. Henrietta advised the officer that 'she was engaging with the Police LSU to obtain support'.

The Police LSU reviewed the incident, and referrals were made to SIDAS, MARAC, and Adult Social Care. The information marker on Henrietta's address was extended for a further twelve months. Whilst dealing with this incident officers found a small amount of drugs in the property. The Police took possession of the drugs but as they were unable to prove ownership, no further action was taken.

5.35 On 24th September 2020 SIDAS received the Police referral and contacted Henrietta on the same day. She did not feel able to accept support, stating, "Lee is already in enough trouble", didn't wish to make a complaint, and had been advised by the Police to ring 999 if Lee returned.

5.36 Shortly before midnight on 27th September 2020 the Police received a call reporting a disturbance at Henrietta's address. Officers attended and Henrietta disclosed that Lee had slapped her across the face and left the address. Henrietta felt unable to make a witness statement or support a prosecution. A high-risk DASH was completed which documented that Henrietta relied heavily on Lee for support as her friends and family had all distanced themselves from her 'due to Lee'. Henrietta stated that Lee seemed to want more from the relationship than just being friends, which is all she said she wanted. Henrietta said that she felt trapped within the 'friendship' and due to her reliance found it difficult to break away. An amber BRAG documented Henrietta's struggles with mobility and possible linked mental health

¹⁶ An ABC is a written agreement between a person who has been involved in antisocial behaviour and one or more local agencies whose role it is to prevent such behaviour. ABCs are most commonly used for young people but may also be used for adults. The contract is agreed and signed at a meeting with the individual and the lead agencies. The contract specifies a list of anti-social acts in which the person has been involved and which they agree not to continue. Where possible the individual should be involved in drawing up the contract. This may encourage them to recognise the impact of their behaviour and take responsibility for their actions. Support to address the underlying causes of the behaviour should be offered in parallel to the contract.

issues. The Police LSU referred Henrietta to the MARAC, Adult Social Care and SIDAS. An evidence-led prosecution had been considered.

5.37 On 28th September 2020 Adult Social Care considered the Police referral in respect of the 19th of September 2020 incident (Paragraph 5.34) which stated that Henrietta had been assaulted by Lee and that she wanted him to leave as he was using drugs. Lee was said to pose a high risk to Henrietta and there had been a number of incidents of domestic abuse from Lee towards Henrietta, and that Lee had a history of domestic violence towards his parents. Henrietta's health needs were highlighted, and it was stated that she was intoxicated when the Police visited. The referral also advised that Henrietta had been referred to MARAC and SIDAS. The SCCC sent the referral to the Adult Social Care safeguarding service for a decision. A safeguarding worker phoned Henrietta who discussed her 'health issues' and the support she received from Lee. Henrietta said that 'everything had settled' and she did not feel unsafe with Lee. After a discussion with the triage safeguarding lead, the safeguarding referral was not accepted, as Henrietta was said to have demonstrated that she was able to protect herself from physical abuse.

5.38 Also on 28th September 2020 Lee's GP practice had a telephone consultation with his parents who reported struggling with Lee's mental health, adding that Lee had 'a lot of anger'. Lee's parents were advised to contact the Police if his behaviour escalated.

5.39 On 5th October 2020 Adult Social Care considered the Police referral in relation to the 27th of September 2020 incident although the ASC recorded it as taking place on 2nd October 2020. The Police referral stated that an argument between Henrietta and Lee had been overheard with Henrietta shouting at him to get off her. Their relationship was described as "volatile and toxic". The report stated that Henrietta had become isolated from family and friends because of Lee and that Henrietta was "stuck in an awkward position where I suspect she wants to separate from Lee but is nervous about doing so due to him helping her so much. This leads her to continue contact with him as she is reliant on him and doesn't have any other support in place currently." Henrietta's home environment was described as messy and cluttered, and Henrietta was said to sleep on a mattress on the floor. The report referred to previous Police referrals and noted that Henrietta and Lee had been heard at MARAC three times in the past few months. The SCCC worker misread the referral and mistakenly believed that it related to the previous Police report which was considered by Adult Social care on 28th September 2020 (Paragraph 5.37). The SCCC worker therefore believed that Adult Social Care Safeguarding had already considered the referral, which was sent to the community triage team highlighting Henrietta's mobility issues. An occupational therapist from that team phoned Henrietta who agreed to be put on the allocation list for a bathing assessment.

5.40 On 5th October 2020 SIDAS received a high-risk referral from the Police in respect of Henrietta and were advised that a DVPO had been issued (It was not issued until 22nd October 2020). On 21st October 2020 the Police advised SIDAS that Henrietta had made a statement. Between 5th and 12th October 2020 SIDAS made 3 unsuccessful attempts to contact Henrietta, following which the referral was closed.

5.41 On 16th October 2020 Henrietta phoned her GP Practice to report ongoing peripheral nerve disease¹⁷ and was offered an in-person consultation but said that she was unable to attend the surgery.

5.42 On 19th October 2020 Henrietta did not attend the scheduled dietetic appointment. The service attempted to ring Henrietta 3 times without reply. Later that day Henrietta rang to apologise for missing the appointment which was rescheduled for 7th December 2020. She reported feeling well. No previous 'dietetic input alerts', safeguarding entries or active referrals were noted.

5.43 During the late evening of 21st October 2020 the Police received a call reporting a disturbance coming from Henrietta's address. Officers attended and spoke to Henrietta, who was alone as Lee had left with his father. Henrietta disclosed that Lee had spat at her and two days earlier had kicked her in the legs causing bruising to her left upper thigh and lower left leg. Henrietta added that on the same date she had suffered a fit, causing further bruising to her legs. A high-risk DASH and an (amber) BRAG was completed, the latter highlighting concerns that Henrietta was not taking her medication or engaging with Adult Social Care. The Police LSU made referrals to SIDAS and MARAC. Lee was arrested in relation to a number of outstanding disclosures by Henrietta. Police investigated but no further action was taken due to insufficient or conflicting evidence and Henrietta's 'refusal' to support a prosecution. A DVPN¹⁸ was sought and issued on 22nd October 2020, along with a subsequent DVPO¹⁹ which applied from 23rd October 2020 for 28 days and prohibited Lee from molesting Henrietta, from entering her address or coming within 100 yards of her. Henrietta was said to be unhappy about the DVPO as she relied on Lee for support.

¹⁷ Peripheral neuropathy develops when nerves in the body's extremities, such as the hands, feet and arms, are damaged. The symptoms depend on which nerves are affected.

¹⁸ A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard.

¹⁹ DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

5.44 On 26th of October 2020 SIDAS received a further Police referral in respect of Henrietta and made 3 unsuccessful attempts to contact her.

5.45 On 3rd November 2020 Lee self-referred to Somerset Drug and Alcohol Service (SDAS). He reported smoking cannabis and drinking alcohol on a daily basis although he said that he did not see this as a problem. He added that he was smoking and sniffing cocaine most days a week. Lee engaged in a comprehensive assessment, but this treatment episode was closed after Lee was sentenced to a period of imprisonment after breaching the DVPO (see Paragraph 5.49)

5.46 On 5th November 2020 the second Covid-19 lockdown began.

5.47 On 7th November 2020 Henrietta attended Yeovil District Hospital after an unwitnessed seizure, having been found by a friend. Superficial wounds to her fingers and right foot were noted.

5.48 During the evening of 16th November 2020 the Police received a call reporting a disturbance between Lee and Henrietta at her address. Police attended and spoke to Henrietta who disclosed that Lee had visited her address on three occasions during that day, shouting and kicking the window, refusing to leave and had pushed his way into the address and assaulted Henrietta by kicking her thigh, spitting on her and slapping her face. Lee had left prior to police attendance but was located nearby and arrested. A high-risk DASH and a (red) BRAG were completed. The Police LSU referred Henrietta to SIDAS and MARAC.

5.49 Lee was released on bail whilst the investigation continued. The Police submitted a prosecution file to the Crown Prosecution Service (CPS). However, Henrietta retracted the witness statement she had provided and 'refused to support' a prosecution. The CPS advised no further action was to be taken due to insufficient evidence. However, Lee was prosecuted for breaching the DVPO and was sentenced to 42 days in custody.

5.50 On 18th November 2020 SIDAS received the Police referral requesting further IDVA support and MARAC listing.

5.51 On 24th November 2020 Henrietta was heard in MARAC. The meeting was advised that Lee was in custody and was due to be released on 7th December 2020. SIDAS was asked to make a further attempt to contact Henrietta. When SIDAS rang Henrietta, the sound of male and female voices could be heard although no-one

spoke directly into the phone before the call ended. No further attempts were made to contact Henrietta as it was unclear if it was safe to do so. SIDAS did not inform the Police of the outcome of the attempt to contact Henrietta. MARAC was also advised that Henrietta was due to move to a new property (bungalow) but there was no support in place to help her with this (unclear if this comment related to support to accomplish the move or post-move support). The DHR has been advised that Henrietta did not request any support with the move and so it is assumed that she must have made her own arrangements. There were concerns around non-compliance/disguised compliance²⁰. The MARAC was advised that Henrietta just wanted Lee to 'come back and look after her'.

5.52 During the early hours of 1st December 2020 the ambulance service found Henrietta sitting on the rear step of a van. There was a strong smell of cannabis and alcohol, but Henrietta denied having either. She gave several conflicting reasons why she was out of doors at that time in the morning. The crew advised she attend hospital due to hypothermia which Henrietta declined as she wished to go home which was close by. She was warmed up in the ambulance and taken home.

5.53 On 2nd December 2020 Henrietta signed up for her new property after attending a viewing several days earlier whilst apparently intoxicated. She signed a tenancy agreement and an acceptable behaviour contract which included not allowing Lee to attend her address.

5.54 After requesting the rescheduling of her 3rd December 2020 dietetic appointment because she was moving home, the appointment took place by phone on 9th December 2020 and a food fortification²¹ approach was to be adopted, and an action plan created. Henrietta was discharged from the dietetic service but was advised of the option to self re-refer. On the same date Henrietta's GP received a letter from dietetic services which expressed concerns about her weight and requested the GP to monitor this. On 18th December 2020 a message was left for Henrietta to contact the surgery to provide monthly weight measurements as recommended by the dietician or to attend the surgery for weight checks.

²⁰ Disguised compliance is a term used to describe the behaviour of parents or carers who appear to co-operate with professionals in order to allay concerns and stop professional engagement. It is unclear what the evidence of disguised compliance related to in this case.

²¹ Food fortification entails adding household ingredients to normal food to increase its nutritional content without increasing the amount of food which needs to be eaten. e.g. 1 tablespoon of skimmed milk powder added to one portion of mashed potato

5.55 On 22nd December 2020 Lee again self-referred to SDAS and remained involved with the service for over a year, attending a psychosocial group.

5.56 During the afternoon of 25th December 2020 Henrietta called the Police for help in removing Lee from her address, the DVPO having expired. She said that Lee had thrown items and water at her and spat at her. She did not feel able to support a prosecution and the Police took no further action. A standard risk DASH was completed. The Police LSU increased the DASH risk assessment to high and made referrals to SIDAS and MARAC. A VWCO spoke to Henrietta who 'refused all support services'. By visiting Henrietta's address, Lee was in breach of Court bail conditions imposed following the 16th of November 2020 incident (Paragraphs 5.48 and 5.49) but this was not dealt with by the officers who attended. This omission was noticed by an Inspector, but by that time Lee had attended Court for another incident which precluded further action for the breach of Court bail conditions. The Inspector set out further action to be taken to enable an evidence-led prosecution to be considered, highlighting the possibility of coercion and control, although a prosecution was unable to proceed.

5.57 On 30th December 2020 SIDAS received the Police referral in respect of Henrietta and phoned her the same day. She said that she wasn't able to talk and a call-back was arranged for 1st January 2021.

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5.58 SIDAS attempted to phone Henrietta on 1st and 4th January 2021. Henrietta answered the second call and SIDAS explained their service options to her. She said that she had moved (home), Lee was in custody, "everything was fine" and that she did not feel she needed SIDAS support.

5.59 On 6th January 2021 the third Covid-19 lockdown began.

5.60 On 18th January 2021 Abri made a new tenancy visit to Henrietta who reported no problems.

5.61 On 19th January 2021 Adult Social Care received the minutes of a recent MARAC meeting at which Henrietta had been discussed. Concerns were raised at MARAC about Henrietta not engaging with occupational therapy (OT) and it had been suggested that a multi-disciplinary team approach was needed to support Henrietta. In response Adult Social Care agreed that Henrietta would be allocated to

an OT and a plan agreed. When phoned by the OT, Henrietta declined an assessment as her new address had an accessible bathroom and she also had support from a 'friend'. The OT decided to review in two weeks' time. At that time (February 2021) Henrietta agreed to a referral to IRT (integrated rehabilitation team)²². A joint visit involving IRT and OT was envisaged due to the potential risk from Lee. However, in April 2021, following discussion between the OT and the Safeguarding Service Henrietta was closed to Adult Social Care as no further OT needs had been identified. The MARAC had also discussed the risk to Henrietta's tenancy if she allowed Lee access to her property.

5.62 On 26th January 2021 Henrietta was again heard at MARAC. There were no actions for SIDAS. MARAC was advised that the OT assessment 'had been completed' and that Henrietta did not want further intervention at that time. It is unclear whether the referral to the IRT was shared with MARAC.

5.63 On 3rd February 2021 the Abri CSO visited Henrietta to discuss a breach of her acceptable behaviour contract and the consequences of further breach discussed (Assumed to relate to allowing Lee to visit). There was no sign of Lee at property and Henrietta said that he did not visit regularly. The CSO discussed the support available to Henrietta, but she didn't feel able to accept support other than that she was receiving from the TAS (tenancy accredited service) which she said she contacted most days.

5.64 On 4th February 2021 Henrietta was seen by her new GP (GP practice 2) for an in-person consultation as she had requested a fit note²³. The GP noticed Henrietta had a history of excess alcohol consumption, and she reported she had been having fits. The GP discussed her alcohol use and Henrietta reported drinking only occasionally. A fit note was issued and a referral made regarding neuropathy²⁴ in her hands for nerve studies.

²² The Community Rehabilitation Service (CRS), formerly known as the IRT, is a county-wide service. It is available to all adults who are having problems carrying out everyday activities due to a medical condition. Service users will need to be motivated and willing to engage in therapy. CRS will aim to help people increase their level of independence by helping them regain or adapt their functional abilities to manage the impact of their condition. They will be supported to work towards improving their ability to do the things that matter most to them. This can be carried out within the service user's usual place of residence or other appropriate community settings. The team consists of Physiotherapists, Occupational Therapists, Pharmacy Technicians as well as Rehabilitation Assistants, Assistant Practitioners and Advanced Clinical Practitioner (ACP) development roles.

²³ Healthcare professionals issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

²⁴ The main types of peripheral neuropathy include:

- sensory neuropathy – damage to the nerves that carry messages of touch, temperature, pain and other sensations to the brain

5.65 On 9th February 2021 the Abri CSO phoned Henrietta who appeared angry about a number of issues following the move to her new address, which she said was “miles away from anyone”. She mentioned she had a ‘black eye’ due to a fall. Abri contacted the Police to request information on Henrietta’s eye injury and the incident on Christmas Day 2020 which Henrietta had shared with the CSO.

5.66 On 21st February 2021 Lee’s mother contacted his GP practice to report that her son had self-harmed by cutting. On this occasion she described Lee as a clinically depressed alcoholic who was in debt from gambling.

5.67 On 23rd February 2021 Lee received a conditional discharge for using threatening, abusive words or behaviour in respect of the 17th of September 2020 incident following which Lee was arrested for public order offences (Paragraph 5.32).

5.68 Also on 23rd February 2021 the IRT began a series of home visits to assess Henrietta’s equipment needs. She was issued with a shower stool and a walking stick set to the correct height. Henrietta was said to mobilise well with the walking stick, was taught bed exercises and supported to apply for a bus pass. She was discharged from the IRT service on 8th April 2021 following ‘no contact from patient’.

5.69 From 8th March 2021 a phased lifting of the restrictions introduced in the third Covid-19 lockdown began.

5.70 On 12th April 2021 the ambulance service conveyed Henrietta to Yeovil District Hospital after she lost consciousness and was woken by her ‘friend’ who had apparently phoned her. She had bitten her tongue, vomited, been incontinent of urine and said she felt like she had banged her head. En-route to the hospital, the crew noted that Henrietta had a 30 second seizure. Henrietta was treated at Yeovil District Hospital then discharged.

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- motor neuropathy – damage to the nerves that control movement
 - autonomic neuropathy – damage to the nerves that control involuntary bodily processes, such as digestion, bladder function and control of blood pressure
 - mononeuropathy – damage to a single nerve outside of the central nervous system

In many cases, someone with peripheral neuropathy may have more than one of these types of peripheral neuropathy at the same time. A combination of sensory and motor neuropathy is particularly common (sensorimotor polyneuropathy).

5.71 On 15th April 2021 Henrietta's GP phoned her to follow up on the above hospital attendance. The GP documented a 'difficult' consultation in which Henrietta repeatedly said that her GP was "doing nothing for her". The GP planned to refer Henrietta to neurology given that she had left the hospital prior to all treatment taking place. Later the same morning Henrietta phoned the GP practice to report that she was having a fit. The reception staff struggled to understand her as her speech appeared slurred. The GP advised reception staff to ring Henrietta back in 10 minutes and if they received no reply to ring 999. Reception staff managed to re-contact Henrietta and advised her to call an ambulance, but she said that she didn't want to go to hospital and she eventually ended the call.

5.72 On 26th April 2021 Somerset NHS Foundation Trust received the neurology clinic referral from Henrietta's GP and an appointment was offered at Musgrove Park Hospital in July 2021 which Henrietta did not attend.

5.73 On 10th May 2021 the ambulance service again conveyed Henrietta to Yeovil District Hospital after a witnessed seizure at home. Lee was documented to have found Henrietta rigid and half on and off the sofa. She had bitten her tongue. The crew noted a strong smell of alcohol and evidence of drug paraphernalia.

5.74 On 19th May 2021 the ambulance crew were called to Henrietta who had had a witnessed seizure outside a pub. The call had been made by a doorman who initially suspected that she was being held up/hugged against her will by her male partner, but it became apparent that she had suffered a short self-limiting fit. Henrietta was said to be upset that the crew were present and declined hospital attendance.

5.75 During the evening of 21st June 2021 the Police were called to a report of a disturbance at Henrietta's address. Officers attended and spoke to Lee and Henrietta separately. No offences were disclosed. An amber BRAG was completed which highlighted concerns for Henrietta as she lived alone and was frequently visited by Lee who was a 'MARAC perpetrator'. Henrietta was said to need support with mental health, drug and alcohol misuse and domestic abuse. The incident was recorded as a Safeguarding incident, and no further police action was taken. The Police LSU reviewed the incident and made no onward referrals as there are no current direct pathways into GP's or mental health services available to the LSU and as no offences were disclosed.

5.76 On 23rd June 2021 the ambulance service attended Henrietta's address after she had a seizure (Lee and his father were present). She had been incontinent of urine and said that she had not eaten that day (it was 5pm). The crew documented that Henrietta was clearly underweight and had multiple bruises on her wrists which

were not apparently explored further, possibly because Lee was present. Many cans and bottles of alcohol were noted to be strewn about. Henrietta declined hospital attendance and she was deemed to have capacity to make this decision. An email was sent to Henrietta's GP for follow up.

5.77 On 28th June 2021 her GP phoned Henrietta following the recent ambulance attendance to a reported seizure. The GP discussed the bruising noted by the ambulance crew and enquired about domestic abuse which Henrietta denied. Henrietta said that her "father-in-law was visiting".

5.78 On 1st July 2021 the Musgrove Park Hospital Neurology Department wrote to Henrietta's GP to advise that she had not attended a clinic appointment. On 14th September 2021 the GP practice re-referred Henrietta to neurology (this time at Yeovil District Hospital) but there is no indication that she attended this further appointment.

5.79 On 29th July 2021 Lee saw his Probation Officer. He said that he was living off pot noodles but was going to Henrietta's house that night for a 'hot meal'. He said that he saw her regularly and that she was still drinking to excess. He said that they argued regularly. He went on to say that she often experienced fits but didn't know they were happening and sustained bruising from falls.

5.80 On 17th August 2021 Henrietta did not attend an epilepsy clinic appointment at Yeovil District Hospital.

5.81 On 14th September 2021 Henrietta rang her GP practice to discuss her mental health and request a fit note. During the call Henrietta said that she continued to experience seizures but had stopped calling for help as no-one had been able to establish the cause of the seizures. The GP advised her that she should always call an ambulance for seizures. The GP re-referred her to Neurology at Yeovil District Hospital, and a text reminder was later sent to her advising her to book an in-person appointment. It appears that Henrietta discussed her difficulty in travelling to the Hospital.

5.82 On 16th September 2021 Lee saw his Probation Officer and said that he was still living with his parents but occasionally staying away or with Henrietta to "give them a break". He said that the Police had been called to his parent's address on 4 occasions over a 3-day period after neighbours had raised concerns about his parent's welfare. He said that shouting had been reported but that it was his father who had been shouting and not him. Lee said that he was "having problems" with

Henrietta, who phoned him twice during the appointment to allege that he had stolen £10 from her. The Probation Officer noted that Lee appeared to find this amusing, which 'wound up' Henrietta who 'shouted obscenities' at Lee.

5.83 Also on 16th September 2021 the ambulance service attended Henrietta's address following 999 calls from both Henrietta and Lee. She said that she had fallen due to her neuropathy and had also fallen the previous day resulting in a small laceration and bruise to her back. The crew documented a strong smell of alcohol and Henrietta said that she had drunk 3 cans of cider, but the crew were unsure whether this was accurate. She declined to attend hospital, saying Lee was coming over to be with her.

5.84 The following day (17th September 2021) her GP reviewed Henrietta during an in-person appointment consultation and advised her that she needed to be seen by a sexual health clinic. Henrietta became angry during the consultation, apparently because she doubted the GP's competence on the grounds that she (the GP) made few interventions and allowed Henrietta to speak. The GP practice later wrote to Henrietta to advise her about verbal abuse of GP practice staff.

5.85 On 21st September 2021 the ambulance service responded to a 999 call from Henrietta who thought she might have had a seizure whilst travelling on a bus. She was found behind a tree having alighted from the bus. She appeared alert. She had bruising to her arms which she said had been caused by falling. A strong smell of alcohol was noted, and she was asked about her alcohol intake which she said was limited to a couple of drinks whilst watching TV. She was advised of the dangers of rapid withdrawal from alcohol. She declined hospital attendance and was collected by Lee. The ambulance service record of the call-out was shared with her GP to request a review, which was said to be the pathway through which Henrietta would be able to access support for drug and alcohol use. Henrietta's GP practice received the ambulance service call-out record, but it is not known what action the GP practice may have taken in response.

5.86 During the late evening of 25th October 2021, the Police attended Henrietta's address following reports of an argument between Henrietta and Lee. Henrietta disclosed that during an argument Lee had wound a phone charging cable around her neck and held it there. He then removed it from her neck and tied it around her wrists. Lee had left the property prior to police arrival. Lee was imprisoned for unrelated offences for 4 weeks (Lee was sentenced to 4 weeks custody for driving matters including Aggravated Vehicle Taking (of his parents' vehicle) and driving whilst under the influence of drugs on 2nd November 2021 and was released on licence on 15th November 2021. He was subject to Probation Supervision under Licence until 29th November 2021 and then Post Sentence Supervision (PSS) until

15th November 2022) during which the Police attempted to encourage Henrietta to make a statement, which she subsequently did, although she later retracted it. Lee was interviewed and denied the offence. The Police submitted a file to the CPS for a charging decision. CPS later advised that there was insufficient evidence to proceed. This incident occurred prior to the introduction of the specific offence of non-fatal strangulation on 7th June 2022, although it is assumed that other offences were considered. A high-risk DASH was completed and the Police LSU made referrals to MARAC and SIDAS. No safeguarding referral was said to have been required as there were no children involved and no adults with care and support needs 'that are suitable for Adult Social Care'.

5.87 On 28th October 2021 Henrietta called Abri customer services. She was distressed about the 25th of October 2021 incident which was documented to involve Lee visiting her property and banging on the doors and windows. When she opened the door she said that Lee strangled her. Lee then left and Henrietta went to a neighbour to ring the Police. She said that she would be 'pressing charges' She asked for a security chain and lock on her front door. The Abri CSO made several phone calls to Henrietta to arrange a home visit without receiving a reply. There was no facility to leave a voice mail. On 23rd November 2021 Henrietta called back and said that she was 'OK' and that there had been no further incidents.

5.88 On 26th of October 2021 SIDAS received a Police referral in respect of Henrietta who felt unable to accept support when contacted.

5.89 On 4th November 2021 SIDAS received an email from the Police LSU advising that Henrietta would like to take up the offer of support. When SIDAS rang Henrietta the following day she said that she had had a long chat with her neighbour who had encouraged her to accept support. SIDAS explained support options. Henrietta advised that Lee was in prison, but only for 2 weeks and she was worried about what would happen when he was released. A call back from an IDVA was arranged but attempts at further phone contact was unsuccessful.

5.90 On 24th November 2021 Henrietta was heard at MARAC. There were no actions for SIDAS who closed the referral in respect of Henrietta on 4th December 2021 due to 'non-engagement'.

5.91 On 26th November 2021 the ambulance service attended to Henrietta after a further seizure whilst waiting for a bus. She had been helped by members of the public to a nearby pharmacy where she had a further seizure. She declined hospital attendance. Lee had arrived and Henrietta was advised to stay with him for 24 hours and contact her GP. SWAST shared their report of the incident with her GP to

request a review. There is no record of Henrietta's GP receiving the ambulance service report.

5.92 On 22nd December 2021 Henrietta saw her GP about a large bruise on her shin which she disclosed had been caused by a kick although she did not wish to divulge who was responsible. Henrietta was accompanied by a female friend and she (Henrietta) smelled strongly of alcohol. The GP advised Henrietta to ring 999 if she felt threatened.

5.93 On 29th December 2021 SDAS closed Lee's case after he declined further support, stating that he had achieved his goal by reducing his cocaine use to a level he was comfortable with.

5.94 During the evening of 30th December 2021 the Police attended Henrietta's address after a call from a third party reporting a disturbance. Henrietta expressed surprise at seeing the Police and did not wish to report any offences. Henrietta disclosed that Lee had visited her address, banged on the door and shouted her name but she had not answered the door. Officers checked that Lee was not present and advised Henrietta to call the Police should Lee make an unwanted visit to her address. No DASH was completed but a Sergeant decided that the incident should be graded as a medium risk in view of previous incidents. No referrals were considered to be justified.

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5.95 On 10th January 2022 Lee called police to report that his 'wife' Henrietta had punched him in the face. Officers attended and spoke to both separately. Neither party reported any offences. Lee did not feel able to assist in the completion of a DASH and so it was completed by the officer based on their observations and the domestic abuse history. (Medium risk). A (green) BRAG was completed which documented Lee's mental health struggles and noted that he said that he would like support with depression. The Police LSU made no referrals as they have no direct pathway to GP or mental health services.

5.96 On 12th January 2022 Henrietta called the Police to disclose that Lee had obtained her PIN number and withdrawn money from her account without her permission. Henrietta advised officers she didn't want to make a formal complaint but would like the matter logged to enable her to report it to the bank. A (green) BRAG was completed which highlighted Henrietta's 'disabilities' and alcohol use. The BRAG also noted that Henrietta's life was 'quite chaotic' and that it was thought that

Lee took advantage of this. She was referred to Vulnerable Victims of Fraud²⁵ who contacted Henrietta and gave her advice on preventing any future frauds in the form of information through the post with contact details should she require them in the future. The Police LSU made a safeguarding referral to Adult Social Care and a referral to SIDAS.

5.97 During the morning of 18th January 2022 the Police received an abandoned 999 call from Henrietta's address in which a male and female could be heard arguing about money. The Police call handler rang back and spoke to Henrietta who stated that the Police were no longer required as Lee had given back the money, he had taken from her. The call handler requested officers attend to check on Henrietta's welfare. Officers attended and Henrietta disclosed that Lee had stolen £60 in cash from her and withdrawn funds from her bank account using her debit card. She went on to disclose that during an argument over the money Lee had hit her on the jaw. There were no signs of injury. A high-risk DASH was completed. The officer noted Henrietta's vulnerabilities due to mobility issues and suspected alcohol dependency. Henrietta also disclosed that Lee isolated her from friends and sabotaged her relationships, meaning that she only had him to rely upon. She disclosed that he had threatened to kill her and others previously. The Police LSU made referrals to Adult Social Care, SIDAS and MARAC. The Police began an investigation, but Henrietta felt unable to continue to support a prosecution and so no further action was taken due to insufficient evidence.

5.98 On 19th January 2022 Adult Social Care considered the Police referral arising from the 18th of January 2022. (Please note that Adult Social Care received the Police referral in relation to the 18th of January 2022 incident prior to receiving the Police referral in relation to the 12th January 2022 incident). The Police referral was sent to Adult Social Care Safeguarding for a 'screening decision' which was made within a day of receipt. Safeguarding phoned Henrietta and discussed her safety, the risks she faced and her mental capacity. It was decided that no safeguarding enquiry was necessary as Henrietta had taken steps to protect herself. At that time she said that she had contacted Abri to have her locks changed (although there is no record of the locks being changed) and had contacted her bank. It was not recorded whether she had been offered a Section 9 Care Act assessment.

²⁵ This is believed to be Action Fraud which aims to ensure that victims of fraud have a central place to go to in order to report crime and get advice and support. An enhanced service is available to vulnerable victims who are classed as:

- Anyone under the age of 17 at the time of the offence.
- Anyone who is suffering from a mental disorder within the meaning of the Mental Health Act 1983.
- Those with a significant impairment of intelligence and social functioning.
- Those with a physical disability or who suffer from a mental disorder.

5.99 On 19th January 2022 SIDAS received a Police referral in respect of Henrietta and spoke to her on the phone two days later. She said that she had mobility issues and was worried about physical abuse from Lee. She said that she had made a statement to the Police and had had helpful contact with the Bank. SIDAS were unable to further engage with Henrietta following this call.

5.100 On 21st January 2022 the Probation Service made a safeguarding referral to Adult Social Care in relation to concerns about Lee's behaviour towards his parents. During a phone call to Lee's parents to discuss a referral to supported housing for people with complex mental health needs for Lee, his Probation Officer heard Lee in the background shouting, swearing and demanding money from his parents. His mother could be heard trying to calm him down, but Lee grew increasingly aggressive and said that he was going to get alcohol and would "get off [his] face". Lee's father added that 3-4 days previously, his son had "got drunk" and overdosed and was admitted to hospital. His parents had hoped that Lee might be admitted to hospital under the Mental Health Act at that time, but this had not happened. Lee had since threatened to take his own life by lying on train tracks.

5.101 On 25th January 2022 Adult Social Care considered the Police referral in respect of the 12th January 2022 incident. The referral stated that Henrietta was a 'self-confessed alcoholic' and as a result was unable to make clear decisions and lived a 'quite chaotic lifestyle' which Lee was said to 'clearly' take advantage of. The referral went on to state that Henrietta may not feel safe in her own property and may not have the confidence to tell Lee that she did not want him in her property. As Henrietta had recently been spoken to by Adult Social Care safeguarding (in relation to the later 18th January 2022 incident) it was decided to treat this Police referral as 'for information only'.

5.102 Also on 25th January 2022 Adult Social care informed the Probation Service that they would be carrying out a non-statutory safeguarding enquiry in response to the 21st January 2022 safeguarding referral (Paragraph 5.100) given that Lee's parents did not have care and support needs. Adult Social Care recommended that the Probation Service arrange a strategy meeting, devise a safety plan and refer Lee to MARAC and Multi-Agency Public Protection Arrangements (MAPPA)²⁶. Probation decided not to refer Lee to MARAC as there had been a recent MARAC 'in relation to issues with a former partner' (assumed to be Henrietta) at which issues in relation to Lee's parents were also raised.

²⁶ Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders. This guidance sets out the responsibilities of the police, probation trusts and prison service. Other partner agencies may also become involved.

5.103 On 28th January 2022 Lee advised his Probation Officer that he was currently staying with Henrietta and that the requirement in her lease that he should not stay in her property had expired. (There is no indication that the Probation Officer verified this information with Abri. Henrietta signed the acceptable behaviour contract on 2nd December 2020. Acceptable behaviour contracts normally last for 6 months (1). When he spoke to his Probation Officer on 11th February 2022, he said that he had been staying with Henrietta for the past two weeks and had only returned to his parent's house the night before.

5.104 On 18th February 2022 Henrietta was heard at MARAC. There were no actions for SIDAS who closed the referral in respect of Henrietta. The MARAC chair was not available and so each agency was tasked with reviewing the information and identifying perceived risk and safety factors.

5.105 During the evening on 19th February 2022 the Police were called by a third party who reported arguing and screaming coming from Henrietta's address. Officers attended and found the property in complete darkness and were unable to obtain any answer. Enquiries with a neighbour established that there had been a power cut and that Henrietta was thought to be inside her property and Lee had been seen to leave. Officers later re-attended and spoke to Henrietta and no offences were disclosed. A medium risk DASH was completed and a referral made to SIDAS.

5.106 On 24th February 2022 Lee informed his Probation Officer that he was 'sofa surfing' between Henrietta's home and that of his parents. He said that his relationship with Henrietta was "going better".

5.107 On 2nd March 2022 the Abri CSO visited Henrietta's address after complaints from neighbours about noise nuisance. No reply was received and so Abri contacted the Police to request a welfare check. The following day the Police visited Henrietta who stated, "everything was fine". Lee was in the property. Officers were concerned about Lee's presence due to previous domestic abuse incidents. Lee was removed from the property and taken to his parent's house. Henrietta told officers she wasn't happy about this action as she needed Lee to support her. A medium risk DASH was completed on the basis of officer observations. The Police documented that Henrietta was 'physically vulnerable' and needed Lee for support. No referrals were made by the Police LSU.

5.108 During the late evening of 16th March 2022 Henrietta called the Police to report a verbal argument with Lee, who was no longer at her address as he had been

collected by his parents. Officers did not attend and Henrietta was advised to ring 999 if Lee returned.

5.109 During the evening on 21st March 2022 Henrietta called the Police to report that her partner Lee was shouting at her. Upon police attendance officers spoke to both parties and no offences were disclosed. Officers took Lee to his parent's address to defuse the situation. The attending officer noted concerns for Henrietta as she did not appear to be in good health, had a 'severe alcohol addiction' and suffered with seizures. A medium risk DASH was completed which noted Henrietta's continued dependence on Lee because of her health needs and an amber BRAG was completed which highlighted Henrietta's support needs in relation to diet, alcohol issues and domestic abuse. The Police LSU made no referrals.

5.110 Also on 21st March 2022 Lee advised his Probation Officer that his father was angry that the Police had visited his parent's address to locate him. He said he thought the Police may have been enquiring into an incident in which it was alleged that he had stolen £60 from Henrietta and "slapped" her (See Paragraph 5.72). Lee said that he was in a new intimate relationship. His Probation Officer discussed his previous relationships and how these had ended, 'partly because of his controlling, suspicious and abusive behaviours towards his partners'. Lee said that he was going to be different this time.

5.111 SIDAS was informed by the Police that there had been a further medium risk incident involving Henrietta. When SIDAS queried whether the Police were making a referral, they were advised that the Police contact with SIDAS was to make them aware. SIDAS took no further action.

5.112 On 23rd March 2022 the ambulance service attended Henrietta's address after she fell and fractured her left femur followed by a seizure of around a minute. She said that she had been celebrating having a new carpet and had been drinking vodka, cider and smoking cannabis. She was conveyed to Yeovil District Hospital. Prior to the ambulance service arriving a 'friend' of Henrietta's rang her GP practice to report that she had had a seizure and fallen, and the 'friend' thought that she had broken her leg. The 'friend' asked if the GP might attend as the ambulance service had advised a 4–5-hour response time. The GP practice advised the 'friend' to re-contact the ambulance service and say that Henrietta was in severe pain. (SWAST has advised the DHR that they received the call at 1.15pm, dispatched an ambulance at 2.24pm which arrived on scene at 2.30pm.

5.113 Yeovil District Hospital noted that Henrietta looked underweight, with epilepsy (Henrietta's seizures were under investigation and so epilepsy had not been

diagnosed) which was not well controlled, experiencing frequent falls arising from peripheral neuropathy/amputation of her toes, increased care needs arising from her fractured hip and surgical wound, decreased mobility and reluctance to engage with services. During her admission she was visited on a number of occasions by the substance misuse nurse but did not accept she had any substance use problems.

5.114 The Abri CSO visited whilst the ambulance service was attending to Henrietta and documented that Lee was heard to say that he had been behind Henrietta when she fell awkwardly. The CSO rang Yeovil District Hospital and spoke to the safeguarding lead to express concern about Henrietta returning to the property without support from anyone but Lee. When the Yeovil District Hospital Domestic Abuse co-ordinator spoke to Henrietta in response to the Abri concerns, Henrietta denied domestic abuse and did not wish to be referred for domestic abuse related support.

5.115 On 25th March 2022 Lee's parents contacted Adult Social Care to request an assessment to support him to live independently. Lee was said to be residing with his parents at that time, and they expressed concern that Lee was unable to manage his finances and that they were in debt themselves as a result of this. After clarifying Lee's diagnoses – which were documented to be ADHD, dyslexia, dyspraxia, emotional personality disorder, borderline schizophrenia and PTSD – it was decided that the mental health team should carry out a Care Act assessment of Lee.

5.117 On 28th March 2022 SIDAS was informed by the Police that there had been a further medium risk incident involving Henrietta. When SIDAS queried whether the Police were making a referral, they were advised that the Police contact with SIDAS was to make them aware. SIDAS took no further action.

5.118 On 29th March 2022 Yeovil District Hospital contacted Adult Social Care to request a DoLS (Deprivation of Liberty Safeguards)²⁷ assessment in respect of Henrietta, who they advised had been admitted following a fractured neck of femur. She also had electrolyte imbalance²⁸ and seizures secondary to alcohol withdrawal.

²⁷ There are 2 types of DoLS authorisations: urgent and standard. Urgent DoLS authorisations can last up to 7 days and are initially granted by the hospital or care home where the person is being cared for, known as the 'managing authority'. If needed, urgent authorisations can be extended for a further 7 days. This type of authorisation can be used if a person urgently needs to be deprived of their liberty before they have had a full assessment.

In all other circumstances, the managing authority should request a standard authorisation. The relevant local authority then has 21 days to carry out assessments to ensure that the deprivation of liberty is appropriate. Standard authorisations should be reviewed regularly and can last up to 12 months.

²⁸ Electrolytes are salts and minerals, such as sodium, potassium, chloride and bicarbonate, which are found in the blood. They can conduct electrical impulses in the body. Treatment for an electrolyte imbalance will depend on which electrolyte is out of balance and by how much. For example, if the

The DoLS was requested as she was trying to leave the hospital whilst continuing to experience seizures. The DoLS request stated that Henrietta had a history of safeguarding concerns relating to domestic abuse and was at high risk of self-harm.

The DoLS request was withdrawn on 1st April 2022 as it was no longer required. It is not clear why the DoLS assessment was no longer required but it is known that Henrietta self-discharged from hospital. Yeovil District Hospital patient records do not provide clarity over any concerns about Henrietta's decision-making capacity regarding discharge and if any capacity assessment was undertaken regarding potential risks arising from self-discharge.

5.119 On 31st March 2022 Lee saw his Probation Officer and informed her that Henrietta had fallen over and broken her hip and she was due to be discharged from hospital that day. He said that he had been staying at her house and intended to remain there to help her recuperate. He said that their relationship had improved, but should the situation deteriorate he would contact 'social services' and return to his parents.

5.120 On 11th April 2022 Henrietta called the Police stating that Lee had refused to leave her address, had thrown items at her and spat at her. Whilst making the call, Henrietta advised the call handler that Lee had now left the property. Upon police attendance Henrietta refused officers entry to her property and did not wish to engage further with them. A medium risk DASH and an (amber) BRAG were completed. It appears that the Police did not become aware of Henrietta's hip fracture during this visit.

5.121 On 21st April 2022 Lee did not attend an in-person appointment with his Probation Officer who later spoke to Lee by phone. He apologised and explained that he had been "having problems" with Henrietta who he said had returned to drinking vodka 'to excess' since leaving hospital and this had affected their relationship. He said that she frequently called the Police for "trivial things" and had "claimed" that he had shouted at her, spat at her and taken away her stroller. Lee added that the Police had "wised up" to her "claims" and he thought that all their investigations had been closed. Lee went on to say that Henrietta liked to control him and regularly insulted him for being homeless. On 28th April 2022 Lee attended an in-person appointment with his Probation Officer smelling strongly of alcohol but not intoxicated. He said that he was still living at Henrietta's address. He said that she was still recovering from her operation and that further problems had arisen between them which mainly concerned money exacerbated by her drinking. Lee's

patient has a sodium imbalance they may be advised to lower their salt intake (if sodium is too high) or reduce their fluid intake (if sodium is too low)

involvement with 'County Lines'²⁹ was discussed and he said that he occasionally heard from a member of the 'gang'.

5.122 Henrietta's GP practice wrote to her regarding abnormal liver function and excessive alcohol use after bloods were taken on 25th April 2022.

5.123 On 13th May 2022 the Probation Service advised a Second Step³⁰ worker that Lee was on no fixed abode but tended to reside with Henrietta, who was described as his ex-partner. The Probation Officer advised that Lee could be quite gullible sometimes and mentioned that Lee looked after Henrietta and did a lot for her.

5.124 On 17th May 2022 the Care Act assessment of Lee was completed, the outcome of which was that Lee had support needs which were not Care Act eligible, and which could be met by other voluntary or community organisations. The professional who carried out the assessment remained involved with Lee in order to refer him to appropriate services including housing. Lee accepted the offer of a tenancy in Yeovil on 23rd June 2022. However, concerns remained in respect of Lee's gambling, drug and alcohol addictions and offending behaviours.

5.125 During the late evening of 10th June 2022 Henrietta called police stating that Lee was refusing to leave her address. Upon police attendance Lee had left and Henrietta did not disclose any offences. Henrietta advised officers that she had recently had surgery on her hip and had limited mobility and was using walking aids to mobilise. A medium risk DASH was completed based on officer observations and a (green) BRAG which highlighted concerns for Henrietta's mental health and her mobility issues. The Police LSU made no referrals as Henrietta was not identified as being a victim of a serious crime, vulnerable, intimidated or persistently targeted as defined by the Code of Practice for Victims of Crime (VCOP)³¹ 2015.

²⁹ County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs.

³⁰ Second Step provides mental health and support. Services include supported housing, men's mental health, support in the community, NHS services and a range of wellbeing courses and therapies.

³¹ A statutory code of practice issued by the Secretary of State for Justice, the code establishes minimum standards on the rights, support and protection of victims of crime. Its objective is to make sure that the criminal justice system puts victims first, therefore making the system more responsive to them and easier to navigate. It also aims to make sure that victims of crime are treated well and receive appropriate support to help them cope and recover, and to protect them from becoming victims again

5.126 On 9th June 2022 (1 day earlier than the date the Police recorded for incident) SIDAS received a Police referral in respect of Henrietta. As the risk was assessed as standard and as Henrietta's consent had not been obtained, SIDAS was unable to offer support. SIDAS explained the position to the Police LSU.

5.127 On 15th June 2022 Lee saw his Probation Officer for an in-person appointment. Lee said that he still loved Henrietta and felt responsible for looking after her as they had been in each other's lives for such a long period of time, which is why he said he felt as though he could not leave her. Lee was said to reside at Henrietta's address the majority of the time as he was of 'no fixed abode'. The conversation was mainly directed at how his drug misuse and his relationship with Henrietta were factors holding Lee back from moving forward and finding accommodation.

5.128 During the morning of 17th June 2022 Henrietta called the Police to report a domestic abuse incident with Lee. Officers attended and spoke to Henrietta and Lee separately. Henrietta said that Lee attended her address uninvited and became aggressive following an argument, using a knife to stab furniture and various items, causing damage. Bruising was noted to Henrietta which she did not explain. Lee said that the bruising had been caused by Henrietta falling. He acknowledged that they had been arguing but said that this had been verbal. Lee was arrested for assault and criminal damage and conveyed to custody. Henrietta did not feel able to complete a DASH and so it was completed based on officer observations. The officer assessed the risk as medium and highlighted Henrietta's physical vulnerability and limited mobility but did not feel that further support was required. The Police LSU referred Henrietta to SIDAS and MARAC.

5.129 The Police considered an evidence-led prosecution but concluded that there was insufficient evidence as Henrietta also stated that the bruising had been caused by her fall and the damage had been caused to a table Lee had purchased for Henrietta and at the time he stabbed the table he was upset due to a friend having a heart attack.

5.130 On 22nd June 2022 SIDAS received a referral for IDVA support and MARAC in respect of Henrietta. SIDAS requested a fully completed DASH in order to be able to process the referral as no risk level had been identified. On 22nd July 2022 the Police LSU replied that a DASH had been completed using only the officer's observations. SIDAS reiterated that without a fully completed DASH they could not process the referral. However, SIDAS had listed Henrietta to be heard at MARAC.

5.131 On 23rd June 2022 the Abri CSO visited Henrietta following 'issues' raised by neighbours. Henrietta was said to have initially denied that Lee was causing any issues for her or her neighbours. She eventually disclosed that Lee abused her physically and financially, used crack cocaine and had a problem with alcohol. She was reminded of the support available to her. The Abri CSO made referrals to Adult Social Care and the Abri Financial Responsibility Team (FRT) for help with her PIP application. Henrietta felt unable to accept referrals in respect of mental health or alcohol use.

5.132 Also on 23rd June 2022 Lee's Probation Officer and professionals from partner agencies who were working together to assist Lee to obtain a tenancy, spoke to him about the current situation in respect of Henrietta, in particular what could be put in place to stop or reduce contact with her. Lee was said to be aware that police callouts were not helping his chances of being offered accommodation. Lee described feeling guilty if he did not look after Henrietta or stay with her but was said to be quite avoidant in terms of why he stayed at her address when this has caused police call outs/arguments to occur.

5.133 On 29th June 2022 Adult Social Care considered the referral from Abri which highlighted Henrietta's recent hip surgery and her dependence on Lee for care including being unable to make a drink for herself or carry a drink whilst using her walking frame. The referral also covered the history of financial and domestic abuse by Lee and Henrietta's isolation from anyone else but him. Henrietta was said to now realise that she needed help with tasks related to her personal care and had therefore agreed to the referral to Adult Social Care. The referral also highlighted Henrietta's alcohol dependence and that she would not be able to speak openly if Lee was present and so she may ask for a call back. The referral was sent to the Adult Social Care community team as high priority for a Care Act assessment but a further referral was received from the Police shortly thereafter and so the Abri referral was not responded to and closed using the information gathered by Adult Social Care safeguarding following the Police referral.

5.134 During the evening of 1st July 2022 Henrietta called the Police to report a domestic abuse incident involving Lee, saying that she needed assistance as Lee was throwing things at her head. When officers attended, neither Henrietta nor Lee wished to make a complaint and said that they had had a verbal argument over money and what to watch on TV. Lee was taken home 'to defuse the situation'. A medium risk DASH risk assessment was completed on the basis of officer observations. An (amber) BRAG was completed which noted that Lee needed support around his mental health issues which were being exacerbated by the pressures of caring for Henrietta. Henrietta was said to need support in moving around her home due to mobility issues and there was currently no care package in place for her. The Police LSU made a referral to Adult Social Care.

5.135 On 4th July 2022 Adult Social Care considered the Police referral relating to the 1st July 2022 incident which stated that Lee had poor mental health and felt like he needed to care for Henrietta, but that this was not helping his situation. The referral also highlighted Henrietta's physical disabilities and suggested that without Lee, she may require a package of care. This contact was sent to the Adult Social Care Community triage as they already had an open referral from Abri. A community triage social worker phoned Henrietta and she responded by saying she was busy and that everything was "OK". The community triage worker then sent the referral to Adult Social Care Safeguarding as she was unsure whether everything was "OK" for Henrietta and asked them to investigate further. On 7th July 2022 the community triage worker sent the Abri referral to Adult Social Care Safeguarding, but they advised that they would triage the Police referral, indicating that the core conversation regarding the Abri referral was to remain with the community team for response. On 11th July 2022 Adult Social Care Safeguarding phoned Henrietta, after which the decision was taken to close the Police referral as Henrietta had advised that the issues were resolved and that she was "OK now", and there was said to be no reason to doubt Henrietta's capacity to decide whether or not to accept Adult Social Care assessment/support. When the community triage worker (who continued to hold the Abri referral) contacted Safeguarding a further 9 days later to ask if Henrietta's case could be closed, the latter service replied that it was for community triage to make that decision. The community triage then closed the Abri referral using the information and decision made by Safeguarding.

5.136 On 11th July 2022 SIDAS received an email from Adult Social Care advising that Henrietta had 'declined safeguarding support' but had the SIDAS telephone number to ring if she wanted help.

5.137 On 12th July 2022 Lee had an in-person meeting with his Probation Officer who discussed the 1st July 2022 incident (Paragraph 5.131) with him. Lee said they had a verbal argument about Lee doing so much for her and that calling the Police was unnecessary. Lee's move into a property in Yeovil was discussed. He said he planned on continuing to visit Henrietta after his new tenancy began because he did not know how Henrietta would cope without him being there. He was said to understand that staying over at Henrietta's address was not a good idea. Lee said that there was the potential for Henrietta to receive help from Adult Social Care. The Probation Officer reiterated the importance of Lee focussing on himself and spending less time with Henrietta.

5.138 On 25th July 2022 Henrietta phoned her GP to advise that she had had two falls since her hip operation, and she was worried that she had done more damage. She was referred for an urgent X-ray, although the referral may not have been sent until 15th August 2022 (see Paragraph 5.142).

5.139 On or around 21st July 2022 (precise date not known) Henrietta was heard at MARAC and SIDAS was requested to write to Henrietta advising her that she had been discussed at MARAC and explaining what this meant. SIDAS wrote to Henrietta on 2nd August 2022 enclosing a leaflet which provided information about SIDAS including how to access the service. MARAC was advised that Adult Social Care intended to complete an assessment of Henrietta's care and support needs. (Adult Social Care closed the referrals from Abri and the Police around 20th July 2022).

5.140 On 4th August 2022 the Abri CSO phoned Henrietta and she said that she was working with the FRT on finances and PIP. She said that she had had a couple of falls and was due to have a full body scan the following week. The CSO documented that Henrietta appeared to only be prepared to accept help from Lee.

5.141 On 4th August 2022 Lee had an in-person meeting with his Probation Officer. Lee had seen Henrietta 2 days earlier but said that he did not stay over. He reported that Henrietta had been finding it difficult without Lee's support. The Probation Officer emphasised the need for Lee to focus on himself as he was struggling.

5.142 On 15th August 2022 the GP practice urgently referred Henrietta to the fracture clinic due to a periprosthetic fracture³². Following an X-ray, Henrietta was admitted to Yeovil District Hospital. She was noted to have fallen in June 2022 and further fractured her hip (The Yeovil District Hospital date for admission is 12th August 2022).

5.143 On 14th August 2022 the community rehabilitation service (CRS) wrote to Henrietta requesting her to contact them after experiencing difficulty in contacting her by phone. The CRS discharged Henrietta from their care after receiving no response to the letter. It is unclear whether Henrietta's GP was informed although the GP practice later advised Henrietta how to self-refer to the CRS (Paragraph 5.154).

5.144 During the evening of 25th August 2022 Henrietta called the Police to report that Lee was at her address intoxicated and losing his temper. Officers attended and Henrietta advised that she did not want to report any offences, but she just wanted Lee to leave. Officers took Lee to his home address to defuse the situation. A standard risk DASH was completed on the basis of officer observations. The Police LSU referred Henrietta to SIDAS.

³² A periprosthetic fracture is a broken bone that occurs around or near an orthopaedic implant.

5.145 On 1st September 2022 SIDAS received a Police report in relation to Henrietta which was for information only.

5.146 On 5th September 2022 Lee attended an in-person meeting with his Probation Officer during which he said that had been seeing Henrietta 2 or 3 times a week. He said that she had been “in a mood” recently and so he had been hesitant about going to see her. Lee said that there had been a Police call-out 2 weeks earlier after Henrietta phoned the Police because Lee “was being anti-social by being on his phone”. Lee said he received a lift home from the Police. The Probation Officer reminded Lee to prioritise himself and his own needs and to think before visiting Henrietta considering the potential consequences.

5.147 On 26th September 2022 Lee had an in-person meeting with his Probation Officer during which he said that Henrietta was “grumpy” because Lee owed her £20. He said that he felt better now that he was able to go somewhere else due to having his own flat.

5.148 During the early morning of 2nd October 2022 the Police attended Lee’s address following a third-party report of a domestic abuse incident. Verbal threats had been heard. Henrietta was removed from the address and taken home in order to safeguard her. Officers noted that Henrietta appeared frail after suffering a broken hip. A medium risk DASH was completed which documented that Henrietta feared that Lee would hurt her when he was loud and aggressive in mood. His issues with drugs, alcohol and mental health were also noted, an (amber) BRAG was also completed which highlighted the vulnerabilities of both Henrietta and Lee. The Police LSU noted that both parties had been discussed at MARAC in the past 12 months and notified SIDAS.

5.149 On 5th October 2022 SIDAS received the Police referral in respect of Henrietta, which wasn’t intended to go to MARAC. SIDAS phoned Henrietta 2 days later and she said that she was unhappy that she had been referred by the Police, that she and her partner were not involved in the incident and ended the call. SIDAS had no further contact with Henrietta after that date.

5.150 On 12th October 2022 Lee had a telephone appointment with his Probation Officer. It was documented that he wanted to talk about a recent Police call-out which he said had occurred after Henrietta and two friends went to Lee’s flat to stay and Henrietta “kicked off” at one of Lee’s friends. Lee said that the Police attended and said that Lee had threatened to hit Henrietta. He added that both he and Henrietta denied any verbal or physical arguments had occurred. Lee said that he had tried to make a complaint against the Police as he described them as “bullies”.

The Probation Officer asked Lee if there had been any issues with borrowing money from Henrietta or his parents. Lee said there hadn't, adding that he and Henrietta often lent each other money and that previous arguments around this had been resolved. Lee mentioned that he had missed a call from a drugs worker because he had been helping Henrietta after a fall. The Probation Officer explored Lee prioritising himself and his own needs.

5.151 On 18th October 2022 Lee's case was closed by the mental health team which had assessed his care and support needs in May 2022. Lee was said to be engaging well with support.

5.152 On 2nd November 2022 Lee attended his final Probation appointment. When the conversation turned to 'relationships', Lee expressed concern about Henrietta showing signs of dementia as she had begun to forget things. He said that he was worried that she was "going to go soon". He said that he planned to assist her to make a fresh application for PIP. The Probation Officer and Lee discussed achieving a balance between helping Henrietta and ensuring that his own wellbeing did not suffer as a result.

5.153 On 7th November 2022 Henrietta called Abri customer services to report that a heater was not working, Henrietta cancelled a booked repair on 23rd November as she had had a fall, and it was rearranged for 1st December 2022. The contractor attended on 1st December 2022 to investigate the repair and follow up works were booked for 12th December 2022 and these were completed. It is assumed that the contractor did not feel there were any cause for concern when he/she visited Henrietta on 1st December 2022. On 12th December 2022 Henrietta would have been staying with Lee.

5.154 On 18th November 2022 her GP Practice sent Henrietta a text message with details of how to refer herself to community rehabilitation services.

5.155 On Wednesday 7th December 2022 Lee's mother contacted the mental health team to express concern that her son was not receiving the support he needed. When the contact was triaged on Friday 9th December 2022, Lee's mother's concerns were documented to relate to Lee's finances, heating in his property, people breaking into the property for food and money, Lee's reluctance to report the incident to the Police for fear of retaliation and a friend in poor health (assumed to be Henrietta) living with Lee, thus increasing the pressure on him. It appears that the contact from Lee's mother was finalised on 6th January 2023 with the provision of advice and information to her (Lee's mother). Reallocation of Lee's case to a social worker was considered but not actioned.

5.156 On Friday 9th December 2022 Henrietta's GP Practice was phoned by her 'friend' (assumed to be Lee) reporting signs of acute liver failure. The friend was advised to call paramedics. The GP Practice noted that Henrietta was currently living out of the GP Practice area and would need to register with a GP Practice in that area.

5.157 Later the same day (Friday 9th December 2022) Lee called the ambulance service via the 999 system to try and obtain help for Henrietta who he was looking after in his home. He said that he had rung SWAST in desperation after contacting Henrietta's GP, Social Care and Henrietta's family. He said that Henrietta had been asleep for most of the day, but she was easily roused by the ambulance crew. She agreed that she would likely die if left in this condition but said that she did not wish to go to hospital and was not able to accept any assessment. She appeared angry that Lee had called the ambulance service and said she just wanted to be left alone. Lee said that he continued to purchase alcohol for Henrietta as she experienced seizures if she didn't drink it. The crew explained to Lee that as they considered Henrietta to have capacity, they could not force her to accept their help. Henrietta was advised that she could call SWAST back at any time if she changed her mind and Lee was advised to call SWAST back if she became confused, unconscious, or seemed to lack capacity. A safeguarding referral was submitted for self-neglect. The safeguarding referral was sent to Henrietta's GP and Adult Social Care on Monday 12th December 2022.

5.158 Henrietta's family have advised the DHR that on the evening of Friday 9th December 2022 Lee rang Henrietta's father and told him that Henrietta was dying, that she was at his flat and that he couldn't care for her anymore as it was too much for him. Henrietta's parents and sister visited Henrietta at Lee's flat which they described as 'really squalid'. They have advised the DHR that Henrietta asked them to get her out of Lee's flat and so they decided to try and move her back to her home and obtain support for her there. The family said that they began contacting 'social services' on the morning of Saturday 10th December 2022 to try and arrange for support to be put in place at Henrietta's home but they said that they were unable to obtain any support for Henrietta despite making further phone calls to 'social services' on the Sunday, Monday and the morning of Tuesday 13th December 2022. Adult Social Care have advised the DHR that they have no record of contacts from the family on 10th or 11th December 2022 and that the first recorded contact from the family was on 12th December 2022.

5.159 During the afternoon of Sunday 11th December 2022 the Police were called by Lee's neighbour who said that Lee had threatened to stab him and appeared to have "lost the plot". Officers attended and spoke to Lee who said that he was looking after Henrietta who was dying and was bed bound on the sofa. Officers observed that

Henrietta appeared skeletal and was wearing adult nappies and could not move to go to the toilet. The flat appeared chaotic and covered in detritus including broken glass, broken pieces of furniture and other items. Officers noted concerns for Lee's ability to care for Henrietta and completed an (amber) BRAG. The Police LSU made a referral to Adult Social Care.

5.160 The Police also contacted the Adult Social Care EDT team during the early hours of Monday 12th December 2022 to advise them of the situation at Lee's address. The details obtained from the Police were sent to Adult Social Care community triage for follow up. Adult Social Care EDT documented that the Police wished to highlight the circumstances and said that they would forward a safeguarding referral. Adult Social Care EDT also documented that there was no need for further urgent action overnight.

5.161 On Monday 12th December 2022 the SCCC received the SWAST safeguarding concern which was sent to the community triage team as they had a contact open from Henrietta 's sister. The SCCC also received the Police referral which was sent directly to Adult Social Care Safeguarding to triage the concern. Their decision was that Henrietta met the criteria for a Section 42 adult safeguarding enquiry.

5.162 Also on Monday 12th December 2022 Henrietta 's sister phoned the SCCC and outlined Henrietta 's significant care and support needs, she explained that Henrietta had been estranged from her family for many years due to Henrietta's relationship with Lee and the verbal abuse the family had received from him. Henrietta 's sister advised that the family were trying to get her back home but needed guidance on how to achieve this. The contact from Henrietta's sister was sent to the community team but was not actioned until a further call was received from Henrietta 's sister on Tuesday 13th December 2022. Advice was sought from the Service Manager and contact made with Henrietta 's GP practice.

5.163 Later in December 2022 Lee called 999 after finding Henrietta in cardiac arrest. SWAST attended and continued the CPR which Lee had commenced. Henrietta's death was confirmed. SWAST requested Police attendance who found no suspicious circumstances.

6.0 Analysis

6.1 In this section of the report each case specific terms of reference questions will be considered in turn.

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

The response to reported domestic abuse incidents

6.2 Henrietta and Lee's intimate relationship is believed to have begun around 2008 Lee was convicted of an offence of battery³³ against Henrietta which took place in December 2017. The Police also attended 3 domestic abuse incidents involving Henrietta and Lee in 2018 and 4 such incidents in 2019. This DHR focusses on the period of almost 3 years from January 2020 until Henrietta's death in December 2022. There was a marked escalation in reported domestic abuse incidents in 2020 (16 in all), 4 reported domestic abuse incidents in 2021 and a further escalation to 15 reported incidents in 2022.

6.3 The overwhelming majority of Police call outs were to Henrietta's 2 home addresses (she moved home in December 2020). On many occasions Henrietta contacted the Police via the 999 system, but 8 incidents were reported to the Police by neighbours. Henrietta was considered to be the victim and Lee the perpetrator in all cases except two when officers considered there was "abuse from both sides" (Paragraph 5.21) and when Lee disclosed that Henrietta punched him in the face (Paragraph 5.95). Several of the incidents involved verbal abuse and were frequently resolved by the Police removing Lee from Henrietta's property or Lee being collected by his parents, with whom he resided for the majority of the period under review.

6.4 However, there were a number of incidents in which the abuse disclosed by Henrietta escalated, including a punch to her jaw (Paragraph 5.97), several kicks and punches to her head, legs, back and shoulder which caused bruising, frequent slapping and even more frequent spitting and a very serious escalation to attempted strangulation with a phone charging cable (Paragraphs 5.86 and 5.87). Henrietta disclosed that Lee threatened to kill her on one occasion (Paragraph 5.97). All of these disclosures were to the Police although Henrietta also disclosed the attempted strangulation to Abri (Paragraph 5.87). Henrietta also appeared to be at risk of injury from Lee damaging or throwing household items and furniture around or at her. The most severe of this type of incident was when Lee became aggressive and began to

³³ Battery is committed by the intentional or reckless application of unlawful force to another person. The offence was placed on a statutory footing by Section 39 Criminal Justice Act 1988. Where battery is selected it should be charged as "assault by beating".

stab furniture with a knife (Paragraph 5.128). There were also several incidents in which Henrietta had visible bruising the causes of which she felt unable to divulge.

6.5 In considering the impact of the incidents of violence Henrietta disclosed, it should be borne in mind that her mobility was restricted by the amputation of some of the toes on both feet and subsequent knee fractures. Her alcohol dependence could lead to thiamine deficiency which could impact on mobility, sensory loss and frailty. From March 2022 until her death 9 months later, Henrietta's mobility was much more severely affected by the fracture of her left femur and several subsequent falls which caused a further fracture of her hip in August 2022. She became an increasingly frail woman who was also severely underweight and prone to frequent seizures. Lee is a physically imposing man nearly 8 years Henrietta's junior who was known to professionals to be frequently violent and aggressive and his anger was often exacerbated by the effects of his alcohol and drug use. However, Henrietta's increasing frailty was just one factor which enabled Lee to subject her to several years of domestic abuse.

6.6 In addition, Henrietta had become increasingly reliant on Lee for support. She disclosed that Lee had isolated her from friends and family and 'sabotaged' her relationships so that she had only him to rely upon (Paragraph 5.97). Henrietta reiterated this point on several other occasions (Paragraphs 5.37 and 5.39). This was also the view of Henrietta's parents and sister. In their contribution to the DHR, Henrietta's family said that they had very little contact with her after 2021 and if they tried to ring her, Lee would interrupt the calls and then make phone calls to her family in the small hours of the morning which they described as 'horrific' and said they almost led to her parents suffering 'breakdowns' (Paragraph 4.12).

6.7 Controlling or coercive behaviour forms part of the definition of domestic abuse.

The Domestic Abuse Act 2021 statutory guidance (2) provides examples of controlling and coercive behaviour. The examples of coercive and controlling behaviour present in this case are set out below:

- *Controlling a victim's access to finances, including monitoring their accounts or coercing them into sharing their passwords to bank accounts in order to facilitate economic abuse* (Henrietta disclosed to the Police that Lee had obtained her PIN number and withdrawn money from her account without her permission (Paragraph 5.96). Additionally, Lee was known to some agencies to also demand money from his parents (Paragraph 5.100) who said that they were in debt as a result of this (Paragraph 5.115). Lee was known to some agencies to have accumulated substantial debts through gambling (Paragraphs 5.6 and 5.88).

- *Isolating the victim from family, friends and professionals who may be trying to support them, intercepting messages or phone calls* (As previously stated, Henrietta's family have advised the DHR that Lee isolated Henrietta from family support. On one occasion Police Officers felt that Henrietta was unable to answer all their questions truthfully (Paragraph 5.11) and noted that she seemed to be afraid of Lee. On another occasion Henrietta disclosed that bruising had been caused by a 'friend' who attended her address every other day to help her around the house, before going on to say that she was frightened and could not bear the situation, which had been going on for years, any longer (Paragraph 5.27). On another occasion Henrietta disclosed that she felt trapped within a friendship and due to her reliance found it difficult to break away (Paragraph 5.37).
- *Preventing the victim from taking medication, or accessing medical equipment and assistive aids, over-medicating them, or preventing the victim from accessing health or social care, which is especially relevant for disabled victims or those with long-term health conditions* (It is difficult to reach a judgment on this point as Henrietta frequently felt unable to accept support from professionals. This issue will be considered in greater depth later in this report. The extent to which Lee may have dissuaded her from accepting support is unclear. Much professional contact with Henrietta was by phone and so it is possible that Lee may have been with her when Henrietta received phone calls and influenced her decisions. (The impact of Covid-19 restrictions undoubtedly contributed to the amount of phone contact with Henrietta). He informed his Probation Officer that if he was unable to adequately care for Henrietta following her neck of femur fracture, then he would contact 'social services' and return to his parents. (Paragraph 5.119). He did not contact social services. Henrietta's family have advised the DHR that when they were clearing Henrietta's belongings out of her flat after her death, they found that the front wheels of her walking frames had been removed (Paragraph 4.14).
- *Using substances to control a victim through dependency or controlling their access to substances* (Lee did not seek help or encourage Henrietta to seek help for her alcohol dependency. She seemed reluctant to access such support and may not have wished Lee to contact substance services on her behalf. It is noted that Lee referred himself to SDAS (Paragraph 5.45).
- *Physical violence, violent or threatening behaviour, sexual abuse, emotional or psychological abuse, economic abuse and verbal abuse* (Henrietta's disclosures of physical violence, threatening behaviour, economic abuse and verbal abuse have been documented earlier in this report).

6.8 The Domestic Abuse Act statutory guidance states that disabled victims of domestic abuse may be at increased risk from a carer who is "personally connected" to them (3). Henrietta had a physical disability in that the amputation of her toes was a physical impairment which had a substantial and long-term effect on her ability to carry out normal day-to-day activities. Lee was "personally connected" to Henrietta

as he was either her intimate partner or ex-partner during the period on which the DHR focusses. For much of this period Henrietta appears to have been dependent on Lee to support her in many of the activities of daily life. He frequently presented himself as Henrietta's informal carer.

6.9 Given the grounds on which the decision to undertake this DHR was taken, it is necessary to explore the extent to which Lee fulfilled the role of informal carer for Henrietta.

6.10 In his contribution to the DHR, Lee was asked if he considered himself to have been Henrietta's carer. He replied that he 'was meant to be her carer' before going on to imply that Henrietta's attempts to apply for PIP (unsuccessful until shortly before her death) would have allowed him to be recompensed for his caring responsibilities. Lee did not claim the carer's allowance benefit in respect of Henrietta.

6.11 He said that he did the best he could for Henrietta. He said he made sure that she ate and assisted her with her mobility. He went on to say that she was reluctant to accept help because 'she didn't want to be here'. He said that Henrietta had a strong wish to die and talked of ending her life multiple times, but he said that she was afraid to take an overdose. (There is no specific indication of suicidal ideation in the records of contact Henrietta had with agencies and the suggestion that she felt unable to accept help because she no longer wanted to live comes from no source other than Lee. The issue of whether her self-neglect could have been construed as self-harm will be addressed later in the report). Lee attributed what he claimed to be her suicidal ideation to her frustrated desire to have children, which he said was impossible due to a termination whilst working abroad which left her unable to conceive. (Henrietta's family have confirmed the termination but stated that the termination did not affect her ability to conceive. They added that a more likely factor in Henrietta deciding not to have children was her fear that any child would be removed from her care as a result of her alcohol dependence).

6.12 Lee said he sought support for Henrietta from the time that she moved into his address around November 2022, although there is no evidence that he sought support for Henrietta before Friday 9th December 2022 when he contacted her GP and the ambulance service (Paragraphs 5.156 and 5.157). He also informed the Police how ill Henrietta was when they attended his address on the same date in relation to another matter (Paragraph 5.159). He said that after Henrietta moved in with him, he and his then partner cared for her until her death in December 2022. He went on to say that he was very upset by Henrietta's death and, in response, took an overdose of prescribed medication, for which he did not seek medical help. He

added that he also felt that a huge weight had been lifted off his shoulders when Henrietta died.

6.13 Lee presented himself to his Probation Officer as Henrietta's carer, for example describing how he planned to stay with her to help her recuperate after her March 2022 hip fracture. Indeed, Lee's Probation Officer appeared to be concerned that Lee's commitment to supporting Henrietta was preventing him moving on in his life and living more independently.

6.14 There is no doubt that Lee spent a great deal of time at Henrietta's address because they were, or had been, in a long-term intimate relationship although this appeared to have become intermittent. He also appeared to stay or spend time at Henrietta's address to give his parents a degree of respite from his aggressive and violent behaviour. This was the case at the time the Probation Service made a safeguarding referral in respect of Lee's abuse of his parents (Paragraph 5.100) and the Probation Service appeared to acquiesce to Lee staying with Henrietta in order to relieve the pressure on his parents (Paragraph 5.103).

6.15 The evidence that Lee actually provided care and support to Henrietta is quite limited. He contacted the ambulance service when Henrietta became gravely ill with sepsis in 2017, contacted the ambulance service in September 2021 after Henrietta had a fall (Paragraph 5.83), contacted the ambulance service when Henrietta fractured her hip in March 2022 and, as stated, contacted the ambulance service and the GP when Henrietta was close to death on 9th December 2022. He moved Henrietta from her home to his address in the weeks before her death and, as stated, has advised the DHR that he and his then partner cared for Henrietta, although Henrietta's family described the conditions in which he was caring for Henrietta as 'squalid' (Paragraph 4.13), a description largely confirmed by the Police who also saw Henrietta on 9th December 2022 and described his flat as 'chaotic' and covered in detritus including broken glass, broken pieces of furniture and other items (Paragraph 5.159). The Police also expressed concern about Lee's ability to care for Henrietta at that time.

6.16 Generally, Lee only contacted services about Henrietta in extremis and there is little, if any, evidence that he sought help or support for her at any other time. It may be worthy of note that Lee sometimes appeared to experience difficulty in seeking support for himself. His mother often contacted his GP on his behalf and also advocated on his behalf with Adult Social Care (Paragraphs 5.14, 5.115 and 5.155).

6.17 It also seems likely that Lee's parents provided some care and support to Henrietta, given their involvement in supporting Lee and in driving him to and from

Henrietta's address. For example, Lee told his Probation Officer that his mother was collecting Henrietta from Hospital following her discharge after fracturing her hip in March 2022 (Paragraph 5.119).

6.18 Lee's language when describing his role in caring for Henrietta to the independent DHR author is of interest. He said that 'the only person Henrietta had was me', and that 'he was her only friend'. This is the type of language often used by controlling intimate partners. Lee also claimed that 'but for him', Henrietta 'would have died years ago' and that 'he gave her an extra 5 years of life'. Henrietta's family held Lee responsible for not seeking medical help before Henrietta became dangerously ill with sepsis in 2017 but they have advised the DHR that Lee claimed to have 'saved her life' by calling an ambulance (Paragraph 4.9). This type of language is described as being characteristic of 'caring heroes' in the SafeLives Spotlight report *Disabled Survivors Too: Disabled People and Domestic Abuse*, which found that abusive carers often presented themselves to outsiders as the saviours of the person they were caring for whilst using their 'caring' role to exert greater control (4).

6.19 The same report found that for a disabled person, the abuse they experience is often directly linked to their impairments and perpetrated by the individuals they are most dependent on for care. The report concluded that intimate partners or family members often act as carers and this position of power can be exploited leading to widespread and pervasive means of coercive control and social isolation. SafeLives' national data showed that disabled victims are much more likely to be suffering abuse from a current partner (31%) than non-disabled victims (18%) (5).

6.20 At no time did any agency in contact with Henrietta or Lee consider referring Lee for a carer's assessment. Somerset Council's website advises that anyone can become a carer (6). A carer's assessment would have provided Lee with the opportunity to discuss his needs as a carer and could also have provided the professional carrying out the assessment with an opportunity to better understand Henrietta's unassessed care and support needs and gain insight into the dynamics of Lee's relationship with Henrietta. The DHR Panel discussed the question of how sensitive carer's assessments are to the possibility that domestic abuse may be present in relationships in which a person is dependent on care provided by an informal carer. The Panel felt that strong reliance was placed on the professional curiosity of those carrying out carer's assessments.

6.21 Lee's Probation Officer was probably the individual professional with whom Lee most frequently discussed his caring role for Henrietta. It was unwise to accept Lee's account of his caring role at face value and there was a striking lack of professional curiosity about how Henrietta was faring under Lee's care. However, the focus of the

Probation Officer's discussions with Lee about his caring role was to encourage Lee to prioritise his own needs (Paragraph 5.146) and spend less time with Henrietta as caring for her was "holding him back" (Paragraph 5.127). This focus on the impact of caring on Lee's wellbeing provided an even stronger justification for considering a carer's assessment. Amongst the objectives of such an assessment is to explore whether the carer gets enough time for themselves and how caring is affecting their mental and physical health (7).

6.22 Having commented on the missed opportunity of Lee's Probation Officer to consider a carer's assessment, the agency which missed repeated opportunities to consider a carer's assessment for Lee was Adult Social Care. Adult Social Care's 17 contacts with Henrietta during the period under review will be considered later in this report. However, there is no indication that Adult Social Care offered Lee a carer's assessment.

6.23 There is also no indication that when responding to referrals in respect of Henrietta, Adult Social Care cross referenced Henrietta with their records of separate contact with Lee. Had Lee been linked to Henrietta as a 'relationship' on the Adult Social Care electronic records system, Henrietta would have appeared as a 'relationship' on his file also. This could have enhanced decision making as both records could have been viewed to support decisions taken. None of the Adult Social Care teams involved with Henrietta searched the electronic records system for Lee or if they did so, this was not recorded. None of the Police reports regarding the domestic abuse between Lee and Henrietta are recorded on Lee's Adult Social Care record. During the period on which the DHR focusses, the Adult Social Care Mental Health Social Care team carried out a Care Act assessment of Lee at the request of his parents (Paragraph 5.115 and 5.124) and received several contacts from Lee's mother in which she raised concerns about her son including a referral shortly before Henrietta's death (Paragraph 5.155).

6.24 The Probation Service also gleaned considerable information about Lee's relationship with Henrietta, albeit filtered through Lee's version of events. However, they do not appear to have considered whether Lee's aggressive and violent behaviour towards his parents might be repeated in his relationship with Henrietta and don't appear to have applied their knowledge of how Lee presented in intimate relationships – 'controlling, suspicious and abusive behaviours towards his partners' (Paragraph 5.110) to his relationship with Henrietta. Lee's Probation Officer became aware that Lee's visits to Henrietta were leading to Police callouts but the focus of the conversations with Lee about these callouts was not on the risk Lee may be presenting to Henrietta but concentrated instead on the adverse impact the callouts could have on Lee's chances of being offered a tenancy.

6.25 Professionals may have struggled to perceive a male in his mid-30s to be the carer of a woman in her early 40s. This perception challenge is reinforced to an extent by the focus of research on domestic abuse in informal carer relationships largely on older people. For example, researchers at Dewis Choice adapted the Duluth Power and Control Wheel – originally developed by Pence, McDonnell and Paymar (1982) to explain the variety of ways in which perpetrators use power and control to manipulate and abuse victims – to examine domestic abuse in later life (8). This adapted Duluth Power and Control wheel is a very powerful tool for examining controlling behaviour, but the clear focus is on ‘Domestic Violence and abuse in later life’. However, the tool is particularly helpful in considering Lee’s observed behaviour towards Henrietta. The Power and Control Wheel describes controlling behaviour under the domains ‘Using emotional abuse’, ‘Using coercion and threats’, ‘Using economic abuse’, ‘Misuse of privilege’, ‘Minimising, denying and blaming’, ‘Limiting environmental mastery’, ‘Using isolation’ and ‘Using intimidation’.

6.26 Applying these domains to Lee’s observed behaviour highlights the following:

- One of the sub-headings under the ‘Using intimidation’ domain is ‘destroying your property’. There were many examples of Lee damaging or destroying Henrietta’s property (Paragraphs 4.15, 5.21 and 5.32).
- One of the sub-headings under the ‘Minimising, denying and blaming’ domain is ‘perpetrator portraying themselves as frail and vulnerable to services’. In his contribution to this DHR and in his interactions with agencies during the period on which the DHR focusses, Lee often drew attention to his own needs and sometimes claimed to have been diagnosed with conditions which is not confirmed by his medical records (Paragraphs 5.31 and 5.115).
- Another sub-heading under the ‘Minimising, denying and blaming’ domain is ‘blaming you for their abusive behaviour’. Lee often attributed Henrietta’s bruising to falls when experiencing seizures, adding that she “didn’t know they were happening” (Paragraph 5.79). Whilst there were many bruises which may have been caused by falling there were also many occasions when bruising was unexplained.
- One of the sub-headings under the ‘Limiting Environmental Mastery’ domain is ‘denying you access to support which promotes your independence, e.g. access to mobility and communication aids’. As previously stated, Henrietta’s family have advised the DHR that the front wheels of her walking frames had been removed (Paragraph 4.15).

6.27 There are several other sub-headings which appear to be applicable to this case such as ‘perpetrator using physical size and strength to intimidate you’ and

‘preventing you having contact with other people’. However, the point of drawing attention to this valuable adaptation of the Duluth Power and Control wheel is that it was developed to inform professionals supporting older victims of domestic abuse but could have been very helpful to the professionals who had contact with the much younger Henrietta and Lee. The emphasis on older people of research on links between self-neglect and domestic abuse will be commented on later in this report.

6.28 A witness statement taken from Henrietta by the Police following a domestic abuse incident in December 2017 has been shared with the DHR (The incident is referred to in paragraph 5.3). The statement provides some sense of how Henrietta perceived her relationship with Lee at that time. She said that she had initially been happy in the relationship but had started to become wary of how he acted around his parents. She said that he had volatile arguments with his parents which she didn’t like. She went on to state that within weeks of renting a property together, Lee became violent and extremely aggressive towards her. She said that Lee was arrested a number of times by the Police and that the worst incident left her covered in bruises. She added that she couldn’t put a number on the number of times Lee had been violent to her. She said that she ended the relationship as a result of his abuse and moved away from the Somerset area in 2009.

6.29 She later returned to Somerset and began a new intimate relationship which lasted for around 5 years, during which time she gradually became friends with Lee again. However, she said that Lee was responsible for her relationship with this other partner ending as he (Lee) would ring her partner when drunk and say things about her which were not true.

6.30 Henrietta went on to say that after becoming seriously ill in August 2017, it had been nice having Lee visit her and help her around the house. She said that it had seemed that the violence was behind Lee until the December 2017 incident in respect of which, Henrietta made the witness statement.

6.31 Reading Henrietta’s statement at a distance of 8 years, she seemed to have good insight into the risks that Lee could present whilst remaining optimistic that he was capable of change. She had sufficient agency to be able to end the relationship previously although she disclosed suffering what appeared to be a prolonged period of physical abuse from Lee prior to ending the relationship. She highlighted Lee’s role in the ending of her 5-year relationship with her other partner but may not have perceived this as an indication of controlling behaviour on Lee’s part. She welcomed Lee’s support following her serious illness in 2017, until he again became violent.

6.32 What is particularly striking is that Henrietta felt able to make a statement and support what was ultimately a successful prosecution of Lee. The period on which the DHR focusses began 3 years later, by which time, she no longer felt able to support prosecutions.

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

6.33 The Police often took positive action in response to reports of domestic abuse and arrested Lee on 5 occasions (Paragraph 5.21, 5.32, 5.43, 5.48, 5.128) and he was prosecuted for a public order offence arising from his conduct at Henrietta's address on one occasion (Paragraph 5.67). Henrietta felt unable to support any prosecutions and evidence-led prosecutions were considered on five occasions (5.10, 5.28, 5.32, 5.37, 5.129) and on one occasion an Inspector set out action to be taken to enable an evidence-led prosecution to be considered, highlighting the possibility of coercion and control (Paragraph 5.56).

6.34 The Police issued a DVPO which took effect from 23rd October 2020 (Paragraph 5.43) for 28 days and prohibited Lee from molesting Henrietta, from entering her address or coming within 100 yards of her. Henrietta was said to be unhappy about the DVPO as she relied on Lee for support (Paragraph 5.43). Lee breached the DVPO by visiting her address on three occasions during one day, shouting and kicking the window, refusing to leave and pushing his way into the address and assaulting Henrietta by kicking her thigh, spitting on her and slapping her face (Paragraph 5.48). Lee was later arrested and was prosecuted for breaching the DVPO and sentenced to 42 days in custody (Paragraph 5.49).

6.35 Thus the agencies working with Henrietta had 2 successive breathing spaces during which they could have convened a multi-agency meeting and developed a support plan, possibly including an assessment of her care and support needs, a formal assessment of her mental capacity in relation to keeping herself safe in her relationship with Lee, encouraged her to self-refer to SDAS and sought her consent to contact her family. This was one of several missed opportunities to convene a multi-agency meeting or arrange a multi-agency discussion. However, Adult Social Care became aware of the DVPO via MARAC minutes and could have considered making contact with Henrietta at that time. The DHR Panel questioned whether agencies have the capacity to work intensively to make effective use of 'breathing spaces' afforded by a DVPO.

6.36 Abri, Henrietta's landlord, also sought to exclude Lee from Henrietta's addresses by explaining that if she allowed him to stay in her flat, this could put her tenancy at risk. Henrietta agreed to sign an acceptable behaviour contract (ABC) which included a clause to prevent Lee from visiting (Paragraphs 5.33, 5.53). However, Lee's visits to Henrietta continued which led Abri to visit her to advise her of the consequences of further breaches of the contract (Paragraph 5.63).

6.37 Although the acceptable behaviour contract achieved a degree of success in reducing the frequency of Lee's visits for a time, the DHR Panel questioned the appropriateness of adopting an anti-social behaviour (ASB) approach to domestic abuse. In response, Abri advised that they felt that the acceptable behaviour contract empowered the victim to say to the perpetrator that they were denying them access on their landlord's instructions. Abri also advised that they needed to consider the impact of the disturbance and distress arising from the domestic abuse on the victim's neighbours. In this connection it is worthy of note that 8 of the domestic abuse incidents attended by the Police during the period under review were reported by Henrietta's neighbours.

6.38 A SafeLives report completed in collaboration with Gentoo, a housing provider in the northeast of England (9), noted that neighbours can be the first to be aware of domestic abuse and in many instances may hear shouting or violence resulting in domestic abuse often being reported to ASB teams and reacted to as nuisance behaviour. The report concluded that this is an inappropriate response to domestic abuse, as it can increase the risk to victims if they try to prevent perpetrators from entry to their address and could increase secrecy and mistrust by victims and act as a further barrier to disclosures from victims. Abri felt that the same challenge – that ASB reports by neighbours about domestic abuse or noise nuisance could inadvertently increase the risk to victims – could also apply to DVPOs. The DHR Panel also noted that victims of domestic abuse may be at higher risk of domestic abuse when the DVPO expires as the victim could face repercussions from a returning perpetrator.

6.39 Abri also advised that an ABC was just one of the tools they would use in domestic abuse cases. If a tenant was disclosing domestic abuse Abri would follow their domestic abuse policy and considering support options and target hardening. Abri advised that they need to be mindful of the impact on neighbours and any evidence gathered could help them to consider enforcement action such as excluding the perpetrator from the property.

6.40 The DHR has been advised that registered housing providers must now abide by the Proposed Consumer Standards³⁴ and the associated Code of Practice. The Code of Practice states that registered housing providers should understand the significant impact that domestic abuse can have both on tenants experiencing it and their household members and so registered providers should have a victim-centred approach to assisting tenants who experience domestic abuse.

6.41 A key dilemma faced by professionals who sought to restrict Lee's access to Henrietta's address was that she appeared to have become dependent on him for support. As previously stated, the evidence that Lee provided adequate care and support to Henrietta is limited but she had become isolated from other sources of support from family, friends and neighbours. Therefore, there was a risk that

³⁴ The proposed new consumer standards are designed to protect tenants and improve the service they receive. They will apply to all social landlords.

Henrietta could be exposed to harm arising from isolation from any form of support when Lee was excluded from her address.

Determine if there were any barriers Henrietta faced in both reporting domestic abuse and accessing services. This should also be explored:

- **Against the Equality Act 2010's protected characteristics.**

6.42 The protected characteristics which applied to Henrietta and Lee are addressed in Paragraphs 3

6.43 Henrietta struggled to attend several healthcare appointments. Whilst there may have been additional factors influencing her non-attendance at appointments, mobility may have been a key issue for her. Henrietta discussed her difficulties in travelling to hospital for a Neurology clinic appointment with her GP practice (Paragraph 5.81). There is limited evidence of reasonable adjustments being considered by professionals with the exception of the decision to change the location of Henrietta's Neurology Clinic appointment from Musgrove Park to Yeovil District Hospital (Paragraph 5.78). The DHR Panel suggested that hospital transport could have been considered for Henrietta although they noted that she was able to use public transport fairly frequently prior to her March 2022 hip fracture. Looking back, there could have been a greater emphasis on considering reasonable adjustments to facilitate travel to appointments or the provision of services via outreach after Henrietta's hip fracture which significantly affected her already limited mobility. However, if it had been possible to provide more support in-person at Henrietta's home address, it seems possible that Lee's presence might have been a barrier, in that he may have been considered to present a risk to professionals (Paragraph 5.61).

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

6.44 The Chronology/Overview appears earlier in the report (Paragraph 5.1 to 5.163)

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, particularly policy and practice in response to evidence of self-neglect.

6.45 Adult Social Care had 17 contacts in relation to Henrietta during the period under review (January 2020 until December 2022). Henrietta was not known to the service prior to this period. Adult Social Care received 9 reports from the Police (Paragraphs 5.7, 5.13, 5.32, 5.36, 5.39, 5.98, 5.101, 5.136 and 5.159), 2 from Abri (Paragraphs 5.26, and 5.133) and 1 from SWAST (Paragraph 5.157). Of the 12 referrals, 6 were made between March and October 2020, 4 were made between January and July 2022 and the SWAST referral and the final Police referral were made shortly before Henrietta's death.

6.46 All Adult Social Care contact with Henrietta was by phone. Although the Police had identified domestic abuse as an issue, no history of domestic abuse was included in the first Police referral. Henrietta's risk of domestic abuse from Lee was clearly an issue in all subsequent referrals received by Adult Social Care but there appeared to be no consideration of whether it was safe to contact Henrietta by phone or whether she would be able to speak freely over the phone should Lee be with her. One of the referrals made by Abri highlighted the possibility that Henrietta may not be able to speak openly if Lee was present and so she may ask for a call back (Paragraph 5.133).

6.47 In response to the referrals Adult Social Care offered Henrietta a Section 9 assessment of her care and support needs on 3 occasions which she did not feel able to accept. There is no indication that Henrietta's reasoning for declining assessments was explored with her.

6.48 On those occasions when ASC safeguarding became involved, the view they took was that although Henrietta had some care and support needs and was at risk of abuse, she had demonstrated that she was able to protect herself from 'physical abuse'. The focus on 'physical' domestic abuse suggests a lack of appreciation of other forms of domestic abuse particularly coercion and control. Adult Social Care's understanding that Lee did not live with Henrietta was considered to be a protective factor despite the fact that it was known that he visited frequently and she appeared to rely on him for care and support. It wasn't always clear whether ASC safeguarding reviewed previous referrals in respect of Henrietta and there is no indication that they considered whether her mobility needs compromised her ability to keep herself safe or whether the presence of alcohol dependence may have affected Henrietta's mental capacity at times.

6.49 One referral was misread by the SCCC call handler who mistakenly formed the view that the report was from the same date as an earlier Police referral and so it was not sent to ASC Safeguarding but forwarded instead to the ASC community team triage highlighting only Henrietta's mobility issues which led to a her being placed on the waiting list for a bathing assessment, which did not address the full concerns set out in the Police report (Paragraph 5.39).

6.50 There was then a gap of a year before Adult Social Care received 2 further referrals from the Police in quick succession during January 2022 (Paragraphs 5.98 and 5.101). Adult Social Care received the second chronological referral before the first and sent it to ASC Safeguarding for screening. During the subsequent telephone contact with Henrietta mental capacity, safety and risk were discussed but it was decided that a Section 42 Safeguarding Enquiry was not required as Henrietta was deemed to have taken positive steps to protect herself. When the first chronological Police referral was later received it was treated as 'for information only' as Henrietta had only recently been spoken to by the ASC Safeguarding team.

6.51 Adult Social Care became aware of Henrietta's hospital admission after the neck of femur fracture although the method of communication was via a DOLS application (Paragraph 5.118) rather than the expected route of the hospital Adult

Social Care Team, who do not appear to have been notified of Henrietta's admission. Somerset NHS Foundation Trust takes the view that there was a missed opportunity for Yeovil District Hospital to have made a safeguarding referral on professional judgement grounds for self-neglect or at least arranged a robust multi-disciplinary discharge planning meeting to consider the risks which applied to Henrietta and devise a plan to mitigate those risks. The Trust feels that there was also a missed opportunity to assess Henrietta's care and support needs whilst an in-patient. Such an assessment could have been conducted without her consent³⁵, although building a relationship with Henrietta would have been the preferred approach.

6.52 Adult Social Care later received a referral from Abri which set out Henrietta's needs and the risks she was exposed to from Lee whilst she recovered at home following the operation on her fractured hip (Paragraph 5.133). Although this referral was passed to the ASC Community team as high priority it was closed by the ASC Community team using information gathered by the ASC Safeguarding team in response to a subsequent separate Police referral in respect of Henrietta (Paragraph 5.136) and so the opportunity to offer support to Henrietta at a time when her mobility needs had become much more pronounced was lost. The author of the Adult Social Care IMR concluded that the concerns appropriately raised by Abri and the Police had fallen between the two ASC teams and that the decision by the ASC community team to close the Abri referral was not justified by the information recorded on the system.

6.53 Considering the extensive history of domestic abuse and the decline in Henrietta's health and mobility, the Adult Social Care IMR author is of the view that an in-person visit should have taken place in response to these two referrals received after Henrietta was discharged home following treatment for the neck of femur fracture.

6.54 Looking back at the series of referrals to Adult Social Care, the 'system' appeared insufficiently sensitive to repeat referrals, the indications that Henrietta's situation was not improving and that the neck of femur fracture potentially heralded a significant escalation in risk to Henrietta. Whilst there was some evidence of managerial oversight, this wasn't consistently present when needed.

6.55 Mention has already been made of the missed opportunity for Yeovil District Hospital to have considered a safeguarding referral in respect of Henrietta. There were also several occasions when the Police could have considered making additional referrals to Adult Social Care (Paragraphs 5.31, 5.75, 5.109, 5.125, 5.128 and 5.148). Key factor in referrals not being made by the Police were either the non-completion of a BRAG, or a completed BRAG which did not identify a specific vulnerability sufficiently clearly or a concern that the level of vulnerability identified

³⁵ The Care Act 2014 places specific duties on the Local Authority in relation to self-neglect
(i) Assessment- The Local Authority must undertake a needs assessment, even when the adult refuses, where it appears that the adult may have needs for care and support - and is experiencing, or is at risk of, self-neglect. This duty applies whether the adult is making a capacitated or incapacitated refusal of assessment.

may not meet Adult Social Care thresholds for accepting referrals. The missed opportunities for Police referrals apparent in Paragraphs 5.125, 5.128 and 5.148 all took place after Henrietta's neck of femur fracture following which her mobility issues worsened and she appeared increasingly frail.

6.56 There could have been a stronger professional focus on self-neglect as an issue of concern. Self-neglect is entwined with possible carer neglect and Henrietta's isolation from other sources of support arising from coercive and controlling behaviours. Somerset Safeguarding Adults Board's website states that there is no one definition of self-neglect but the term is used to cover a wide range of behaviour of a person neglecting their own health, personal hygiene or their surroundings and includes behaviour such as hoarding. The Board's guidance goes on to give 3 examples of the types of behaviour which are considered to be self-neglecting (10):

- Lack of self-care and not attending to personal hygiene, nutrition and hydration, or health needs, to an extent that it may endanger their safety or wellbeing or that of their community (Henrietta was frequently described as appearing underweight (Paragraph 5.27) or very underweight (Paragraph 5.76). Although she engaged with dietetic services (Paragraph 5.54) she continued to appear underweight and when seen by paramedics around 5pm she said that she hadn't eaten that day (Paragraph 5.76). Henrietta also drank alcohol to excess and frequently appeared intoxicated which affected her health and wellbeing, may have been the cause of her seizures and increased her risk of falling).
- Lack of care of environment and living in situations that could lead to domestic squalor or elevated levels of risk in the domestic environment (for example, health or fire risks caused by hoarding) (Henrietta's home environment was described as messy and cluttered and she slept on a mattress on the floor (5.39) although there is ample evidence that Lee degraded her home conditions through damaging items when angry (Paragraph 5.21 and 5.128)).
- Refusal of assistance that might help resolve these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment (Henrietta felt unable to accept a Section 9 assessment of her care and support needs on at least 3 occasions, she left hospital before all treatment had taken place (Paragraph 5.71), declined hospital attendance (Paragraph 5.157) and informed her GP that she had stopped calling for help with her seizures as no-one had been able to establish the cause (Paragraph 5.81).

6.57 The level of self-neglect was sufficiently serious that agencies could have considered a safeguarding referral on the grounds of self-neglect prior to SWAST submitting such a referral shortly before Henrietta's death (Paragraph 5.157).

6.58 Agencies in contact with Henrietta became concerned that was very underweight (Paragraphs 5.27 and 5.29). Her GP referred Henrietta to dietetic services who worked with her to develop a food fortification action plan (Paragraph 5.54) and discharged her back to the care of her GP who offered Henrietta the opportunity to attend the surgery for weight checks. The DHR has received no indication that weight checks took place and shortly afterwards Henrietta changed her GP practice following her house move and the new GP practice does not appear to have addressed the concerns about Henrietta's weight thereafter.

6.59 Research which specifically explores links between self-neglect and domestic abuse is not plentiful and tends to focus on the relationship between 'elder abuse' and self-neglect (11). However, self-neglect research finds that whilst there is no single overarching explanatory model for self-neglect, causation is associated with physical health issues, mental health issues, substance misuse and psycho-social issues (12). Psycho-social issues can include 'diminished social networks' and 'traumatic histories/life changing events'. This suggests that 'diminished social networks' arising from coercive and controlling behaviour and a 'traumatic history' of domestic abuse could increase the risk of self-neglect. The self-neglect research goes on to emphasise the importance of a 'relational approach' in order to help professionals 'find the person'. Sadly, no professional was able to work sufficiently closely with Henrietta to adopt a 'relational approach' and Henrietta was never found as a person by any professional.

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.

6.60 Agencies communicated with each other primarily by making referrals. Feedback loops to ensure the referring agency was aware of the outcome of the referral did not appear to be a consistent feature of communication between agencies (Paragraph 5.26). It is unclear why SIDAS and Abri were unable to establish contact with each other (Paragraph 5.25) and Henrietta's first GP did not share SIDAS contact details with Henrietta or explore domestic abuse as requested by MARAC (Paragraph 5.29).

6.61 Agencies had no contact with Henrietta's family during the period under review until Henrietta's sister began contacting Adult Social Care for support shortly before Henrietta's death. Given the concerns agencies had about Henrietta's dependence on Lee for support, the risks that he clearly presented to her and her isolation from family and friends, it is surprising that no agency appears to have considered seeking Henrietta's consent to contact her family. Agencies perceived Henrietta to be a woman in her forties who had lived independently for many years but after fracturing the neck of her femur in March 2022, her vulnerability became more pronounced, and she became increasingly more frail.

Multi-agency working

6.62 The only multi-agency forum at which Henrietta was considered was MARAC, where she was discussed 8 times during the period under review (Paragraphs 5.15, 5.23, 5.51, 5.61, 5.62, 5.90, 5.104 and 5.139). The DHR has found it challenging to clarify information shared at MARAC and actions taken as there was no central repository for the South Somerset MARAC minutes. Therefore, the DHR has relied upon partner agency chronologies to gain some understanding of what was discussed. However, this is far from a complete picture.

6.63 Henrietta's case was quite a complex one for MARAC to discuss given the number of cases MARAC meetings often consider and the limited amount of time available. It is open to MARAC to recommend that a separate strategy meeting or MDT is convened where the person referred to them has complex needs (and in this case, the perpetrator Lee also had quite complex needs).

6.64 The MARAC raised concerns about Henrietta's unassessed care and support needs (Paragraph 5.15) and later proposed the adoption of an MDT approach (Paragraph 5.61) which led to a period of joint working between occupational therapy (OT) and the integrated rehabilitation team but Henrietta's case was closed prematurely and there appeared to be no feedback loop to MARAC to inform them of the outcome of the MDT approach they had proposed (Paragraph 5.61).

6.65 Given the number of times Henrietta was heard at MARAC and the absence of evidence that the risks to which she exposed were diminishing in any way, this could have led to the MARAC questioning whether the 'system' was working for her and considering whether an alternative approach was required. The MARAC could have considered referring Henrietta to the Multi-Agency Risk Management (MARM) or its predecessor "What to do if it's not safeguarding" process. Somerset Safeguarding Adults Board's MARM guidance advises that a MARM meeting is likely to be useful to any professional who is working with an adult who is experiencing an unmanageable level of risk as a result of circumstances which create the risk of harm but not relating to abuse or neglect by a third party. Although Henrietta was experiencing abuse or neglect from a third party (Lee) other criteria for a MARM referral were present including:

- ongoing concerns despite Safeguarding Alert not being progressed through formal safeguarding section 42 enquiry work
- Self-neglect including hoarding and fire safety
- Refusal or disengagement from care and support services

- Complex or diverse needs which either fall between, or spanning a number of agencies' statutory responsibilities or eligibility criteria
- On-going needs or behaviour leading to lifestyle choices placing the adult and/or others at significant risk and
- combination of domestic violence, mental health and substance misuse (13).

6.66 There were several points at which it could have been useful to convene a multi-agency meeting or discussion such as when the DVPO was granted and when Lee was briefly imprisoned to both exploit the breathing space Lee's absence from Henrietta's life allowed and when Henrietta was about to be discharged from Yeovil District Hospital after being treated for the neck of femur fracture.

6.67 SIDAS received 10 referrals for Henrietta. On 5 occasions they managed to speak to her directly and she declined support each time. SIDAS could have considered working with agencies which were in contact with Henrietta, such as Abri. Henrietta was referred to SIDAS on 2 occasions around the time that the DVPO was in place and they closed her case after being unable to obtain a reply to phone calls. When a DVPO is in place it could be particularly helpful for the SIDAS to make enquiries to establish which agencies are in contact with the victim as the temporary protection afforded by the DVPO may give the victim the confidence to engage with SIDAS. Had any of the referrals to Adult Social Care progressed to a Section 42 Safeguarding Enquiry this could have provided an accountable multi-agency process in which to address the risks to Henrietta.

Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice. In particular, explore the extent to which opportunities to safely make routine enquiry were taken by professionals.

6.68 Both of Henrietta's GP practices missed opportunities for targeted enquiry about domestic abuse (Paragraphs 5.29 and 5.64). NHS Somerset developed a standard operating procedure for responding to domestic abuse in 2023 which provided detailed guidance on targeted enquiry for Primary Care.

6.69 Arguably, the concerns that Henrietta was becoming gravely ill and may be at imminent risk of death could have received a more urgent response. Lee informed his Probation Officer that Henrietta was going to 'go soon' (Paragraph 5.152). Assuming that this comment was interpreted as Henrietta being near death, the Probation Officer could have considered whether Henrietta was in need of medical attention. SWAST assessed Henrietta as having capacity to decide to decline hospital attendance on 9th December 2022. It is unclear whether this was a formal capacity assessment. SWAST submitted a safeguarding referral but could have considered contacting the local authority Emergency Duty Team (EDT).

Given that agencies frequently struggled to engage with Henrietta, explore any barriers to accessing support she may have experienced, including the possibility that Henrietta may have been the victim of coercion and control. Is there any learning to be derived from Henrietta's contact with agencies which were more successful in working with her?

6.70 Agencies did indeed frequently struggle to engage with Henrietta. It is difficult to gauge the extent to which Lee influenced her decisions not to accept support but given Henrietta's disclosure that he had isolated her and sabotaged her relationships (Paragraph 5.97) it seems likely to have been a factor. Having said that, Henrietta's reluctance to accept support in relation to her alcohol use pre-dated her relationship with Lee (Paragraph 4.3). As a result, Henrietta's care and support needs were unassessed and unaddressed.

6.71 Henrietta engaged with dietetic services to the extent that an action plan was developed but then appeared reluctant to engage with her GP to enable her weight to be monitored. However, her second GP practice did not follow up on the earlier concerns about her weight. Sometimes, services closed her case quite promptly, without apparently considering the risks of case closure or considering whether they might need to make reasonable adjustments in respect of her mobility issues (Paragraph 5.143).

6.72 On one occasion Henrietta did not receive the contact that she had agreed to. A health coach phoned her and noted that Henrietta 'did not have much of a voice' and appeared to be struggling to speak. Henrietta agreed to further contact but there is no indication that any subsequent phone call was made (Paragraph 5.29).

6.73 Additionally, there were a limited number of occasions when Henrietta appeared ready to engage with services. She disclosed to Yeovil District Hospital A & E staff that "she was frightened and could not bear the situation, which had been going on for years, any longer" (Paragraph 5.27). She advised Abri that she now realised "that she needed help with tasks related to her personal care and had therefore agreed to the referral to Adult Social Care" (Paragraph 5.133). Unfortunately, neither of these opportunities were capitalised on.

6.74 At times the language used by professionals to describe her reluctance to accept support was quite harsh. For example, Henrietta was said to have 'refused to engage' with the Police despite the Police documenting that she was 'afraid of' and 'reliant on' Lee (Paragraph 5.32). This language implied that Henrietta enjoyed unfettered free will, which did not appear to be the case. On another occasion victim blaming language was used in a MARAC meeting (Paragraph 5.51) when it was stated that Henrietta just wanted Lee to 'come back and look after her'.

6.75 The DHR Panel discussed what action partner agencies should consider when a person does not feel able to engage with a range of services. People have a right not to pick up the phone and to continually contact a person who appears reluctant to accept services could constitute harassment. However, the risk to the person arising from not accepting services should be fully considered, particularly at the

point of case closure. The DHR Panel also felt that a trauma-informed approach to case closure should be taken in that any barriers to engagement which may have their origin in trauma in the person's earlier life should be considered.

6.76 Where Henrietta's capacity was considered by professionals, they did not deem her to lack capacity, although capacity often appears to have been assumed rather than formally tested. Therefore, Henrietta's decisions to decline support were not questioned on capacity grounds. However, the Mental Capacity Act Code of Practice states that there may be cause for concern if somebody appears to be under undue pressure when making decisions. The impact of her alcohol dependence on her capacity was rarely considered. An exception was a Police referral to Adult Social Care which stated that Henrietta was a "self-confessed alcoholic" and as a result was unable to make clear decisions (Paragraph 5.101).

6.77 *How to use legal powers to safeguard highly vulnerable dependant drinkers in England and Wales* (14) suggests factors to consider when assessing mental capacity, frontal lobe damage and dependant drinkers. Approx 50% of dependant drinkers have frontal lobe damage as a result of brain injury. The frontal lobe is the behavioural centre of the brain which has a key role in impulsive control. Many are considered to have capacity, because of a 'simple' assessment process they know the correct things to say and do. But when they need to act upon their knowledge in the complex settings of the real world they are driven by impulse and therefore cannot weigh up their options. Her alcohol dependence may have been affecting Henrietta's capacity for some time. An Abri referral to Adult Social Care in August 2020 described her 'forgetting and repeating things' (Paragraph 5.26) although this appears to have been attributed to being 'very emotional' rather than the effects of alcohol. There may have been other issues which contributed to her forgetfulness.

6.78 The DHR Panel felt that professionals would be better equipped to work with people who appeared reluctant to accept support if there was a stronger focus on listening to voices of victims and survivors of domestic abuse, in particular their views on why they felt unable to engage with professionals. The DHR Panel drew attention to the Safelives Authentic Voices principles (15). The Authentic Voice model aims to hold space for survivors to choose the level of involvement that best meets their needs at the time. There are currently a number of Authentic Voice projects taking place in local areas. Additionally, the independent author is aware of work with survivors of domestic abuse carried out in other areas which has provided illuminating insights into the types of approach adopted by professionals which survivors have valued. The DHR Panel was advised that Somerset Domestic Abuse Service has appointed a Volunteer and Survivor Co-ordinator to develop a survivor's peer support group and to facilitate opportunities for survivor's voices to be heard.

Henrietta was frequently noted to be affected by alcohol use. Explore how professionals responded to this including the extent to which Henrietta was offered, or encouraged to access, support.

6.79 There were many opportunities when Henrietta's apparent alcohol dependence could have been explored with her by professionals.

6.80 Her GP practices could have discussed her alcohol use in the context of her mental health as alcohol is a depressant, her increasingly poor physical health and the strong evidence of abuse in her relationship with Lee. When GP Practice 2 sent her a letter outlining the results of her bloods, including 'abnormal liver function', this could have been followed up with the offer of a consultation to discuss the impact of her alcohol use and the possibility of a referral for support. Additionally, although the cause of her seizures had not been fully investigated, they may have been secondary to alcohol use and so there appear to have been many missed opportunities to ask Henrietta whether she had stopped drinking or reduced her alcohol intake for any reason prior to each seizure.

6.81 SWAST attended many of Henrietta's seizures but did not have a means of directly referring her to SDAS, had she consented to this. Referring her to her GP for consideration of a referral to SDAS ran the risk of missing the opportunity to refer directly at a time when Henrietta's may have been motivated to seek support with her alcohol use. SWAST has advised the DHR that they are in the process of requesting the addition of the SDAS email address is added to the electronic patient record system so that the option of direct referral is available to crews in the future.

6.82 The SWAST IMR states that Henrietta declined hospital attendance on 9th December 2022 on the grounds that 'she could not drink there and hated hospital'. There may have been an opportunity to explain to Henrietta that in hospital there are specialist substance use nurses who would be able to support her around the drinking and during her hospital admission she would be medicated so she would not go into withdrawal due to not being able to access alcohol. Additionally, if the clinical need was established, she may have been detoxed (if this is something she wanted). Hospital is also a route into SDAS, which has a good working relationship with the specialist nurses. SWAST has responded by advising that there is a slight error in the wording of their IMR as the ambulance crew asked Henrietta if she didn't want to go into hospital because she couldn't drink there. However the issue was raised, it provided the opportunity to discuss the support available to her in a hospital setting.

6.83 Adult Social Care could have considered whether the 27th August 2020 referral which stated that Henrietta was 'forgetting and repeating things' suggested alcohol related dementia Whilst Adult Social Care would not be in apposition to diagnose, greater awareness or other factors such as the effects of the menopause, of the impact of alcohol consumption on cognition, could have prompted greater professional curiosity around Henrietta's mental capacity and mental functioning. (Lee also expressed concern about Henrietta showing signs of dementia as she had

begun to forget things in his conversation with his Probation Officer in November 2022 (Paragraph 5.152).

6.84 A significant opportunity to discuss SDAS support and make referrals was during the many Police callouts to domestic abuse incidents when there was invariably evidence of Henrietta's alcohol consumption. Currently there is no route for the Police LSU to make SDAS referrals.

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

6.85 Many DASH risk assessments were officer completed because Henrietta did not feel able to engage with the DASH risk assessment process. When carrying out other DHRs, the independent author has noticed that victims can sometimes begin to question the point of completing 'yet another' DASH risk assessment and question the value of answering the same questions, some of which are quite personal.

6.86 There were missed opportunities for non-criminal justice professionals to complete DASH risk assessments (Paragraphs 5.24, 5.27 and 5.92).

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.

6.87 As previously stated there were missed opportunities for professionals to consider seeking Henrietta's consent to contact her family, given that she disclosed that Lee's had 'sabotaged' her relationships with family and friends. This could have been actively considered after Henrietta fractured her hip in March 2022 and began to appear increasingly frail.

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.

6.88 Protected characteristics relevant to Henrietta are addressed in Section 3 of this report.

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

6.89 The most significant organisational changes noted during the period under review were the major alterations to the way in which all partner agencies delivered their services during the Covid-19 pandemic. In addition, the MARM process was introduced during the period under review.

Whether the offer and/or provision of services to Henrietta was impacted by the restrictions introduced as a result of the Covid-19 pandemic.

6.90 There was a significant escalation in reported incidents of domestic abuse involving Lee and Henrietta during 2020 which was the first year of the Covid-19 pandemic when restrictions were placed on the ability of people to interact with others and access services on an in-person basis during 2 periods of national lockdown and additional periods when local restrictions applied. Police recorded crime data showed an increase in offences flagged as domestic abuse related during the pandemic although it cannot be determined whether the increase can be directly attributed to the pandemic (16). The Police were called to incidents of domestic abuse at Henrietta's address during the lockdown periods. It is possible that the pandemic restrictions may have resulted in Lee spending more time at her property by staying there overnight rather than visiting her regularly when movement between his parent's address and Henrietta's address was not restricted.

6.91 Henrietta's first GP practice closed during the pandemic, but the sister GP practice remained open. She may have experienced difficulties in accessing the sister GP practice. The pandemic also saw a significant change in the way that many types of healthcare appointments and contacts with a range of other services took place with a shift away from in-person to telephone contact which may have continued as the pandemic restrictions eased and become the 'new normal' post pandemic. The tendency for many agencies to use the telephone as their sole or primary means of contact with Henrietta is a prominent feature of this DHR.

Good Practice

- Police officers who attended domestic abuse incidents explored the complex dynamics of the relationship between Henrietta and Lee and highlighted support needs in BRAG assessments.
- A Police Inspector proactively developed a plan to try and secure sufficient evidence to initiate an evidence-led prosecution.
- The Abri CSO shared information about Henrietta's needs with Yeovil District Hospital's safeguarding lead after her admission following the neck of femur fracture.
- MARAC proposed an MDT approach and in response the OT and IRT worked together to plan support for Henrietta for a time.

7.0 Conclusion

7.1 Henrietta died from natural causes at the age of 44. After becoming seriously ill with sepsis in 2017, toes from both feet were amputated leaving a previously active woman in her late thirties with significant mobility issues. Henrietta had gradually become increasingly dependent on alcohol. Her family have described their efforts to encourage Henrietta to access support, but she tended to minimise her alcohol intake and the impact it was having on her health and wellbeing. She began experiencing seizures which may have been linked to her alcohol use. She was also significantly underweight.

7.2 Henrietta had been in an intimate relationship with Lee since 2008. He had not insubstantial needs and presented a longstanding risk of domestic abuse to his parents who struggled to cope with his behaviours whilst attempting to support him to leave the family home and live more independently. He was also abusive in his relationship with Henrietta. He is a physically imposing man several years her junior and the Police were called to a large number of domestic abuse incidents in which he was invariably regarded as the perpetrator.

7.3 During the period on which the DHR focusses, Henrietta's relationship with Lee was perceived by professionals as one in which she appeared dependent on him for support having lost contact with family and friends. Although Lee began presenting himself as Henrietta's carer, the extent to which he provided her with care and support is debatable. For her part, Henrietta periodically disclosed that she felt trapped in an abusive relationship which she felt unable to leave. Given her isolation from alternative sources of support, which her family felt had been engineered by Lee, she appeared to a victim of coercion and control by Lee. In his contribution to the DHR, Lee presented himself as Henrietta's saviour, which is completely contradicted by the evidence on which the DHR has drawn.

7.4 Professionals from a range of agencies had substantial contact with both Henrietta and Lee over the final 3 years of Henrietta's life. Tragically, this substantial contact made little difference to the trajectory of Henrietta's life. No professional was able to engage with Henrietta in a meaningful way in order to gain insight into why she presented as she did and to explore how to support her to achieve change in her circumstances.

7.5 The DHR highlights many familiar themes from past DHRs, including continuing doubts about how fit for purpose the MARAC process is for handling cases in which both the victim and the perpetrator have complex needs, the absence of an alternative multi-agency forum for considering such cases, the extent to which

professionals are able to adopt a holistic approach, the extent to which Adult Social Care professionals are equipped to fully understand the complexity of domestic abuse and the extent to which partner agencies are equipped to work together to support and encourage serious problem drinkers to engage with support.

8.0 Lessons to be learnt and recommendations

Domestic abuse in informal caring relationships

8.1 The dynamics of Henrietta's relationship with Lee, who was a more or less constant presence in her home, were explored and appeared to be understood to an extent by both the Police and Abri. However, their relationship was complex. Henrietta appeared to be dependent on Lee for support, but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered. Periodically Henrietta disclosed to agencies that she felt trapped in the relationship with Lee and wanted it to end. Lee is a physically imposing man with a history of violence and aggression towards his parents and a history of controlling, suspicious and abusive behaviour towards intimate partners. His behaviour towards the increasingly frail Henrietta included non-fatal strangulation, threats to kill and destruction of household items when angry.

8.2 As previously stated research indicates that when intimate partners or family members act as carers, this position of power can be exploited leading to pervasive means of coercive control and social isolation. There is compelling evidence of coercion and control in Lee's role as informal carer for Henrietta. Research also indicates that disabled victims of domestic abuse are much more likely to suffer abuse from a current partner than non-disabled victims. However, research on domestic abuse in informal caring relationships and on links between domestic abuse and self-neglect largely focusses on older people. As previously stated, professionals from a range of agencies may have struggled to perceive a male in his mid-30s to be the carer of a woman in her early 40s. It is important that professionals are encouraged to keep an open mind, avoid making assumptions that it is only or primarily older people who are likely to be at risk of coercion and control in informal caring relationships and deal with the circumstances 'in front of them'.

Recommendation 1 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team draws upon the learning from this DHR to increase understanding across a range of agencies that domestic abuse,

including coercion and control, in caring relationships is not restricted to older people.

MARAC effectiveness

8.3 This section of the report contains 3 recommendations relating to MARAC effectiveness. However, the DHR has been advised that since the period on which the DHR focusses (January 2020 until December 2022), substantial changes have been made to the MARAC process in Somerset. Additionally, as the DHR was nearing completion, the DHR Panel was advised that what appears to be a fundamental review of the Somerset MARAC process had commenced. It is therefore suggested that the following 3 recommendations (Recommendations 2, 3 and 4) are shared with the recently commenced Somerset MARAC review.

8.4 Henrietta's needs were complex and intersected with each other to a large extent. Her mobility issues were already significant before the fall from which she fractured the neck of her femur. Her reliance on Lee therefore increased which he may have further exploited given that, after her death, Henrietta's family found that the front wheels of her walking frames had been removed. Although Henrietta's alcohol dependence pre-dated her relationship with Lee, she may have been using alcohol as a coping mechanism for her abusive relationship. She was at serious risk from falls arising from her seizures which may have been linked to her alcohol use. She was often seen with unexplained bruising which may, or may not, have been caused by falls. Her alcohol dependence may have impaired her mental capacity at times. It is not known why Henrietta was underweight, but this may have been an element of the self-neglecting behaviours which became increasingly prominent. As previously stated, there is insufficient research into the links between domestic abuse and self-neglect in younger people, but domestic abuse is known to chip away at the victim's self-esteem and adversely affect their self-care. Alcohol dependence is also linked to poor self-care.

8.5 Given Lee's history and his needs he did not appear to be suited to an informal carer role and at times was clearly struggling to cope with supporting Henrietta, if indeed he was actually providing her with tangible support. It is not evident that professionals fully appreciated the manner in which Henrietta's needs intersected with each other, the extent to which Lee's needs increased the likelihood that he would struggle to care for her and the extent to which this combination of intersecting needs of victim and informal carer/ intimate partner/domestic abuser contributed to the abuse which Henrietta suffered.

8.6 The DHR has been advised that a lack of appreciation and understanding of intersecting needs of victims and perpetrators was not highlighted in a recent training needs analysis. However, a related issue was highlighted in a Safeguarding Adults Review (SAR Juliet) recently completed by the independent reviewer for Somerset Safeguarding Adults Board. The circumstances of that case were similar to this DHR. SAR Juliet found that the MARAC often did not appreciate the range of risks to which Juliet was exposed and so the intersecting impact was therefore overlooked.

Recommendation 2 (MARAC Officer)

That the MARAC officer, with the support of the MARAC operating group, reflect on learning from DHRs and MARAC cases to inform future training to better understand intersectionality of those subject to MARAC.

8.7 This and several other DHRs have challenged the extent to which MARAC remains fit for purpose to consider victims with complex needs, particularly if the perpetrator (as in this case) also has quite complex needs. SafeLives recommends that in such cases MARAC considers arranging an MDT meeting to discuss complex cases. MARAC proposed this approach with Henrietta, but this led only to a period of joint working rather than the MDT envisaged by MARAC. The issue of how MARAC handles cases in which the needs of the victim are complex may need to be further reviewed by SafeLives, possibly drawing upon initiatives taken in different parts of the country such as twin-track MARACs where more complex cases are considered by a 'complex needs' MARAC where much more time is available to devote to each case.

8.8 The Somerset MARAC Operating Protocol (which at the time of writing was awaiting approval) stresses that MARAC is not a corporate body, does not hold a caseload and does not own risk associated with any case. The risk remains with individual agencies. The Operating Protocol states that if a victim is not engaging with any agency or services, despite repeated and vigorous attempts to initiate/maintain contact, then the lead agency (which the Protocol states will be the agency who referred the case into MARAC unless an alternative lead agency is identified at MARAC) must take steps to identify, reduce and manage the presenting risk by escalating to partners who may be able to assist. This may include holding a risk management meeting with multiple agencies to discuss concerns. The weakness identified in the system in Henrietta's case is that MARAC identified Adult Social Care as the lead agency to adopt an MDT approach which achieved a relatively brief period of joint working between occupational therapy and the integrated rehabilitation team which did not really accord with a full MDT approach. There appeared to be no feedback loop to MARAC to inform them of the limited

outcome of the MDT approach they had proposed. The DHR has been advised that there is now a system for agencies to update the MARAC on the outcome of actions.

However, the DHR Panel has been advised that the volume of cases being heard at MARAC means that MARAC simply does not have the capacity to review progress on actions agreed at previous MARAC meetings. This independent author fully accepts the point that MARAC manages very high demand in terms of referrals of high-risk cases but feels that there needs to be a mechanism for checking whether a MARAC recommendation for a separate risk management meeting to be held has been implemented or not. Otherwise, there is a risk that the case will simply be referred back to MARAC (possibly repeatedly as in Henrietta's case) thus placing greater pressure on the MARAC process.

Recommendation 3 (MARAC Steering Group)

That where the MARAC has recommended that a multi-disciplinary approach should be adopted in complex cases, MARAC should consider developing a system to monitor the report back from the agency responsible for leading the MDT approach to accurately ascertain the effectiveness or otherwise of the MDT approach.

8.9 After reviewing the recommendations made in this DHR Overview Report, the Safer Somerset Partnership has advised the independent author that Recommendation 3 should be amended to read as follows:

Recommendation 3 (MARAC Steering Group)

That the MARAC chair/panel ensure that where there are complex cases that may require a further multi-agency risk management meeting (MARM) an action is set to ensure the lead agency/agencies are made aware of the need to convene a MARM.

8.10 Please note that the amended Recommendation 3 does not address the finding from this DHR that the MARAC has no system for checking whether the MDT or MARM recommended by MARAC was actioned by the lead agency.

8.11 The MARAC Operating Protocol goes on to state that the 'repeat referral' process is the safety net which ensures that victims at continuing risk are returned to MARAC. Henrietta's case was repeatedly returned to MARAC. There may need to be more clarity about what action the MARAC should take when a case is repeatedly

referred in. The MARAC could consider whether the 'whole system' is working for the victim and explore how the system could work better to reduce the risk to the victim. In Henrietta's case, if the MARAC had adopted this approach and held the 'whole system' to account it may have felt that SIDAS could have considered more creative ways of engaging with Henrietta and questioned the absence of in-person contact with Henrietta by Adult Social Care for example.

Recommendation 4 (MARAC Steering Group)

That the MARAC steering group to gain an understanding of the rational for repeat cases including auditing if all agencies were present, effectively working together, and what were the barriers/missed opportunities.

Management of referrals to Adult Social Care

8.12 Adult Social Care's response to the referrals they received in respect of Henrietta highlights several areas of learning for the service, specifically:

- The need for enhanced awareness of forms of domestic abuse, particularly coercion and control and coercion and control within informal caring relationships.
- The need for enhanced appreciation of how the needs of a victim of domestic abuse may intersect and increase their vulnerability and possibly impair their ability to protect themselves from abuse or neglect.
- The need for staff to be encouraged to exercise professional curiosity. An important example of where professional curiosity could have been of benefit in this case was in linking the information Adult Social Care held about both the victim and the perpetrator.
- Stressing the importance of recognising brief windows of opportunity in relation to people who are subject to coercion and control.
- The importance of carefully considering when home visits are preferable in order to better understand the needs of people referred to Adult Social Care.
- The need for a system which flags repeat referrals for management oversight.

8.13 Adult Social Care has developed a detailed action plan to address the learning from this DHR, which includes a review of core training to ensure that professional curiosity, forms of abuse, coercion and control, alcohol misuse and dependence and the importance of seizing brief windows of opportunity are robustly addressed; that an audit focusing on professional curiosity is incorporated into their Practice Quality Framework programme; and a review of business processes about linking Intel, including Police reports, between files to ensure that key information is recorded on the victim and perpetrators file, considering GDPR.

Recommendation 5 (Adult Social Care)

That Adult Social Care implement the programme of development identified as a result of the learning from this DHR which addresses staff awareness of coercion and control, how intersecting needs can increase the risk of abuse and/or neglect, support for staff to exercise professional curiosity, the importance of recognising and responding to brief windows of opportunity to engage with victims, recognising when in-person contact is preferable to telephone contact and ensuring that a pattern of repeat referrals is recognised and receives management attention. The comprehensive single-agency action plan developed by Adult Social Care would be a suitable vehicle for implementing this recommendation.

Use of 'breathing space' afforded by a DVPO

8.14 The Police use of DVPO powers and their subsequent arrest of Lee for breaching the DVPO enabled successive 'breathing spaces' during which Lee was largely prevented from visiting Henrietta's home. Partner agencies could have exploited this opportunity to convene a multi-agency meeting and develop a support plan, possibly including an assessment of Henrietta's care and support needs, a formal assessment of her mental capacity in relation to keeping herself safe in her relationship with Lee, encouraged her to self-refer to SDAS and sought her consent to contact her family. The DHR Panel questioned whether the Police and partner agencies have sufficient capacity to resource a multi-agency approach to exploiting the breathing spaces afforded by DVPOs. There were 1,132 DVPOs granted in the Southwest of England during the 12 months up to 31st March 2024 (17) and so the resource implications are substantial. However, in cases in which the victim has particularly complex needs the resources needed for a multi-agency approach to DVPOs is justified.

8.15 The independent author was minded to therefore recommend that a DVPO should always trigger a multi-agency meeting to consider how to make the most effective use of the 'breathing space' to support a high-risk victim of domestic abuse who has complex needs. However, Avon and Somerset Police does not accept this recommendation as they are satisfied that they already have processes in place to address this recommendation which has been subject to assurance work. Specifically, the Police advise that when an application for a DVPN is sought a task is sent to the LSU to review the circumstances and make appropriate referrals, including to agencies already involved and others who may need to become involved. The Police advise that they have carried out a dip sample audit of 16 DVPN applications and in all cases the LSU were tasked and made appropriate onwards referrals from these. This includes to MARAC or any other lead professional as appropriate based on the circumstances.

8.16 The proposed recommendation is therefore withdrawn. However, if the Police are satisfied that they have an assured process for making referral to relevant agencies when a DVPN is sought, the focus then shifts to what agencies who are advised that a DVPN has been sought do in response to this information. As suggested in Paragraph 6.31 a multi-agency meeting or discussion could have been helpful.

Henrietta's contact with her GP practices

8.17 There is learning for both GP practices with which Henrietta was registered during the period on which the DHR focusses, in particular the need to improve the use of targeted enquiry accompanied by professional curiosity. There is also a need to ensure that all patients in respect of whom there are safeguarding concerns are discussed in GP practice safeguarding meetings. Action plans for both GP practices are shown later in this DHR report.

Recommendation 6 (NHS Somerset Integrated Care Board)

That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases. The NHS Integrated Care Board obtain assurance that GP practices are following the Standard Operating Procedure which outlines the use of target clinical enquiry into domestic abuse.

Acceptable behaviour contracts

8.18 The use of acceptable behaviour contracts can support a victim of domestic abuse to exclude the perpetrator from their property, contribute to the safety of the victim and may alleviate the impact of domestic abuse incidents on neighbours. However, the use of acceptable behaviour contracts may also have negative consequences such as increasing the risk to victims if they try to prevent perpetrators from entry to their address for example. Where acceptable behaviour contracts are used, they should be an element in a victim-centred multi-agency approach in which any legal action should be focussed on the perpetrator of domestic abuse.

8.19 The independent author was minded to recommend that the Safer Somerset Partnership obtained assurance via the Domestic Abuse Local Partnership Board that registered housing providers have effective policies in place to support tenants who experience domestic abuse and that registered housing providers adopt a victim-centred multi-agency approach in which any legal action is focussed on the perpetrator of domestic abuse. The DHR Panel advised that this recommendation may not be achievable given the number of registered housing providers (around 20) from whom assurance would need to be sought.

8.20 The independent author is a former independent chair of local Safeguarding Children Partnerships. Safeguarding Children Partnerships conduct periodic audits of the compliance of partner agencies with their duties under Section 11 of the Children Act 2004 (to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children). This Section 11 audit is conducted by formulating a questionnaire which is completed by partner agencies, the responses analysed and a summary report prepared. It is a substantial piece of work. However, a similar approach could be adopted to enable the Domestic Abuse

Local Partnership Board to gain assurance in respect of registered housing providers policies.

Carers Assessment

8.21 At no time did any agency in contact with Henrietta or Lee consider referring Lee for a carer's assessment. As previously stated, professionals may have struggled to perceive a male in his mid-30s to be the carer of a woman in her early 40s. A carer's assessment would have provided Lee with the opportunity to discuss his needs as a carer and would also have provided the professional carrying out the assessment an opportunity to gain insight into Henrietta's care and support needs, the extent to which they were being met by Lee and shed light on the dynamics of Lee's relationship with Henrietta.

Recommendation 7 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team shares the learning from this DHR with Somerset Safeguarding Adults Board and requests the Board to consider how to highlight the fact that informal caring relationships take many forms and to highlight the rights of carers to a carers assessment, particularly to agencies (such as the Probation Service) which may not be familiar with carers assessments.

Support for bereaved families where domestic abuse victims do not die by homicide

8.22 When Henrietta's family read and commented on a late draft of the DHR report they highlighted the lack of specialist support for families bereaved in circumstances similar to Henrietta's death. Only bereaved families affected by murder or manslaughter are eligible for support from the Victim Support Homicide Service, although direct eyewitnesses of the murder or manslaughter can also contact the service. This means that the families of victims of domestic abuse who die by suicide or where their death results in part from a combination of neglect and coercion and control from the perpetrator are not eligible for support from the Victim Support Homicide Service. Given increasing awareness of the impact of domestic abuse on deaths other than homicides, there may be a case for the Home Office to review the eligibility of bereaved families for specialist support from the Victim Support Homicide Service.

Safeguarding Adults Review (SAR) 'Juliet'

8.23 The independent reviewer for DHR Henrietta has also completed a separate SAR for the Somerset Safeguarding Adults Board (SAR 'Juliet'). This SAR also relates to the death of female (who was around 20 years older than Henrietta) who was frequently the victim of domestic abuse from her on/off intimate partner who presented himself as her carer. In that case there was also substantial involvement with a range of agencies and concerns about the victim's self-neglect and alcohol dependence. Several of the learning themes present in DHR Henrietta are replicated to an extent in SAR Juliet. The SAR Juliet report was approved by Somerset Safeguarding Adults Board in May 2025. There may be opportunities for Somerset Safeguarding Adults Board and the Safer Somerset Partnership to collaborate on the implementation of the recommendations from each review. Additionally, it is recommended that a learning event is arranged to jointly disseminate the learning from the 2 reviews.

Recommendation 8 (Safer Somerset Partnership and Safeguarding Adults Board)

That Somerset Safeguarding Adults Board and the Somerset Council Community Safety Team arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

Single agency action plans

Abri

- To ensure that Abri professionals explore appropriate support avenues during home visits to residents.
- If a CSO is unable to make successful contact with an individual, alternative options may be explored including carrying out a home visit or offering support in writing (may be a letter, email, portal message or text) if it is deemed safe to do so.
- Where Abri refer residents to Adult Social Care and do not receive feedback in response to the referral, the issue will be escalated to Abri management.

Adult Social Care

- That Adult Social Care implement the programme of development identified as a result of the learning from this DHR which addresses staff awareness of coercion and control, how intersecting needs can increase the risk of abuse and/or neglect, support for staff to exercise professional curiosity, the importance of recognising and responding to brief windows of opportunity to engage with victims, recognising when in-person contact is preferable to telephone contact and ensuring that a pattern of repeat referrals is recognised and receives management attention.
- That SC ASC supports staff to recognise when in-person contact is preferable to telephone contact.
- It is recommended that core SC ASC training is reviewed to ensure there is robust content in relation to professional curiosity, forms of abuse, coercion and control, alcohol misuse and dependence, and how intersecting needs can increase the risk of abuse and/or neglect.
- It is recommended that an audit focusing on professional curiosity is incorporated into the SC ASC Practice Quality Framework programme.
- It is recommended that SC ASC core training is reviewed to ensure robust content about the importance of brief windows of opportunity in relation to people who are subject to coercive control.

GP Practice 1

- To improve record keeping in relation to targeted enquiry.
- To ensure appropriate follow up of appointments
- To improve the use of targeted enquiry and professional curiosity.
- To ensure that all patients in respect of whom there are safeguarding concerns are discussed in practice safeguarding meetings

GP Practice 2

- To improve use of targeted enquiry and professional curiosity.

- That the Practice evidence that a patient's mental capacity has been considered when making decisions about care and consider use of a Mental Capacity Act (MCA) template such as Ardens to facilitate this.
- That the Practice considers accessing safeguarding supervision from NHS Somerset Integrated Care Board.

Probation

- That Home Visits should be completed in line with Probation Home Visit Policy, including when there has been a significant change in circumstances.
- That Management Oversight recordings are structured and include SMART objectives, including deadlines for actions to be undertaken. Such actions should also be followed up to ensure they are completed.
- That practitioners are advised to clearly consider, record and validate/confirm the role and responsibilities of People on Probation who state that they are in receipt of carers allowance or perform a carer role. This will include the type of carer responsibilities required and the frequency of this. Understanding this will enable appointments and support to be implemented and also for consideration to be given, if this relationship breaks down.

Somerset NHS Foundation Trust

- To consider how domestic abuse routine enquiry can be embedded within Emergency Departments.
- To remind Emergency Departments staff of the importance of being professionally curious when patients are presenting with injuries for which the explanation given seems/could be questionable.
- Consideration /discussion of onward referral to specialist services/support. Emergency Department staff to contact SFT safeguarding advisory service if unsure.

You Trust (SIDAS Provider)

- That professionals participate in annual case note recording training (mandatory).

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Safer Somerset Partnership

Domestic Homicide Review Executive Summary

Henrietta died in December 2022

Independent Author – David Mellor BA QPM

Report completed in December 2025

Report published in October 2026

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1.0 Introduction

1.1 This is an Executive Summary of a Domestic Homicide Review (DHR) undertaken by Safer Somerset Partnership following the death of Henrietta (a pseudonym).

1.2 Henrietta died at her ex-partner Lee's address in December 2022. She was 44 years of age. Henrietta had lived independently in social housing for a number of years. She had been in an intimate relationship with Lee for over a decade and although the relationship had become intermittent, Lee was a frequent visitor to Henrietta's home and as her health declined he began presenting himself to partner agencies as her informal carer. Henrietta had become dependent on alcohol but appeared reluctant to acknowledge the issue or seek help. She regularly experienced seizures and her mobility was adversely affected by the amputation of some of her toes after contracting sepsis. She began to experience falls more frequently and in March 2022 sustained a fracture of the neck of her femur which further reduced her mobility and increased her dependence on Lee. There was a significant escalation in domestic abuse incidents involving Henrietta and Lee during 2020 and again in 2022. Henrietta was almost always perceived to be the victim and Lee the perpetrator and he was imprisoned after breaching a Domestic Violence Protection Order which prohibited him from molesting Henrietta. Henrietta appeared to be dependent on Lee for support, but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered.

1.3 The DHR process began with an initial meeting of representatives of the Safer Somerset Partnership on 7th January 2024 when the decision to hold a DHR was unanimously agreed. All agencies that potentially had contact with Henrietta were contacted and asked to confirm whether they had involvement with her. The agencies which confirmed contact were asked to secure their files.

1.4 The following agencies provided Individual Management Reviews to inform the review:

- Abri (Housing Provider)
- Avon and Somerset Police
- Oaklands Surgery
- Probation Service
- Somerset Council Adult Social Care
- Somerset Council Housing
- NHS Somerset Integrated Care Board
- Somerset NHS Foundation Trust
- South West Ambulance Service NHS Foundation Trust
- West Coker Surgery
- You First (provider of Somerset Domestic Abuse Service)

After Lee consented to relevant information from his medical records being used to inform the DHR, Somerset Council Adult Social Care, NHS Somerset Integrated Care Board and Somerset NHS Foundation Trust provided additional summary reports.

1.5 The authors of each IMR were independent in that they had had no prior involvement in the case.

The DHR Panel Members

1.6 The DHR Panel consisted of:

David Mellor	Independent Chair of DHR Panel and Independent Author
Community Safety Manager	Somerset Council
Deputy Designated Nurse for Safeguarding Adults	NHS Somerset Safeguarding Team, Integrated Care Board

Detective Chief Inspector	Avon and Somerset Police
Group Community Safety Manager	Abri
Head of Somerset Probation Delivery Unit	HM Prisons and Probation Service
Service Manager	Somerset Domestic Abuse Service
Principal Social Worker/Strategic Manager Safeguarding & DOLS	Somerset Adult Social Care
Project Change and Improvement Officer	Somerset Council
Housing Specialist	Somerset Council
Safeguarding Manager	Somerset Drug & Alcohol Service
Safeguarding Specialist	South West Ambulance Service NHS Foundation Trust
Strategic Lead & Named Professional Safeguarding Adults; Prevent Lead/Domestic Abuse & Sexual Violence Lead	Somerset NHS Foundation Trust

1.7 DHR Panel members were independent of the line management of any staff involved in the case. The Panel met on six occasions – 25th June, 10th September, 16th October and 4th December 2024, 30th January, 1st April and 7th May 2025.

1.8 Following the decision to commission a DHR, Safer Somerset Partnership wrote to Henrietta's parents and her sister to advise them that the DHR had been commissioned and to invite them to contribute to the review. Their views have informed this report. Henrietta's partner Lee was also invited to contribute to this DHR. His views have also informed the report.

Author of the overview report

1.9 David Mellor was appointed as the independent author and chair of the DHR Panel established to oversee the review. David is a retired police chief officer who has thirteen years' experience as an independent author of DHRs and other statutory reviews.

Statement of independence

1.10 Since 2006 he has been an independent consultant. He was a police officer in Derbyshire Constabulary, Greater Manchester Police and Fife Constabulary between 1975 and 2005. He retired as a Deputy Chief Constable.

1.11 He was independent chair of Cheshire East Local Safeguarding Children Board (2009-2011), Stockport Local Safeguarding Children Board (2010-2016) and Stockport Safeguarding Adults Board (2011-2015). Since 2012 he has been an independent chair/author/lead reviewer of a number of Serious Case Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews.

1.12 He has no connection to services in Somerset.

2.0 Terms of Reference

2.1 The general terms of reference are as follows:

7. Establish what lessons are to be learned from Henrietta's death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
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;
9. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
10. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
11. Contribute to a better understanding of the nature of domestic violence and abuse;
12. Highlight good practice.

2.2 The case specific terms of reference are as follows:

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Henrietta faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.
- 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.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice. In particular, explore the extent to which opportunities to safely make routine enquiry were taken by professionals.
- Given that agencies frequently struggled to engage with Henrietta, explore any barriers to accessing support she may have experienced, including the possibility that Henrietta may have been the victim of coercion and control. Is there any learning to be derived from Henrietta's contact with agencies which were more successful in working with her?
- Henrietta was frequently noted to be affected by alcohol use. Explore how professionals responded to this including the extent to which Henrietta was offered or encouraged to access support.
- 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.
- Whether the offer and/or provision of services to Henrietta was impacted by the restrictions introduced as a result of the Covid-19 pandemic.

3.0 Summary Chronology

Background information (Paragraph 3.1 to 3.4)

3.1 Henrietta was a White British woman who was born in 1978. She and her younger sister were brought up by their parents in a Somerset town. After graduating, Henrietta worked abroad in the hospitality sector for a number of years before returning to the UK. After contracting sepsis in 2017, Henrietta had the big toe and the second toe on both her left and right feet amputated which adversely affected her mobility and, in the words of her family, left her 'terribly frustrated'. Over time Henrietta appeared to become dependent on alcohol although there is no indication that she accessed support from substance services. She also suffered seizures which were under investigation but may have been secondary to alcohol withdrawal. She appeared to have been very underweight for several years although she had not been diagnosed with an eating disorder. She also began to sustain injuries from falling and fractured her knee in 2019 or 2020.

3.2 Lee is a White British male who was born in 1985. From his childhood years he behaved in a violent and aggressive manner towards his parents and was supported by CAMHS from the age of 10. As an adult he disclosed childhood sexual abuse. It is not clear from information held by agencies whether this was formally investigated. His first contact with Adult Mental Health services was in 2008 and he subsequently received support from the community mental health team (CMHT) and the Dual Diagnosis team. He was diagnosed with ADHD (attention deficit hyperactivity disorder)³⁶ and conduct disorder³⁷ during his childhood years. As an adult he was diagnosed with mental and behavioural disorders due to multiple drug use and use of other psychoactive substances. Later assessment indicated probable traits aligned with antisocial personality disorder, although this was not formally diagnosed. Lee (or his mother who often contacted agencies on his behalf) frequently requested

³⁶ ADHD is a neurodevelopmental disorder and refers to a pattern of behaviour that affects a child in most situations, is evident from an early age and can persist into adolescence and adulthood. Core symptoms of ADHD are difficulty concentrating, hyperactivity, and acting impulsively (such as doing things without thinking through the consequences).

³⁷ Conduct disorders' describes persisting disruptive or dissocial behaviour.

prescriptions of Diazepam³⁸, which his GP practice prescribed cautiously given the risk of misuse and addiction.

3.3 Henrietta and Lee's relationship began in 2008. During the earlier years of their relationship, Henrietta made several disclosures of domestic abuse by Lee to the Police. Lee was prosecuted for an offence of battery³⁹ against Henrietta which took place in December 2017, and he received a Conditional Discharge for 18 months. Henrietta became increasingly isolated from her family. Factors which contributed to this isolation appear to have primarily been Lee's aggressive and controlling behaviour and parental disapproval of Henrietta's alcohol use to an extent.

3.4 Lee's relationship with his parents became increasingly fraught and professionals became concerned about the risk to his parents from Lee's aggression and violence. Lee appeared to live between his parent's and Henrietta's address and as her health declined began presenting himself as her carer.

3.5 The Police attended 3 domestic abuse incidents involving Henrietta and Lee in 2018 and 4 such incidents in 2019. This DHR focusses on the period of almost 3 years from January 2020 until Henrietta's death in December 2022. There was a marked escalation in reported domestic abuse incidents in 2020 (16 in all), 4 reported domestic abuse incidents in 2021 and a further escalation to 15 reported incidents in 2022.

2020

3.6 On 2nd February 2020 Henrietta called the Police to report that her 'ex-partner' Lee was refusing to leave her address. The call handler spoke to Lee and advised him to leave the property, which he apparently did. Henrietta advised the police that a verbal argument had taken place. No offences were disclosed. Henrietta did not wish to complete a DASH (Domestic Abuse, Stalking and Honour Based Violence)⁴⁰ risk assessment and so a standard risk DASH was completed by an officer on the basis of their own observations.

³⁸ Assault by beating is the charge relating to the offence of battery which is committed by the intentional or reckless application of unlawful force to another person (Section 39 Criminal Justice Act 1988).

³⁹ Battery is committed by the intentional or reckless application of unlawful force to another person. The offence was placed on a statutory footing by Section 39 Criminal Justice Act 1988. Where battery is selected it should be charged as "assault by beating".

⁴⁰ The DASH risk assessment is a nationally implemented tool used to identify and assess risks when a potential victim discloses domestic abuse, honour based violence or stalking.

3.7 On 5th March 2020 Henrietta called the Police to report that Lee had stolen her bank card. Officers were dispatched and spoke to Henrietta who stated that Lee had called at her address asking for money. When Henrietta refused his request, Lee picked up her bank cards and attempted to leave. Henrietta locked the doors and Lee pushed her when trying to get out. Henrietta did not wish to support any further action by the Police. A medium risk DASH was completed. The officers noted that Henrietta was recovering from a fractured knee (Henrietta sustained a knee fracture, apparently caused by a fall, in late 2019/early 2020), and, as stated, had previously had some of her toes amputated. The officers felt that Henrietta required the support of a care package, noting that she did not have anyone other than Lee for support. A BRAG (which stands for Blue, Red, Amber and Green)⁴¹ assessment rated amber, was completed. The Police Lighthouse Safeguarding Unit (LSU)⁴² made a referral to Adult Social Care. Due to insufficient evidence, no further police action was taken.

3.8 On 12th March 2020 Adult Social Care considered the above Police referral. The history of domestic abuse in her relationship with Lee was not included. The SCCC (Somerset County Council Contact Centre) phoned Henrietta to gather more information. She shared her health and mobility difficulties – describing herself as ‘housebound’, the help and support she received from Lee and her housing and benefits situation. She also said she had seen her GP in respect of depression and anxiety. The Police referral was then sent to the Adult Social Care community team who phoned Henrietta and offered her a Section 9 Care Act assessment⁴³, which she decided not to avail herself of. The SCCC number was shared with her in case she changed her mind.

3.9 On 23rd March 2020 the first national lockdown began in response to the Covid-19 pandemic. The unprecedented demands of the pandemic led to partners adopting alternative service delivery models which significantly limited in-person contact with citizens.

⁴¹ The BRAG is a tiered assessment tool introduced in 2018 to objectively risk assess and record all forms of vulnerability or safeguarding concerns. The outcome of the BRAG assessments helps determine immediate action as well as helping LSU to triage and signpost or refer to appropriate partner agencies.

⁴² The LSU is a team with joint function of supporting victims/witnesses of crime including onward referral to other agencies and, where appropriate, being a point of contact during a CJS process.

⁴³ Section 9 of the Care Act assessment states that local authorities must carry out an assessment of anyone who appears to have needs for care and support, regardless of whether those needs are likely to be eligible; focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve; involve the person in the assessment and, where appropriate, their carer and/or someone else they nominate; provide access to an independent advocate to support the person's involvement in the assessment, if required and consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support).

3.10 Shortly after midnight on 20th May 2020 Henrietta called the Police to report that Lee was intoxicated and screaming. Officers attended and spoke to Henrietta and Lee separately. Lee stated that Henrietta had hit him on the head with a TV remote but had no visible injuries and did not wish to make a complaint. There was felt to be insufficient evidence to consider an evidence-led prosecution⁴⁴.

3.11 On 26th May 2020 the Police were called to reports of a disturbance between Lee and Henrietta. A standard risk DASH was completed but officers did not feel that Henrietta was able to answer all of the questions truthfully. A (red) BRAG was completed which documented that Henrietta was unable to look after herself and relied on Lee, who she was afraid of. The Police added an information marker to Henrietta's address for 12 months. The Police LSU reviewed the risk assessments and made referrals to Adult Social Care, the Multi-Agency Risk Assessment Conference (MARAC)⁴⁵ and IDVA⁴⁶ services. SIDAS made 4 attempts to ring Henrietta and on the 4th call spoke to her and explored support options which she felt unable to accept.

3.12 On 27th May 2020 Adult Social Care considered the above Police referral. The SCCC sent the report to the Adult Social Care community triage team to request a Section 9 assessment of Henrietta's care and support needs. The triage team phoned Henrietta and discussed available support options such as direct payments and community agent referral which Henrietta did not feel able to accept at that time and so the referral was closed. Henrietta was advised to make contact if and when she required support.

3.13 On 23rd June 2020 Henrietta was discussed at MARAC following which SIDAS contacted her GP to request that her patient records were flagged as at that time there was no primary care engagement with the MARAC process. MARAC noted that Adult Social Care had received 2 contacts from the Police, but Henrietta had declined an assessment of her care and support needs. It was stated that her (unassessed) care and support needs could increase her vulnerability.

3.14 On 24th July 2020 the Ambulance Service attended a shop after Henrietta fell to the floor shaking inside the shop. The crew asked her about bruises on her arms and

⁴⁴ Evidence-led prosecutions are prosecutions that enable the prosecution team to deliver justice without requiring the support of the victim.

⁴⁵ MARAC is a meeting where information is shared on the highest risk domestic abuse cases and is attended by representatives from police, health, child protection, housing, independent domestic violence advisors (IDVAs), probation and other specialists from the statutory or voluntary sectors. They share all relevant information they have about a victim, discuss options for increasing the victim's safety and create a co-ordinated action plan

⁴⁶ An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members, with the aim of securing their, and their children's, safety.

she initially said that she had 'done it' on a gas stove and later said she had fallen against a wall. The crew established that she lived alone but spent time with her friend Lee. She was asked about safety concerns and stresses in the relationship but said there were none.

3.15 On 27th July 2020 Henrietta contacted the Police and reported that during an argument with Lee, a glass TV stand had been smashed after Lee fell on it whilst intoxicated. Both Henrietta and Lee were described as intoxicated. Lee had sustained injuries from the glass but declined medical attention. Henrietta said that she did not want Lee in her property and his mother was asked to collect him. No offences were considered to have taken place at that time. Officers completed a DASH and a BRAG based on officer observations. The Police LSU made referrals to MARAC and SIDAS.

3.14 On 29th July 2020 Lee was sentenced to a 24 month Community Order with 30 days of Rehabilitation Activity Requirement (RAR)⁴⁷ for the offence of possession of a bladed article in a public place. The victim of the offence was a neighbour of his parents. Lee was supervised by a Community Rehabilitation Company until such entities were disbanded following the reunification of Probation Services in June 2021. The Probation Service then supervised Lee until the Community Order was terminated on 2nd November 2021 as a result of further offending.

3.15 During the early hours of 2nd August 2020 the Police were called to Henrietta's address where she disclosed that Lee had assaulted her causing visible bruising to her left shoulder and had hit her on the head causing a lump. Lee had also caused damage at her address, smashing a window, Henrietta's phone and a TV. Lee was arrested and transported to custody. A medium DASH was completed with the officer noting the relationship appeared to be 'abusive from both sides' and 'neither could leave due to their vulnerabilities'. The Police LSU reviewed the incident and upgraded the risk to high due to a previous MARAC referral within the past 12 months and a further referral to MARAC was made.

3.16 On 25th August 2020 Henrietta was discussed at MARAC following which SIDAS contacted her GP to request that her patient records were flagged. Henrietta's GP was informed that MARAC was concerned that she lacked support, and the GP was requested to share the contact details for SIDAS with her, should she contact the GP Practice. Her GP records were appropriately coded. Concern that Henrietta was at risk of homelessness were raised.

⁴⁷ The RAR is one of the requirements that can be included within a community order or suspended sentence order. The main purpose is to secure someone's rehabilitation, restoring service users to a purposeful life in which they do not reoffend.

3.17 On 26th August 2020 an Abri⁴⁸ community safety officer (CSO) visited Henrietta. Also present was a male who was initially identified by the name of a former partner of Henrietta, but whom the CSO subsequently established was actually Lee. Henrietta disclosed that she had fled abuse from Lee 2 years previously but they had resumed contact during the first Covid-19 lockdown so that Lee could help her with her shopping. She said that Lee had subsequently assaulted her and smashed her window. She added that Lee had stolen money from her which had put her in debt. Henrietta said that she was no longer seeing Lee. She went on to say that she struggled with daily tasks such as cooking, taking a bath and shopping. The Abri CSO referred Henrietta to SIDAS and Adult Social Care. (There is no indication that a DASH was completed). SIDAS attempted to contact both Henrietta and Abri Housing without success and so the contact was closed.

3.18 On 27th August 2020 the SCCC considered the Abri referral in which Lee was said to be an informal carer who was present during their visit although Abri had been introduced to him using the name of a former partner. The referral also stated that Henrietta had been very emotional during the visit, 'forgetting and repeating things'. The SCCC followed this up in the first instance by phoning Henrietta to gather further information. She said that her former partner, who she said was not Lee, visited her daily to provide support and when asked to clarify the identity of her informal carer, she said that Abri must have got them muddled up. Henrietta expressed interest in finding out what support could be available for future reference. The ASC community triage team then phoned Henrietta who felt unable to accept an assessment, advising that she had support from her friends and neighbour. No further action was taken and the referral was closed.

3.19 On 28th August 2020 Henrietta attended Yeovil District Hospital. Three fungal wounds were noted on her back. She appeared underweight. Bruising to her wrists and back were noted. When asked about how the bruising was caused, Henrietta denied that she had been a victim of domestic abuse. On 1st September 2020 the Police received a call from the Yeovil District Hospital Safeguarding Team raising concern about Henrietta's attended Accident and Emergency (A&E) following a seizure and was found to have bruising. When questioned, Henrietta had disclosed that the bruising had been caused by a friend who attended her address every other day to help her around the house. Henrietta disclosed that she was frightened and could not bear the situation, which had been going on for years, any longer. The Police investigated the above incident, but Henrietta did not feel able to provide a statement, consent to her medical records being accessed or support a prosecution. An evidence-led prosecution was considered and as a result of Lee's denials in relation to Henrietta's injuries and his admission that he had caused the criminal damage in his police interview he was dealt with by way of a community resolution

⁴⁸ Abri is a housing association based in the South of England. Abri was Henrietta's landlord.

and was given a conditional caution for the offence of criminal damage. The condition required Lee to complete a CARA course (Cautioning and Relationship Abuse) by the 3rd March 2021. A CARA course is a diversionary course for domestic abusers providing 'awareness training and a reflection journey'.

3.20 Also on 1st September 2020 Henrietta's GP was advised of current domestic abuse concerns about Henrietta by the Yeovil District Hospital safeguarding team. On the same day the GP carried out a phone review of Henrietta's health following her recent hospital admission and referred her to dietetic services as she was 'very underweight'. The earlier MARAC request to share details of SIDAS with her was not actioned and domestic abuse was not explored with her. It is not known whether the GP was concerned that Henrietta may not be alone. The GP arranged for a health coach to contact Henrietta. The health coach phoned her on 7th September 2020 and noted that Henrietta 'did not have much of a voice' and appeared to be struggling to speak. Henrietta agreed to further contact but there is no indication that any subsequent phone call was made.

3.21 On 9th September 2020 a dietetic triage of Henrietta was carried out by phone. She was noted to have a very low BMI. She was said to have denied that she had an eating disorder. She said that she ate protein and vegetables but not carbohydrates. A clinic appointment was arranged for 19th October 2020.

3.22 On 15th September 2020 Henrietta called the Police to report that she had been locked out of her house by Lee. Officer attended and noted that Henrietta depended on Lee due to her mobility issues and whilst they were no longer in a relationship (they both were said to have new partners) Lee spent a lot of time at her address helping her. It was noted Lee drank heavily, had diagnoses of ADHD and Asperger's⁴⁹ (No diagnosis of Aspergers is recorded for Lee) and struggled to control his temper at times and there appeared to be some jealousy around Henrietta's new partner. The Police LSU reviewed the incident and made a referral to SIDAS. No further police action was taken.

3.23 On 17th September 2020 the Abri CSO visited Henrietta's address and received no reply. Lee was heard to be shouting and swearing very loudly and the sound of items being thrown around could be heard. The CSO was concerned for Henrietta's safety but then saw her returning to the flat. Lee then appeared naked at the window of the flat shouting and swearing. Abri called the Police who attended promptly and

⁴⁹ Asperger syndrome (often shortened to Asperger's) is no longer used as a diagnostic term for autism and is considered controversial due to the history of Hans Asperger. Historically, Asperger syndrome was used as a diagnostic term for some autistic people who did not also have a diagnosis of a learning disability. Broadly, it is now agreed that what was referred to as Asperger syndrome is part of the autism spectrum and there is no need for a separate term.

arrested Lee for public order offences and removed him from the scene. Henrietta 'refused to engage' with the Police and following the investigation there was insufficient evidence to seek a charging decision for an evidence-led prosecution. However Lee was prosecuted for public order offences. A high-risk DASH was completed on the basis of officer observations which documented that Henrietta was at risk of serious harm due to her vulnerabilities regarding her health and reliance on support from Lee. An amber BRAG was completed noting that Henrietta was not taking her medication or engaging with Adult Social Care and was thought to be drinking a litre of vodka a day. The officer noted Henrietta was in 'desperate need of help' but was reluctant to involve any support services. Henrietta was documented to be reliant on Lee helping her with bathing, shopping and cleaning and Lee was said to believe that Henrietta would die if she did not seek help. The Police LSU reviewed the incident and made referrals to SIDAS, Adult Social Care and MARAC. The Abri CSO noted that the flat was dirty and untidy. The CSO also advised Henrietta that if she allowed Lee to stay in her flat this could put her tenancy at risk and a further visit was arranged so that Henrietta could sign an acceptable behaviour contract (ABC)⁵⁰ which would include a clause to prevent Lee from visiting.

3.24 On 19th September 2020 the Police received an abandoned 999 call which was traced to Henrietta and officers visited her. She disclosed that Lee had kicked her in the back leaving no visible injuries. Henrietta did not feel able to make a statement or support a prosecution. A medium risk DASH was completed which noted Henrietta 's reliance on Lee 'due to her disabilities'. The Police LSU reviewed the incident and referrals were made to SIDAS, MARAC, and Adult Social Care. The information marker on Henrietta 's address was extended for a further twelve months.

3.25 On 24th September 2020 SIDAS received the Police referral and contacted Henrietta on the same day. She did not feel able to accept support, stating, "Lee is already in enough trouble".

3.26 On 27th September 2020 the Police attended a report of a disturbance at Henrietta's address. She disclosed that Lee had slapped her across the face and left the address. Henrietta felt unable to make a witness statement or support a prosecution. A high risk DASH was completed which documented that Henrietta relied heavily on Lee for support as her friends and family had all distanced themselves from her 'due to Lee'. Henrietta stated that Lee seemed to want more

⁵⁰ An ABC is a written agreement between a person who has been involved in antisocial behaviour and one or more local agencies whose role it is to prevent such behaviour. ABCs are most commonly used for young people but may also be used for adults. The contract is agreed and signed at a meeting with the individual and the lead agencies. The contract specifies a list of anti-social acts in which the person has been involved and which they agree not to continue. Where possible the individual should be involved in drawing up the contract. This may encourage them to recognise the impact of their behaviour and take responsibility for their actions. Support to address the underlying causes of the behaviour should be offered in parallel to the contract.

from the relationship than just being friends, which is all she said she wanted. Henrietta said that she felt trapped within the 'friendship' and due to her reliance found it difficult to break away. An amber BRAG documented Henrietta's struggles with mobility and possible linked mental health issues. The Police LSU referred Henrietta to MARAC, Adult Social Care and SIDAS. An evidence-led prosecution had been considered.

3.27 On 28th September 2020 Adult Social Care considered the Police referral in respect of the 19th September 2020 incident (Paragraph 3.24) which stated that Lee posed a high risk to Henrietta and there had been a number of incidents of domestic abuse from Lee towards Henrietta, and that Lee had a history of domestic violence towards his parents. The SCCC sent the referral to the Adult Social Care safeguarding service for a decision. A safeguarding worker phoned Henrietta who discussed her 'health issues' and the support she received from Lee. Henrietta said that 'everything had settled' and she did not feel unsafe with Lee. After a discussion with the triage safeguarding lead, the safeguarding referral was not accepted, as Henrietta was said to have demonstrated that she was able to protect herself from physical abuse.

3.28 On 5th October 2020 Adult Social Care considered the Police referral in relation to the 27th September 2020 incident (Paragraph 3.26). The Police referral stated that Henrietta was "stuck in an awkward position where I suspect she wants to separate from Lee but is nervous about doing so due to him helping her so much. This leads her to continue contact with him as she is reliant on him and doesn't have any other support in place currently." Henrietta's home environment was described as messy and cluttered and Henrietta was said to sleep on a mattress on the floor. The report referred to previous Police referrals and noted that Henrietta and Lee had been heard at MARAC three times in the past few months. The SCCC worker misread the referral and mistakenly believed that it related to the previous Police report which was considered by Adult Social care on 28th September 2020 (Paragraph 3.27). The SCCC worker therefore believed that Adult Social Care Safeguarding had already considered the referral, which was sent to the community triage team highlighting Henrietta's mobility issues. An occupational therapist from that team phoned Henrietta who agreed to be put on the allocation list for a bathing assessment.

3.29 On 19th October 2020 Henrietta did not attend the scheduled dietetic appointment. The service attempted to ring Henrietta 3 times without reply. Later that day Henrietta rang to apologise for missing the appointment which was rescheduled for 7th December 2020. She reported feeling well. No previous 'dietetic input alerts', safeguarding entries or active referrals were noted.

3.30 On 21st October 2020 the Police attended a report of a disturbance at Henrietta's address. She disclosed that Lee had spat at her and two days earlier had kicked her in the legs causing bruising to her left upper thigh and lower left leg. Henrietta added that on the same date she had suffered a fit, causing further bruising to her legs. A high risk DASH and an (amber) BRAG were completed, the latter highlighting concerns that Henrietta was not taking her medication or engaging with Adult Social Care. The Police LSU made referrals to SIDAS and MARAC. Lee was arrested in relation to a number of outstanding disclosures by Henrietta. Police investigated but no further action was taken due to insufficient or conflicting evidence and Henrietta's 'refusal' to support a prosecution. A DVPN⁵¹ was sought and issued on 22nd October 2020, along with a subsequent DVPO⁵² which applied from 23rd October 2020 for 28 days and prohibited Lee from molesting Henrietta, from entering her address or coming within 100 yards of her. Henrietta was said to be unhappy about the DVPO as she relied on Lee for support. SIDAS made 3 unsuccessful attempts to contact Henrietta.

3.31 On 16th November 2020 the Police attended a report of a disturbance between Lee and Henrietta at her address. Henrietta disclosed that Lee had visited her address on three occasions during that day, shouting and kicking the window, refusing to leave and had pushed his way into the address and assaulted her by kicking her thigh, spitting on her and slapping her face. Lee had left prior to police attendance but was located nearby and arrested. A high risk DASH and a (red) BRAG were completed. The Police LSU referred Henrietta to SIDAS and MARAC. Lee was prosecuted for breaching the DVPO and was sentenced to 42 days in custody.

3.32 On 24th November 2020 Henrietta was heard at MARAC. The meeting was advised that Lee was in custody and was due to be released on 7th December 2020. SIDAS was asked to make a further attempt to contact Henrietta. When SIDAS rang Henrietta, the sound of male and female voices could be heard although no-one spoke directly into the phone before the call ended. No further attempts were made to contact Henrietta as it was unclear if it was safe to do so. SIDAS did not inform the Police of the outcome of the attempt to contact Henrietta. MARAC was also advised that Henrietta was due to move to a new property (bungalow) but there was no support in place to help her with this (unclear if this comment related to support to accomplish the move or post-move support). The DHR has been advised that

⁵¹ A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard.

⁵² DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions.

Henrietta did not request any support with the move and so it is assumed that she must have made her own arrangements. There were concerns around non-compliance/disguised compliance⁵³. The MARAC was advised that Henrietta just wanted Lee to 'come back and look after her'.

3.33 On 2nd December 2020 Henrietta signed up for her new property after attending a viewing several days earlier whilst apparently intoxicated. She signed a tenancy agreement and an acceptable behaviour contract which included not allowing Lee to attend her address.

3.34 After requesting the rescheduling of her 3rd December 2020 dietetic appointment because she was moving home, the appointment took place by phone on 9th December 2020 and a food fortification⁵⁴ approach was to be adopted and an action plan created. Henrietta was discharged from the dietetic service but was advised of the option to self re-refer. On the same date Henrietta's GP received a letter from dietetic services which expressed concerns about her weight and requested the GP to monitor this. On 18th December 2020 a message was left for Henrietta to contact the surgery to provide monthly weight measurements as recommended by the dietician or to attend the surgery for weight checks.

3.35 On 22nd December 2020 Lee self-referred to SDAS and remained involved with the service for over a year, attending a psychosocial group.

3.36 On 25th December 2020 Henrietta called the Police for help in removing Lee from her address, the DVPO having expired. She said that Lee had thrown items and water at her and spat at her. She did not feel able to support a prosecution and the Police took no further action. A standard risk DASH was completed. The Police LSU increased the DASH risk assessment to high and made referrals to SIDAS and MARAC. By visiting Henrietta's address, Lee was in breach of Court bail conditions imposed following the 16th November 2020 incident (Paragraph 3.31), but this was not dealt with by the officers who attended. This omission was noticed by an Inspector, but by that time Lee had attended Court for another incident which precluded further action for the breach of Court bail conditions. The Inspector set out further action to be taken to enable an evidence-led prosecution to be considered,

⁵³ Disguised compliance is a term used to describe the behaviour of parents or carers who appear to co-operate with professionals in order to allay concerns and stop professional engagement. It is unclear what the evidence of disguised compliance related to in this case.

⁵⁴ Food fortification entails adding household ingredients to normal food to increase its nutritional content without increasing the amount of food which needs to be eaten. e.g. 1 tablespoon of skimmed milk powder added to one portion of mashed potato

highlighting the possibility of coercion and control, although a prosecution was unable to proceed.

3.37 On 30th December 2020 SIDAS received the Police referral in respect of Henrietta and phoned her the same day. She said that she wasn't able to talk and SIDAS called her back on 4th January 2021, when Henrietta said that she had moved (home), Lee was in custody, "everything was fine" and that she did not feel she needed SIDAS support.

2021

3.38 On 6th January 2021 the third Covid-19 lockdown began.

3.39 On 19th January 2021 Adult Social Care received the minutes of a recent MARAC meeting at which Henrietta had been discussed. Concerns were raised at MARAC about Henrietta not engaging with occupational therapy (OT) and it had been suggested that a multi-disciplinary team approach was needed to support Henrietta. In response Adult Social Care agreed that Henrietta would be allocated to an OT and a plan agreed. When phoned by the OT, Henrietta declined an assessment as her new address had an accessible bathroom and she also had support from a 'friend'. The OT decided to review in two weeks' time. At that time (February 2021) Henrietta agreed to a referral to IRT (integrated rehabilitation team)⁵⁵. A joint visit involving IRT and OT was envisaged due to the potential risk from Lee. However, in April 2021, following discussion between the OT and the Safeguarding Service Henrietta was closed to Adult Social Care as no further OT needs had been identified.

3.40 On 3rd February 2021 the Abri CSO visited Henrietta to discuss a breach of her acceptable behaviour contract and the consequences of further breach discussed (assumed to relate to allowing Lee to visit). There was no sign of Lee at property and Henrietta said that he did not visit regularly. The CSO discussed the support available to Henrietta but she didn't feel able to accept support other than that she

⁵⁵ The Community Rehabilitation Service (CRS), formerly known as the IRT, is a county-wide service. It is available to all adults who are having problems carrying out everyday activities due to a medical condition. Service users will need to be motivated and willing to engage in therapy. CRS will aim to help people increase their level of independence by helping them regain or adapt their functional abilities to manage the impact of their condition. They will be supported to work towards improving their ability to do the things that matter most to them. This can be carried out within the service user's usual place of residence or other appropriate community settings. The team consists of Physiotherapists, Occupational Therapists, Pharmacy Technicians as well as Rehabilitation Assistants, Assistant Practitioners and Advanced Clinical Practitioner (ACP) development roles.

was receiving from the TAS (tenancy accredited service) which she said she contacted most days.

3.41 On 4th February 2021 Henrietta was seen by her new GP (GP practice 2) for an in-person consultation as she had requested a fit note⁵⁶. The GP noticed Henrietta had a history of excess alcohol consumption and she reported she had been having fits. The GP discussed her alcohol use and Henrietta reported drinking only occasionally. A fit note was issued and a referral made regarding neuropathy⁵⁷ in her hands for nerve studies.

3.42 On 9th February 2021 the Abri CSO phoned Henrietta who appeared angry about a number of issues following the move to her new address, which she said was “miles away from anyone”. She mentioned she had a ‘black eye’ due to a fall. Abri contacted the Police to request information on Henrietta’s eye injury and the incident on Christmas Day 2020 which Henrietta had shared with the CSO.

3.43 On 23rd February 2021 Lee received a conditional discharge for using threatening, abusive words or behaviour in respect of the 17th September 2020 incident following which he had been arrested for public order offences (Paragraph 3.23).

3.44 Also on 23rd February 2021 the IRT began a series of home visits to assess Henrietta’s equipment needs. She was issued with a shower stool and a walking stick set to the correct height. Henrietta was said to mobilise well with the walking stick, was taught bed exercises and supported to apply for a bus pass. She was discharged from the IRT service on 8th April 2021 following ‘no contact from patient’.

3.45 From 8th March 2021 a phased lifting of the restrictions introduced in the third Covid-19 lockdown began.

⁵⁶ Healthcare professionals issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

⁵⁷ The main types of peripheral neuropathy include:

- sensory neuropathy – damage to the nerves that carry messages of touch, temperature, pain and other sensations to the brain
- motor neuropathy – damage to the nerves that control movement
- autonomic neuropathy – damage to the nerves that control involuntary bodily processes, such as digestion, bladder function and control of blood pressure
- mononeuropathy – damage to a single nerve outside of the central nervous system

In many cases, someone with peripheral neuropathy may have more than one of these types of peripheral neuropathy at the same time. A combination of sensory and motor neuropathy is particularly common (sensorimotor polyneuropathy).

3.46 On 12th April 2021 the ambulance service conveyed Henrietta to Yeovil District Hospital after she lost consciousness and was woken by her 'friend' who had apparently phoned her. She had bitten her tongue, vomited, been incontinent of urine and said she felt like she had banged her head. En-route to the hospital, the crew noted that Henrietta had a 30 second seizure. Henrietta was treated at Yeovil District Hospital then discharged.

3.47 On 15th April 2021 Henrietta's GP phoned her to follow up on the above hospital attendance. The GP documented a 'difficult' consultation in which Henrietta repeatedly said that her GP was "doing nothing for her". The GP planned to refer Henrietta to neurology given that she had left the hospital prior to all planned treatment taking place. Later the same morning Henrietta phoned the GP practice to report that she was having a fit. The reception staff struggled to understand her as her speech appeared slurred. The GP advised reception staff to ring Henrietta back in 10 minutes and if they received no reply to ring 999. Reception staff managed to re-contact Henrietta and advised her to call an ambulance but she said that she didn't want to go to hospital and she eventually ended the call.

3.48 On 26th April 2021 Somerset NHS Foundation Trust received the neurology clinic referral from Henrietta's GP and an appointment was offered at Musgrove Park Hospital in July 2021 which Henrietta did not attend.

3.49 On 10th May 2021 the ambulance service again conveyed Henrietta to Yeovil District Hospital after a witnessed seizure at home. Lee was documented to have found Henrietta rigid and half on and off the sofa. She had bitten her tongue. The crew noted a strong smell of alcohol and evidence of drug paraphernalia.

3.50 On 19th May 2021 the ambulance crew were called to Henrietta who had had a witnessed seizure outside a pub. The call had been made by a doorman who initially suspected that she was being held up/hugged against her will by her male partner but it became apparent that she had suffered a short self-limiting fit. Henrietta was said to be upset that the crew were present and declined hospital attendance.

3.51 On 21st June 2021 the Police were called to a report of a disturbance at Henrietta's address. An amber BRAG was completed which highlighted concerns for Henrietta as she lived alone and was frequently visited by Lee who was a 'MARAC perpetrator'. Henrietta was said to need support with mental health, drug and alcohol misuse and domestic abuse. The incident was recorded as a Safeguarding incident and no further police action was taken. The Police LSU reviewed the incident and

made no onward referrals as there are no current direct pathways into GP's or mental health services available to the LSU and as no offences were disclosed.

3.52 On 23rd June 2021 the ambulance service attended Henrietta's address after she had a seizure (Lee and his father were present). She had been incontinent of urine and said that she had not eaten that day (it was 5pm). The crew documented that Henrietta was clearly underweight and had multiple bruises on her wrists which were not apparently explored further, possibly because Lee was present. Many cans and bottles of alcohol were noted to be strewn about. Henrietta declined hospital attendance and she was deemed to have capacity to make this decision. An email was sent to Henrietta's GP for follow up.

3.53 On 28th June 2021 her GP phoned Henrietta following the above ambulance attendance. The GP discussed the bruising noted by the ambulance crew and enquired about domestic abuse which Henrietta denied. Henrietta said that her "father-in-law was visiting".

3.54 On 1st July 2021 the Musgrove Park Hospital Neurology Department wrote to Henrietta's GP to advise that she had not attended a clinic appointment. On 14th September 2021 the GP practice re-referred Henrietta to neurology (this time at Yeovil District Hospital) but there is no indication that she attended this further appointment.

3.55 On 29th July 2021 Lee saw his Probation Officer. He said that he was living off pot noodles but was going to Henrietta's house that night for a 'hot meal'. He said that he saw her regularly and that she was still drinking to excess. He said that they argued regularly. He went on to say that she often experienced fits but didn't know they were happening and sustained bruising from falls.

3.56 On 14th September 2021 Henrietta rang her GP practice to discuss her mental health and request a fit note. During the call Henrietta said that she continued to experience seizures but had stopped calling for help as no-one had been able to establish the cause of the seizures. The GP advised her that she should always call an ambulance for seizures. The GP re-referred her to Neurology at Yeovil District Hospital and a text reminder was later sent to her advising her to book an in-person appointment. It appears that Henrietta discussed her difficulty in travelling to the Hospital.

3.57 On 16th September 2021 Lee saw his Probation Officer and said that he was still living with his parents but occasionally staying away or with Henrietta to "give

them a break". He said that the Police had been called to his parent's address on 4 occasions over a 3 day period after neighbours had raised concerns about his parent's welfare. He said that shouting had been reported but that it was his father who had been shouting and not him. Lee said that he was "having problems" with Henrietta, who phoned him twice during the appointment to allege that he had stolen £10 from her. The Probation Officer noted that Lee appeared to find this amusing, which 'wound up' Henrietta who 'shouted obscenities' at Lee.

3.58 Also on 16th September 2021 the ambulance service attended Henrietta's address following 999 calls from both Henrietta and Lee. She said that she had fallen due to her neuropathy and had also fallen the previous day resulting in a small laceration and bruise to her back. The crew documented a strong smell of alcohol and Henrietta said that she had drunk 3 cans of cider but the crew were unsure whether this was accurate. She declined to attend hospital, saying Lee was coming over to be with her.

3.59 On 21st September 2021 the ambulance service responded to a 999 call from Henrietta who thought she might have had a seizure whilst travelling on a bus. She was found behind a tree having alighted from the bus. She appeared alert. She had bruising to her arms which she said had been caused by falling. A strong smell of alcohol was noted and she was asked about her alcohol intake which she said was limited to a couple of drinks whilst watching TV. She was advised of the dangers of rapid withdrawal from alcohol. She declined hospital attendance and was collected by Lee. The ambulance service record of the call-out was shared with her GP to request a review, which was said to be the pathway through which Henrietta would be able to access support for drug and alcohol use. Henrietta's GP practice received the ambulance service call-out record but it is not known what action the GP practice may have taken in response.

3.58 On 25th October 2021, the Police attended Henrietta's address following reports of an argument between Henrietta and Lee. Henrietta disclosed that during an argument Lee had wound a phone charging cable around her neck and held it there. He then removed it from her neck and tied it around her wrists. Lee had left the property prior to police arrival. Lee had been imprisoned for unrelated offences (Lee was sentenced to 4 weeks custody for driving matters including Aggravated Vehicle Taking (of his parents' vehicle) and driving whilst under the influence of drugs on 2nd November 2021 and was released on licence on 15th November 2021. He was subject to Probation Supervision under Licence until 29th November 2021 and then Post Sentence Supervision (PSS) until 15th November 2022) During this period the Police attempted to encourage Henrietta to make a statement, which she subsequently did, although she later retracted it. Lee was interviewed and denied the offence. The Police submitted a file to the CPS for a charging decision. The CPS later advised that there was insufficient evidence to proceed. This incident occurred

prior to the introduction of the specific offence of non-fatal strangulation on 7th June 2022, although it is assumed that other offences were considered. A high risk DASH was completed and the Police LSU made referrals to MARAC and SIDAS. No safeguarding referral was said to have been required as there were no children involved and no adults with care and support needs 'that are suitable for Adult Social Care'.

3.59 On 28th October 2021 Henrietta called Abri customer services. She was distressed about the 25th October 2021 incident which was documented to involve Lee visiting her property and banging on the doors and windows. When she opened the door she said that Lee strangled her. Lee then left and Henrietta went to a neighbour to ring the Police. She said that she would be 'pressing charges' She asked for a security chain and lock on her front door. The Abri CSO made several phone calls to Henrietta to arrange a home visit without receiving a reply. There was no facility to leave a voice mail. On 23rd November 2021 Henrietta called back and said that she was 'OK' and that there had been no further incidents.

3.60 On 4th November 2021 SIDAS received an email from the Police LSU advising that Henrietta would like to take up the offer of support. When SIDAS rang Henrietta the following day she said that she had had a long chat with her neighbour who had encouraged her to accept support. SIDAS explained support options. Henrietta advised that Lee was in prison, but only for 2 weeks and she was worried about what would happen when he was released. A call back from an IDVA was arranged but attempts at further phone contact was unsuccessful.

3.61 On 24th November 2021 Henrietta was heard at MARAC. There were no actions for SIDAS who closed the referral in respect of Henrietta due to 'non-engagement'.

3.62 On 26th November 2021 the ambulance service attended to Henrietta after a further seizure whilst waiting for a bus. She had been helped by members of the public to a nearby pharmacy where she had a further seizure. She declined hospital attendance. Lee had arrived and Henrietta was advised to stay with him for 24 hours and contact her GP. SWAST shared their report of the incident with her GP to request a review. There is no record of Henrietta's GP receiving the ambulance service report.

3.63 On 22nd December 2021 Henrietta saw her GP about a large bruise on her shin which she disclosed had been caused by a kick although she did not wish to divulge who was responsible. Henrietta was accompanied by a female friend and she

(Henrietta) smelled strongly of alcohol. The GP advised Henrietta to ring 999 if she felt threatened.

3.65 On 29th December 2021 SDAS closed Lee's case after he declined further support, stating that he had achieved his goal by reducing his cocaine use to a level he was comfortable with.

3.66 On 30th December 2021 the Police attended Henrietta's address after a call from a third party reporting a disturbance. Henrietta expressed surprise at seeing the Police and did not wish to report any offences. Henrietta disclosed that Lee had visited her address, banged on the door and shouted her name but she had not answered the door. Officers checked that Lee was not present and advised Henrietta to call the Police should Lee make an unwanted visit to her address. No DASH was completed but a Sergeant decided that the incident should be graded as a medium risk in view of previous incidents. No referrals were considered to be justified.

2022

3.67 On 10th January 2022 Lee called police to report that his 'wife' Henrietta had punched him in the face. Officers attended and spoke to both separately. Neither party reported any offences. Lee did not feel able to assist in the completion of a DASH and so it was completed by the officer based on their observations and the domestic abuse history. (Medium risk). A (green) BRAG was completed which documented Lee's mental health struggles and noted that he said that he would like support with depression. The Police LSU made no referrals as they have no direct pathway to GP or mental health services.

3.68 On 12th January 2022 Henrietta called the Police to disclose that Lee had obtained her PIN number and withdrawn money from her account without her permission. Henrietta advised officers she didn't want to make a formal complaint but would like the matter logged to enable her to report it to the bank. A (green) BRAG was completed which highlighted Henrietta's 'disabilities' and alcohol use. The BRAG also noted that Henrietta's life was 'quite chaotic' and that it was thought that Lee took advantage of this. She was referred to Vulnerable Victims of Fraud⁵⁸ who

⁵⁸ This is believed to be Action Fraud which aims to ensure that victims of fraud have a central place to go to in order to report crime and get advice and support. An enhanced service is available to vulnerable victims who are classed as:

- Anyone under the age of 17 at the time of the offence.
- Anyone who is suffering from a mental disorder within the meaning of the Mental Health Act 1983.
- Those with a significant impairment of intelligence and social functioning.
- Those with a physical disability or who suffer from a mental disorder.

contacted Henrietta and gave her advice on preventing any future frauds in the form of information through the post with contact details should she require them in the future. The Police LSU made a safeguarding referral to Adult Social Care and a referral to SIDAS.

3.69 On 18th January 2022 the Police received an abandoned 999 call from Henrietta's address in which a male and female could be heard arguing about money. The Police call handler rang back and spoke to Henrietta who stated that the Police were no longer required as Lee had given back the money he had taken from her. The call handler requested officers attend to check on Henrietta's welfare. Officers attended and Henrietta disclosed that Lee had stolen £60 in cash from her and withdrawn funds from her bank account using her debit card. She went on to disclose that during an argument over the money Lee had hit her on the jaw. There were no signs of injury. A high risk DASH was completed. The officer noted Henrietta's vulnerabilities due to mobility issues and suspected alcohol dependency. Henrietta also disclosed that Lee isolated her from friends and sabotaged her relationships, meaning that she only had him to rely upon. She disclosed that he had threatened to kill her and others previously. The Police LSU made referrals to Adult Social Care, SIDAS (who were unable to engage with Henrietta beyond an initial telephone call) and MARAC. The Police began an investigation but Henrietta felt unable to continue to support a prosecution and so no further action was taken due to insufficient evidence.

3.70 On 19th January 2022 Adult Social Care considered the Police referral arising from the 18th January 2022 (Paragraph 3.69) and sent it to Adult Social Care Safeguarding for a 'screening decision' which was made within a day of receipt. Safeguarding phoned Henrietta and discussed her safety, the risks she faced and her mental capacity. It was decided that no safeguarding enquiry was necessary as Henrietta had taken steps to protect herself. At that time she said that she had contacted Abri to have her locks changed (although there is no record of the locks being changed) and had contacted her bank. It was not recorded whether she was offered a Section 9 Care Act assessment.

3.71 On 21st January 2022 the Probation Service made a safeguarding referral to Adult Social Care in relation to concerns about Lee's behaviour towards his parents. During a phone call to Lee's parents to discuss a referral to supported housing for people with complex mental health needs for Lee, his Probation Officer heard Lee in the background shouting, swearing and demanding money from his parents. His mother could be heard trying to calm him down, but Lee grew increasingly aggressive and said that he was going to get alcohol and would "get off [his] face". Lee's father added that 3-4 days previously, his son had "got drunk" and overdosed

and was admitted to hospital. His parents had hoped that Lee might be admitted to hospital under the Mental Health Act at that time, but this had not happened. Lee had since threatened to take his own life by lying on train tracks. Adult Social care subsequently informed the Probation Service that they would be carrying out a non-statutory safeguarding enquiry given that Lee's parents did not have care and support needs. Adult Social Care recommended that the Probation Service arrange a strategy meeting, devise a safety plan and refer Lee to MARAC and Multi-Agency Public Protection Arrangements (MAPPA)⁵⁹. Probation decided not to refer Lee to MARAC as there had been a recent MARAC 'in relation to issues with a former partner' (assumed to be Henrietta) at which issues in relation to Lee's parents were also raised.

3.72 On 25th January 2022 Adult Social Care considered the Police referral in respect of the 12th January 2022 incident (Paragraph 3.68). The referral stated that Henrietta was a 'self-confessed alcoholic' and as a result was unable to make clear decisions and lived a 'quite chaotic lifestyle' which Lee was said to 'clearly' take advantage of. The referral went on to state that Henrietta may not feel safe in her own property and may not have the confidence to tell Lee that she did not want him in her property. As Henrietta had recently been spoken to by Adult Social Care safeguarding (in relation to the later 18th January 2022 incident) it was decided to treat this Police referral as 'for information only'.

3.73 On 28th January 2022 Lee advised his Probation Officer that he was currently staying with Henrietta and that the requirement in her lease that he should not stay in her property had expired. (There is no indication that the Probation Officer verified this information with Abri. Henrietta signed the acceptable behaviour contract on 2nd December 2020. Acceptable behaviour contracts normally last for 6 months (1)). When he spoke to his Probation Officer on 11th February 2022 he said that he had been staying with Henrietta for the past two weeks and had only returned to his parent's house the night before.

3.74 On 18th February 2022 Henrietta was heard at MARAC. The MARAC chair was not available and so each agency was tasked with reviewing the information and identifying perceived risk and safety factors.

3.75 On 2nd March 2022 the Abri CSO visited Henrietta's address after complaints from neighbours about noise nuisance. No reply was received and so Abri contacted the Police to request a welfare check. The following day the Police visited Henrietta who stated "everything was fine". Lee was in the property. Officers were concerned

⁵⁹ Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders. This guidance sets out the responsibilities of the police, probation trusts and prison service. Other partner agencies may also become involved.

about Lee's presence due to previous domestic abuse incidents. Lee was removed from the property and taken to his parent's house. Henrietta told officers she wasn't happy about this action as she needed Lee to support her. A medium risk DASH was completed on the basis of officer observations. The Police documented that Henrietta was 'physically vulnerable' and needed Lee for support. No referrals were made by the Police LSU.

3.76 On 21st March 2022 Henrietta called the Police to report that her partner Lee was shouting at her. Upon police attendance officers spoke to both parties and no offences were disclosed. Officers took Lee to his parent's address to defuse the situation. The attending officer noted concerns for Henrietta as she did not appear to be in good health, had a 'severe alcohol addiction' and suffered with seizures. A medium risk DASH was completed which noted Henrietta's continued dependence on Lee because of her health needs and an amber BRAG was completed which highlighted Henrietta's support needs in relation to diet, alcohol issues and domestic abuse. The Police LSU made no referrals.

3.77 On 23rd March 2022 the ambulance service attended Henrietta's address after she fell and fractured her left femur followed by a seizure of around a minute. She said that she had been celebrating having a new carpet and had been drinking vodka, cider and smoking cannabis. She was conveyed to Yeovil District Hospital. Prior to the ambulance service arriving a 'friend' of Henrietta's rang her GP practice to report that she had had a seizure and fallen and the 'friend' thought that she had broken her leg. The 'friend' asked if the GP might attend as the ambulance service had advised a 4-5 hour response time. The GP practice advised the 'friend' to re-contact the ambulance service and say that Henrietta was in severe pain. (SWAST has advised the DHR that they received the call at 1.15pm, dispatched an ambulance at 2.24pm which arrived on scene at 2.30pm).

3.78 Yeovil District Hospital noted Henrietta to look underweight, with epilepsy (Henrietta's seizures were under investigation and so epilepsy had not been diagnosed) which was not well controlled, experiencing frequent falls arising from peripheral neuropathy/amputation of her toes, increased care needs arising from her fractured hip and surgical wound, decreased mobility and reluctance to engage with services. During her admission she was visited on a number of occasions by the substance misuse nurse but did not accept she had any substance use problems.

3.79 The Abri CSO visited whilst the ambulance service was attending to Henrietta and documented that Lee was heard to say that he had been behind Henrietta when she fell awkwardly. The CSO rang Yeovil District Hospital and spoke to the safeguarding lead to express concern about Henrietta returning to the property without support from anyone but Lee. When the Yeovil District Hospital Domestic

Abuse co-ordinator spoke to Henrietta in response to the Abri concerns, Henrietta denied domestic abuse and did not wish to be referred for domestic abuse related support.

3.78 On 25th March 2022 Lee's parents contacted Adult Social Care to request an assessment to support him to live independently. Lee was said to be residing with his parents at that time, and they expressed concern that Lee was unable to manage his finances and that they were in debt themselves as a result of this. After clarifying Lee's diagnoses – which were documented to be ADHD, dyslexia, dyspraxia, emotional personality disorder, borderline schizophrenia and PTSD – it was decided that the mental health team should carry out a Care Act assessment of Lee.

3.79 On 29th March 2022 Yeovil District Hospital contacted Adult Social Care to request a DoLS (Deprivation of Liberty Safeguards)⁶⁰ assessment in respect of Henrietta, who they advised had been admitted following a fractured neck of femur. She also had electrolyte imbalance⁶¹ and seizures secondary to alcohol withdrawal. The DoLS was requested as she was trying to leave the hospital whilst continuing to experience seizures. The DoLS request stated that Henrietta had a history of safeguarding concerns relating to domestic abuse and was at high risk of self-harm. The DoLS request was withdrawn on 1st April 2022 as it was no longer required. It is not clear why the DoLS assessment was no longer required but it is known that Henrietta self-discharged from hospital. Yeovil District Hospital patient records do not provide clarity over any concerns about Henrietta's decision-making capacity regarding discharge and if any capacity assessment was undertaken regarding potential risks arising from self-discharge.

3.80 On 31st March 2022 Lee saw his Probation Officer and informed her that Henrietta had fallen over and broken her hip and she was due to be discharged from hospital that day. He said that he had been staying at her house and intended to remain there to help her recuperate. He said that their relationship had improved, but

⁶⁰ There are 2 types of DoLS authorisations: urgent and standard. Urgent DoLS authorisations can last up to 7 days and are initially granted by the hospital or care home where the person is being cared for, known as the 'managing authority'. If needed, urgent authorisations can be extended for a further 7 days. This type of authorisation can be used if a person urgently needs to be deprived of their liberty before they have had a full assessment.

In all other circumstances, the managing authority should request a standard authorisation. The relevant local authority then has 21 days to carry out assessments to ensure that the deprivation of liberty is appropriate. Standard authorisations should be reviewed regularly and can last up to 12 months.

⁶¹ Electrolytes are salts and minerals, such as sodium, potassium, chloride and bicarbonate, which are found in the blood. They can conduct electrical impulses in the body. Treatment for an electrolyte imbalance will depend on which electrolyte is out of balance and by how much. For example, if the patient has a sodium imbalance they may be advised to lower their salt intake (if sodium is too high) or reduce their fluid intake (if sodium is too low)

should the situation deteriorate he would contact 'social services' and return to his parents.

3.81 On 11th April 2022 Henrietta called the Police stating that Lee had refused to leave her address, had thrown items at her and spat at her. Whilst making the call, Henrietta advised the call handler that Lee had now left the property. Upon police attendance Henrietta refused officers entry to her property and did not wish to engage further with them. A medium risk DASH and an (amber) BRAG were completed. It appears that the Police did not become aware of Henrietta's hip fracture during this visit.

3.82 On 21st April 2022 Lee did not attend an in-person appointment with his Probation Officer who later spoke to Lee by phone. He apologised and explained that he had been "having problems" with Henrietta who he said had returned to drinking vodka 'to excess' since leaving hospital and this had affected their relationship. He said that she frequently called the Police for "trivial things" and had "claimed" that he had shouted at her, spat at her and taken away her stroller. Lee added that the Police had "wised up" to her "claims" and he thought that all their investigations had been closed. Lee went on to say that Henrietta liked to control him and regularly insulted him for being homeless.

3.83 On 13th May 2022 the Probation Service advised a Second Step⁶² worker that Lee was on no fixed abode but tended to reside with Henrietta, who was described as his ex-partner. The Probation Officer advised that Lee could be quite gullible sometimes and mentioned that Lee looked after Henrietta and did a lot for her.

3.84 On 17th May 2022 the Care Act assessment of Lee was completed (see Paragraph 3.78) the outcome of which was that Lee had support needs which were not Care Act eligible and which could be met by other voluntary or community organisations. The professional who carried out the assessment remained involved with Lee in order to refer him to appropriate services including housing. Lee accepted the offer of a tenancy in Yeovil on 23rd June 2022. However, concerns remained in respect of Lee's gambling, drug and alcohol addictions and offending behaviours.

3.85 On 10th June 2022 Henrietta called police stating that Lee was refusing to leave her address. Upon police attendance Lee had left and Henrietta did not disclose any offences. Henrietta advised officers that she had recently had surgery on her hip and had limited mobility and was using walking aids to mobilise. A medium risk DASH

⁶² Second Step provides mental health and support. Services include supported housing, men's mental health, support in the community, NHS services and a range of wellbeing courses and therapies.

was completed based on officer observations and a (green) BRAG which highlighted concerns for Henrietta's mental health and her mobility issues. The Police LSU made no referrals as Henrietta was not identified as being a victim of a serious crime, vulnerable, intimidated or persistently targeted as defined by the Code of Practice for Victims of Crime (VCOP)⁶³ 2015.

3.86 On 15th June 2022 Lee saw his Probation Officer for an in-person appointment. Lee said that he still loved Henrietta and felt responsible for looking after her as they had been in each other's lives for such a long period of time, which is why he said he felt as though he could not leave her. Lee was said to reside at Henrietta's address the majority of the time as he was of 'no fixed abode'. The conversation was mainly directed at how his drug misuse and his relationship with Henrietta were factors holding Lee back from moving forward and finding accommodation.

3.87 On 17th June 2022 Henrietta called the Police to report a domestic abuse incident with Lee. Henrietta said that Lee attended her address uninvited and became aggressive following an argument, using a knife to stab furniture and various items, causing damage. Bruising was noted to Henrietta which she did not explain. Lee said that the bruising had been caused by Henrietta falling. He acknowledged that they had been arguing but said that this had been verbal. Lee was arrested for assault and criminal damage and conveyed to custody. Henrietta did not feel able to complete a DASH and so it was completed based on officer observations. The officer assessed the risk as medium and highlighted Henrietta's physical vulnerability and limited mobility but did not feel that further support was required. The Police LSU referred Henrietta to SIDAS and MARAC. The Police considered an evidence-led prosecution but concluded that there was insufficient evidence as Henrietta later stated that the bruising had been caused by her fall and the damage had been caused to a table Lee had purchased for Henrietta and at the time he stabbed the table he was upset due to a friend having a heart attack.

3.88 On 22nd June 2022 SIDAS received a referral for IDVA support and MARAC in respect of Henrietta. SIDAS requested a fully completed DASH in order to be able to process the referral as no risk level had been identified. On 22nd July 2022 the Police LSU replied that a DASH had been completed using only the officer's observations. SIDAS reiterated that without a fully completed DASH they could not process the referral. However, SIDAS had listed Henrietta to be heard at MARAC.

⁶³ A statutory code of practice issued by the Secretary of State for Justice, the code establishes minimum standards on the rights, support and protection of victims of crime. Its objective is to make sure that the criminal justice system puts victims first, therefore making the system more responsive to them and easier to navigate. It also aims to make sure that victims of crime are treated well and receive appropriate support to help them cope and recover, and to protect them from becoming victims again

3.89 On 23rd June 2022 the Abri CSO visited Henrietta following 'issues' raised by neighbours. Henrietta was said to have initially denied that Lee was causing any issues for her or her neighbours. She eventually disclosed that Lee abused her physically and financially, used crack cocaine and had a problem with alcohol. She was reminded of the support available to her. The Abri CSO made referrals to Adult Social Care and the Abri Financial Responsibility Team (FRT) for help with her PIP application. Henrietta felt unable to accept referrals in respect of mental health or alcohol use.

3.90 Also on 23rd June 2022 Lee's Probation Officer and professionals from partner agencies who were working together to assist Lee to obtain a tenancy, spoke to him about the current situation in respect of Henrietta, in particular what could be put in place to stop or reduce contact with her. Lee was said to be aware that police call-outs were not helping his chances of being offered accommodation. Lee described feeling guilty if he did not look after Henrietta or stay with her but was said to be quite avoidant in terms of why he stayed at her address when this has caused police call outs/arguments to occur.

3.91 On 29th June 2022 Adult Social Care considered the referral from Abri which highlighted Henrietta's recent hip surgery and her dependence on Lee for care including being unable to make a drink for herself or carry a drink whilst using her walking frame. The referral also covered the history of financial and domestic abuse by Lee and Henrietta's isolation from anyone else but him. Henrietta was said to now realise that she needed help with tasks related to her personal care and had therefore agreed to the referral to Adult Social Care. The referral also highlighted Henrietta's alcohol dependence and that she would not be able to speak openly if Lee was present and so she may ask for a call back. The referral was sent to the Adult Social Care community team as high priority for a Care Act assessment but a further referral was received from the Police shortly thereafter (see Paragraph 3.93) and so the Abri referral was not responded to and closed using the information gathered by Adult Social Care safeguarding following the Police referral.

3.92 On 1st July 2022 Henrietta called the Police to report a domestic abuse incident involving Lee, saying that she needed assistance as Lee was throwing things at her head. When officers attended, neither Henrietta nor Lee wished to make a complaint and said that they had had a verbal argument over money and what to watch on TV. Lee was taken home 'to defuse the situation'. A medium risk DASH risk assessment was completed on the basis of officer observations. An (amber) BRAG was completed which noted that Lee needed support around his mental health issues which were being exacerbated by the pressures of caring for Henrietta. Henrietta was said to need support in moving around her home due to mobility issues and there was currently no care package in place for her. The Police LSU made a referral to Adult Social Care.

3.93 On 4th July 2022 Adult Social Care considered the Police referral relating to the 1st July 2022 incident. This contact was sent to the Adult Social Care Community triage as they already had an open referral from Abri (see Paragraph 3.91). A community triage social worker phoned Henrietta and she responded by saying she was busy and that everything was “OK”. The community triage worker then sent the Police referral to Adult Social Care Safeguarding as she was unsure whether everything was “OK” for Henrietta and asked them to investigate further. On 7th July 2022 the community triage worker sent the Abri referral to Adult Social Care Safeguarding, but they advised that they would triage the Police referral, indicating that the core conversation regarding the Abri referral was to remain with the community team for response. On 11th July 2022 Adult Social Care Safeguarding phoned Henrietta, after which the decision was taken to close the Police referral as Henrietta had advised that the issues were resolved and that she was “OK now”, and there was said to be no reason to doubt Henrietta’s capacity to decide whether or not to accept Adult Social Care assessment/support. When the community triage worker (who continued to hold the Abri referral) contacted Safeguarding a further 9 days later to ask if Henrietta’s case could be closed, the latter service replied that it was for community triage to make that decision. The community triage then closed the Abri referral using the information and decision made by Safeguarding.

3.94 On 12th July 2022 Lee had an in-person meeting with his Probation Officer who discussed the 1st July 2022 incident (Paragraph 3.92) with him. Lee said they had a verbal argument about Lee doing so much for her and that calling the Police was unnecessary. Lee’s move into a property in Yeovil was discussed. He said he planned on continuing to visit Henrietta after his new tenancy began because he did not know how Henrietta would cope without him being there. He was said to understand that staying over at Henrietta’s address was not a good idea. Lee said that there was the potential for Henrietta to receive help from Adult Social Care. The Probation Officer reiterated the importance of Lee focussing on himself and spending less time with Henrietta.

3.95 On or around 21st July 2022 (precise date not known) Henrietta was heard at MARAC which was advised that Adult Social Care intended to complete an assessment of Henrietta’s care and support needs. (Adult Social Care closed the referrals from Abri and the Police around 20th July 2022).

3.96 On 25th July 2022 Henrietta phoned her GP to advise that she had had two falls since her hip operation and she was worried that she had done more damage. She was referred for an urgent X-ray, although the referral may not have been sent until 15th August 2022, when the GP practice urgently referred Henrietta to the fracture

clinic due to a periprosthetic fracture⁶⁴. Following an X-ray, Henrietta was admitted to Yeovil District Hospital. She was noted to have fallen in June 2022 and further fractured her hip (The Yeovil District Hospital date for admission is 12th August 2022).

3.97 On 14th August 2022 the community rehabilitation service (CRS) wrote to Henrietta requesting her to contact them after experiencing difficulty in contacting her by phone. The CRS discharged Henrietta from their care after receiving no response to the letter. It is unclear whether Henrietta's GP was informed although the GP practice later (18th November 2022) advised Henrietta how to self-refer to the CRS.

3.98 On 2nd October 2022 the Police attended Lee's address following a third party report of a domestic abuse incident. Henrietta was removed from the address and taken home in order to safeguard her. Officers noted that Henrietta appeared frail after suffering a broken hip. A medium risk DASH was completed which documented that Henrietta feared that Lee would hurt her when he was loud and aggressive in mood. His issues with drugs, alcohol and mental health were also noted, An (amber) BRAG was also completed which highlighted the vulnerabilities of both Henrietta and Lee. The Police LSU noted that both parties had been discussed at MARAC in the past 12 months and notified SIDAS.

3.99 On 18th October 2022 Lee's case was closed by the mental health team which had assessed his care and support needs in May 2022. Lee was said to be engaging well with support.

3.100 On 2nd November 2022 Lee attended his final Probation appointment. When the conversation turned to 'relationships', Lee expressed concern about Henrietta showing signs of dementia as she had begun to forget things. He said that he was worried that she was "going to go soon". He said that he planned to assist her to make a fresh application for PIP. The Probation Officer and Lee discussed achieving a balance between helping Henrietta and ensuring that his own wellbeing did not suffer as a result.

3.101 On Wednesday 7th December 2022 Lee's mother contacted the mental health team to express concern that her son was not receiving the support he needed. When the contact was triaged on Friday 9th December 2022, Lee's mother's concerns were documented to relate to Lee's finances, heating in his property, people breaking into the property for food and money, Lee's reluctance to report the incident to the Police for fear of retaliation and a friend in poor health (assumed to be Henrietta) living with Lee, thus increasing the pressure on him. It appears that the

⁶⁴ A periprosthetic fracture is a broken bone that occurs around or near an orthopaedic implant.

contact from Lee's mother was finalised on 6th January 2023 with the provision of advice and information to her (Lee's mother). Reallocation of Lee's case to a social worker was considered but not actioned.

3.102 On Friday 9th December 2022 Henrietta's GP Practice was phoned by her 'friend' (assumed to be Lee) reporting signs of acute liver failure. The friend was advised to call paramedics. The GP Practice noted that Henrietta was currently living out of the GP Practice area and would need to register with a GP Practice in that area. Later the same day Lee called the ambulance service via the 999 system to try and obtain help for Henrietta who he was looking after in his home. He said that he had rung SWAST in desperation after contacting Henrietta's GP, Social Care and Henrietta's family. He said that Henrietta had been asleep for most of the day but she was easily roused by the ambulance crew. She agreed that she would likely die if left in this condition but said that she did not wish to go to hospital and was not able to accept any assessment. She appeared angry that Lee had called the ambulance service and said she just wanted to be left alone. Lee said that he continued to purchase alcohol for Henrietta as she experienced seizures if she didn't drink it. The crew explained to Lee that as they considered Henrietta to have capacity, they could not force her to accept their help. Henrietta was advised that she could call SWAST back at any time if she changed her mind and Lee was advised to call SWAST back if she became confused, unconscious, or seemed to lack capacity. A safeguarding referral was submitted for self-neglect. The safeguarding referral was sent to Henrietta's GP and Adult Social Care on Monday 12th December 2022.

3.103 Henrietta's family have advised the DHR that on the evening of Friday 9th December 2022 Lee rang Henrietta's father and told him that Henrietta was dying, that she was at his flat and that he couldn't care for her anymore as it was too much for him. Henrietta's parents and sister visited Henrietta at Lee's flat which they described as 'really squalid'. They have advised the DHR that Henrietta asked them to get her out of Lee's flat and so they decided to try and move her back to her home and obtain support for her there. The family said that they began contacting 'social services' on the morning of Saturday 10th December 2022 to try and arrange for support to be put in place at Henrietta's home but they said that they were unable to obtain any support for Henrietta despite making further phone calls to 'social services' on the Sunday, Monday and the morning of Tuesday 13th December 2022. Adult Social Care have advised the DHR that they have no record of contacts from the family on 10th or 11th December 2022 and that the first recorded contact from the family was on 12th December 2022.

3.104 During the afternoon of Sunday 11th December 2022 the Police were called by Lee's neighbour who said that Lee had threatened to stab him and appeared to have "lost the plot". Officers attended and spoke to Lee who said that he was looking after Henrietta who was dying and was bed bound on the sofa. Officers observed that

Henrietta appeared skeletal and was wearing adult nappies and could not move to go to the toilet. The flat appeared “chaotic” and covered in detritus including broken glass, broken pieces of furniture and other items. Officers noted concerns for Lee's ability to care for Henrietta and completed an (amber) BRAG. The Police LSU made a referral to Adult Social Care.

3.105 The Police also contacted the Adult Social Care EDT team during the early hours of Monday 12th December 2022 to advise them of the situation at Lee's address. The details obtained from the Police were sent to Adult Social Care community triage for follow up. Adult Social Care EDT documented that the Police wished to highlight the circumstances and said that they would forward a safeguarding referral. Adult Social Care EDT also documented that there was no need for further urgent action overnight.

3.106 On Monday 12th December 2022 the SCCC received the SWAST safeguarding concern which they sent to the community triage team as they had a contact open from Henrietta 's sister. The SCCC also received the Police referral which was sent directly to Adult Social Care Safeguarding to triage the concern. Their decision was that Henrietta met the criteria for a Section 42 adult safeguarding enquiry.

3.107 Also on Monday 12th December 2022 Henrietta 's sister phoned the SCCC and outlined Henrietta 's significant care and support needs, She explained that Henrietta had been estranged from her family for many years due to her relationship with Lee and the verbal abuse the family had received from him. Henrietta 's sister advised that the family were trying to get her back home but needed guidance on how to achieve this. The contact from Henrietta's sister was sent to the community team but was not actioned until a further call was received from Henrietta 's sister on Tuesday 13th December 2022. Advice was sought from the Service Manager and contact made with Henrietta 's GP practice.

3.108 Later in December 2022 Lee called 999 after finding Henrietta in cardiac arrest. SWAST attended and continued the CPR which Lee had commenced. Henrietta's death was confirmed. SWAST requested Police attendance who found no suspicious circumstances.

4.0 Key issues raising from the review.

Domestic abuse in informal caring relationships

4.1 There is no doubt that Lee spent a great deal of time at Henrietta's address because they were, or had been, in a long term intimate relationship although this appeared to have become intermittent. He also appeared to stay or spend time at Henrietta's address to give his parents a degree of respite from his aggressive and violent behaviour. The evidence that Lee actually provided care and support to Henrietta is quite limited. However, their relationship was complex. Henrietta appeared to be dependent on Lee for support but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered. Periodically Henrietta disclosed to agencies that she felt trapped in the relationship with Lee and wanted it to end. Lee is a physically imposing man with a history of violence and aggression towards his parents and a history of controlling, suspicious and abusive behaviour towards intimate partners. His behaviour towards the increasingly frail Henrietta included non-fatal strangulation, threats to kill and destruction of household items when angry. The dynamics of Henrietta's relationship with Lee were explored and appeared to be understood to an extent by both the Police and Abri. However, Lee's Probation Officer was probably the individual professional with whom Lee most frequently discussed his caring role for Henrietta. It was unwise to accept Lee's account of his caring role at face value and there was a striking lack of professional curiosity about how Henrietta was faring under Lee's care. Indeed, the focus of the Probation Officer's discussions with Lee about his caring role was to encourage Lee to prioritise his own needs and spend less time with Henrietta as caring for her was "holding him back."

4.2 The SafeLives Spotlight report *Disabled Survivors Too: Disabled People and Domestic Abuse* found that for a disabled person, the abuse they experience is often directly linked to their impairments and perpetrated by the individuals they are most dependent on for care. The report concluded that intimate partners or family members often act as carers and this position of power can be exploited leading to widespread and pervasive means of coercive control and social isolation (2). There is compelling evidence of coercion and control in Lee's role as informal carer for Henrietta. SafeLives' national data showed that disabled victims are much more likely to be suffering abuse from a current partner (31%) than non-disabled victims (18%) (3).

4.3 However, research into domestic abuse in informal caring relationships and into links between domestic abuse and self-neglect largely focusses on older people. For example researchers at Dewis Choice adapted the Duluth Power and Control Wheel – originally developed by Pence, McDonnell and Paymar (1982) to explain the variety of ways in which perpetrators use power and control to manipulate and abuse victims – to examine domestic abuse *in later life* (4). However, the tool is particularly helpful in considering Lee's observed behaviour towards Henrietta. The Power and Control Wheel describes controlling behaviour under the domains 'Using emotional abuse', 'Using coercion and threats', 'Using economic abuse', 'Misuse of privilege',

Minimising, denying and blaming', 'Limiting environmental mastery', 'Using isolation' and 'Using intimidation'.

4.4 Applying these domains to Lee's observed behaviour highlights the following:

- One of the sub-headings under the 'Using intimidation' domain is 'destroying your property'. There were many examples of Lee damaging or destroying Henrietta's property.
- One of the sub-headings under the 'Minimising, denying and blaming' domain is 'perpetrator portraying themselves as frail and vulnerable to services'. In his contribution to this DHR and in his interactions with agencies during the period on which the DHR focusses, Lee often drew attention to his own needs and sometimes claimed to have been diagnosed with conditions which is not confirmed by his medical records.
- Another sub-heading under the 'Minimising, denying and blaming' domain is 'blaming you for their abusive behaviour'. Lee often attributed Henrietta's bruising to falls when experiencing seizures, adding that she "didn't know they were happening". Whilst there were many bruises which may have been caused by falling there were also many occasions when bruising was unexplained.
- One of the sub-headings under the 'Limiting Environmental Mastery' domain is 'denying you access to support which promotes your independence, e.g. access to mobility and communication aids'. Henrietta's family have advised the DHR that the front wheels of her walking frames had been removed.

4.5 There are several other sub-headings which appear to be applicable to this case such as 'perpetrator using physical size and strength to intimidate you' and 'preventing you having contact with other people'. However, the point of drawing attention to this valuable adaptation of the Duluth Power and Control wheel is that it was developed to inform professionals supporting older victims of domestic abuse but could have been very helpful to the professionals who had contact with the much younger Henrietta and Lee.

4.6 Professionals from a range of agencies may have struggled to perceive a male in his mid 30s to be the carer of a woman in her early 40s. It is important that professionals are encouraged to keep an open mind, avoid making assumptions that it is only or primarily older people who are likely to be at risk of coercion and control in informal caring relationships and deal with the circumstances 'in front of them'.

Recommendation 1 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team draws upon the learning from this DHR to increase understanding across a range of agencies that domestic abuse, including coercion and control, in caring relationships is not restricted to older people.

MARAC effectiveness

4.7 This section of the report contains 3 recommendations relating to MARAC effectiveness. However, the DHR has been advised that since the period on which the DHR focusses (January 2020 until December 2022), substantial changes have been made to the MARAC process in Somerset. Additionally, as the DHR was nearing completion, the DHR Panel was advised that what appears to be a fundamental review of the Somerset MARAC process had commenced. It is therefore suggested that the following 3 recommendations (Recommendations 2, 3 and 4) are shared with the recently commenced Somerset MARAC review.

4.8 Henrietta's needs were complex and intersected with each other to a large extent. Her mobility issues were already significant before the fall from which she fractured the neck of her femur. Her reliance on Lee therefore increased which he may have further exploited given that, after her death, Henrietta's family found that the front wheels of her walking frames had been removed. Although Henrietta's alcohol dependence pre-dated her relationship with Lee, she may have been using alcohol as a coping mechanism for her abusive relationship. She was at serious risk from falls arising from her seizures which may have been linked to her alcohol use. She was often seen with unexplained bruising which may, or may not, have been caused by falls. Her alcohol dependence may have impaired her mental capacity at times. It is not known why Henrietta was underweight but this may have been an element of the self-neglecting behaviours which became increasingly prominent. There is insufficient research into the links between domestic abuse and self-neglect in younger people but domestic abuse is known to chip away at the victim's self-esteem and adversely affect their self-care. Alcohol dependence is also linked to poor self-care.

4.9 Given Lee's history and his needs he did not appear to be suited to an informal carer role and at times was clearly struggling to cope with supporting Henrietta, if indeed he was actually providing her with tangible support. It is not evident that professionals fully appreciated the manner in which Henrietta's needs intersected with each other, the extent to which Lee's needs increased the likelihood that he would struggle to care for her and the extent to which this combination of intersecting

needs of victim and informal carer/ intimate partner/domestic abuser contributed to the abuse which Henrietta suffered.

4.10 The DHR has been advised that a lack of appreciation and understanding of intersecting needs of victims and perpetrators was not highlighted in a recent training needs analysis. However, a related issue was highlighted in a Safeguarding Adults Review (SAR Juliet) recently completed by the independent reviewer for Somerset Safeguarding Adults Board. The circumstances of that case were similar to this DHR. SAR Juliet found that the MARAC often did not appreciate the range of risks to which Juliet was exposed and so the intersecting impact was therefore overlooked.

Recommendation 2 (MARAC Officer)

That the MARAC officer, with the support of the MARAC operating group, reflect on learning from DHRs and MARAC cases to inform future training to better understand intersectionality of those subject to MARAC.

4.11 This and several other DHRs have challenged the extent to which MARAC remains fit for purpose to consider victims with complex needs, particularly if the perpetrator (as in this case) also has quite complex needs. SafeLives recommends that in such cases MARAC considers arranging an MDT meeting to discuss complex cases. MARAC proposed this approach with Henrietta but this led only to a period of joint working rather than the MDT envisaged by MARAC (Paragraph 3.39). The issue of how MARAC handles cases in which the needs of the victim are complex may need to be further reviewed by SafeLives, possibly drawing upon initiatives taken in different parts of the country such as twin-track MARACs where more complex cases are considered by a 'complex needs' MARAC where much more time is available to devote to each case.

4.12 The Somerset MARAC Operating Protocol (which at the time of writing was awaiting approval) stresses that MARAC is not a corporate body, does not hold a caseload and does not own risk associated with any case. The risk remains with individual agencies. The Operating Protocol states that if a victim is not engaging with any agency or services, despite repeated and vigorous attempts to initiate/maintain contact, then the lead agency (which the Protocol states will be the agency who referred the case into MARAC unless an alternative lead agency is identified at MARAC) must take steps to identify, reduce and manage the presenting risk by escalating to partners who may be able to assist. This may include holding a risk management meeting with multiple agencies to discuss concerns. The weakness identified in the system in Henrietta's case is that MARAC identified Adult Social Care as the lead agency to adopt an MDT approach which achieved a

relatively brief period of joint working between occupational therapy and the integrated rehabilitation team which did not really accord with a full MDT approach. There appeared to be no feedback loop to MARAC to inform them of the limited outcome of the MDT approach they had proposed. The DHR has been advised that there is now a system for agencies to update the MARAC on the outcome of actions.

4.13 However, the DHR Panel has been advised that the volume of cases being heard at MARAC means that MARAC simply does not have the capacity to review progress on actions agreed at previous MARAC meetings. This independent author fully accepts the point that MARAC manages very high demand in terms of referrals of high risk cases but feels that there needs to be a mechanism for checking whether a MARAC recommendation for a separate risk management meeting to be held has been implemented or not. Otherwise there is a risk that the case will simply be referred back to MARAC (possibly repeatedly as in Henrietta's case) thus placing greater pressure on the MARAC process.

Recommendation 3 (MARAC Steering Group)

That where the MARAC has recommended that a multi-disciplinary approach should be adopted in complex cases, MARAC should consider developing a system to monitor the report back from the agency responsible for leading the MDT approach to accurately ascertain the effectiveness or otherwise of the MDT approach.

4.14 After reviewing the recommendations made in this DHR Overview Report, the Safer Somerset Partnership has advised the independent author that Recommendation 3 should be amended to read as follows:

Recommendation 3 (MARAC Steering Group)

That the MARAC chair/panel ensure that where there are complex cases that may require a further multi-agency risk management meeting (MARM) an action is set to ensure the lead agency/agencies are made aware of the need to convene a MARM.

4.15 Please note that the amended Recommendation 3 does not address the finding from this DHR that the MARAC has no system for checking whether the MDT or MARM recommended by MARAC was actioned by the lead agency.

4.16 The MARAC Operating Protocol goes on to state that the 'repeat referral' process is the safety net which ensures that victims at continuing risk are returned to MARAC. Henrietta's case was repeatedly returned to MARAC. There may need to be more clarity about what action the MARAC should take when a case is repeatedly referred in. The MARAC could consider whether the 'whole system' is working for the victim and explore how the system could work better to reduce the risk to the victim. In Henrietta's case, if the MARAC had adopted this approach and held the 'whole system' to account it may have felt that SIDAS could have considered more creative ways of engaging with Henrietta and questioned the absence of in-person contact with Henrietta by Adult Social Care for example.

Recommendation 4 (MARAC Steering Group)

That the MARAC steering group to gain an understanding of the rationale for repeat cases including auditing if all agencies were present, effectively working together, and what were the barriers/missed opportunities.

Henrietta's alcohol use.

4.17 There were many opportunities when Henrietta's apparent alcohol dependence could have been explored with her by professionals. Her GP practices could have discussed her alcohol use in the context of her mental health as alcohol is a depressant, her increasingly poor physical health and the strong evidence of abuse in her relationship with Lee. When GP Practice 2 sent her a letter outlining the results of her bloods, including 'abnormal liver function', this could have been followed up with the offer of a consultation to discuss the impact of her alcohol use and the possibility of a referral for support. Additionally, although the cause of her seizures had not been fully investigated, they may have been secondary to alcohol use and so there appear to have been many missed opportunities to ask Henrietta whether she had stopped drinking or reduced her alcohol intake for any reason prior to each seizure.

4.18 SWAST attended many of Henrietta's seizures but did not have a means of directly referring her to SDAS, had she consented to this. Referring her to her GP for consideration of a referral to SDAS ran the risk of missing the opportunity to refer directly at a time when Henrietta's may have been motivated to seek support with her alcohol use. SWAST has advised the DHR that they are in the process of requesting the addition of the SDAS email address is added to the electronic patient record system so that the option of direct referral is available to crews in the future.

4.19 The SWAST IMR states that Henrietta declined hospital attendance on 9th December 2022 on the grounds that ‘she could not drink there and hated hospital’. There may have been an opportunity to explain to Henrietta that in hospital there are specialist substance use nurses who would be able to support her around the drinking and during her hospital admission she would be medicated so she would not go into withdrawal due to not being able to access alcohol. Additionally, if the clinical need was established, she may have been detoxed (if this is something she wanted). Hospital is also a route into SDAS, which has a good working relationship with the specialist nurses. SWAST has responded by advising that there is a slight error in the wording of their IMR as the ambulance crew asked Henrietta if she didn’t want to go into hospital because she couldn’t drink there. However the issue was raised, it provided the opportunity to discuss the support available to her in a hospital setting.

4.20 Adult Social Care could have considered whether the 27th August 2020 referral which stated that Henrietta was ‘forgetting and repeating things’ suggested alcohol related dementia Whilst Adult Social Care would not be in apposition to diagnose, greater awareness or other factors such as the effects of the menopause, of the impact of alcohol consumption on cognition, could have prompted greater professional curiosity around Henrietta’s mental capacity and mental functioning.

4.21 A significant opportunity to discuss SDAS support and make referrals was during the many Police call-outs to domestic abuse incidents when there was invariably evidence of Henrietta’s alcohol consumption. Currently there is no route for the Police LSU to make SDAS referrals.

Self-neglect

4.22 The level of Henrietta’s self-neglect was sufficiently serious that agencies could have considered a safeguarding referral on the grounds of self-neglect prior to SWAST submitting such a referral shortly before Henrietta’s death (Paragraph 3.102). Research which specifically explores links between self-neglect and domestic abuse is not plentiful and tends to focus on the relationship between ‘elder abuse’ and self-neglect (11). However, self-neglect research finds that whilst there is no single overarching explanatory model for self-neglect, causation is associated with physical health issues, mental health issues, substance misuse and psycho-social issues (12). Psycho-social issues can include ‘diminished social networks’ and ‘traumatic histories/life changing events’. This suggests that ‘diminished social networks’ arising from coercive and controlling behaviour and a ‘traumatic history’ of domestic abuse could increase the risk of self-neglect. The self-neglect research goes on to emphasise the importance of a ‘relational approach’ in order to help professionals ‘find the person’. Sadly, no professional was able to work sufficiently

closely with Henrietta to adopt a 'relational approach' and Henrietta was never found as a person by any professional.

Management of referrals to Adult Social Care

4.23 Adult Social Care's response to the referrals they received in respect of Henrietta highlights several areas of learning for the service, specifically:

- The need for enhanced awareness of forms of domestic abuse, particularly coercion and control and coercion and control within informal caring relationships.
- The need for enhanced appreciation of how the needs of a victim of domestic abuse may intersect and increase their vulnerability and possibly impair their ability to protect themselves from abuse or neglect.
- The need for staff to be encouraged to exercise professional curiosity. An important example of where professional curiosity could have been of benefit in this case was in linking the information Adult Social Care held about both the victim and the perpetrator.
- Stressing the importance of recognising brief windows of opportunity in relation to people who are subject to coercion and control.
- The importance of carefully considering when home visits are preferable in order to better understand the needs of people referred to Adult Social Care.
- The need for a system which flags repeat referrals for management oversight.

4.24 Adult Social Care has developed a detailed action plan to address the learning from this DHR, which includes a review of core training to ensure that professional curiosity, forms of abuse, coercion and control, alcohol misuse and dependence and the importance of seizing brief windows of opportunity are robustly addressed; that an audit focusing on professional curiosity is incorporated into their Practice Quality Framework programme; and a review of business processes about linking Intel, including Police reports, between files to ensure that key information is recorded on the victim and perpetrators file, considering GDPR.

Recommendation 5 (Adult Social Care)

That Adult Social Care implement the programme of development identified as a result of the learning from this DHR which addresses staff awareness of coercion and control, how intersecting needs can increase the risk of abuse and/or neglect, support for staff to exercise professional curiosity, the importance of recognising and responding to brief windows of opportunity to engage with victims, recognising when in-person contact is preferable to telephone contact and ensuring that a pattern of repeat referrals is recognised and receives management attention. The comprehensive single-agency action plan developed by Adult Social Care would be a suitable vehicle for implementing this recommendation.

Use of 'breathing space' afforded by a DVPO

4.25 The Police use of DVPO powers and their subsequent arrest of Lee for breaching the DVPO enabled successive ‘breathing spaces’ during which Lee was largely prevented from visiting Henrietta’s home. Partner agencies could have exploited this opportunity to convene a multi-agency meeting and develop a support plan, possibly including an assessment of Henrietta’s care and support needs, a formal assessment of her mental capacity in relation to keeping herself safe in her relationship with Lee, encouraged her to self-refer to SDAS and sought her consent to contact her family. The DHR Panel questioned whether the Police and partner agencies have sufficient capacity to resource a multi-agency approach to exploiting the breathing spaces afforded by DVPOs. There were 1,132 DVPOs granted in the South West of England during the 12 months up to 31st March 2024 (7) and so the resource implications are substantial. However, in cases in which the victim has particularly complex needs the resources needed for a multi-agency approach to DVPOs is justified.

4.26 The independent author was minded to therefore recommend that a DVPO should always trigger a multi-agency meeting to consider how to make the most effective use of the ‘breathing space’ to support a high risk victim of domestic abuse who has complex needs. However, Avon and Somerset Police does not accept this recommendation as they are satisfied that they already have processes in place to address this recommendation which has been subject to assurance work. Specifically, the Police advise that when an application for a DVPN is sought a task is sent to the LSU to review the circumstances and make appropriate referrals, including to agencies already involved and others who may need to become involved. The Police advise that they have carried out a dip sample audit of 16 DVPN applications and in all cases the LSU were tasked and made appropriate onwards referrals from these. This includes to MARAC or any other lead professional as appropriate based on the circumstances.

4.27 The proposed recommendation is therefore withdrawn. However, if the Police are satisfied that they have an assured process for making referral to relevant agencies when a DVPN is sought, the focus then shifts to what agencies who are advised that a DVPN has been sought do in response to this information. In Henrietta’s case a multi-agency meeting or discussion could have been helpful.

Henrietta’s contact with her GP practices

4.28 There is learning for both GP practices with which Henrietta was registered during the period on which the DHR focusses, in particular the need to improve the use of targeted enquiry accompanied by professional curiosity. NHS Somerset developed a standard operating procedure for responding to domestic abuse in 2023 which provided detailed guidance on targeted enquiry for Primary Care.

4.29 There is also a need to ensure that all patients in respect of whom there are safeguarding concerns are discussed in GP practice safeguarding meetings.

Recommendation 6 (NHS Somerset Integrated Care Board)

That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases. The NHS Integrated Care Board obtain assurance that GP practices are following the Standard Operating Procedure which outlines the use of target clinical enquiry into domestic abuse.

4.30 Arguably, the concerns that Henrietta was becoming gravely ill and may be at imminent risk of death could have received a more urgent response. Lee informed his Probation Officer that Henrietta was going to 'go soon' (Paragraph 3.100). Assuming that this comment was interpreted as Henrietta being near death, the Probation Officer could have considered whether Henrietta was in need of medical attention. SWAST assessed Henrietta as having capacity to decide to decline hospital attendance on 9th December 2022 (Paragraph 3.102). It is unclear whether this was a formal capacity assessment. SWAST submitted a safeguarding referral but could have considered contacting the local authority Emergency Duty Team (EDT).

Acceptable behaviour contracts

4.31 The use of acceptable behaviour contracts can support a victim of domestic abuse to exclude the perpetrator from their property, contribute to the safety of the victim and may alleviate the impact of domestic abuse incidents on neighbours. However, the use of acceptable behaviour contracts may also have negative consequences such as increasing the risk to victims if they try to prevent perpetrators from entry to their address for example. Where acceptable behaviour contracts are used, they should be an element in a victim-centred multi-agency approach in which any legal action should be focussed on the perpetrator of domestic abuse.

4.32 The independent author was minded to recommend that the Safer Somerset Partnership obtained assurance via the Domestic Abuse Local Partnership Board that registered housing providers have effective policies in place to support tenants who experience domestic abuse and that registered housing providers adopt a victim-centred multi-agency approach in which any legal action is focussed on the perpetrator of domestic abuse. The DHR Panel advised that this recommendation may not be achievable given the number of registered housing providers (around 20) from whom assurance would need to be sought.

4.33 The independent author is a former independent chair of local Safeguarding Children Partnerships. Safeguarding Children Partnerships conduct periodic audits of the compliance of partner agencies with their duties under Section 11 of the

Children Act 2004 (to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children). This Section 11 audit is conducted by formulating a questionnaire which is completed by partner agencies, the responses analysed and a summary report prepared. It is a substantial piece of work. However, a similar approach could be adopted to enable the Domestic Abuse Local Partnership Board to gain assurance in respect of registered housing providers policies.

Carers Assessment

4.34 At no time did any agency in contact with Henrietta or Lee consider referring Lee for a carer's assessment. As previously stated, professionals may have struggled to perceive a male in his mid 30s to be the carer of a woman in her early 40s. A carer's assessment would have provided Lee with the opportunity to discuss his needs as a carer and would also have provided the professional carrying out the assessment an opportunity to gain insight into Henrietta's care and support needs, the extent to which they were being met by Lee and shed light on the dynamics of Lee's relationship with Henrietta.

Recommendation 7 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team shares the learning from this DHR with Somerset Safeguarding Adults Board and requests the Board to consider how to highlight the fact that informal caring relationships take many forms and to highlight the rights of carers to a carers assessment, particularly to agencies (such as the Probation Service) which may not be familiar with carers assessments.

Support for bereaved families where domestic abuse victims do not die by homicide

4.35 When Henrietta's family read and commented on a late draft of the DHR report they highlighted the lack of specialist support for families bereaved in circumstances similar to Henrietta's death. Only bereaved families affected by murder or manslaughter are eligible for support from the Victim Support Homicide Service, although direct eyewitnesses of the murder or manslaughter can also contact the service. This means that the families of victims of domestic abuse who die by suicide or where their death results in part from a combination of neglect and coercion and control from the perpetrator are not eligible for support from the Victim Support Homicide Service. Given increasing awareness of the impact of domestic abuse on deaths other than homicide, there may be a case for the Home Office to review the

eligibility of bereaved families for specialist support from the Victim Support Homicide Service.

Safeguarding Adults Review (SAR) ‘Juliet’

4.36 The independent reviewer for DHR Henrietta has also completed a separate SAR for the Somerset Safeguarding Adults Board (SAR ‘Juliet’). This SAR also relates to the death of female (who was around 20 years older than Henrietta) who was frequently the victim of domestic abuse from her on/off intimate partner who presented himself as her carer. In that case there was also substantial involvement with a range of agencies and concerns about the victim’s self-neglect and alcohol dependence. Several of the learning themes present in DHR Henrietta are replicated to an extent in SAR Juliet. The SAR Juliet report was approved by Somerset Safeguarding Adults Board in May 2025. There may be opportunities for Somerset Safeguarding Adults Board and the Safer Somerset Partnership to collaborate on the implementation of the recommendations from each review. Additionally, it is recommended that a learning event is arranged to jointly disseminate the learning from the 2 reviews.

Recommendation 8 (Safer Somerset Partnership and Safeguarding Adults Board)

That Somerset Safeguarding Adults Board and the Safer Somerset Partnership arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

Good Practice

- Police officers who attended domestic abuse incidents explored the complex dynamics of the relationship between Henrietta and Lee and highlighted support needs in BRAG assessments.
- A Police Inspector proactively developed a plan to try and secure sufficient evidence to initiate an evidence-led prosecution.
- The Abri CSO shared information about Henrietta’s needs with Yeovil District Hospital’s safeguarding lead after her admission following the neck of femur fracture.
- MARAC proposed an MDT approach and in response the OT and IRT worked together to plan support for Henrietta for a time.

5.0 Conclusion

5.1 Henrietta died from natural causes at the age of 44. After becoming seriously ill with sepsis in 2017, toes from both feet were amputated leaving a previously active woman in her late thirties with significant mobility issues. Henrietta had gradually become increasingly dependent on alcohol. Her family have described their efforts to encourage Henrietta to access support but she tended to minimise her alcohol intake and the impact it was having on her health and wellbeing. She began experiencing seizures which may have been linked to her alcohol use. She was also significantly underweight.

5.2 Henrietta had been in an intimate relationship with Lee since 2008. He had not insubstantial needs and presented a longstanding risk of domestic abuse to his parents who struggled to cope with his behaviours whilst attempting to support him to leave the family home and live more independently. He was also abusive in his relationship with Henrietta. He is a physically imposing man several years her junior and the Police were called to a large number of domestic abuse incidents in which he was invariably regarded as the perpetrator.

5.3 During the period on which the DHR focusses, Henrietta's relationship with Lee was perceived by professionals as one in which she appeared dependent on him for support having lost contact with family and friends. Although Lee began presenting himself as Henrietta's carer, the extent to which he provided her with care and support is debatable. For her part, Henrietta periodically disclosed that she felt trapped in an abusive relationship which she felt unable to leave. Given her isolation from alternative sources of support, which her family felt had been engineered by Lee, she appeared to a victim of coercion and control by Lee. In his contribution to the DHR, Lee presented himself as Henrietta's saviour, which is completely contradicted by the evidence on which the DHR has drawn.

5.4 Professionals from a range of agencies had substantial contact with both Henrietta and Lee over the final 3 years of Henrietta's life. Tragically, this substantial contact made little difference to the trajectory of Henrietta's life. No professional was able to engage with Henrietta in a meaningful way in order to gain insight into why she presented as she did and to explore how to support her to achieve change in her circumstances.

5.5 The DHR highlights many familiar themes from past DHRs, including continuing doubts about how fit for purpose the MARAC process is for handling cases in which both the victim and the perpetrator have complex needs, the absence of an alternative multi-agency forum for considering such cases, the extent to which professionals are able to adopt a holistic approach, the extent to which Adult Social Care professionals are equipped to fully understand the complexity of domestic

abuse and the extent to which partner agencies are equipped to work together to support and encourage serious problem drinkers to engage with support.

6.0 Lessons to be learnt/recommendations.

Domestic abuse in informal caring relationships

Recommendation 1 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team draws upon the learning from this DHR to increase understanding across a range of agencies that domestic abuse, including coercion and control, in caring relationships is not restricted to older people.

MARAC effectiveness

Recommendation 2 (MARAC Officer)

That the MARAC officer, with the support of the MARAC operating group, reflect on learning from DHRs and MARAC cases to inform future training to better understand intersectionality of those subject to MARAC.

Recommendation 3 (MARAC Steering Group)

That the MARAC chair/panel ensure that where there are complex cases that may require a further multi-agency risk management meeting (MARM) an action is set to ensure the lead agency/agencies are made aware of the need to convene a MARM.

Recommendation 4 (MARAC Steering Group)

That the MARAC steering group to gain an understanding of the rational for repeat cases including auditing if all agencies were present, effectively working together, and what were the barriers/missed opportunities.

Management of referrals to Adult Social Care

Recommendation 5 (Adult Social Care)

That Adult Social Care implement the programme of development identified as a result of the learning from this DHR which addresses staff awareness of coercion and control, how intersecting needs can increase the risk of abuse and/or neglect, support for staff to exercise professional curiosity, the importance of recognising and responding to brief windows of opportunity to engage with victims, recognising when in-person contact is preferable to telephone contact and ensuring that a pattern of repeat referrals is recognised and receives management attention. The comprehensive single-agency action plan developed by Adult Social Care would be a suitable vehicle for implementing this recommendation.

Henrietta's contact with her GP practices

Recommendation 6 (NHS Somerset Integrated Care Board)

That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases. The NHS Integrated Care Board obtain assurance that GP practices are following the Standard Operating Procedure which outlines the use of target clinical enquiry into domestic abuse.

Carers Assessment

Recommendation 7 (Somerset Council Community Safety Team)

That the Somerset Council Community Safety Team shares the learning from this DHR with Somerset Safeguarding Adults Board and requests the Board to consider how to highlight the fact that informal caring relationships take many forms and to highlight the rights of carers to a carers assessment, particularly to agencies (such as the Probation Service) which may not be familiar with carers assessments.

Safeguarding Adults Review (SAR) 'Juliet'

Recommendation 8 (Safer Somerset Partnership and Safeguarding Adults Board)

That Somerset Safeguarding Adults Board and the Safer Somerset Partnership arrange a joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.

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Appendix a. Action Plan (working document subject to changes)

Action Plan DHR 052 (working document, subject to change)

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 the Somerset Council Community Safety Team draws upon the learning from this DHR to increase understanding across a range of agencies that domestic abuse, including coercion and control, in caring relationships is not restricted to older people.	Local	Highlight this specific area in a learning brief which identifies that domestic abuse can be prevalent in a caring relationship. Learning brief to be shared with partners.	Somerset Council Community Safety Team	Template in place ready for publication	On publication of the review	Completed October 2026
That the Somerset Council Community Safety Team shares the learning from this DHR with Somerset Safeguarding Adults Board and requests the Board to consider how to highlight the fact that informal caring relationships take many forms and to highlight the rights of carers to a carers assessment, particularly to agencies (such as the Probation Service) which may not be familiar with carers assessments.	Local	Somerset Council Community Safety Team circulate learning briefing on publication with the support of the Safeguarding Adults Board and ask them to include in this in their newsletter	Somerset Council Community Safety Team	Template in place ready for publication	On publication of the review	Completed October 2026
That Somerset Safeguarding Adults Board and the Somerset Council Community Safety Team arrange a	Local	Both SSAB and SC CST meet to discuss and arrange a joint	Somerset Safeguarding Adults	Email sent to SSAB 30.12.2025 to arrange meeting to discuss	On publication	Completed Oct 2026

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
joint learning event to disseminate the learning from SAR Juliet and DHR Henrietta.		learning event for SAR Juliet and DHR Henrietta.	Board and Somerset Council Community Safety Team	ideas Approach SSAB to include SAR learning into briefing. Attempts were meant to liaise on joint learning event. SAR Juliet was shared in Safeguarding Adults Board Learning Event. We will add to learning briefing, highlighting similarities between SAR Juliet and DHR Henrietta	on of the review.	
That the MARAC officer, with the support of the MARAC operating group, reflect on learning from DHRs and MARAC cases to inform future training to better understand intersectionality of those subject to MARAC.	Local	The MARAC officer and MARAC operating group to use this case as a professional discussion around intersectionality and to identify any training needs for MARAC reps. Things to note: When did the discussion take place, who was involved and was there a training need identified?	Somerset Domestic Abuse Service MARAC Officer to lead	Discussion slides to be created for the MARAC reps Complete on publication	March 2026	
That the MARAC chair/panel ensure that where there are complex cases that may require a further multi-agency risk management meeting (MARM) an action is set to ensure the lead agency/agencies are made	Local	The MARAC protocol to clearly state that reps can use a MARM as an option for further multi agency discussions. If this was taken as an agency action, as with any agency taking an	MARAC Steering Group	Steering group to be updated in February Now included in protocol	March 2026	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
aware of the need to convene a MARM.		action, this would be recorded on the appropriate case management system. If required, an audit of cases where a MARM is the focus can be carried out by the MARAC Steering Group to highlight its effectiveness.				
That the MARAC steering group to gain an understanding of the rational for repeat cases including auditing if all agencies were present, effectively working together, and what were the barriers/missed opportunities.	Local	The MARAC steering group to complete an audit with a sample of 5 repeat MARAC cases. Using a similar auditing tool used previously but include how many times they were heard, were there differing agencies present at each MARAC meeting, were there any barriers or missed opportunities, the type of actions set and the agencies completing them. The findings and some possible recommendations to be included in the MARAC Steering Group quarterly report for the SDAB.	MARAC Steering Group	Steering group to be updated in February Included in MARAC assurance reporting - case audits completed every quarter	March 2026	Completed
That Adult Social Care implement the programme of development identified	Local	The comprehensive single-agency action plan developed	Adult Social Care		31 March 2026	Completed 31 December 2023

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
as a result of the learning from this DHR which addresses staff awareness of coercion and control, how intersecting needs can increase the risk of abuse and/or neglect, support for staff to exercise professional curiosity, the importance of recognising and responding to brief windows of opportunity to engage with victims, recognising when in-person contact is preferable to telephone contact and ensuring that a pattern of repeat referrals is recognised and receives management attention. That SC ASC supports staff to recognise when in-person contact is preferable to telephone contact.		by Adult Social Care would be a suitable vehicle for implementing this recommendation. Webinars delivered by Principal Social Worker (Adults) to practitioners in SC ASC in 2023 about Proportionate Assessment Guidance. This included decision-making about in-person vs telephone contact.				
That SC ASC ensures that a pattern of repeat referrals is recognised and receives management attention.	Local	Somerset Safeguarding Pathways Guidance document to be written to include guidance about recognising patterns of repeat referrals and escalation processes. Guidance to include whole Somerset Safeguarding	Adult Social Care	Somerset Safeguarding Pathways Guidance launched at the Somerset Safeguarding Adults Board in December 2025.	31 January 2026	Completed January 2026

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
		pathway including the 'front door', the Somerset Council Customer Contact Centre which screens concerns/referrals.		Guidance implemented in the Somerset Customer Contact Centre and SC ASC Safeguarding Service in December 2026. Guidance to be promoted across all SC ASC teams in January 2026.		
It is recommended that core SC ASC training is reviewed to ensure there is robust content in relation to professional curiosity, forms of abuse, coercion and control, alcohol misuse and dependence, and how intersecting needs can increase the risk of abuse and/or neglect.	Local	To be included within existing or new core training programmes for 2026/7. Programme planning and commissioning will take place from March 2026 following the annual SC ASC Learning Needs Analysis.	Adult Social Care	Meeting scheduled for 27/1/2026 with training provider for core Safeguarding and MCA training to discuss potential incorporation into existing core programmes. The action about inclusion in training has been completed. The annual learning needs analysis has been superseded by the improvement plan following CQC assessment.	31 March 2026	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
It is recommended that an audit focusing on professional curiosity is incorporated into the SC ASC Practice Quality Framework programme.	Local	Professional curiosity is to be incorporated into the SC ASC Practice Quality Framework audit programme which is being updated in January 2026. <i>Since 2022, SC ASC has developed practitioner resources about professional curiosity, held learning sessions and promoted relevant Somerset Safeguarding Adults Board learning opportunities.</i>	Adult Social Care	Updated Practice Quality Framework to be signed off by the SC Practice Quality Board and Director's Management Team in March 2026. The review of the Practice Quality Framework in early 2026 was superseded by the CQC assessment. A Strengths-based Approach Framework which highlights the importance of professional curiosity has been published and training for all operational teams will be delivered before the end of 2026. The Practice Quality Framework is being reviewed and updated in October 2026 and	1 Jan 2027	

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
				will be informed by the Strengths-based Approach Framework. Professional curiosity will be a key part of the subsequent audit programme that is planned to commence in early 2027.		
It is recommended that SC ASC core training is reviewed to ensure robust content about the importance of brief windows of opportunity in relation to people who are subject to coercive control.	Local	To be included within existing or new core training programmes for 2026/7. Programme planning and commissioning will take place from March 2026 following the annual SC ASC Learning Needs Analysis.	Adult Social Care	Meeting scheduled for 27/1/2026 with training provider for core Safeguarding and MCA training to discuss potential incorporation into existing core programmes.	31 March 2026	Completed March 2026
That NHS Somerset Integrated Care Board obtains assurance that GP practices provide regular dedicated time to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases. The NHS Integrated Care Board ensure that GP practices are aware of the ICB Responding to Domestic	Local	Feedback from ICB Named Professional for Safeguarding for Primary Care and Pharmacy, Optical and Dental Services (PODs) Modified SOP to be shared to GP practices with slide set on how to manage domestic abuse concerns on phone/virtual consultations.	NHS ICB	Evidence from assurance visits indicates that safeguarding lists include adults. Recent guidance has been provided around the monitoring of SG cases.	Jan 2026	Completed 26.06.2026

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
Abuse Standard Operating Procedure (SOP) which outlines the use of target clinical enquiry into domestic abuse.						
GP Practice 1: To improve record keeping in relation to targeted enquiry. To ensure appropriate follow up of appointments To improve the use of targeted enquiry and professional curiosity. To ensure that all patients in respect of whom there are safeguarding concerns are discussed in practice safeguarding meetings	Local	ICB Named Professional for Safeguarding for Primary Care and Pharmacy, Optical and Dental Services (PODs) to meet with the practice to discuss the case and the associated learning for the practice.	NHS ICB	DS produced new guidance for practices re safeguarding meetings shared at all GP meetings	March 2026	Completed 26.03.2026
GP Practice 2: To improve use of targeted enquiry and professional curiosity. That the Practice evidence that a patient's mental capacity has been considered when making decisions about care and consider use of a	Local	Dental Services (PODs) to meet with the practice to discuss the case and the associated learning for the practice.	NHS ICB	Unable to complete action – GP practice has not engaged. The learning from the review has been shared with the GP practice. Multiple attempts have been made to meet/engage	March 2026	Unachievable

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
Mental Capacity Act (MCA) template such as Ardens to facilitate this. That the Practice considers accessing safeguarding supervision from NHS Somerset Integrated Care Board.				them in supervision. This has been escalated to the ICB primary care team who are following up the lack of engagement		
To ensure that Abri professionals explore appropriate support avenues during home visits to residents.	Local	This has been drafted into the new DA procedure	Abri	Procedure going for approval in February 2026	March 2026	Completed March 2026
That where there have been periods of non-contact with residents, home visits should be undertaken.	Local	This has been drafted into the new DA procedure	Abri	Procedure going for approval in February 2026	March 2026	Completed March 2026
Where Abri refer residents to Adult Social Care and do not receive feedback in response to the referral, the issue will be escalated to Abri management.	Local	Escalation process explored via Safeguarding training to frontline colleagues. Abri has a safeguarding and deputy safeguarding lead for escalation queries	Abri	NA		In place already/completed
That Home Visits should be completed in line with Probation Home Visit Policy, including when there has been a significant change in circumstances.	Local	Somerset Probation Delivery Unit (PDU) Head of Service is a regional lead (South West) on Home Visits and during 2025 delivered a number of briefings to staff about Home Visits. This included expectations around when Home Visits should be completed, tips on good Home	Probation	Briefings have been delivered, with further 'refresh' briefings arranged for early 2026. Since these briefings there has regionally been an improvement in practice regarding		Completed throughout 2025.

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
		Visit practice, and also the process for Home Visit Risk Assessments and the use of Personal Safety Devices. These briefings were aligned to and referenced the Probation Home Visits Policy Framework (13.01.2025).		Home Visit Risk Assessments and the use of Personal Safety Devices. In addition, there has been improvement regarding home visit performance targets regarding 'initial' visits.		
That Management Oversight recordings are structured and include SMART objectives, including deadlines for actions to be undertaken. Such actions should also be followed up to ensure they are completed.	Local	Probation has in place a Management Oversight Framework which is available to all staff and should be followed by managers, particularly Senior Probation Officer's (SPO's). A briefing has been composed for delivery to the Somerset Management team which will review this framework to ensure understanding of expectations. There will be a particular focus on setting deadlines for actions and ensuring these are followed up.	Probation	Probation Managers in Somerset are already sighted on the Management Oversight Framework; however, this action will be used as a refresh exercise and future practice will be monitored by the Head of Service as part of their oversight of work in Somerset Probation Delivery Unit (PDU).		Completed February 2026
That practitioners are advised to clearly consider, record and validate/confirm the role and	Local	Whilst there is no specific guidance for staff around this subject, it falls under the	Probation	Contact has been made with our regional quality development		Completed May 2026

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
responsibilities of People on Probation who state that they are in receipt of carers allowance or perform a carer role. This will include the type of carer responsibilities required and the frequency of this. Understanding this will enable appointments and support to be implemented and also for consideration to be given, if this relationship breaks down.		category of 'professional curiosity'. Practitioners in Somerset Probation Delivery Unit (PDU) have been in receipt of a number of briefings regarding professional curiosity during 2024/2025; however, it has now been arranged for further briefings to be delivered before the end of March 2026 which will include a focus on People on Probation who state they are 'carers'.		team and one of their officers is going to support with delivery of briefings. The effectiveness of these briefings will be assessed via business as usual quality assurance auditing of case work. In the end this was not covered in any briefings, but communications went out to all Probation Practitioners in May 2026 advising/reminding them of the need to consider, record and validate/confirm the role and responsibilities of People on Probation who state that they are in receipt of carers allowance or perform a carer role. Briefings regarding professional curiosity more broadly are ongoing BAU.		

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 consider how domestic abuse routine enquiry can be embedded within Emergency Departments.	Local	Review of ongoing training programme within SFT - To develop / deliver the DARE workshop.	Somerset NHS FT	Development and provision of DARE Simulation training within EDs Ongoing due to rotation of ED colleagues and continued review and development of processes.		All actions complete and ongoing.
To remind Emergency Departments staff of the importance of being professionally curious when patients are presenting with injuries for which the explanation given seems/could be questionable.	Local	To be addressed in Safeguarding supervision and dissemination of the professional curiosity 7-minute briefing.	Somerset NHS FT	DARE included in mandatory Safeguarding level 3 training. Ongoing due to rotation of ED colleagues and continued review and development of processes.		All actions complete and ongoing.
Consideration /discussion of onward referral to specialist services/support. Emergency Department staff to contact SFT safeguarding advisory service if unsure.	Local	To be discussed in Department meetings/safeguarding supervision – consider development of separate ED	Somerset NHS FT	2025 in liaison with Somerset DA Service, developed ED referral pathway for high-risk DA cases (to trial as a		All actions complete and 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
		domestic abuse referral pathway for high-risk cases		pilot and if successful consider utilising pathway in community hospital urgent treatment centres and minor injuries units Professional curiosity 7-minute briefing document developed and disseminated. Routinely shared via various routes such as supervision, 'Our News' Safeguarding Advisory Service Newsletter. Ongoing due to rotation of ED colleagues and continued review and development of processes.		
That professionals participate in annual case note recording training (mandatory).	Local	Training provided by operational managers within each team on an annual basis	Somerset Domestic Abuse Service - The YOU Trust	Completed and ongoing for annual refresh training.	July 2025	Complete

Appendix b. Home Office Quality Assurance Feedback

Laura Wilson
Somerset Council
County Hall, The Crescent
Taunton
TA1 4DY

28th July 2026

Dear Laura,

Thank you for submitting the Domestic Homicide Review (DHR) report (Henrietta) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 24 June 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

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

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Henrietta
COMMUNITY SAFETY PARTNERSHIP	Somerset
DATE REVIEWED BY QA BOARD	24 June 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There is good use of language to describe Henrietta's interactions with agencies and good challenges are made to victim blaming language. • There is good use of research in the analysis. • Reference to learning from other DHRs and SARs is helpful. • Henrietta's behaviours and coping mechanisms (linked to her experiences as a domestic abuse) are well explored within the analysis of the report, including the analysis of perceived self-neglect. • The inclusion of a good practice section is useful. • Recommendations have clearly been shared and considered by partner agencies before publication.
FEEDBACK FOR FUTURE DHRs	Please avoid terms such as 'abusive relationship/domestic abuse between' (see, for example, 3.17/6.23) as this does not describe who is doing what to who and fails to hold the abuser accountable for their actions.

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	Title Page	Please mark as confidential until publication. Same feedback on executive summary.
2	Contents Page	No amendments required.
3	Pen Portrait	Please consider developing a pen portrait based on conversations with Henrietta's family and what the panel learned about her during the review. There is relevant information at sections 4.1, 4.2, 4.11 which can be drawn on.
4	Condolences	No amendments required.

5	Confidentiality and Anonymity	No amendments required.
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6	Terms of Reference	Please state whether Henrietta's family were involved in developing these within the body of the report.
7	Equality and Diversity	No amendments required.
8	Background Information	The section states, "However, Henrietta had become very isolated from family and friends and so partner agencies wrestled with the dilemma of attempting to safeguard Henrietta from abuse from Lee whilst acknowledging that supporting her to leave the relationship may leave her without the support that Lee may or may not have successfully provided to her given his own quite complex needs and volatile behaviour." This may be a matter of interpretation, but the wording of this sentence could perhaps be refined: the suggestion that Lee "may not have successfully provided" support suggests that this should not have been a dilemma. The circumstances are more accurately worded in 8.1 "Henrietta appeared to be dependent on Lee for support, but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered." Please consider amending.
9	Combined Chronology	No amendments required.
10	Overview	No amendments required.
11	Analysis	No amendments required.
12	Conclusions	No amendments required.
13	Lessons learnt and recommendations	No amendments required.
14	Timescales	Please account for delays between April 2024 and June 2025.

15	Involvement of family / friends / community	Please indicate whether the Home Office and AAFDA leaflets were shared with Henrietta's family. This is pertinent in relation to learning point 8.22.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	Please outline relevant training attended by the chair.
19	Parallel Reviews	No amendments required.

20	Dissemination	Please indicate, in the body of the report, whether Henrietta's family will be consulted about key dates to avoid publication and whether additional support will be needed at that time.
21	Action Plan	• Please indicate where overall responsibility for implementation of the action plan sits. • As per the family's feedback, please set out how the CSP will update them on the implementation of the action plan.
22	Has there been a request to withhold publication? <i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i>	No requests to withhold publication.
23	Any other comments	

Chair response to Home Office QA feedback

Feedback for future DHRs:

Please avoid terms such as 'abusive relationship/domestic abuse between' (see, for example, 3.17/6.23) as this does not describe who is doing what to who and fails to hold the abuser accountable for their actions.

Noted thank you.

Title page:

Please mark as confidential until publication. Same feedback on executive summary.

Amended as suggested

Pen picture:

Please consider developing a pen portrait based on conversations with Henrietta's family and what the panel learned about her during the review. There is relevant information at sections 4.1, 4.2, 4.11 which can be drawn on.

Pen portrait added – paragraphs 1.10 – 1.13

Terms of reference:

Please state whether Henrietta's family were involved in developing these within the body of the report

The terms of reference were shared with the family and they were invited to comment upon them. They expressed themselves satisfied with the terms of reference questions. The DHR guidance states that the DHR Chair and Review Panel should draw up clear terms of reference. It is necessary to draw up the terms of reference before the IMR templates are sent out for completion. It is not usually possible to engage with the family until after the IMR templates have been sent out for completion. Therefore it is difficult to offer families the opportunity to develop the terms of reference questions. Paragraph 3.8 amended.

Background information

The section states, "However, Henrietta had become very isolated from family and friends and so partner agencies wrestled with the dilemma of attempting to safeguard Henrietta from abuse from Lee whilst acknowledging that supporting her to leave the relationship may leave her without the support that Lee may or may not have successfully provided to her given his own quite complex needs and volatile behaviour." This may be a matter of interpretation, but the wording of this sentence could perhaps be refined: the suggestion that Lee "may not have successfully provided" support suggests that this should not have been a dilemma. The circumstances are more accurately worded in 8.1 "Henrietta appeared to be dependent on Lee for support, but this dependence arose in the context of isolation from family, friends and neighbours which Lee appeared to have engineered." Please consider amending.

This is a fair point. I have amended paragraph 1.3 in both the overview and executive summary reports.

Timescales:

Please account for delays between April 2024 and June 2025.

The delay during this period was caused by the time needed to analyse the volume of chronological information held by involved partner agencies. Paragraph 1.7 amended.

Involvement of family/friends/community:

Please indicate whether the Home Office and AAFDA leaflets were shared with Henrietta's family. This is pertinent in relation to learning point 8.22.

Could Safer Somerset Partnership advise on whether the Home Office and AFFDA leaflets were sent to the family. I will amend the DHR report accordingly.

DHR chair:

Please outline relevant training attended by the chair.

Amended as suggested.

Dissemination

Please indicate, in the body of the report, whether Henrietta's family will be consulted about key dates to avoid publication and whether additional support will be needed at that time.

I will be very happy to continue liaising with Henrietta's family to check whether there are any dates to avoid and whether they will need any additional support in relation to publication.

Action plan:

- Please indicate where overall responsibility for implementation of the action plan sits.
- As per the family's feedback, please set out how the CSP will update them on the implementation of the action plan.

To be addressed by the Safer Somerset Partnership.