

Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Jasmine

Date of death: March 2023

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**Safer Somerset Partnership
Domestic Homicide Review
Into the death of Jasmine
In March 2023**

Overview Report

**Independent Review Chair and Author: Safer
Somerset Partnership**

Review Completed: September 2025

Pen Portrait by Review Panel

Information shared to the panel by family shows that Jasmine was a devoted and loving mother, daughter, and sister who always put her family first.

Described by her daughter as caring and affectionate, she reminded her children every day how much they were loved. She took great pride in her home, enjoyed watching soaps, especially Hollyoaks, and liked playing colouring games on her phone.

Despite experiencing significant adversity, including domestic abuse and the loss of several children from her care, Jasmine remained a kind and loving person with hopes and dreams for herself and her family. She was deeply loved by those closest to her, and her loss is felt profoundly by her children, wider family, and the grandchildren she never had the chance to meet.

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Glossary

Terminology	Definition
Attention deficit hyperactivity disorder (ADHD)	Attention deficit hyperactivity disorder (ADHD) is a condition that affects people's behaviour.
BRAG Tool	Used by Avon and Somerset Police to risk assess vulnerability and safeguarding concerns.
CARA (Cautioning and Relationship Abuse)	An early intervention for domestic abuse offenders who have received a conditional caution.
COPD (Chronic Obstructive Pulmonary Disease)	Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.
CCB (Coercive and Control Behaviour)	A form of domestic abuse that was made a criminal offence in England and Wales in 2015 in Serious Crime Act 2015.
Cycle of Change	6 stage model to help users (substance misuse) understand their behaviour and motivations around it.
Domestic Abuse, Stalking and Honour Based Violence Risk Identification Checklist (DASH RIC)	A nationally implemented tool used to assess victim risk in cases of domestic abuse.
Domestic Violence Protection Notice (DVPN)	An emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator.
Domestic Violence Protection Order (DVPO)	A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days
EDT (Emergency Duty Team)	Emergency duty team takes emergency referrals outside of office hours for adult and children's social care.
FAST (Family Assessment and Support Team)	- Provide placements to parents and their children (0-5) together for a time limited assessment or support.
First Response	First Response is the front door for Somerset Children's Social Care services.
Independent Domestic Violence Advocate (IDVA)	A specialist professional who works with a victim of domestic abuse to help increase safety and wellbeing.
Lighthouse Safeguarding Unit (LSU)	A dedicated department within Avon and Somerset Police for victim and witness care and safeguarding.
Multiagency Public Protection Arrangement (MAPPA)	Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders
Multi-Agency Risk Assessment Conference (MARAC)	A meeting where information is shared on the highest risk domestic abuse cases.
Non-Molestation Order	A (civil) court order that protects a victim and any relevant child from abuse or harassment by a named person.
Post Traumatic Stress Disorder (PTSD)	Post Traumatic Stress Disorder (PTSD) is a mental health problem that may develop after experiencing traumatic events.

Pre-Sentence Report	Pre-sentence report is usually a written or verbal report prepared by a probation officer following an interview assessment with a defendant.
Restraining Order	A (criminal) court order to help prevent a named person harassing or stalking a victim
Talking Therapies	Psychological therapies provided by NHS.

Preface

The Safer Somerset Partnership on behalf of all those involved in this review, wish to express their sincere condolences and sympathy to Jasmine's family and all who have been affected by her tragic and untimely death.

This review has been undertaken in an open and constructive manner, with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and determine learning and recommendations appropriately.

1. Introduction

- 1.1. This report of a domestic homicide review examines agency responses and support given to Jasmine, a resident of Somerset prior to the point of her death in March 2023.
- 1.2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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. This review was commissioned following the death of Jasmine as a result of a road traffic accident, where she was the passenger of a car driven by her partner Doug. An occupant of another vehicle involved in the accident also was seriously injured. It's understood from both agency records and family that Jasmine and Doug had a long history of domestic abuse within their relationship, and this provided the rationale as to why a local agency made a notification to the Safer Somerset Partnership to consider commissioning a Domestic Homicide Review.
- 1.4. Following the fatal incident, in January 2024 the Courts sentenced Doug as a result of his pleading guilty of causing death through careless driving whilst over the prescribed limit for alcohol, causing serious injury through careless driving, driving while disqualified and driving without insurance.
- 1.5. The key purpose for undertaking this review is to enable lessons to be learned, where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. 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, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2. Timescales

- 2.1.** Jasmine died in March 2023, and on the 3rd of April 2023, Somerset NHS Foundation Trust made a referral to the Safer Somerset Partnership to consider the death for a Domestic Homicide Review. A decision to undertake a Domestic Homicide Review (DHR) was taken by the chair of the Safer Somerset Partnership on the 16th of May 2023, and the Home Office informed of this decision the same day. An independent Domestic Homicide Review chair was appointed in June 2023.
- 2.2.** In consultation with the Avon and Somerset Police Senior Investigating Officer, it was decided to delay certain aspects of the review, such as engagement with Jasmine's family members and potential witnesses until all the criminal justice proceedings had concluded. The police agreed that other aspects of the review could continue, such as production of chronologies, Individual Management Reviews and drafting of the overview report.
- 2.3.** In October 2023, Jasmine's partner was charged with offences in respect of the road traffic accident in which she tragically died. In November 2023, he entered a guilty plea in respect of offences relating to the fatal road traffic accident. In January 2024, he was sentenced.
- 2.4.** The review panel had 5 meetings (virtually) on Microsoft Teams: 5th September 2023, 15th November 2023, 28th March 2024, 5th July 2024 and 10th March 2025.
- 2.5.** The review was concluded in September 2025. The delay beyond the statutory guidance requirement of 6 months is due to several reasons outlined below in 2.5/2.6.
- 2.6.** As stated in 2.2 above, the criminal justice proceedings did delay progress of the review. Additionally, the independent chair who was originally appointed did complete a draft report in 2024, however the review panel and Community Safety Partnership decided it was of a poor quality. Subsequently the independent chair's contract for this review was terminated, as a mutually agreed way forward could not be achieved.
- 2.7.** The Safer Somerset Partnership (SSP) contacted the Home Office in January 2025 to clarify whether a new independent chair should be appointed, or if the SSP could complete the report, and as a means of ensuring some independence, another independent DHR chair would review the finalized report. The Home Office advised that either course of action was suitable, therefore, the SSP decided to proceed with the second option. Dr Susan Haile was appointed to review the finalised report.

3. Confidentiality

- 3.1. The findings of the DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. During the review information was available only to participating officers/professionals and their line managers.
- 3.2. To protect the identity of the deceased and her family, pseudonyms have been used throughout this report. 'Jasmine' was chosen by one of her daughters, and the other pseudonyms were chosen by the Review Panel. These are detailed in the table below along with their ages:

Pseudonym	Age (at time of death)	Relationship to victim
Jasmine	41	Victim (deceased)
Doug	32	Partner
Child 1	25	Jasmine and previous partner's child 1
Child 2	22	Jasmine and previous partner's child 2
Child 3	21	Jasmine and previous partner's child 3
Child 4	20	Jasmine and previous partner's child 4
Tina	16	Jasmine and previous partner's child 5
Child 6	9	Jasmine and Doug's eldest child
Child 7	2	Jasmine and Doug's youngest child

- 3.3 Jasmine and Doug's ethnicities were understood to be both White British.

4. Terms of Reference

- 4.1. The family were informed of the purpose and aims of the review; however, the terms of reference were established through the review process. With the terms of reference being agreed by the review panel at their first meeting in September 2023. The scope was agreed to be from January 2020 until Jasmine's death in March 2023. This timescale was chosen as it incorporated the period of the Covid-19 pandemic, and additionally for the birth of Jasmine's youngest child.
- 4.2. There were no key lines of enquiry clearly set out for the review by the independent chair who was originally appointed. However, the terms of reference did include the following points (the terms of reference can be found in appendix 1):
- 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 Jasmine or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.

- In regard to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify how interventions designed to manage perpetrators were implemented (including Integrated Offender Management), and impact this had on Jasmine.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- 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.

5. Methodology

- 5.1. Following notification from Somerset NHS Foundation Trust to consider Jasmine's death as a Domestic Homicide Review, the Safer Somerset Partnership (SSP) chair considered that in accordance with the Domestic Homicide Review (DHR) statutory guidance, that a review should be commissioned.
- 5.2. The SSP chair reached this decision after receiving initial scoping information from 16 local statutory and voluntary sector agencies. Of those 16, 13 agencies confirmed they had had records relating to either Jasmine or Doug or related children, however, only 8 had records of significance to the review.
- 5.3. All agencies identified as having contact relevant to the review were required to participate in the review panel, complete a chronology and an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations regarding service delivery.
- 5.4. Additionally, the independent chair who was initially appointed had discussions with the charity "The Nelson Trust", for their specialist expertise around women

experiencing multiple disadvantages, and as provider of the “Pause Project” which is discussed within the report.

- 5.5. Jasmine’s family were invited to contribute to the review, and some of whom provided valuable insights about Jasmine’s life and experiences of domestic abuse.
- 5.6. There were limitations to some of the information provided to the review, where professionals who had had contact with Jasmine were no longer in post, for instance Children’s Social Care and Probation.

6. Involvement of Family

- 6.1. The independent chair contacted Jasmine’s mum by letter in September 2023, November 2023, January, February 2024, March and April 2024. All correspondence included information about the review, and / or its progress, the Home Office leaflet for families, and details of Advocacy after Fatal Domestic Abuse (AAFDA). No response was received at that time.
- 6.2. The independent chair contacted the named social worker for Tina, Jasmine’s daughter via email in October 2023, November 2023, January 2024, and February 2024. Due to an administrative error, contacts were not received by Tina’s social worker until early February 2024.

At this time, the social worker advised that Tina was currently experiencing significant challenges in her life, in particular with accommodation. And given the closeness to the one-year anniversary of Jasmine’s death, the review chair was advised that engagement with Tina would be best placed after the anniversary had passed. Following the anniversary, the independent chair had several further contacts with the social worker, including with assistance of the Children Social Care DHR panel member, who confirmed Tina did not wish to engage an AAFDA advocate and instead requested to be supported by her social worker. Tina reviewed a copy of the draft report, and confirmed that Jasmine’s mother, brother, sister, and adult daughter did not feel able to take part in the review.

- 6.3. However, as the independent chair had the contact details of Jasmine’s brother, sisters and another of Jasmine’s daughters they were each contacted by letter twice (November 2023, January 2024) and also via email twice (May 2024). They were provided with details of AAFDA’s specialist service. No response was received from any of these relatives.
- 6.4. The independent chair and review panel discussed the feasibility of speaking with Doug or his family, specifically his mother as she had a special guardianship placement for Jasmine’s youngest child. However, upon assessing the unique risks and vulnerabilities surrounding this case, it was decided that this would not be completed to avoid increasing safeguarding risks and potential harm.
- 6.5. In December 2024, Probation’s Head of Service confirmed to the Safer Somerset Partnership that following their Probation Serious Further Offence (SFO) Review, they were liaising with Jasmine’s mother regarding that report. They met with

Jasmine's mother and her partner in January 2025 to provide her with the SFO Review Report and talk her through it. Prior to this visit Jasmine's mother confirmed that she was aware a DHR was still being completed and that she was happy to meet to discuss the SFO review report prior to the DHR concluding.

7. Contributors to the Review

7.1. The following agencies contributed to this review.

Agency	Involvement in Review
Avon and Somerset Police	IMR
Children Social Care	IMR
NHS Somerset Integrated Care Board	IMR
Probation	IMR
Public Health Nursing	IMR
Somerset Drug and Alcohol Service (Turning Point)	IMR
Somerset Council Housing (formerly Mendip District Council)	IMR
Somerset Domestic Abuse Service	IMR
Somerset NHS Foundation Trust	Panel member- expertise around mental health and acute hospitals
Stonewater Housing	IMR
The Nelson Trust	Expert advisor

7.2. All IMR authors were independent of any direct involvement with Jasmine or Doug.

8. The Review Panel

8.1. As stated in 2.3, the review panel met five times, with all panel members being independent of any direct involvement with Jasmine or Doug.

8.2. The panel and Safer Somerset Partnership agreed that panel member names would not be included due to the potential risks to both the public and professionals. It was also noted the draft revised statutory guidance published in 2024 also did not include professional names. The panel members were:

Agency	Role
Independent Chair	Chair
Avon and Somerset Police	Detective Chief Inspector
Children's Social Care	Head of Service Team Manager
Probation Service	Senior Probation Officer

NHS Integrated Care Board	Designated Nurse for Safeguarding Adults
Safer Somerset Partnership (Somerset Council)	Community Safety Manager
Turning Point (Somerset Drug and Alcohol Service)	Young Person & Family Team Ops Manager
Somerset NHSFT	Strategic Lead & Named Professional Safeguarding Adults - Prevent Lead / Domestic Abuse & Sexual Violence Lead
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Service Manager
Somerset Council Housing (former Mendip area)	Senior Housing Options Manager
The Nelson Trust / Pause	Criminal Justice Services Lead
Stonewater	Mentoring Manager (Resolution Team)
Public Health Nursing	Operational Service Manager

9. Review Chair and Author of the Overview Report

- 9.1.** The Safer Somerset Partnership originally appointed an independent chair and report author for this review, who had several years' experience within the areas of violence against women and girls and safeguarding adults. She had no connection with the Safer Somerset Partnership, any of its agencies and no prior knowledge of any of the subjects of the review.
- 9.2.** As stated in section 2, due to performance issues, the chair's contract was terminated and agreement subsequently reached between the Home Office and Safer Somerset Partnership on how to conclude the review. A Community Safety Manager within Somerset Council who has completed the Home Office accredited chair training edited the report, and another AAFDA trained independent chair was appointed to critically review the report to help ensure it is robust.

10. Parallel Reviews

- 10.1.** Police completed a criminal investigation and prepared a case for the Crown Prosecution Service. In October 2023, Doug was charged with offences in respect of the road traffic accident in which she tragically died. In November 2023, he

entered a guilty plea in respect of offences relating to the fatal road traffic accident. In January 2024, he was sentenced.

- 10.2.** Due to the criminal trial thoroughly establishing all the facts relating to Jasmine's death, there was no coronial inquest.
- 10.3.** As referred to in 6.4, Probation conducted a Serious Further Offence Review due to Doug being under probation supervision at the time of the fatal road traffic collision. The SFO Review was concluded in March 2024 and the action plan was signed off as completed in November 2024. Somerset's Probation Head of Service and Victim Liaison Officer then met with Jasmine's mother and her partner in January 2025 to talk them through the review and provide them with a copy of the report. The independent chair did not receive a copy of the SFO report, and the panel were not fully sighted on the content until after its conclusion.

11. Equality and Diversity

- 11.1.** The review panel considered all nine protected characteristics of the Equality Act 2010 (Section 4). These are defined as follows:
- Race
 - Age
 - Sex
 - Disability
 - Pregnancy and maternity
 - Marriage and civil partnership
 - Sexual orientation
 - Gender reassignment
 - Religion or belief
- 11.2.** The review panel determined that sex, disability, race and pregnancy and maternity were all relevant and are discussed below.
- 11.3.** Sex: The panel considered this a relevant protected characteristic as Jasmine was female. Women are disproportionately affected by domestic abuse, with the Office for National Statistics Crime Survey of England and Wales figures (2022/23)ⁱ showing that of the 2.1 million people who experienced domestic abuse in the year ending March 2023, 1.4 million of those were women.
- 11.4.** Disability: Jasmine was diagnosed with Chronic Obstructive Pulmonary Disease (COPD)¹ during 2021, and this impacted her day-to-day living, making her unable to work due to her shortness of breath and limited her activity at home. This appears to indicate that Jasmine may have been a disabled person as per the definition. Additionally, Jasmine was also treated for anxiety and depression.
- 11.5.** The panel also considered whether Doug should have been deemed to have a disability under the Equality Act 2010. This is because Doug is known to have had

¹ [Chronic obstructive pulmonary disease \(COPD\) - NHS](#)

diagnoses of depression and attention deficit hyperactivity disorder (ADHD). However, the adverse impacts on his daily living are unknown and so the panel could not determine if this is a relevant protected characteristic for him.

- 11.6.** Race: Agency records generally described Jasmine and Doug as White British nationals. A single reference within one agency record contained different information regarding Jasmine's heritage; however, this could not be verified by the review panel and was not considered relevant to the review's findings.
- 11.7.** Pregnancy: Jasmine was not pregnant at the time of her death but had had 7 children. With the youngest child being born within the scope of this review. The review found that the impact of multiple child removal and two of her children's Special Guardianship Placement with Doug's mother were materially relevant in this case.
- 11.8.** Other impacts: Addiction and dependency to alcohol or drugs are excluded from the definition of disability contained in the Equality Act 2010.ⁱⁱ Both Jasmine and Doug had significant contact with drug and alcohol services, both proceeding and during the review timeline. As the links between substance misuse and domestic abuse are well researched areas, including Gadd, Henderson et al (2019)ⁱⁱⁱ who state that "Substance use features in around half of all UK domestic homicides." The panel were cognisant of the couple's alcohol use being a significant factor in this case.

12. Dissemination

- 12.1.** The Individual Management Reviews (IMRs) will not be published but the DHR report will be made public.
- 12.2.** Once the reports and action plan for this DHR have been approved by the Home Office, they will be published on the Somerset Domestic Abuse website following liaison with Jasmine's family around publication date via a SW Victim Contact Scheme advocate, and will be widely disseminated including, but not limited to:
- Jasmine's family
 - Members of the Community Safety Partnership
 - Somerset Domestic Abuse Board
 - Avon and Somerset Police and Crime Commissioner
 - Domestic Abuse Commissioner for England and Wales
 - Somerset Safeguarding Children Partnership
 - Somerset Safeguarding Adults Board

13. Background Information

- 13.1.** Jasmine's daughter (Tina) advised the review that Jasmine was "*extremely loving and caring and always put her family first*". Tina recounted how Jasmine reminded her and her younger siblings daily how much she loved them. She took a lot of pride in her home, and she spent lots of time cleaning. She loved to watch soaps, with Hollyoaks being her favourite. She also enjoyed playing colouring games on her phone.

- 13.2.** Other than the professionals involved in her life, Jasmine seemed to have had a very limited support network, with only one reference to a close friend found. Her daughter said that this friend had been in her mum's life since school. And her friend's daughter and Tina remain close. However, it seemed their friendship had become strained due to conflict between them, and alcohol use. At times, Jasmine appeared to distance herself from her friend in an effort to address her alcohol use. She was not thought to have been in contact with her friend at the time of her death.
- 13.3.** Tina was asked to share a good memory of her mum with the review. Jasmine was out in the garden with the family dog one afternoon when a rat came running through the garden. The dog chased after it, ran through Jasmine's legs and knocked her over and she went flying. Tina watched this happening while laughing very hard, while Jasmine didn't quite see the funny side at the time, afterwards they would often joke about this incident together.
- 13.4.** Jasmine was subjected to domestic abuse by her previous partner, the father of her five older children. This relationship reportedly started when she was fifteen years old, and he was twenty-one years old. Children's Social Care had involvement with her children; child 1, child 2, child 3, and child 4. All 4 children were adopted, with there having been child protection concerns for the children around exposure to domestic abuse from their father to Jasmine, parental drug use and mental health issues. The four older children were adults at the time of Jasmine's death, and it is unknown the precise details of any contact or relationship she had with these children, although it is understood she had contact with at least one of her adult children.
- 13.5.** Jasmine's fifth child, Tina, was known to Children Social Care pre-birth due to concerns around parental substance misuse and domestic abuse.
- 13.6.** Jasmine lived in a Stonewater Housing Association property in Somerset at the time of her death. She had a sole tenancy.
- 13.7.** It's understood that Jasmine and Doug were in a long-term relationship and had been together for at least ten years at the time of her death, with domestic abuse having been reported or suspected by professionals. They had lived together and resided separately at various points during their relationship and had brief periods of separation.
- 13.8.** Jasmine's daughter shared that Doug came into her life when she was three, and *'for as long as she can remember the relationship was horrible because of his abuse'*. She didn't like him, and many people had told Jasmine to stay away from him. She reflected that there were lots of times she wished she hadn't been in the house because of his abuse. She described Jasmine, herself and the children living in fear of him, and that most nights, things were scary in their house. Jasmine's mum was also very fearful of him. On several occasions she observed that her mum had urinated herself due to her fear of him, and she frequently asked Tina to sleep in her bed with her because she was so scared. Tina often saw clumps of her mum's hair around the house where he had pulled it out during assaults. She had frequent bruising and injuries, which she did her best to hide with makeup or clothes.

- 13.9.** Jasmine was so controlled by him that she couldn't even have a bath. She was constantly having to try to defend and protect herself and her children. He would break into their house, often using a ladder and take their house keys. Eventually, they had to hide all their house keys. He blackmailed, coerced and threatened her into having sex with him. He frequently took money from Jasmine, despite him being the one who worked, leaving her in financial hardship. Jasmine would often go without herself to make sure her children had what they needed. He forced Jasmine to have an abortion against her wishes via blackmail and physical violence.

He involved his family in abusing Jasmine. Tina stated that he '*was destroying her*'. And there were times her mum said, '*she'd rather be dead than carry on living with his abuse*'. She reflected that Jasmine loved him very much. There were moments of joy and affection in their relationship, like chasing each other with a leaf blower and spraying the other with the garden hose in summer. She acknowledged that alcohol was a big factor in their relationship. While abuse still happened when one or both were sober, overall, things were better at home when they weren't drinking. She also shared that he protected Tina when she was being bullied by older children in the neighborhood. She emphasised that she doesn't want anyone to have to go through what her mum did.

- 13.10.** Jasmine and Doug had two children together, child 6, and child 7. Child protection proceedings occurred for both of these children, focusing on parental substance misuse and domestic abuse. At the time of Jasmine's death, child 6 and child 7 were residing with, Doug's mother via a Special Guardianship Placement.
- 13.11.** It's understood from agency records that Doug reported experiencing trauma in his early life and had long-term challenges with drug and alcohol use. It was noted that he had family support from his mum and his sister. It is thought he may have worked in the construction industry. In total, he had sixteen convictions for thirty-seven criminal offences, dated between 2007 to the date of Jasmine's death. Primarily offences against the person. Alcohol misuse was linked to his offending behaviour.

He had one domestic abuse related offence against a former partner in 2010 which was dealt with by way of a Community Order. His next offence in an intimate relationship was in 2017 and this was an offence of assault where Jasmine was the victim. He received a Suspended Sentence Order. At the time of Jasmine's death, he was subject to a twelve-month Community Order with the requirement to complete unpaid work for an assault against an unknown male. He was disqualified from driving on 14th March 2023, just days before the fatal road traffic collision in which he was driving the vehicle, that killed Jasmine, and caused life changing injuries to the driver of the other vehicle.

- 13.12.** Jasmine's death: Doug was driving with Jasmine as the front passenger in the car. The car was travelling at high speed and swerved into the path of an oncoming vehicle travelling on the opposite side of the road, colliding with it head on. The oncoming vehicle was driven by an individual with no known connections to Jasmine or Doug. A witness at the scene called 999 at 20:03 and asked for police attendance reporting a two-vehicle road traffic collision. One of the witnesses at the scene was a nurse and administered first aid to Jasmine. Doug was thought at the time, to be

in a life-threatening condition and was airlifted to hospital. Medical staff noted Doug smelt of alcohol. Jasmine was sadly, pronounced deceased at the scene by paramedics at 20:44 hours and was transported to Hospital. The collision and Jasmine's death took place in Somerset in March 2023.

13.13. Jasmine's cause of death was given as, '*Multiple injuries*'. A post-mortem was conducted, and it was found that she had experienced several injuries consistent with being involved in a fatal road traffic accident.

13.14. Criminal Justice Outcomes: Upon investigation, Doug was found to have consumed alcohol and was over twice the legal limit whilst driving at the time of the fatal incident. Doug had been disqualified from driving on 14th March 2023 at South Somerset Magistrates Court, several days before Jasmine's death. He received twenty-two months of disqualification for previously driving a vehicle over the prescribed limit. In October 2023, Doug was charged with offences in respect of the road traffic collision in which Jasmine tragically died. In November 2023 Doug entered a guilty plea in respect of offences relating to the fatal road traffic collision. In January 2024, Doug received a custodial sentence of seven years and nine months, and he was banned from driving for ten years.

The Judge said he took into account Doug's early guilty plea and ongoing problems with alcohol, adding that Doug's decision to drink and drive had "devastating" consequences resulting in a "catastrophic" collision. Doug is currently due for release in December 2027 and he will remain on licence until October 2031.

14. Chronology

14.1. This chronology details relevant contacts and interactions Jasmine and Doug had with professionals from 1st January 2020 until the date of her death in March 2023, the agreed time period for this review.

14.2. It's important to note that during the time period for this chronology the Covid-19 Pandemic occurred and resulting restrictions² included three national 'lockdowns', March – June 2020, November – December 2020, and January – March 2021. During lockdowns, all but essential services and facilities were closed and there were significant restrictions on movement and social contact.

14.3. 2020

14.3.1. In late **January**, Jasmine attends a Maternity Antenatal Booking Assessment at Royal United Hospital (Bath) where various questions are asked of her as part of routine screening. As part of this Jasmine states she has the full support of her partner, family, and friends. She has two children ages thirteen and six in foster care and she's working with social care to regain custody. They talk about previous alcohol abuse, recent cannabis use, mental health, and medication. She doesn't

² [timeline-coronavirus-lockdown-december-2021 \(instituteforgovernment.org.uk\)](https://www.instituteforgovernment.org.uk/timeline-coronavirus-lockdown-december-2021)

disclose any domestic abuse from Doug. On 4th **March**, Jasmine has a telephone appointment with Turning Point. She shares that she's five months pregnant.

- 14.3.2.** In early-mid **April**, Jasmine has telephone appointments with Turning Point (Somerset Drug and Alcohol Service). She shares that she's abstinent from alcohol but using cannabis daily due to COVID-19 and feelings of isolation. She says all is going well with pregnancy, and she's engaging with Children's Social Care. There's no alcohol use and reduced low level but daily cannabis use. On 11th May, Jasmine has a telephone appointment where she shares low level cannabis use only. They talk about the plan to close her case.
- 14.3.3.** During **May**, Jasmine has a couple of appointments with Children Social Care, including a Children and Families Assessment. Jasmine shares she's not living with Doug. He's living with his mum. She's in a private rented two bed property but hopes to secure a larger property so Tina and child 6 can return to her care. She's claiming benefits and Doug is out of work within the building trade due to COVID-19.
- 14.3.4.** In **May**, Doug also has contact with Children's Social Care over the phone to complete the Children and Families assessment due to COVID-19 restrictions. He's staying with his mum, not living with Jasmine and he's out of work in the building trade because of lockdown.
- 14.3.5.** Jasmine also has a telephone appointment with the nurse practitioner at the GP practice in **May**. Where she shares she's working with Turning Point, and will be two years sober (from alcohol) in July and her cannabis use is down to £5 worth every couple of days. She's thirty weeks pregnant and has a supportive family. Two children in care have a reunited plan in place. She's taking fluoxetine which helps with mood. She's sleeping and eating well and getting outdoors in the garden.
- 14.3.6.** During **June**, Jasmine has three telephone appointments with Turning Point where she says everything is going well, but that the COVID-19 lockdowns are affecting her. Jasmine also has a telephone appointment with the health visitor in mid-June. They talk about her health needs around smoking cannabis. She shares she's not drank alcohol for two years and there's no domestic abuse between her and Doug.
- 14.3.7.** In early **July**, child 7 is born at Royal United Hospital (Bath).
- 14.3.8.** Over the course of the next month, Jasmine has visits and telephone calls with the health visitor. These include discussion around an ongoing parenting assessment, and caring for her new baby, plus contact with her other children. Additionally, Jasmine meets with the FAST-Parenting Assessor in the community five times, where they talk about healthy relationships in these sessions. These FAST appointments also take place with Doug, including at his sister's house.
- 14.3.9.** During **October**, Jasmine sees the GP and nurse practitioner three times, where contraception is discussed, and also Jasmine confirmed there was no change in her

mood, and she continues to take fluoxetine³. The face-to-face appointment with the GP was with Doug present.

Jasmine has a couple of appointments with Children's Social Care relating to the FAST assessment. During the process, Jasmine says she experienced parental alcohol misuse and domestic abuse in her childhood and that she'd used drugs as a teenager. She shares significant domestic abuse between her and the father of her eldest children. She acknowledges that her relationship with Doug is violent and feels this links in with their alcohol use, which plays a big part in the cycle of domestic abuse. She shares that Doug doesn't live with her permanently, and historically he'd often turn up to her address intoxicated and cause damage. Jasmine says she can't recall any learning from a previous online Freedom Programme course she completed.

During the FAST assessment, Doug stated that in his childhood, he used drugs as a teenager, and there was violence in his previous relationship. He acknowledges his relationship with Jasmine is violent and feels this links in with their alcohol use. Doug recalls several aspects of his learning from an online domestic abuse course. Including the consequences of his actions and behaviour for victims of his abuse. He says this made him feel ashamed of his violent behaviour. He used to blame Jasmine for disputes and violence and often felt scared when on the following day he couldn't remember how he had behaved.

14.3.10. In early **November**, Jasmine has a home visit from the health visitor, where she describes feeling low in mood when Tina and child 7 go back to foster placement, and it seems a very slow process. Doug is working and spends time with child 6 and child 7 so she can spend time with Tina.

14.3.11. In mid-**December**, Jasmine has a home visit with the health visitor where she talks about previous alcohol abuse and her childhood. She says there's been no recent domestic abuse from Doug. She feels well emotionally. She blames herself for her children being removed.

14.4 2021

14.4.1. During **January**, Jasmine has appointments with her health visitor and three telephone consultations and a face-to-face appointment with the nurse practitioner at the GP practice. She describes challenges with her housing, as now two of her children are residing with her again, the property is small, and she's on a waiting list for a bigger property. She has good support from family. Jasmine advises she has sore throat symptoms and shortness of breath. In **February**, Jasmine had a telephone consultation with a doctor at the GP practice about suspected Chronic Obstructive Pulmonary Disease (COPD).

14.4.2. During **March**, Jasmine has a telephone consultation with the nurse practitioner and asks for a referral to Talking Therapies to discuss her childhood, as the social worker

³ Anti-depressant medication

has advised this as part of the plan. Jasmine goes to Royal United Hospital for a chest Xray and results. Jasmine also meets with her health visitor, and no domestic abuse is disclosed.

- 14.4.3.** In late **April**, Jasmine has a home visit from the health visitor for the nine - twelve-month review. She shares that she and Doug are having relationship counselling.
- 14.4.4.** During **May**, Jasmine has telephone consultations with the GP about COPD, including requesting a sick note for three months as she's applying for Universal Credit.
- 14.4.5.** At the beginning of **July**, Jasmine has a home visit from the health visitor, who offers her a schedule of Growing Skills assessment due to concerns over child 6's development, and Jasmine declines. However, this issue is revisited in October, where it is completed.
- 14.4.6.** During **July and August**, Jasmine has one appointment with the GP, and another with the nurse practitioner at the practice, regarding her COPD causing her difficulties with day to day living. She discloses she lives alone, although Doug helps with the children.
- 14.4.7.** It is of note that in 2021, other than those mentioned here in 14.4 there were very few contacts recorded by agencies. Others were a handful of routine contacts with the GP about vaccinations and also safeguarding concerns around Tina (not domestic abuse specific).

14.5. 2022

- 14.5.1.** In late **January**, police get a third-party report saying Tina was assaulted by Jasmine and Doug. Police attend and investigate, and the allegation is found to be untrue. A referral to the Lighthouse Safeguarding Unit was made and a BRAG rated amber was completed for Tina, with referrals made to CSC and Education. A DASH was completed and rated as standard.
- 14.5.2.** In early **February**, Jasmine has a home visit with the health visitor to complete a schedule of Growing Skills for paediatric referrals for child 7. They talk about domestic abuse and Jasmine says there's been no recent incidents.
- 14.5.3.** In mid-**March**, an incident happens at a hotel in Wiltshire where Doug assaults Jasmine causing injuries to her face. Doug drives away in a vehicle after the assault. In the privacy of her hotel room, Jasmine says to Wiltshire police that she's been in a relationship with Doug for about 10 years, and live together intermittently. Jasmine describes Doug controlling her finances, although she does not let him stop her seeing the GP and family. She says she's not frightened of him.

Jasmine says the assault happened following an argument, and that Doug had been drinking and left with their vehicle. Jasmine said she didn't want to pursue a criminal complaint of assault, but maybe willing to provide a statement. Jasmine stated she

did not want medical help for her facial injuries. Both child 6 and child 7 witness the incident. A DASH was completed and the PPN was shared with Somerset Children Social Care.

Subsequently, a strategy request was made by Somerset Children Social Care regarding concerns over the welfare of Jasmine's children, and a strategy meeting was held in late April, with a further initial child protection conference held two weeks later in May. There were no police actions to arise out of the meeting.

- 14.5.4.** In mid-**April**, Jasmine has a telephone call with the health visitor about her concerns that child 7 may be autistic. She's looking forward to moving to a new area for a fresh start and for Tina coming out of placement in May and potentially coming to stay with them.
- 14.5.5.** In early **May**, police get reports from Jasmine and Doug's sister reporting assaults on each other. Both advised the police that they don't want to make a complaint against the other. There were no witnesses, but Police did complete a 'BRAG assessment' rated as amber regarding concerns for Jasmine's children, and it was noted Children Social Care would be following up on this.
- 14.5.6.** In late May Jasmine has a relapse prevention session with her drug and alcohol recovery support worker. She says she was feeling good, but that she had a very emotional weekend. She shared that because of high emotions, she went to see an old friend and they shared a four-pack of beer. Jasmine confirmed she had enjoyed seeing her friend but hadn't seen this friend in a really long time because she still has a problem with alcohol. Jasmine knows she cannot be around her while she is staying sober. Her worker reflects that is a really good and strong thing to do, especially for so long. They discuss the Cycle of Change, and Jasmine says she thinks she is in the 'Action' stage. They also talked about triggers and Jasmine says she only really has one trigger, which is negative emotions. When she feels down or annoyed or sad this triggers her to drink, and this had always been the case for her.
- 14.5.7.** In late May, Jasmine has a home visit with the health visitor. They talk about child 7's development, impacts of domestic abuse, Children's Social Care involvement and the Child Protection plan, and safety planning. Jasmine says she's being supported by a Turning Point worker and plans to move to a new area in December.
- 14.5.8.** On 28th May, an incident happens at a hotel where Doug assaults another hotel guest after they had been drinking during the evening, along with Jasmine. Doug is arrested and taken into police custody. Hotel staff say Jasmine left child 7 alone in the room for long periods of time (without having a baby monitor) and Doug was aggressive towards her during the evening when at the bar drinking with child 7 present. The Police LSU reviewed the incident and referred to Children Social Care.
- 14.5.9.** In **May**, Doug commenced support around his substance misuse as part of the Family Safeguarding Model.
- 14.5.10.** During early **June**, Jasmine and Doug have face-to-face home visit with the drug and alcohol recovery support worker for a joint assessment. Jasmine agrees

to engage in face-to-face relapse prevention support to regain abstinence from alcohol. She says that although there was historical domestic abuse with her ex-partner, it's not an issue in her relationship with Doug. She asks for mental health support but declines support from a domestic abuse worker. Jasmine says that they are *'both happy to have their session of relapse prevention together.'* They explore long and short-term positives and negatives of continuing drinking behaviours, and strategies for how to avoid relapsing.

14.5.11. In June, Doug is sentenced to 12-month community order and 150 hours unpaid work and compensation of £150 with costs of £85. He starts to be managed by probation. This relates to a non-domestic abuse related assault (with an unrelated male). This offence related to a non-domestic abuse assault involving an unrelated male. The Court did not request a pre-sentence report from Probation. Any relevant domestic abuse context associated with the index offence may have been presented through other information available to the Court and considered during sentencing.

14.5.12. At the end of June, the family's social worker contacts the drug and alcohol recovery support worker to say that Jasmine didn't answer the door to the mental health worker, who was there for a planned appointment. They try to contact Jasmine but get no response.

14.5.13. In late June, Doug has his first appointment with probation practitioner 1 (PP1) following his sentence on 17th June (14.5.11)

14.5.14. In mid-**July**, Jasmine has an initial appointment with the domestic abuse worker as part of the Family Safeguarding Team. Jasmine says there's no current domestic abuse but that her and Doug bicker and argue. The last incident of physical abuse was about three years ago when Doug pushed and held her around the throat and strangled her. She shares that she's drinking again following her children no longer being in her care, and that she does this to relieve her feelings of loss. She says she'll complete a healthy relationship support programme with the domestic abuse worker.

14.5.15. In late July, Doug has telephone appointments with probation where they discuss his new offence and how it's impacting on his mental health, and he shares that he's contacted his GP. He has been prescribed anti-depressants and has a mental health referral.

14.5.16. Also, in late July Doug advises his probation worker he was arrested for being under the influence and in charge of a vehicle and has been released under investigation. The car broke down, so he and Jasmine went to a pub in Bridgwater and began drinking. He states that 'Jasmine and her daughter Tina were having an argument and Jasmine was on the phone'. He went to the petrol station as he thought he might be able to get a car battery there. He purchased some more alcohol. He went to sleep in the car with the keys in the ignition, police found him at 4:30am and arrested him. He says his mood is quite low and he's frustrated that he's unable to control things in his life and get things back on track. Probation

records indicates that Doug provided the same information to his Social Worker, but it is unclear how PP1 were aware of this information.

- 14.5.17.** In early **August**, Doug has a telephone appointment with probation where he says he's cut down his alcohol intake and shows some understanding of the complex nature of his relationship with Jasmine and her daughter (Tina). On 12th August, Doug has a telephone call with probation where he says he's in hospital with internal bleeding. He has multiple contacts with his probation worker over the few weeks.
- 14.5.18.** In mid-**September**, Tina calls police to say Doug physically assaulted Jasmine, who says no offences occurred, it was just an argument, and she doesn't want to make a complaint. It was noted no domestic incident had occurred, so no DASH RIC was completed. The incident was reviewed by Police LSU, and checks showed there had been no reported incidents to Avon and Somerset Police between parties since 2017. However, Children Social Care, Health and Education were all notified.
- 14.5.19.** A couple of days later, Jasmine has a telephone appointment with the domestic abuse worker. She shares that she was defrauded recently, and Doug ended up going to this person's house and smashed a few of their windows with a hammer. She shares that she'd received the keys for her new house and is focusing her efforts on making it a fresh start for herself. They talk about making sure Jasmine has a single tenancy in light of her fluctuating relationship with Doug.
- 14.5.20.** In late September Jasmine moved to her new (social housing) rented property.
- 14.5.21.** In mid-**October**, Jasmine has a face-to-face appointment with the drug and alcohol recovery support worker. They discuss group work, and she agreed to attend face-to-face Managing Alcohol Programme (MAP).
- 14.5.22.** In late October, Jasmine reports an assault by Doug to police. She says he pushed her onto the sofa, Doug has left the property, and she doesn't want to make a complaint. A DASH RIC is completed and assessed as standard risk. She declines support saying she was fully supported already and knows how to contact workers. She mentions drug and alcohol and mental health support and social workers.
- 14.5.23.** During October, Doug has a mixture of face-to-face home visits and telephone appointments with drug and alcohol recovery and mental health support workers. They work on skills to manage worries. Doug starts to be more open about the impact of his dad's death, but he isn't open about his relationship with Jasmine. Doug feels that Jasmine blames him for the removal of the children from their care. He's not open about his alcohol use.
- 14.5.24.** During early **November**, Jasmine has contacts with Somerset Drug and Alcohol Service, including that she's unable to join group intervention. She says she's drinking four cans of Stella (lager) in the evenings.

14.5.25. In mid-November, a third-party call the police reporting an assault. Jasmine and Doug have been drinking excessively throughout the day and arguing. Jasmine and Doug drove away in a car to get some tobacco and upon returning she has a minor mark to her face. She says she doesn't want to talk to officers and denies any assault occurred. An officer observed DASH RIC was completed, and rated as medium. Due to the lack of evidence to support a prosecution, no police action was taken.

14.5.26. A couple of days later, Jasmine calls police to report that her brother threatened to '*smash her face in*'. She shares that her brother is known to be violent, and she's concerned. Jasmine says it's a family argument, it's now sorted, and she doesn't want to proceed with a complaint. A DASH RIC was completed and rated as standard due to low risk. Relevant safeguarding referrals were made to Children Social Care, health and education.

14.5.27. At the beginning of **December**, Jasmine calls police saying Doug had a road traffic collision earlier in the day. When he returned home, he talked about being depressed and began self-harming. Doug had consumed alcohol and left the address with a knife. She's concerned for his welfare and reports him as a missing person. Jasmine doesn't disclose any offences but describes their relationship as toxic. She asks police to remove Doug from the property to prevent any incidents occurring. Doug did stay with a relative, and police provided him with details for local mental health support.

14.5.28. The next day, Jasmine calls police saying Doug has a pizza cutter and is trying to cut himself with it. Doug is aggressive, drags her by her hair, stamps on her ribs and grabs her by the throat saying, "*You've got to die.*" He steals her phone and drives off. She says she's fearful of further injury and violence and doesn't want Doug back at her address. A couple of days later, Jasmine contacts police to say she no longer wants to make a complaint, and that the incident was fuelled by alcohol and she was scared at the time, but she feels ok now. She disclosed having the support of the domestic abuse service and drug and alcohol service.

A DASH RIC was completed by Police and rated as high risk. It was determined there was insufficient evidence to pursue an evidence led prosecution, so no further action taken.

14.5.29. In mid-December, Jasmine contacts police saying Doug's sister phoned her, making threats to kick her door through. She says she wants the incident logged, doesn't want to take any further action, and doesn't believe the threats are credible. The police did visit Jasmine's property and found security to be substantial, Jasmine did not support a prosecution, and no further police action taken.

14.5.30. Towards the end of December, police get a third-party report of an argument where a female was dragged into a vehicle by a male, and they'd driven away. Jasmine says there was a verbal argument between her and Doug but nothing physical occurred. A DASH RIC was refused, but the officer completed one through observation and rated as medium. A BRAG assessment was not completed as it was understood all children were in the care of other relatives. Jasmine is provided with injunction advice.

14.6. 2023

- 14.6.1.** During **January**, Doug has a combination of face-to-face and telephone appointments with probation where they do motivational work regarding engaging with alcohol agencies. On 17th January, Doug has a telephone appointment where they review his progress. Doug says he's had no contact with Jasmine. He's drinking sporadically and he's motivated to complete unpaid work hours. On 19th January, he has a telephone appointment where they talk about him receiving unconditional bail from court, and his plan is to go back to Jasmine's. On 23rd January, he has a face-to-face appointment where he says he's having full days of not drinking and attending weekly mental health appointments. At the end of January, Doug talks about his alcohol consumption, and support from Turning Point, and says there's no relationship issues with Jasmine.
- 14.6.2.** In mid-**February**, Jasmine calls the police to say Doug attended her home address intoxicated, stamped on her takeaway, and left. She says Doug grabbed her by the wrists a couple of days previously and she had grabbed him. She says she doesn't want to make a statement or support a prosecution. She doesn't want any support, saying she's in contact with her IDVA but hasn't spoken to her since before Christmas. A victimless prosecution was considered but there was insufficient evidence to proceed. A DASH RIC was completed and rated as high. A referral was made by police LSU to the Somerset Domestic Abuse Service and MARAC plus a marker added to Jasmine's address.
- 14.6.3.** In late February, Jasmine has a telephone appointment with Turning Point to discuss her moving to their core service as her case has been closed to the Family Safeguarding Model.
- 14.6.4.** At the end of February, police get a report of a male beating up his partner and her pregnant daughter. Police attend and find Jasmine and Tina at the property (and a search of the property could find no evidence of Doug). Both say they had a verbal argument over smoking, and they don't want to talk to police. A DASH RIC was completed on officer observation as Jasmine did not want to engage, this was rated as high risk, due to feeling Jasmine and Tina were both scared and vulnerable.
- 14.6.5.** During February, Doug has two telephone appointments and a face-to-face appointment with his probation worker. Alcohol consumption and the risks of this are discussed, including how to manage this so not to put Tina and Jasmine at risk.
- 14.6.6.** In early **March**, police get a call reporting screaming and shouting coming from Jasmine's address. Officers attend and find Jasmine intoxicated. She says she was arguing with Tina about being pregnant. Officers call Tina who is safe and well at her grandmother's house. A DASH RIC was completed and rated as standard risk. The police LSU reviewed the incident and made referrals to health, Children Social Care and education.
- 14.6.7.** In early March, Doug has two telephone appointments with probation to try to build his understanding of the protective measures. Doug says he's resistant to these being in place. PP1 gives support to improve compliance with measures, and he

advises he is living with Jasmine. They discuss court hearings and unpaid work. Doug is disqualified from driving on 14th March at South Somerset Magistrates court. He receives twenty-two months of disqualification for previously driving a vehicle over the prescribed limit. In mid-March he's advised his court appearance is adjourned until 18th March.

- 14.6.8.** The day before Jasmine's death in March 2023, Jasmine calls police saying she was assaulted by Doug. She says they had both been drinking and an argument occurred. Doug verbally abused her and grabbed her by the hair, pulling out a clump. She says they often argue, and it could be over anything and nothing, like this argument that was about loading the dishwasher. She says, *'there's usually no issues, but they had both been drinking that evening'*. Jasmine says she's already engaging with You Trust (provider of Somerset's Domestic Abuse Service). She contacts an officer later in the evening to say she spoke to Doug whilst he was out driving and he said, *'she was dead.'* The officer returns to Jasmine's address to check on her welfare and she says Doug hadn't returned.

The police completed an area search and could not find Doug. A new door chain was fitted with security advice, and a 'treat as urgent marker' placed on the address. A DASH RIC was refused, but the officer completed one on observation and rated it as standard risk as Jasmine was already engaging with the domestic abuse service.

15. Overview

- 15.1.** This section provides context and an overview for each of the agencies who had contact with Jasmine and Doug.
- 15.2. GP (NHS Somerset ICB)** – the GP had 16 contacts with Jasmine (a mixture of face to face and telephone contacts), and a further 11 appointments where she failed to attend. No contacts were recorded as related to domestic abuse, with Jasmine not making any disclosures. However, references to domestic abuse were present during the GP practice multi-disciplinary team meetings and within police reports received by the practice.
- 15.3. Public health nursing/health visiting** – this service had contact with Jasmine on 20 occasions, 6 of which related to domestic abuse (in direct relation to health visiting).
- 15.3.1.** The health visitor had one home visit with Jasmine for the 9-12-month review. The health visitor completed an Edinburgh Postnatal Depression Screening with Jasmine who scored five out of thirty. It's noted that and Jasmine and Doug were having relationship counselling and child 6 was at home with chicken pox. The GP had two telephone consultations with Jasmine about COPD and issued a three-month fit note to support her Universal Credit application, she also had a COVID-19 vaccination at the GP practice. Jasmine didn't attend one nurse practitioner telephone consultation. The health visitor participated in the GP's Multidisciplinary

Team meeting but no concerns around domestic abuse were shared by the health visitor. The school nurse reported the family had an intervention worker supporting the older children. In May, the health visitor recorded that child 7 was closed to Child in Need as there were no safeguarding concerns at this time.

15.4. Turning Point (Somerset Drug and Alcohol Service) had contact with Jasmine on 21 occasions, and Doug on 22 occasions. Apart from in Jasmine's initial assessments when she reported historic domestic abuse in her previous relationships, as this was through the Family Safeguarding Model, domestic abuse specific work was completed by the domestic abuse worker, therefore Turning Point had limited (one) conversations about domestic abuse recorded. Her engagement was sporadic. She reported significant periods of abstinence, however when life became challenging, she *'reverted to alcohol use as a coping strategy'*. She engaged intermittently both in one-to-one support and group work (Motivational Enhancement Therapy, Recovery Skills Program, and Managing Alcohol Program). Jasmine's last episode of treatment was through the Family Safeguarding Model, starting in May 2022, a multidisciplinary team including social workers, drug and alcohol, mental health and domestic abuse workers provided holistic family support. Jasmine and Doug had the same parental substance misuse worker, and they often requested to be seen together. They had some appointments separately and some jointly, although they didn't attend the same groupwork programmes.

15.4.1. Although there were conversations with Doug about minor arguments and assaults on other individuals, there were no conversations relating to domestic abuse. It was noted he was known to Turning Point as someone who used domestic abuse as a result of Jasmine's disclosures and professional information sharing, not disclosures from Doug.

15.4.2. There is evidence that Turning Point worked proactively as part of the collaborative multi-disciplinary Family Safeguarding Team.

15.5. Stonewater – this housing provider had contact with Jasmine on 9 occasions, with her tenancy starting on 1st September 2022. Whilst Stonewater had contacts with a neighbour and police regarding domestic abuse, there were no direct contacts with Jasmine regarding domestic abuse. Stonewater advised the review that Jasmine's contacts were *'as expected during the lifetime of a tenancy'*, e.g. making rent payments and reporting repairs.

15.5.1 Given the neighbour reported multiple, separate incidents to Stonewater, the framing of this in Stonewater records as being a *'one off argument'* is curious. This appeared to indicate a lack of understanding of domestic abuse dynamics, types, and patterns of abuse, and housing-related indicators of domestic abuse. The lack of follow up with police and Jasmine herself before closing her case was noted as an area of learning. Stonewater reflected to the review that,

“We have made changes to our case management process, so no case would be closed without this follow up contact and attempts to carry out DASH-RIC. We are in the middle of DAHA accreditation, with lots of changes in progress, such as training. But these changes are not yet embedded. We have created a bespoke training package with SafeLives that has different levels of training for different housing professionals, all the way to accredited IDVA training. This training was co-created with SafeLives to include housing specific training. We still need to develop a training offer for contractors / repairs staff, and we want to make this really bespoke. We have created a QR code for this staff group to report domestic abuse that takes them to a form they fill out with concerns. This goes to the dedicated safeguarding email for resolution. We could increase use of this via embedded training.’

As a result of discussions with the review panel, Stonewater are now working to ensure they are included appropriately in multiagency spaces such as MARAC.

- 15.6. Probation** – this agency engaged with Doug in respect of his various offences and convictions, in a supervisory and risk management capacity, including his unpaid work requirement from summer 2022, until the date of Jasmine’s death. It was noted that he failed to attend unpaid work multiple times. Their contact with Doug was in person and over telephone. In the main, he appeared to attend his planned appointments with his probation officer.

As stated in 14.5.11, the Court did not request a pre-sentence report, and the sentence imposed was an Unpaid Work Requirement. As a result, Doug’s domestic abuse risks were not considered as part of any pre-sentence assessment by Probation. Following sentencing, a risk assessment should have been completed as part of the initial assessment process. However, given the nature of an Unpaid Work Requirement, there would have been limited opportunities within a sentence plan to actively manage identified domestic abuse risks.

- 15.7. Children’s Social Care (Somerset Council)** – this agency had extensive involvement with the family and the reason for assessment has always been down to parental alcohol and/or drug misuse and domestic abuse.

- 15.7.1.** Throughout children social care files there is evidence of good practice and intervention with the family, and this was also despite a time when Covid restrictions were in play and meant that interventions were completed over a longer duration.

- 15.7.2.** It could be suggested that the family safeguarding model (a multiagency working model comprising children’s social care, drugs and alcohol, mental health and domestic abuse workers) could have been utilised sooner at the time of the initial assessment with the family. There was clear evidence of sustained change over time when alcohol was not a factor for this family. The IMR author noted that earlier intervention was needed, especially when referring to growing concerns in January

2022 for parental drinking and the subsequent domestic incidences in March 2022. In conjunction with the family's history and the strong and evidential links between parental alcohol misuse and domestic abuse the actions taken should have happened a little sooner.

Having said that there was strong evidence of good management oversight, multi-agency working, good escalation when risks were identified and clear safety planning for the children overall.

It was acknowledged that one of the older siblings noted a concern around one of Jasmine and Doug's children being pre-verbal and more could have been done in assessments to incorporate views of other children in a household. A recommendation is made by this agency to reflect this.

- 15.8. Police** had contact with Jasmine and Doug multiple times in respect of domestic abuse incidents between them, starting in March 2022. Their last contact with Jasmine was the day before her death. They also had contact with Doug in respect of offences he committed that were not against Jasmine.

The IMR author noted that some risk assessment issues were identified during the course of this review. These were not raised as a formal recommendation as work has already been undertaken within the police to promote DA training, which incorporates these assessments. This was delivered between September 2022-March 2023. This will continue to be embedded as part of ongoing training for the constabulary and requires time to ensure effectiveness.

16. Analysis

- 16.1.** The review panel considered the information made available by agencies and family against the terms of reference, which is analysed as follows:
- 16.2. Minimisation, denial, and blame shifting** can be seen throughout Jasmine's contacts with many professionals. In the first recorded incident of domestic abuse in the review timeline in March 2022 (14.5.3), where Doug assaulted Jasmine in front of their two youngest children at a hotel, police noted that Jasmine disclosed that, "*she's not frightened of him.*" This is contradicted by Tina's account of her mum's extreme fear of Doug. Police recorded she said there was an argument between her and Doug. Jasmine had a scratch to her face that was bleeding, and she wouldn't say how the injury happened.
- 16.3.** Police certainly considered Jasmine's denial and minimisation to be credible when attending the incident in February 2023 (14.6.2). Professionals engaging with Jasmine also expressed views that she may have felt unable to share information with professionals openly due to fear of reprisals from Doug, and concerns about unwanted professional involvement, particularly in respect of her children.

- 16.4.** Agencies noted on several occasions that Jasmine (and sometimes Tina who was present), “*were uncooperative*” or “*refused to engage with this process*”. A police officer recorded that they “*believed Jasmine and Tina would not disclose full details of what happened... were withholding information, protecting Doug through fear of Tina being removed from the address.*” However, it is unclear whether this awareness was fully cognisant of why this was in terms of coercive controlling behaviour.
- 16.5.** The phenomenon discussed in research (Veldhuis 2024)^{iv} notes how “coercive tactics lead to a victim’s increasing dependence and self-blame and even lowering their awareness that what is happening is abusive.” Whilst coercive controlling behaviour has been a specific offence since 2015^v the awareness of the breadth and depth of this type of behaviour and its consequences cannot be only misunderstood but also challenging for professionals to deal with, in terms of how they both engage and support a victim.
- 16.6. Impact of Mental Health:** Jasmine’s self-reporting of mental health issues as the causation of Doug’s abuse are significant. For example, in respect of the incident in December 2022, Jasmine shared her uncertainty about going through with her police statement because, ‘*his issues are to do with his mental health and not anything else*’ and ‘*Doug was finding it hard with the court case and not seeing the children as much*’.
- 16.7.** It’s known that Doug was recorded as self-harming using a bladed article and expressing suicidal ideations. The context of this behaviour is not known. If Doug made threats to harm himself or take his own life in an attempt to coerce Jasmine into doing something (such as not going out with friends or not ending their relationship), this would be an example of him using mental health within the context of coercive control. On balance of the evidence made available to the review, it is credible that Doug may have used his mental health needs, suicidal ideations and intent and Jasmine’s desire to support him as a form of coercive control. Women’s Aid note in their myths around domestic abuse^{vi} that mental illness is not a cause of perpetration.
- 16.8. The role of substance misuse in domestic abuse between Jasmine and Doug:** Jasmine and Doug had histories of long-term substance use, alcohol in particular. Their cannabis and cocaine use were also documented. Jasmine’s self-reporting (see 14.3.9) on her perceived connections between alcohol use and Doug’s abuse is highly relevant. For example, on 6th December 2022, police contacted Jasmine about her withdrawal of support for prosecution of Doug and she stated that, “*this incident was fuelled by alcohol.*” This may genuinely have been her perspective and belief regarding the causation of abuse. It is unclear how much professionals discussed this perspective with Jasmine. Or if they explored with her the disinhibitory role alcohol can play in domestic abuse, rather than it being the cause. It could be seen that Jasmine was attempting to minimise the abuse she was being subjected to and shift the blame and responsibility for Doug’s choices to use abuse and situate this within his alcohol use.

The panel noted that a common myth is that alcohol causes domestic abuse, when it does not. Whilst research (Sontate, et al, 2021)^{vii} suggests that “aggression is the

precursor of violence and individuals prone to aggressive behaviors are more likely to commit impulsive violent crimes, especially under the influence of alcohol”, this in itself argues that alcohol can exacerbate someone’s underlying behaviour.

16.9. The link between drink driving, substance misuse and domestic abuse: This review considered the reported incidents of domestic abuse alongside Doug’s use of a vehicle, including while under the influence of alcohol, as follows:

- March 2022 involved both alcohol and a vehicle
- October 2022 no mention of alcohol or a vehicle but likely Doug drove to and from Jasmine’s property
- November 2022 involved both alcohol and a vehicle
- December 2022 three incidents that involved alcohol and a vehicle, with one indicating an assault took place in a vehicle driven by Doug
- February 2023 involved alcohol. Vehicle not mentioned but likely Doug drove to and from Jasmine’s property
- March 2023 involved alcohol and vehicle (and Doug was disqualified from driving)

The chronology clearly demonstrates that each of these incidences, was closely tied to domestic abuse related incidents between Doug and Jasmine (and also Tina). These were not always described as physical abuse, and instead emotional or psychological abuse. It’s clear that drink driving was a risk factor for Doug, being inextricably linked to his domestic abuse.

Due to the nature of the community order, there was limited action that Probation could enforce.

16.10. Jasmine’s daughter Tina described a pattern of Doug’s reckless views and behaviour around driving. He thought his car was a big toy, and he would often ram other drivers. He frequently drove at dangerously high speeds, including when Tina was in the car with him and was pregnant. She reflected this was a deliberate attempt to cause her fear. She stated that there were multiple times when he assaulted Jasmine in the car, or serious conflict would happen while he was driving. She described an incident where she tried to pull her mum out of his car while Doug was assaulting her. This aspect of domestic abuse, including professional risk identification and management regarding domestic abuse and Doug’s use of a vehicle is discussed further within this report.

16.11. Situational couple violence, intimate terrorism and violent resistance⁴: Johnson’s Typology includes situational couple violence, a type of domestic abuse that is much less common than intimate terrorism. Johnson reflects that a relationship characterised by situational couple violence commonly features violent conflict incidents, triggered by various situations that escalate as a result of rising tension or emotions, but with an absence of ongoing the coercive control that is

⁴ Michael Johnson's Typology of Domestic Violence — Be The Peace Institute and Coercive Control: How Men Entrap Women in Personal Life | Oxford Academic (oup.com)

seen in intimate terrorism. Often, violent incidents happen when one or both parties are intoxicated and / or there has been a 'trigger' event.

However, as noted in 16.8, alcohol does not cause domestic abuse. Using violence in intimate relationships is a choice and it is unacceptable, regardless of contextual or situational factors. This review does not support the perspective that Jasmine and Doug's relationship was one characterised by situational couple violence. It is significantly more likely that this relationship was characterised by intimate terrorism, with Doug exerting systematic and sustained control and domination over Jasmine using coercion and control tactics, underpinned by his desire to obtain, and maintain power and control over her.

This review also finds that Jasmine and her daughter Tina's use of violence towards Doug was a likely result of violent resistance, which Johnson and Stark reflect are violent acts committed by female victims of intimate terrorism, against their male perpetrator, in response to the abuse they are subjected to.

16.12. Domestic abuse risk identification, assessment, and management

16.12.1. Jasmine's DASH-RIC timeline:

- 29th January 2022, police DASH-RIC, rated standard risk.
- 18th March 2022, police DASH-RIC, rated standard risk. It is not recorded if this was completed with Jasmine or based on officer observations.
- 27th October 2022, police DASH-RIC, rated standard risk. It appeared the information Jasmine felt able to provide was limited (14.5.22).
- 12th November 2022, police officer observed DASH-RIC, rated medium risk.
- 13th November 2022, police DASH-RIC, rated standard risk. Owing to the nature of the incident (see 14.5.26), this DASH-RIC was completed in relation to the risk Jasmine's brother posed to her, rather than risks from Doug.
- 2nd December 2022, police DASH-RIC, rated high. Doug's escalating behaviour, and Jasmine's fear of further injury and violence were noted. Jasmine completed the DASH-RIC with the officer.
- 23rd December 2022, police officer observed DASH-RIC, rated medium risk.
- 15th February 2023, police DASH-RIC, rated high risk (Jasmine completed with officer).
- 27th February 2023, police officer observed DASH-RIC, rated high risk.
- 6th March 2023, police DASH-RIC, rated standard. Completed with Jasmine.
- Day before Jasmine's death March 2023, police officer observed DASH-RIC, rated standard.

16.12.2. Excluding the DASH-RIC that may have been completed for Tina in March 2023, and the DASH-RIC completed in respect of risks posed by Jasmine's brother rather than Doug, there were ten DASH-RIC assessments for Jasmine. All but one

were completed by police, who completed at least six on officer observations, citing Jasmine's unwillingness to engage on several occasions. The review panel felt that professionals took a common view of the high risk of harm Doug posed to Jasmine at this time.

16.12.3. Police identification and assessment of risk: The police IMR author reflected, *"Avon and Somerset Constabulary's protocol is in line with the College of Policing Authorised Professional Practice (APP) on domestic abuse."*

16.12.4. The vast majority of incidences that the police attended resulted in a DASH RIC being completed. However, this was not always the case, and the police IMR author reflected, *"If a DASH had been completed on the previous incident this may have better informed the officer and provided a wider picture for Jasmine and Doug's current situation"*. The review concurs with these findings and reflects that this highlights the importance of using the DASH-RIC to follow perpetrator behaviour and patterns of abuse, rather than seeing each incident in isolation, and unconnected to a wider pattern of perpetrator behaviour.

16.12.5. This review understands that police processes do not require attending officers to check for previous DASH-RIC ratings during attendances, and the LSU reviews of domestic abuse incidents often results in upgrading of risk ratings. However, it appears that these LSU reviews are not completed until after the incident, sometimes days later. A rating of high-risk means that there are identifiable indicators of risk of serious harm, the potential event could happen at any time and the impact would be serious. Not appropriately identifying a victim as high-risk of serious and possibly imminent harm during an attendance but rather, days afterwards, means that opportunities to implement immediate risk management actions and approaches in response can be missed. Police reflected that after Jasmine's death the LSU noted that *'the standard risk assessment would have been upgraded to high, due to past incidents and a referral to MARAC'*.

16.12.6. In the first recorded incident of domestic abuse in the review timeline in March 2022 (14.5.3), where Doug assaulted Jasmine in front of both child 6 and child 7 at a hotel in another police force area, Doug was not arrested, as it's understood that Jasmine did not want to provide any details. Police officers spoke to Jasmine in the privacy of her hotel room and she disclosed he was controlling her, took disclosures from her, and officers noted both children were seen and appeared well. The Public Protection Notice was shared with Somerset Children's Social Care. The IMR author notes that, *"Wiltshire police dealt with this incident as it occurred within their area. There appeared to be a proportionate response with appropriate safeguarding referrals."*

16.12.7. Professional identification, assessment and management of risks associated with separation: In November 2022, Jasmine disclosed to her drug and alcohol recovery support worker that she wanted to end the relationship with Doug. Information provided to the review indicated that at this time, Jasmine had prepared

to and tried leave many times before but felt unable to do so. The view held by Family Safeguarding Model workers engaging with Jasmine at this time appeared to be that *“Jasmine continued to experience abuse and violence which appeared to be increasing in severity. Primary person causing harm was Doug. Jasmine remained against moving away from her relationship with Doug and wished to continue to support him through his struggles with his mental health and alcohol use”*.

16.12.8. There was no evidence that risks associated with separation were discussed at MARAC, which is especially notable as Jasmine’s disclosure and attempt to leave took place only weeks before she was discussed at MARAC in December 2022. The review was unable to find any evidence of professional activity in relation to managing risks around Jasmine leaving the relationship, including supporting her with safety planning. The links between attempting to and leaving abusive relationships and heightened risk of serious harm, including homicide are well-documented. Chopra’s (2024) *domestic homicide review research* noted that *“whilst only 18% (n = 45) were separated or divorced, separation was imminent in an additional 22% (n = 60) of cases”*.^{viii}

16.12.9. The role of Multiagency Risk Assessment Conference (MARAC) in risk identification, and management: Jasmine was referred to MARAC twice in the review time period. Her case was heard on 13th December 2022 and 1st March 2023. Jasmine had last been discussed at MARAC in 2017, in relation to risks posed by Doug.

16.12.10. It appeared that some risks to Jasmine were identified, escalation of abuse, non-fatal strangulation, physical injury, and alcohol use. It is not known if professionals shared information about their perceptions that Jasmine was likely minimising the abuse she was subjected to and withholding information from professionals.

It is noteworthy that the chronology and agency narratives indicate that abuse continued despite Jasmine and Doug no longer living together. This raises the question of whether there may have been an implicit assumption amongst professionals that the risks associated with domestic abuse reduce once a couple ceases cohabitation. Whilst physical separation can remove some opportunities for abuse, research suggests that separation does not necessarily equate to safety and can, in some circumstances, represent a period of heightened risk.

Contemporary understanding of domestic abuse increasingly recognises that abuse is often rooted in patterns of coercive control, power, and entitlement rather than solely in shared living arrangements. Research on post-separation abuse highlights that perpetrators may continue, adapt, or even escalate abusive behaviours following separation through harassment, stalking, intimidation, threats, manipulation of children, misuse of legal processes, or other forms of coercive control. Studies have identified separation as a significant risk factor in serious

domestic abuse and domestic homicide cases, with abuse often persisting long after a relationship has formally ended^{ix x xi}.

Although there is limited research directly comparing domestic abuse prevalence between couples who cohabit and those who maintain intimate relationships whilst living separately, the available evidence suggests that risk assessments should focus on the nature, pattern, and severity of abusive behaviours rather than assumptions about living arrangements. The absence of cohabitation should not be viewed as a protective factor in isolation. Instead, professional curiosity should consider the extent of ongoing contact, shared parenting responsibilities, previous patterns of coercive control, separation-related conflict, and any evidence of continued intimidation or harassment.

This review therefore highlights a potential learning point for practitioners across agencies: assessments of domestic abuse risk should remain dynamic and evidence-based, recognising that abuse can continue after separation and that periods of relationship breakdown, separation, or attempts to leave an abusive partner may represent increased vulnerability rather than reduced risk^{xii}.

16.12.11. Tina's pregnancy, known to be a source of conflict between Jasmine and Doug, appeared to have been discussed, along with her intention to move back home. This review found that Doug abused Tina before, and during her pregnancy, with the abuse escalating towards her once her pregnancy was known in December 2022. However, the extent to which Doug's abuse of Tina was known by the agencies in attendance at MARAC cannot be determined. Due to the fact that the Domestic Abuse Act 2021, recognises children and young people as victims of domestic abuse in their own right if they '*see, hear or otherwise experience the effects of abuse*'⁵. Despite the focus of the discussion being on Jasmine as the victim, this review finds that this risk should have been considered further. Particularly as they shared a common perpetrator, and Doug's abuse towards Tina was often associated with Tina's attempts to defend her mum during assaults and vice versa. Appropriate consideration should have been given to risk management approaches, and associated agency actions. An appropriate action could have been to find out more information about risks associated with Tina returning to live with Jasmine, and/or consideration of bringing Tina to MARAC as a victim in her own right.

16.12.12. All relevant agencies contributing to MARAC: Stonewater were not invited to share information with MARAC and so did not contribute to the discussion. They were not aware that Jasmine's case was discussed at MARAC or made aware of the resulting risk management plan or agency actions. As a large landlord of social housing, this is of relevance, given the critical role housing plays in the coordinated community response to domestic abuse^{xiii}.

⁵ <https://www.legislation.gov.uk/ukpga/2021/17>

16.12.13. Safety planning: This review found limited evidence regarding the content of safety plans for Jasmine in respect of domestic abuse. One reference was noted to be of some concern. This was recorded by Jasmine's domestic abuse worker in November 2022, *'Jasmine does have a safety plan in place where if she and Doug feel a situation is escalating between them one will leave to allow each other time, de-escalating the situation, the plan also states that Jasmine and Doug will not drink alcohol when in the presence of each other or their children.'*

This safety plan does not appear to account for the dynamics of coercive control, instead framing 'escalating situations' within a relationship problem between Jasmine and Doug, rather than a result of his choice to use domestic abuse. This was most likely a result of professional perspectives on the relationship dynamics held at the time. In addition, for two individuals known to be alcohol dependent, it is unlikely that they could have adhered to the aspect of the safety plan regarding alcohol consumption. As such, the effectiveness of this safety plan in increasing Jasmine's safety was likely extremely limited.

The review panel agreed that the safety planning expertise from the family safeguarding domestic abuse worker could have been improved, and were reassured that this has already been addressed through training by the commissioned service provider.

16.12.14. Protective orders for Jasmine: In information provided by police there was almost a complete absence of consideration of evidence of any protective orders for Jasmine. There is a reference to police referring Jasmine to the National Centre for Domestic Violence (NCDV) in December 2022 (see 14.5.30). Additionally, it is noted that protective orders could have been considered by the family safeguarding domestic abuse workers, including at their group supervision, and do not appear to have done. While not explicitly stated, this is thought to refer to their Domestic Abuse and Violence Emergency Legal Protection Service,⁶ which is a free, fast emergency injunction service. There was no evidence that an injunction was ever served on Doug, as such, it is likely that the referral did not result in an injunction being granted and served. Given Jasmine's experiences of family court in connection with child removal, her views on engaging with this part of the legal system again were unlikely to have been positive, which an application for a non-molestation order would require her to do. It was unlikely she saw the family court as an institution that would offer her and her children protection from Doug. Neither the NCDV referral nor the officer's advice appeared to have been effective in increasing Jasmine's safety, as Doug continued to abuse her in the months following these interventions, which were also her last months of life.

⁶ <https://www.ncdv.org.uk/> A free, fast emergency injunction service to survivors of domestic abuse and violence regardless of their financial circumstances, race, gender or sexual orientation. Domestic abuse is common in the UK and anyone can be a victim, regardless of gender, age, ethnicity, socio-economic status, sexuality or background. Our award-winning free service allows anyone who has recently experienced or been threatened with domestic abuse or violence to apply for an emergency court injunction. This can sometimes be issued within 24 hours of making contact with us. We work in close partnership with the police, solicitors and other support agencies (Refuge, Women's Aid, Mankind etc) to help victims obtain speedy protection.

16.12.15. This review cannot find any rationale about why agencies (e.g. domestic abuse service, police, etc) did not consider a DVPN or DVPO or other protective orders in this case or if in fact they did, it was not recorded as such, or the information was not provided to the review. A DVPO / DVPN could have been considered following incidents on 27th October, 2nd December, 23rd December 2022, 15th February, 27th February and March 2023, the day before Jasmine's death. Doug was arrested, charged and convicted of offences during the review timeline.

16.12.16. This review understood that there were police bail conditions following an assault by Doug in early December 2022, which included conditions not to contact Jasmine either directly or indirectly, and not to attend her address. In late December 2022, an incident was reported by a neighbour of a disturbance at Jasmine's property and advised police that Doug was often there, which would have been a breach of bail. There was a further incident in mid-January 2023, in which Jasmine reported Doug making a comment on a social media post. This was reviewed by a police inspector but deemed not to be a breach of bail. It would appear the previous breach was not dealt with as Jasmine had not felt able to cooperate with the police and did not want to prosecute for the original offence.

16.12.17. Probation, Doug's risk assessment, identification and management:
Probation had detailed knowledge of Doug's previous offending behaviour and risk assessments. Dynamic and static risk factors were considered when assessing Doug's risk. This included compliance with previous probation supervision, seriousness of the offence and his engagement with other services. It also considered a break in offending that matched his self-reported three-year abstinence from alcohol. These were the factors that led to the assessment of Doug posing a medium risk of harm at commencement of the order in June 2022, representative of the dynamic risk at that time. This assessment was considered to be correct based on the information at that time. Previous records and offending behaviour highlighted a risk of abusive behaviour within intimate relationships. Monitoring the situation was a feature of Doug's supervision sessions. Doug was monitored as part of his community order. It is important to note that the Serious Further Offence review (10.3) found that the impact on the child was not considered in relation to the index offence, which indicated that the full CPS had not been reviewed by PP1. The SFO review also found that not all information provided by the Police and Social Services was considered in the assessment in relation to current and previous domestic abuse incidents involving Doug. It was felt in the SFO review that the risk of serious harm had been underassessed initially and Doug should have been assessed as posing a high risk of serious harm to known adults from the start of his order. A risk review was undertaken in December and at this point his risk was increased to high.

16.12.18. Probation's supervision of Doug and the risk management approach fit the plan and assessment of a medium risk of harm. Appropriate services were offered, including motivational work to re-engage with Turning Point or Alcoholics

Anonymous, the child protection process, and his GP for mental health issues. Following the assessment to a high risk of harm, probation practitioner 1 (PP1) requested the court to consider imposing a rehabilitative requirement as a response to his breach of the unpaid work element of his order. A rehabilitative requirement would have enabled the criminogenic needs to be more closely addressed and monitored. (NB: At the time of Jasmine's death, Doug had not been sentenced for these matters). It is important to note that the Serious Further Offence review found omissions in the risk of serious harm assessment which led to further omissions in the Risk Management Plan. For example, there was no mention or consideration in relation to undertaking home visits as per Home Visit Policy for Probation. The Risk Management Planning referenced undertaking regular Police intelligence checks for domestic abuse but the frequency of these were not recorded. The SFO review also highlighted omissions in that PP1 should have highlighted unpaid work as a relevant intervention and also outlined what support and access he had for his mental health. There was no recording or evidence of planning or signposting to other agencies to reference the risk factors of mental health. There was a further non-inclusion in relation to child safeguarding, in relation to Doug's contact with Children's Social Care and Care Order in place, no reflection of the contact arrangements in place. These should have all been reflected in the Risk Management Planning. This led to the contingency planning not being in place for all risk concerns regarding his relationship with Jasmine and his children. In addition, the Serious Further Offence review concluded that not all victims were fully identified in the risk of serious harm assessment and the assessment of factors increasing risk to them were not identified. This also led to them not being included in the contingency plan. The Serious Further Offence review also assessed that the sentence plan completed was insufficient and did not address domestic abuse and child safeguarding concerns, it focussed on his UPW and alcohol use.

16.12.19. The Spousal Assault Risk Assessment (SARA) was completed following the increase in risk on 15th December 2022 by a probation practitioner. At this time the SARA assessment found imminent risks of violence towards his partner, and imminent risks of violence towards others were high. The risk assessments of Doug were appropriate and adjusted within expected timescales to reflect changes in dynamic risk factors. The case was not referred to Multiagency Public Protection Arrangement (MAPPA) prior to Jasmine's death, as there was insufficient evidence that the risk of harm to Jasmine reached the threshold for a MAPPA referral prior to this time. Jasmine was subject to MARAC following the increase in risk and PP1 attended these meetings and used information from this forum to inform management and assessment of Doug. It is important to acknowledge that the SFO review found that referral to MAPPA should have been considered and any decision about this recorded.

16.12.20. Following management oversight of Doug's case, it was agreed in December 2022 that he would be referred to the Integrated Offender Manager (IOM) team. At this point Doug was assessed as posing a high risk of serious harm which is defined as, *"there are identifiable indicators of risk of serious harm. The potential event could*

happen at any time and the impact would be serious.” During interview with the probation practitioner, justification was provided for the high risk of serious harm assessment, which included Doug having continued alcohol misuse and the increase in the frequency and seriousness of the assaults against Jasmine. Considering the dynamic risk factors, the high risk of serious harm assessment is in line with the Risk of Harm Guidance. The Probation IMR author shared, *“I am satisfied that the Risk Management Plan (RMP), aims to mitigate the risk factors outlined within the risk assessment sections of the report. Key agencies, including police, Children’s Services, GP and SDAS⁷ staff are referenced with contact details within the Supervision Plan”*. Probation were managing the case at the correct risk level (High) at the time of Jasmine’s death. There is evidence that the probation worker was knowledgeable of potential indicators of the risk of domestic abuse through the sentence plan and the referral to the Integrated Offender Management team when risk had escalated. The monitoring of risk factors including substance misuse, relationships, and the protective factors in maintaining relationships with the children and employment demonstrates a sufficient level of understanding of managing risk. Doug’s assessment was reviewed as per the policy guidelines. It is clear in the Serious Further Offence review that there was a significant delay in referring into the Integrated Offender Management team, the referral was not made until March 2025. The Probation IMR contradicted the Serious Further Offence review based on the initial risk of serious harm assessment and factors which had not been considered or addressed. In addition, when the risk review was undertaken and his risk level increased to high, it was completed by PP1 but it should have been completed by PP2, a qualified Probation Officer.

16.12.21. Risk identification, assessment and management of Doug’s driving offences and connections to domestic abuse. *‘Approximately 50% of our drink driver cases have a link to domestic abuse perpetration.’* (Probation panel member)

16.12.22. Doug was arrested and charged multiple times for driving offences during the review period. This aspect of Doug’s offending behaviour was known by probation. The probation panel member shared that following the findings of the Commission on Alcohol Harm Report in 2020⁸, the emerging local intelligence, data on links between driving offences (particularly relating to alcohol) and domestic abuse where probation assumes offender management responsibilities for an individual convicted of driving while under the influence, they cross-reference intelligence and information relating to domestic abuse for that offender. They highlight connections with the offender and utilise an integrated approach to supporting the offender with all aspects of their offending behaviour. In relation to the information that probation was aware of, the SFO review found that probation should have been more collaborative with the police in terms of their knowledge of Doug continuing to drink drive and sharing this information in a timelier manner.

⁷ Turning Point is also known as SDAS. For consistency, and clarity, this report refers to Turning Point by the agency name throughout, except where directly quoting a professional.

⁸, <https://ahauk.org/commission-on-alcohol-harm/>

16.12.23. The review panel reasonably concluded that all agencies who had substantive contact with Doug were aware of his driving offending behaviour. Probation was the lead agency working with Doug on his offending, as aligned with their role and remit.

16.12.24. On 14th March 2023, Doug was disqualified from driving, mere days prior to Jasmine's death. The probation panel member reflected that his unpaid work order imposed by the court was typical in their experience, but it was somewhat surprising the court had not issued him with a disqualification earlier. They emphasised that imposing a driving disqualification is a court decision made during sentencing. It remains unclear why the court did not impose this disqualification sooner. Had Doug been disqualified earlier in the timeline, it is highly likely that Doug would have continued to drive, as he did so after his disqualification in March 2023. Disqualification alone was, therefore, unlikely to have been a sufficient deterrent for Doug. The probation panel member reflected that, *'at times, nothing was a deterrent for him'*. Had the disqualification been in place earlier in the timeline, it may not have stopped him driving. But it would have offered additional opportunities for police to detect and disrupt his offending. It could have led to additional penalties and restrictions for Doug, which ultimately could have altered the outcome in this case.

16.12.25. The review panel was interested to understand more about policing approaches to prolific/repeat driving offenders and how they were or could have been utilised in this case. The police panel member shared that Avon and Somerset Constabulary have a dedicated road policing unit, who focus on road safety. This is an area of priority policing for the force.

They typically utilise a range of approaches to manage and reduce offending such as proactive patrols and using information and intelligence to direct activity. This includes using Automatic Number Plate Recognition (ANPR⁹) technology to help detect, deter and disrupt criminal activity at a local, force, regional and national level. Avon and Somerset Constabulary also have daily ANPR briefings, where information and intelligence on driving offenders are shared with relevant officers, with tasking issued to officers as appropriate.

16.12.26. The police panel member and IMR Author made significant efforts to ascertain if Doug was included within the work of the road policing unit or if he appeared on any of the ANPR briefings at any point in the review timeline. It cannot be determined if he was. It appeared that these records were exceptionally challenging to access retrospectively. This was noted as a barrier to understanding more about how Doug's offending behaviour may have been managed by road policing unit officers, and limits analysis of this. What is apparent is that if they were involved in management of this aspect of Doug's offending, it was insufficiently effective to disrupt Doug's committal of driving offences. *'Police should have removed his car from him in March 2023 after he was disqualified from driving. But instead, they left him with the vehicle. Had that not happened, my mum would still be alive'*. (Tina, Jasmine's daughter)

⁹ <https://www.police.uk/advice/advice-and-information/rs/road-safety/automatic-number-plate-recognition-anpr>

16.12.27. Police confirmed that the car Doug was driving when he caused the fatal road traffic collision was registered to him. Doug remained in possession of his vehicle after disqualification, which is not uncommon. The night before her death, Jasmine reported Doug's committal of an offence against her to police (a threat to kill) issued to her over the telephone while he was driving (see 14.6.8). As he was driving post-disqualification, this was another offence he committed, also reported to police, albeit indirectly. It is not known if Jasmine was aware Doug was disqualified from driving at this time.

16.12.28. It's clear that Jasmine was aware of the dangers of Doug's driving, as she disclosed to her domestic abuse worker that it would not have been safe for her if she was in a vehicle with Doug following an argument, due to his high levels of anger. Although it's unclear as to her rationale for this danger, as it was unrecorded. These are positive examples of Jasmine's insights into risks from Doug. While not recorded as such, this was also an example of Jasmine enacting her own safety plan, by not getting into the vehicle with him. This was also an example of Doug's use of coercive control, enabled and facilitated by his vehicle. Doug's actions, and Jasmine's prioritisation of her safety left her, and Tina stranded, and impacted on their planned family time with their two children (child 6 and child 7). It also contributed to the views held by some professionals that Jasmine was missing family time due to her alcohol use, rather than as a result of Doug's abuse and its impacts.

16.12.29. It is notable that the DASH-RIC, which would have been used by the domestic abuse worker, does not include specific questions relating to the use of a vehicle, including while intoxicated. This means that a professional completing the assessment would not get a prompt to ask a victim about this specifically. If they were to inquire about use of a vehicle, and the victim disclosed this as a factor, the worker could not record this as a 'yes' response to one of the standard DASH-RIC questions. To use professional judgment in the context of domestic abuse and vehicles would require a professional to make a connection between a perpetrator's use of a vehicle, their domestic abuse tactics, and impacts on the victim. This would clearly be aided by the professional's understanding the connections between domestic abuse and driving offending.

16.13. Professional responses to and their perspectives on Jasmine and Doug's drug and alcohol use, mental health needs and domestic abuse dynamics.

16.13.1. Mental Health: Jasmine was known to have anxiety and depression and was accessing primary health care for support with this, including prescribed medication. Additionally, Jasmine's mental health was assessed by a psychiatrist during the children and family's assessment. While there is one reference to Jasmine experiencing trauma as a result of domestic abuse, this is cited as a possible reason for her non-engagement with domestic abuse support. Jasmine was offered Talking Therapies by social workers and FAST therapeutic sessions. The outcome of these and to know if Jasmine would have found additional support of benefit is unknown.

16.13.2. The findings of the Domestic Abuse Commissioner's Report, Patchwork of Provision¹⁰, revealed that 85% of domestic abuse victims wanted to access counselling or therapeutic services, and this was the most common type of support they needed, with only 45% of victims reporting they were able to access this provision.

16.13.3. Drug and alcohol use: Jasmine and Doug had well-known and documented histories of long-term challenges with drug and alcohol use. Alcohol appeared to be considered by professionals as the substance that had the most negative impacts on them as individuals (e.g. their health) and as a couple, including in the context of domestic abuse. Their cannabis and cocaine use were also documented. Along with domestic abuse, drug and alcohol use was identified as a significant presenting factor in child safeguarding concerns.

16.13.4. Jasmine's use of alcohol (and drugs to a lesser extent) were self-reported by her as being associated with feelings of loss over the removal of her children. The review panel found that Jasmine did use alcohol while Tina, child 6 and child 7 were in her care, and her denial and minimisation of alcohol use was evident. However, it is likely that Jasmine felt a profound sense of loss regarding the removal of her older children, and significant anxiety and fear regarding the ongoing Children's Social Care interventions with her younger children. It appeared that professionals did not fully consider the impacts of historical trauma as a result of child removal in respect of Jasmine's alcohol use. Jasmine clearly described her trigger for drinking as struggling to cope with stress and negative emotions.

It does not appear that professionals considered Jasmine's alcohol use as her response to trauma associated with being subjected to domestic abuse, over a sustained and prolonged period of time. Which would certainly have caused her both stress and negative emotions. This review found no evidence Jasmine was supported therapeutically with the trauma of child removal. Interventions to prevent Doug using domestic abuse and reduce harm to Jasmine were largely ineffective. As such, interventions to reduce or cease drinking alcohol were also likely to be limited in their effectiveness, as the two self-reported reasons / triggers remained unaddressed.

16.13.5. Both Doug and Jasmine were perceived to withhold information from professionals regarding their alcohol use. In 2022, Jasmine is noted to have disagreed with the findings of a hair strand test, which showed higher alcohol use than she was reporting and to have denied allegations regarding domestic abuse incidents and alcohol use when contacted by Children's Social Care.

16.13.6. Couples counselling and healthy relationships interventions: In domestically abusive relationships, interventions such as couples counselling are not recommended or likely to be effective. Respect^{xiv} strongly recommends abusers are directed towards individual domestic abuse perpetrator programmes instead of

¹⁰ https://domesticabusecommissioner.uk/wp-content/uploads/2023/02/DAC_Mapping-Abuse-Survivors_Summary-Report_Feb-2023_Digital.pdf

anger management courses, mediation and attending counselling sessions with their partner, as the victim may be coerced or put at risk of retaliation¹¹. While there can be benefits for couples who have couple's counselling or similar interventions, this poses a significant risk to victims who attend counselling with their abuser. Counselling is often considered a "safe space" for people to talk, but for a domestic abuse victim, their safety outside sessions can actually be decreased.

16.13.7. During the FAST-parenting assessment in October 2020, it was recorded for, *"Jasmine and Doug to be supported to access couples counselling to continue to build on their own healthy relationship."* Doug and Jasmine were referred to this intervention as a couple and this referral was noted to have been accepted. This intervention was likely considered to be appropriate by referring professionals at the time, due to the fact that it was generally perceived that domestic abuse was not occurring in the relationship at this time. The review panel noted there were likely to have been strong motivations for Jasmine and Doug to present this perspective on their relationship to professionals.

16.13.8. During the FAST assessment process, it was recorded that 'Building Healthy Relationships' work was completed with Jasmine and Doug. The 'Cycle of Abuse' tool was used to support Jasmine and Doug to provide examples of the 'tension building stage' of abuse and identify how they're able to manage situations to avoid an argument. They both showed insight into the impacts of past domestic abuse upon their children. They acknowledged that the relationship was violent and made links with their alcohol use, which played *"a big part in the cycle of domestic abuse"*. When Doug misused alcohol, Jasmine also then used alcohol, and this had escalated following the birth of child 6. Jasmine could not recall learning from a previous online Freedom Programme domestic awareness course she completed. Regardless of the assessment of appropriateness made at the time of the referral, this intervention was ineffective in that it did not lead to Doug no longer choosing to use domestic abuse in his relationship with Jasmine.

16.14. Housing responses to 'Anti-Social Behaviour' (ASB), safe enquiry, information sharing with police and multiagency working: *'There was arguing and screaming heard. At one point, Jasmine shouted, 'get off me.' Jasmine locked Doug out and he was banging on the door and shouting, 'open the door you fucking bitch'... there was doors banging late at night and Jasmine and Doug were drunk, and he drove off in a car.'* (October and November 2022 report to Stonewater from Jasmine's Neighbour)

16.14.1. For people experiencing domestic abuse, their home is often the most dangerous place. Nowhere is this more evident than when we consider the number of victims, the majority of whom are women, who are killed inside their own homes. The Femicide Census in 2018 reported that there were 149 women killed by 147

¹¹ <https://www.ncdv.org.uk/domestic-abuse-counselling/>

men and that 72% were killed by an intimate current or former male partner or family member. Of those, 68% were killed inside their own home.¹²

16.14.2. Research¹³ shows that domestic abuse has been estimated to create housing costs of £160 million per year, even before considering issues such as debts left by perpetrators in cases of financial abuse. Neighbours are often the first to be aware of domestic abuse and in many instances may hear shouting or violence. This means domestic abuse can often be reported to antisocial behaviour teams (ASB) and reacted to as nuisance behaviour. This is an inappropriate response to domestic abuse, as it can significantly increase the risk to victims, prevent future disclosures and will not prevent further incidents. Therefore, it is essential for housing and ASB community safety teams to be trained to identify domestic abuse and refer those households onto appropriate support services. Any punitive approach in relation to ASB in respect of the perpetrator should be in partnership with specialist services to ensure risk management and safety planning is in place for the victim.

16.14.3. In September 2022, when her tenancy commenced, Jasmine provided Stonewater with an email address for contact with her. While it cannot be definitively confirmed, the email address appeared to belong to Doug. There is no evidence that Jasmine provided alternative contact details during her tenancy. As such, any contact made with Jasmine via email may have been accessible to Doug. At the time of letting her tenancy, Stonewater did not appear to be aware of the history of domestic abuse with Doug. As such, there were no grounds at this time for Stonewater to query the email address.

16.14.4. Following the ‘anti-social behaviour’ reports received by Stonewater from Jasmine’s neighbour on 6th October and 25th November 2022, Stonewater created a new Anti-Social Behaviour Report about drug use (smell of cannabis), and ASB related nuisance (noise, continuous screaming, shouting, arguing, and smashing doors). They did not record domestic abuse at this time.

16.14.5. In December 2022, there were professional liaisons between Stonewater’s Domestic Abuse and Safeguarding Resolutions Team and police regarding the ASB reports from Jasmine’s neighbour. This correspondence included that reports were around “arguments”, and the review panel noted these did not appear to be framed as domestic abuse, and instead actually minimised the situation Jasmine was experiencing.

16.14.6. There was one reference found in information made available to the review regarding target hardening at Jasmine’s property. This was in connection with the incident the day before Jasmine’s death and involved a new door chain being fitted at her property, and security advice issued to Jasmine. There was evidence that Doug had broken into Jasmine’s property multiple times, including following her

¹² https://www.dahalliance.org.uk/media/11066/whole-housing-project-report_year-two_final.pdf

¹³ IBID

attempt to leave the relationship in November 2022. There was no evidence that police and Stonewater worked in partnership to consider appropriate target hardening measures at Jasmine's property

16.15. Health responses to Jasmine and safe enquiry:

16.15.1. COPD: Jasmine was diagnosed with COPD around the same time the children returned to her care. Jasmine clearly struggled with symptoms of COPD, and it was likely having an impact on her ability to carry out her tasks of daily living, and it meant she was unable to work. There are no clear linkages made between her COPD diagnosis and Doug's domestic abuse. It is not known if Doug used specific forms of abuse linked to COPD and her resulting needs.

16.15.2. Whilst health visitors did enquire about domestic abuse, they did not always routinely do so, which is noted by the review as an area for improvement. However, when Jasmine was asked by the health visiting team she did not make any disclosures.

16.15.3. In 14.4.3, Jasmine self-reported that she and Doug were having relationship counselling. This presented an opportunity for the health visitor to make professionally curious enquiries about the dynamics of their relationship, how the counselling was going, and any impacts on their relationship. There is no evidence that this took place. Older records (pre the scope of this review) indicated that Jasmine had declined referrals for domestic abuse support and there would have been opportunities to revisit this, particularly considering the implementation of the Domestic Abuse Act 2021¹⁴.

16.15.4. The review found that many interactions by health professionals and sharing of information relating to domestic abuse were in relation to Jasmine's children, and to enable child safeguarding procedures to be followed.

16.16. COVID-19 pandemic and impacts:

16.16.1. This review found no evidence of self-reported, or professional recorded domestic abuse incidents between Jasmine and Doug during the covid-19 pandemic. Jasmine self-reported to professionals on several occasions that Doug was not subjecting her to domestic abuse in 2020 and 2021. However, the absence of reports to professionals does not mean that domestic abuse was not happening during this period. The evidence shared to this review by Jasmine's daughter Tina revealed the continual and sustained nature of Doug's domestic abuse. This review finds it very likely that domestic abuse was taking place during this period. And that

¹⁴ [Domestic Abuse Act 2021 - GOV.UK](https://www.gov.uk/domestic-abuse-act-2021)

Jasmine would have found it more challenging to disclose domestic abuse to professionals as a result of pandemic restrictions particularly the reduction or cessation of face-to-face contact.

It's of note that child 7 was born in July 2020 and given her experiences of previous child safeguarding concerns and removal due to domestic abuse, this may have impacted upon her making disclosures even when she did have face to face appointments.

16.16.2. As Jasmine was diagnosed with COPD in March 2021, it's likely she would have been deemed 'clinically vulnerable'¹⁵ following this diagnosis and potentially prior to it, given her recorded history of asthma. While restrictions had eased by the date of her diagnosis, her COPD diagnosis and clinical vulnerability may have impacted on Jasmine's ability to have professional and social contact and increased her isolation from support.

16.16.3. While Jasmine had a number of missed appointments with agencies, this pattern pre-dated the pandemic and can be seen post-pandemic. And so cannot be fully attributed to a change in the method of support being provided. There's evidence of on-going proactive engagement, and regular contacts made with Jasmine, particularly from Turning Point and the health visitor during the pandemic. Turning Point explored impacts of COVID-19 and restrictions with Jasmine in appointments, where she disclosed that she struggled with impacts of lockdown and her cannabis use increased as a result.

16.17. Children's Social Care assessments management and strategy discussions, child protection conferences and proceedings and decision-making.

16.17.1. Impacts of domestic abuse on Jasmine's children: During 2022, Tina made a disclosure that Jasmine was using substances. The children said that the atmosphere and relationships within the home were negative and there was a lot of conflict. Child 6 shared that, '*she wants her parents to stop drinking 'shandy' as it makes her sad*'. To the review author, Tina described that she was often placed in the role of caregiver for her younger siblings and felt a strong need to protect them. As a result, this caused a significant disruption to her education. Tina often had to protect her younger siblings from Doug, detailing times when she would hide them under the bed or take them out of the house in the middle of the night in their pyjamas to keep them safe. She reported that Doug hurt all the children, including child 7 when he was a baby. She mentioned they tried to go on a family holiday

¹⁵ 'Clinically vulnerable' refers to people who were at increased risk of contracting COVID-19 (e.g. those whose immune system made it more likely they would contract COVID-19) and / or those who would be more at risk of serious complications, or death if they contracted it. Clinically vulnerable people were advised to take additional protective measures to avoid contracting COVID-19. Guidance and definitions shifted in response to emerging research and information throughout the course of the Pandemic. At times, 'clinical vulnerability' applied to individuals with respiratory conditions, such as asthma.

once, but it was awful because of how he acted. She shared that she felt she had to show him she wasn't scared of him, but she has nightmares after everything he subjected her, her mum and her siblings to.

16.17.2. Tina described multiple incidents of Doug's direct abuse of her including an attempt to run her over in his car after she tried to pull her mum out to safety, his threats to kill her and her unborn child, and him threatening her with not being able to see her siblings if she didn't comply with his wishes. He assaulted her when she was pregnant, and when Jasmine tried to defend her, he escalated pinning Tina to the wall and hitting her in the stomach. Tina described feeling unable to disclose information to police on the occasions that they were contacted and attended, due to fear of Doug, and loyalty to her mum, who asked her not to tell.

16.17.3. The impacts of domestic abuse on the children and both parents were considered by professionals, with three psychological assessments considering domestic abuse's impacts on their parenting.

16.18. Family safeguarding model.

16.18.1. Joint Work: During the period of Jasmine's and Doug's involvement with the Family Safeguarding Team in 2022 where there was *"evidence of weekly contact and support being offered... A mixture of joint sessions between Jasmine and Doug, and individual sessions were delivered. A combination of text, telephone, and face to face support."* At this time, there had been one recorded domestic abuse incident (14.5.3) in March 2022, and it is now known that Jasmine was subjected to domestic abuse in a sustained and continual manner throughout their relationship. It was unclear if Jasmine was asked about domestic abuse in front of Doug, which would very likely have inhibited her ability to disclose. In addition, concerns about the children, in respect of contact and custody may have been a factor in Jasmine feeling unable to disclose.

16.18.2. While Family Safeguarding Model multidisciplinary working with Jasmine was evident, and issues regarding her non-engagement had been discussed by Family Safeguarding Model professionals, this review was unable to identify specific examples of these professionals working together to find ways to coordinate and balance Jasmine's support to reduce any feelings of overwhelm she may have had at this time.

16.18.3. While some of the likely reasons for Jasmine not engaging in support were appropriately identified, as seen above, there are two significant reasons missing. The first is that Jasmine had experienced the trauma of having four children permanently removed from her care. While her trauma associated with domestic abuse was identified as a potential reason for non-engagement, trauma associated with child removal was not. Her needs regarding child removal appeared to be

completely absent from information provided to the review. The second was that the FSM is embedded within Children's Social Care. Social workers are part of the multi-disciplinary team. During part of her engagement with FSM, there was active Children's Social Care involvement with the family, which resulted in the permanent removal of child 6 and child 7 plus Tina.

While Jasmine's potential for 'disguised compliance' and motivations for concealing information was noted, there was limited evidence that FSM considered Jasmine's experiences and views of Children's Social Care and her perceptions about FSM's connections to social care as a reason she did not feel able to engage with FSM workers. Or that they explored how support could be provided in a different way to Jasmine. It is likely that Jasmine associated FSM professionals closely with Children's Social Care and the loss of her children. This raised the question, would Jasmine have felt more able to openly engage with professionals, particularly regarding domestic abuse, who she didn't perceive as part of Children's Social Care and care proceedings for her children?

16.19. Impacts of multiple child removal and Pause: *'Child removal has been shown to have a devastating impact on women's mental and physical health, with women experiencing "an immediate psychosocial crisis following child removal". It has also been evidenced to heighten "the vulnerability of mothers whose lives were already characterised by multiple and long-standing disadvantage.'* (Pause Research).

16.19.1. "Pause" practices are in place nationally, in numerous locations. Sometimes they are embedded within Children's Social Care. Sometimes the service is provided by a voluntary sector agency. Pause *'works directly with women, so that no woman should ever have to experience the removal of a child more than once. They offer an intensive, supportive 18-month programme that involves a trusting relationship between a woman and their Pause Practitioner'*¹⁶. In Somerset, for the scope of this review period the Pause Practice was located within a voluntary sector organisation called the Nelson Trust¹⁷.

16.19.2. In total Jasmine had seven children removed from her care by Children's Social Care. Four children were removed pre-scope of this review. Doug expressed that he felt Jasmine blamed him for the removal of Tina, child 6 and child 7. In July 2022, Jasmine self-reported drinking again following her children no longer being in her care, and that she did this to relieve her feelings of loss. It is likely that Jasmine felt a profound sense of loss regarding the removal of her older children, and significant anxiety and fear regarding the ongoing Children's Social Care interventions with her younger children. Her self-reported reason for alcohol use is highly significant, but appeared to have been somewhat dismissed by professionals, and indicative of her disguised compliance and denial around alcohol use, rather than the repeat traumas of historical child removal, and anxieties and fears regarding removal of her younger children. *'Social services didn't help my mum.*

¹⁶ <https://www.pause.org.uk/what-we-do/>

¹⁷ <https://www.nelsontrust.com/rise/>

Instead of taking actions against him to stop his abuse, they took her kids away instead, and that made things worse for her.' (Tina, Jasmine's daughter)

16.19.3. Jasmine's Pause eligibility and identification by professionals: There was no evidence that Jasmine's eligibility for Pause was discussed by multiagency professionals working with Jasmine during the review time period or that she was offered a referral to the service. Although the review panel found that Jasmine was eligible for Pause during the review time period in scope, most likely, this would have been around December 2022. There was very little evidence that the impacts of child removal were explored with Jasmine. There is strong evidence that she had unmet needs relating to these impacts. Pause was ideally placed to meet these needs, with one of its priorities being helping women maintaining relationships with their children who are no longer in their care.

16.19.4. The review panel was interested to understand what the working relationships were like between Pause, and Children's Social Care, including the FSM, and how likely it was that professionals were aware of Pause. It was confirmed that multi-agency awareness took place across health and social care, and it was understood that the list of Pause eligible women uses data from the Children's Social Care electronic records system for its generation. It relies on the presence of appropriate 'tags' on the woman's record that indicate she is Pause eligible. If these tags are not added, women will not appear on the list. It's unclear whether this record 'tagging' occurred for Jasmine.

It is notable that women are able to self-refer to Pause in Somerset. It cannot be determined if Jasmine was aware of the service or how she could refer herself. This could indicate that promotion of this pathway into the service may not have been as prominent in the awareness raising work, which appeared to predominantly be with professionals. As such, this places a degree of reliance on professionals to either refer a woman or inform her that she could refer herself. There was no evidence this happened for Jasmine.

16.19.5. This review is hesitant to say that accessing Pause would have led to a different outcome in respect of Jasmine's death, as that cannot be definitively concluded. However, it does conclude that Jasmine was Pause eligible. She could and should have been referred, whether this was via identifying her in the Children's Social Care dataset, proactive referral from a professional, or a self-referral. This opportunity was missed due to a combination of factors as detailed above.

Had she been referred and engaged with Pause, it is likely that a range of benefits would have been realised for Jasmine. Her needs would have been better understood and met. Barriers to accessing appropriate services reduced. The issues with the Special Guardianship Placement were more likely to have been identified and responded to. The dynamics of domestic abuse better understood, and responded to more appropriately, with her risks reduced, and her safety

increased. Jasmine's needs, and experiences aligned with many of those captured in Pause research and included here.

The review panel found from the evidence provided, that a contributing factor to Jasmine's interactions with professionals was likely to have been a lack of trust, due to the removal of multiple children from her care. Agencies could have been more cognisant of this and worked better to improve their support to her.

17. Conclusions

17.1.1. Ultimately, Jasmine was killed as result of the choices and actions of Doug in March 2023, who plead guilty and was sentenced accordingly. Before Jasmine's death, there were many missed opportunities to understand and meet her needs, including to protect Jasmine and her children from Doug's abuse. For instance, via the implementation of effective measures to prevent Doug from continuing to abuse her.

17.2. The stark and tragic reality is that Jasmine is now represented in the early mortality statistics for women who experienced multiple child removal^{xv}. Jasmine is so much more than a statistic. Jasmine was a kind, and loving person, and a devoted mother. She had dreams and hopes for herself, and her children. Jasmine was a much-loved mother, sister, and daughter. She would have been a grandma twice over now, but sadly she never got to meet her grandchildren, and they will grow up without her in their lives, along with her own children.

17.2.1. Tina expressed to the review that she held (and has) fear of Doug and his family. Tina feels very strongly that he did not get long enough in prison for *'taking away my mum, leaving her kids to grow up without her, and a granddaughter who will never get to meet her grandma.'*

"Doug knew full well the risk he posed by getting behind the wheel. He had only just been banned from driving after damaging his own car in a drink drive incident. His decisions last year had devastating consequences." (Police officer in Case)

17.2.2. There was significant evidence that professionals who engaged with Jasmine and Doug were highly proactive and responsive to their engagement and attendance patterns. For example, Jasmine's GP contacted her after each missed appointment, encouraged her to rebook, offered her follow up appointments and reviews, and *"sometimes chased to support Jasmine with her healthcare needs"*.

17.2.3. This review finds that the following were the overall factors that most likely led to these opportunities being missed:

- Insufficient professional curiosity regarding Jasmine and Doug's relationship dynamics and Doug's domestic abuse.
- A cumulative understanding of Jasmine's needs, including as a mother who experienced the trauma of multiple child removal.

- Consideration of Jasmine and Doug's relationship issues as being 'situational', with substance misuse being the primary issue, rather than being a domestically abusive one characterised by coercive and controlling behaviour.

17.2.4. This resulted in:

- Misunderstanding the role of alcohol in their relationship, including domestic abuse, and the reasons why Jasmine used alcohol. Leading to professionals positioning alcohol as the central issue, rather than Doug's abuse, and Jasmine's trauma as a result of multiple child removal.
- Lack of consideration of how Doug could utilise the child protection proceedings to enable him to position Jasmine's withdrawal from family time to professionals as primarily related to her alcohol use, rather than the impacts of his abuse. Whilst family time has oversight of the court and scrutiny by the judge and children's guardian, the impacts of coercive control may not have been recognised.
- Lack of consideration of the additional barriers Jasmine faced in attending family time, such as limited access to public transport and the financial means to travel to see her children.
- Lack of consideration of measures that could have been implemented to more robustly address Doug's choice to continue to be domestically abusive, such as referral to a perpetrator behaviour change programme.
- Jasmine not being referred to service provision that would have better met her needs, and increased her safety, such as Pause and specialist therapeutic provision. Meaning, for example, her alcohol use continued because the underlying causes for her use were not addressed.
- Insufficient understanding of the role of vehicles in Doug's patterns of domestic abuse, leading to this risk being mostly unrecognised and unmanaged by professionals in the context of domestic abuse specifically (see 16.9).
- Lack of joined up working and coordination across policing units, e.g. between officers responding to domestic abuse, and the road policing unit, as a mechanism to detect and disrupt Doug's offending around driving.
- Stonewater not being present at MARAC when Jasmine was being discussed, meaning they could neither share information or receive information being shared, be part of the coordinated multiagency response to domestic abuse, and shape their responses to Jasmine accordingly.

Overall, there could have been a more holistic understanding of the issues Jasmine was facing, combined with increased professional curiosity, and understanding of the dynamics of domestic abuse in all its forms.

17.2.5. This review concludes that was the combination of all these outcomes, rather than any single one, coupled with Doug's choices and actions on the day he caused her death.

18. Learning

- 18.1. Professional curiosity:** The role of professional curiosity is absolutely vital and integral in effectively identifying and responding to domestic abuse. It is even more important to use professional curiosity in certain situations, such as where alcohol use is a factor, dynamics of abuse are unclear, and there is evidence or suspicion of information being withheld by a victim or of their perceived denial and minimisation, for example. And in such situations, the use of professional curiosity needs to be extended, rather than limited, as was seen in this case.
- 18.2.** Additionally, children and young people can be vital sources of information and insight into domestic abuse happening at home. Extended professional curiosity could include increased consideration of the insights they might hold. For example, had information shared by Tina with her healthcare worker been shared in a multiagency setting, it could have added to the picture of escalating risk, the level of violence used in the assault, Jasmine and Tina's significant fear of Doug, and supported the view that Jasmine and Tina were not able to disclose to police what took place during this incident. It was through interview with Tina that the review author was able to better understand Doug's use of domestic abuse and the impacts on Jasmine.
- 18.3. Misidentification of relationship dynamics:** This can have serious consequences, such as non-identification of risk, ineffective safety planning, inappropriate and poorly timed withdrawal of services and interventions, provision of inappropriate, ineffective, and unsafe services and interventions, all of which were seen in this case. Missing the identification of critical risk factors, such as separation and pregnancy, and resulting risk management responses can increase risk for victims, and lead to missed opportunities to safeguard. Where there is minimisation, denial and withholding of information, or lack of understanding of relationship dynamics, risk factors can be easier to miss. For example, in this case, patterns of escalation were identified by professionals, but they did not connect this escalation to Jasmine's reported desire to leave the relationship.
- 18.4. Disguised compliance:** Using labels such as 'difficult to engage' and showing 'disguised compliance' such as those that were given to Jasmine could be seen to demonstrate that professionals failed to consider and properly address the underlying reasons that she was finding it so hard to engage, such as trauma, fear of Doug, and negative experiences and perceptions of services. Children's Social Care in particular, although she did have different social workers.

It could be seen to demonstrate that insufficient efforts were made to find different ways to engage with Jasmine, in light of her difficulties. Instead of situating the problem with her, e.g. her continued use of alcohol instead of the failure of services to properly understand and meet her needs. This is often underpinned by an expectation that people will fit into the services and systems that professionals design, and frustration from professionals when people cannot engage in the services and systems that do not work for them.

This is backed by the NSPCC in its 2025 “Why language matters: how using the term ‘disguised compliance’ can be problematic”^{xvi}, which discusses how “labelling behaviour in this way can create an atmosphere of suspicion rather than collaboration.”

- 18.5. The role of alcohol in domestic abuse:** Understanding this is imperative. Both in terms of alcohol as an aggravating, rather than causal factor, and as connected to the victim’s use of alcohol in response to the abuse they are subjected to and resulting trauma. As outlined in 16.13.4, it was unclear how professionals considered Jasmine’s relationship with alcohol. By not understanding this properly, in turn this can lead to ineffective interventions that both fails to address the real issue of domestic abuse and does not enable victims to make changes regarding alcohol use, because the primary cause of their alcohol use, domestic abuse and trauma, remains unaddressed.

Blaming victims for their ‘failure’ to reduce or stop drinking can often occur as a result, which can lead to further negative outcomes for a victim, such as impacts on having care of their children, and can serve to reinforce abusers’ tactics, which may include positioning a victim as to blame for the abuse they are being subjected to and resulting negative outcomes. Had Jasmine and Doug’s relationship been understood by professionals to be one characterised by intimate terrorism as its dynamic, rather than situational couple violence, this would most likely have changed the identification and assessment of risk and enabled professionals to implement more appropriate and effective risk management approaches and interventions.

Additionally, it is unclear whether workers were sometimes trying to engage with Jasmine whilst she was intoxicated, and this may have directly impacted on her ability to work with professionals.

- 18.6. DASH-RIC practices:** By considering each DASH RIC assessment in isolation, it means the ‘golden thread’ of the perpetrator’s pattern of abuse can become lost. Patterns of escalation, such as increased numbers of incidents, a key indicator of risk of serious harm, can be missed. In addition, a DASH-RIC rating of high-risk should lead to specific professional risk management actions, usually including referral to MARAC which may not always be taken where a DASH-RIC is rated medium or standard risk. The impacts of this can be seen in this case. Not appropriately identifying a victim as high-risk of serious and possibly imminent harm during an attendance but rather, days afterwards, means that opportunities to implement immediate risk management actions and approaches in response can be missed. In this case, police reflected that after Jasmine’s death the LSU noted that *‘the standard risk assessment would have been upgraded to high, due to past incidents and a referral to MARAC’*.

- 18.7. MARAC and information sharing:** The lack of MARAC discussions led to there being no multi-agency forum to discuss Jasmine's domestic abuse experiences. Whilst the family safeguarding model enables multi-disciplinary working, this is only between children's social care, mental health, substance misuse and domestic abuse teams. Therefore, others such as police, wider health and housing are excluded from ordinary conversations around sharing of information and safety planning. This also meant that wider conversations around protective orders were not discussed. Whilst it is not known if they would have made a practical difference, the opportunity should nonetheless be there.

There does not appear to have been an intersectional view of Jasmine, and the multiple needs she was experiencing and facing every day. An improvement in knowledge and confidence in responding to domestic abuse victims who have multiple needs maybe required, including clarity that those who may not be co-habiting with their abuser are equally at risk of harm.

- 18.8. Understanding nuances of risk:** The unique tactics of abuse tailored by a perpetrator for maximum impact on a victim can make a significant difference in risk management approaches. In this case, Jasmine had experience of Doug's dangerous use of vehicles, including his drink-driving which is likely to have increased her fear of him. However, it did not appear to the review that professionals supporting Jasmine fully understood any links to domestic abuse, including within safety planning.

There was no evidence that dynamics, impacts on Jasmine, or risks posed by Doug in relation to vehicles and driving were raised at MARAC. This maybe due to a lack of confidence in understanding the links between driving offences and other criminal behaviour and seeing domestic abuse through that lens.

Bates, Alexander and Webster (2022)^{xvii} note "that individuals who individuals who commit certain driving offences are more likely to also have a general criminal history. In particular, driving under the influence, driving unlicensed and high-range speeding offences were associated with other forms of criminal behaviour."

Overall, it appeared that risks relating to Doug's driving were understood by professionals, especially those supporting Jasmine, in the general sense of risk posed by any driver who drives recklessly and dangerously, including when under the influence. It does not appear that connections were explicitly made that Doug used his vehicle to enable and facilitate his abuse of Jasmine, including as a form of restricting and controlling her contact with her children. Had this been done, it may have resulted in different views held by professionals, e.g. rather than viewing Jasmine missing family time as due to her alcohol use, they could have seen this as an outcome of Doug's abuse and its impacts. This could have led to different decisions and actions by professionals in several areas, including the child custody and family time arrangements, and criminal justice responses. It is important to note that the Serious Further Offence Review found that the probation should have

undertaken more professional multiagency meetings where critical risk information was shared and then recorded.

- 18.9. Road Safety:** The night before her death, Jasmine reported Doug's committal of an offence against her to police (a threat to kill) issued to her over the telephone while he was driving (14.6.8). Police did not appear to respond to this domestic abuse incident in respect of his alleged driving offence, including information sharing and coordination with road policing unit colleagues, which may have enabled them to use mechanisms to locate Doug via his vehicle. There is no evidence of any monitoring or detecting of Doug's registered vehicle, including via the 'hot list' or ANPR briefings. It is known that he drove on the day of Jasmine's death, including other journeys in addition to that where Jasmine was killed. A holistic intra-agency approach to sharing intelligence around risks may have helped, e.g. the police linking the risks of domestic abuse and driving between their relevant departments.
- 18.10. Failure to consider protective orders such as DPVN / DVPO:** This review cannot find any rationale about whether police considered a DVPN or DVPO in this case. If in fact they did, it was not recorded as such. Although the review was assured that an evidence-led prosecution was always considered. A DVPO / DVPN could have been considered following incidents on 27th October, 2nd December, 23rd December 2022, 15th February, 27th February and March 2023, the day before Jasmine's death.
- 18.11. Recording of information:** There is a need to consistently, accurately and clearly record information on electronic case management systems. This is especially important where recording is linked to the generation of data and allocation of services, such as identifying a woman as Pause eligible or responding to breach of bail conditions.

This review has been unable to confirm why information regarding Doug's bail and protective measures were either not recorded fully at the time or not available to the police panel member at the time of this review. While this cannot be fully substantiated, the back-and-forth communication between police and probation, and the inability to access information may reflect either a lack of clarity regarding Doug's bail conditions and protective measures or inadequate consistent recording of these by all criminal justice agencies. Or a combination thereof. While this can't be fully substantiated, a lack of clarity regarding bail and protective measures would likely have impacted on the ability to employ effective and timely responses to any breaches.

- 18.12. Targeted vs routine enquiry:** There are some health settings where targeted enquiry about domestic abuse is most appropriate, and pragmatic, such as GP practices. And some settings where routine enquiry is required, such as maternity, health visiting, and sexual health. The IMR author for health visiting reflected that, *"Where there is either current or historic domestic abuse in the relationship, this should be discussed routinely in contacts. If nothing else, this is an opportunity to*

raise awareness and understanding of the impact of domestic abuse as part of expectations outlined in the Domestic Abuse Act 2021.” In all health settings, having clear policies and procedures that support effective and safe enquiry practices and that are promoted to staff, and accompanied by training, are of significant benefit.

18.13. Housing providers: Providers are integral to an effective, local coordinated community response to domestic abuse. This includes registered providers of social housing, such as Stonewater. Where a housing provider holds a large stock in a local area, there are benefits to them being part of multiagency processes, such as MARAC. MARAC was an opportunity for Stonewater to be part of the local Coordinated Community Response to domestic abuse, share and gather intelligence about Jasmine, including her experiences of domestic abuse, use this to inform their actions and decision making, and undertake actions to increase Jasmine’s safety. Because they were not part of MARAC at this time, this opportunity was lost.

19. Recommendations

Single agency recommendations

19.1. Turning Point

1. DHR’s that are regarding individuals who are being supported by the family safeguarding model need to be completed as one document with input from all services involved rather than individual documents.
2. The recording of the outcomes of the family safeguarding group supervisions to be recorded on Turning Points case management system rather than just the joint family safeguarding case management system

19.2. NHS Somerset ICB

3. Face to face targeted/clinical enquiry into domestic abuse to be used on patients where there are concerns around domestic abuse.
4. Holistic approach when carrying out contacts with patients who have complex social situations.
5. Police Reports to be reviewed upon receipt by GP
6. Domestic abuse alerts to be added to records and be considered for adults at risk to be discussed at safeguarding MDT meetings.

19.3. Public Health Nursing / Health Visitor

7. Routine enquiry relating to domestic abuse is clearly evidenced at all core contacts for all families (universal offer)
8. Safeguarding Supervisors should routinely ask about Domestic abuse in safeguarding supervision for families

9. HV to continue with the practice of looking for patterns of concerning behaviours in complex families, sharing them with other professionals and considering the impact this has on the children in the home.
10. Where there is current or historic domestic abuse for it to be raised in contacts routinely as part of the visit as per policy, bearing in mind when and where this is safe to do so. These considerations include whether the perpetrator is present or able to overhear conversations, and if children are present and able to understand what is being said. All staff to “think family” considering the impact of older children as well as adults when dealing with difficult and emotional issues. Staff should all be practicing in a Trauma informed way and have the necessary skills to support families with complex social and emotional needs

19.4. Stonewater Housing

11. Where domestic abuse is reported or indicated by a 3rd party, contact to be made with person affected on every occasion
12. Contact with other agencies to be followed up
13. Where there is a case open on our system and routine contact is made, this is to be used as an opportunity to have a conversation with customer to discuss the open case

19.5. Children Social Care (including Family Safeguarding Team)

14. Ensure the needs of all children are considered and assessments completed if required taking into account the voice of the child/lived experience.
15. Ensure social workers are considering referral to Pause project
16. Practitioners should ensure that perpetrators of domestic abuse are offered referral to relevant support or intervention services, noting that participation may require the individual's consent.

19.6. Probation

17. To implement a process to expediate sharing information of police call outs in DA cases.
18. To ensure joint agency home visits are undertaken in high-risk domestic abuse and child protection cases. (Home visit Policy covers this).
19. Information sharing between agencies. Implement a process to ensure that arrests or interviews by police are actively shared with PS as soon as possible, particularly when police interest is linked to offending related behaviour
20. PS to ensure less experienced staff regularly seek support of SPO or PP officially holding the case.

19.7. Multi Agency Recommendations

21. Social housing landlords across Somerset, ensure they have specific domestic abuse policies each for staff and tenants.

22. Improve awareness of the complexity and intersectional nature of women's experiences across the health and social care system within the county, using this review as a case study/learning briefing example.
23. Within 12 months of the publication of this review, the Somerset Council Community Safety Team should develop and disseminate, through the Somerset Domestic Abuse Board and Somerset Domestic Abuse website, practitioner guidance on assessing domestic abuse risk in non-cohabiting and post-separation relationships, ensuring that assessments are informed by patterns of abuse and coercive control rather than living arrangements.

20. Appendices

Terms of Reference

1. Introduction

- 1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Jasmine. The death is believed to be as a result of a road traffic accident whereby her partner was the driver, and domestic abuse was a factor in their relationship.
- 1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

- 2.1 Review the circumstances that led to the death in March 2023 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family
- 2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- 2.3 To produce a report which:
 - summarises concisely the relevant chronology of events including:
 - the actions of all the involved agencies;
 - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
 - analyses and comments on the appropriateness of actions taken;

- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.
- 2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
 - Apply these lessons to service responses including changes to policies and procedures as appropriate
 - Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working
- 2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The Review will:

- Focus on the most relevant time period in this case, 01.01.2020 to March 2023.
- For this time period, request detailed Individual Management Reviews (IMR's) by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the Review.
- Request IMR's include relevant information of any earlier or subsequent incidents or events where the Panel agrees this would be beneficial and informative to the Review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the criminal justice proceedings in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including 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 Jasmine or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
 - In regards to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify how interventions designed to manage perpetrators were implemented (including Integrated Offender Management), and impact this had on Jasmine.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

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

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

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency
Independent Chair
Avon and Somerset Police
Children's Social Care
Probation Service
Integrated Care Board
Safer Somerset Partnership (Somerset Council community safety)
Somerset Drug and Alcohol Service
Somerset NHSFT
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)
Somerset Council Housing (former Mendip area)
Pause
Stonewater
Public Health Nursing
Nelsons Trust

This was confirmed at the first Review Panel meeting on 5 September 2023

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

5.3 Panel Members will:

- Attend every Panel meeting. When attendance is not possible, provide updates / relevant information in advance of the meeting to Somerset Council and the Independent Chair.
- Follow online meeting good practice, enabling focused and productive Panel meetings that respect and honour the victim. Including but not limited to having cameras on throughout and avoiding undertaking other work during meetings.
- Actively participate in meetings, and proactively contribute guidance, expertise and experience to inform the Review.
- Complete actions set at Panel meetings by agreed deadlines.
- Where there is a split between the role of Panel Member and IMR author, work effectively in partnership with their agency's IMR author, ensuring provision of timely and high quality IMR's to inform the Review.
- Proactively and promptly address issues with IMR's raised by the Chair and / or Safer Somerset Partnership.
- Work collaboratively and cooperatively in partnership with the Chair to produce the Overview Report, including timely reviews, edits and comments on drafts.

6 **Outline Plan for DHR** (subject to change depending on information found during the review) – Please note 1 day equates to 7 hours.

June 2023	o Independent Chair appointed by Safer Somerset Partnership	
July 2023	o Independent Chair establishes ToR and timetable with Safer Somerset Partnership	
September 2023	o First Review Panel meeting (05.09.2023) o IMRs/chronologies to commence o IMR submission deadline (19.10.23)	o 1 Day
August/ September 2023	o Liaison with Police, Coroner, relatives and friends	o 2 ½ Days
October 2023	o IMRs (with chronologies) returned	o 1 Days (review by Chair)*
November 2023	o Second Panel Meeting (15.11.2023)	o ½ Day
November/ December 2023	o Further interviews with family/friends	o 2 Days
November/ December 2023	o IMR clarifications/additional info provided & combined chronology compiled (22.12.2023)	o 2 Days

December 2023/January 2024	○ Overview reported drafted (10.1.2024)	
January 2024	○ Draft report to be circulated via email. (11.01.2024)	○ 3 Days (collation of report)
January/ February 2024	○ Review Panel Meeting discuss OVR (to agree report and recommendations) (25.01.2024)	○ 2 ½ Days (including any final revisions of report)
February 2024	○ OVR finalised as far as possible. Family involvement may be pending due to CJS proceedings timeline (currently unknown)	
February/ March 2024	○ Overview report to be finalized and submitted to the Safer Somerset Partnership Chair and signed off / sent to Home Office	○ 1 Day
○ Remainder of timeline: TBC following knowledge of CJS proceedings timeline		

6.1 It is envisaged that this review will take the appointed DHR Chair no more than 13 days (91 hours), (as indicated above).

6.2 *The chronologies will be compiled by SC to assist the Chair in analysis.

7 **Family Involvement:**

- This Review will seek to involve the family, friends, and other relevant people who knew the victim, such as neighbours, and employers.
- With the support and guidance of Panel Members and relevant professionals, e.g., Family Liaison Officers, the Chair will proactively seek to engage family members and other relevant people throughout the Review process, offering them multiple opportunities to be involved.
- Where applicable, family members, including children, will be signposted and / or supported to access specialist and expert advocacy services to support their involvement.
- Involvement may include but is not limited to:
 - assisting with agreeing the scope of the DHR
 - meeting the Chair, and Panel Members
 - providing information, views and opinions in their preferred format to inform the Review
 - attending Panel meetings
 - reviewing the draft Overview Report, with sufficient time granted for them to do this
 - choosing a pseudonym for the victim
 - helping to create and implement change after the Review, including involvement in sharing learning, awareness campaigns and monitoring action plans.
- Unless explicitly directly not to do so by the family, the Chair will provide relevant family members with regular updates using available forms of communication (e.g. letter or email) or in the format agreed with the family member. Updates may include: progress on the Review, next steps, draft timetable for completion and sharing Review inputs as the Review is ongoing. For example, the Individual Management Reviews (IMRs).
- Where the Chair holds in-person meetings with family, and friends and other relevant people they will be accompanied by either a Panel Member, or an appropriate professional from a relevant agency, such as a social worker or police officer.

8 **Liaison with Media**

- 8.1 Somerset Council as lead agency for domestic abuse for the Safer Somerset Partnership will handle any media interest in this case.
- 8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

References

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- ¹ Veldhuis, C.B. Cultivating Dependence, Denial, and Self-Blame: A Narrative Review of the use and Effects of Coercive Tactics in Intimate Partner Violence. *Gend. Issues* **41**, 10 (2024). <https://doi.org/10.1007/s12147-024-09327-7>
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- ¹ [Intimate partner homicide: Risk constellations in separation conflicts and points of intervention for the police | Policing: A Journal of Policy and Practice | Oxford Academic](#)
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- ¹ [Early maternal death following child removal—A short report using observational data - Devaney - 2024 - Child Abuse Review - Wiley Online Library](#)
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**Safer Somerset Partnership
Domestic Homicide Review
Into the death of Jasmine
In March 2023**

**Executive Summary
Independent Review Chair and Author: Safer Somerset
Partnership
Review Completed: September 2025**

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1. The Review Process

- 1.1 This summary outlines the process undertaken by the Safer Somerset Partnership Domestic Homicide Review panel in reviewing the death of Jasmine who was a resident in their area.
- 1.2 The following pseudonyms have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members.

Pseudonym	Age time (at of death)	Relationship to victim
Jasmine	41	Victim (deceased)
Doug	32	Partner
Child 1	25	Jasmine and previous partner's child 1
Child 2	22	Jasmine and previous partner's child 2
Child 3	21	Jasmine and previous partner's child 3
Child 4	20	Jasmine and previous partner's child 4
Tina	16	Jasmine and previous partner's child 5
Child 6	9	Jasmine and Doug's eldest child
Child 7	2	Jasmine and Doug's youngest child

- 1.3 Following the fatal incident, in January 2024 the Courts sentenced Doug as a result of his pleading guilty of causing death through careless driving whilst over the prescribed limit for alcohol, causing serious injury through careless driving, driving while disqualified and driving without insurance.
- 1.4 The process began with the Safer Somerset Partnership Chair on 16th May 2023 deciding that a domestic homicide review should be commissioned. All agencies that potentially had contact with Jasmine or Doug prior to the point of death were contacted and asked to confirm whether they had involvement with them.
- 1.5 8 of the 16 agencies contacted confirmed they had information of significance to the review relating to Jasmine, Doug and children involved and were asked to secure their records.

2 Contributors to the review

- 2.1 The following agencies contributed to this review.

Agency	Involvement in Review
Avon and Somerset Police	IMR
Children Social Care	IMR
NHS Somerset Integrated Care Board	IMR
Probation	IMR

Public Health Nursing	IMR
Somerset Drug and Alcohol Service (Turning Point)	IMR
Somerset Council Housing (formerly Mendip District Council)	IMR
Somerset Domestic Abuse Service	IMR
Somerset NHS Foundation Trust	Panel member- expertise around mental health and acute hospitals
Stonewater Housing	IMR
The Nelson Trust	Expert advisor

2.2 All IMR authors were independent of any direct involvement with Jasmine or Doug.

3 Review Panel Members

3.1 The panel and Safer Somerset Partnership agreed that panel member names would not be included due to the potential risks to both the public and professionals. It was also noted the draft revised statutory guidance published in 2024 also did not include professional names. The panel members were:

Agency	Role
Independent Chair	Chair
Avon and Somerset Police	Detective Chief Inspector
Children's Social Care	Head of Service Team Manager
Probation Service	Senior Probation Officer
NHS Integrated Care Board	Designated Nurse for Safeguarding Adults
Safer Somerset Partnership (Somerset Council)	Community Safety Manager
Turning Point (Somerset Drug and Alcohol Service)	Young Person & Family Team Ops Manager
Somerset NHSFT	Strategic Lead & Named Professional Safeguarding Adults - Prevent Lead / Domestic Abuse & Sexual Violence Lead
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	Service Manager

Somerset Council Housing (former Mendip area)	Senior Housing Options Manager
The Nelson Trust / Pause	Criminal Justice Services Lead
Stonewater	Mentoring Manager (Resolution Team)
Public Health Nursing	Operational Service Manager

- 3.2 The review panel had 5 meetings (virtually) on Microsoft Teams: 5th September 2023, 15th November 2023, 28th March 2024, 5th July 2024 and 10th March 2025.
- 3.3 All review panel members were independent of any direct involvement with the individuals subject to this review.

4 Author of the overview report

- 4.1 The Safer Somerset Partnership originally appointed an independent chair and report author for this review, who had several years' experience within the areas of violence against women and girls and safeguarding adults. She had no connection with the Safer Somerset Partnership, any of its agencies and no prior knowledge of any of the subjects of the review.
- 4.2 This independent chair did complete a draft report in 2024, however the review panel and Community Safety Partnership decided it was of a poor quality. Subsequently the independent chair's contract for this review was terminated, as a mutually agreed way forward could not be achieved.
- 4.3 The Safer Somerset Partnership (SSP) contacted the Home Office in January 2025 to clarify whether a new independent chair should be appointed, or if the SSP could complete the report, as a Community Safety Manager within Somerset Council has completed the Home Office accredited DHR chair training. With then as a means of ensuring some independence, another independent DHR chair would review the finalized report. The Home Office advised that either course of action was suitable, therefore, the SSP decided to proceed with the second option. Dr Susan Haile was appointed to review the finalised report.

5 Terms of Reference

- 5.1 The terms of reference were agreed by the review panel at their first meeting in September 2023. The scope was agreed to be from January 2020 until Jasmine's death in March 2023. This timescale was chosen as it incorporated the period of the Covid-19 pandemic, and additionally for the birth of Jasmine's youngest child.

5.2 There were no key lines of enquiry clearly set out for the review by the independent chair who was originally appointed. However, the terms of reference did include the following points (the terms of reference can be found in appendix 1):

- 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 Jasmine or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
 - In regard to children and pregnancy and any potential impact this had ensuring the safeguarding of any children during the review.
 - Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
 - Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
 - Identify how interventions designed to manage perpetrators were implemented (including Integrated Offender Management), and impact this had on Jasmine.
 - Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
 - Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
 - Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
 - Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

6 Summary Chronology

- 6.1 It's understood that Jasmine and Doug were in a long-term relationship and had been together for at least ten years at the time of her death, with domestic abuse having been reported or suspected by professionals. They had lived together and resided separately at various points during their relationship and had brief periods of separation.
- 6.2 Jasmine's first five children were all removed by Children Social Care (prior to the scoping period for this review). The reasons for this were around parental mental health, parental substance misuse and domestic abuse. This is something that she told professionals she blamed herself for.
- 6.3 In 2020 Jasmine is pregnant with her seventh child, (who is her second with Doug as the father). During her pregnancy, Jasmine talks to professionals about her abstinence from alcohol, but that she was using a small amount of cannabis several times a week, due to feelings of isolation due to the Covid-19 pandemic. She did not disclose any domestic abuse.
- 6.4 During this early part of the Covid-19 pandemic, Doug also disclosed to professionals that he was out of work in the building trade due to the lockdown. Jasmine and Doug were not living together at this time.
- 6.5 Doug and Jasmine's second child (child 7) was born in July 2020. There were subsequent contacts with health visitors, GP's, and Children Social Care. During a FAST assessment for child 7 in the autumn, Jasmine acknowledged to Children Social Care that her relationship with Doug was violent. Doug also shared during the FAST assessment that he knew he had been violent and had not always remembered the next day due to his alcohol misuse. The assessor noted that both Doug and Jasmine were seeking to have both child 5 (Tina) and child 6 in their care in the future. In December 2020, Jasmine told her health visitor that there had been no recent domestic abuse from Doug.
- 6.6 During 2021, Jasmine had a variety of routine contacts with health visitors, together with contacts with the GP for a long-term respiratory condition that she had. Jasmine did tell her healthcare practitioner that she lived alone although Doug helps with the children. There were few contacts with professionals during this year.
- 6.7 In January 2022, the police receive a third-party report that Tina was assaulted by Jasmine and Doug, which is subsequently found to be untrue. A DASH was completed and rated as standard. When Jasmine speaks to her health visitor in February, she says there has been no recent domestic abuse incidents.
- 6.8 During March, an incident happens in a hotel in a neighbouring county, where Doug assaults Jasmine, causing injuries to her face. Jasmine discloses to the attending police that the assault happened following an argument, but she is not frightened of Doug, and that he does control her finances. A DASH assessment was completed, and a police notification shared with Somerset Children Social Care. Subsequently there was a strategy meeting held in April, and an initial child protection conference (ICPC) held in May.
- 6.9 During the spring 2022, Jasmine and her health visitor discuss child 7's development and her wish to move to a new area later in the year. Jasmine also has a relapse prevention session with her drug and alcohol worker.

- 6.10 In late May, Jasmine and Doug have a stay in a hotel, where Doug assaults another guest and was aggressive towards Jasmine. The police attend and refer this incident to Children's Social Care.
- 6.11 It is at this time following the ICPC (6.8) that the case is transferred to the family safeguarding model, which includes is an integrated model with social workers and adult practitioners from drug and alcohol, mental health and domestic abuse services
- 6.12 Doug is sentenced in June to a to 12-month community order, 150 hours of unpaid work and compensation of £150 with costs of £85. He starts to be managed by probation. This relates to a non-domestic abuse related assault (with an unrelated male). It's of note that probation did not complete a pre-sentence report, and so any domestic abuse would not have been considered as part of the sentencing.
- 6.13 Subsequently, Doug has a number of appointments with a probation practitioner, many of these were via the telephone, and he discloses that he has low mood. Doug also then has appointments with a mental health worker and drug and alcohol workers. He said he felt Jasmine blamed him for the removal of children from their care.
- 6.14 In late September, Jasmine moves to a new rented property, which she describes to professionals as being a 'fresh start'.
- 6.15 Later in the year, Jasmine and Doug are reported to have been drinking excessively together and arguing. When police attend incidents, Jasmine denies any assaults, and does not want to make complaints, saying incidents were fuelled by alcohol. In December, one incident is rated by the police on a DASH risk assessment as being high risk, but no further action as taken, due to there being insufficient evidence.
- 6.16 In early 2023, Doug has appointments with his probation worker and substance misuse worker, he says there are no relationship issues with Jasmine.
- 6.17 In mid-February, Jasmine calls the police to say Doug attended her home address intoxicated, stamped on her takeaway, and left. She says Doug grabbed her by the wrists a couple of days previously and she had grabbed him. She says she doesn't want to make a statement or support a prosecution. She doesn't want any support, saying she's in contact with her IDVA but hasn't spoken to her since before Christmas. A victimless prosecution was considered but there was insufficient evidence to proceed. A DASH RIC was completed and rated as high. A referral was made by police LSU to the Somerset Domestic Abuse Service and MARAC plus a marker added to Jasmine's address.
- 6.18 In early March, police get a call reporting screaming and shouting coming from Jasmine's address. Officers attend and find Jasmine intoxicated. She says she was arguing with Tina about being pregnant. Officers call Tina who is safe and well at her grandmother's house. A DASH RIC was completed and rated as standard risk. The police LSU reviewed the incident and made referrals to health, Children Social Care and education.
- 6.19 Doug is disqualified from driving on 14th March at South Somerset Magistrates Court. He receives twenty-two months of disqualification for previously driving

a vehicle over the prescribed limit. In mid-March he's advised his court appearance is adjourned until 18th March.

- 6.20 The day before Jasmine's death in March 2023, Jasmine calls police saying she was assaulted by Doug. She says they had both been drinking and an argument occurred. Doug verbally abused her and grabbed her by the hair, pulling out a clump. She says they often argue, and it could be over anything and nothing, like this argument that was about loading the dishwasher. She says, *'there's usually no issues, but they had both been drinking that evening'*. Jasmine says she's already engaging with The YOU Trust (provider of Somerset's Domestic Abuse Service). She contacts an officer later in the evening to say she spoke to Doug whilst he was out driving and he said, *'she was dead.'* The officer returns to Jasmine's address to check on her welfare and she says Doug hadn't returned.

The police completed an area search and could not find Doug. A new door chain was fitted with security advice, and a 'treat as urgent marker' placed on the address. A DASH RIC was refused, but the officer completed one on observation and rated it as standard risk as Jasmine was already engaging with the domestic abuse service.

- 6.21 In Somerset in late March 2023, Doug was driving with Jasmine as the front passenger in the car. The car was travelling at high speed and swerved into the path of an oncoming vehicle travelling on the opposite side of the road, colliding with it head on. The oncoming vehicle was driven by an individual with no known connections to Jasmine or Doug. A witness at the scene called 999 at 20:03 and asked for police attendance reporting a two-vehicle road traffic collision. One of the witnesses at the scene was a nurse and administered first aid to Jasmine. Doug was thought at the time, to be in a life-threatening condition and was airlifted to hospital. Medical staff noted Doug smelt of alcohol. Jasmine was sadly pronounced deceased at the scene by paramedics at 20:44 hours and was transported to hospital.

7 Key Issues Arising from the Review

- 7.1 The review panel found throughout many of Jasmine's contacts with professionals there was evidence of minimisation, denial and blame shifting. On occasion Jasmine did express her view that if she shared information about domestic abuse, she was fearful of reprisals by Doug.
- 7.2 Jasmine did report that Doug's issues were due to his mental health. From the information made available to the review, the panel found it credible that Doug may have used his mental health needs as a method of coercively controlling Jasmine.
- 7.3 Both Jasmine and Doug had histories of substance misuse. Jasmine reported her perceived connection between alcohol use and domestic abuse. The panel noted it is a common myth that alcohol causes domestic abuse when it does not.

- 7.4 In this case, Jasmine sadly died due to a road traffic collision, from being in a car driven by Doug. Agencies had information that Doug committed road traffic offences including through being intoxicated. In fact, he was also driving whilst disqualified at the time of Jasmine's death. Jasmine's daughter Tina advised the review that Doug frequently drove at high speeds and considered his vehicle a 'big toy'. It was unclear to the panel whether agencies were fully cognisant of the risks and links between Doug's domestic abuse, his alcohol use and his driving.
- 7.5 The panel discussed 'situational couple violence' and noted that where Jasmine and her daughter had 'been violent' towards Doug it was in the context of violent resistance. Additionally, the panel were fully aware that alcohol does not cause domestic abuse, and there was a long pattern of coercive and controlling behaviour by Doug towards Jasmine.
- 7.6 Jasmine's domestic abuse risk was assessed using a DASH risk indicator checklist on multiple occasions during 2022 and 2023. These did not take place on every occasion, and the majority were rated as standard or medium, with 3 (at end of December 2022 and two in February 2023) being rated high. A Multi Agency Risk Assessment Conference (MARAC¹⁸) took place in December 2022, and this was noted by the panel to have been when Jasmine disclosed domestic abuse and wanted to leave the relationship. The panel found no evidence that the risk of separation was discussed at the MARAC. Jasmine was also subject to MARAC in early March 2023, and it is unknown whether the impacts and risk of domestic abuse on children was considered. Additionally, not all relevant agencies were at MARAC, for example Jasmine's social housing landlord are not routinely part of Somerset's MARAC.
- 7.7 Jasmine's social housing landlord also appeared to have received reports from neighbours of 'arguments' but these did not appear to be framed as domestic abuse and instead minimised what Jasmine was experiencing as part of her coercive and controlling relationship. If they had been at the MARAC meetings in December 2022 and March 2023, that would have given them more clarity of the situation and may have been able to be part of the multi-agency response to help her.
- 7.8 The impacts for Jasmine of having her children put into care was clearly significant. The panel noted that this was an added dynamic which was used as part of the coercion in the relationship between Jasmine and Doug. Additionally, it may have impacted on her ability to engage with professionals particularly around the domestic abuse she was experiencing, given that she had her seventh child in 2020, who she clearly wanted to ensure remained with her.

¹⁸ [Marac resources and guidance - SafeLives](#)

8 Conclusions

8.1 Ultimately, Jasmine was killed as result of the choices and actions of Doug in March 2023, who pleaded guilty and was sentenced accordingly. Before Jasmine's death, there were many missed opportunities to understand and meet her needs, including to protect Jasmine and her children from Doug's abuse. For instance, via the implementation of effective measures to prevent Doug from continuing to abuse her.

8.2 The stark and tragic reality is that Jasmine is now represented in the early mortality statistics for women who experienced multiple child removal^{xviii}. Jasmine is so much more than a statistic. Jasmine was a kind, and loving person, and a devoted mother. She had dreams and hopes for herself, and her children. Jasmine was a much-loved mother, sister, and daughter. She would have been a grandma twice over now, but sadly she never got to meet her grandchildren, and they will grow up without her in their lives, along with her own children.

8.3 Tina expressed to the review that she held (and has) fear of Doug and his family. Tina feels very strongly that he did not get long enough in prison for *'taking away my mum, leaving her kids to grow up without her, and a granddaughter who will never get to meet her grandma.'*

"Doug knew full well the risk he posed by getting behind the wheel. He had only just been banned from driving after damaging his own car in a drink drive incident. His decisions last year had devastating consequences." (Police officer in the case)

8.4 There was significant evidence that professionals who engaged with Jasmine and Doug were highly proactive and responsive to their engagement and attendance patterns. For example, Jasmine's GP contacted her after each missed appointment, encouraged her to rebook, offered her follow up appointments and reviews, and *"sometimes chased to support Jasmine with her healthcare needs"*.

8.5 This review finds that the following were the overall factors that most likely led to these opportunities being missed:

- Insufficient professional curiosity regarding Jasmine and Doug's relationship dynamics and Doug's domestic abuse.
- A cumulative understanding of Jasmine's needs, including as a mother who experienced the trauma of multiple child removal.
- Consideration of Jasmine and Doug's relationship issues as being 'situational', with substance misuse being the primary issue, rather than being a domestically abusive one characterised by coercive and controlling behaviour.

8.6 This resulted in:

- Misunderstanding the role of alcohol in their relationship, including domestic abuse, and the reasons why Jasmine used alcohol. Leading to professionals positioning alcohol as the central issue, rather than Doug's abuse, and Jasmine's trauma as a result of multiple child removal.

- Lack of consideration of how Doug could utilise the child protection proceedings to enable him to position Jasmine's withdrawal from family time to professionals as primarily related to her alcohol use, rather than the impacts of his abuse. Whilst family time has oversight of the court and scrutiny by the judge and children's guardian, the impacts of coercive control may not have been recognised.
- Lack of consideration of the additional barriers Jasmine faced in attending family time, such as limited access to public transport and the financial means to travel to see her children.
- Lack of consideration of measures that could have been implemented to more robustly address Doug's choice to continue to be domestically abusive, such as referral to a perpetrator behaviour change programme.
- Jasmine not being referred to service provision that would have better met her needs, and increased her safety, such as Pause and specialist therapeutic provision. Meaning, for example, her alcohol use continued because the underlying causes for her use were not addressed.
- Insufficient understanding of the role of vehicles in Doug's patterns of domestic abuse, leading to this risk being mostly unrecognised and unmanaged by professionals in the context of domestic abuse specifically (see 16.9).
- Lack of joined up working and coordination across policing units, e.g. between officers responding to domestic abuse, and the road policing unit, as a mechanism to detect and disrupt Doug's offending around driving.
- Stonewater not being present at MARAC when Jasmine was being discussed, meaning they could neither share information or receive information being shared, be part of the coordinated multiagency response to domestic abuse, and shape their responses to Jasmine accordingly.

8.7 Overall, there could have been a more holistic understanding of the issues Jasmine was facing, combined with increased professional curiosity, and understanding of the dynamics of domestic abuse in all its forms.

8.8 This review concludes that was the combination of all these outcomes, rather than any single one, coupled with Doug's choices and actions on the day he caused her death.

9 Lessons to be Learned

9.1 Professional curiosity: The role of professional curiosity is absolutely vital and integral in effectively identifying and responding to domestic abuse. It is even more important to use professional curiosity in certain situations, such as where alcohol use is a factor, dynamics of abuse are unclear, and there is evidence or suspicion of information being withheld by a victim or of their perceived denial and minimisation, for example. And in such situations, the use of professional curiosity needs to be extended, rather than limited, as was seen in this case.

9.2 Additionally, children and young people can be vital sources of information and insight into domestic abuse happening at home. Extended professional curiosity could include increased consideration of the insights they might hold.

For example, had information shared by Tina with her healthcare worker been shared in a multiagency setting, it could have added to the picture of escalating risk, the level of violence used in the assault, Jasmine and Tina's significant fear of Doug, and supported the view that Jasmine and Tina were not able to disclose to police what took place during this incident. It was through interview with Tina that the review author was able to better understand Doug's use of domestic abuse and the impacts on Jasmine.

9.3 Misidentification of relationship dynamics: This can have serious consequences, such as non-identification of risk, ineffective safety planning, inappropriate and poorly timed withdrawal of services and interventions, provision of inappropriate, ineffective, and unsafe services and interventions, all of which were seen in this case. Missing the identification of critical risk factors, such as separation and pregnancy, and resulting risk management responses can increase risk for victims, and lead to missed opportunities to safeguard. Where there is minimisation, denial and withholding of information, or lack of understanding of relationship dynamics, risk factors can be easier to miss. For example, in this case, patterns of escalation were identified by professionals, but they did not connect this escalation to Jasmine's reported desire to leave the relationship.

9.4 The use of language by professionals can be powerful, and labels such as 'difficult to engage' and showing 'disguised compliance' which were given to Jasmine could be seen to demonstrate that professionals failed to consider and properly address the underlying reasons that she was finding it so hard to engage, such as trauma, fear of Doug, and negative experiences and perceptions of services. Children's Social Care in particular, although she did have different social workers.

The review discussed whether professionals found it frustrating when people cannot engage in the services and systems, but do not work for them due to their intersectional needs.

This is backed by the NSPCC in its 2025 "Why language matters: how using the term 'disguised compliance' can be problematic"^{xix}, which discusses how "labelling behaviour in this way can create an atmosphere of suspicion rather than collaboration."

9.5 The role of alcohol in domestic abuse needs to be better understood. The review panel were unclear that professionals working with Jasmine were clear as to why she used alcohol and in relation to the domestic abuse she was experiencing. This then impacted on the effectiveness of interventions to support Jasmine.

Additionally, it is unclear whether workers were sometimes trying to engage with Jasmine whilst she was intoxicated, and this may have directly impacted on her ability to work with professionals.

- 9.6 Risk assessing in domestic abuse is essential, however, considering each DASH RIC assessment in isolation, can mean the ‘golden thread’ of the perpetrator’s pattern of abuse can become lost. Patterns of escalation, such as increased numbers of incidents, a key indicator of risk of serious harm, can be missed. The impacts of this can be seen in this case. Not appropriately identifying a victim as high-risk of serious and possibly imminent harm during an attendance but rather, days afterwards, means that opportunities to implement immediate risk management actions and approaches in response can be missed. In this case, police reflected that after Jasmine’s death the LSU noted that *‘the standard risk assessment would have been upgraded to high, due to past incidents and a referral to MARAC’*.

- 9.7 There were few MARAC discussions and so minimal multi-agency opportunities to discuss Jasmine’s domestic abuse experiences.

Whilst the family safeguarding model enables multi-disciplinary working, this is only between children’s social care, mental health, substance misuse and domestic abuse teams. Therefore, others such as police, wider health and housing are excluded. This also meant that wider conversations around protective orders were not discussed. Whilst it is not known if they would have made a practical difference, the opportunity should nonetheless be there.

There does not appear to have been an intersectional view of Jasmine, and the multiple needs she was experiencing and facing every day. An improvement in knowledge and confidence in responding to domestic abuse victims who have multiple needs maybe required, including clarity of the risks faced even when not co-habiting with their abuser.

- 9.8 The unique tactics of abuse tailored by a perpetrator for maximum impact on a victim can make a significant difference in risk management approaches. In this case, Jasmine had experience of Doug’s dangerous use of vehicles, including his drink-driving which is likely to have increased her fear of him. However, it did not appear to the review that professionals supporting Jasmine fully understood any links to domestic abuse, including within safety planning.

There was no evidence that dynamics, impacts on Jasmine, or risks posed by Doug in relation to vehicles and driving were raised at MARAC. This may be due to a lack of confidence in understanding the links between driving offences and other criminal behaviour and seeing domestic abuse through that lens. Bates, Alexander and Webster (2022)^{xx} note “that individuals commit certain driving offences are more likely to also have a general criminal history. In

particular, driving under the influence, driving unlicensed and high-range speeding offences were associated with other forms of criminal behaviour.”

Overall, it appeared that risks relating to Doug’s driving were understood by professionals, especially those supporting Jasmine, in the general sense of risk posed by any driver who drives recklessly and dangerously, including when under the influence. However it does not appear that connections were explicitly made that Doug used his vehicle to enable and facilitate his abuse of Jasmine, including as a form of restricting and controlling her contact with her children. Had this been done, it may have resulted in different views held by professionals, e.g. rather than viewing Jasmine missing family time as due to her alcohol use, they could have seen this as an outcome of Doug’s abuse and its impacts.

- 9.9 Failure to consider protective orders such as DPVN / DVPO: This review cannot find any rationale about whether police considered a DVPN or DVPO in this case. If in fact they did, it was not recorded as such. Although the review was assured that an evidence-led prosecution was always considered. A DVPO / DVPN could have been considered following incidents on 27th October, 2nd December, 23rd December 2022, 15th February, 27th February and March 2023, the day before Jasmine’s death.

- 9.10 There is a need to consistently, accurately and clearly record information on electronic case management systems. This is especially important where recording is linked to the generation of data and allocation of services, such as identifying a woman as Pause eligible or responding to breach of bail conditions.

This review has been unable to confirm why information regarding Doug’s bail and protective measures were either not recorded fully at the time or not available to the police panel member at the time of this review. While this can’t be fully substantiated, a lack of clarity regarding bail and protective measures would likely have impacted on the ability to employ effective and timely responses to any breaches.

- 9.11 There are some health settings where targeted enquiry about domestic abuse is most appropriate, and pragmatic, such as GP practices. And some settings where routine enquiry is required, such as maternity, health visiting, and sexual health. In all health settings, having clear policies and procedures that support effective and safe enquiry practices and that are promoted to staff, and accompanied by training, are of significant benefit.
- 9.12 Housing providers are integral to an effective, local coordinated community response to domestic abuse. This includes registered providers of social housing, such as Stonewater. Where a housing provider holds a large stock in a local area, there are benefits to them being part of multiagency processes,

such as MARAC. MARAC was an opportunity for Stonewater to be part of the local Coordinated Community Response to domestic abuse, share and gather intelligence about Jasmine, including her experiences of domestic abuse, use this to inform their actions and decision making, and undertake actions to increase Jasmine's safety. Because they were not part of MARAC at this time, this opportunity was lost.

10 Recommendations from the Review

Single agency recommendations

10.1 Turning Point

7. DHR's that are regarding individuals who are being supported by the family safeguarding model need to be completed as one document with input from all services involved rather than individual documents.
8. The recording of the outcomes of the family safeguarding group supervisions to be recorded on Turning Points case management system rather than just the joint family safeguarding case management system

10.2 NHS Somerset ICB

9. Face to face targeted/clinical enquiry into domestic abuse to be used on patients where there are concerns around domestic abuse.
10. Holistic approach when carrying out contacts with patients who have complex social situations.
11. Police Reports to be reviewed upon receipt by GP
12. Domestic abuse alerts to be added to records and be considered for adults at risk to be discussed at safeguarding MDT meetings.

10.3 Somerset Council Public Health Nursing / Health Visitor

24. Routine enquiry relating to domestic abuse is clearly evidenced at all core contacts for all families (universal offer)
25. Safeguarding Supervisors should routinely ask about Domestic abuse in safeguarding supervision for families
26. HV to continue with the practice of looking for patterns of concerning behaviours in complex families, sharing them with other professionals and considering the impact this has on the children in the home.
27. Where there is current or historic domestic abuse for it to be raised in contacts routinely as part of the visit as per policy, bearing in mind when and where this is safe to do so. These considerations include whether the perpetrator is present or able to overhear conversations, and if children are present and able to understand what is being said. All staff to "think family" considering the impact of older children as well as adults when dealing with difficult and emotional issues. Staff should all be practicing in a Trauma informed way and

have the necessary skills to support families with complex social and emotional needs

10.4 Stonewater Housing

28. Where domestic abuse is reported or indicated by a 3rd party, contact to be made with person affected on every occasion
29. Contact with other agencies to be followed up
30. Where there is a case open on our system and routine contact is made, this is to be used as an opportunity to have a conversation with customer to discuss the open case

10.5 Somerset Council Children Social Care (including Family Safeguarding Team)

31. Ensure the needs of all children are considered and assessments completed if required taking into account the voice of the child/lived experience.
32. Ensure social workers are considering referral to Pause project
33. Practitioners should ensure that perpetrators of domestic abuse are offered referral to relevant support or intervention services, noting that participation may require the individual's consent.

10.6 Probation

34. To implement a process to expediate sharing information of police call outs in DA cases.
35. To ensure joint agency home visits are undertaken in high-risk domestic abuse and child protection cases. (Home visit Policy covers this).
36. Information sharing between agencies. Implement a process to ensure that arrests or interviews by police are actively shared with PS as soon as possible, particularly when police interest is linked to offending related behaviour
37. PS to ensure less experienced staff regularly seek support of SPO or PP officially holding the case.

10.7 Multi Agency Recommendations

38. Social housing landlords across Somerset, ensure they have specific domestic abuse policies each for staff and tenants.
39. Improve awareness of the complexity and intersectional nature of women's experiences across the health and social care system within the county, using this review as a case study/learning briefing example.
40. Within 12 months of the publication of this review, the Somerset Council Community Safety Team should develop and disseminate, through the Somerset Domestic Abuse Board and Somerset Domestic Abuse website, practitioner guidance on assessing domestic abuse risk in non-cohabiting and post-separation relationships, ensuring that assessments are informed by patterns of abuse and coercive control rather than living arrangements.

¹ [Early maternal death following child removal—A short report using observational data - Devaney - 2024 - Child Abuse Review - Wiley Online Library](#)

¹ <https://learning.nspcc.org.uk/news/why-language-matters/disguised-compliance-problematic>

¹ [The link between dangerous driving and other criminal behaviour: a scoping review | Safer Communities | Emerald Publishing](#)

Appendix A

DHR053 ACTION PLAN

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
1. DHR's that are regarding individuals who are being supported by the family safeguarding model need to be completed as one document with input from all services involved rather than individual documents.	Local	It has been agreed that DHR's for family safeguarding clients will be completed collaboratively by those elements of the family safeguarding team engaging with the parent.	Turning Point	This is now in place Future DHRs will be completed collaboratively		Completed October 2025
2. The recording of the outcomes of the family safeguarding group supervisions to be recorded on Turning Points case management system rather than just the joint family safeguarding case management system.	Local	This is now happening. All family safeguarding recovery workers have been informed and now record the supervisions on both case management systems.	Turning Point	This is now in place This is now in place and Turning Point line managers can access and review.		Completed October 2025
3. Face to face targeted/clinical enquiry into domestic abuse to be used on patients where there are concerns around domestic abuse.	Local	Include in learning from reviews level 3 safeguarding training. Produce briefing paper on learning to share in	NHS ICB	Presented at level 3 safeguarding training event 6.10.2025. Briefing shared to primary care bulletin 22.10.2025. On		22.10.2025 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
		primary care bulletin, at GP supervision, SG admin forum and best practice meeting.		agenda for GP supervision, SG admin forum and best practice meetings 22.10.2025.		
4. Holistic approach when carrying out contacts with patients who have complex social situations.	Local	Include in learning from reviews level 3 safeguarding training. Produce briefing paper on learning to share in primary care bulletin, at GP supervision, SG admin forum and best practice meeting.	NHS ICB	Presented at level 3 safeguarding training event 6.10.2025. Briefing shared to primary care bulletin 22.10.2025. On agenda for GP supervision, SG admin forum and best practice meetings 22.10.2025.	October 2025	22.10.2025 Completed
5. Police Reports to be reviewed upon receipt by GP.	Local	Include in learning from reviews level 3 safeguarding training. Produce briefing paper on learning to share in primary care bulletin, at GP supervision, SG admin forum and best practice meeting.	NHS ICB	Presented at level 3 safeguarding training event 6.10.2025. Briefing shared to primary care bulletin 22.10.2025. On agenda for GP supervision, SG admin forum and best practice meetings 22.10.2025.		22.10.2025 Completed
6. Domestic abuse alerts to be added to records and be considered for	Local	Include in learning from reviews level 3 safeguarding training.	NHS ICB	Presented at level 3 safeguarding training event 6.10.2025. Briefing		22.10.2025 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
adults at risk to be discussed at safeguarding MDT meetings.		Produce briefing paper on learning to share in primary care bulletin, at GP supervision, SG admin forum and best practice meeting.		shred to primary care bulletin 22.10.2025. On agenda for GP supervision, SG admin forum and best practice meetings 22.10.2025.		
7. Routine enquiry relating to domestic abuse is clearly evidenced at all core contacts for all families (universal offer).	Local	Change template so there is clear evidence routine enquiry is happening	Somerset Council Public Health Nursing/Health Visitor			Completed January 2025
8. Safeguarding Supervisors should routinely ask about Domestic abuse in safeguarding supervision for families.	Local	Supervisors to routinely ask about domestic abuse	Somerset Council Public Health Nursing/Health Visitor	Ongoing	January 2025	
9. HV to continue with the practice of looking for patterns of concerning behaviours in complex families, sharing them with other professionals and considering the impact this has on the children in the home.	Local	Part of the Domestic Abuse Policy and supervision	Somerset Council Public Health Nursing/Health Visitor	Ongoing	November 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
10. Where there is current or historic domestic abuse for it to be raised in contacts routinely as part of the visit as per policy, bearing in mind when and where this is safe to do so. These considerations include whether the perpetrator is present or able to overhear conversations, and if children are present and able to understand what is being said. All staff to “think family” considering the impact of older children as well as adults when dealing with difficult and emotional issues. Staff should all be practicing in a Trauma informed way and have the necessary skills to support families with complex social and emotional needs.	Local	Ensure stand-alone Domestic Abuse policy is clear. All staff to receive trauma informed training	Somerset Council Public Health Nursing/Health Visitor	Policy changes in November 2025 Training ongoing	November 2025	
11. Where domestic abuse is reported or indicated by a 3rd party, contact to be made with person affected on every occasion.	Local	Our Domestic Abuse Policy (customers) at section 10. sets out our approach and expectation to contacting customer	Stonewater Housing	We have now separated our specialist domestic abuse service from our ASB related Service (as part of a DAHA recommendation) this	May 2025	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
		when we're notified that one of our customers is subject to a report of domestic abuse.		service now sits under out Support and Wellbeing Directorate. Resolution Service restructure completed 5/25. DA Team transition in August 2024		
12. Contact with other agencies to be followed up	Local	Our DA Policy sets out the following at section 10 in relation to partnership working: <i>Stonewater colleagues will ensure they have good local knowledge within the communities they work in of specialist support providers around domestic abuse including IDVA (Independent Domestic Violence Advocacy) services,</i>	Stonewater Housing	Completed August 2024		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
		<i>MARAC (Multi Agency Risk Assessment Conference), MASH (Multi Agency Safeguarding Hubs) co-ordinators and other specialist services. We will work in partnership with appropriate agencies to support or signpost perpetrators of domestic abuse who recognise and want to change their behaviour.</i>				
13. Where there is a case open on our system and routine contact is made, this is to be used as an opportunity to have a conversation with customer to discuss the open case.	Local	Our specialist DA Caseworkers manage open cases via our Active H case management system. They complete a DASH at the start of the case and agree an action plan with the survivor.	Stonewater Housing	As part of our service restructure in since August 2024 our DA team now sits separately to our ASB/Housing Management teams within our wider specialist DA Services (such as refuge). This has enabled us to		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
		This includes method and frequency of contact. Our Peer Leader and DA Service Manager carry out monthly case reviews to ensure contact is maintain and set actions for the case.		improve our service offer to our customers as well and ensure our staff receive the appropriate specialist training alongside our other colleagues supporting domestic abuse survivors August 2024 Restructure completed and service improvement action (more broadly) implemented		
14. Ensure the needs of all children are considered and assessments completed if required taking into account the voice of the child/lived experience.	Local	Dip review to be completed	CSC including FST	This has been implemented following the DHR. As below recent Dip review completed which highlighted new action around support and training for staff around ensuring children receive support as victims of domestic abuse.	Implemented New action April 26	Completed and new action implemented

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
15. Ensure social workers are considering referral to Pause project.	Local	Share this with social workers	CSC including FST	This has been implemented following the DHR.	Implemented	Complete
16. Practitioners should ensure that perpetrators of domestic abuse are offered referral to relevant support or intervention services, noting that participation may require the individual's consent..	Local	Dip review to be completed	CSC including FST	This has been implemented following the DHR. We have completed a recent dip review into children open to our service where domestic abuse was a concern which highlighted that further training is required to upskill staff in working with perpetrators. Training has been arranged.	Implemented April 26	Completed and new action implemented
17. To implement a process to expediate sharing information of police call outs in DA cases.	Local to Avon and Somerset	No current action required. This process has already been implemented following the incident. We now receive daily Police call-out information for any domestic abuse (DA)	Probation	This process has already been implemented following the incident. Embedded into practise now across the Somerset PDU.	Implemented.	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
		incidents involving individuals currently under Probation supervision. This information includes: • Details of the incident • The Officer in Charge • Follow-up actions undertaken by the allocated Probation Practitioner or Senior Probation Officer.				
18. To ensure joint agency home visits are undertaken in high-risk domestic abuse and child protection cases. (Home visit Policy covers this).	National Policy in place.	Home visits are reviewed as part of the Performance Management Framework.	Probation	Whilst this process has been implemented, it remains subject to staff availability across all involved agencies.	Implemented.	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
		- Home visits can only be undertaken where there is a registered address and no identified risk to staff. - Each visit must be recorded with management oversight on Delius to ensure tracking and completion. Joint Home Visits – Multi-Agency Practice The Probation Service undertakes joint home visits with Social Services when the case is under Child Protection Plan (CPP).		There is ongoing monitoring of this arrangement to ensure continued effectiveness and responsiveness. Embedded into practise now across the Somerset PDU.		

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 home visits are also conducted with the Police for cases subject to the Integrated Offender Management (IOM) Free Cohort – Domestic Abuse. If not under CPP or IOM DA Cohort – then high risk home visits are undertaken by 2 Probation Practitioners				
19. Information sharing between agencies. Implement a process to ensure that arrests or interviews by police are actively shared with PS as soon as possible, particularly when police interest is linked to offending related behaviour	Local information sharing protocol and agreements in place.	Integrated Offender Management (IOM) Free Cohort – Domestic Abuse The IOM DA Free Cohort has now been established and operational for two years. Initial teething issues have been	Probation	There is ongoing monitoring of this arrangement to ensure continued effectiveness and responsiveness. Embedded into practise now across the Somerset PDU.	Implemented.	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
		resolved, and the process is now embedded. Cases are actively referred and discussed, resulting in the allocation of both Police Offender Managers and Probation Practitioners. This approach promotes joined-up working and ensures timely information sharing across agencies. For individuals not under the IOM DA Cohort, we continue to receive daily Police call-out information for any domestic abuse (DA) incidents involving those currently under Probation supervision.				

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
20. PS to ensure less experienced staff regularly seek support of SPO or PP officially holding the case.	National	Performance Management and Management Oversight Frameworks The Probation Service has implemented both the Performance Management Framework and the Management Oversight Framework. All Senior Probation Officers (SPOs) have received training in relation to these frameworks. Key components include: Management Oversight must be recorded at key stages of each case to ensure accountability and quality assurance. Reflective Practice is undertaken six times per year, supporting	Probation	There is ongoing monitoring of this arrangement to ensure continued effectiveness and responsiveness. Embedded into practise now across the Somerset PDU.	Implemented.	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
		practitioner development and critical thinking. Two formal observations are completed annually. These activities are in addition to routine supervision and case discussions.				
21. Social housing landlords across Somerset, ensure they have specific domestic abuse policies each for staff and tenants.	Local	Community Safety Team to send communications to Social Landlords across Somerset. Promote online training and specifically mention how training can support understanding responsibilities linked to domestic abuse under the DA Act and Social Housing Act. Also highlight the Somerset DA website	Somerset Council (Community Safety Team)	To be included into the Community Safety comms plan	Prior to review publication	

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
		for resources to support creating a DA policy. To filter out this message, link in with Somerset Council Housing for how to contact Somerset housing providers.				
22. Improve awareness of the complexity and intersectional nature of women's experiences across the health and social care system within the county, using this review as a case study/learning briefing example.	Local	Community Safety team to create learning brief when this review is published. Circulate brief with partners and highlight on local SDAB brief information linked to complexity and intersectional nature of women's experiences across the health and social care system.	Somerset Council (Community Safety Team)	Template created Information to be included once review quality assured by the Home Office	On publication of review	
23. Within 12 months of the publication of this review, the Somerset Council Community Safety Team should develop and	Local	Identify and review relevant national research, Domestic Homicide Reviews,	Somerset Council (Community Safety Team)	Evidence review completed Guidance drafted	Within 12 months of publication of this review	

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
disseminate, through the Somerset Domestic Abuse Board and Somerset Domestic Abuse website, practitioner guidance on assessing domestic abuse risk in non-cohabiting and post-separation relationships, ensuring that assessments are informed by patterns of abuse and coercive control rather than living arrangements.		relating to non-cohabiting and post-separation domestic abuse. Develop practitioner guidance outlining: • The risks associated with non-cohabiting and post-separation relationships. • The impact of coercive control beyond cohabitation. • Key considerations for risk assessment and safety planning.		Guidance consulted with DA Board Guidance published online and then promoted via DA Board		

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
		Relevant local referral pathways and support services. Share the draft guidance with Somerset Domestic Abuse Board Once approved publish online at Somerset DA website and promoting via Domestic Abuse Board				

Appendix B - Home Office Quality Assurance feedback and amendments

Heidi Hill
Somerset Council
County Hall
The Crescent
Taunton
TA1 4DY

06 July 2026

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jasmine) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 20th May 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	Jasmine
COMMUNITY SAFETY PARTNERSHIP	Somerset
DATE REVIEWED BY QA BOARD	20 th May 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The inclusion of insights regarding the link between domestic abuse and dangerous driving is particularly noteworthy and adds valuable depth to the analysis. • Early engagement by the initial Chair with The Nelson Trust, given their expertise in supporting women experiencing multiple disadvantage and their involvement in the <i>Pause Project</i>, is good practice and enhances the contextual understanding of the case. • The report provides strong, insightful reflections on the victim perspective, demonstrating an understanding of the impact of trauma, child removal, and ongoing safeguarding interventions. This significantly strengthens the analysis and reflects a trauma-informed approach. • The decision by the Safer Somerset Partnership to seek advice from the Home Office and proceed with completion of the report internally, supported by an independent external reviewer, was a pragmatic approach. It demonstrates appropriate regard for maintaining a degree of independence and quality assurance.
FEEDBACK FOR FUTURE DHRs	

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	Title Page	No amendments required.
2	Contents Page	No amendments required.

3	Pen Portrait	No dedicated pen portrait has been provided. Please draft a pen portrait drawing on the information contained in paragraphs 13.1, 13.3 and 17.2. Including a pen portrait would help to humanise the report, providing a clearer understanding of Jasmine as a person and strengthening the presence of her lived experience throughout the review.
4	Condolences	No amendments required.
5	Confidentiality and Anonymity	Please clarify, if known, who chose the pseudonyms for the report.
6	Terms of Reference	Please clarify, if known, whether Jasmine's family were involved in the development of the Terms of Reference.
7	Equality and Diversity	No amendments required.
8	Background Information	Please indicate how long Doug was imprisoned for in this section.
9	Combined Chronology	At 14.5.11 it is of note that Probation did not complete a pre-sentence report, and so any domestic abuse would not have been considered as part of the sentencing. This wording suggests a misrepresentation: it is a decision of the court to request a presentence report from Probation. It should be clarified that the Court did not ask Probation to complete a pre-sentence report. It may also be necessary to consider that if any domestic abuse context is presented by the police to the CPS in relation to the index offence, this may have been considered as part of the sentencing.
10	Overview	At 15.6. Probation – As stated in 14.5.11, due to there being no pre-sentence report, Doug's domestic abuse risks were not considered as part of the sentencing/oversight. Please clarify that due to the absence of a request for PSR, and the nature of the sentence (Unpaid Work), domestic abuse risks were not considered. As part of the initial assessment following sentence, a risk assessment should have been completed, however due to the nature of an unpaid work requirement, there will have been little that could have been put in place in terms of a sentence plan to manage these risks.

11	Analysis	At 16.12.10, this section suggests that professionals may have assumed that the risk of domestic abuse reduces where couples do not cohabit. This is an interesting point, but it is not expanded upon within the analysis. Please consider developing this further. Current research in this area is limited, with available evidence tending to compare married and unmarried cohabiting couples, rather than those who live apart. This presents a potential gap in understanding and could be identified as a learning point. The review would be strengthened by either expanding the analysis or including a recommendation to explore this further, for example through research, local review, or practitioner guidance to improve understanding of risk in non-cohabiting relationships.
12	Conclusions	No amendments required.

13	Lessons learnt and recommendations	No amendments required.
14	Timescales	No amendments required.
15	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	Please confirm that Jasmine's family has been consulted about key dates to avoid publication and whether they will need support at this time.

21	Action Plan	• Please include details of who holds overall responsibility for implementing the recommendations. This will strengthen accountability and ensure clear oversight of delivery. • Action 16 (Children’s Social Care) contains a typographical error which affects clarity. The wording currently reads: <i>“Ensure that referrals are offered made to perpetrators of Domestic abuse, consent would be needed.”</i> Please amend this to ensure it is clear and grammatically accurate. • It is also disappointing to note the absence of updates from Children’s Social Care within the action plan. This limits assurance regarding progress and implementation, and the report would benefit from confirming the status of these actions.
22	Has there been a request to withhold publication? <i>If Yes, include the reason for the request.</i>	No request to withhold publication.
	<i>Is it proportionate and appropriate?</i>	
23	Any other comments	• Paras 16.2–16.4. These sections could be interpreted as containing elements of victim-blaming language, as they do not fully acknowledge the reasons why individuals experiencing domestic abuse may adopt the behaviours described in the section headings. While this is addressed well elsewhere in the report, it is not consistently reflected here. Please review accordingly. In addition, the terms <i>“minimisation/denial/blame”</i> are typically associated with perpetrator behaviour and may not be appropriate in this context. Please consider revising this language to better reflect the experiences of victims. • Para 16.5. This paragraph introduces more balanced and well-supported thinking; however, this should be expanded further to ensure that the section does not read as a critique of Jasmine’s behaviour. It is important to explicitly acknowledge that there are many complex reasons why victims may not fully disclose abuse to professionals or the police, including fear, coercive control, trauma, dependency, and concerns about consequences. Strengthening this section to reflect a trauma-informed, victim-centred approach would ensure consistency with the stronger analysis presented elsewhere in the report.

DHR SECTION		DHR QA BOARD FEEDBACK (improvements required before publication)	Comment
1	Title Page	No amendments required.	n/a
2	Contents Page	No amendments required.	n/a
3	Pen Portrait	No dedicated pen portrait has been provided. Please draft a pen portrait drawing on the information contained in paragraphs 13.1, 13.3 and 17.2. Including a pen portrait would help to humanise the report, providing a clearer understanding of Jasmine as a person and strengthening the presence of her lived experience throughout the review.	Added
4	Condolences	No amendments required.	n/a
5	Confidentiality and Anonymity	Please clarify, if known, who chose the pseudonyms for the report.	Added
6	Terms of Reference	Please clarify, if known, whether Jasmine's family were involved in the development of the Terms of Reference.	Added
7	Equality and Diversity	No amendments required.	n/a
8	Background Information	Please indicate how long Doug was imprisoned for in this section.	Is already included
9	Combined Chronology	At 14.5.11 it is of note that Probation did not complete a pre-sentence report, and so any domestic abuse would not have been considered as part of the sentencing. This wording suggests a misrepresentation: it is a decision of the court to request a pre-sentence report from Probation. It should be clarified that the Court did not ask Probation to complete a pre-sentence report. It	Amended

		may also be necessary to consider that if any domestic abuse context is presented by the police to the CPS in relation to the index offence, this may have been considered as part of the sentencing.	
10	Overview	At 15.6. Probation – As stated in 14.5.11, due to there being no pre-sentence report, Doug’s domestic abuse risks were not considered as part of the sentencing/oversight. Please clarify that due to the absence of a request for PSR, and the nature of the sentence (Unpaid Work), domestic abuse risks were not considered. As part of the initial assessment following sentence, a risk assessment should have been completed, however due to the nature of an unpaid work requirement, there will have been little that could have been put in place in terms of a sentence plan to manage these risks.	Amended
11	Analysis	At 16.12.10, this section suggests that professionals may have assumed that the risk of domestic abuse reduces where couples do not cohabit. This is an interesting point, but it is not expanded upon within the analysis. Please consider developing this further. Current research in this area is limited, with available evidence tending to compare married and unmarried cohabiting couples, rather than those who live apart. This presents a potential gap in understanding and could be identified as a learning point. The review would be strengthened by either expanding the analysis or including a recommendation to explore this further, for example through research, local review, or practitioner guidance to improve understanding of risk in non-cohabiting relationships.	Amended 16.12.10 Added 18.7 Recommendation 23 added
12	Conclusions	No amendments required.	

13	Lessons learnt and recommendations	No amendments required.	
14	Timescales	No amendments required.	
15	Involvement of family / friends / community	No amendments required.	
16	DHR contributors	No amendments required.	
17	DHR Panel	No amendments required.	
18	DHR Author	No amendments required.	
19	Parallel Reviews	No amendments required.	
20	Dissemination	Please confirm that Jasmine's family has been consulted about key dates to avoid publication and whether they will need support at this time.	Added into 12.2
21	Action Plan	- Please include details of who holds overall responsibility for implementing the recommendations. This will strengthen accountability and ensure clear oversight of delivery. - Action 16 (Children's Social Care) contains a typographical error which affects clarity. The wording currently reads: "<i>Ensure that referrals are offered made to perpetrators of Domestic abuse, consent would be needed.</i>" Please amend this to ensure it is clear and grammatically accurate.	Updated clarity that Somerset Council is overall responsible for PHN/Health Visitors Updated

		It is also disappointing to note the absence of updates from Children's Social Care within the action plan. This limits assurance regarding progress and implementation, and the report would benefit from confirming the status of these actions.	Now updated since been in quality assurance
22	Has there been a request to withhold publication? <i>If Yes, include the reason for the request.</i>	No request to withhold publication.	n/a

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- ⁱ [Domestic abuse in England and Wales overview - Office for National Statistics](#)
- ⁱⁱ [The Equality Act 2010 \(Disability\) Regulations 2010](#)
- ⁱⁱⁱ David Gadd, Juliet Henderson, Polly Radcliffe, Danielle Stephens-Lewis, Amy Johnson, Gail Gilchrist, The Dynamics of Domestic Abuse and Drug and Alcohol Dependency, *The British Journal of Criminology*, Volume 59, Issue 5, September 2019, Pages 1035–1053, <https://doi.org/10.1093/bjc/azz011>
- ^{iv} Veldhuis, C.B. Cultivating Dependence, Denial, and Self-Blame: A Narrative Review of the use and Effects of Coercive Tactics in Intimate Partner Violence. *Gend. Issues* **41**, 10 (2024). <https://doi.org/10.1007/s12147-024-09327-7>
- ^v [Serious Crime Act 2015](#)
- ^{vi} [Myths about domestic abuse - Women's Aid](#)
- ^{vii} [Frontiers | Alcohol, Aggression, and Violence: From Public Health to Neuroscience](#)
- ^{viii} <https://doi.org/10.1111/hsc.13753>
- ^{ix} [Post-separation abuse: A concept analysis - PMC](#)
- ^x [Lethality Risk Factors Series: Recent Separation - DV RISC](#)
- ^{xi} [Intimate partner homicide: Risk constellations in separation conflicts and points of intervention for the police | Policing: A Journal of Policy and Practice | Oxford Academic](#)
- ^{xii} [Refuge data exposes scale of post-separation abuse amid widespread public misunderstanding](#)
- ^{xiii} [In Search of Excellence — Standing Together](#)
- ^{xiv} [Respect | Home](#)
- ^{xv} [Early maternal death following child removal—A short report using observational data - Devaney - 2024 - Child Abuse Review - Wiley Online Library](#)
- ^{xvi} <https://learning.nspcc.org.uk/news/why-language-matters/disguised-compliance-problematic>
- ^{xvii} [The link between dangerous driving and other criminal behaviour: a scoping review | Safer Communities | Emerald Publishing](#)
- ^{xviii} [Early maternal death following child removal—A short report using observational data - Devaney - 2024 - Child Abuse Review - Wiley Online Library](#)
- ^{xix} <https://learning.nspcc.org.uk/news/why-language-matters/disguised-compliance-problematic>
- ^{xx} [The link between dangerous driving and other criminal behaviour: a scoping review | Safer Communities | Emerald Publishing](#)